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Indigent Care Annual Reporting Template

Provider Name: San Juan Regional Medical Center

Provider Medicaid Number: 299

Provider Medicare Number: 32-0005

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):

$485,000.04

The above payments are used to pay for the 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):

$1,504,809.36 Hospital Access Payments

$6,591,935.00 Targeted Access Payments

$18,686,629.51 SNCP DRG Enhanced Rate Payments

The above payments are used to pay for the 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:

$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)

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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	541
Input number of Medicaid Claims	169,092
Input number of Medicaid patients served (patient with multiple visits would be counted once)	39,100
Total Patients Reported Above (formula)	169,633

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	0.239678	$3,105,156.00	$744,237.58
Direct cost paid to post acute care providers on behalf of patients qualifying for indigent care	0.239678	$0.00	$0.00

Total Costs From Table Below	$108,567,961.64
Total Costs for Indigent Care (sum of G22, G23 and G25)	$109,312,199.22

	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	$ 1,361.72		15313			$ 20,852,018.36
	31	ICU	$ 1,402.84		2290			$ 3,212,503.60
	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	$ 1,671.76		1548			$ 2,587,884.48
	42	Other Subprovider	$ -					$ -
	43	Nursery	$ 103.89		1370			$ 142,329.30
			$ -					$ -
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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. $ 2,548,069.06

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

2. 23%

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

Utilizing total bad debt expense from our FY2024 Cost Report, we derived an estimate of bad debt expense attributable to patients eligible for our financial assistance program by applying the county povery rate of 23.1% as determined through our CHNA. Our charity policy has a sliding scale, meaning that patients may qualify for a portion of their bill as charity, leaving the remaining as patient responsibility. This patient responsibility may result in bad debt, however we feel this amount is very low as it is our experience that those who apply and qualify for assistance will pay their portion. We also assume that some self pay patients who don't apply for financial assistance may qualify and so are using the poverty rate to calculate this total which is consistent with other required reporting.

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 Mayer		CFO	505-609-6114	
Email of Authorized Person				
jmayer@sjrmc.net				
Signature of Authorized Person		Date of Signature		
DocuSigned by: John Mayer 38BEA710424B431...		11/10/2025 | 9:55 AM MST		
Address of Authorized Person				
Street or P.O. Box		City	State	Zip Code
801 W Maple		Farmington	NM	87401

Name of Preparer		Title	Telephone Number	
Email of Preparer		Date of Preparation		
Address of Preparer				
Street or P.O. Box		City	State	Zip Code