Indigent Care Annual Reporting Template

Provider Name	Mimbres Memorial Hospital
Provider Medicaid Number	B-2113
Provider Medicare Number	32-1309

Fiscal Year Begin 1/1/2021 Fiscal Year End 12/31/2021

From SB71 Section 8

Health care facilities and third-party health care providers shall annually report to the department how the following funds are used:

1 Indigent care funds and safety net care pool funds pursuant to the Indigent Hospital and County Health Care Act

In the box below please report any funds received from county health plan for indigent patients (Do not include Mill Levy Revenue)

11,753.00

(Please describe the use of the funds reported above)
Cover cost of providing care to indigent and Medicaid patients.

In the box below please report any safety net care funds received by the facility. Please include Hospital Access Payments, Targeted Access Payments, and Enhanced DRG Payments (Do not include Mill Levy Revenue)

4,037,987.00 Hospital Access Payments

2,253.00 Targeted Access Payments

612,528.00 SNCP DRG Enhanced Rate Payments

(Please describe the use of the funds reported above)
Cover costs of providing care to indigent and Medicaid patients.

2

Funds raised to pay the cost of operating and maintain county hospitals, pay contracting hospitals in accordance with health care facilities contracts or pay a county's transfer to the county-supported Medicaid fund pursuant to the Hospital Funding Act

In the box below please report any Mill Levy funds received by the facility

-

(Please describe the use of the funds reported above)
N/A

In the box below please report any County/Municipal Bond Proceeds received by the facility

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(Please describe the use of the funds reported above)
N/A

From SB71: A health care facility's or third-party health care provider's report to the department shall include:

1

The number of indigent patients whose health care costs were paid directly from the funds described in Subsection A of this section and the total amount of funds expended for these health care costs

Input number of Indigent patients	15.00
Input number of Medicaid Claims	20,633.00
Input number of Medicaid patients served (patient with multiple visits would be counted once)	8,912.00
Total Patients Reported Above (formula)	20,648.00

Populate the table below utilizing your cost report that ends in calendar year 2021, and claims data for the patients included in the figure in section 1 of this tab.

Total Costs From Table Below: 13,483,539

	Cost Center Line Number	Cost Center Description	Per Diem from Worksheet D-1 of the cost report	Cost to Charge Ratio from Worksheet C Part I	Days Associated with Patients Above (Mapped to Appropriate Routine Cost Center)	Inpatient Ancillary Charges Associated with Patients Above (Mapped to Appropriate Routine Cost Center)	Outpatient Ancillary Charges Associated with Patients Above (Mapped to Appropriate Routine Cost Center)	Calculated Costs
Routine Cost Centers	30	Adults and Pediatrics	1,593.33		1033			1,645,909.89
	31	ICU	4,756.07		33			156,950.31
	32	Coronary Care Unit	-					-
	33	Burn Intensive Care Unit	-					-
	34	Surgical Intensive Care Unit	-					-
	35	Other Special Care Unit	-					-
	40	Subprovider I	-					-
	41	Subprovider II	-					-
	42	Other Subprovider	-					-
	43	Nursery	1,271.48		315			400,516.20
			-					-
Ancillary Cost Centers	50	OPERATING ROOM		0.198930		1,852,079	6,705,834	1,702,425.63
	52	DELIVERY ROOM & LABOR ROOM		0.889649		803,969	3,878	718,700.28
	53	ANESTHESIOLOGY		0.042924		305,588	830,216	48,753.25
	54	RADIOLOGY-DIAGNOSTIC		0.058704		1,589,593	23,336,723	1,463,274.45
	56	RADIOISOTOPE		0.000000		-	-	-
	57	CT SCAN		0.000000		-	-	-

58	MAGNETIC RESONANCE IMAGING (MRI)		0.000000		-	-	-
60	LABORATORY		0.112819		1,737,490	12,609,349	1,618,596.03
62	WHOLE BLOOD		0.138045		-	-	-
65	RESPIRATORY THERAPY		0.547012		117,485	635,153	411,702.02
66	PHYSICAL THERAPY		0.377150		8,447	2,249,804	851,699.36
67	OCCUPATIONAL THERAPY		0.240810		-	-	-
68	SPEECH PATHOLOGY		0.001304		-	-	-
69	ELECTROCARDIOLOGY		0.085682		185,660	1,920,716	180,478.51
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.179533		704,276	700,651	252,230.76
72	IMPL. DEV. CHARGED TO PATIENT		0.216791		151,389	477,444	136,325.33
73	DRUGS CHARGED TO PATIENTS		0.174362		1,599,315	3,047,837	810,286.72
88	RHC		0.759528		-	-	-
90	CLINIC		0.174407		-	223,963	39,060.71
91	EMERGENCY		0.182358		720,344	14,154,453	2,712,538.23
92	OBSERVATION BEDS (NON-DISTINCT PAR		0.714236		118,770	348,990	334,091.03
			0.000000				-
				1,381	**9,894,405**	**67,245,011**	**13,483,539**

From SB71
Section 8.B.(2)

As applicable, the health care facility's estimated annual amount and percentage of the health care facility's bad debt expense attributable to patients eligible under the health care facility's financial assistance policy and an explanation of the methodology used by the health care facility to estimate this amount and percentage.

In the box below, please report the amount of bad debt expense attributable to patients that are eligible for the facilities financial assistance program

1 2,718,259.00

What percentage of total bad debt expense is represented by the amount reported above?

2 60%

In the space provided below, please explain the methodology used to create the estimates reported in boxes 1 and 2

We pulled all transaction codes that were write offs to bad debt. We then looked at the insurance provider for those patients. We included Charity, Private Pay, and Self Pay to determine the patients that were eligible for the facilities financial assistance program.

Our total bad debt written off in 2021 was $4.5m. In addition, we wrote off $38k to charity.