HHS Provider Relief Fund FAQs

Overview

Will HHS allow providers to make corrections to the data used to determine Targeted Distribution eligibility and payment amounts? *(Added 10/28/2020)*

Going forward, HHS will allow providers that submitted data as part of the COVID-19 High Impact Area Distribution and/or the Nursing Home Infection Control/Quality Incentive Payment Distribution, a limited opportunity to submit corrected data for up to 5 business days after the submission deadline. HHS will only accept corrections within the 5-day time period that are accompanied by a justification for why the provider erred in the initial data submission. HHS will review each request for correction on a case-by-case basis and may determine that a previous payment be amended to align with the updated data. Providers who submit updated data may have their payments delayed for up to 90 days from the date of submission pending review and adjudication. All HHS decisions are final and there is no appeals process.

If a provider returns a Provider Relief Fund payment to HHS, must it also return any accrued interest on the payment? *(Added 10/28/2020)*

Yes, for Provider Relief Fund payments that were held in an interest-bearing account, the provider must return the accrued interest associated with the amount being returned to HHS. However, if the funds were not held in an interest-bearing account, there is no obligation for the provider to return any additional amount other than the Provider Relief fund payment being returned to HHS. HHS reserves the right to audit Provider Relief Fund recipients in the future to ensure that payments that were held in an interest-bearing account were subsequently returned with accrued interest.

Attestation

What action does a provider need to take after receiving a Provider Relief Fund payment? *(Modified 10/28/2020)*

The CARES Act requires that providers meet certain terms and conditions if a provider retains a Provider Relief Fund payment. If a provider chooses to retain the funds, it must attest that it meets these terms and conditions of the payment. The CARES Act Provider Relief Fund Payment Attestation Portal or the Provider Relief Fund Application and Attestation Portal will guide you through the attestation process to accept or reject the funds. Not returning the payment within 90 days of receipt will be viewed as acceptance of the Terms and Conditions. A provider must attest for each of the Provider Relief Fund distributions received.

Do the Provider Relief Fund attestation portals require payment recipients to attest that the payment amount was received? *(Added 10/28/2020)*

Yes. The attestation portals require payment recipients to (1) confirm they received a payment and the specific payment amount that was received; and (2) agree to the Terms and Conditions of the payment.

How should a provider return a payment it received via check? *(Modified 10/28/2020)*

If the provider received a payment via check and has not yet deposited it, destroy, shred, or securely dispose of it. If the provider has already deposited the check, mail a refund check for the full amount, payable to "UnitedHealth Group" to the address below via United States Postal Service (USPS); mailing services such as FedEx and UPS cannot be used with this PO box. Please list the check number from the original Provider Relief Fund check in the memo. Mail a refund check for the full amount payable to "UnitedHealth Group" to the address below.

UnitedHealth Group
Attention: Provider Relief Fund
PO Box 31376
Salt Lake City, UT 84131-0376

If I changed my mind after I rejected a Provider Relief Fund payment through one of the attestation portals and returned the payment, can I receive a new payment? *(Modified 10/28/2020)*

No, HHS will not issue a new payment to a provider that received and then subsequently rejected and returned the original payment. The provider may be considered for future distributions if it meets the eligibility criteria for that distribution.

Terms and Conditions

Can Provider Relief Fund payments be used to support COVID-19 vaccine distribution? *(Added 10/28/2020)*

Yes. Provider Relief Fund payments may be used to support distribution of a COVID-19 vaccine licensed or approved by the Food and Drug Administration (FDA). Funds may also be used ahead of an FDA-licensed or approved vaccine becoming available. This may include using funds to purchase additional refrigerators, personnel costs to provide vaccinations, and acquiring doses of a vaccine (including transportation costs not otherwise reimbursed).

Can Provider Relief Funds be used to pay for vaccination, including doses and administration fees, for Medicare, Medicaid, or CHIP beneficiaries? *(Added 10/28/2020)*

No. In line with the Terms and Conditions, funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are ***obligated*** to reimburse, which includes, but is not limited to, Medicare, Medicaid, and CHIP.

Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19? *(Modified 10/28/2020)*

As explained in the notice of reporting requirements on the Provider Relief Fund website, funds must be expended no later than June 30, 2021. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for increased health care-related expenses or lost revenue attributable to coronavirus.

