NOTICE OF MEETING OF
THE BOARD OF MANAGERS OF THE LAMB COUNTY HOSPITAL, ALSO KNOWN AS THE LAMB HEALTHCARE CENTER AND
THE COMMISSIONERS COURT OF LAMB COUNTY, TEXAS
*** immediately to be followed by Regular Meeting of the Board of Managers of the Lamb County Hospital, also known as the Lamb Healthcare Center**

Notice if hereby given that a Special Joint Meeting of the Board of Managers of the Lamb County Hospital, also known as the Lamb Healthcare Center and the Lamb County Commissioners Court (immediately to be followed by regular meeting of the Board of Managers of the Lamb County Hospital, also known as the Lamb Healthcare Center) will be held on the 18th day of May, 2021 at 12:00 o'clock p.m. at the Lamb Healthcare Center Atrium, Littlefield, Texas, at which time the following subjects will be discussed and appropriate action taken, to-wit:

SPECIAL JOINT MEETING AGENDA

I. Call to Order
II. Discuss Operations of Lamb Healthcare Center (LHC) & LHC Board of Managers Plan to use remainder of Care Act Funding.
III. FUTURE AGENDA ITEMS; AND
IV. ADJOURNMENT

The Board of Managers of the Lamb County Hospital, also known as the Lamb Healthcare Center may vote and/or act upon each of the items listed on the Agenda. The Board of Managers of the Lamb County Hospital, also known as the Lamb Healthcare Center may meet in Executive Session on any of the above items as authorized by the Texas Open Meetings Act, and pursuant to Government Code 551, sub-chapter D. The Board of Managers of the Lamb County Hospital, also known as the Lamb Healthcare Center also reserves the right to reconvene in a Regular Session and consider action, if any, on the items discussed in Executive Session.

(1)

General and Targeted Distribution

Post-Payment Notice of Reporting Requirements

January 15, 2021

Purpose

The purpose of this notice is to inform Provider Relief Fund (PRF) recipients, who received one or more payments exceeding $10,000 in the aggregate, of the data elements that they will be required to report as part of the post-payment reporting process. This document supersedes the November 2, 2020 Post-Payment Notice of Reporting Requirements.

Please note that these reporting requirements do not apply to the Nursing Home Infection Control distributions or the Rural Health Clinic Testing distribution. Separate reporting requirements will be or have been announced for these distributions. These reporting requirements also do not apply to reimbursement from the Health Resources and Services Administration (HRSA) COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program and the HRSA COVID-19 Vaccine Administration Assistance Fund. Additional reporting may be announced in the future for these reimbursements.

Overview

The Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136), the Paycheck Protection Program (PPP) and Health Care Enhancement Act (P.L. 116-139), and the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act (P.L. 116-123) appropriated funds to reimburse eligible healthcare providers for healthcare related expenses or lost revenues attributable to coronavirus. These funds were distributed by HRSA through the PRF program. Recipients of these funds agreed to Terms and Conditions, which require compliance with reporting requirements as specified by the Secretary of Health and Human Services in program instructions.

Purpose

This notice informs recipients of the categories of data elements that they must submit as part of the reporting process. HRSA has amended this notice to reflect changes to the reporting process in accordance with the CRRSA. HRSA plans to offer Question and Answer Sessions via webinar in advance of the reporting deadline, and as needed, HRSA will also issue Frequently Asked Questions to provide greater clarity about the reporting process.

Reporting Instructions on Use of Funds

Recipients will report their use of PRF payments using their normal method of accounting (cash or accrual basis) by submitting the following information:

1. Healthcare related expenses attributable to coronavirus that another source has not reimbursed and is not obligated to reimburse, which includes General and Administrative (G&A) and/or other healthcare related expenses (further defined within the data elements section below).
2. PRF payment amounts not fully expended on healthcare related expenses attributable to coronavirus are then applied to patient care lost revenues. Documentation requirements for lost revenue calculations are further defined within the data elements section below.

