Community Benefit Reporting: *Health Professions Education*

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COMMUNITY BENEFIT REPORTING: HEALTH PROFESSIONS EDUCATION

For many years, the Catholic Health Association of the United States and Vizient (CHA/Vizient) have published guidelines to help hospitals plan and report community benefits. CHA and Vizient are pleased to provide this additional resource which contains information designed to help hospital organizations report Health Professions Education as community benefit.

For community benefit reporting purposes on IRS Form 990, Schedule H, *Health Professions Education* is defined as:

> *"educational programs that result in a degree, certificate or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty."*

The expenses that hospital organizations incur in providing the education that physicians, nurses and other health professionals need to obtain and maintain licenses or certifications to practice in their health profession(s) thus are reportable as community benefit, net of certain revenues associated with these programs.

On Schedule H, hospital organizations also can report contributions they make to other entities (e.g., medical schools, nursing schools and ambulatory care entities) that provide Health Professions Education as defined by the Schedule H instructions.

Several issues and questions have arisen over the years regarding how to report this important category of community benefit. This document is designed to help and is organized into the following sections:

- Why Health Professions Education is reported as community benefit,
- Summary of Schedule H instructions regarding Health Professions Education,
- Health Professions Education: What Counts, and
- Health Professions Education: Accounting and Reporting Issues and Approaches.

What you need to know

- Many tax-exempt hospitals support Health Professions Education programs that provide community benefits.
- Hospitals sometimes under-report allied health education programs (e.g., nurses, occupational therapists, pharmacists, and other professions).
- Hospitals have become more conservative when reporting expenses for precepting nursing and other allied health students.
- This paper describes how information can be gathered and assessed for reporting.

WHY HEALTH PROFESSIONS EDUCATION IS REPORTED AS COMMUNITY BENEFIT

The IRS has determined that **advancing medical training and education** is a factor in considering whether a hospital organization operates to benefit the community, is "described in Section 501(c)(3)"

of the Internal Revenue Code,[1] and thus qualifies for tax-exempt status.

IRS Rev. Rul. 69-545 provides examples illustrating whether a hospital organization is described in Section 501(c)(3) and provides community benefit, including "using surplus funds to advance **medical training, education,** and research."[2] The IRS further states that "by using surplus funds to advance its **medical training, education,** and research programs, a hospital is promoting the health of the community."[3]

Schedule H instructions integrate these and other concepts into the definition of *community benefit*. The instructions state:

"Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following.

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial or cultural barriers to accessing health services and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to health care services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- **Advance increased general knowledge through education or research that benefits the public."**[4]

Many hospital organizations devote resources to educate health professionals as an important component of their missions. They provide clinical and educational experiences for many more students than are needed for their own medical and hospital staffs. They recognize that these programs are important to addressing current and future shortages of health professionals and to assuring that communities preserve and enhance access to care.

Medicare and Medicaid reimbursement provided to hospitals to offset costs of Health Professions Education further illustrates wide consensus that medical training and education benefits communities.

- Since the beginning of the Medicare program, the federal government has recognized the importance of supporting Graduate Medical Education (GME) and education of allied health professionals (e.g., nurses, physical therapists, laboratory technicians, pharmacists, and others).[5] When establishing the Medicare program and specifying that Medicare should provide financial support, Congress indicated that medical education benefits society broadly.[6]

1. https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3
2. Ibid, emphasis added.
3. Ibid.
4. Instructions for Schedule H (Form 990), emphasis added.
5. https://www.nhpf.org/uploads/Handouts/Miller-slides_02-20-15.pdf
6. Ibid.

The Medicare program provided a mechanism for helping to address physician, nursing and other allied health professionals shortages.[7,8]

- Similarly, over 40 states also provide Medicaid reimbursement specifically to offset costs incurred by hospitals in providing GME.[9]

SCHEDULE H INSTRUCTIONS: HEALTH PROFESSIONS EDUCATION

The Schedule H instructions provide a definition of *Health Professions Education* activities and programs that hospital organizations may report as community benefit. The instructions state:

> *"Health professions education" means educational programs that result in a degree, certificate or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty. It doesn't include education or training programs available exclusively to the organization's* ***employees*** *and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community. Costs for medical residents and interns can be included, even if they are considered "employees" for purposes of Form W-2, Wage and Tax Statement."*[10]

The instructions also provide examples of activities or programs that should and shouldn't be reported. As with other types of community benefit, Health Professions Education activities and programs are reportable if they are intended primarily to benefit the community, rather than the organization. Accordingly, hospitals are instructed that if students are required to become employees upon graduation, the expenses incurred in training them are not reportable as community benefit. Expenses for continuing medical education (CME) also are not reportable if the programs are available only to members of the organization's medical staff or only to its employees.