The Terms and Conditions state that Provider Relief Fund payments will only be used to prevent, prepare for, and respond to coronavirus and shall reimburse the Recipient only for health care-related expenses or lost revenues that are attributable to coronavirus. What expenses or lost revenues are considered eligible for reimbursement? *(Modified 10/28/2020)*

Please refer to the Post-Payment Notice of Reporting Requirements, released on September 19 and updated October 22, 2020, and associated FAQs on reporting for the most current information on use of funds, as well as the definitions on health care-related expenses and lost revenue.

In order to accept a payment, must the provider have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received? *(Modified 10/28/2020)*

No. Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if on June 30, 2021, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately.

What if my payment is greater than expected or received in error? *(Modified 10/28/2020)*

Providers that have been allocated a payment must sign an attestation confirming receipt of the funds and agree to the Terms and Conditions within 90 days of payment. In accordance with the Terms and Conditions, if you believe you have received an overpayment and expect that you will have cumulative lost revenues and increased costs that are attributable to coronavirus during the COVID-19 public health emergency that exceed the intended calculated payment, then you may keep the payment.

If a provider does not have or anticipate having these types of COVID-19-related eligible expenses or lost revenues equal to or in excess of the Provider Relief Fund payment received, it should reject the payment in Provider Relief Fund Attestation Portal or the Provider Relief Fund Application and Attestation Portal and return the entire payment. Please call the Provider Support Line at (866) 569-3522 (for TYY, dial 711) for step-by-step instructions on returning the payment and receive the correct payment when relevant.

Ownership Structures and Financial Relationships

Can an organization that sold its only practice or facility under a change in ownership in 2019 or 2020 and is no longer providing services accept payment and transfer it to the new owner? *(Modified 10/28/2020)*

No. A provider that sold its only practice or facility must reject the Provider Relief Fund payment because it cannot attest that it was providing diagnoses, testing, or care for individuals with

possible or actual cases of COVID-19 on or after January 31, 2020, as required by the Terms and Conditions. Seller organizations should not transfer a payment received from HHS to another entity. If the current TIN owner has not yet received any payment from the Provider Relief Fund, it may still receive funds in other distributions.

Can a provider that purchased a TIN in 2019 or 2020 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? *(Modified 10/28/2020)*

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment. However, the new TIN owner may still receive funds in other distributions.

Can a provider that purchased a TIN in 2019 or 2020 accept a Provider Relief Fund payment from a previous owner and complete the attestation for the Terms and Conditions? *(Modified 10/28/2020)*

No. The new TIN owner cannot accept the payment from another entity nor attest to the Terms and Conditions on behalf of the previous owner in order to retain the Provider Relief Fund payment. If the new TIN owner did not receive a direct payment under the Provider Relief Fund, it is not eligible to receive a payment under the General Distribution. However, the new TIN owner may still receive funds in other distributions.

Use of Funds

What is included in use of funds for salaries and employee compensation? *(Added 10/28/2020)*

Direct employee (full and part-time), contract labor, and temporary worker expenses are eligible expenses provided they are not reimbursed from other sources, or only the incremental unreimbursed amounts are claimed.

Are fringe benefits for both patient care staff and General and Administrative (G&A) staff considered Provider Relief Fund eligible expenses under the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*

Yes, fringe benefits associated with both types of personnel may be eligible if not reimbursed by other sources.

When reporting my organization's healthcare expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources?" *(Added 10/28/2020)*

Healthcare related expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, employees, and other healthcare related costs/expenses for the calendar year. The classification of items into categories should align with how Provider Relief Fund recipients maintain their records. Providers can identify their healthcare related expenses, and then apply any amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance

Program (CHIP), or other funds received from the Federal Emergency Management Agency (FEMA), the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, and the Small Business Administration (SBA) and Department of Treasury's Paycheck Protection Program (PPP) that offset the healthcare related expenses. Provider Relief Fund payments may be applied to the remaining expenses or cost, after netting the other funds received or anticipated to offset those expenses. The Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus. For example, assume the following:

A $5 increase in expense or cost to provide an office visit is calculated by pre-pandemic cost vs. post-pandemic cost, regardless of reimbursement source:

- Pre-pandemic average expense or cost to provide an office visit = $80
- Post-pandemic average expense or cost to provide an office visit = $85

