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Technical Line

Accounting and compliance matters for health care entities receiving US government aid for COVID-19

In this issue:

What you need to know

- Both not-for-profit and for-profit health care entities that have received or expect to receive government assistance due to the COVID-19 pandemic need to evaluate whether the aid is an income tax credit, a payment for goods or services, or a loan before concluding that it is a grant or a contribution.
- To account for grants or contributions, not-for-profit health care entities apply ASC 958-605, while for-profit health care entities must analogize to accounting guidance, such as IAS 20 (the IFRS guidance on government grant accounting), because there is no required US GAAP guidance.
- Recent changes to the HHS requirements for distributions from the Provider Relief Fund have both financial reporting and compliance implications, underscoring the need for entities to monitor developments in the rules for government programs.
- Health care entities receiving COVID-19 aid from the federal government may for the first time be subject to government audit requirements if they expend $750,000 or more in federal or HHS funds in their fiscal year.

Overview

Both not-for-profit and for-profit health care entities that have received or expect to receive government assistance relating to the COVID-19 pandemic need to consider the financial reporting and compliance implications of accepting the aid.

Building a better working world

For example, the US government has provided various forms of economic support for individuals and organizations affected by the COVID-19 pandemic through programs authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, including some just for health care entities, such as the Provider Relief Fund. The aid is intended to help health care entities prevent, prepare for and respond to COVID-19.

This publication addresses the accounting and financial reporting implications of receiving government assistance as well as certain government compliance reporting and audit requirements for entities that receive federal funding. The publication may be updated to reflect changes to requirements issued by regulatory agencies such as the US Department of Health and Human Services (HHS), which oversees the Provider Relief Fund.

This publication does not address asset impairment, the details of income tax relief provided by the CARES Act, or other COVID-19-related accounting and financial reporting topics that affect entities in all industries. For information about those topics, refer to our Technical Line, ***Accounting and reporting considerations for the effects of the coronavirus outbreak.***

Accounting considerations for government assistance

A health care entity must first consider whether the government assistance it receives is an income tax credit, a loan or revenue from a contract with a customer.

To help entities deal with the economic fallout of the COVID-19 pandemic, the US government has provided various forms of assistance, including loan programs (e.g., the Paycheck Protection Program or PPP), tax relief and support specifically for health care entities, such as aid available through the Provider Relief Fund and payments for medical services provided to patients (e.g., diagnostic testing for COVID-19).

A health care entity that receives assistance from a government entity will need to consider the facts and circumstances and evaluate whether the assistance is in the form of an income tax credit, a payment for goods or services, or a loan before concluding that the assistance is a grant or contribution. The accounting and disclosure implications (e.g., timing of recognition, financial statement presentation) vary significantly, depending on the type of assistance.

How we see it

An entity's accounting for and disclosures about government assistance depend on the type of government assistance it receives. While legislation that provides assistance may use terms such as "grant" or "credit" to describe the form of the assistance, entities need to carefully evaluate the substance of the assistance to determine the appropriate accounting treatment.

Government assistance related to income taxes

We generally believe that a health care entity that receives government assistance in the form of an income tax credit should account for the assistance in accordance with Accounting Standards Codification (ASC) 740, *Income Taxes*.

ASC 740 applies to all federal, foreign, state and local (including franchise) taxes based on income. That is, any tax levied on (or credited to) an entity based on the entity's income (or income tax liability) is generally subject to the provisions of ASC 740. A tax credit from a government entity that isn't based on taxable income would generally be considered a government grant or a contribution and would, therefore, be out of the scope of ASC 740. Refer to section 4.2.8 of our Financial reporting developments (FRD) publication, ***Income taxes***, for additional information on the accounting for government assistance that is in the scope of ASC 740.

Government assistance that represents revenue from a customer

A health care entity that receives assistance from a government entity must consider whether the payment represents revenue or other consideration (e.g., contract liability) related to a contract for the transfer of goods or services to a customer under ASC 606, *Revenue from Contracts with Customers*. It will likely be accounted for under ASC 606 if the government entity making the payment is a third-party payor on behalf of an entity's customer (e.g., a patient). A health care entity should also evaluate whether the assistance is a modification of an existing contract under ASC 606. The guidance in ASC 958-605-55-3A through 55-7 may help the health care entity determine whether individual asset transfers are contributions, exchange transactions (to be accounted for under ASC 606, for example) or a combination of both.

Government assistance related to a loan

We generally believe that an entity that receives government assistance in the form of a loan should account for it as debt under ASC 470, *Debt*, unless the loan may be forgiven. In those circumstances, it may be acceptable to account for the government assistance as a grant or contribution (e.g., PPP loans, as discussed further below) rather than a loan.

When the government assistance is accounted for as a loan, entities should recognize a liability for the full amount of loan proceeds received and accrue interest over the term of the loan. For below-market interest rate loans, an entity may not need to impute additional interest at a market rate, depending on the facts and circumstances of the government assistance. This is because the guidance on imputing interest in ASC 835-30, *Interest — Imputation of Interest*, excludes transactions where interest rates are prescribed by a government agency (e.g., government-guaranteed obligations).

Accounting for a government grant

Not-for-profit health care entities

A not-for-profit health care entity that receives government assistance that is not an income tax credit, revenue from a contract with a customer or a loan should apply the guidance in ASC 958-605, *Not-For-Profit Entities — Revenue Recognition*.[1] Generally, government grants are treated as contributions received and should be recognized as revenue or gains in the period received, unless donor-imposed conditions exist. As discussed in ASC 958-605-25-5A, a contribution is conditional when the agreement includes both:

- A barrier (or barriers) that must be overcome for the recipient to be entitled to the resources
- A right of return for the assets transferred (or a right of release of the promisor's obligation to transfer assets)

Under ASC 958-605-25-5F, if a recipient determines that it must meet specific conditions imposed by the government entity to be entitled to either receive or keep the grant, recognition of contributions in the income statement is deferred until the condition, or conditions, are "substantially met." "Substantially met" is not defined in the standard, but it is generally considered to be a higher threshold than "probable" or "reasonably assured." The likelihood that conditions will be met is not considered by a not-for-profit health care entity in determining whether grants are conditional or unconditional.

