Indigent Care Annual Reporting Template

Provider Name	Rehoboth McKinley Christian Hospital
Provider Medicaid Number	331
Provider Medicare Number	32-1313

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):

$232,865.89

If a patient is true self pay the hospital will first attempt to put them on Medicaid. If they don't qualify for Medicaid the hospital will attempt to get them approved for McKinley County Indigent (MCI). And if they are not approved for MCI, then the hospital will submit a Financial Assistance application. MCI approved encounters are paid via check and posted directly to the patient's account.

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):

$2,260,525.00 Hospital Access Payments

$839,423.00 Targeted Access Payments

$1,649,604.00 SNCP DRG Enhanced Rate Payments

Medicaid, uninsured, and indigent total costs were $17.1M with Medicaid payments totaling $14.8M. Consequently, the total shortfall for providing patient care to these indigent beneficiaries was $2.3M.

The provider contends that the true cost of providing patient care to indigent (uninsured and Medicaid) patients in the Gallup, New Mexico service area amounts to $17.1M vs. the combined claims payments, HAP payments, TAP payments, and SNCP enhanced rate payments of $19.5M for a combined excess of $2.4M.

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:

$2,974,433.43

These funds are used ONLY for the maintenance and upkeep of the hospital facility. They may NOT be used for subsidizing patient operations and indigent care.

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	718
Input number of Medicaid Claims	24,786
Input number of Medicaid patients served (patient with multiple visits would be counted once)	9,798
Total Patients Reported Above (formula)	25,504

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	0.245578	$1,300,005.43	$319,252.60
Direct cost paid to post acute care providers on behalf of patients qualifying for indigent care			$0.00

Total Costs From Table Below	$16,151,049.62
Total Costs for Indigent Care (sum of G22, G23 and G25)	$16,470,302.22

	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	$ 1,396.20		1075			$ 1,500,919.05
	31	ICU	$ 4,644.18		257			$ 1,193,553.62
	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	$ -					$ -
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Ancillary Cost Centers	50	Operating Room		0.234255		$ 1,358,908.50	$ 3,175,555.00	$ 1,062,219.90
	54	Radiology - Diagnostic		0.369022		$ 321,881.00	$ 2,525,078.22	$ 1,050,589.95
	57	CT Scan		0.089337		$ 1,121,652.50	$ 5,666,201.16	$ 606,408.01
	58	MRI		0.088384		$ 65,869.00	$ 1,910,943.00	$ 174,718.48
	60	Laboratory		0.249894		$ 2,080,592.00	$ 6,584,373.21	$ 2,165,321.17
	65	Respiratory Therapy		1.764670		$ 121,523.00	$ 85,168.00	$ 364,741.51
	66	Physical Therapy		0.535693		$ 135,664.01	$ 1,028,471.00	$ 623,619.25
	69	Electrocardiology		0.420902		$ 104,650.00	$ 397,248.00	$ 211,249.88
	71	Medical Supplies Charged to Patients		0.262856		$ 256,378.13	$ 536,350.52	$ 208,373.60
	72	Imp. Dev. Charged to Patients		0.621392		$ 177,323.20	$ 208,599.06	$ 239,808.91
	73	Drugs Charged to Patients		0.384195		$ 1,532,920.13	$ 1,675,940.20	$ 1,232,828.76
	74	Renal Dialysis		1.012255		$ 104,029.00	$ 22,278.00	$ 127,854.88
	88	College Clinic		0.817975		$ -	$ 2,094,237.17	$ 1,713,033.34
	90	Clinic		2.617555		$ -	$ 176.10	$ 460.95
	90.02	Red Rock Clinic		10.484886		$ -	$ 11,111.45	$ 116,502.28
	90.03	BHS Clinic		0.159202		$ -	$ 315,288.20	$ 50,194.63
	91	Emergency		0.174964		$ 1,154,277.00	$ 16,929,628.60	$ 3,164,028.69
	92	Observation Bed		0.457841		$ 122,293.00	$ 630,420.00	$ 344,622.77
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				1,332	**$ 8,657,960.47**	**$ 43,797,066.89**	**$ 16,151,049.62**

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. $ -

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:

Rehoboth McKinley Christian Hospital offers financial assistance to any patient that applies during or after care and who meets certain eligibility criteria. Since the patient must apply for financial assistance and provide financial data that supports their eligibility, the hospital cannot estimate which patients are eligibile for financial assistance who do not apply and submit documentation. Based on an internal review of bad debt write-offs posted to the patient accounting system, there were no write-offs to bad debt expense of patient balances for patients eligible for the financial assistance program based on a submitted application.

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**	
David McGrail		CFO	267-307-7379	
Email of Authorized Person				
dmcgrail@rmchcs.org				
Signature of Authorized Person		**Date of Signature**		
Address of Authorized Person				
Street or P.O. Box		**City**	**State**	**Zip Code**
1901 Red Rock Drive		Gallup	NM	87301

Name of Preparer		**Title**	**Telephone Number**	
Clay Good		Manager	469-405-1863	
Email of Preparer		**Date of Preparation**		
claygood@hrpllc.org		10/21/2025		
Address of Preparer				
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17950 Preston Road, Suite 720		Dallas	TX	75252