Examples of reimbursed amounts may include, but not be limited to:

- Example 1

  Medicaid reimbursement: $70 (Report $85-$80 = $5 as expense attributable to coronavirus but unreimbursed by other sources)

- Example 2

  Medicare reimbursement: $80 (Report $85-$80 = $5 as expense attributable to coronavirus but unreimbursed by other sources)

- Example 3

  Commercial Insurance reimbursement: $85 (Report $5, commercial insurer did not reimburse for $5 increased cost of post-pandemic office visit)

- Example 4

  Commercial Insurance reimbursement: $85 + $5 insurer supplemental coronavirus-related reimbursement (Report zero since insurer reimbursed for $5 increased cost of post-pandemic office visit)

- Example 5

  COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured: $80 (Report $5 as expense attributable to coronavirus but unreimbursed by other sources)

When reporting my organization's G&A expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*

Providers should calculate incremental G&A expenses incurred that were attributable to coronavirus and then estimate the portion of those expenses that were not covered through operational revenues, other direct assistance, donations or other sources.

Examples may include expenses such as:

Hiring additional security personnel, increased hazard pay, increased cost of utilities to operate temporary facilities, or similar items attributable to the coronavirus that were not normally incurred.

When reporting my organization's other healthcare related expenses attributable to coronavirus, how do I calculate the "expenses attributable to coronavirus not reimbursed by other sources"? *(Added 10/28/2020)*

Providers first calculate their expenses for supplies, equipment, IT, facilities, employees, and other healthcare related costs/expenses for calendar years 2019 and 2020, calculate the change in year over year expenses and identify the portion that is attributable to coronavirus. Provider will then apply reasonable assumptions to determine the amount of their "Total Revenue /Net Charges from Patient Care Related Sources" and "Other Assistance Received" that applies to each type of healthcare expense attributable to coronavirus.

For example:

PPE Supplies in 2019 = $1,000
PPE supplies in 2020 = $4,000
$4,000 – $1,000 = $3,000 in expenses over and above normal operations attributable to coronavirus

Of that $3,000, approximately $2,500 was attributable to coronavirus, and of that $2,500 approximately $1,000 was reimbursed, leaving a balance of $1,500 in unreimbursed healthcare related expenses attributable to coronavirus.

Do providers report total purchase price of capital equipment or only the depreciated value? *(Added 10/28/2020)*

Providers who use accrual or cash basis accounting may report the relevant depreciation amount based on the equipment useful life, purchase price and depreciation methodology otherwise applied.
Providers may report an expense for items purchased with a useful life of 12 months or less if in accordance with their existing accounting policies.

Can providers allocate parent overhead costs to the entities that received CARES Act Provider Relief Funds? *(Added 10/28/2020)*

Yes, providers that already have a cost allocation methodology in place, may allocate normal and reasonable overhead costs to their subsidiaries which may be an eligible expense if attributable to coronavirus and not reimbursed from other sources.

When reporting use of funds, how will my organization's "lost revenues attributable to coronavirus" be calculated? *(Added 10/28/2020)*

Lost revenues attributable to coronavirus are calculated based upon a calendar year comparison of 2019 to 2020 actual revenue/net charges from patient care (prior to netting with expenses).

The amount of lost revenues eligible for reimbursement through the Provider Relief Fund is capped at the change in 2019 to 2020 actual revenue from patient care related sources, less the Provider Relief Fund amount used to cover healthcare expenses attributable to coronavirus not reimbursed by other sources.

Reporting Entities with unused funds after December 31, 2020, must submit a second and final report no later than July 31, 2021 that includes patient care related revenue and expenses for January 1–June 30, 2021.

Note: Reported patient care revenue is net of uncollectible patient service revenue recognized as bad debts.

What is the maximum allotment of my organization's Provider Relief Fund amount that can be allocated to lost revenue in 2020? *(Added 10/28/2020)*

Unreimbursed expenses attributable to coronavirus are considered first in the overall use of funds calculation. Provider Relief Fund payment amounts not fully expended on unreimbursed healthcare related expenses attributable to coronavirus are then applied to lost revenues for 2020, which is capped at the change in 2019 to 2020 actual revenue from patient care (i.e., patient care revenue in 2019 less patient care revenue in 2020).