Under ASC 958-605-25-2A, entities are also required to consider whether government grants contain restrictions on the use of funds. If restrictions exist, contributions should be reported as an increase in net assets with donor restrictions (assuming any conditions have been substantially met). When the restrictions are satisfied, the contribution is reclassified to net assets without donor restrictions.

Under ASC 958-605-45-4A, a not-for-profit entity may elect to report donor-restricted contributions in net assets without donor restrictions if the restrictions are met in the same reporting period that the revenue is recognized, provided that the not-for-profit entity has a similar policy for reporting investment gains and income, reports consistently from period to period and discloses its accounting policy. This is referred to as the simultaneous release option.

In accordance with ASC 958-605-25-2, the classification of contributions received as revenue or gains depends on whether they are transactions that are part of the not-for-profit entity's ongoing major or central activities or are peripheral or incidental to the not-for-profit entity. If the contributions are part of the entity's ongoing major or central activities, they should be presented as revenue (separate from revenue from contracts with customers). Otherwise, they should be presented as gains.

Entities accounting for contributions under ASC 958-605 should also consider the guidance in ASC 958-205-45-11, which is generally known as the first-dollar rule, to determine when conditional, donor-restricted awards should be recognized (e.g., Provider Relief Fund distributions, Federal Emergency Management Agency (FEMA) Public Assistance awards). The first-dollar rule states, "If an expense is incurred for a purpose for which both net assets without donor restrictions and net assets with donor restrictions are available, a donor-imposed restriction is fulfilled to the extent of the expense incurred unless the expense is for a purpose that is directly attributable to another specific external source of revenue." That is, contributions should not be deferred to allow attributable expenses to be offset by cash flows generated from other sources (e.g., general operations) if the conditional, donor-restricted funding is available to be used for the purposes intended.

For-profit health care entities

There is no US GAAP guidance for for-profit health care entities that receive government grants that are not in the form of an income tax credit, revenue from a contract with a customer or a loan. As such, these entities will need to determine the appropriate accounting treatment by analogy to other guidance.

We generally believe that these entities should account for assistance that is not an income tax credit, revenue from a contract with a customer or a loan by analogy to International Accounting Standards (IAS) 20, *Accounting for Government Grants and Disclosure of Government Assistance*, in IFRS. However, analogies to other guidance, such as ASC 958-605 for contributions received by not-for-profits or ASC 450-30, *Contingencies — Gain Contingencies*, also may be appropriate.

Before selecting an accounting policy, a for-profit health care entity should consider whether it has a pre-existing policy for similar grants. If not, it should consider the facts and circumstances of the grant to determine which accounting model would best reflect the nature of the grant. A for-profit health care entity should adequately disclose its accounting policy for such grants and the impact of the grants on the financial statements.

Recognition and measurement overview under IAS 20

Generally, government grants fall into two categories: grants related to assets and grants related to income. The type of grant an entity receives will determine how it presents the grant in its financial statements. Grants related to assets are government grants whose primary condition is that an entity qualifying for them should purchase, construct or otherwise acquire long-term assets. IAS 20 defines grants related to income as all grants, other than those related to assets.

An entity may receive a grant as part of a package of financial or fiscal aid to which a number of conditions are attached. In these cases, the entity may need to exercise judgment to determine whether the criteria for recognizing the grant have been met. Further, grants could have clawback provisions that require the entity to repay the grant if certain conditions are not satisfied. An entity would need to carefully consider these provisions.

Government grants are recognized in the income statement when there is "reasonable assurance" that the for-profit health care entity will comply with any conditions attached to the grant and that the entity will receive the grant. The term "reasonable assurance" is generally considered analogous to "probable" in US GAAP. However, once this threshold is met, an entity does not necessarily recognize the entire grant as income.

Grants should be recognized in the income statement on a systematic and rational basis over the periods in which the for-profit health care entity recognizes as expenses the costs the grants are intended to defray. The method of income recognition should also consider any conditions and clawback provisions. For example, immediate income recognition of grants solely based on cash receipts would only be appropriate if no basis exists for allocating the grant to periods other than the one in which it was received or if it is specifically for expenses already incurred and there are no repayment or clawback provisions.

To determine the timing and pattern of recognition, for-profit health care entities should carefully evaluate the substance of the government assistance arrangement and the conditions attached to the grant. Additionally, for-profit health care entities should adopt a method that is consistently applied to similar fact patterns.

Recognition of grants related to assets under IAS 20

IAS 20 indicates that grants related to assets should be presented in the balance sheet using one of two methods. Under the first method, the grants are recorded as deferred income when they are received. The deferred income is then recognized as grant income over the useful life of the related asset(s), which is frequently the period of depreciation for the related asset, although other periods may also be appropriate.

Under the second method, the funds received are deducted from the carrying amount of the related asset. This results in the qualifying asset being recorded at a lower amount and, therefore, a reduction of depreciation over the life of the asset.

The choice of a method isn't expected to result in fundamentally different income statement effects. However, we understand that it is more common to account for the assistance received as a deduction from the carrying amount of the asset.

Recognition of grants related to income under IAS 20

IAS 20 provides that grants related to income can be presented in one of two ways:

- A credit in the income statement, either separately or under a general heading, such as "other income"
- A reduction to the related expense

These types of grants are recognized in the income statement beginning in the period that the recognition criteria are met, which will likely depend on the conditions of the grant. In many cases, the appropriate method to recognize the grant in income will be apparent. For example, grants and subsidies to reimburse expenses incurred or to supplement sales proceeds are credited in the period in which the expenses or sales are recorded. Grants and subsidies received to defray future expenses (e.g., salaries of a new labor force) or to supplement future sales revenues are deferred and recognized in proportion to the expenses or sales to which they relate.

Accounting considerations for certain government programs

Provider Relief Fund

The CARES Act created a $100 billion Public Health and Social Services Emergency Fund, also known as the Provider Relief Fund, for eligible health care entities. Through other legislation, another $75 billion has been added to the fund. The money is being distributed by HHS, which has created a **website** dedicated to the program that includes, among other things, information on the program, reporting requirements and frequently asked questions (FAQs).

