Jeff Grandia: Brooke thank you, and thank you for joining us in this historic week. All the excitement that's going on. We want to start off with kind of the elephant in the room. We suspect you're all asking yourselves, so why are we holding a webinar on stimulus funding today, the day after the election with all the uncertainty. I want to give you just a couple of quick response to that. One, the recognition that the current election doesn't have much of an impact on the stimulus funding that's available today. Two, there's a lot of questions that are hitting all of us related to stimulus funding and we love this simple frequently asked questions document from HHS, which now getting close to 60 pages.

The third item is that there's a lot of uncertainty right now and there's some big decisions that each of us face over the next six to eight weeks that we wanted to discuss, and then the final two items that are pretty important. One, recognition that there's probably some significant additional funding on its way no matter what direction we go, and then the final recognition which to me is the most important that we're all experiencing a COVID surge across the country and that the current funding that's available could be appropriately used to save lives and help our health systems out.

Before we get started, we wanted to share a few polling questions and get your feedback. Brooke, you mind helping us out?

Brooke MacCourtney: Absolutely. All right. Here's our first question. Our first question is how many ventilators has the auto industry manufactured since May? Your options are 400, 8,000, 40,000, 80,000 or 140,000. We'll give you a few seconds to respond. Looks like we've got some votes coming in. It's good. We'll see what people think. All right, looks like we're leveling off. Okay. I'm going to kind of close the poll and will share the results. It looks like 11% said 400, 9% said 8,000, 21% said 40,000, 27% said 80,0000, and 33% said 140,000. What is the correct answer, Jeff?

Jeff Grandia: Brooke. Thank you. It's an interesting recognition that when we're talking about COVID response and we're talking about stimulus funding, they're pretty sobering topics, but it's worth highlighting and it's worth recognizing the efforts of citizens, industry in our communities in this response. Think about the auto industry. Five months ago or eight months ago, what they were focused on and within a five month period of time they actually produced and we now have in operation 80,000 ventilators across system saving lives. Brooke, do you want to jump to the next question?

Brooke MacCourtney: Yes. All right. Our next poll question. Okay. Next question is, our organization received COVID-19 relief funding from the following sources, select all that apply. This is for your organization. CMS Medicare Accelerated and Advance Payment Programs, HHS Provider Relief Funds, treasury Coronavirus Relief Funds such as Cares Act money, FEMA, or other. Respond on behalf of your organization. It's like we're getting lots of votes coming in. All right, a couple

more seconds and I will go ahead and close that poll and we will share the results.

All right we have, 42% said CMS Medicare Accelerated and Advance Payment Programs, 62% said HHS Provider Relief Funds, 65% said treasury Coronavirus Relief Funds or Cares Act money, 17% FEMA and 26% other. Greg, I'm going to ask you to respond to that. Is that what you expected to see from our audience?

Greg Anderson: It's not too far off, Brooke. Thank you very much for handling that poll question for us. Not everybody certainly has taken advantage of the Medicare Accelerated payments. We saw that early on in the process when CMS first offered that up. There was a lot of concern initially about just the recoupment process, the challenge of getting those monies back, and also just the challenges to the revenue cycle process of recoupment. It's not surprising to me to see HHS Provider Relief Funds and Coronavirus Relief Funds kind of neck and neck there.

That's not too big a surprise there and of course I would expect those to be some of the larger numbers. FEMA is usually the resource of last resort in many cases and so it's not surprising at all to see that number actually being the lowest on the screen here, and then others would include, I would imagine FCC, tele-health money, Paycheck Protection Program money and other types of grants. Not too much of a surprise, maybe a little higher than I would have expected if I had to guess, but still a pretty good number there. Thank you for the results and Brooke, back to you.

Brooke MacCourtney: All right. Got another poll question for you because this is another one testing your knowledge. How much money is available for healthcare across all stimulus bills already funded. Your options are a hundred billion, 125 billion, 175 billion, 250 billion or 325 billion. Give you a couple seconds to answer this. Thanks again for participating in our poll. We've got one more after this and then we'll jump into the content. Couple more seconds. Okay. Looks like our votes are starting to level off. I will close the poll and share the results. We had, 7% said a hundred billion, 5% said 125 billion, 24% said 175 billion, 37% said 250 billion, and 28% said 325 billion. Jeff, I'm going to hand that to you to talk us through the right answer here.

Jeff Grandia: I'm impressed that... it seems like we were kind of coming together. If you look across the four bills, there's currently about $250 billion, actually a little more than $250 billion available. We're not including actually some other programs into that, but there's a little more than $250 billion for healthcare.

Brooke MacCourtney: Great. Okay. Here is our last poll question for you all. Now that we've received funding, please select one of the following. Have you spent it all and forgot about it? Have you locked it away? Have you given it back? Have you spent it and started documenting compliance, or not sure, looking to phone a friend. I'll

give you a few seconds to answer that one. We're getting lots of votes coming in. Thanks again, give you a couple more seconds to respond.

I'm going to go ahead and close the poll and we'll share the results. We have, 3% said they spent it and forgot about it. 18% said locked it away. 0% said given it back. 62% said they've spent it and starting to document compliance. 17% said not sure, looking to phone a friend. What do you think, Greg, of that response?

Greg Anderson: Thank you, Brooke and thanks everybody for participating in our poll. I'm really surprised at the third item, giving it back. We've seen so much in the media lately about some large organizations giving back some of these dollars. I'm surprised that that none of our participants at least admitted that they had given it back. The numbers, the 62% starting the documentation and compliance processes, that certainly is not surprising. Certainly we've seen some uncertainty out there, the 17% on the last item is not that surprising for me either. Again, thanks very much.

Brooke MacCourtney: All right, Greg. It's back to you. You should be able to advance to the next slide.

Greg Anderson: Now all right.