Recipients that reported increased revenue from patient care in 2020 as compared to 2019, are eligible to use Provider Relief Fund payments toward expenses attributable to coronavirus not reimbursed by other sources, however, they would not be considered to have lost revenues attributable to coronavirus for the initial reporting period.

Is interest earned on Provider Relief Fund funds considered a reportable revenue source to HHS? *(Added 10/28/2020)*

Yes, if funds were held in an interest-bearing account. Interest earned would then be reported in "Other Assistance." If interest is earned on Provider Relief Fund disbursements that the Reporting Entity expended in full, the interest amounts may be retained and applied toward a reportable use of funds.

If interest is earned on funds that are only partially expended, the interest on remaining unused funds must be calculated, reported and returned if not applied to a permissible use of funds.

Can I use 2020 budgeted revenues as a basis for reporting lost revenues? *(Added 10/28/2020)*

No. When reporting use of Provider Relief Fund money toward lost revenues attributable to coronavirus, Reporting Entities must report actual patient care revenues and expenses for 2019 and 2020, to allow for a year-over-year calculation of change in revenue. In cases where funds are not fully expended by December 31, 2020, the Reporting Entity must report actuals from January 1-June 30, 2021 to be compared against the same six-month period in 2019.

How does "other assistance received" factor into my reported expenses? *(Added 10/28/2020)*

Other assistance received is reported as operating revenue and used in the calculation of year-over-year change in patient care related revenue.

What is considered when calculating "Total Revenue/Net Charges?" *(Added 10/28/2020)*

Revenue from Patient Care Payer Mix (2019 and 2020, and for some recipients, 2021 where applicable)

a) Medicare Part A+B: The actual revenues/net charges received from Medicare Part A+B for patient care for the calendar year.

b) Medicare Part C: The actual revenues/net charges received from Medicare Part C for patient care for the calendar year.

c) Medicaid: The actual revenues/net charges received from Medicaid/Children's Health Insurance Program (CHIP) for patient care for the calendar year.

d) Commercial Insurance: The actual revenues/net charges received from commercial payers for patient care for the calendar year.

e) Self-Pay (No Insurance): The actual revenues/net charges received from self-pay patients, including the uninsured or individuals without insurance who bear the burden of paying for healthcare themselves, for the calendar year.

f) Other: The actual gross revenues/net charges from other sources received for patient care services and not included in the list above for the calendar year.

Note: All sources of patient care revenue should be reported net of uncollectible patient service revenue recognized as bad debts.

How does cost reimbursement relate to my Provider Relief Fund payment? *(Added 10/28/2020)*

Recipient must follow CMS instructions for completion of cost reports. Under cost reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. In these instances, if the full cost was reimbursed based upon this method, there is nothing eligible to report as an expense attributable to coronavirus because the expense was fully reimbursed by another source. In cases where a ceiling is applied to the cost reimbursement and the reimbursed amount does not fully cover the actual cost due to unanticipated increases in providing care attributable to coronavirus, those incremental costs that were not reimbursed are eligible for reimbursement under the Provider Relief Fund.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? *(Added 10/28/2020)*

HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money and/or allocate the money to other subsidiary TINs, as it deems appropriate.

Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

Funds from the Federal Emergency Management Administration (FEMA) are generally intended to be the last source of reimbursement, however, the Post-Payment Notice of Reporting Requirements indicates that FEMA funds would be applied prior to the Provider Relief Fund distributions. In which order should governmental funding sources be applied and reported? *(Added 10/28/2020)*

As it relates to expenses, providers identify their health care-related expenses, and then apply any amounts received through other sources (e.g., direct patient billing, commercial insurance, Medicare/Medicaid, reimbursement from the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured, or funds received from FEMA or SBA/Department of Treasury's Paycheck Protection Program) that offset the health care-related expenses. PRF

payments may be applied to the remaining expenses or cost, after netting the other funds received or anticipated to offset those expenses.

Supporting Data

What documentation is required for reporting? *(Added 10/28/2020)*

No external documentation is required at the time information is submitted via the reporting portal. Supporting worksheets (for providers who received $500,000 or above in Provider Relief Fund payments) will be included to assist providers within the reporting tool.