As of the date of this publication, HHS has made or plans to make the following distributions from the Provider Relief Fund:

- A total of $88 billion in three phases of "General Distributions"
- Approximately $56 billion in "Targeted Distributions" for health care providers in areas particularly impacted by the COVID-19 outbreak (e.g., skilled nursing facilities, high-impact area hospitals, rural providers)
- An unspecified amount to be distributed to health care entities for the testing and treatment of uninsured COVID-19 patients provided on or after 4 February 2020

General and Targeted Distributions

Health care entities that receive General and Targeted Distributions must agree to certain legal terms and conditions.

Terms and conditions

Health care entities that receive General and Targeted Distributions must agree to certain legal terms and conditions, including the following:

- The funds are to reimburse the recipient only for health care-related expenses or lost revenues that are attributable to COVID-19.
- The funds may only be used to prevent, prepare for and respond to COVID-19.
- Noncompliance with the terms and conditions is grounds for the recoupment of some or all of the payments by HHS.
- The recipient will not use the funds to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Not-for-profit health care entities

We believe that the terms and conditions described above create both a barrier and a right of return that requires not-for-profit entities to account for these grants as conditional contributions. Further, we generally believe that the requirement that the funds be used for COVID-19-related purposes creates a donor-imposed restriction.[2]

However, we believe that certain other terms and conditions may not create a barrier because they are more administrative in nature, as described in ASC 958-605-25-2C and 25-2D. For example, these administrative requirements relate to attestation of compliance with the terms and conditions, reporting on the use of the funds, consent for public disclosure of the payments received and restrictions on "balance billing," which means a health care provider must not seek collection of out-of-pocket payments from a patient that are greater than what the patient would have been required to pay if the care had been provided by an in-network provider.

Not-for-profit health care entities should account for the receipt of any distributions as refundable advances until they determine that the conditions have been substantially met, as required by ASC 958-605. If the conditions are met in the same period as the restrictions are released, an entity may choose to account for the contribution using the simultaneous release option described above.

For-profit health care entities

The terms described above that would be considered conditions under ASC 958-605 would also be considered conditions under IAS 20. Therefore, a for-profit health care entity should also account for the receipt of funds as refundable advances until it determines that the conditions are reasonably assured to have been met if it is analogizing to IAS 20 or have been substantially met if it is analogizing to ASC 958-605.

Health care-related expenses and lost revenue

The requirements for calculating health care-related expenses and lost revenue attributable to COVID-19 that recipients of General and Targeted Distributions must report to HHS have changed several times since the Provider Relief Fund was created in March 2020.

These changes have financial reporting implications because, after health care entities meet the recognition threshold in the guidance they are applying (i.e., whether the conditions have been substantially met under ASC 958-605 or are reasonably assured to have been met under IAS 20), they use these calculations to determine how much of the Provider Relief Fund distributions they can recognize in the income statement in each reporting period. That is, entities need to consider the HHS requirements that were in effect at the end of each reporting period.

As of the date of this publication, HHS has not issued reporting requirements, or associated calculations, for the Nursing Home Infection Control Program or the Rural Health Clinic Testing Program.

The HHS Post-Payment Notice of Reporting Requirements issued in September (**the September notice**) required health care entities to significantly change the process they previously used to determine amounts to recognize in their financial statements, based on previous HHS guidance. For example, among other changes, HHS revised the measurement of "lost revenues" from a calculation based on declines in monthly revenue due to COVID-19 to a measure more akin to lost operating margins calculated on a cumulative, calendar-year basis. The September notice also required entities to use the following two-step process to calculate and report COVID-19 expenses and lost revenue:

Step 1: Unreimbursed health care-related expenses attributable to COVID-19

Health care expenses attributable to COVID-19 are reported net of other reimbursed sources (e.g., payments received through insurance and/or patients, amounts received from federal, state or local governments) in at least two categories: (1) general and administrative and (2) other health care-related operating expenses. Entities that have received $500,000 or more in payments are required to report these expenses in other subcategories.

Step 2: Lost revenue attributable to COVID-19

The September notice required lost revenue attributable to COVID-19 to be calculated as the negative year-over-year change in patient care operating income, net of health care-related expenses attributable to COVID-19 identified in Step 1. Patient care operating income was defined as an entity's patient care revenue less patient care expenses, and patient care was defined as health care-related services and support provided in a medical setting, home or in the community. Patient care does not include insurance, retail, real estate values, grants or tuition.

Further, the September notice established that lost revenue should be calculated on a cumulative, calendar-year basis, and that an entity can only apply Provider Relief Fund distributions to lost revenue to the extent that the amounts do not exceed the net gain from patient care operating income generated during the same period in 2019. If an entity experienced a net patient care operating loss during calendar year 2019, it may not apply Provider Relief Fund distributions toward lost revenue that would exceed a net zero gain/loss in calendar year 2020.

If recipients do not use the Provider Relief Fund distributions in full by the end of calendar year 2020, they have an additional six months to apply the remaining amounts toward health care-related expenses and lost revenue attributable to COVID-19. Under the September notice, the amount of lost revenue applied in the first six months of 2021 cannot exceed the net income generated in the same period in 2019 (i.e., the first six months).

Health care entities are further required to report various source components included in the Step 1 and Step 2 calculations. These include a breakdown of revenue from various patient care payors (e.g., Medicare, Medicaid, commercial insurance, self-pay) and other governmental assistance received (e.g., PPP loans, FEMA payments).

In its October Post-Payment Notice of Reporting Requirements (**the October notice),** among other changes, HHS revised the definition of lost revenue to be "a negative change in year-over-year actual revenue from patient care related sources." That is, the October notice moved the definition back to lost *revenue* rather than lost *margin*. The overall two-step process introduced in the September notice remained, with corresponding edits for this change.[3]

Further, as of the October notice, entities may only apply Provider Relief Fund distributions up to the difference between their 2019 and 2020 actual patient care revenue for calendar year 2020. The amount of lost revenue applied in the first six months of 2021 cannot exceed the difference between 2019 and 2021 actual revenue (e.g., the first six months of 2021 less the first six months of 2019).

A not-for-profit health care entity may analogize to ASC 606 or IAS 20 to estimate the amount of Provider Relief Fund aid it can recognize as contributions in its income statement.