The instructions also include Worksheet 5 and direct hospital organizations to:

- Include both direct and indirect (overhead) costs — but not to include the estimated cost of "indirect medical education" (IME).[11]
- Include stipends, fringe benefits of interns, residents, and fellows in accredited graduate medical education programs (GME).
- Include salaries and fringe benefits of faculty directly related to intern and resident education.
- Include salaries and fringe benefits of faculty directly related to teaching:
  1. Medical students,[12]
  2. Students enrolled in nursing programs that are licensed by state law or, if licensing isn't required, accredited by the recognized national professional organization for the particular activity,
  3. Students enrolled in allied health professions education programs, licensed by state law or, if licensing isn't required, accredited by the recognized national professional organization for the particular activity, including, but not

7. https://oig.hhs.gov/oas/reports/region9/99300096.pdf

8. https://www.kslaw.com/attachments/000/006/065/original/Emerging_Issues_in_Reimbursement_for_Allied_Health_Education_-_Scrutiny_of_N_AH_programs_ramps_up.pdf?1531249360

9. https://store.aamc.org/downloadable/download/sample/sample_id/284/

10. Instructions for Schedule H (Form 990).

11. IME expenses represent additional *clinical* costs associated with operating a hospital that trains interns and residents (beyond costs recognized as direct graduate medical education or DGME). IME reimbursement provided by the Medicare program (and in some states by Medicaid) also is not included in direct offsetting revenue.

12. Sometimes referred to as undergraduate medical education or UME.

limited to, programs in pharmacy, occupational therapy, dietetics, and pastoral care, and

4. Continuing health professions education open to all qualified individuals in the community, including payment for development of online or other computer-based training accepted as continuing health professions education by the relevant professional organization.

- Include the costs of scholarships provided by the organization to community members.

Regarding direct offsetting revenues, hospital organizations are to include:

- Medicare reimbursement for direct GME,[13]
- Direct GME reimbursement received for services provided to Medicare Advantage patients,
- Medicare reimbursement for approved nursing and allied health education activities,[14]
- The direct portion of Children's Hospital Graduate Medical Education (CHGME) reimbursement,
- The direct portion of Medicaid reimbursement for GME and for nursing and allied health education (if any),[15]
- Revenue received for continuing health professions education reimbursement or tuition, and
- Other revenue (e.g., reimbursement provided by other payers like TriCare that follows the Medicare payment model and grants received for Health Professions Education).

Several issues and questions have arisen over the years regarding how to report Health Professions Education. The following sections are intended to provide helpful clarifications.

HEALTH PROFESSIONS EDUCATION: WHAT COUNTS ISSUES

The section that follows discusses several issues regarding "what counts" as Health Professions Education, including:

- Assuring that all reportable Health Professions Education programs have been identified,
- Whether program start-up, library, and other education-related expenses are reportable,
- Understanding education-related activities and programs that are **not** reportable as community benefit,
- Whether a shortage of health professionals must be demonstrated before expenses can be reported,
- Whether precepting nursing and other allied health students is reportable, and
- Reporting contributions that support Health Professions Education provided by other entities.

Inventory of Reportable Health Professions Education Programs. Almost all not-for-profit hospital organizations with accredited graduate medical education programs report expenses for GME as community benefit. Some organizations with GME programs, however, under-report expenses they incur for other, allied health professions.

13. CMS describes Medicare DGME reimbursement here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html. Over the years, certain caps to Medicare DGME reimbursement have been implemented — both the number of full-time equivalent interns and residents for which a given hospital can receive DGME reimbursement, and the "per resident amount" or PRA reimbursed.

14. Medicare reimburses net expenses for approved nursing and allied health education on a "pass-through" basis.

15. If Medicaid GME reimbursement is provided on a lump sum basis, the amount needs to be split between direct and indirect components. The direct versus indirect proportions can be derived from Medicare reimbursement amounts (e.g., Medicaid direct GME = Total Medicaid GME x (Medicare direct GME / (Medicare direct GME + Medicare IME)).

Compiling a comprehensive inventory of reportable programs helps to avoid under-reporting. To develop an inventory, the following steps can be undertaken by staff who have community benefit reporting responsibilities.