Jeff Grandia: At the beginning of our discussion today, Greg and I, from a background standpoint, really we've been around federal grants and federal funding for decades. The question that's been asked to us many times recently is, have we seen this stuff before or is this really a brand new experience, all this stimulus funding. I actually wanted to give you one example, my first experience, which is actually over 20 years ago. As Brooke mentioned with the FCC and how Congress actually provided $2.25 billion a year to the FCC to then give out to schools and libraries, and it was amazing. They were given 18 months and it was a crisis back then in this 18 month period to put together a program, get the money distributed appropriately and kind of move forward.

Through that process, there were very difficult audits. There were bad actors in the process. There was compliance changes and challenges through the entire process and quite frankly, there were millions of dollars in fines. When I look back and you realize that program is still in existence today, and the number of schools, the number of libraries in this country, actually every one of them has received federal funding related to secure internet access, advanced education services, and really built their businesses based on this funding and I look at the value to our communities.

We see Provider Relief Funding the same way. We wanted to point that out as over 20 years ago we had a similar experience. In 2001, we had some very similar experiences in 2008 and now today. What are the differences? Why does this feel so different? And the recognition that historically we've been talking

about millions, individual millions, maybe hundreds of millions of dollars, maybe into a low billions and now all of a sudden we're talking about hundreds of billions, quite frequently talking about trillions. And then you go from the process that... these processes have gone 18 months, two years to get distributions out and now we've converted to, now we're talking about days and weeks to get these vast dollars a month.

How does this really, really kind of change things? How are we thinking through the process? Well, the reality is the foundations and the fundamentals are the same. We just have to deal with the challenges in an escalated process. Greg, do you want to jump onto the next slide?

Greg Anderson: If I can get it to advance I sure will. There we go. All right. Well, what we're going to do, Jeff, and I appreciate the lead in that I think sets the stage very well. We're going to talk primarily today about the Provider Relief Funds, but there are various sources as you saw from one of our polling questions about the types of federal financial assistance that's out there. We saw this money come out in droves back early on in the pandemic.

It's covered a lot of different agencies, a lot of different agencies have been involved. A lot of agencies are responsible for accounting for and overseeing these funds and these programs. HHS, Health and Human Services is a big part of that and we'll spend a good bit of time talking about that. As you saw from the questions there, there are other sources like CMS's Accelerated Program, the treasury Coronavirus Relief Funds which are usually passed through state and local governments, the FCC as their tele-health funding and of course, for those of you are familiar with FEMA, they had the Category B, Public Assistance grant.

Like I mentioned, we'll talk specifically about the Provider Relief Fund and that came in to the tune of $175 billion. Jeff, when we look back at the Cares Act it was signed into law on March 27th and a hundred billion dollars was appropriated for the Provider Relief Fund. As I said, that's administered by HHS. Then about a month later, I think the date was around April 24th, the PPP and Health Care Enhancement Act was signed in law and that providing for another $75 billion appropriation to the Provider Relief Fund. That's where we get the $175 billion and this is really one of the biggest financial relief provisions for healthcare providers and it's one that I've seen used quite often even as we saw in the polling questions, and it's the one so far that has the greatest amount of confusion.

We're going to try to set some of the confusion straight, if you will, maybe give a little clarity around the Provider Relief Fund to the extent we can and try to give you perhaps a steering wheel to go along with the car that you're driving, pedal to the metal. How does the Provider Relief Fund shake out? Out of the $175 billion of appropriations, this screen kind of shows the breakdown, at least as it

currently stands with regard to the Provider Relief Fund money. Of the monies that have been set aside, $88 billion are set aside in general distributions so far. That consists of 50 billion in phase one. You'll probably recall back in April, there were two tranches of money that came out from HHS that made up this $50 billion. Then there was phase two of 18 billion, and now we're in the process of applying for phase three, which would be another $20 billion and I'll talk about that a little bit more in just a second.

Targeted distributions are about 58 billion. It's crazy to think that we're talking just throwing out loosely terms like billions of dollars. The high impact targeted distribution is 22 billion; the rural is 11.3; SNFs getting 4.9 billion; tribal facilities, only 500 million; safety net hospitals, 13.3 billion; nursing homes, five billion; children's hospitals, 1.4 billion, and that leaves about almost $30 billion for really additional distributions, maybe they're targeted or general distributions and also for the uninsured claims program that is also sponsored out of this appropriation.

As I mentioned, the phase three, which is in the gray here, the $20 billion number is still in the application process. The application window closes in a couple of days on November 6th. This payment's really made up of two components. The first is really kind of a catch-up for those providers that did not receive 2% of their revenues in the first two phases of the general distribution, and then there's a second to be announced, if you will, type of distribution that's part of phase three. The first component of this will be to catch up Medicaid providers, dentists' other providers that maybe didn't get 2% of their revenues in the first couple of phases.

The second part of this, the to be determined amount, will represent a distribution that kind of accounts for the change in revenues and expenses from 2019 to 2020, that formula has not yet been disclosed by HHS. They're not really going to disclose that formula until the application process closes and they're able to see who's applied and how much money is out there for distribution within that $20 billion framework. Part of the complexity of the Provider Relief Fund has been the guidance. I think if you look back at the overall purpose of the Provider Relief Fund, it's really to prepare for, prevent, and respond to COVID-19.

Provider Relief Fund monies can be used to reimburse providers for their lost revenues and for healthcare related expenses attributable to coronavirus that aren't reimbursed by another source. Whatever is not used in that regard will have to be returned at some point. Other than specific rules that have been in place around documentation required associated with federal programs, HHS has for the most part regulated the Provider Relief Fund through terms and conditions, frequently asked questions, and then a document that's called Post-Payment Notice of Reporting Requirements.