How we see it

While the changes to the HHS reporting requirements will change an entity's measurement of the amount of Provider Relief Fund distributions it can recognize, we do not believe any of the changes will affect an entity's conclusion about whether it has met the recognition threshold (i.e., whether the conditions have been substantially met under ASC 958-605 or are reasonably assured to have been met under IAS 20).

For financial reporting periods ended after the HHS notices were issued on 19 September 2020 and 22 October 2020, health care entities will need to base their calculations on the applicable reporting requirements. For example, entities with reporting periods ended 30 September 2020 need to use the September notice as their basis of measurement. See the *Subsequent events* section below for further discussion.

Not-for-profit measurement and recognition

A not-for-profit health care entity that determines it has met the threshold for recognizing General and Targeted Distributions from the Provider Relief Fund will also need to consider how to measure the amount it can recognize in the income statement in each period. ASC 958-605 does not specifically address the measurement of contributions that are similar in nature to the Provider Relief Fund distributions. Accordingly, not-for-profit health care entities will need to apply other guidance by analogy. Acceptable choices include, but are not limited to, ASC 606 and IAS 20.

An entity that applies the measurement principles of ASC 606 by analogy would use the concepts of variable consideration (including the constraint) to estimate the contribution amount that it "expects to receive" (i.e., the amount of Provider Relief Fund distributions the entity believes it will retain at the end of the measurement period) using the applicable HHS definitions of health care-related expenses and lost revenues attributable to COVID-19 and its projected and actual results. That is, an entity would not recognize in income any amounts for which it is probable that a significant reversal would occur when the uncertainty associated with the measurement is resolved (e.g., due to improving year-over-year operations).

A not-for-profit health care entity that uses this approach would be required to update the estimated variable consideration (including its estimate of the constraint) at the end of each reporting period. Changes from period to period would be recognized in income in the period of the change (i.e., on a cumulative catch-up basis). A not-for-profit health care entity would not recast any amounts recorded in the income statement for these grants in an earlier period (e.g., 30 June 2020).

Not-for-profit health care entities should consider whether ASC 606 disclosures regarding the estimate of the variable consideration would be helpful to users of the financial statements. For example, an entity may disclose the significant payment terms of the grant, whether the consideration amount is variable and whether the amount has been constrained, as well as the methods, inputs and assumptions used in estimating variable consideration and assessing whether the estimate is constrained.

If at the end of a reporting period an entity determines that it cannot fully recognize the distribution received in the income statement, the remaining amount would continue to be treated as a refundable advance until it can be recognized.

Illustration 1 — Determining the accounting treatment for grant awards received from the Provider Relief Fund

System J, a not-for-profit health care entity with a calendar year end, is experiencing increases in health care-related expenses and lost revenue due to the COVID-19 pandemic. In April 2020, System J received $150 million through the General Distribution allocation of the Provider Relief Fund. Management received the terms and conditions in the same period and attested to compliance through the HHS-provided web portal.

Management determined that the contribution was both conditional and donor-restricted. As such, upon receipt of the $150 million, management recorded the following entry:

Dr. Cash	$150m	
Cr. Refundable advance		$150m

As of 30 June 2020, management concluded that it had substantially met the conditions of the grant and it therefore would be able to recognize contribution revenue. To measure the amount to be recorded, management used the HHS reporting guidance available as of 30 June 2020 and determined that System J incurred $25 million of COVID-19 attributable health care-related expenses through 30 June 2020. Additionally, management determined that System J had experienced $40 million in lost revenue attributable to COVID-19 through 30 June 2020. Management, in accordance with its policy, applied the simultaneous release option and recorded the entire $65 million as contribution revenue in net assets without donor restrictions for the period ended 30 June 2020, as follows:

Dr. Refundable advance	$65m	
Cr. Contribution (other) revenue		$65m

The remaining amount of $85 million, which management expected to recognize in future periods, continued to be recorded as a refundable advance at 30 June 2020.

At 30 September 2020, management updated its measurement of health care-related expenses and lost revenue attributable to COVID-19 using the new guidance and definitions provided by HHS in the September notice. The entity applied the measurement principles of ASC 606 by analogy and used the concept of variable consideration (including the constraint) to estimate the related contribution amount.

For the nine-month period ended 30 September 2020, health care-related expenses attributable to COVID-19, not reimbursed by other sources, were estimated to be $45 million. Lost revenue, as defined in the September notice, was estimated to be $35 million.

Management made these estimates by considering the actual and projected results for both calendar year 2020 and the first six months of 2021 compared with the results for the same periods in calendar year 2019 (e.g., first six months of 2021 compared to the first six months of 2019). Management considered the variable consideration constraint under ASC 606, and these estimates did not include any amounts for which it was probable that a significant reversal of cumulative contribution revenue recognized would occur.

At 30 September 2020, management determined that based on the guidance provided in the September notice, a cumulative total of $80 million of unreimbursed health care-related expenses and lost revenue could be recognized. Accordingly, the entity recorded an additional $15 million[a] of contribution revenue for the period ended 30 September 2020, as follows:

Dr. Refundable advance	$15m	
Cr. Contribution (other) revenue		$15m

The remaining amount of the $150 million distribution (i.e., $70 million) continued to be recorded as a refundable advance at 30 September 2020.

At 31 December 2020, management updated its measurement of health care-related expenses and lost revenue attributable to COVID-19, using the new guidance and definitions provided by HHS in the October and November notices. The entity continued to apply the measurement principles of ASC 606 by analogy, including the concept of variable consideration and the constraint to estimate the contribution amount it could recognize, using both projected and actual results.

For the 12-month period ended 31 December 2020, health care-related expenses attributable to COVID-19, not reimbursed by other sources, were estimated to be $48 million. The measurement of lost revenue was estimated to be $60 million.

Management considered the variable consideration constraint under ASC 606 to estimate any amounts for which it is probable that a significant reversal of cumulative contribution revenue recognized will occur.

