Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

Indigent Care Annual Reporting Template

Provider Name: COVENANT HEALTH HOBBS HOSPITAL

Provider Medicaid Number: 27238369

Provider Medicare Number: 320065

Fiscal Year Begin: 1/1/2025 Fiscal Year End: 12/31/2025

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 calendar year 2025).

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)

In the box below please report any safety net care funds received by the facility. Please include the Enhanced DRG Payments (Do not include Mill Levy Revenue):

$1,291,761.86 SNCP DRG Enhanced Rate Payments

Funds received by the facility are used to ensure comprehensive hospital care at an acuity that aligns with the population 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 hospital, that allows for medical services like emergency care, general surgery, and inpatient medical care for Flu, Pneumonia, Sepsis, etc. It also allows us to maintian ICU level care for our sickest patients.

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

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)

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

Indigent Care Annual Reporting Template

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	16,311
Input number of Medicaid patients served (patient with multiple visits would be counted once)	7,966
Total Patients Reported Above (formula)	16,311

Populate the table below utilizing your cost report that ends in the calendar year 2025, 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	0.000000	$0.00	$0.00
Direct cost paid to post acute care providers on behalf of patients qualifying for indigent care	0.000000	$0.00	$0.00

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

	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	$ 1,553.24					$ -
	31	ICU	$ 3,658.24					$ -
	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	$ 2,978.40					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -
			$ -					$ -

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

Ancillary Cost Centers

50	OPERATING ROOM		0.258310		$ -	$ -	
51	RECOVERY ROOM		0.387275				
52	DELIVERY ROOM & LABOR ROOM		0.626520				
53	ANESTHESIOLOGY		0.000000				
54	RADIOLOGY-DIAGNOSTIC		0.208489				
54.01	ULTRA SOUND		0.069622				
55	RADIOLOGY-THERAPEUTIC		0.000000				
56	RADIOISOTOPE		0.000000				
57	CT SCAN		0.023931				
58	MRI		0.057953				
59	CARDIAC CATHETERIZATION		0.000000				
60	LABORATORY		0.106753				
65	RESPIRATORY THERAPY		0.190142				
66	PHYSICAL THERAPY		1.228681				
67	OCCUPATIONAL THERAPY		0.000000				
68	SPEECH PATHOLOGY		0.000000				
69	ELECTROCARDIOLOGY		0.000000				
70	ELECTROENCEPHALOGRAPHY		0.000000				
71	MEDICAL SUPPLIES CHARGED TO PATIENT		0.338750				
72	IMPL. DEV. CHARGED TO PATIENTS		0.152112				
73	DRUGS CHARGED TO PATIENTS		0.144803				
74	RENAL DIALYSIS		0.000000				
75	ASC (NON-DISTINCT PART)		0.000000				
77	ALLOGENEIC HSCT ACQUISITION		0.000000				
78	CAR T-CELL IMMUNOTHERAPY		0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				

			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
			0.000000				
				-	$ -	$ -	

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

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:

Patients eligible for financial assistance are not sent to collections.

New for this year:

Please enter the URL/web address used for prior year reporting of information.

ww.providence.org/locations/covenant-health/hobbs-hospital/about-us/indigent-car

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

Indigent Care Annual Reporting Signature Page

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				
Name of Authorized Person		**Title**	**Telephone Number**	
Derrick Jones		Chief Administrative Officer	1 (575) 492-5103	
Email of Authorized Person				
Derrick.v.jones@providence.org				
Signature of Authorized Person		**Date of Signature**		
Signed by: Derrick Jones FB1DAFBB4E14498...		11/16/2026		
Address of Authorized Person				
Street or P.O. Box		**City**	**State**	**Zip Code**
4900 N Lovington Highway		Hobbs	NM	88240

Name of Preparer		**Title**	**Telephone Number**
Thu Nguyen		Sr. Manager Reim. Reg. Rpt	503-586-7238
Email of Preparer		**Date of Preparation**	
thu.nguyen2@providence.org		11/12/2026	
Address of Preparer			
Street or P.O. Box		**City**	**State**	**Zip Code**
1801 Lind Ave SW		Renton	WA	98057

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

Indigent Care Annual Reporting Te

Definitions

1. Indigent patient means a patient with a household income that does not exceed two hundre

Docusign Envelope ID: 90D6CF16-29AF-82B9-82D2-4647ADE974A3

emplate

ed percent of the federal poverty level.