The terms and conditions have remained largely unchanged so there really hasn't been a lot of modification of the terms and conditions and for those of you who received general and targeted distributions, you'll recall that you've seen the terms and conditions and a lot of those are very similar across all the different types of funds. The frequently asked questions however, are changing almost weekly. There were some released on the 22nd again on the 28th and again on November 2nd. As you can see almost weekly, we're getting new updates to those frequently asked questions. And then the post-payment notice has been issued in four different versions, if you will, since July.

There's this constant feeling of drinking from the fire hose with new information that's coming out. Unfortunately some of it is contradictory and I'm sure some of you are aware of some of those contradictions and changes in definitions. It's just put the definition of things like lost revenue into a constant state of flux, and there's been really noticeable lack of guidance on healthcare related expenses. Also, the order of the calculation changed and we'll talk about that some later. I guess, unfortunately, it's left a lot of providers in the dark with a number of unanswered questions, and we'll try to shed some light on some of those but unfortunately we don't have all the answers to the questions at this point.

Let's start by talking about some of the reporting guidance on the use of funds. The frequently asked questions and the post payment notices from HHS currently dictate a two-step process to figure out how the Provider Relief Funds can be retained. Step one means we identify the health care related expenses attributable to coronavirus that haven't been reimbursed by other sources, such as fee for service reimbursement, FEMA Paycheck Protection Program, those kinds of things have to be eliminated from the expenses that we use before we can claim them against provider relief fund dollars. And then those funds are broken out, those expenses are broken down into two categories.

First is general and administrative, you'll hear me call them G&A and the other is healthcare related expenses. HHS says that these expenses can be used in both direct patient care and overhead activities related to the treatment of confirmed or suspected cases of coronavirus, including preparing for possible and national coronavirus cases and maintaining health care delivery capacity. That's a pretty broad statement. Maintaining healthcare delivery capacity can include operating and maintaining facilities. You can see how broad that definition is. If the expenses in step one fully support the Provider Relief Fund dollars that have been received, then there's really no other calculation that you can do, but if the provider received more Provider Relief Fund monies than can be supported in step one, then we go to step two, which is the calculation of lost revenue from patient care.

Before I talk about step two, we're going to look a little closer at the expenses in step one and try to give you a few insights there. Remember that the first group

of expenses in step one are the G&A expenses. This screen shows the categories of types of G&A expenses that HHS said are allowable. Again, it's fairly broad, especially when you look in the bottom right and you see other G&A. The guidance is clear, as we mentioned before that the cost are those that are not otherwise reimbursed. FAQ guidance continues to come out on these expenses. There was a good bit of FAQ guidance back on October 28th around expenses.

In fact, just last week, HHS clarified that they're really looking at incremental expenses associated with COVID-19. I'll read here a statement from HHS, 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, and other sources. HHS gives us some examples of these. Those include things like hiring additional security personnel, paying increased hazard pay, increased cost of utilities to operate temporary facilities, and other types of items like that that are attributable to coronavirus that wouldn't normally be incurred.

We've actually been peppering HHS with questions about some of these expenses, including things like utilities and our question around utilities was, if you've gotten utilities for a facility and you've apportioned a part of the facility by creating a floor for COVID, for example, can you apportion your utility cost based on square footage? And the answer we got was, yes. There is a process, there's a way of allocating these types of expenses, but again, you have to be careful that you don't capture expenses that have been reimbursed in some other fashion, and certainly you don't want to use expenses that are being claimed against other types of funds.

As you remember from step one, there are also these healthcare related expenses attributable to COVID-19. Here's a list on this slide of the items that HHS defines in the guidance. Again, and probably importantly costs that can be claimed against Provider Relief Fund dollars are those that aren't reimbursed by other sources. I know I sound like a broken record, but this comes up over and over again in the HHS guidance. Interestingly last week, HHS gave us an example. One of the few examples we've had on cost that showed an example of a patient office visit where the cost of providing a patient office visit was $80 and that was pre pandemic, and then once COVID hit, then it went up. It increased to $85.

There were examples of Medicare, Medicaid, even commercial insurance that didn't have any sort of add on for COVID-19 patients, and so therefore that additional $5 in cost, that incremental additional $5 in cost of that office visit could be claimed and used against the Provider Relief Fund dollars. There was an example of a payer that actually did provide an add on of $5 and they completely absorbed the $5 in additional cost and the HHS said, "No way. We can't use that toward Provider Relief Fund." Jeff, I realized this is a complex

analysis and the detail given is a little bit beyond these basic examples, but that's at least the kind of examples we're getting from HHS.

Jeff Grandia: Greg, from your expertise and experience, I'm real curious as to how you're addressing all of the changes related to and how you're advising organizations when it comes to all of the frequently asked questions updates. I mean, when I think of frequently asked questions, I go, we're 60 pages into this now.

Greg Anderson: Right.

Jeff Grandia: That's a lot of frequently asked questions.

Greg Anderson: It is.

Jeff Grandia: How do you stay on top of these things? What is your recommendation for organizations as they think through this? Because it feels like there has been some shifting in what's been eligible and what's not been eligible, how to respond, those kinds of things.

Greg Anderson: You're so right, Jeff, and what may be defined one way one day might a week later be defined something completely differently and we've certainly seen that in the post-payment notice, the four versions of that, that we've seen. What we do is, we've got a team that just stays on top of these. They search every day for updates to these frequently asked questions. I know that's a little hard for providers to do, but we've seen some providers that have watched this fairly closely. They've got somebody attuned to keeping up with these and of course we try to stay in weekly conversations with our clients to just let them know what's going on, advise them of any changes that we've seen in the post-payment notice or the frequently asked questions in particular.

