HRSA
Health Resources & Services Administration

# Provider Relief Fund
# Phase 4 General Distribution
# Supporting Documentation

***Wednesday, October 13, 2021***

Vision: Healthy Communities, Healthy People

## Welcome

Thank you for joining. Please allow a few minutes for attendees to join the webcast.

## Webcast Recording

A recording will be made available on HRSA's website in the days following today's session.

## Questions

Please submit all questions through the webcast chat feature. We will compile all inquiries and review them after the webcast to address via the program's FAQs.

# Today's Speakers

**Chris Lundquist**

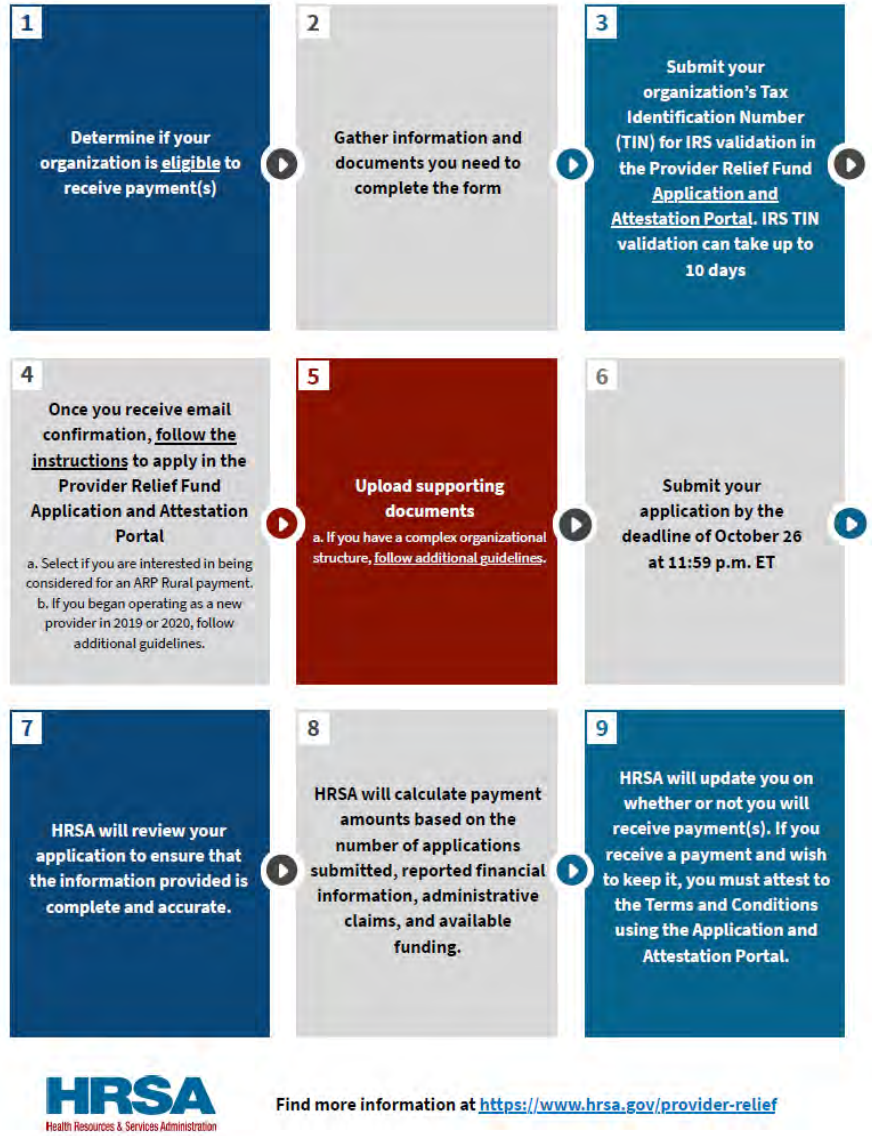
Health Communications Specialist
Division of Policy and Program Operations
Health Resources & Services Administration (HRSA)
Provider Relief Bureau

**Sara Williams**

Senior Advisor
Division of Policy and Program Operations
Health Resources & Services Administration (HRSA)
Provider Relief Bureau

# Agenda

- Supporting Documentation: Operating Revenues and Expenses from Patient Care
- Supporting Documentation: Total Annual Revenues and Annual Net Patient Care Revenues
    - Financial Scenarios



# Preparation for Today's Webinar

- Overview and Portal Demo – view the webcast
- Phase 4 and ARP Rural application instructions: hrsa.gov/provider-relief/future-payments/phase-4-arp-rural
- Fact Sheet - Complex Organizational Structures
- Annual Revenues from Patient Care Worksheet
- Annual Revenues Adjustment Worksheet

# The Importance of Supporting Documentation

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# Phase 4 Payment Methodology

***Step 1:*** TIN Validation

***Step 2:*** Calculation of Initial Loss Ratio and Provider-Type Loss Ratio

***Step 3:*** Identifying Flags

***Step 4:*** In-Depth Review (i.e. Supporting Documentation review)

***Step 5:*** Payment Adjustments, Caps, and No Payment

## Payment Adjustments Based on Review in Step 4

| Anomalous Financial information | Resolved (documentation fully supports reported figures) | Not Resolved - Reasonable (some inaccuracies in supporting documentation) | Not Resolved - Insufficient (missing or inaccurate information) |
|---|---|---|---|
| Loss ratio greater than $N^{th}$ for their provider type | Paid based on ***submitted*** figures | Adjusts Quarterly Losses to **$N^{th}$ percentile** based on provider type | *No Payment* |
| Single quarter revenues or expenses greater than X% of the applicant's total annual revenues | Paid based on ***submitted*** figures | Caps Quarterly Losses at **mean** Provider-Type Loss Ratio | *No Payment* |
| High potential payment | Paid based on ***submitted*** figures | Caps Quarterly Losses at **mean** Provider-Type Loss Ratio | *No Payment* |

*More information is available at [www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural/payment-methodology](www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural/payment-methodology).*

# Supporting Documentation: Operating Revenues and Expenses from Patient Care

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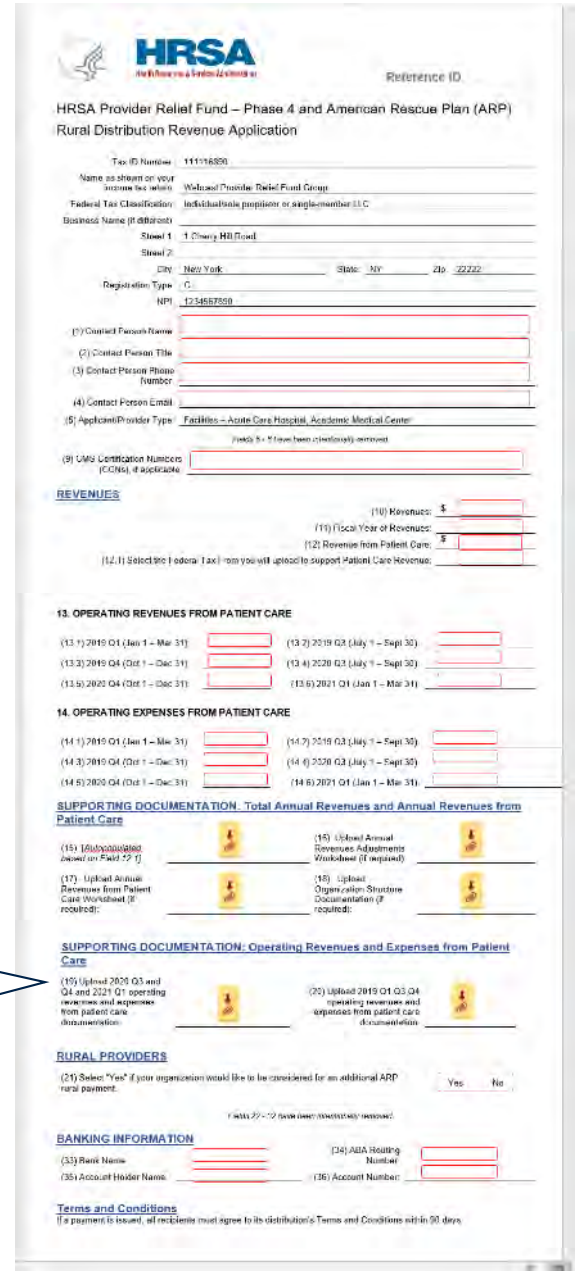
# Supporting Documentation: Operating Revenues and Expenses from Patient Care

