Indigent Care Annual Reporting Template

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

Fiscal Year Begin	1/1/2022	Fiscal Year End	12/31/2022

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:

Report the data below on the cash basis (monies received during the calendar year 2022)

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)

4,220.00

(Please describe the use of the funds reported above)
cover cost of providing services

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)

4,524,321.00	Hospital Access Payments
69,509.00	Targeted Access Payments
-	SNCP DRG Enhanced Rate Payments

(Please describe the use of the funds reported above)
cover cost of providing services

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)

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

-

(Please describe the use of the funds reported above)

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 Claims	1,032.00
Input number of Medicaid Claims	20,931.00
Input number of Medicaid patients served (patient with multiple visits would be counted once)	8,558.00
Total Patients Reported Above (formula)	21,963.00

Populate the table below utilizing your cost report that ends in calendar year 2022, and claims data for the **Indigent** patients included in the figure in section 1 of this tab.

	Cost to charge ratio	Charges	Calculated Costs
Cost of care related to portion of bill for insured patients qualifying for indigent care	0.187148	$ 9,139,836.00	1,710,503
Direct cost paid to post acute care providers on behalf of patients qualifying for indigent care			$ -

Total Costs From Table Below	13,184,002
Total Costs for Indigent Care (sum of F22, F23 and F25)	14,894,505

	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		937			1,492,950.21
	31	ICU	4,756.07		45			214,023.15
	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		281			357,285.88
			-					-
Ancillary Cost Centers	50	OPERATING ROOM		0.198930		1,194,886	4,994,163	1,231,187.41
	52	DELIVERY ROOM & LABOR ROOM		0.889649		801,754		713,279.78
	53	ANESTHESIOLOGY		0.042924		164,696	634,240	34,293.55
	54	RADIOLOGY-DIAGNOSTIC		0.058704		1,847,343	30,229,478	1,883,037.71
	56	RADIOISOTOPE		0.000000				-
	57	CT SCAN		0.000000				-
	58	MAGNETIC RESONANCE IMAGING (MRI)		0.000000				-
	60	LABORATORY		0.112819		1,856,736	15,306,411	1,936,329.05
	62	WHOLE BLOOD		0.138045				-
	65	RESPIRATORY THERAPY		0.547012		106,209	169,416	150,769.99
	66	PHYSICAL THERAPY		0.377150		10,812	1,365,884	519,220.96
	67	OCCUPATIONAL THERAPY		0.240810				-
	68	SPEECH PATHOLOGY		0.001304				-
	69	ELECTROCARDIOLOGY		0.085682		197,758	2,052,725	192,825.86
	71	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.179533		336,242	495,642	149,350.58
	72	IMPL. DEV. CHARGED TO PATIENT		0.216791		28,221	531,370	121,314.30
	73	DRUGS CHARGED TO PATIENTS		0.174362		1,323,146	3,455,969	833,296.02
	88	RHC		0.759528				-
	90	CLINIC		0.174407				-
	91	EMERGENCY		0.182358		778,997	16,261,213	3,107,418.55
	92	OBSERVATION BEDS (NON-DISTINCT PART)		0.714236		57,875	288,535	247,418.64
				0.000000				-
					1,263	**8,704,675**	**75,785,045**	**13,184,002**

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 6,646,091.00

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

2 70%

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 2022 was $9.5m. In addition, we wrote off $563k to charity.