Another thing we're doing, and I would encourage providers to do this. If you've got questions, submit those questions. There are addresses and certainly we're happy to provide that after the fact if you shoot us a note, but there's an email address. You can pose your questions too, there are phone numbers that you can use. I would encourage people to ask questions. HHS has been fairly good about getting back to us with questions. As I mentioned earlier on Jeff, we've been peppering HHS with questions and it's good to see them actually show up in the FAQ document. Several of those and we noticed, oh yeah, that was a question that we ask on behalf of several clients, and so they are responding. Sometimes it might take a little longer, and if they're asked that question enough, it shows up in those asked questions.

Again, the guidance, it changes. You got to stay on top of it, or at least engage with somebody that's watching it closely for you and keeping you up to date on things. Great question, Jeff. Thank you. I think I'll turn now to the lost revenue calculation. This is probably been one of the biggest sources of frustration and

confusion among the hospitals and physician practices that we work with. As I mentioned before, Provider Relief Fund dollars that you've received are first supported by two categories of expenses, the G&A and the healthcare related expenses, and if those expenses don't rise to the level of Provider Relief Fund monies that you've received, the provider can then look to lost revenue.

Now, that hasn't been always the case. In the initial guidance, it was more of a lost revenue first sort of calculation. It's flipped now. We're looking at expenses first and then lost revenue. Lost revenue is defined as lost revenues attributable to coronavirus represented as a negative change in year over year actual revenue from patient care related sources. What we're looking at here is a comparison of calendar year 2020 actual patient care revenue compared to calendar year 2019 patient care revenue. If revenues in calendar year 2020 are less than calendar year 2019, then essentially there is lost revenue that can be used if you didn't use up your Provider Relief Funds with those expenses.

There are a few providers we work with, more than a few who have higher revenues in 2020 than in 2019. In one case we worked with a physician practice that expanded and their 2020 revenues are higher. They have no lost revenue. Another case of hospital added services and added a second campus and their revenues in 2020 are higher when you look at it on the calendar year to calendar year basis. In the third case, a surgical practice we work with was able to make up ground on elective cases after the shutdown, and their 2020 revenue is higher than 2019. All of these situations result in no lost revenue by definition.

Just on Tuesday of this week, we got additional clarification that other assistance, which would be monies like PPP and FEMA, that those are used in the calculation of 2020 operating revenue in that calculation of year over year change and that's defined here. That's also added in here in the first bullet. It shows you how quickly things can change and how quickly a definition can be changed or clarified. Now, I mentioned, of course we try to use up all of our Provider Relief Fund monies with expenses and then lost revenue. What if we don't? What if we are still left with some unused Provider Relief Fund monies at the end of 2020?

Well, HHS has said they'll give us until June 30th of 2021 to be able to expend those dollars. There's actually a formula that compares 2021, the first six months, against the same period in 2019, and then if at that point you've not absorbed all of the Provider Relief Fund dollars you've received, then there's probably going to be a need to return that money. We're still waiting on guidance as to actually how you go about returning those funds.

Jeff Grandia: Hey Greg.

Greg Anderson: Yes, Jeff.

Jeff Grandia: I think we've heard this from numerous organizations on both sides of us, which is just holding onto my money right now to kind of see where things land and then I'll kind of decide what I'm doing. I think what I just heard from you is the clock is ticking and we need to start thinking about that right now. Is that true?

Greg Anderson: We really do, and we're going to talk a little bit about the reporting requirements. While I threw out a July... a June 30th period of 2021 to complete the expenditure of the Provider Relief Funds or the use through lost revenues, there's some reporting requirements that are going to sneak up on us pretty quickly and I'll talk about those in just a minute. Great question. Thank you. All right, this slide gives us an example of how we put the numbers on the paper. I've got a couple of scenarios for a year to think about.

The first scenario is where we have lost revenue. The second scenario is where we have no lost revenue. In both cases assume that our provider received $70 or $70 million or $70,000, however you want to look at it and so $70 in Provider Relief Fund payments received. We first apply our expenses against that $70 number. In our case, our provider had $64 or $64 million in healthcare related expenses, the G&A and the other healthcare expenses attributable to coronavirus and they had $20 reimbursed by other sources. This leaves $44 then that we can apply to our Provider Relief Fund payments to support the dollars that we've received. There's $26 left over now that we have to figure out what to do with.

This is where the step two comes into play, the lost revenue calculation. If you look down below the $26, you see in scenario one, our provider had $370 in patient care revenue in 2019 and in 2020, that number dropped to $315. We have to include others assistance received as I mentioned from the guidance we got last week, so the calculus is 370 minus 325 means that we've got lost revenues of $45. We can use all of our $26, we're not capped, and we can use it all the way up to $45. Of course, all we had was $26 of Provider Relief Fund money's left, so we're able to use all of those monies and we don't have to worry about any unexpended Provider Relief Funds.

In the right-hand column though, our scenario two, we only had $300 in lost revenue in 2019, so we have zero lost revenue when you compare it to 2020 and so therefore we have no lost revenues to use to absorb our $26 that remained. That money will have to be carried over into 2021, and there's a possibility we might have to give some of that money back. I hope that gives you an example of how this thing actually works and you'd be surprised... You probably wouldn't be surprised to see how many iterations of this we've had as the guidance has changed.

Jeff, to your point about just how quickly we need to be thinking about these things, when does this stuff get reported to HHS? We know, and it's mentioned even in the terms and conditions that all our providers signed when they

received money, that we're going to have to report this stuff and fortunately, we didn't have to report on July 10th for for June 30th money. We didn't have to report the third quarter, but we do have a reporting period that's coming due January 15th of 2021. Between January 15th and February 15th, we'll have to report on our uses of the Provider Relief Fund monies through December 31st of 2020.