- Ask the Office of Education (if one exists) for information regarding Health Professions Education programs with students receiving clinical experiences at the hospital(s). These offices will have a variety of information about programs (e.g., student on-site schedules), particularly those governed by written agreements between the hospital(s) and academic institutions (medical schools, nursing schools, and colleges and universities with programs for other allied health professions).

- Ask the Human Resources department for information it likely has available regarding students and trainees who participate in on-site Health Professions Education programs. Even though many students may not be employees of the organization, Human Resources is likely to have information about them. Similarly, the Information Technology department may also have information about Health Professions Education participants, because many students and trainees need access to electronic health records and other systems.

- Ask the Legal department for information on programs with students and trainees on-site. The Legal department also is likely to have information on affiliation agreements and contracts, including any financial terms.

- Ask the Medical Director's (Chief Medical Officer's) office for information on CME programs — including those that are supported financially by the hospital.

- Ask Finance for information regarding Health Professions Education programs that generate Medicare reimbursement. Medicare Cost Reports will have information on approved GME and allied health professions, including:
  - The number of full-time equivalent interns and residents,
  - Salaries and benefits paid to interns and residents,
  - Expenses incurred for GME faculty supervision,
  - Direct and indirect expenses for various allied health professions programs, and
  - Medicare reimbursement for approved programs.

- Search state websites for information on the types of health professions that require state licensure. California, for example, requires individuals in the following health professions to be licensed.[16]

Acupuncturists	Midwives	Physicians and surgeons
Audiologists	Naturopathic doctors	Physician assistants
Chiropractors	Nurse practitioners	Podiatric medical doctors
Clinical social workers	Occupational therapists	Professional clinical counselors
Contact lens dispensers/spectacle lens dispensers	Ophthalmologists	Psychiatric technicians
Dental assistants	Opticians	Psychiatrists
Dental hygienists	Optometrists	Psychologists
Dentists	Osteopathic physicians	Registered nurses
Educational psychologists	Pharmacists	Respiratory therapists
Hearing aid dispensers	Pharmacy technicians	Speech-language pathologists
Marriage and family therapists	Physical therapists	Vocational nurses

16. New York is another example. See: http://www.op.nysed.gov/prof/

In California, hospital expenses for training students in the above health professions are reportable as community benefit — if the education is being provided in alignment with Schedule H instructions.

The Schedule H instructions also indicate that education provided to dietetics and pastoral care students is reportable if state licensing is not required but the programs are "accredited by the recognized national professional organization."

Program start-up, library and other education-related expenses. Hospital organizations can incur substantial expenses when working to establish new GME and allied health professions programs. New programs are reviewed by various accrediting organizations before they can accept students. If the new programs are intended to be accredited and would be reportable as community benefit, then expenses incurred to establish them also should be reported.

The Schedule H instructions indicate that certain types of expenses are reportable — including salaries, benefits, scholarships, indirect costs/overhead, and stipends. Other types of expenses, including (for example) costs to operate libraries used by Health Professions Education students, facilities-related expenses for CME and other programs, and others aren't explicitly mentioned. These other expenses also are reportable as community benefit if they are directly related to Health Professions Education programs.

Care should be taken, however, to avoid double counting. Library and facilities-related expenses, for example, may already be included in amounts for GME and allied health professions in the hospital's Medicare Cost Report.

Programs that are not counted as Health Professions Education. Expenses incurred in providing the following types of programs are not reportable as Health Professions Education:

- Educational programs that do **not** result in a degree, certificate or training necessary to be licensed or certified to practice as a health professional. This includes unaccredited programs and certain nursing internships that aren't required for licensure purposes.
- Continuing education that is **not** necessary to retain state licensure or certification by a board in a relevant health profession specialty.
- Education or training programs available exclusively to the organization's employees and medical staff (e.g., in-service training, staff orientation and CME programs) or scholarships provided to those individuals.
- Scholarships, tuition reimbursement, or financial supports provided as an employee benefit to staff who are advancing their own educational credentials.
- Educational experiences not leading to licensure or certification to practice in a clinical health profession, e.g., internships in administration, accounting, and public health.[17]
- Programs focused on attracting individuals to join the health care workforce (e.g., job fairs and experiential programs provided to high school students).[18]
- Programs where students are required to become employees of the organization upon graduation.