Recipients may choose to apply PRF payments toward lost revenue using one of the following options, up to the amount:

a) of the difference between 2019 and 2020 actual patient care revenue;

b) of the difference between 2020 budgeted and 2020 actual patient care revenue. If recipients elect to use 2020 budgeted patient care revenue to calculate lost revenue, they must use a budget that was established and approved prior to March 27, 2020. Providers using 2020 budgeted patient care revenue to calculate the amount of lost revenues they may permissibly claim will be required to submit additional documentation at the time of reporting; or

c) calculated by any reasonable method of estimating revenue. If a recipient wishes to use an alternate reasonable methodology for calculating lost revenues attributable to coronavirus, the recipient must submit a description of the methodology, an explanation of why the methodology is reasonable, and establish how the identified lost revenues were in fact a loss attributable to coronavirus, as opposed to a loss caused by any other source. All recipients seeking to use an alternate methodology face an increased likelihood of an audit by HRSA. HRSA will notify a recipient if their proposed methodology is not reasonable, including because it does not establish with a reasonable certainty that claimed lost revenues were caused by coronavirus. If HRSA determines that a recipient's proposed alternate methodology is not reasonable, the recipient must resubmit its report within 30 days of notification using either 2019 calendar year actual revenue or 2020 calendar year budgeted revenue to calculate lost revenues attributable to coronavirus.

If recipients do not expend PRF funds in full by the end of calendar year 2020, they will have an additional six months in which to use remaining amounts toward expenses attributable to coronavirus but not reimbursed by other sources, and/or lost revenues in an amount not to exceed the difference between: 1) 2019 Quarter 1 to Quarter 2 and 2021 Quarter 1 to Quarter 2 actual revenue, or 2) 2020 Quarter 1 to Quarter 2 budgeted revenue and 2021 Quarter 1 to Quarter 2 actual revenue.

Data Elements

The following data elements in the PRF Reporting System will allow HRSA to assess whether recipients properly used PRF payments, consistent with the Terms and Conditions associated with payment.

1. Demographic Information

a. **Reporting Entity:**

Type of PRF recipient(s)	***Definition***
General Distribution recipient that received payment in Phase 1 only	Entity that received Phase 1 General Distribution payments totaling more than $10,000in aggregate
General Distribution with no parent organization or subsidiaries except PRF recipients that received Phase 1 General Distributions only	Entity (at the Tax Identification Number (TIN) level) that received one or more General Distribution payments totaling more than $10,000 in aggregate
General Distribution recipient with one or more subsidiaries that received payments in Phases 1-3	Entity that meets the following three criteria: 1. Is the parent of one or more subsidiary billing TINs that received General Distribution payments in Phases 1-3,

	2. Has providers associated with it that were providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020, and 3. Is an entity that can otherwise attest to the Terms and Conditions.
Targeted Distribution recipient	Entity (at the Tax Identification Number (TIN) level) that received Targeted Distribution payments totaling more than $10,000 in aggregate

If a parent organization has subsidiary TINs that either received General Distribution payments directly from HRSA or which were transferred to them by their parent organization, the parent entity may report on the use of these General Distribution payments. This requirement stands regardless of whether the parent or the subsidiary attested to accepting the payments. The entity reporting on the funds becomes the Reporting Entity. The original Targeted Distribution recipients, regardless of whether the parent or subsidiary received the payment and regardless of whether that original recipient subsequently transferred it, becomes the Reporting Entity and must report on the use of funds in accordance with the CRRSA.

b. **Tax Identification Number (TIN):** The TIN associated with the eligible healthcare provider that is filing the report. For some recipients, this may be analogous to Social Security number (SSN) or Employer Identification Number (EIN).

c. **National Provider Identifier (NPI)** ***[optional]*****:** The unique 10-digit numeric identifier for covered healthcare providers.

d. **Fiscal Year-End Date:** Month in which the Reporting Entity reports its fiscal year-end financial results.

e. **Federal Tax Classification:** Designated business type associated with the Reporting Entity's primary TIN used for filing taxes. Classifications include Sole Proprietor, Limited Liability Corporation (LLC), Partnership, C Corporation, S Corporation, Trust or Estate, or a tax-exempt organization or entity.

2. Additional Provider Payment Information

Interest Earned on PRF Payment – For Reporting Entities that held the PRF payment(s) being reported on in an interest-bearing account, the dollar value of interest earned on those PRF payment(s) must be reported. The total reportable use of PRF distributions will be inclusive of the interest earned on those PRF distributions.

3. Healthcare Related Expenses Attributable to Coronavirus Not Reimbursed by Other Sources

Healthcare related expenses are limited to costs incurred to prevent, prepare for, and/or respond to coronavirus.

Reporting Entities that received **between $10,001 and $499,999 in aggregated PRF payments** are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed

sources (e.g., payments received from insurance and/or patients, and amounts received from federal, state, or local governments, etc.) in two categories: (1) G&A expenses and (2) other healthcare related expenses. These are the actual expenses incurred over and above what has been reimbursed by other sources.

