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LOBBYING REPORT

Lobbying Disclosure Act of 1995 (Section 5) - **All Filers Are Required To Complete This Page**

1. Registrant Name
Baker Healthcare Consulting, Inc.

2. Address ☐ Check if different than previously reported
One American Square, Suite 2000, Box 82058

3. Principal Place of Business (if different from line 2)
City: Indianapolis State/Zip (or Country) In 46282

4. Contact Name	Telephone	E-mail (optional)	5. Senate ID #
Dale E. Baker	317-631-3613	bakerhealthcare@yahoo.com	5164

7. Client Name ☐ Self
Katherine Shaw Bethea Hospital

6. House ID # 33560

TYPE OF REPORT 8. Year 2000 Midyear (January 1-June 30) ☐ **OR** Year End (July 1-December 31) ☐

9. Check if this filing amends a previously filed version of this report ☐

10. Check if this is a Termination Report ☐ ⇨ Termination Date _____ 11. No Lobbying Activity ☐

INCOME OR EXPENSES - Complete Either Line 12 **OR** Line 13

12. Lobbying Firms

INCOME relating to lobbying activities for this reporting period was:

Less than $10,000 ☒

$10,000 or more ☐ ⇨ $_____ Income (nearest $20,000)

Provide a good faith estimate, rounded to the nearest $20,000, of all lobbying related income from the client (including all payments to the registrant by any other entity for lobbying activities on behalf of the client).

13. Organizations

EXPENSES relating to lobbying activities for this reporting period were:

Less than $10,000 ☐

$10,000 or more ☐ ⇨ $_____ Expenses (nearest $20,000)

14. REPORTING METHOD. Check box to indicate expense accounting method. See instructions for description of options.

☐ **Method A.** Reporting amounts using LDA definitions only

☐ **Method B.** Reporting amounts under section 6033(b)(8)of the Internal Revenue Code

☐ **Method C.** Reporting amounts under section 162(e) of the Internal Revenue Code

Signature Dale E. Baker

Printed Name and Title DALE E. BAKER, President

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Registrant Name Baker Healthcare Consulting Client Name Katherine Shaw Bethea Hosp.

LOBBYING ACTIVITY. Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. **Using a separate page for each code**, provide information as requested. Attach additional page(s) as needed.

15. General issue area code MMM (one per page)

16. Specific lobbying issues

See attachment

17. House(s) of Congress and Federal agencies contacted ☐ Check if None

Senate
House of Representatives

18. Name of each individual who acted as a lobbyist in this issue area

Name	Covered Official Position (if applicable)	New
DALE E BAKER		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

19. Interest of each foreign entity in the specific issues listed on line 16 above ☐ Check if None

Signature Dale E Baker Date 8/14/00

Printed Name and Title DALE E BAKER, President

Form LD-2 (Rev. 6/98)

EXECUTIVE SUMMARY

In 1989 Congress established the Medicare Geographic Classification Review Board. The Board accepts applications for hospitals that can show that they meet certain criteria to be reclassified either from a rural area to an adjacent urban area or from one urban area to another adjacent urban area if the hospital can demonstrate that its costs are more like the adjacent area. This allows such hospitals to obtain either a wage index or the standardized amount of the adjacent area and in essence rewards the hospital with additional payment. The Department of Health and Human Services has long recognized that by reclassifying a high paid rural hospital into a nearby urban area, if the high paying hospitals wages and hours are removed from the statewide rural areas wage index, then the statewide rural wage index would plummet causing the remaining rural hospitals to have a lower wage index and therefore lower Medicare payment. The Health Care Financing Administration implemented a "floor" to prevent the rural hospital wage index from going down as a result of hospitals reclassifying to urban areas. In essence, they left the reclassifying hospitals wages and costs in the rural wage index.

Congress, however, apparently failed to consider that an urban hospital reclassifying to another urban area could similarly cause the remaining hospitals in the original area to end up with a lower wage index and thereby lower payment as a result of the reclassification of one or more hospitals out of that Metropolitan Statistical Area (MSA).

The hospitals seek either a regulatory or legislated "floor" which would protect the un-reclassified urban hospitals in exactly the same way Congress has protected the rural hospitals since geographic reclassification was implemented in federal fiscal year 1992.