| | Pre-pandemic | Quarters for Calculating Phase 4 Base Payment |
|---|---|---|
| Comparison quarters | 2019 Q3 | 2020 Q3 |
| | 2019 Q4 | 2020 Q4 |
| | 2019 Q1 | 2021 Q1 |

**SUPPORTING DOCUMENTATION: Operating Revenues and Expenses from Patient Care**

(19) Upload 2020 Q3 and Q4 and 2021 Q1 operating revenues and expenses from patient care documentation:

(20) Upload 2019 Q1,Q3,Q4 operating revenues and expenses from patient care documentation:



# Supporting Documentation: Operating Revenues and Expenses from Patient Care

**Required**: All applicants to substantiate operating revenues and expenses (Fields 13.1 – 13.6 and 14.1 – 14.6)

Applicant may submit internally-generated financial statements or a classified trial balance groupings report reconciled to the claimed amounts in the application

Patient Care Operating Revenues:

- Net patient service revenues (gross charges minus contractual adjustments)
- Exclude "other operating revenue" and non-operating revenue, such as investment income, joint venture income, etc.

Patient Care Operating Expenses:

- Salaries and benefits
- Supplies
- Professional services
- Administrative
- Depreciation
- Interest

# Operating Revenues

| | 2019 Q1 | | | 2019 Q3 | | | 2019 Q4 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Patient | Non-Patient | Total | Patient | Non-Patient | Total | Patient | Non-Patient | Total |
| Patient service fees | 100,100 | - | 100,100 | 100,300 | - | 100,300 | 100,400 | - | 100,400 |
| Management fees | - | 10,100 | 10,100 | - | 10,300 | 10,300 | - | 10,400 | 10,400 |
| Rental income | - | 25,100 | 25,100 | - | 25,300 | 25,300 | - | 25,400 | 25,400 |
| Interest & dividends | - | 1,100 | 1,100 | - | 1,300 | 1,300 | - | 1,400 | 1,400 |
| Miscellaneous income | 100 | 2,100 | 2,200 | 300 | 2,300 | 2,600 | 400 | 2,400 | 2,800 |
| Total revenues | 100,200 | 38,400 | 138,600 | 100,600 | 39,200 | 139,800 | 100,800 | 39,600 | 140,400 |

| | 2020 Q3 | | | 2020 Q4 | | | 2021 Q1 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Patient | Non-Patient | Total | Patient | Non-Patient | Total | Patient | Non-Patient | Total |
| Patient service fees | 150,300 | - | 150,300 | 150,400 | - | 150,400 | 150,100 | - | 150,100 |
| Management fees | - | 15,300 | 15,300 | - | 15,400 | 15,400 | - | 15,100 | 15,100 |
| Rental income | - | 40,300 | 40,300 | - | 40,400 | 40,400 | - | 40,100 | 40,100 |
| Interest & dividends | - | 1,300 | 1,300 | - | 1,400 | 1,400 | - | 1,100 | 1,100 |
| Miscellaneous income | 1,300 | 1,300 | 2,600 | 400 | 1,400 | 1,800 | 100 | 1,100 | 1,200 |
| Total revenues | 151,600 | 58,200 | 209,800 | 150,800 | 58,600 | 209,400 | 150,200 | 57,400 | 207,600 |

**13. OPERATING REVENUES FROM PATIENT CARE**

(13.1) 2019 Q1 (Jan 1 – Mar 31): 100,200

(13.2) 2019 Q3 (July 1 – Sept 30): 100,600

(13.3) 2019 Q4 (Oct 1 – Dec 31): 100,800

(13.4) 2020 Q3 (July 1 – Sept 30): 151,600

(13.5) 2020 Q4 (Oct 1 – Dec 31): 150,800

(13.6) 2021 Q1 (Jan 1 – Mar 31): 150,200

# Expenses from Patient Care

| | 2019 Q1 | | | 2019 Q3 | | | 2019 Q4 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Patient | Non-Patient | Total | Patient | Non-Patient | Total | Patient | Non-Patient | Total |
| Salaries & wages | 50,100 | 20,100 | 70,200 | 50,300 | 20,300 | 70,600 | 50,400 | 20,400 | 70,800 |
| Payroll taxes | 5,100 | 2,100 | 7,200 | 5,300 | 2,300 | 7,600 | 5,400 | 2,400 | 7,800 |
| Employee Benefits | 8,100 | 3,100 | 11,200 | 8,300 | 3,300 | 11,600 | 8,400 | 3,400 | 11,800 |
| Purchased services | 3,100 | 2,100 | 5,200 | 3,300 | 2,300 | 5,600 | 3,400 | 2,400 | 5,800 |
| Medical supplies | 15,100 | - | 15,100 | 15,300 | - | 15,300 | 15,400 | - | 15,400 |
| Office expenses | 2,100 | 1,100 | 3,200 | 2,300 | 1,300 | 3,600 | 2,400 | 1,400 | 3,800 |
| Rent | 5,100 | 5,100 | 10,200 | 5,300 | 5,300 | 10,600 | 5,400 | 5,400 | 10,800 |
| Interest | 1,100 | - | 1,100 | 1,300 | - | 1,300 | 1,400 | - | 1,400 |
| Depreciation | 7,100 | 2,100 | 9,200 | 7,300 | 2,300 | 9,600 | 7,400 | 2,400 | 9,800 |
| Total Expenses | 96,900 | 35,700 | 132,600 | 98,700 | 37,100 | 135,800 | 99,600 | 37,800 | 137,400 |

| | 2020 Q3 | | | 2020 Q4 | | | 2021 Q1 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Patient | Non-Patient | Total | Patient | Non-Patient | Total | Patient | Non-Patient | Total |
| Salaries & wages | 60,300 | 15,300 | 75,600 | 60,400 | 15,400 | 75,800 | 60,100 | 15,100 | 75,200 |
| Payroll taxes | 7,300 | 3,300 | 10,600 | 7,400 | 3,400 | 10,800 | 7,100 | 3,100 | 10,200 |
| Employee Benefits | 10,300 | 5,300 | 15,600 | 10,400 | 5,400 | 15,800 | 10,100 | 5,100 | 15,200 |
| Purchased services | 5,300 | 3,300 | 8,600 | 5,400 | 3,400 | 8,800 | 5,100 | 3,100 | 8,200 |
| Medical supplies | 50,300 | - | 50,300 | 50,400 | - | 50,400 | 50,100 | - | 50,100 |
| Office expenses | 4,300 | 2,300 | 6,600 | 4,400 | 2,400 | 6,800 | 4,100 | 2,100 | 6,200 |
| Rent | 10,300 | 10,300 | 20,600 | 10,400 | 10,400 | 20,800 | 10,100 | 10,100 | 20,200 |
| Interest | 2,300 | - | 2,300 | 2,400 | - | 2,400 | 2,100 | - | 2,100 |
| Depreciation | 15,300 | 4,300 | 19,600 | 15,400 | 4,400 | 19,800 | 15,100 | 4,100 | 19,200 |
| Total Expenses | 165,700 | 44,100 | 209,800 | 166,600 | 44,800 | 211,400 | 163,900 | 42,700 | 206,600 |

