

## Indigent Care Annual Reporting Template

Provider Name Mimbres Memorial Hospital

Provider Medicaid Number B-2113

Provider Medicare Number 32-1309

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):

\$0.00

(Please describe the use of the funds reported above) Indigent care funds received were used to cover unreimbursed cost of providing services to indigent 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):

\$4,384,393.00 Hospital Access Payments

\$25,077.00 Targeted Access Payments

\$0.00 SNCP DRG Enhanced Rate Payments

(Please describe the use of the funds reported above) funds received were used to cover unreimbursed cost of providing services to indigent 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:

\$0.00

(Please describe the use of the funds reported above)

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

\$0.00

(Please describe the use of the funds reported above)

From (67) (A),  $M_{\text{max}} \ln M_{\text{max}}$  is the maximum benefit cost to add a smart to the data base of  $\ln M_{\text{max}}$ .

The number of indigeneations, where health care costs were paid directly from the funds described in turn 100-01.

of the section and the total area

(continued)	
(continued)	

Input number of days and nights per week	2.00%
--	-------

(scored with multiple choice, would be counted twice)

Populate the table below utilizing your cost report that ends in state fiscal year 2024 and 12/31/24 data for the following columns, included in the data in section 3 of this tab.

	Control	Treatment	Referral Source
Cost of care related to provision of full care for insured patients qualified for the program	\$1,200,000	\$1,200,000	\$1,200,000
Direct cost paid to providers for services rendered to patients qualifying for the program			\$1,200,000

Total Costs From Vehicle Bodies

Total Cost for Design = \$ 1,000

[illegible]

Additional Cost Charge:

Category	Item	Value	Unit	Notes
1. 设备购置费	1.1 购置费	10000000	元	
	1.2 运杂费	1000000	元	
	1.3 安装调试费	1000000	元	
	1.4 其他费用	1000000	元	
	1.5 预备费	1000000	元	
	1.6 建设期利息	1000000	元	
	1.7 流动资金	1000000	元	
	1.8 其他	1000000	元	
	1.9 合计	10000000	元	
	1.10 备注			
2. 建安工程费	2.1 建筑工程费	10000000	元	
	2.2 安装工程费	1000000	元	
	2.3 其他费用	1000000	元	
	2.4 预备费	1000000	元	
	2.5 建设期利息	1000000	元	
	2.6 流动资金	1000000	元	
	2.7 其他	1000000	元	
	2.8 合计	10000000	元	
	2.9 备注			
	2.10 其他			
3. 其他费用	3.1 其他费用	1000000	元	
	3.2 其他费用	1000000	元	
	3.3 其他费用	1000000	元	
	3.4 其他费用	1000000	元	
	3.5 其他费用	1000000	元	
	3.6 其他费用	1000000	元	
	3.7 其他费用	1000000	元	
	3.8 其他费用	1000000	元	
	3.9 其他费用	1000000	元	
	3.10 其他费用	1000000	元	
4. 预备费	4.1 预备费	1000000	元	
	4.2 预备费	1000000	元	
	4.3 预备费	1000000	元	
	4.4 预备费	1000000	元	
	4.5 预备费	1000000	元	
	4.6 预备费	1000000	元	
	4.7 预备费	1000000	元	
	4.8 预备费	1000000	元	
	4.9 预备费	1000000	元	
	4.10 预备费	1000000	元	
5. 建设期利息	5.1 建设期利息	1000000	元	
	5.2 建设期利息	1000000	元	
	5.3 建设期利息	1000000	元	
	5.4 建设期利息	1000000	元	
	5.5 建设期利息	1000000	元	
	5.6 建设期利息	1000000	元	
	5.7 建设期利息	1000000	元	
	5.8 建设期利息	1000000	元	
	5.9 建设期利息	1000000	元	
	5.10 建设期利息	1000000	元	
6. 流动资金	6.1 流动资金	1000000	元	
	6.2 流动资金	1000000	元	
	6.3 流动资金	1000000	元	
	6.4 流动资金	1000000	元	
	6.5 流动资金	1000000	元	
	6.6 流动资金	1000000	元	
	6.7 流动资金	1000000	元	
	6.8 流动资金	1000000	元	
	6.9 流动资金	1000000	元	
	6.10 流动资金	1000000	元	
7. 其他	7.1 其他	1000000	元	
	7.2 其他	1000000	元	
	7.3 其他	1000000	元	
	7.4 其他	1000000	元	
	7.5 其他	1000000	元	
	7.6 其他	1000000	元	
	7.7 其他	1000000	元	
	7.8 其他	1000000	元	
	7.9 其他	1000000	元	
	7.10 其他	1000000	元	
8. 合计	8.1 合计	10000000	元	
	8.2 合计	10000000	元	
	8.3 合计	10000000	元	
	8.4 合计	10000000	元	
	8.5 合计	10000000	元	
	8.6 合计	10000000	元	
	8.7 合计	10000000	元	
	8.8 合计	10000000	元	
	8.9 合计	10000000	元	
	8.10 合计	10000000	元	

## Indigent Care Annual Reporting Template

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. \$ 3,590,869.00

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

2. 70%

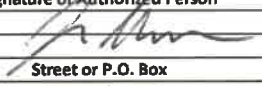
In the space provided below, please explain the methodology used to create the estimates reported in boxes 1 and 2:

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 2024 was \$5.1m. In addition, we wrote off \$336k to charity.

### 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
John Schoonover	Chief Financial Officer	575-546-5802
Email of Authorized Person		
jschoonover@qhcs.com		
Signature of Authorized Person	Date of Signature	
	Nov. 20, 2025	
Address of Authorized Person		
Street or P.O. Box	City	State
900 W. Ash Street	Deming	NM
		Zip Code
		88030

Name of Preparer	Title	Telephone Number
Daniel Olvera	Director, Reimbursement	806-543-0541
Email of Preparer	Date of Preparation	
dolvera@qhcs.com	Nov. 19, 2025	
Address of Preparer		
Street or P.O. Box	City	State
1573 Mallory Lane, Suite 100	Brentwood	TN
		Zip Code
		37027

## **Indigent Care Annual Reporting Template**

### **Definitions**

1. Indigent patient means a patient with a household income that does not exceed two hundred percent of the federal poverty level.