At 31 December 2020, management determined that, based on the guidance provided in the October and November notices, a cumulative total of $108 million of unreimbursed health care-related expenses and lost revenue could be recognized. Accordingly, the entity recorded an additional $28 million[b] of contribution revenue for the period ended 31 December 2020, as follows:

Dr. Refundable advance	$28m	
Cr. Contribution (other) revenue		$28m

The remaining amount of the $150 million distribution (i.e., $42 million) continued to be recorded as a refundable advance at 31 December 2020.

[a] $15 million = $80 million of unreimbursed expenses and lost revenues attributable to COVID-19 determined as of 30 September 2020 less $65 million determined as of 30 June 2020.

[b] $28 million = $108 million of unreimbursed expenses and lost revenues attributable to COVID-19 determined as of 31 December 2020 less $80 million determined as of 30 September 2020.

For-profit measurement and recognition

For-profit entities analogizing to IAS 20 (and not-for-profit health care entities analogizing to IAS 20 to measure the amount they can recognize) should generally consider General and Targeted Distributions received as grants related to income. Under IAS 20, after an entity

determines it is reasonably assured that it will comply with the conditions attached to the grant (as described above), it recognizes distributions received from the Provider Relief Fund in the income statement on a systematic and rational basis.

Under IAS 20, we believe that health care entities should estimate the fair value of the grant using the applicable HHS definitions of health care-related expenses and lost revenue attributable to COVID-19, considering the entity's projected and actual results, at the end of each reporting period. Any changes in estimate will be recognized in the income statement in the period of change and in future periods in accordance with the guidance in ASC 250 on changes in estimates. That is, the entity would not recast any amounts recorded in the income statement for these grants in an earlier period (e.g., 30 June 2020). The disclosure requirements of ASC 250 related to changes in estimates also apply.

If at the end of a reporting period an entity determines that it cannot fully recognize the distribution received in the income statement, the remaining amount would continue to be treated as a refundable advance until it can be recognized.

Other reporting considerations and deadlines

Health care entities that have received and retained Provider Relief Fund distributions may be subject to audits by HHS to validate the accuracy of data submitted (in addition to the federal expenditure audit requirements discussed later in this publication). Any inaccurate information provided may make distributions subject to recoupment or legal actions. Recipients of distributions from the Provider Relief Fund should maintain appropriate records and cost documentation, using, as reference, guidance provided in the following sections of the Code of Federal Regulation (CFR): 45 CFR § 75.302 – *Financial management* and 45 CFR § 75.361 through 75.365 – *Record retention and access*.[4]

In **the September notice**, HHS defined the Reporting Entity as the entity that received one or more Provider Relief Fund payments at the tax identification number (TIN) level and said that General Distributions received by a Reporting Entity and its subsidiaries may be directed for use and reported by the Reporting Entity. However, Targeted Distributions received by subsidiary entities could not be aggregated and must be reported at the subsidiary TIN level.

In **the October notice**, HHS changed the definition of the Reporting Entity to be the entity that received one or more Provider Relief Fund payments at the TIN level *or* an entity that meets the following three criteria: (1) it is the parent of one or more subsidiary billing TINs that received General Distribution payments, (2) it 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 31 January 2020, and (3) it can attest to the terms and conditions of the Provider Relief Fund distributions. Consistent with the September notice, the determined Reporting Entity may continue to aggregate, direct for use and report General Distributions; however, the Targeted Distributions received by subsidiary entities may not be aggregated and must be reported at the subsidiary TIN level.

How we see it

HHS' changes to its reporting requirements have generated numerous questions from health care entities regarding how the reporting guidance should be applied and how health care-related expenses and lost revenue attributable to COVID-19 should be calculated. Entities should monitor the HHS website for any new guidance or FAQs HHS may issue because they could have a significant impact on the measurement, recognition and reporting of the distributions received.

All recipients of Provider Relief Fund distributions must submit an initial report to HHS within 45 days of the end of calendar year 2020 (i.e., by 15 February 2021) on the use of funds through the period ending 31 December 2020. Recipients with funds they haven't used as of 31 December 2020 must also submit a second and final report no later than 31 July 2021.

As of the date of this publication, HHS planned to open its system for recipients to submit their reports beginning on 15 January 2021.[4]

For information regarding other government funding audit requirements, including government compliance audits, please see the *Audit requirements for entities expending federal funds* section below.

Uninsured patient testing and treatment programs

Health care entities providing COVID-19 testing and treatment for individuals who were uninsured at the time of treatment may receive funding reimbursement, generally from the Health Resources and Services Administration (HRSA), an HHS agency, at standard Medicare rates. Because claim reimbursements are made based on care provided to patients, entities should account for those services as exchange transactions subject to ASC 606.[5] These reimbursements are excluded from the HHS reporting requirements discussed above. As of the date of this publication, HHS has not released audit and reporting requirements related to these programs.

CMS Accelerated and Advance Payments Program

Section 3719 of the CARES Act expanded the Centers for Medicare & Medicaid Services (CMS) Accelerated and Advance Payments Program and allowed it to be used by a broader group of health care entities for the duration of the public health emergency.

Advance payments from CMS should initially be recorded as contract liabilities.

Generally, health care entities that receive advance Medicare payments for patient care should account for payments they receive through the CMS Accelerated and Advance Payments Program as contract liabilities in accordance with ASC 606.[6] CMS recoups those amounts by deducting them from newly submitted claims. During the recoupment period, health care entities should reduce the contract liability for the amount of Medicare claims recognized as revenue.

A health care provider that does not expect to use all of the advance payments it received before the end of the recoupment period should reclassify the amount it doesn't expect to use as a refund liability. Entities should perform this assessment at the end of each reporting period. Entities also need to reevaluate the current and long-term portions of their liabilities.

On 1 October 2020, a continuing resolution extended the recoupment period in the CMS Accelerated and Advance Payments Program to give health care entities one year from receipt of advance payments before CMS begins to recoup any amounts. Before this change, the recoupment period was from 120 to 210 days after receipt. See the *Subsequent events* section below for details on how this change may affect financial statements for periods ending before 1 October 2020 that weren't issued, or available to be issued, before the change.