What are the documentation retention requirements for the Provider Relief Fund? *(Added 10/28/2020)* Providers need to retain original documentation for three years after the date of submission of the final expenditure report, in accordance with 2 CFR 200.333.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? *(Added 10/28/2020)*

HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money and/or allocate the money to other subsidiary TINs, as it deems appropriate.

Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

Change of Ownership

Who is responsible for reporting use-of-funds in the event of a change of ownership after receipt of a Provider Relief Fund payment? (Added 10/28/2020)

The following chart outlines Provider Relief Fund reporting actions in the event of change of ownership of a subsidiary that received Provider Relief Fund dollars.

Distribution	Change of Ownership Scenario	Program Guidance	Reporting Action
General Distribution	Purchase of stock or membership interest of subsidiary	*If the transaction is a purchase of the recipient entity (e.g., a purchase of its stock or membership interests), then the Provider Relief Fund recipient may continue to use the funds, regardless of its new owner.* ***FAQ dated 6/22/2020***	Subsidiary may use the Provider Relief Fund dollars and report on the use, or its new parent/owner (if an eligible healthcare provider) may direct and report on the use.
General Distribution	Asset Purchase of subsidiary	*If the transaction is an asset purchase (whether for some or all of the Provider Relief Fund recipient's assets), then the original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS. In these circumstances, the Provider Relief Fund money does not transfer to the buyer, however, buyers in these circumstances will be eligible to apply for future Provider Relief Fund payments.* ***FAQ dated 6/22/2020***	Subsidiary must use the Provider Relief Fund payment (returning any unused funds) and must report on the use itself. The new owner of the assets cannot use the relief fund money or report on the use.
General Distribution	Subsidiary entity is acquired and merged with another entity	*The entity resulting from the merger is the successor entity and can use the Provider Relief Fund payment. If this successor entity is a subsidiary of a new parent, that new parent, if it is an eligible healthcare provider, can direct the use of the relief fund money*	Subsidiary may use the Provider Relief Fund money and report on its use, or its new owner (if an eligible healthcare provider) may direct the use of the relief fund money and report on the use.
Targeted Distributions	Purchase of stock or membership interest of recipient subsidiary Asset purchase of recipient entity Subsidiary is acquired and merged with another entity	*Only the subsidiary can use the Targeted Distribution.* ***FAQ dated 9/3/2020***	Subsidiary reports on use of Targeted Distribution.

Non-Financial Data

What are the categories for classifying personnel? *(Added 10/28/2020)*

a) Full-time: personnel employed on average 30 hours of service per week, or 130 hours for a calendar month.

b) Part-time: personnel employed any time between 1 and 34 hours per week, whom may or may not qualify for benefits.

c) New hires: personnel not previously employed by the employer; or previously employed but voluntarily or involuntarily separated for at least 60 consecutive days.

d) Re-hires: personnel that left a company due to voluntary or involuntary separation and are brought back to work by employer.

e) Voluntary separation: personnel voluntarily submits a written or verbal notice of resignation.

f) Involuntary separation: management decides to terminate its relationship with an employee because of either economic necessity or poor fit; includes lay-offs and expired contracts.

g) Furloughed: when a staff member involuntarily takes unpaid leave of absences.

h) Leave of Absence: personnel voluntarily take an extended period of time away from work while still maintaining their employee status; can be paid or unpaid.

Note: Definitions of personnel are derived from either the Internal Revenue Service or the National Institute for Aging, as applicable.

What are the categories for patient admission? *(Added 10/28/2020)*

a) Inpatient Admissions: someone admitted to the hospital on a doctor's order (i.e. direct admit); someone formally admitted from the Emergency Room to the hospital (i.e. emergency admission).

b) Outpatient Admissions: also called a department use/event/encounter is made during the person's visit to the healthcare center that provides health and medical services but does not require stay exceeding 23 hours.

c) Emergency Visit: someone seen in an Emergency Department for care/treatment of an acute episode; following treatment or stabilization the patient is discharged back to their primary place of residence. This may include patients on observation status who are cared for no longer than 72 hours but not formally admitted to a hospital.

What is a resident patient for the purpose of Provider Relief Fund payment? *(Added 10/28/2020)*

A patient that is admitted to a Nursing Home or Skilled Care Facility (with at least 6 beds) for continued short or long term care.

What is considered a "staffed bed" for reporting KPI? *(Added 10/28/2020)*

A staffed bed is licensed and physically available with staff on hand to attend to patients; includes both occupied and available beds.

