Indigent Care Annual Reporting Template

Provider Name	Memorial Medical Center - Las Cruces
Provider Medicaid Number	67939864
Provider Medicare Number	32-0018

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):

None

(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):

$1,350,935.00	Hospital Access Payments
$127,270.00	Targeted Access Payments
$9,868,882.22	SNCP DRG Enhanced Rate Payments

To provide healthcare services to 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:

None

(Please describe the use of the funds reported above)

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

None

(Please describe the use of the funds reported above)

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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. $ 22,461,515.47

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

2. 81%

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

The estimate was based on bad debts written off for uninsured patients who did not have any type of third party insurance.

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**	
Brian Day		Reimbursement Manager	615-920-7290	
Email of Authorized Person				
brian.day@lpnt.net				
Signature of Authorized Person		**Date of Signature**		
Brian Day		11/27/25		
Address of Authorized Person				
Street or P.O. Box		**City**	**State**	**Zip Code**
330 Seven Springs Way		Brentwood	TN	37027

Name of Preparer		**Title**	**Telephone Number**	
Brian Day		Reimbursement Manager	615-920-7290	
Email of Preparer		**Date of Preparation**		
brian.day@lpnt.net		11/27/25		
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