Once the recoupment period begins, 25% of the claims amount will be withheld for the 11 months that follow and 50% of the claims amount will be withheld for the following six months. In total, a health care entity will have 29 months from the time it receives the first advance payment to repay any advances. After the repayment period expires, the remaining balance will be subject to interest. The interest rate, which was previously 10.25%, has been reduced to 4%.[7]

FEMA Public Assistance

FEMA is providing eligible not-for-profits with reimbursements for emergency protective measures taken to respond to the COVID-19 pandemic, which may include expanding existing medical care capacity and increasing costs of operating emergency departments or temporary medical care facilities, through its Public Assistance program. The expenses must qualify for reimbursement, and any disallowed costs are required to be refunded to FEMA.

This assistance should generally be accounted for as a contribution in accordance with ASC 958-605. The contribution is both conditional and donor-restricted because of the requirement that the entity incur qualifying expenses. Due to the terms and conditions of the contribution, the donor restrictions would likely be satisfied simultaneously when the conditions of the award are met.

Contributions should not be recorded in income until a "promise to give" is specified, which we believe occurs when both federal and state government approvals have been received. In many cases, both the condition and the donor restriction will be met when the grant is approved because the expenditures have already been incurred. However, if a FEMA claim includes estimates of future expenses, entities should treat the portion of the award received as a refundable advance until the related expenses have been incurred.[8]

Entities receiving FEMA Public Assistance or applying for it need to consider whether other relief they are receiving (e.g., distributions from the Provider Relief Fund) makes them ineligible for FEMA assistance. FEMA funding cannot be used to offset expenses that have already been reimbursed or offset through other funding sources. Accordingly, appropriate tracking of expenses and their related reimbursements will be important.

For-profit health care entities are not eligible for FEMA Public Assistance awards but may receive funding through contracts with government entities that have received FEMA distributions. Depending on the facts and circumstances of such a contract, this type of funding will be accounted for as either an exchange transaction or a grant.

Paycheck Protection Program

The CARES Act created the PPP to provide certain small businesses with liquidity to support their operations during the COVID-19 pandemic. Entities had to meet certain eligibility requirements to receive PPP loans, and they must maintain specified levels of payroll and employment over a specified period to have the loans forgiven. Details about the PPP can be found in ***FAQs*** published by the Small Business Administration (SBA). The conditions are subject to audit by the US government (although they are currently not subject to a Uniform Guidance audit as discussed below).

Because the legal form of a PPP loan is debt, it is acceptable for all health care entities to account for PPP proceeds as debt under ASC 470, regardless of whether they expect their loans to be forgiven. Further, a health care entity that does not expect to meet the PPP eligibility and loan forgiveness criteria must account for the proceeds as debt.

However, a health care entity that expects to meet the PPP's eligibility and loan forgiveness criteria could elect to account for the proceeds as a government grant (as discussed above). That is, a not-for-profit health care entity would apply ASC 958-605 and a for-profit-health care entity could analogize to either IAS 20, ASC 958-605 or ASC 450-30. The loan eligibility and forgiveness requirements are the conditions that would need to be either substantially met (under ASC 958-605) or reasonably assured to be met (under IAS 20) for the PPP proceeds to be accounted as a government grant.

A health care entity that accounts for the PPP proceeds as a government grant will need to continually reassess its ability to meet the forgiveness conditions, and it may have to reverse income if it can no longer support a conclusion that it expects to meet the conditions.

How we see it

To participate in the PPP, entities needed to certify that economic uncertainty related to the COVID-19 pandemic made the loan necessary to support their operations. Therefore, both for-profit and not-for-profit health care entities with alternate sources of funding need to carefully evaluate whether they met the eligibility requirements and can support that view. Further, while the criteria for loan forgiveness appear to be objective, entities that received PPP loans should closely monitor developments because the SBA has continued to issue guidance (mainly in the form of FAQs) to address questions from borrowers and lenders.

For further information about the program, see our Technical Line, ***How to account for proceeds from Paycheck Protection Program loans***.

Employee Retention Credit

The Employee Retention Credit (ERC) is designed to encourage entities to keep employees on their payroll, despite economic hardship due to the COVID-19 pandemic. A health care entity is eligible for the ERC if it has not received a PPP loan and (1) its operations have been fully or partially suspended because of COVID-19 or (2) its gross receipts in a calendar quarter in 2020 declined by more than 50% from the same period in 2019.

An eligible entity may take a credit against the employer portion of Social Security taxes withheld on qualified wages. Qualifying wages include wages, certain compensation and certain health plan expenses and are defined by the average number of employees the entity had in 2019.

The credit is limited to 50% of up to $10,000 of qualified wages paid to each employee from 13 March through 31 December 2020. An entity can also receive an advance payment if it anticipates receiving a credit that exceeds the amount of the entity's employment tax deposits.

Because this assistance is not an income tax credit in the scope of ASC 740, a not-for-profit health care entity would account for the credit as a contribution under ASC 958-605, while a for-profit health care entity could analogize to IAS 20, ASC 958-605 or ASC 450-30. Under ASC 958-605 and IAS 20, respectively, a health care entity would perform an assessment of whether the conditions of the grant have been substantially met or are reasonably assured of being met before it could recognize the assistance in its income statement.

To date, entities have found it challenging to determine what wages qualify for the ERC and that they have complied with all the conditions to realize the ERC due to the lack of clear guidance on qualification. An entity will need to perform a careful analysis of its facts and circumstances to determine whether it meets the criteria required under the standard it applies to recognize the ERC benefit in its financial statements.

Other accounting considerations

Transaction price and variable consideration

Health care entities need to consider whether there have been any changes in their pricing and terms and conditions of both new and existing contracts with customers as a result of the COVID-19 pandemic. Any such changes and any government aid entities are receiving for exchange transactions will affect transaction price estimates under ASC 606.

Health care entities also need to consider whether the historical collection data they may use to estimate variable consideration, such as explicit price concessions (e.g., contract adjustments) and implicit price concessions, continues to be appropriate for determining the transaction price they expect to be entitled to receive for transferring goods and services to a customer.