And then as I mentioned before, if there's any monies that are not used by 12/31/20, we'll have a second report that's due after June 30th, that will be due July 31st of 2021. Here we are now, November 4th and we've got a January 15th opening date for the reporting system. It's really time to start thinking about this kind of stuff. Do we expect additional guidance between now and January 15th? Additional guidance on how to report what has to be reported and what we can use clarification's about expenses and lost revenue? Absolutely yes. Again, back to Jeff's question earlier, these are definitely things that we need to be thinking about.

Jeff Grandia: So Greg.

Greg Anderson: Yeah.

Jeff Grandia: We've both been in numerous conversations related to reporting and how reporting happens. Now, in most organizations that I think we talked to, are somewhere between 15 and a hundred million dollars in receiving funds.

Greg Anderson: Yes.

Jeff Grandia: When it comes up to reporting, the organization really quickly says, "Hey, the finance team, or even the legal team, they're kind of handling this for us." And everybody kind of puts their head down and walks away. Help me understand is that... As we're talking to people about the reporting and preparing themselves for reporting, is this just a finance issue? Is this just a legal issue? I think you went through some other slides when it went to all the eligible services which I think are clinical items, and just wanted your perspective on that.

Greg Anderson: Yeah. It's an all hands on deck process, Jeff. That is an outstanding question. Just to give you a couple of examples of hospitals that we've worked with in this. First of all, it is truly all hands on deck. They've created a cost center, for example, for COVID and they're relying on people in departments and service lines to cost correctly to the COVID cost center. In some cases they're having to go back and turn over some stones because their concerns are that some of those costs have not been captured, especially when it became an expense first calculus.

Now people are going back to the drawing board saying, have we really captured all the costs that we need to capture, especially if they have a situation

where they don't have lost revenues. Of course, it is a big issue for finance. It's a big issue for legal and compliance. We've seen folks in finance that have said this is just an additional burden that I can't take on in addition to what I already have in the way of duties and responsibilities. They've called in help, if you will, to just kind of pick up and help with expense capture, making sure these expenses are captured in the right place and making sure the documentation is in place.

I mentioned early on in the session today, Jeff, that FEMA is oftentimes viewed as the source of last resort for funding. That's because in some cases there's limited applicability of these types of expenses to the FEMA Category B funds, but also there's a large local matching requirement, and so it becomes a process quite often of saying, okay, we've got money from FEMA, we've got money from the state through the Cares Act, we've got Provider Relief Fund dollars. We've got buckets, where do we put this money? Which bucket does this money go into so that we can maximize the amount of money that we have and minimize the money that we've got to send back.

That's a big question, especially for finance and it's something where Jeff, frankly, a lot of our clients are saying, "I've got my hands full already and really needs some help dealing with this." Is that what you're hearing as well, Jeff?

Jeff Grandia: Absolutely. Is there a standard approach that you would suggest, or there are multiple different approaches to solving this challenge?

Greg Anderson: Yeah. There are multiple approaches. We work with anywhere from physician practices of varying sizes to very large healthcare systems and it varies. It varies from provider to provider, varies depending on the type of money you received as well. As you know and probably everybody in the audience today, the requirements of each of these different types of funds vary as well and so it's important to track all of those funds and their requirements so that you don't run afoul of those. Jeff, that question is a great segue into the audit responsibility, because a big part of this is going to be audit enforcement oversight that comes along with this.

For example, the single audit is something that some of our clients have not really experienced before, but because they received $750,000 or expended more than $750,000 in federal financial assistance, then they're going to be subject to a single audit. This slide gives some of the overview of that and kind of a synopsis of the single audit. I guess it goes without saying that because the federal funding is involved, I think we have to look at federal oversight and enforcement as inevitable. I think the big push in 2020 has been to get dollars out to providers but I think as time passes, memories will grow a little short and we'll see bad actors and fraudsters.

Fortunately I think what we hear from both the... from the prognosticators, and I guess the folks with the crystal balls is that maybe providers are not as much in the cross hairs of enforcement maybe as fraudsters might be, but I still think we're likely to see some enforcement down the road and it's just better to be prepared now, whether we're talking about a single audit or to be prepared now for the possibility that there might be some enforcement activity. It's better to do that now than to try to cobble together information when an auditor shows up or want to know why OIG investigator shows up at the door. In this slide here's some audit... Yeah. Jeff.

Jeff Grandia: Related to that, I think we've heard a few times recently of, okay, with the new administration coming in, the possibility of a new administration coming in or changes in the government, does the auditing process change or is this is a unique experience? I'd love to share that... when we talk about A-133 audits or those single audits. They've been around for a long, long time.

Greg Anderson: They have.

Jeff Grandia: It didn't just start with these bills, and compliance requirements have been around for a long, long time and I think people just need to expect this isn't going to change and the idea that, oh, we're going to get a new administration. Maybe the auditing process is going to change or... well, this is a foundation that people need to prepare themselves for.

Greg Anderson: It absolutely is. This is not new news. This is stuff that's been around for a long time, as you said. As people start thinking about budget deficits and liquidity of the Medicare program and that kind of fiscal responsibility for the nation, I think enforcement's still going to be... when you think about the ROI that enforcement agencies or that agencies experience in their enforcement activities, it's a good return on the investment. This is something that's been around and it's not going to go away. There's another thing about all of this as well and it relates a lot to the audit.

There've been a lot of contentious issues around the delay and the fluid definitions especially as it relates to lost revenue. The fact that the calendar year measurement is so important in this case, it's really created havoc for a lot of our fiscal year clients. Fiscal year hospital systems have been really kind of struggling with what is our revenue recognition look like for our fiscal year or 9/30 fiscal year end or June 30 fiscal year end during 2020. Because this being calendar year, it really can't make that determination until after December 31.

