

Indigent Care Annual Reporting Template

Provider Name	COVENANT HEALTH HOBBS HOSPITAL		
Provider Medicaid Number	27238369		
Provider Medicare Number	320065		
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):

\$0.00	Hospital Access Payments
\$51,776.00	Targeted Access Payments
\$3,526,248.00	SNCP DRG Enhanced Rate Payments

Funds received by the facility are used ot ensure comprehensive hospital care at an acuity that aligns with the pupulation of the community we serve. Our community cannot support more complex and profitable procedure based hospital care. Supplemental payments are utilized to bridge the gap between revenue short falls and the core expenses to maintain a functioning hospitals that allows for medical services like emergency care, general surgery, and inpatient medical cre for flu, pneumonia, sepsis, etc. It also allowes us to maintain ICU level care of our sickest 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: 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	0
Input number of Medicaid Claims	15,669
Input number of Medicaid patients served (patient with multiple visits would be counted once)	7,933
Total Patients Reported Above (formula)	15,669

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			\$0.00
Direct cost paid to post acute care providers on behalf of patients qualifying for indigent care			\$0.00

Total Costs From Table Below	\$0.00
Total Costs for Indigent Care (sum of G22, G23 and G25)	\$0.00

[illegible]

Ancillary Cost Centers

[illegible]

[illegible]

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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:

Patients eligible for financial assistance are not sent to collections.

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	
Derrick Jones			Chief Administrative Officer	
Email of Authorized Person				
Derrick.v.jones@providence.org				
Signature of Authorized Person			Date of Signature	
<div><div>Signed by:</div><div></div><div>FB1DAFBBE1E14402</div></div>			11/23/2025	
Address of Authorized Person				
Street or P.O. Box			City	State
4900 N Lovington Highway			Hobbs	NM
			Zip Code	88240

Name of Preparer			Title	
Thu Nguyen			Sr. Manager Reim. Reg. Rpt	
Email of Preparer			Date of Preparation	
thu.nguyen2@providence.org			11/20/2025	
Address of Preparer				
Street or P.O. Box			City	State
1801 Lind Ave SW			Renton	WA
			Zip Code	98057

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Definitions

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