**14. OPERATING EXPENSES FROM PATIENT CARE**

(14.1) 2019 Q1 (Jan 1 – Mar 31): 96,900

(14.2) 2019 Q3 (July 1 – Sept 30): 98,700

(14.3) 2019 Q4 (Oct 1 – Dec 31): 99,600

(14.4) 2020 Q3 (July 1 – Sept 30): 165,700

(14.5) 2020 Q4 (Oct 1 – Dec 31): 166,600

(14.6) 2021 Q1 (Jan 1 – Mar 31): 163,900

# Key Take Aways

- All applicants must submit supporting documentation in Fields 19 and 20
- Documentation must match operating revenues and expenses reported in Fields 13.1 – 13.6 and 14.1 – 14.6
- Exclude “other operating revenue” and non-operating revenue, such as investment income, joint venture income, etc.
- If documentation is broken down by months within a quarter, ensure the total is equal to the respective quarterly amount.

# Supporting Documentation: Total Annual Revenues and Annual Net Patient Care Revenues

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# Fields for Supporting Documentation

- Field 15 - Annual Revenues
- Field 16 - Annual Revenues Adjustments Worksheet and documentation
- Field 17 - Annual Revenues from Patient Care Worksheet
- Field 18 - Organization Structure

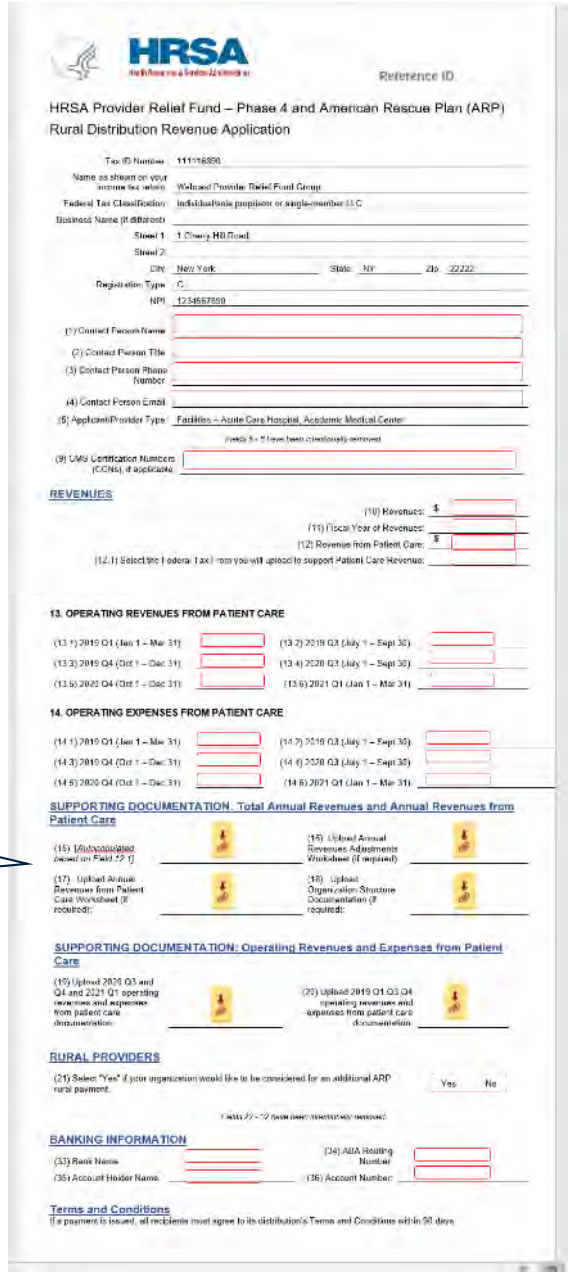
**SUPPORTING DOCUMENTATION: Total Annual Revenues and Annual Revenues from Patient Care**

(15) *[Auto-populated based on Field 12.1]*

(16) Upload Annual Revenues Adjustments Worksheet (if required):

(17) Upload Annual Revenues from Patient Care Worksheet (if required):

(18) Upload Organization Structure Documentation (if required):


HRSA

Reference ID:

HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP)
Rural Distribution Revenue Application

REVENUES

13. OPERATING REVENUES FROM PATIENT CARE

14. OPERATING EXPENSES FROM PATIENT CARE

SUPPORTING DOCUMENTATION: Total Annual Revenues and Annual Revenues from Patient Care

SUPPORTING DOCUMENTATION: Operating Revenues and Expenses from Patient Care

RURAL PROVIDERS

BANKING INFORMATION

Terms and Conditions

# Field 15 - Annual Revenues Documentation

**Required**: All Applicants

Supports figures reported in Field 10 - Total Annual Revenues and Field 12 - Annual Net Patient Care Revenues

**Requirements**:

- Document submitted in its entirety
- Use documentation from most recently filed or completed fiscal year

# Field 15 - Annual Revenues Documentation

| If the applicant for tax purposes is a… | The applicant must submit: |
|---|---|
| **Sole proprietor or disregarded entity owned by an individual** | IRS Form 1040 including Schedule C |
| **Trust or estate** | IRS Form 1041 including Schedule C |
| **Partnership** | IRS Form 1065 |
| **C corporation** | IRS Form 1120 |
| **S corporation** | IRS Form 1120-S |
| **Tax-exempt organization** | IRS Form 990 |
| **Not required to file federal income taxes (e.g. Government entities)** | Most recent audited financial statements (or management-prepared financial statements) and a statement explaining why the entity is not required to file a federal income tax form. |

If the applicant is required to file a federal income tax return

**Filed federal income tax return** for 2018, 2019, or 2020

If the applicant is exempt from filing a federal income tax return

**Audited financial statements**

If the applicant does not have tax filings or audited financial statements

Internally-generated **financial statements** (e.g., four quarters of SF-425 forms; annual report submitted to Unified Financial Management System)

# Scenarios Requiring Annual Revenue Documentation

Additional documentation is needed in the following scenarios:

1. Provider is **not required to file** federal income taxes
2. Amounts reported in Fields 10 and/or 12 are more than **5% greater or 50% less than** the amounts in the document uploaded in Field 15
3. Parent entity is applying on behalf of **multiple subsidiaries**
4. Applicant's TIN **does not match** TIN in the document uploaded in Field 15
5. Annual revenues are **not entirely related to patient care**

# Scenario 1: Not required to file federal income taxes

**Required**: Tribal entities, and state and local governments that are not required to file taxes

**Field 15:**

- Most recent audited financial statements or internally prepared management statements
- Statement explaining why the entity is not required to file a federal income tax form

This Form is Provided for Information Only **Reference ID**

# HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP) Rural Distribution Revenue Application

Tax ID Number: 11-1111111
Name as shown on your income tax return: EXAMPLE COUNTY HOSPITAL
Federal Tax Classification: GOVERNMENT
Business Name (if different):
Street 1:
Street 2:
City: State: Zip:
Registration Type:
NPI:

(1) Contact Person Name:
(2) Contact Person Title:
(3) Contact Person Phone Number:
(4) Contact Person Email:
(5) Applicant/Provider Type:

*Fields 6 - 8 have been intentionally removed*

(9) CMS Certification Numbers (CCNs), if applicable:

## REVENUES

(10) Revenues: $ 4,364,054,000
(11) Fiscal Year of Revenues: 2020
(12) Revenue from Patient Care: $ 3,915,931,000
(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: Audited financial statements

**EXAMPLE COUNTY HOSPITAL**
4567 Edgefield Road, Rhinebeck, MD 02134-0000

October 12, 2021

To whom it may concern;

Per the instructions, I am attaching this statement affirming that Example County Hospital is a county-owned hospital and, as such, is not required to file a federal income tax form.