A lot of our hospital clients have been talking with their audit firms to just get some consensus around what the revenue recognition strategy looks like for this fiscal year ending in 2020. I would encourage you that if you've... If you're thinking about audit, if you have a financial statement audit and you're concerned about revenue recognition, definitely requires some collaboration

with your audit firm to make sure that all of that is clear and that you're not hit with any huge surprises at the end of the year, any major audit adjustments that you weren't expecting. Jeff, I'll turn it back over to you for some of the immediate issues that you're seeing in the way of financial survival and cashflow pressures and things like that.

Jeff Grandia: Well, I think when we discuss immediate issues, Greg, you and I have talked about this for months and months. The financial impacts are very clear, but the organizational impacts are really clear too. When you think about staffing challenges, when you think about tracking of patients, when you think about team members that have acquired the virus and are outside of... do organizations actually have the foundations in place to be able to track revenues and to predict what next week looks like, what next month looks like.

When we start thinking about the common issues and immediate challenges, what we hear a lot is, okay, I'm trying to react to what's happened to me this week. The daily stand-ups, the emergency calls, the community changes across all these communities, all of our communities is so tough to deal with, but do you have the financial tools? Do you have the technical foundation and the organization structure to be able to do... as you can see in the bottom report and have insights and to predict what's happening. If you really haven't structured those to address those immediate issues, we would highlight that this is something that you should be looking at right now, because... and we'll talk about it in a minute or two.

The effects of this funding, the effects of the virus isn't something that's going to be going away as quickly as everyone likes to announce, but the reality is we have some long-term preparation. Building that foundation and making sure the foundation is in place so that you can track patients, so that you can track your costs as Greg defined earlier, so that you can track your team members, you can predict. We would just highly encourage that. We have a lot more to discuss there, but based on timing kind of move, but wanting to make sure as you're thinking about immediate issues, have you really thought about the foundation in the organization to be able to respond.

Greg Anderson: And Jeff, I'd like to insert an observation here too, if I can. A lot of folks that I talk with are looking at timing of funding and timing of payback as a way to manage working capital. For example, consider a hospital that got Medicare Advanced payments. Now that there's a longer recoupment window there, they're using those funds along with their line of credit to manage their short term cash flow needs. I would encourage you if you're not already doing so, look at this as a way of perhaps even addressing short-term cashflow struggles especially if you're having to reduce elective cases and things of that nature. Just wanted to insert that, Jeff.

Jeff Grandia: Awesome. Greg, are you covering this one?

Greg Anderson: I'll be glad to. The stimulus dollars that we've seen have been great, but they fallen far short of the impact. When we look at some hospitals that have a combination of lost revenue and a combination of additional expenses associated with the pandemic, the stimulus dollars have not really risen to the level that was necessary to keep the liquidity that was needed. Now, on the other hand, we've seen some rural facilities for example, small rural hospitals got rural dollars that are actually flushed with cash. Cash they haven't ever seen. They've not seen that much money in their bank accounts before.

There is a dichotomy, if you will, of providers and how they're affected by this additional funding, the emergency funding. It's certainly something that we realized that a lot of cases there are providers that don't have the funds necessary to really go into the future as strong as we'd like. Obviously the documentation associated with care is critically important and not only the care itself, but also the documentation that supports all of the expenses, the decisions about reassigning, furloughing people, all of these things that go into that.

There's also perhaps a potential in pent up demand. We've seen anywhere from patient visitor policies to patient concerns about the cleanliness and sanitary conditions in a hospital. A lot of it is just folks don't know, and they're a little hesitant to make a trip to the doctor's office or to the hospital and I think there's demand there that's still untapped that we may see. We were talking about cash before, but expense management is of course an important part of this as well as just the fact that the payer mix is going to look different.

Our payer mix is gonna look different. Our rates are going to look different. Our case mix will look different. Patient acuity will look different, so all of these things come into play and of course it's important to have support from legal and compliance, and it's great to have a plan, but as... Jeff, I appreciate the quote here. A good plan today is better than a perfect plan tomorrow. Thanks to General Patton. Jeff.

Jeff Grandia: Yeah. We also want to talk about... and we talked about it earlier in this conversation, so we'll be quick. We certainly recognize all the different organizational structures in addressing recovery funding, but we want to make sure that as you're thinking about your funding and how you handle it, it's not just turned over to the finance team or the legal team to manage that process. That there are vast opportunities for the clinical team to explore, the operations teams to evaluate, and then mutually prepare yourselves for the audits and make sure that there's a decision-making process.

We can go into deep discussions about organizational structures and looking at the time here, Greg and so we kind of jumped from there. I wanted to make sure that you think about the organizational structure and if it's prepared to really deal with these funds appropriately, and then the second thing that we

wanted to talk about was quickly around team structure. We hear quite frequently, "Hey, we've just set up this team to deal with this funding and you're planning on it on a temporary basis." Why don't you just... to think about based on experience, think about the 2009 Obama stimulus or ARA funding. It was primarily for infrastructure builds and infrastructure growth across the country, but there was a bunch of different funding elements.

You recognize that was $800 billion in funding and how massive that was, and recognizing the process that audits and compliance and tracking of that funding was literally ended basically December of 2019. There was 10 years of processing that happened through that funding. The idea of, hey, I'm going to structure a temporary team or a small team to deal with my A-133 or simple audit that's coming in and then we don't need to worry about this. Well, be prepared that this is a long-term journey. When you think about the... you have $25 million to expand your ED or to buy a physician group or to partner in different ways, how many meetings, how much of the organization is involved in that conversation? And now we're talking about the same kind of things needed for COVID recovery and the organization structure and how the stimulus funding can tie to those.

It really does have all facets of the organization to think through and the dollars are significant enough for everyone to pay attention and then that permanent team to realize that there's going to be audits and tracking for many years to come.

