Indigent Care Annual Reporting Template

Provider Name	Otero County Hospital Association
Provider Medicaid Number	00018
Provider Medicare Number	32-0004

Fiscal Year Begin 7/1/2023 Fiscal Year End 6/30/2024

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 state fiscal year 2024).

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):

(Please describe the use of the funds reported above)

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):

$0.00	Hospital Access Payments
$341,107.00	Targeted Access Payments
$4,078,139.85	SNCP DRG Enhanced Rate Payments

(Please describe the use of the funds reported above)

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)

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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	1,517
Input number of Medicaid Claims	51,973
Input number of Medicaid patients served (patient with multiple visits would be counted once)	9,131
Total Patients Reported Above (formula)	53,490

Populate the table below utilizing your cost report that ends in state fiscal year 2023, 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	0.138680	$29,454,997.50	$4,084,819.05
Direct cost paid to post acute care providers on behalf of patients qualifying for indigent care			$0.00

Total Costs From Table Below	$2,163,804.27
Total Costs for Indigent Care (sum of G22, G23 and G25)	$6,248,623.32

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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. $ -

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

2. 0%

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

Certification Statement
This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to Indigent Care Annual Reporting Requirements in New Mexico. I understand this information is used to ensure that uninsured and underinsured residents of New Mexico have access to necessary healthcare services, including ambulance transport and hospital care. I understand that any false claims, statements, or documents, or concealment of material facts may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge.

Name of Authorized Person		Title	Telephone Number
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Signature of Authorized Person		**Date of Signature**	
CEO		11/6/2025	
Address of Authorized Person			
Street or P.O. Box		**City**	**State** / **Zip Code**
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Name of Preparer		Title	Telephone Number
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