Instead, I have attached the audited financial statements for Example County Hospital for fiscal year 2020 in Field 15. Please see page 20 for total annual revenues and annual net patient care revenues.

Thank you,

J Doe
President

P (555) 555.0123 F (555) 555.0124 E info@governmententitycommunityhospital.com

# Scenario 2: Reported revenues 5% greater or 50% less

**Required**: Applicants with Fields 10 and/or 12 that are more than 5% greater or 50% less than the amounts in the document uploaded in Field 15

## Field 16 - Annual Revenues Adjustments Worksheet

- Report on acquisitions or dispositions from the date of sale through the Phase 4 application deadline
- Include supporting documentation for any adjustments reflected on the worksheet (e.g., internally-generated financial statements, valuation reports that would reflect revenue, and budget-to-actual revenues comparisons)

**PARENT COMPANY, LP**

4567 Edgefield Road, Rhinebeck, MD 02134-0000

October 12, 2021

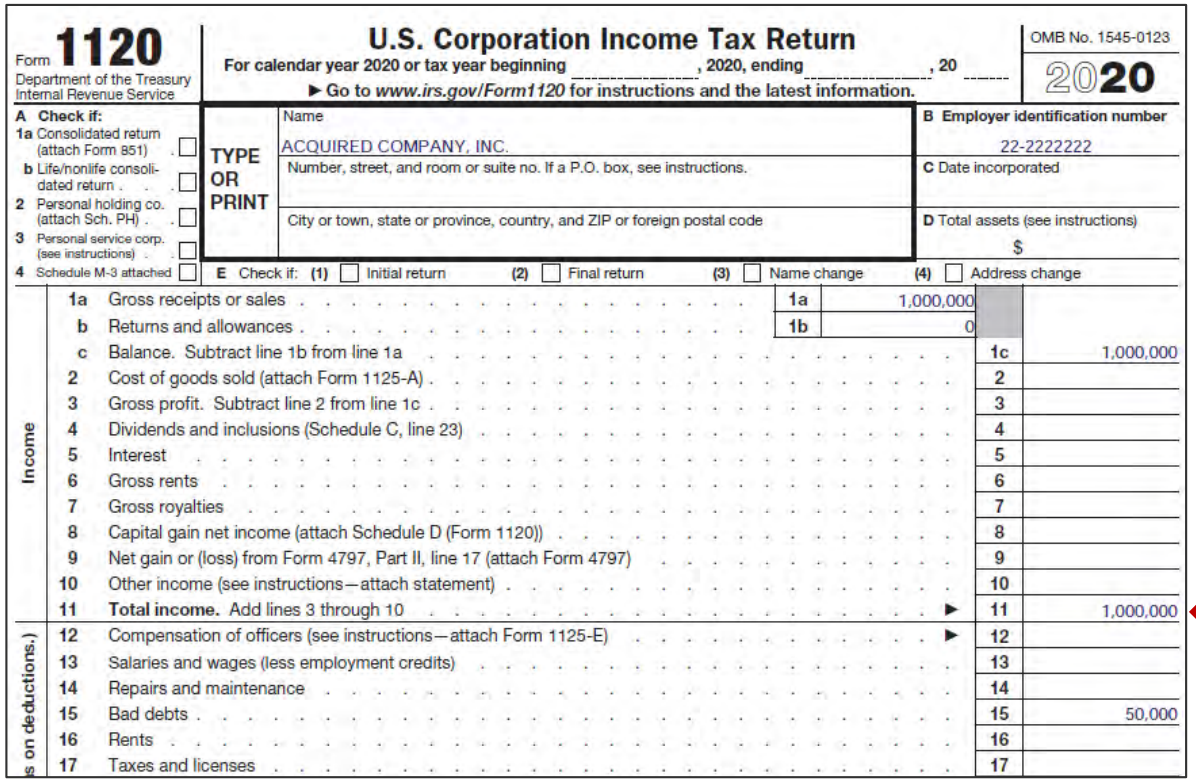
On January 31, 2020, Parent Company, LP (EIN: 11-1111111) acquired 100% of the stock in Acquired Company, Inc. (EIN: 22-2222222). All of Acquired Company, Inc.'s revenues for 2020 are being included in this application. See the attached Form 1120 filed for Acquired Company, Inc. and for Parent Company, LP for 2020 as support.

Thank you,

J Doe

President

P (555) 555.0123 F (555) 555.0124 E info@parentcompany.com



Form **1120** — Department of the Treasury, Internal Revenue Service

**U.S. Corporation Income Tax Return**

For calendar year 2020 or tax year beginning _____, 2020, ending _____, 20 _____

▶ Go to *www.irs.gov/Form1120* for instructions and the latest information.

OMB No. 1545-0123

**2020**

A Check if: 1a Consolidated return (attach Form 851) ☐ b Life/nonlife consolidated return ☐ 2 Personal holding co. (attach Sch. PH) ☐ 3 Personal service corp. (see instructions) ☐ 4 Schedule M-3 attached ☐

TYPE OR PRINT

Name: ACQUIRED COMPANY, INC.

B Employer identification number: 22-2222222

Number, street, and room or suite no. If a P.O. box, see instructions.

