the type of services covered by the LOA.

(2) For HCPs located on Tribal lands, if the health care facility is a contract facility that is run solely by the tribe, the appropriate tribal leader, such as the tribal chairperson, president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another tribal government representative.

[78 FR 13985, Mar. 1, 2013]

§ 54.633 Health care provider contribution.

(a) *Health care provider contribution.* All health care providers receiving support under the Healthcare Connect Fund shall receive a 65 percent discount on the cost of eligible expenses and shall be required to contribute 35 percent of the total cost of all eligible expenses.

(b) *Limits on eligible sources of health care provider contribution.* Only funds from eligible sources may be applied toward the health care provider's required contribution.

(1) Eligible sources include the applicant or eligible health care provider participants; state grants, funding, or appropriations; federal funding, grants, loans, or appropriations except for other federal universal service funding; Tribal government funding; and other grant funding, including private grants.

(2) Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from vendors or other service providers, including contractors and consultants to such entities; and for-profit entities.

(c) *Disclosure of health care provider contribution source.* Prior to receiving support, applicants are required to identify with specificity their sources of funding for their contribution of eligible expenses.

(d) *Future revenues from excess capacity as source of health care provider contribution.* A consortium applicant that receives support for participant-owned network facilities under § 54.636 may use future revenues from excess capacity as a source for the required health care provider contribution, subject to the following limitations.

(1) The consortium's selection criteria and evaluation for ''cost-effectiveness'' pursuant to § 54.642 cannot provide a preference to bidders that offer to construct excess capacity.

(2) The applicant must pay the full amount of the additional costs for excess capacity facilities that will not be part of the supported health care network.

(3) The additional cost of constructing excess capacity facilities may not count toward a health care provider's required contribution.

(4) The inclusion of excess capacity facilities cannot increase the funded cost of the dedicated health care network in any way.

(5) An eligible health care provider (typically the consortium, although it may be an individual health care provider participating in the consortium) must retain ownership of the excess capacity facilities. It may make the facilities available to third parties only under an indefeasible right of use (IRU) or lease arrangement. The lease or IRU between the participant and the third party must be an arm's length transaction. To ensure that this is an arm's length transaction, neither the vendor that installs the excess capacity facilities nor its affiliate is eligible to enter into an IRU or lease with the participant.

(6) Any amount prepaid for use of the excess capacity facilities (IRU or lease) must be placed in an escrow account. The participant can then use the escrow account as an eligible source of funds for the participant's 35 percent contribution to the project.

(7) All revenues from use of the excess capacity facilities by the third party must be used for the health care provider contribution or for sustainability of the health care network supported by the Healthcare Connect Fund. Network costs that may be funded with any additional revenues that remain include administration, equipment, software, legal fees, or other costs not covered by the Healthcare Connect Fund, as long as they are relevant to sustaining the network.

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