Shortages of Health Professionals. Many communities across the United States are home to one or more Health Professional Shortage Areas (HPSA). A geographic area can receive a HPSA designation if the federal government determines that a shortage of primary medical care, dental care or mental health care professionals is found to be present.

However, to report Health Professions Education as community benefit, hospital organizations

17. Note that expenses for public health-related internships can be reported as community benefit operations expense, if interns are working in community benefit or community health departments.

18. Expenses incurred in advancing the health care workforce are reportable in community building (Part II of Schedule H).

don't need to establish that shortages exist in local communities they serve:

- First, it's well established that physician and nursing shortages exist nationally.[19,20] While hospitals with Health Professions Education programs hope that program graduates practice locally, many physicians, nurses, and other professionals establish practices in other areas upon graduation, including medically underserved communities.[21] Hospitals with Health Professions Education programs thus are helping to address well-established regional and national workforce needs.

- Second, the IRS states in Rul. 69-545 that "by using surplus funds to advance its **medical training, education** and research programs, a hospital is promoting the health of the community."

Precepting Nursing and Other Allied Health Students. Over the years, there has been debate regarding how to report expenses associated with precepting nursing and other allied health students. Hospitals are encouraged to report these expenses based on their unique circumstances and programs and based on analyses that document the impacts of precepting programs on how hospital staff spend their time.

Preceptors are experienced staff nurses and other allied health professionals who work with students in clinical settings to help prepare them for practice. Preceptors thus play an important role in educating allied health professionals.

Many studies have been conducted regarding the direct and indirect costs incurred by hospitals in educating physicians. Comparatively few have been conducted regarding costs (and benefits) associated with precepting students.

One such study found that participating hospitals did not find it necessary to augment staff due to the presence of nursing students.[22] Impacts on hospital operations diminish after the first two weeks that students are assigned to units as both staff and students adjust. Other available studies have reached similar conclusions.

However, many hospitals have found that the presence of allied health students does shift how clinical staff (e.g., nurses, pharmacists, laboratory medical technologists, radiology technologists) spend their time. If clinical staff are devoting time solely to instructing, training or precepting students, then they are less available to perform clinical duties. In these circumstances, the expenses associated with "teaching time" should be counted.

Supporting Health Professions Education provided by other entities. Cash and in-kind contributions that support Health Professions Education programs provided by other entities also are reportable as community benefit. Cash contributions must be restricted by the hospital *in writing* to be used for that purpose.

HEALTH PROFESSIONS EDUCATION: ACCOUNTING AND REPORTING ISSUES AND APPROACHES

Hospital organizations can approach community benefit accounting for Health Professions Education programs through the following steps:

- Extract expense and reimbursement data from Medicare Cost Reports,

- Supplement Medicare Cost Report data with Medicaid, TriCare, and any other "direct offsetting revenues" that apply to GME and allied health professions programs,

- Quantify expenses associated with precepting nursing and other students,

- Quantify expenses for qualifying CME programs,

19. https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage

20. https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Factsheet.pdf

21. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1356

22. https://www.nursingeconomics.net/necfiles/ImpactsInnovations/II_JF14.pdf

- Assure that Health Professions Education-related "Contributions for Community Benefit" have been identified, and
- Identify and quantify other reportable expenses and revenues (e.g., program start-up costs).

As with other categories of community benefits, it's important for Finance staff to be integrally involved in the reporting process.

Medicare Cost Reports. Medicare Cost Reports are the preferred data source for reporting expenses and revenues for GME and allied health education. These reports include information on:

- The number of full-time equivalent interns and residents participating in hospital GME programs (Worksheet S-3, Part I of the Medicare Cost Report).
- Medicare-allowable expenses for GME and for approved allied health professions programs, both before and after the inclusion of overhead costs (Worksheet B-1, Part I).

For facilities that are not Critical Access Hospitals, Medicare Cost Reports also include information on:

- Direct Medicare reimbursement for GME (Worksheet E, Part A for inpatient services and Worksheet E, Part B for outpatient services — with amounts derived from Worksheet E-4).
- Direct Medicare reimbursement for allied health professions programs (Worksheet E, Part A and Worksheet E, Part B - with amounts derived from Worksheet D, Part III for inpatient and Worksheet D, Part IV for ancillary and outpatient services).

The following table portrays information derived from an example Medicare Cost Report for a facility that is not classified as a Critical Access Hospital.