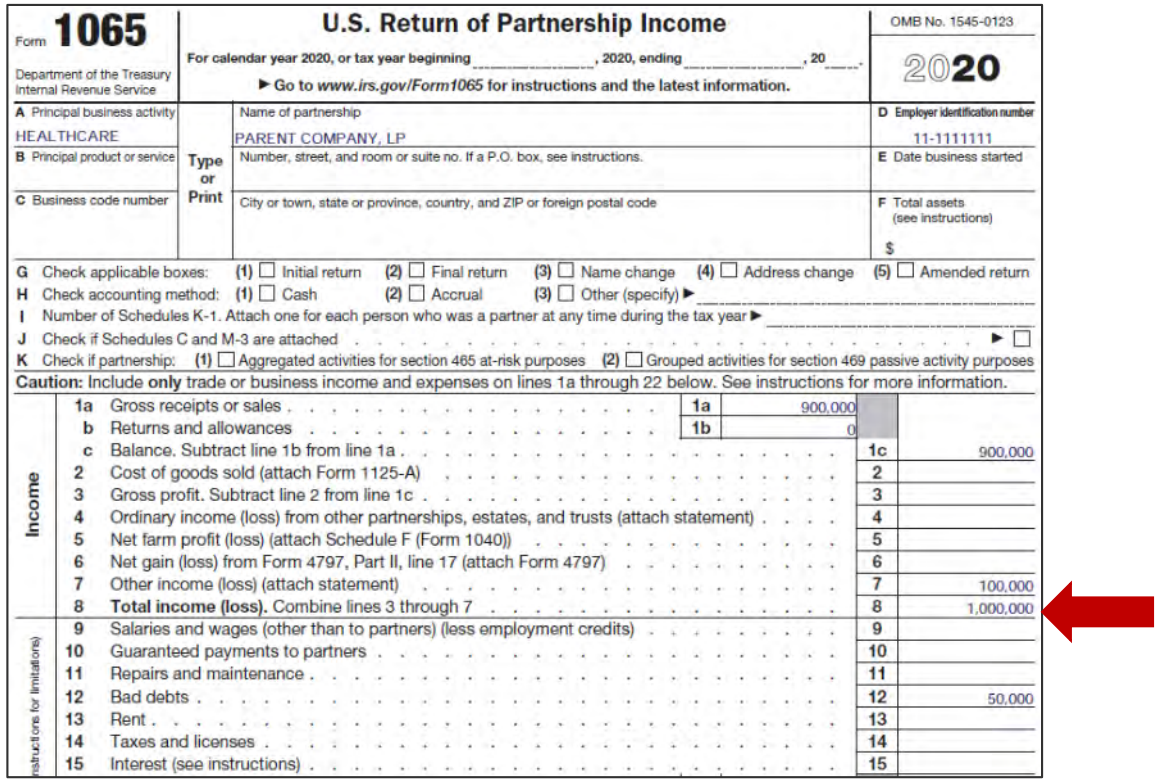
C Date incorporated

City or town, state or province, country, and ZIP or foreign postal code

D Total assets (see instructions) $

E Check if: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change

| | | | | | |
|---|---|---|---|---|---|
| Income | 1a | Gross receipts or sales | 1a | 1,000,000 | |
| | b | Returns and allowances | 1b | 0 | |
| | c | Balance. Subtract line 1b from line 1a | | | 1c 1,000,000 |
| | 2 | Cost of goods sold (attach Form 1125-A) | | | 2 |
| | 3 | Gross profit. Subtract line 2 from line 1c | | | 3 |
| | 4 | Dividends and inclusions (Schedule C, line 23) | | | 4 |
| | 5 | Interest | | | 5 |
| | 6 | Gross rents | | | 6 |
| | 7 | Gross royalties | | | 7 |
| | 8 | Capital gain net income (attach Schedule D (Form 1120)) | | | 8 |
| | 9 | Net gain or (loss) from Form 4797, Part II, line 17 (attach Form 4797) | | | 9 |
| | 10 | Other income (see instructions—attach statement) | | | 10 |
| | 11 | **Total income.** Add lines 3 through 10 ▶ | | | 11 1,000,000 |
| s on deductions.) | 12 | Compensation of officers (see instructions—attach Form 1125-E) ▶ | | | 12 |
| | 13 | Salaries and wages (less employment credits) | | | 13 |
| | 14 | Repairs and maintenance | | | 14 |
| | 15 | Bad debts | | | 15 50,000 |
| | 16 | Rents | | | 16 |
| | 17 | Taxes and licenses | | | 17 |



Form **1065** — Department of the Treasury, Internal Revenue Service

**U.S. Return of Partnership Income**

For calendar year 2020, or tax year beginning _____, 2020, ending _____, 20 _____

▶ Go to *www.irs.gov/Form1065* for instructions and the latest information.

OMB No. 1545-0123

**2020**

A Principal business activity: HEALTHCARE

B Principal product or service

C Business code number

Type or Print

Name of partnership: PARENT COMPANY, LP

D Employer identification number: 11-1111111

Number, street, and room or suite no. If a P.O. box, see instructions.

E Date business started

City or town, state or province, country, and ZIP or foreign postal code

F Total assets (see instructions) $

G Check applicable boxes: (1) ☐ Initial return (2) ☐ Final return (3) ☐ Name change (4) ☐ Address change (5) ☐ Amended return

H Check accounting method: (1) ☐ Cash (2) ☐ Accrual (3) ☐ Other (specify) ▶

I Number of Schedules K-1. Attach one for each person who was a partner at any time during the tax year ▶

J Check if Schedules C and M-3 are attached ▶ ☐

K Check if partnership: (1) ☐ Aggregated activities for section 465 at-risk purposes (2) ☐ Grouped activities for section 469 passive activity purposes

**Caution:** Include **only** trade or business income and expenses on lines 1a through 22 below. See instructions for more information.

| | | | | | |
|---|---|---|---|---|---|
| Income | 1a | Gross receipts or sales | 1a | 900,000 | |
| | b | Returns and allowances | 1b | 0 | |
| | c | Balance. Subtract line 1b from line 1a | | | 1c 900,000 |
| | 2 | Cost of goods sold (attach Form 1125-A) | | | 2 |
| | 3 | Gross profit. Subtract line 2 from line 1c | | | 3 |
| | 4 | Ordinary income (loss) from other partnerships, estates, and trusts (attach statement) | | | 4 |
| | 5 | Net farm profit (loss) (attach Schedule F (Form 1040)) | | | 5 |
| | 6 | Net gain (loss) from Form 4797, Part II, line 17 (attach Form 4797) | | | 6 |
| | 7 | Other income (loss) (attach statement) | | | 7 100,000 |
| | 8 | **Total income (loss).** Combine lines 3 through 7 | | | 8 1,000,000 |
| nstructions for limitations) | 9 | Salaries and wages (other than to partners) (less employment credits) | | | 9 |
| | 10 | Guaranteed payments to partners | | | 10 |
| | 11 | Repairs and maintenance | | | 11 |
| | 12 | Bad debts | | | 12 50,000 |
| | 13 | Rent | | | 13 |
| | 14 | Taxes and licenses | | | 14 |
| | 15 | Interest (see instructions) | | | 15 |

**Acquired**: $1,000,000 (total income)
- $50,000 (bad debts)
$950,000 Annual Net Patient Care

**Parent**: $1,000,000 (total income)
- $150,000 (non-patient care and bad debts)
$850,000 Annual Net Patient Care

# Annual Revenues Adjustment Worksheet (Updated 10-12-2021)

**(1)** Applicant Name:

PARENT COMPANY, LP

**(2)** Applicant's Taxpayer identification number (TIN):

111111111

**(3)** Gross Revenues:

$1,000,000

**(4)** Total Annual Revenues (i.e., Gross Revenues (Cell A7) + the sum of Total Gross Revenues (Cells G17 and below)):

**$2,000,000**

**(5)** Annual Net Patient Care Revenues:

$850,000

**(6)** Adjusted Annual Revenues from Patient Care (i.e., Annual Net Patient Care Revenues (Cell A11) + the sum of Net Patient Care Revenues (Cells I17 and below)):

**$1,800,000**

**(7)** Acquisition and Disposition Information

| (a) Subsidiary/ Billing TIN | (b) Acquisition (A) or Disposition (D) | (c) Name | (d) Total gross revenues | (e) Net patient care revenues |
|---|---|---|---|---|
| *123456789* | *A* | *Sample City Hospital, LLC* | *$ 50,000,000* | *$ 50,000,000* |
| 222222222 | A | ACQUIRED COMPANY, INC. | $1,000,000 | $950,000.0 |

This Form is Provided for Information Only **Reference ID**

# HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP)
# Rural Distribution Revenue Application

Tax ID Number: 11-1111111

Name as shown on your income tax return: PARENT COMPANY, LP

Federal Tax Classification: PARTNERSHIP

Business Name (if different):

Street 1:

Street 2:

City: State: Zip:

Registration Type:

NPI:

(1) Contact Person Name:

(2) Contact Person Title:

(3) Contact Person Phone Number:

(4) Contact Person Email:

(5) Applicant/Provider Type:

*Fields 6 - 8 have been intentionally removed*

(9) CMS Certification Numbers (CCNs), if applicable:

## REVENUES

(10) Revenues: $ 2,000,000

(11) Fiscal Year of Revenues: 2020

(12) Revenue from Patient Care: $ 1,800,000

(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: FORM 1065

# Scenario 3: Parent entity is applying on behalf of multiple subsidiaries

**Required**: Parent entity is applying on behalf of multiple subsidiaries

## Field 17- Annual Revenues from Patient Care Worksheet

- Identifying the proportion of revenues from non-patient and patient care by billing TIN.
- Separating the patient care revenues from other revenues (e.g., tuition, prescription sales)
- Accurately reporting non-patient care revenues and expenses for subsidiaries that are pharmacies or durable medical equipment (DME) suppliers

Form **1120-S**

Department of the Treasury
Internal Revenue Service

# U.S. Income Tax Return for an S Corporation

▶ Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation.
▶ Go to *www.irs.gov/Form1120S* for instructions and the latest information.