Greg Anderson: Jeff, thank you. I hope that our conversation today has given you a steering wheel to use as you're driving flat out pedal to the metal in the car along this journey. Things are coming out so fast as we talked about today. It's kind of helpful to take inventory of where you are and think clearly about some of the stops along the journey. We've put together a roadmap for you here that includes monitoring new rounds of funding, studying ever-changing guidance, executing a plan around documentation, using fact-based decision-making, engaging your leadership to think about kind of a post COVID strategy including virtual care and brick and mortar strategies and capitalizing on changes in patients and considering who your competitors and consolidators in your market will be.

I guess, as we kind of wrap up and you exit the chicane, it turned six here on our map. Jeff and I'd like for you to think about really beyond the pandemic and the next four years to what's possible in your healthcare business. COVID-19 will come to an end and there will be future challenges, even perhaps future pandemics to overcome. How we move on from here will determine longevity, patients' wellbeing for years to come, and so we hope that this gives you an opportunity to steward your resources a little better and to communicate a little better with your teams and think forwardly about what goes on beyond the pandemic.

Jeff, if you have any other thoughts, welcome those, if not we'll pass it to Brooke for the Q&A session.

Jeff Grandia: Thank you, Greg. Now, let's turn it over to Brooke.

Brooke MacCourtney: Right. Thanks Greg, thanks Jeff for the great presentation. If anyone has questions for Greg and Jeff, now's a great time to submit them in the GoToWebinar control panel. Before we jump into our Q&A, we have one last poll question for you. Go ahead and launch that. While today's webinar was focused on how to appropriately receive and optimize COVID-19 relief funding, some of you may want to learn more about HORNE and, or Health Catalyst's other products and professional services.

If you'd like to learn more, please answer this poll question. I'm going to go ahead and leave that open for a few minutes while we start with our questions. All right. Looks like we have bit of a scenario question from Robert. He says, so no matter what, if your revenues in 2020 were higher than 2019 than disallows any of that which was the main source of…Yeah.

Jeff Grandia: Can you repeat the question, you kind of cut out on us.

Greg Anderson: Broke up a little bit there.

Brooke MacCourtney: Sorry about that. Okay. Let me start again. This is a bit of a scenario question, we've got kind of three comments coming in from Robert. He says, so no matter what, if your revenues in 2020 were higher than 2019, that disallows any of that, which was the main source of our original app, even though during the eight week period, late March, early April and May, our revenues were way down. He says, can and should we pay some back in 2019? This will have per year tax implications for cash basis, taxpayers. Then he says a step further, we had collection issues in 2019 that carried over so a good chunk of our 2020 collections was a catch-up from 2019, but as a cash basis there, it looks like 2020 was higher. I guess he just looked for some advice on that situation.

Greg Anderson: Yeah. There are several questions built into that one. Thank you, Robert. I appreciate the question there. That's a very good one and one that we've heard more than once I can assure you. Decisions that were made between 2019 and 2020, things like changes in rev cycle, things like catching up on collections and doing things like that, that pushed revenue from 2019 into 2020 really resulted in like the example that I gave you earlier on the screen. No lost revenue in the calculation, but the good thing is we do have the ability to look first at the expenses.

My encouragement to you would be, I assume you've received some Provider Relief Fund dollars. Look at the Provider Relief Fund dollars you got. If you received a hundred dollars in Provider Relief Funds, look to your expenses.

Doesn't sound like you've got a lost revenue number for that step two calculation, but look at your expenses. Look at the general and administrative expenses. Look at those healthcare related expenses that were defined on the slides. There's some guidance dated October 28th in the frequently asked questions to give you some more guidance about how to calculate those expenses.

I would do what we talked about a few slides back, and that is have your finance team turn over as many stones as they can looking for those direct expenses associated with COVID that you've had to... additional security, hiring people to do temperature checks at the doors, renting a tent for testing, incurring PPE costs and testing supplies. All of those things that are expenses that you've incurred in 2020 that you didn't have in the previous year, and then also look at that general and administrative cost categories well. There may be some costs associated with that like the example I gave of the cost of an office visit that you can capitalize on and use against your Provider Relief Funds.

Unfortunately, if you don't have many expenses or even if you do, and they just don't rise to the level of the hundred dollars you got and Provider Relief Fund, doesn't sound like you've got lost revenues yet. Keep that lost revenue calculation open all the way through June 30th of next year and let's see how that actually looks because you might have an opportunity to calculate loss revenues for 2021, and they give us until June 30th. I would look at expenses, I'd look at both of the categories of expenses. I'd leave that loss revenue kind of equation in the back of your mind and look at that even beyond the calendar year 2020, because you may be able to pick up some dollars there in 2021 by looking at loss revenues of January to June 2021 compared to January to June of 2019.

Again, I hate that it's a calendar year. This was something that came out on September 19th in some of the guidance but unfortunately I think that's the cards we're dealt, I guess. But thank you for the question. Excellent question.

Jeff Grandia: Hey Greg.

Greg Anderson: Yeah. Jeff.

Jeff Grandia: One deeper dive there. We've talked a lot about this in the past related to command centers and COVID stand up meetings where you have organized... and I think the vast majority of our organizations have those internal meetings happening daily or weekly and training. Well, are those eligible expenses in the process?

Greg Anderson: Yes. [crosstalk 00:58:38].

Jeff Grandia: The preparation time of those meetings, the meeting time... the labor that's in those meetings, is that available?

Greg Anderson: Yes. Yes it is. We're capturing those kinds of calls from a regular basis. If you've got folks that are reassigned from administration, physician. I mean this is counting a multifaceted sort of team approach to this. We're capturing the cost of the time associated with the pay rates because these are expenses that we're incurring directly in preparing for and responding to coronavirus.

Jeff Grandia: Good deal. Thank you.

Greg Anderson: All right. Brooke, any other questions?

Brooke MacCourtney: Yes. We've got another one from Scott. He says, I believe you stated that PPP... can you hear me?

Greg Anderson: Yes.