Category	Graduate Medical Education	Allied Health Professions	Cost Report Worksheet
Full-Time Equivalent Interns and Residents	87.00		S-3, Part I
Expenses Including Overhead			
Interns and Residents - Salaries and Fringes	$ 6,000,000		B-1, Part I
Interns and Residents - Other Program Costs	$ 7,500,000		B-1, Part I
Allied Health Professions		$ 700,000	B-1, Part I
Total Expenses	**$ 13,500,000**	**$ 700,000**	
Medicare Reimbursement			
Inpatient Direct GME Payment	$ 2,300,000		E, Part A (or E-4)
Outpatient Diret GME Payment	$ 1,400,000		E, Part A (or E-4)
Indirect Medical Education (IME)	Not Included		
Allied Health - Inpatient Pass Through Reimbursements		$ 115,000	E, Part A (or D, Part III)
Allied Health - Outpatient Pass Through Reimbursements		$ 11,00	E, Part B (or D, Part IV)
Total Medicare Reimbursements	**$ 3,700,000**	**$ 126,000**	
Expenses minus Medicare Reimbursements	**$ 9,800,000**	**$ 574,000**	

In the above example, the hospital's GME programs accounted for $13.5 million in expense (including indirect or overhead costs) as determined by the Medicare Cost Report. The example hospital operated one approved allied health program (pharmacy residency) with expense of $700,000. Medicare reimbursement totaled $3.7 million for GME and $126,000 for the pharmacy residency. Pursuant to the Schedule H instructions, Medicare IME reimbursement is not included in offsetting revenue.

Critical Access Hospitals are reimbursed differently. Critical Access Hospitals don't receive explicit Medicare reimbursements for GME and allied health programs. Instead, the Medicare program reimburses 101 percent of its share of each hospital's allowable, total expenses after amounts for approved GME and allied health programs have been included.

A preferred approach for Critical Access Hospitals is to:

- Obtain total GME and allied health program expenses from Worksheet B-I of the Medicare Cost Report, including overhead costs allocated to these cost centers,
- Obtain total allowable expenses from Worksheet B-1,
- Calculate a percentage based on the above amounts: total expenses for GME and allied health programs divided by total allowable expenses (e.g., 10 percent), then
- Estimate Medicare reimbursement associated with Health Professions Education by multiplying the hospital's total Medicare reimbursement (as documented in the cost report) by this percentage.

If, for example, a Critical Access Hospital's total Medicare reimbursement is $4 million and Health Professions Education expenses represent 10 percent of the facility's total allowable expenses, then Medicare revenue of $400,000 should be included in direct offsetting revenue for this category.

Medicare Cost Report Timing Issues. Medicare Cost Reports typically are finalized and filed several months after each fiscal year ends. Some hospitals need to finalize their community benefit information before their Medicare Cost Report is available.

In this circumstance, hospitals can combine certain current year data with information from prior year cost reports to develop accurate estimates.

- Current year data include: the amount of direct GME expenses (from the hospital's general ledger) that will be included in the current year cost report when prepared, an updated estimate for Medicare DGME reimbursement per intern, and resident and the number of current year interns and residents.
- Data from the prior year cost report include: a percentage factor to estimate adjustments to direct expenses likely to occur in the upcoming cost report, GME expenses before and after the allocation (step-down) of overhead amounts, and the actual Medicare DGME reimbursement amount per intern and resident.

The following table shows an example analysis. This hospital's estimated GME expenses and Medicare reimbursement amounts for fiscal year 2019 are based on data from 2019 and from its 2018 Medicare Cost Report.

Value	Amount	Fiscal Year
General Ledger Accounts (Cost Centers) with Direct GME Expenses	**$ 15,000,000**	2019
Expense Adjustments, if Any, to Direct GME Expenses	**-8.0%**	2018
Estimated Direct DGME Expenses	$ 13,800,000	2019
GME Expenses After Step-Down (from Medicare Cost Report)	**$ 18,900,000**	2018
GME Expenes Before Step-Down (from Medicare Cost Report)	**$ 13,500,000**	2018
Ratio: Total Expenses/Direct Expenses	1.40	
Total Community Benefit Expense	$ 19,320,000	2019
DGME Reimbursement per Intern & Resident (I&R)	**$ 15,000.00**	2018
DGME Amount per I&R Update Factor	**1.50%**	2019
DGME Reimbursement per Intern & Resident (I&R)	$ 15,225.00	2019
Interns and Residents	**320.0**	2019
Estimated Medicare DGME Reimbursements	**$ 4,8000,000**	2019
Net Benefit Expense	**$ 14,520,000**	2019

Total GME expenses for 2019 are based on direct expenses from the general ledger, the impact of adjustments that are made in the 2018 cost report, and a factor also from the 2018 cost report to add indirect, overhead expenses. Medicare GME reimbursement is estimated based on amounts reimbursed in 2018 as updated to 2019.