OMB No. 1545-0123

**2020**

For calendar year 2020 or tax year beginning , 2020, ending , 20

**A** S election effective date

**B** Business activity code number (see instructions)

**C** Check if Sch. M-3 attached ☐

TYPE OR PRINT

Name: PARENT COMPANY, INC.

Number, street, and room or suite no. If a P.O. box, see instructions.

City or town, state or province, country, and ZIP or foreign postal code

**D** Employer identification number: 11-1111111

**E** Date incorporated

**F** Total assets (see instructions) $

**G** Is the corporation electing to be an S corporation beginning with this tax year? ☐ Yes ☐ No If "Yes," attach Form 2553 if not already filed

**H** Check if: (1) ☐ Final return (2) ☐ Name change (3) ☐ Address change (4) ☐ Amended return (5) ☐ S election termination or revocation

**I** Enter the number of shareholders who were shareholders during any part of the tax year . . . . . ▶

**J** Check if corporation: (1) ☐ Aggregated activities for section 465 at-risk purposes (2) ☐ Grouped activities for section 469 passive activity purposes

**Caution:** Include **only** trade or business income and expenses on lines 1a through 21. See the instructions for more information.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Income** | 1a | Gross receipts or sales | 1a | 1,000,000 | | |
| | b | Returns and allowances | 1b | 0 | | |
| | c | Balance. Subtract line 1b from line 1a | | | 1c | |
| | 2 | Cost of goods sold (attach Form 1125-A) | | | 2 | |
| | 3 | Gross profit. Subtract line 2 from line 1c | | | 3 | |
| | 4 | Net gain (loss) from Form 4797, line 17 (attach Form 4797) | | | 4 | |
| | 5 | Other income (loss) (see instructions—attach statement) | | | 5 | |
| | 6 | **Total income (loss).** Add lines 3 through 5 ▶ | | | 6 | 1,000,000 |
| **Deductions** (see instructions for limitations) | 7 | Compensation of officers (see instructions—attach Form 1125-E) | | | 7 | |
| | 8 | Salaries and wages (less employment credits) | | | 8 | |
| | 9 | Repairs and maintenance | | | 9 | |
| | 10 | Bad debts | | | 10 | |
| | 11 | Rents | | | 11 | |
| | 12 | Taxes and licenses | | | 12 | |
| | 13 | Interest (see instructions) | | | 13 | |
| | 14 | Depreciation not claimed on Form 1125-A or elsewhere on return (attach Form 4562) | | | 14 | |
| | 15 | Depletion **(Do not deduct oil and gas depletion.)** | | | 15 | |
| | 16 | Advertising | | | 16 | |
| | 17 | Pension, profit-sharing, etc., plans | | | 17 | |
| | 18 | Employee benefit programs | | | 18 | |
| | 19 | Other deductions (attach statement) | | | 19 | |
| | 20 | **Total deductions.** Add lines 7 through 19 ▶ | | | 20 | |
| | 21 | **Ordinary business income (loss).** Subtract line 20 from line 6 | | | 21 | |
| **Tax and Payments** | 22a | Excess net passive income or LIFO recapture tax (see instructions) | 22a | | | |
| | b | Tax from Schedule D (Form 1120-S) | 22b | | | |
| | c | Add lines 22a and 22b (see instructions for additional taxes) | | | 22c | |
| | 23a | 2020 estimated tax payments and 2019 overpayment credited to 2020 | 23a | | | |
| | b | Tax deposited with Form 7004 | 23b | | | |
| | c | Credit for federal tax paid on fuels (attach Form 4136) | 23c | | | |
| | d | Reserved for future use | 23d | | | |
| | e | Add lines 23a through 23d | | | 23e | |
| | 24 | Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ ☐ | | | 24 | |

# Annual Net Patient Care Revenues Worksheet

(1) Applicant Name:

PARENT COMPANY, INC.

(2) Applicant's Taxpayer Identification Number (TIN):

11-1111111

(3) Applicant's Total Annual Revenues:

$1,000,000

(4) Applicant's Annual Net Patient Care Revenues:

$450,000

(5) Gross Revenues:

$1,000,000

(6) Annual Revenues Information

| (a) Subsidiary/ Billing TIN | (b) Subsidiary/Billing TIN Name | (c) Net patient care revenues | | (d) Non-patient care revenues | (e) Total revenues |
|---|---|---|---|---|---|
| | | $ 450,000.00 | | $ 550,000.00 | $ 1,000,000.00 |
| | | $ | | | |
| 111111111 | PARENT COMPANY, INC. | $ - | * | $ 100,000 | $ 100,000.00 |
| 222222222 | SUBSIDIARY 1, INC. | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 333333333 | SUBSIDIARY 2, INC. | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 444444444 | SUBSIDIARY 3, INC. | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 555555555 | SUBSIDIARY 4, INC. | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 666666666 | SUBSIDIARY 5, INC. | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 777777777 | SUBSIDIARY 6, LLC | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 888888888 | SUBSIDIARY 7, LLC | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 999999999 | SUBSIDIARY 8, LLC | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| 000000000 | SUBSIDIARY 9, LLC | $ 50,000 | * | $ 50,000 | $ 100,000.00 |
| | | | * | | $ - |

This Form is Provided for Information Only **Reference ID**_____

# HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP)
# Rural Distribution Revenue Application

Tax ID Number: 11-1111111

Name as shown on your income tax return: PARENT COMPANY, INC.

Federal Tax Classification: S CORPORATION

Business Name (if different): _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Registration Type: _____

NPI: _____

(1) Contact Person Name: _____

(2) Contact Person Title: _____

(3) Contact Person Phone Number: _____

(4) Contact Person Email: _____

(5) Applicant/Provider Type: _____

*Fields 6 - 8 have been intentionally removed*

(9) CMS Certification Numbers (CCNs), if applicable: _____

## REVENUES

(10) Revenues: $ 1,000,000

(11) Fiscal Year of Revenues: 2020

(12) Revenue from Patient Care: $ 450,000

(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: FORM 1120-S

# Scenario 4: Applicant TIN does not match TIN in supporting documentation

**Required**: Applicants with TINs that do not match the TIN in the IRS tax form submitted in Field 15

**Field 17- Annual Revenues from Patient Care Worksheet**

- Identifying patient care and non-patient care revenues that are part of the application
- Clarifying the portion of total revenues in the document in Field 15 that are attributable to the applicant

**Field 18 - Organizational Structure Documentation**

- Documentation of the legal relationship between the applicant and the federal income tax return, audited financial statements, or internally-generated financial statements uploaded in Field 15
- CMS change of ownership tie-in notification
- Purchase or disposition documents

**SUBSIDIARY, LLC**

4567 Edgefield Road, Rhinebeck, MD 02134-0000

October 12, 2021

To whom it may concern:

The tax form attached in Field 15 is filed under our parent company, Parent Company, Inc (TIN 11-1111111) and our income is part of the total income on the IRS Form 1120-S.