Miscellaneous

What does "primary Tax Identification Number (TIN)" and "subsidiary TIN" refer to? *(Added 10/28/2020)*

Primary TIN refers to the TIN of the parent company, and subsidiary TIN refers to the TIN of an entity that is a subsidiary of the parent company. Providers may have received payments directly to a parent and/or its subsidiary entities.

What is meant by "For some recipients, this may be analogous to Social Security number (SSN) or Employer Identification Number (EIN)" with respect to the TIN? *(Added 10/28/2020)*

Some recipients may be individual providers for whom their TIN will be their SSN; similarly, for some entities the TIN will be the EIN.

What are the required timelines for reporting? *(Added 10/28/2020)*

All recipients of aggregated Provider Relief Fund payments greater than $10,000 must report use of funds as of December 31, 2020 at any time during the window that begins January 15, 2021, but no later than February 15, 2021.

Recipients with funds unexpended after December 31, 2020, have six more months from January 1 – June 30, 2021 to use remaining funds, and then must submit a second and final report no later than July 31, 2021.

If an entity incurred enough lost revenue in April and May 2020 to justify its use of the Provider Relief Fund payments received, can it only report those two months? *(Added 10/28/2020)*

No. The Reporting Entity must report revenue and expense for the full calendar years 2019 and 2020. If funds were not expended in full by December 31, 2020 then a second and final report will be required on use of funds for the period January 1, 2021 - June 30, 2021 which is due no later than July 31, 2021.

What is the process to return unused funds? *(Added 10/28/2020)*

Details on how to return unused amounts will be provided in advance of the second 2021 reporting deadline, which is July 31, 2021.

If an entity received payments totaling over $10,000, but returned some, do they still have to report? *(Added 10/28/2020)*

A Reporting Entity must report only when they have retained $10,000 or more in aggregated Provider Relief Fund dollars. This includes payments received by the parent and general distribution payments received by related subsidiaries for which the parent will report on behalf of.

Should entrance fee amortization be excluded from patient care? *(Added 10/28/2020)*

If the provider includes entrance fee amortization as operating revenue on its financial statements, it should be considered as revenue associated with patient services. Entrance fee amortization must be handled in a consistent manner in both 2019 and 2020.

How do shareholder or partnership payments impact the lost revenue calculation? *(Added 10/28/2020)*

"Lost revenue attributable to coronavirus" is calculated based on operating revenue from patient care sources. Shareholder and partnership payments are not eligible to be included in the lost revenue calculation.

If all funds are expended through the G&A and healthcare related expenses, are recipients still required to submit lost revenue information? *(Added 10/28/2020)*

Yes, all providers above the $10,000 threshold are required to report both revenues and expenses for the calendar year.

Are Intergovernmental Transfers (IGTs) related to state provider taxes allowable G&A expenses? *(Added 10/28/2020)*

A portion of a Provider Relief Fund recipient's state provider taxes may be eligible expenses, but only to the extent the Provider Relief Fund recipient owes incrementally increased state provider taxes, where the incremental increase is attributable to coronavirus.

General Distribution Phase 3

Overview and Eligibility

Are providers that received payments under Phase 3 of the General Distribution limited to using these funds to cover coronavirus-related losses or increased expenses experienced during the first two quarters of calendar year 2020? *(Modified 10/28/2020)*

No. The Terms and Conditions require payment recipients to certify that funds will only be used to prevent, prepare for, and respond to coronavirus, and will only reimburse the recipient for health care-related expenses or lost revenues that are attributable to coronavirus. The Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses provided that funds are expended by June 30, 2021, per reporting guidelines. HHS is collecting information on the losses and expenses associated with the first two quarters of 2020 for purposes of making additional General Distribution payments to those providers with demonstrated financial need.

Tax Identification Number (TIN) Validation Process

When is the deadline to submit an application? *(Modified 10/28/2020)*

The deadline to submit an application under Phase 3 – General Distribution is November 6, 2020 at 11:50 EST for those that have had their TIN validated in Phase 2 or received funds as part of Phase 1.