Some factors entities should consider include:

- Expected increases in the admission of uninsured or underinsured patients who are unable to pay
- Increased lag times in expected payments from third-party payors
- Changes in both the third-party payor mix and patient mix (e.g., due to changes in the mix of elective and essential services)
- Extended inpatient stays
- The temporary suspension of the 2% payment adjustment to Medicare fee-for-service claims due to sequestration (i.e., CARES Act Section 3709)[9]

- Medicare reimbursement increases up to 20% for individuals being treated for COVID-19 (i.e., CARES Act Section 3710)[9]

For more information about evaluating the potential effects on revenue recognition related to COVID-19, please see our Technical Line, ***Revenue recognition considerations for the effects of the COVID-19 pandemic***.

Contributed nonfinancial assets

Contributed nonfinancial assets, including inventory (e.g., personal protective equipment called PPE, equipment such as ventilators), should be measured, when initially recognized, at fair value in accordance with ASC 820. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. It may be challenging for a health care entity to estimate the fair value of certain contributed assets that are not common to the marketplace (e.g., new drugs). In these cases, entities should use the best information available when they apply the fair value framework. An entity's valuation technique should maximize the use of observable inputs, which may mean news articles and research publications.

Once recognized, contributed inventory is evaluated for impairment under ASC 330, *Inventory*, as described further below. Contributed equipment should be evaluated for impairment in accordance with ASC 360, *Property, Plant, and Equipment*. More information about long-lived asset impairment is available in in our Technical Line, ***Accounting and reporting considerations for the effects of the coronavirus outbreak***.

Inventory valuation and impairment

Health care entities may have experienced a significant increase in inventory (e.g., PPE), especially in the initial months of the pandemic. That is, when demand increased sharply and supply was limited, health care entities often paid as much as 10 times the average cost for PPE and may have purchased more PPE than they normally carry on hand. These two factors may put pressure on a health care entity's assessment of the recoverability of its inventory.

Health care entities generally measure their inventory at the lower of cost (typically determined using the first-in, first-out or average cost methods) or net realizable value. If there is a decline in the net realizable value or utility of inventory, ASC 330 requires entities to recognize the decline as a charge in the period in which it occurs. A loss may result from damage, contamination, physical deterioration, obsolescence, changes in price levels or other causes.

ASC 330 defines the term net realizable value as "estimated selling prices in the ordinary course of business, less reasonably predictable costs of completion, disposal and transportation." Determining estimated selling prices can be challenging for health care entities because their inventory generally comprises material to be used in providing health care services rather than finished goods to be sold to customers. In addition, because of the unique reimbursement methodologies at health care entities, determining the net realizable value of inventory may be challenging and require the use of significant judgment, particularly when prices are declining or volatile.

All relevant factors should be considered when estimating net realizable value and determining the appropriateness of a potential write-down of inventory.

Financial statement disclosures

The financial statement disclosures of government assistance that health care entities should make depend on which accounting standards they apply (e.g., ASC 958-605, IAS 20). Further, if the amount of government assistance received is material, the method of accounting for the assistance should be included in the disclosure of accounting policies.

An entity may also consider disclosing (1) a description of the nature and extent of the grants recognized, (2) the amount included in the income statement or deferred, (3) the basis for recognizing deferred amounts, (4) the terms and conditions of the grants and any unfulfilled conditions, and (5) contingent liabilities for repayment. If benefits are recognized in the income statement as they are received, the entity might disclose how long it expects the benefits to continue, if the amounts are material.

Health care entities that are Securities and Exchange Commission (SEC) registrants also need to consider disclosures required by SEC rules. For more information, see the *SEC reporting and disclosures* section our Technical Line, ***Accounting and reporting considerations for the effects of the coronavirus outbreak***.

Subsequent events

Health care entities need to consider whether changes to the requirements for government assistance programs that occur after their balance sheet date but before the financial statements are issued, or are available to be issued, represent recognized (Type I) or nonrecognized (Type II) subsequent events under ASC 855, *Subsequent Events*.

Type I subsequent events are those that provide additional evidence about conditions that existed at the balance sheet date. Type II subsequent events are those that provide evidence about conditions that did not exist at the balance sheet date and arose subsequent to that date but before the financial statements are issued (or are available to be issued).

HHS notices of reporting requirements for the Provider Relief Fund

We generally expect affected entities to consider the changes in HHS' 19 September 2020 Post-Payment Notice of Reporting Requirements for calculating health care-related expenses and lost revenue attributable to COVID-19 to be a Type II subsequent event if they hadn't yet issued, or made available for issuance, financial statements for periods that ended before the notice was issued (e.g., a period ended 30 June 2020). That is, we would expect these entities to conclude that the conditions did not exist at the balance sheet date and are not recognized in the financial statements.

We would expect an entity to reach the same conclusion about HHS' 22 October 2020 Post-Payment Notice of Reporting Requirements if it hadn't yet issued, or made available for issuance, financial statements for periods that ended before the notice was issued (e.g., a period ended 30 September 2020).

However, these events may be of such a nature that disclosure of them is required to keep the financial statements from being misleading. When disclosures are required to keep the financial statements from being misleading, ASC 855 requires that entities should disclose both the nature of the event and an estimate of its financial effect, or a statement that such an estimate cannot be made.

Medicare Accelerated and Advance Payments Continuing Resolution

We generally expect entities that received funding from the CMS Accelerated and Advance Payments Program to consider the changes to the rules that were enacted on 1 October 2020 a Type II subsequent event if they had not yet issued, or made available for issuance, financial statements for periods that ended before the continuing resolution was enacted (e.g., a period ended 30 September 2020). That is, we would expect them to conclude that any impact of the changes should not be recognized in the financial statements for the period. However, ASC 855 disclosures may need to be made.

Audit requirements for entities expending federal funds

Many not-for-profit and for-profit health care entities that are receiving COVID-19 assistance from the federal government may for the first time be subject to a federal requirement that they have certain federal or HHS funds audited because the amount of relief exceeds the threshold for an audit. These audit requirements are summarized below.

However, certain government assistance programs, such as the PPP, are subject to audit by the issuing agency (e.g., SBA) but are not subject to the further federal audit requirements discussed in this section. The American Institute of Certified Public Accountants (AICPA) has issued nonauthoritative guidance that includes a summary of all new federal programs created in response to the COVID-19 pandemic, which has additional information on the applicability of federal compliance and audit requirements.[10] Entities should consult all available guidance to understand which requirements apply.