In order to correctly identify the revenues for Subsidiary, LLC (TIN 22-2222222), we have completed the Annual Patient Care Revenues Worksheet (uploaded in Field 16), which identifies the income earned specifically by Subsidiary, LLC.

In addition, we attached in Field 18 documentation that substantiates this relationship.

Thank you,

J Doe

President

P (555) 555.0123 F (555) 555.0124 E info@sub.com

Form **1120-S**

Department of the Treasury
Internal Revenue Service

# U.S. Income Tax Return for an S Corporation

▶ Do not file this form unless the corporation has filed or is attaching Form 2553 to elect to be an S corporation.
▶ Go to *www.irs.gov/Form1120S* for instructions and the latest information.

OMB No. 1545-0123

**2020**

For calendar year 2020 or tax year beginning , 2020, ending , 20

| | | |
|---|---|---|
| **A** S election effective date | Name: PARENT COMPANY, INC. | **D** Employer identification number: 11-1111111 |
| **B** Business activity code number (see instructions) | TYPE OR PRINT — Number, street, and room or suite no. If a P.O. box, see instructions. | **E** Date incorporated |
| **C** Check if Sch. M-3 attached ☐ | City or town, state or province, country, and ZIP or foreign postal code | **F** Total assets (see instructions) $ |

**G** Is the corporation electing to be an S corporation beginning with this tax year? ☐ Yes ☐ No If "Yes," attach Form 2553 if not already filed

**H** Check if: **(1)** ☐ Final return **(2)** ☐ Name change **(3)** ☐ Address change **(4)** ☐ Amended return **(5)** ☐ S election termination or revocation

**I** Enter the number of shareholders who were shareholders during any part of the tax year . . . . . ▶

**J** Check if corporation: **(1)** ☐ Aggregated activities for section 465 at-risk purposes **(2)** ☐ Grouped activities for section 469 passive activity purposes

**Caution:** Include **only** trade or business income and expenses on lines 1a through 21. See the instructions for more information.

| | | | | | |
|---|---|---|---|---|---|
| Income | 1a | Gross receipts or sales | 1a | 121,000,000 | |
| | b | Returns and allowances | 1b | 0 | |
| | c | Balance. Subtract line 1b from line 1a | | | 1c |
| | 2 | Cost of goods sold (attach Form 1125-A) | | | 2 |
| | 3 | Gross profit. Subtract line 2 from line 1c | | | 3 |
| | 4 | Net gain (loss) from Form 4797, line 17 (attach Form 4797) | | | 4 |
| | 5 | Other income (loss) (see instructions—attach statement) | | | 5 |
| | 6 | **Total income (loss).** Add lines 3 through 5 ▶ | | | 6 121,000,000 |
| ns for limitations) | 7 | Compensation of officers (see instructions—attach Form 1125-E) | | | 7 |
| | 8 | Salaries and wages (less employment credits) | | | 8 |
| | 9 | Repairs and maintenance | | | 9 |
| | 10 | Bad debts | | | 10 |
| | 11 | Rents | | | 11 |
| | 12 | Taxes and licenses | | | 12 |

# Annual Revenues from Patient Care Worksheet *(Updated 10-12-2021)*

(1) Applicant Name:

Subsidiary, LLC

(2) Applicant's Taxpayer Identification Number (TIN):

222222222

(3) Applicant's Total Annual Revenues (i.e., sum of Total Revenues (Cell E14)):

$250,000

(4) Applicant's Annual Net Patient Care Revenues (i.e., sum of Net Patient Care Revenues (Cell C14)):

$100,000

(5) Gross Revenues (i.e., sum of Total Applicant Revenues (Cell E14) and Total Revenues that are not part of the application (Cell F14)):

$121,000,000

(6) Annual Revenues Information

| (a) Subsidiary/ Billing TIN | (b) Subsidiary/Billing TIN Name | (c) Net Patient Care Revenues | (d) Non-Patient Care Revenues | (e) Total Applicant Revenues | (f) Total Revenues that are not part of the application, if applicable |
|---|---|---|---|---|---|
| | | $ 100,000 | $ 150,000 | $ 250,000 | $120,750,000 |
| *123456789* | *Sample City Hospital, LLC* | *$ 50,000,000* | *$ 50,000,000* | *100,000,000* | |
| 222222222 | Subsidiary, LLC | $ 100,000 | $ 150,000 | $250,000 | |
| | | | | | |
| | | | | $0 | |

This Form is Provided for Information Only **Reference ID**_____

# HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP)
# Rural Distribution Revenue Application

Tax ID Number: 22-2222222

Name as shown on your income tax return: SUBSIDIARY, LLC

Federal Tax Classification: SINGLE-MEMBER LLC

Business Name (if different): _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Registration Type: _____

NPI: _____

(1) Contact Person Name: _____

(2) Contact Person Title: _____

(3) Contact Person Phone Number: _____

(4) Contact Person Email: _____

(5) Applicant/Provider Type: _____

*Fields 6 - 8 have been intentionally removed*

(9) CMS Certification Numbers (CCNs), if applicable: _____

## REVENUES

(10) Revenues: $ 250,000

(11) Fiscal Year of Revenues: 2020

(12) Revenue from Patient Care: $ 100,000

(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: FORM 1120-S

# Scenario 5: Annual revenues are not entirely related to patient care

**Required**: Based on supporting documentation, revenues are not entirely related to patient care

## Field 17 - Annual Revenues from Patient Care Worksheet

- Identifying patient care and non-patient care revenues that are part of the application
- Identifies the proportion of revenues from non-patient and patient care by billing TIN
- Separates out the patient care revenues from other revenues (e.g., tuition, prescription sales)

# Form 990 — Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2020

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

► Do not enter social security numbers on this form as it may be made public.

► Go to *www.irs.gov/Form990* for instructions and the latest information.

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

**A** For the 2020 calendar year, or tax year beginning , 2020, and ending , 20

**B** Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

**C** Name of organization
Doing business as EXAMPLE NONPROFIT
Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
City or town, state or province, country, and ZIP or foreign postal code

**D** Employer identification number
11-1111111

**E** Telephone number

**G** Gross receipts $

**F** Name and address of principal officer:

**H(a)** Is this a group return for subordinates? ☐ Yes ☐ No

**H(b)** Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. See instructions

**H(c)** Group exemption number ►

**I** Tax-exempt status: ☐ 501(c)(3) ☐ 501(c) ( ) ◄ (insert no.) ☐ 4947(a)(1) or ☐ 527

**J** Website: ►

**K** Form of organization: ☐ Corporation ☐ Trust ☐ Association ☐ Other ► **L** Year of formation: **M** State of legal domicile:

## Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: HEALTHCARE AND EDUCATION