Application Process

An organization has the sale of medical supplies, such as durable medical equipment and prescription glasses and contacts, as part of its revenue and expenses. Can these sales be captured in the data submitted as a part of revenue and operating expenses from patient care? *(Added 10/28/2020)*

No. Any revenue or expenses related to the sale of medical supplies, including durable medical equipment and prescription glasses and contacts, may not be included as part of revenue or expenses from patient care. Only patient care revenues from providing health care, services, and supports, as provided in a medical setting, at home, or in the community may be included.

Hospitals and health care systems may have joint ventures, such as a hospital or health system that owns a portion of an ambulatory surgery center, in which the hospital or health care system provides services. Should the revenue and expenses associated with these agreements and ventures be included from reported revenues and expenses in the Phase 3 application? *(Added 10/28/2020)*

No. The associated revenues and expenses that are associated with joint ventures with other health care entities should not be included in the hospital or health care system's application for Phase 3 funds.

Does "operating expenses from patient care" include costs that support the delivery of care, such as the health care providers' information technology, finance, and human resources costs? *(Added 10/28/2020)*

Yes. Applicant may include costs that support the delivery of care, such as the health care providers' information technology, finance, and human resources costs, as part of "operating expenses from patient care" when applying for Phase 3 General Distribution payments.

Does "most recent federal income tax return of 2017, 2018, or 2019" mean filed return? *(Added 10/28/2020)*

Yes. Applicants must submit the most recently filed tax return along with their application for Phase 3 General Distribution payments. If an applicant has applied for funds in previous General Distributions and filed taxes in the interim, it must use its most recent tax return; the applicant is not required to submit the same return included with previous General Distribution applications.

If a parent entity is applying for the Phase 3 General Distribution on behalf of itself and multiple subsidiaries, and the parent and subsidiaries file a group tax return, should the parent entity submit the joint tax return as part of its application? *(Added 10/28/2020)*

Yes. Similar to the Phase 2 General Distribution application, in cases where a parent files a group tax return for itself and all/or some of its subsidiaries, the parent entity should submit the group tax return that includes all subsidiaries on behalf of which the parent entity is applying.

Should a parent entity applying on behalf itself and subsidiaries report the proportion of revenues from patient care, along operating revenue and operating expenses for patient care, aggregated across all entities or break out each figure by TIN? *(Added 10/28/2020)*

The parent entity that is applying on behalf of itself and multiple subsidiaries should break out by TIN revenues and operating expenses for patient and non-patient care when applying for Phase 3 funds on behalf of multiple subsidiaries. The applying entity should ensure that these figures reconcile to ones provided on the submitted tax return.

May a parent entity applying on behalf of multiple subsidiaries that would like each subsidiary to receive its own payment submit as documentation for each individual subsidiary the common group tax return? *(Added 10/28/2020)*

Yes. The parent entity that is applying on behalf of multiple subsidiaries may submit the same required financial documentation as part of multiple applications if the documentation includes the requested financial information for each of the subsidiaries. The parent entity that is applying on behalf of multiple subsidiaries should include a break-out by TIN of the revenues and operating expenses for patient and non-patient care for each of the TINs included in the filed tax return that reconciles to the figures on the return.

How should intercompany rent be treated when reporting "operating expenses from patient care?" *(Added 10/28/2020)*

Intercompany rent should be included when reporting "operating expenses from patient care" as well as "operating revenue from patient care."

What is "operating revenues from patient care?" *(Modified 10/28/2020)*

HHS considers "operating revenues from patient care" to be net patient service revenue from the delivery of health care services directly to patients. "Net patient service revenue" is defined as gross charges for patient services delivered, minus contractual adjustments from all third party payors, charity care adjustments, bad debt, and any other discounts or adjustments necessary to arrive at net patient service revenue. For the definition of "revenue" for purposes of reporting and use of funds, please refer to the reporting requirements available at www.hhs.gov/providerrelief.com.

What is "operating expense from patient care?" *(Modified 10/28/2020)*

HHS considers "operating expenses from patient care" to be the operating expenses incurred as part of the delivery of care, including salaries, benefits, medical supplies, contracted and/or

employed physicians, interest, and depreciations. Operating expenses from patient care do not include any non-operating expenses, such as costs incurred on any rental property that is not the site of patient care delivery, as well as contributions made, gains, and/or losses on investments. For the definition of “expenses” for purposes of reporting and use of funds, please refer to the reporting requirements available at www.hhs.gov/providerrelief.com.