Brooke MacCourtney: Can you hear me, Greg?

Greg Anderson: Yes.

Brooke MacCourtney: Okay. Let's start over. Sorry. Scott says, I believe you stated that PPP revenue must be included in the 2020 revenues used in the lost revenue calculation. That contradicts the phase three application instructions definition of revenues as patient service only excluding grants, PRF and it seems to not be in the spirit of the calculation. If PPP must be included, I assume it would only be considered 2020 revenue if forgiven in 2020.

Greg Anderson: That is correct. Scott. That's a great question. I'm looking at my frequently asked questions. I may not be able to pinpoint it while we're on the call today, but it is clearly identified in the frequently asked questions. Actually, if you look to the version that was dated November 2nd, that question is specifically addressed in that guidance. I would point you to that. If you still are unable to find that and want to talk offline, I'm happy to have a conversation with you and share with you that guidance. Yeah. It's unfortunate that you have to make that as part of the calculation but that is clearly spelled out in the guidance.

Brooke MacCourtney: Okay. Next question is from Chris. He says, if a hospital was forced to stop providing most of its services by the state for a period of time, would the cost during that period spent preparing for COVID and maintaining operating capacity, the allowable expenses to charge the Provider Relief Fund even if they're not incremental expenses?

Greg Anderson: That's another good question. Thank you, Chris for the question, and I actually have seen that question come up this week. There is a tax credit that's available

for employee expenses during the shutdown where employees were cut back in terms of their workload. There are other sources of repayment for that. It kind of becomes a question of, is this a better program to use? We talked about the buckets and where you might put costs in this bucket versus that bucket. The tax credit approach might be one way of looking at this without getting into the Provider Relief Fund dollars but if you're really looking to support the Provider Relief Fund dollars, I think there's clearly opportunity to look at those costs that are, especially those incremental costs that you might've paid during the shutdown.

For example, if you had to keep... if you had to have somebody on call while you were shut down and you paid somebody extra during that period of time, during the shutdown just to remain on call, that's a cost I would clearly capture and consider for the Provider Relief Fund.

Brooke MacCourtney: All right. Thanks Greg. Okay. We've got another question. Nicole asks follow up on the [S&W 01:02:16] related to people in meetings. It was just said those are eligible costs, but I was thinking those are not incremental costs because those employees are likely salary and preexisting expenses.

Greg Anderson: I didn't catch all of the question. I thought there was something I heard early on, Brooke. Can you read that back one more time please?

Brooke MacCourtney: Yeah. Yes. Nicole asks, follow up on the S&W related to people in meetings, it was just said those are eligible costs, but I was thinking those are not incremental costs because those employees are likely salary and preexisting expenses.

Greg Anderson: We have seen... of course there are some limitations on what you can pay employees. There's executive level to limit of $197,300. There've been some guidance actually released on recently. I think maybe October 28th with some additional guidance about just the calculation of payroll. If you are reassigning somebody that's salaried we've actually used an overhead allocation based on the time that the individuals have been spending in those command center meetings to capture those hours as being associated with preparing and responding to COVID-19.

While I certainly see that it's not an incremental expense if that's a salaried individual, we have looked at the allocation of cost if somebody has been reassigned to participate in that command center as an expense of responding to COVID.

Jeff Grandia: So Greg, I think this question's been asked a lot, which was the reason why it was highlighted. When you think about these funds that were primarily to prepare, prevent, and recover from coronavirus, and you think about a meeting that's structured for the organization to address coronavirus. Well, yes, all those

FTEs in the organization are already salary team members. Well, the cost and allocation for that time, if you can figure out a reasonable way to manage that and be able to document that cost, it actually is an eligible cost and an expense for us to track.

Greg Anderson: That's right. Well said.

Brooke MacCourtney: Great. Okay.

Greg Anderson: Brooke.

Brooke MacCourtney: We've got two more. We're a couple of minutes over at the top of the hour, but we'll keep going. Joel asks, can a critical access hospital that is cost reimbursed have COVID related costs that are not covered elsewhere?

Greg Anderson: We've actually... we said that was a critical access hospital, Brooke?

Brooke MacCourtney: Yeah.

Greg Anderson: Okay. Yeah. That question has come up a lot, Joel, the issue of critical access hospitals. There's actually been some guidance released about the cost report based reimbursement. If that reimbursement is kept and so therefore there's no additional reimbursement at the critical access hospital level, then there's not really considered to be an additional reimbursement to offset against those expenses. We've also seen a need for critical access hospitals to really kind of stop and take inventory of what their numbers look like through maybe an interim cost report calculation, just to see if there is any sort of impact on their revenues for purposes of financial statement reporting.

I think that's kind of a two-part answer to your question, but I think, yes, you kind of have to look at the cost-based reimbursement and if it is not subject to a cap, then you could run into some problems there. If it is subject to a cap, then it's highly likely that you can use the expenses without offsetting against those Provider Relief Fund dollars. Brooke.

Brooke MacCourtney: Okay. Thanks, Greg. All right. Our last question, it's from Robert again to follow up on his first question. He said, what about after taking all you said into account, we will still have excess funds received at June at 2021. Should or can we still pay back funds in 2020 if we choose?

Greg Anderson: No, I have not seen any provision that allows you to pay back any monies now. HHS has said they will come out with guidance on repayment of those funds before the July 31 reporting deadline, the July 31, 2021 reporting deadline. There was a process during the attestation phase where if you wanted to reject those funds, you could reject them in the attestation portal and send the entire check back to HHS, but if you've kept that money, if you've attested to the

receipt of those funds, now you're really kind of in a holding pattern until you identify how much of those funds are excess beyond your lost revenues in COVID expenses that you would have to return and we're expecting to receive direction from HHS.

I would say somewhere in the summer of 2021 with guidance on how to return those monies.