

**NEW MEXICO MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT  
UTILIZATION RATE INFORMATION - ELIGIBILITY DETERMINATION  
QUESTIONNAIRE**

**FOR STATE FISCAL YEAR 2024**

Name of Hospital	Central Desert Behavioral Hospital		
Address of Hospital	1525 N Renaissance Blvd, NE		
City/State/Zip Code of Hospital	Albuquerque, NM 87107		
Medicaid Provider Number	Hospital	Subprovider(s)	
	15870855		
Medicare Provider Number	32-4014		
Calendar Year	1/1/2021	Through	12/31/2021

**Does the provider wish to participate in the DSH program for 2024?**  
*(If you do not wish to participate, please select "No" below and complete only questions 1 and 2 on Page 2 and the certification section on Page 4.)*

YES  NO

**OBSTETRICAL SERVICES INFORMATION**

Are the Inpatients served by your facility predominately individuals under 18 years of age?

YES  NO

Prior to December 22, 1987 did the hospital offer non-emergency obstetrical services to the general population?

YES  NO

Has the hospital discontinued offering non-emergency obstetrical services to the general population since December 22, 1987? (If Yes, please indicate date services were terminated <sup>N/A</sup>\_\_\_\_\_)

YES  NO

Does your facility have at least **two** obstetricians with staff privileges who have agreed to provide non-emergency obstetrical services to individuals entitled to such services under Medicaid? (In the case of rural hospitals, the term "Obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetrical procedures.)

YES  NO

Please list obstetricians below or attach a listing of the obstetricians.

N/A

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**UTILIZATION**

Central Desert Behavioral Hospital

<b>1)</b>	<b><u>Total number of inpatient days for the Calendar Year</u></b>	<b>2021</b>	
	(Hospital & Sub-Providers plus admitted Observation Beds, less Swing Bed Days)		<u>19,336</u>
<b>2)</b>	<b><u>Total number of Medicaid inpatient days for the Calendar Year</u></b>	<b>2021</b>	
	(Hospital & Sub-Providers plus admitted Observation Beds, less Swing Bed Days)		<u>0</u>
	Fee-for-Service (Xerox)		<u>6,892</u>
	HMO/Medicaid MCO***		<u>1,912</u>
	FFS Medicare Cross-Over Days		<u>0</u>
	Other Medicare Cross-Over Days		
	Other Medicaid Eligible Days		
	Medicaid Secondary (Commercial Primary)		
	Out-of-State Medicaid Days		
	Grand Total Medicaid Days		<u>8,804</u>

*(Items listed above in red are reported for informational purposes only.)*

<b>3)</b>	<b><u>Hospital services charity/uninsured gross charges and payments for the Calendar Year</u></b>	<b>2021</b>	
		Inpatient	Outpatient
		Total	
	<u>Charity Care Charges</u>		<u>0</u>
	<u>Uninsured Charges</u>		<u>0</u>
	Uninsured <u>Payments</u> (cash basis)		<u>0</u>

Charity/uninsured care is care provided to individuals who have no health insurance or other third-party coverage. The total charges attributed to charity/uninsured care shall not include contractual allowances and discounts that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross. Charity/uninsured care charges would also not include bad debts, unless the amounts meet the definitions given above. Information to support this number must be maintained by the hospital and is subject to review and/or audit.

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4) **Amount of cash subsidies received from state and local governments during the Calendar Year** **2021**

*Examples of Subsidies: Mill Levy, Indigent, or State Appropriations*

*Do NOT include supplemental payments such as: Graduate Medical Education, Indirect Medical Education, Safety Net Care Pool/UCC*

<u>Source/Type:</u>	Inpatient	Outpatient	Unspecified***	Total
a) _____				0
b) _____				0
c) _____				0
d) _____				0
<b>Total Cash Subsidies from State and Local Governments</b>	0	0	0	0

\*\*\*If you identified any cash subsidies as "Unspecified", please enter total inpatient and outpatient hospital charges from the as-filed cost report. This ratio will be used to allocate "Unspecified".

Inpatient	Outpatient	Total
17,256,810		17,256,810

5) **Medicaid claim/service payments (net revenue) received for the Calendar Year** **2021**

	Inpatient	Outpatient	Total
Medicaid Fee-for-Service (Xerox) - must agree with Tab Run	0		0
HMO/Medicaid MCO	5,710,209		5,710,209
Medicare Cross-Over	117,623		117,623
Other Medicaid Eligible			0
Out-of-State Medicaid			0
<b>Total Medicaid Payments (Net Revenue)</b>	<b>5,827,833</b>	<b>0</b>	<b>5,827,833</b>

6) **Total hospital payments (net revenue) received and Billed Charges for the Calendar Year** **2021**

Total Hospital Payments (Net Revenue)	16,208,564		16,208,564
<b>Total Hospital Billed Charges</b>	<b>17,256,810</b>		<b>17,256,810</b>

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References: New Mexico specific regulations and instructions pertaining to DSH payments may be found in the New Mexico Administrative Code (NMAC). Section 8.311.3.13.

**MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.**

**CERTIFICATION BY OFFICER OR ADMINISTRATOR FOR PROVIDER**

I HEREBY CERTIFY that I have read the above statement and that I have examined the contents of this report and that to the best of my knowledge and belief, it is a true, correct and complete statement from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of healthcare services and that the services identified in this report were provided in compliance with such laws and regulations.

(Signed:)

  
\_\_\_\_\_  
Officer or Administrator of Provider

Date

2/2/2023

Printed Name

Kelley Whitaker

Title

President

Report prepared by

Jennifer Johnson

Phone number of person preparing report

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**Please return this signed and dated page to:**

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**Subject line: 2024 DSH Eligibility**