Reporting Entities that received **$500,000 or more in PRF payments** are required to report healthcare related expenses attributable to coronavirus, net of other reimbursed sources, in greater detail then the two categories of G&A expenses and other healthcare related expenses, according to the following sub-categories of expenses:

General and Administrative Expenses Attributable to Coronavirus[1]
The actual G&A expenses attributable to coronavirus that were incurred over and above what has been reimbursed by other sources.

a. **Mortgage/Rent:** Payments related to mortgage or rent for a facility.
b. **Insurance:** Premiums paid for property, malpractice, business insurance, or other insurance relevant to operations.
c. **Personnel:** Workforce-related actual expenses paid to prevent, prepare for, or respond to coronavirus during the reporting period, such as workforce training, staffing, temporary employee or contractor payroll, overhead employees, or security personnel. [2]
d. **Fringe Benefits:** Extra benefits supplementing an employee's salary, which may include hazard pay, travel reimbursement, and employee health insurance.
e. **Lease Payments:** New equipment or software leases.
f. **Utilities/Operations:** Lighting, cooling/ventilation, cleaning, or additional third party vendor services not included in "Personnel."
g. **Other General and Administrative Expenses:** Costs not captured above that are generally considered part of overhead structure.

Healthcare Related Expenses Attributable to Coronavirus[2]
The actual healthcare related expenses attributable to coronavirus that were incurred over and above what has been reimbursed by other sources.

a. **Supplies:** Expenses paid for purchase of supplies used to prevent, prepare for, and/or respond to coronavirus during the reporting period. Such items may include personal protective equipment (PPE), hand sanitizer, or supplies for patient screening.
b. **Equipment:** Expenses paid for purchase of equipment used to prevent, prepare for, and/or respond to coronavirus during the reporting period, such as ventilators, updates to HVAC systems, etc.

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[1] As noted above, expenses attributable to coronavirus may be incurred in both direct patient care and overhead activities related to preventing, preparing for, and responding to coronavirus.

[2]The Terms and Conditions associated with each PRF payment do not permit recipients to use PRF money to pay any salary at a rate in excess of Executive Level II which is currently set at $197,300. For the purposes of the salary limitation, the direct salary is exclusive of fringe benefits and indirect costs. The limitation only applies to the rate of pay charged to PRF payments and other HHS awards. An organization receiving PRF may pay an individual's salary amount in excess of the salary cap with non-federal funds.

c. **Information Technology (IT):** Expenses paid for IT or interoperability systems to expand or preserve care delivery during the reporting period, such as electronic health record licensing fees, telehealth infrastructure, increased bandwidth, and teleworking to support remote workforce.
d. **Facilities:** Expenses paid for facility-related costs used to prevent, prepare for, and/or respond to coronavirus during the reporting period, such as lease or purchase of permanent or temporary structures, or to modify facilities to accommodate patient treatment practices revised due to coronavirus.
e. **Other Healthcare Related Expenses:** Any other expenses, not previously captured above, that were paid to prevent, prepare for, and/or respond to coronavirus.

4. Lost Revenues Attributable to Coronavirus

Reporting Entities provide information used to calculate lost revenues attributable to coronavirus.[3]

Total Revenue[4]/Net Charges from Patient Care[5] Related Sources in 2020: Revenue/net charges from patient care (prior to netting with expenses) for the calendar year 2020. Calendar year actual revenues will be entered by quarter (e.g., January–March 2020) and by payer mix:

a. **Medicare Part A or B:** Actual revenues/net charges received from Medicare Part A or B for patient care for the calendar year.
b. **Medicare Part C:** Actual revenues/net charges received from Medicare Part C for patient care for the calendar year.
c. **Medicaid/Children's Health Insurance Program (CHIP):** Actual revenues/net charges received from Medicaid/CHIP for patient care for the calendar year.
d. **Commercial Insurance:** Actual revenues/net charges from commercial payers for patient care for the calendar year.
e. **Self-Pay (No Insurance):** Actual revenues/net charges received from self-pay patients, including the uninsured or individuals without insurance who bear the burden of paying for healthcare themselves, for the calendar year.
f. **Other:** Actual gross revenues/net charges from other sources received for patient care services and not included in the list above for the calendar year.

Additional Revenue Information

In addition to providing 2020 actual patient care revenue, Reporting Entities will need to provide additional revenue information, depending on which of the lost revenue calculation options they select:

- Reporting Entities electing to calculate lost revenues attributable to coronavirus using the difference between their 2019 and 2020 actual patient care revenue must also submit Revenue from Patient Care Payer Mix as outlined above for the 2019 calendar year (by quarter).
- Reporting Entities electing to calculate lost revenues attributable to coronavirus using the difference between their 2020 budgeted and 2020 actual patient care revenue must submit their 2020 budgeted amount of patient care revenue. Recipients must also submit: 1) a copy of their 2020 budget, which must have been approved before March 27, 2020, and 2) an attestation from the Reporting Entity's Chief Executive Officer, Chief Financial Officer, or similar

[3] Note that if a Reporting Entity expends all of its PRF distributions on healthcare related expenses attributable to coronavirus, the Reporting Entity will still need to submit 2020 actual patient care revenue and 2019 actual patient care revenue.