Not-for-profit health care entities

Not-for-profit health care entities that expend $750,000 or more in federal awards in a fiscal year are required to obtain an audit (called a single audit) for that fiscal year under Title 2 U.S. *CFR* Part 200, *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (Uniform Guidance).

Many not-for-profit and for-profit health care entities receiving COVID-19 assistance may for the first time be subject to government audit requirements.

Federal expenditures that are subject to Uniform Guidance audit requirements must be reported on the Schedule of Expenditures of Federal Awards (SEFA). To do so, entities will need to identify each federal program from which they expend awards by both their Assistance Listing number and their program name. Assistance Listing numbers (formerly known as the Catalog of Federal Domestic Assistance number) are assigned to help nonfederal entities identify (1) federal programs, (2) the related program objectives and (3) the program-specific requirements. New federal programs that are subject to the Uniform Guidance audit requirements are identified at beta.sam.gov.

Entities that expend distributions from the CARES Act Provider Relief Fund will need to determine, based on where the funding came from and how it was used, the appropriate Assistance Listing numbers and program names under which expenditures should be reported. Programs related to CARES Act Provider Relief Fund distributions include 93.461 — COVID-19 Testing for the Uninsured, 93.697 — COVID-19 Testing for Rural Health Clinics and 93.498 — Provider Relief Fund.

The following is a list of certain new federal programs that were created by the CARES Act and related appropriations that are subject to the Uniform Guidance audit requirements as noted in beta.sam.gov as of the date of this publication. Many not-for-profit health care entities may expend federal awards under these programs, and they should be aware of these programs when assessing the completeness of their SEFA.

Assistance Listing #	Federal program name
21.019	Coronavirus Relief Fund
32.006	COVID-19 Telehealth Program
84.425	Higher Education Emergency Relief Fund
93.461	COVID-19 Testing for the Uninsured
93.498	Provider Relief Fund
93.665	Emergency Grants to Address Mental and Substance Use Disorders During COVID-19
93.697	COVID-19 Testing for Rural Health Clinics

The table above does not list all federal grant programs that health care entities may receive and expend funds from. It is meant to identify new COVID-19 programs that health care entities are likely to participate in. Not all of the programs listed are discussed in this publication.

Not-for-profit health care entities that are subject to Uniform Guidance audit requirements are also generally required to have the following:

- An audit of the entity's financial statements in accordance with Government Auditing Standards (GAS), which should include an independent auditor's report on internal control over financial reporting and on compliance and other matters based on the audit of the financial statements
- An audit of the SEFA in relation to the financial statements in accordance with GAS
- A compliance audit of each major federal program, including an independent auditor's report on internal control over compliance, a schedule of findings and questioned costs, a summary schedule of prior audit findings (if applicable) and a corrective action plan (if applicable)

The US Office of Management and Budget (OMB) has indicated that the compliance requirements subject to audit for certain new federal programs will be issued in the form of an addendum to the 2020 OMB Compliance Supplement (the Addendum). Entities are responsible for complying with all of the requirements for a federal program.

As of the date of this publication, guidance has not yet been issued on (1) when expenditures of federal awards and lost revenue for certain new federal programs should be reported on the SEFA, (2) the amounts of federal expenditures and lost revenue for the Provider Relief Fund that should be reported on the SEFA and (3) whether PPE and pharmaceuticals received from federal sources should be reported on the SEFA and, if so, how these contributions should be valued. Answers to these questions are critical to determining whether a not-for-profit entity will meet the expenditure threshold to require a Uniform Guidance audit and the number of federal programs that would be audited as major federal programs.

For-profit health care entities

For-profit health care entities that expend $750,000 or more in their given fiscal year in HHS awards are not automatically subject to the Uniform Guidance audit requirements. However, HHS regulations indicate that for-profit entities that expend HHS assistance in annual amounts at or above the $750,000 threshold (e.g., Provider Relief Fund distributions) can elect to have either of the following to be performed:

- A full Uniform Guidance audit, similar to the audit conducted for a not-for-profit entity
- A "financial related audit" of a schedule of expenditures of HHS Awards or equivalent statement (Schedule), in accordance with GAS

As of the date of this publication, guidance is still being developed on the financial related audit of the Schedule. This guidance is expected to include information regarding which HHS awards are to be included in the Schedule, when and what amount of HHS expenditures are to be recorded on the Schedule and the form of the related audit report(s).

How we see it

We expect most for-profit entities subject to the HHS audit requirements will elect to have a financial related audit of the Schedule performed rather than a full audit because it is likely less costly.

Endnotes:

1 We have assumed the adoption of Accounting Standards Update No. 2018-08, *Not-For-Profit Entities (Topic 958): Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made*, which amended ASC 958-605.

2 This is consistent with the conclusion reached in the non-authoritative AICPA Q&A Section 6400.64, *Health Care Entities — Accounting for Provider Relief Fund Phase 1 General Distribution Payments.*

3 On 2 November 2020, HHS issued another Post-Payment Notice of Reporting Requirements, which confirmed the intent of its October notice (i.e., health care-related expenses attributable to COVID-19 identified in Step 1 are no longer required to be netted against patient care lost revenues in Step 2).

4 See **https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/reporting-auditing/index.html** for further information.

5 This is consistent with the conclusion reached in the non-authoritative AICPA Q&A Section 6400.67, *Health Care Entities — Accounting for Uninsured Pool Portion of Provider Relief Funds*.

6 This is consistent with the conclusion reached in the non-authoritative AICPA Q&A Section 6400.68, *Health Care Entities — Accounting for Payments Received Under the Medicare Accelerated and Advance Payment Program*.

7 See **https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf** for further information.

8 This is consistent with the conclusion reached in the non-authoritative AICPA Q&A Section 6400.70, *Health Care Entities — FEMA Public Assistance Payments to NFP Health Care Entities for Emergency Protective Measures During the COVID-19 Pandemic*.

9 See AICPA Q&A Section 6400.69, *Health Care Entities — Accounting for Temporary Increases in Medicare and Medicaid Payments*.

10 Refer to the AICPA Governmental Audit Quality Center's *Summary of Uniform Guidance (UG) Applicability for New COVID-19-Related Federal Programs, as of 4 September 2020*.