2 Check this box ► ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

| | | | |
|---|---|---|---|
| 3 | Number of voting members of the governing body (Part VI, line 1a) | 3 | |
| 4 | Number of independent voting members of the governing body (Part VI, line 1b) | 4 | |
| 5 | Total number of individuals employed in calendar year 2020 (Part V, line 2a) | 5 | |
| 6 | Total number of volunteers (estimate if necessary) | 6 | |
| 7a | Total unrelated business revenue from Part VIII, column (C), line 12 | 7a | |
| b | Net unrelated business taxable income from Form 990-T, Part I, line 11 | 7b | |

| | | Prior Year | Current Year |
|---|---|---|---|
| Revenue | 8 Contributions and grants (Part VIII, line 1h) | | 100,000 |
| | 9 Program service revenue (Part VIII, line 2g) | | 750,000 |
| | 10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) | | 50,000 |
| | 11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) | | 100,000 |
| | 12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) | | 1,000,000 |
| Expenses | 13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) | | |
| | 14 Benefits paid to or for members (Part IX, column (A), line 4) | | |
| | 15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10) | | |
| | 16a Professional fundraising fees (Part IX, column (A), line 11e) | | |
| | b Total fundraising expenses (Part IX, column (D), line 25) ► | | |
| | 17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) | | |
| | 18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) | | |
| | 19 Revenue less expenses. Subtract line 18 from line 12 | | |

| | | Beginning of Current Year | End of Year |
|---|---|---|---|
| Net Assets or Fund Balances | 20 Total assets (Part X, line 16) | | |
| | 21 Total liabilities (Part X, line 26) | | |
| | 22 Net assets or fund balances. Subtract line 21 from line 20 | | |

## Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

**Sign Here**

Signature of officer — Date

Type or print name and title

**Paid Preparer Use Only**

Print/Type preparer's name | Preparer's signature | Date | Check ☐ if self-employed | PTIN

Firm's name ► | Firm's EIN ►

Firm's address ► | Phone no.

May the IRS discuss this return with the preparer shown above? See instructions ☐ Yes ☐ No

**For Paperwork Reduction Act Notice, see the separate instructions.** Cat. No. 11282Y Form 990 (2020)



## Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII ☐

| | | | (A) Total revenue | (B) Related or exempt function revenue | (C) Unrelated business revenue | (D) Revenue excluded from tax under sections 512–514 |
|---|---|---|---|---|---|---|
| Contributions, Gifts, Grants and Other Similar Amounts | 1a Federated campaigns | 1a | | | | |
| | b Membership dues | 1b | | | | |
| | c Fundraising events | 1c | | | | |
| | d Related organizations | 1d | | | | |
| | e Government grants (contributions) | 1e | 100,000 | | | |
| | f All other contributions, gifts, grants, and similar amounts not included above | 1f | | | | |
| | g Noncash contributions included in lines 1a–1f | 1g $ | | | | |
| | h Total. Add lines 1a–1f ► | | 100,000 | | | |
| | | Business Code | | | | |
| Program Service Revenue | 2a PATIENT SERVICE FEES, NET | | 500,000 | 500,000 | | |
| | b TUITION & FEES | | 250,000 | 250,000 | | |
| | c | | | | | |
| | d | | | | | |
| | e | | | | | |
| | f All other program service revenue | | | | | |
| | g Total. Add lines 2a–2f ► | | 750,000 | | | |
| Other Revenue | 3 Investment income (including dividends, interest, and other similar amounts) ► | | 50,000 | | | 50,000 |
| | 4 Income from investment of tax-exempt bond proceeds ► | | | | | |
| | 5 Royalties ► | | | | | |
| | | | (i) Real | (ii) Personal | | |
| | 6a Gross rents 6a | | | | | |
| | b Less: rental expenses 6b | | | | | |
| | c Rental income or (loss) 6c | | | | | |
| | d Net rental income or (loss) ► | | | | | |
| | | | (i) Securities | (ii) Other | | |
| | 7a Gross amount from sales of assets other than inventory 7a | | | | | |
| | b Less: cost or other basis and sales expenses 7b | | | | | |
| | c Gain or (loss) 7c | | | | | |
| | d Net gain or (loss) ► | | | | | |
| | 8a Gross income from fundraising events (not including $ ____ of contributions reported on line 1c). See Part IV, line 18 | 8a | | | | |
| | b Less: direct expenses | 8b | | | | |
| | c Net income or (loss) from fundraising events ► | | | | | |
| | 9a Gross income from gaming activities. See Part IV, line 19 | 9a | | | | |
| | b Less: direct expenses | 9b | | | | |
| | c Net income or (loss) from gaming activities ► | | | | | |
| | 10a Gross sales of inventory, less returns and allowances | 10a | | | | |
| | b Less: cost of goods sold | 10b | | | | |
| | c Net income or (loss) from sales of inventory ► | | | | | |
| | | Business Code | | | | |
| Miscellaneous Revenue | 11a MISCELLANEOUS INCOME | | 100,000 | | | 100,000 |
| | b | | | | | |
| | c | | | | | |
| | d All other revenue | | | | | |
| | e Total. Add lines 11a–11d ► | | | | | |
| | 12 Total revenue. See instructions ► | | 1,000,000 | 750,000 | | 150,000 |

# Annual Revenues from Patient Care Worksheet *(Updated 10-12-2021)*

(1) Applicant Name:

EXAMPLE NONPROFIT

(2) Applicant's Taxpayer Identification Number (TIN):

111111111

(3) Applicant's Total Annual Revenues (i.e., sum of Total Revenues (Cell E14)):

$1,000,000

(4) Applicant's Annual Net Patient Care Revenues (i.e., sum of Net Patient Care Revenues (Cell C14)):

$500,000

(5) Gross Revenues (i.e., sum of Total Applicant Revenues (Cell E14) and Total Revenues that are not part of the application (Cell F14)):

$1,000,000

(6) Annual Revenues Information

| (a) Subsidiary/ Billing TIN | (b) Subsidiary/Billing TIN Name | (c) Net Patient Care Revenues | (d) Non-Patient Care Revenues | (e) Total Applicant Revenues | (f) Total Revenues that are not part of the application, if applicable |
|---|---|---|---|---|---|
| *123456789* | | $ 500,000 | $ 500,000 | $ 1,000,000 | $0 |
| 111111111 | EXAMPLE NONPROFIT | $ 500,000 | $ 500,000 | $1,000,000 | |
| | | | | | |

This Form is Provided for Information Only **Reference ID**_____

# HRSA Provider Relief Fund – Phase 4 and American Rescue Plan (ARP) Rural Distribution Revenue Application

Tax ID Number: 11-1111111

Name as shown on your income tax return: EXAMPLE NONPROFIT

Federal Tax Classification: TAX-EXEMPT

Business Name (if different): _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Registration Type: _____

NPI: _____

(1) Contact Person Name: _____

(2) Contact Person Title: _____

(3) Contact Person Phone Number: _____

(4) Contact Person Email: _____

(5) Applicant/Provider Type: _____

*Fields 6 - 8 have been intentionally removed*

(9) CMS Certification Numbers (CCNs), if applicable: _____

## REVENUES

(10) Revenues: $ 1,000,000

(11) Fiscal Year of Revenues: 2020

(12) Revenue from Patient Care: $ 500,000

(12.1) Select the Federal Tax From you will upload to support Patient Care Revenue: FORM 990

# Helpful Links

- Overview and Portal Demo webinar Tuesday, October 5 – view the webcast
- Fact Sheet - Complex Organizational Structures
- Phase 4 and ARP Rural application instructions: hrsa.gov/provider-relief/future-payments/phase-4-arp-rural
- Annual Revenues from Patient Care Worksheet
- Annual Revenues Adjustment Worksheet
- Application and Attestation Portal: cares.linkhealth.com/#/

Provider support line: **(866) 569-3522**; for TTY dial 711.

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# Thank You

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