[4] Net of uncollectible patient service revenue recognized as bad debts.

[5] "Patient care" means health care, services and supports, as provided in a medical setting, at home, or in the community. It should not include: 1) insurance, retail, or real estate values (except for SNFs, where that is allowable as a patient care cost), or 2) grants or tuition unrelated to patient care.

CARES Act Provider Relief Fund Frequently Asked Questions
Health and Human Services –
https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html

Use of Funds

Will the Provider Relief Fund limit qualifying expenses for capital equipment purchases to 1.5 years of depreciation, or can providers fully expense capital equipment purchases? (Added 11/18/2020)
Expenses for capital equipment and inventory may be fully expensed only in cases where the purchase was directly related to prevent, prepare for and respond to the coronavirus. Examples of these types of equipment and inventory expenses include:

- Ventilators, computerized tomography scanners, and other intensive care unit-(ICU)related equipment put into immediate use or held in inventory
- Masks, face shields, gloves, gowns
- Biohazard suits
- General personal protective equipment
- Disinfectant supplies

Can providers include the entire cost of capital facilities projects as eligible expenses, or will eligible expenses be limited to the depreciation expense for the period? (Added 11/18/2020)
Expenses for capital facilities may be fully expensed only in cases where the purchase was directly related to preventing, preparing for and responding to the coronavirus. Examples of these types of facilities projects include:

- Upgrading a heating, ventilation, and air conditioning (HVAC) system to support negative pressure units
- Retrofitting a COVID-19 unit
- Enhancing or reconfiguring ICU capabilities
- Leasing or purchasing a temporary structure to screen and/or treat patients
- Leasing a permanent facility to increase hospital or nursing home capacity

Is there a set period of time in which providers must use the funds to cover allowable expense or lost revenues attributable to COVID-19? (Modified 3/31/2021))
Yes. As explained in the notice of reporting requirements on the Provider Relief Fund website, available at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html, funds must be expended no later than June 30, 2021. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients now or in the future, and is authorized to collect any Provider Relief Fund amounts that were overpaid or not used in a manner consistent with program requirements or applicable law. All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for health care-related expenses or lost revenue attributable to coronavirus.

Can a parent organization with a direct ownership relationship with a subsidiary that received a Provider Relief Fund Targeted Distribution payment control and allocate that Targeted Distribution payment among other subsidiaries that were not themselves eligible and did not receive a Targeted Distribution (i.e., Skilled Nursing Facility, Safety Net Hospital, Rural, Tribal, High Impact Area) payment? ***(Added 7/22/2020)***
No. The parent entity may not transfer a Provider Relief Fund Targeted Distribution payment from the recipient subsidiary to a subsidiary that did not receive the payment. Control and use of the funds must remain with the entity that received the Targeted Distribution payment. The purpose of Targeted Distribution payments is to support the specific financial needs of the payment recipient.

A parent TIN with multiple subsidiary TINs each received a General Distribution payment. The subsidiary TINs attested to and accepted the General Distribution payments they received. Can the subsidiary TINs allocate the General Distribution payments up to the parent TIN or to another subsidiary TIN? How does the parent TIN formally acknowledge acceptance of those payments that were attested and accepted by the subsidiary TIN? ***(Added 10/28/2020)***
HHS initially advised providers that once a subsidiary TIN attested to and accepted a General Distribution payment, the money must stay with, and be used by, the subsidiary TIN. However, HHS has received feedback indicating that some subsidiary TINs accepted a General Distribution payment prior to the release of this guidance, and that they would have had their parent TIN accept the money, had they known earlier of HHS's position. In light of these timing concerns, HHS is revising its prior guidance and clarifying that, for General Distribution payments only, a subsidiary TIN can transfer its General Distribution payment to a parent TIN; this is true even if a subsidiary TIN initially attested to accepting a General Distribution payment. Consistent with other longstanding guidance, the parent TIN may use the money and/or allocate the money to other subsidiary TINs, as it deems appropriate.
Regardless of which entity (the parent or subsidiary) attested to the receipt of the General Distribution payments, the parent entity can report on the use of the General Distribution payment as part of the HHS reporting process.

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FOR IMMEDIATE RELEASE
May 4, 2021

Contact: HHS Press Office
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HHS Announces Nearly $1 Billion from American Rescue Plan for Rural COVID-19 Response

Funding Will Help Communities, Hospitals, Health Clinics Respond to the Pandemic and Support Local Efforts to Increase Vaccine Confidence and Uptake in Rural Communities

Today, thanks to the American Rescue Plan, the U.S. Department of Health and Human Services (HHS) is announcing the availability of nearly $1 billion to strengthen COVID-19 response efforts and increase vaccinations in rural communities. As part of the Biden Administration's commitment to expanding access to vaccines and ensuring equity in the COVID-19 response, the Health Resources and Services Administration, a part of HHS, will increase the number of vaccines sent to rural communities, expand testing and other COVID-19 prevention services, and work to increase vaccine confidence by empowering trusted local voices with additional funding for outreach efforts in underserved communities.

"Rural health providers are vital to ensure equity in COVID-19 testing, vaccinations and in making sure rural residents have the information about vaccine safety, especially for populations who are at an increased risk for COVID-19 infection or severe illness due to systemic health and social inequities and geographic isolation," said HHS Secretary Xavier Becerra. "Support to Rural Health Clinics and small rural hospitals for COVID-19 testing, strengthening vaccine allocation and confidence, and vaccine outreach will help rural residents make informed health decisions about COVID-19 to protect themselves and their communities."

HRSA's Rural Health Clinic COVID-19 Testing and Mitigation Program will provide $460 million to more than 4,600 rural health clinics (RHCs) across the country. RHCs will use the funds to maintain and increase COVID-19 testing, expand access to testing for rural residents, and broaden efforts to mitigate the spread of the virus in ways tailored to their local communities. RHCs are a special certification given to health care practices in underserved rural areas by the Centers for Medicare and Medicaid Services (CMS) to help ensure access to care for rural residents. HRSA will provide up to $100,000 per RHC-certified clinic site and will issue the funds this summer.

To further support COVID-19 testing in rural areas, HRSA will provide $398 million to existing grantees of the Small Rural Hospital Improvement Program (SHIP) to work with approximately 1,730 small rural hospitals – those with fewer than 50 beds – and Critical Access Hospitals on COVID-19 testing and mitigation. SHIP state grantees will use the funding to support all eligible rural hospitals, up to $230,000 per hospital, and will issue the funds later in the year.

"Addressing the health care challenges rural areas face requires a targeted approach that's tailored to the needs of local communities," said HRSA Acting Administrator Diana Espinosa. "This critical funding strengthens our ability to deliver on President Biden's commitment to ensure that the nation's underserved communities and those who are disproportionately affected by COVID-19 get the help they need."

HRSA will also support RHCs to increase the availability of COVID-19 vaccines in rural communities and expand outreach to build vaccine confidence. Working in partnership with the Centers for Disease Control and Prevention (CDC), HRSA is inviting Medicare-certified RHCs to join the new Rural Health Clinic COVID-19 Vaccine Distribution (RHCVD) Program to directly receive vaccines from the Biden Administration. HRSA and CDC will continue to enroll interested RHCs to receive COVID-19 vaccines, the allocation for which is separate from jurisdictions' weekly allocations.

In addition, through the Rural Health Clinic Vaccine Confidence (RHCVC) Program, HRSA will make nearly $100 million available in grants to eligible RHCs nationwide to address health equity gaps by offering support and resources to medically underserved rural communities where COVID-19 vaccine uptake lags in comparison to more populated areas. HRSA will fund all eligible RHCs that apply. The RHCVC Program is the first targeted RHC grant since the passage of the Rural Health Clinic Service Act in 1977.

RHCs will be able to use the funds to increase vaccine confidence, improve health care in rural areas, and reinforce key messages about prevention and treatment of COVID-19 and other infectious diseases. Implementation efforts in rural communities will include disseminating information to rural residents about how and where to get vaccinated, and coordinating with existing vaccination sites and public health partners to identify strategies to increase vaccine confidence among key populations. RHCs may also use funding to promote vaccination and bolster patient literacy in rural areas on the benefits of broad vaccination and vaccine safety in support of continued efforts to return to a more normal lifestyle.

For more information about HRSA's rural programs, visit the Federal Office of Rural Health Policy website: https://www.hrsa.gov/rural-health/index.html

To learn more about HRSA's allocation to Rural Health Clinics for COVID-19 testing visit: https://www.hrsa.gov/rural-health/coronavirus/rural-health-clinics-covid-19-testing-fy20-awards

To learn more about the Small Rural Hospital Improvement Program (SHIP), visit https://www.hrsa.gov/rural-health/rural-hospitals.