Possible Double Counting. Organizations that rely on Medicare Cost Reports should use care to avoid double counting certain expenses. Those preparing community benefit reports should be informed about the expenses that staff preparing Medicare Cost Reports already have included.

For example, Medicare Cost Reports generally include faculty support paid to an affiliated medical school in direct GME expenses. These amounts should not be reported separately if they already have been included in the cost report.

Medicaid, TriCare, and Other Revenues. As previously mentioned, over 40 states also provide Medicaid reimbursement specifically to offset costs incurred by hospitals in providing GME.[23]

Pursuant to the Schedule H instructions, Medicaid reimbursement (and also TriCare and any other third-party payers) specifically designated for GME (and also for allied health professions expenses) is to be included in direct offsetting revenues.

Critical Access Hospitals also should include an appropriate percentage of their overall Medicaid revenue, if their home states provide reimbursement using a methodology like Medicare's.

Other revenues include restricted grants received to support Health Professions Education and any tuition or fees paid by participants in programs that have been reported.

Precepting Nursing and Other Allied Health Students. Hospital organizations are encouraged to report expenses they incur for the following:

- Costs associated with clinical staff hours when staff are unavailable to perform clinical duties because they are devoting time solely to instructing, training, or precepting students,

23. https://store.aamc.org/downloadable/download/sample/sample_id/284/

- Additional compensation paid to nurses and other staff members to serve as preceptors for nursing and other allied health professions students,
- Costs to train staff to serve as preceptors,
- Costs of time spent by instructors when they interact with students in classroom settings and simulation labs, and
- Administrative costs associated with having nursing and other allied health professions students and faculty in the facility.

Hospitals are encouraged to ask nursing (and other staff) to estimate the average percent of time that precepting students takes them away from performing clinical duties. Time studies also can be informative. Having this type of information is important to documenting the basis for amounts reported.

The table that follows portrays an example calculation for the costs of precepting nursing students. The table is based on the following assumptions:

- During the year, 100 nursing students participated in clinical rotations at the hospital. Each student was on-site 27 days during the year, for 8 hours per day. The total number of hours that nursing students were on-site was 21,600 (100 students x 27 days/year x 8 hours/day).
- Nursing leadership estimates that the average percentage of time that one staff nurse devotes to precepting one student (when students are present) is 12.5 percent (or 1 hour for every 8 hours that students are on-site). This percentage represents the average percent of time staff nurses are away from clinical duties when students are present.
- In the example, this means that 2,700 additional hours of staff nurse time was devoted to instructing or training students.
- During the year, a total of 12 classroom sessions were held with nursing students and hospital registered nurses served as faculty.
- The hospital also provided preceptors some differential pay ($2.00 per hour) while serving that role.
- The hospital also provided opportunities for nurse preceptors to attend training seminars and a portion of an administrative position was devoted to coordinating schedules and providing related support.

Nursing Student Preceptor Program	Example Calculations
Nursing student hours on site	
Number of nursing students (unique individuals)	100
Average hours each student is on-site per day	8
Total nursing student hours on site	21,600
Preceptor nurses hours	
Percent of staff nurse time devoted to precepting while students are present (time away from clinical duties)	12.5%
Staff nurse hours devoted to precepting	2,700.0
Average hourly staff nurse compensation	$ 42.90
Expenses for staff nurses precepting	$ 115,830

Classroom time	
Classroom sessions held per year	12
Hours per classroom session	1.5
Average hourly compensation for instructors	$ 42.60
Classroom expenses	$ 821
Differential pay (if provided)	
Staff nurse differential pay while precepting	$ 2.00
Differential pay amount	$ 43,200
Other expenses	
Preceptor training seminars (if offered)	$ 10,000
Program administration	$ 20,000
Total Expenses	$189,851

Based on these assumptions, this example hospital incurred $189,851 in expense for precepting nursing students.

Continuing Medical Education (CME) Programs. Expenses incurred by hospitals when providing CME programs that (a) are necessary for participating health professionals to remain licensed or certified to practice in their profession and (b) that are open to staff beyond those who work at/for the hospital (e.g., open to unaffiliated community physicians) are reportable as Health Professions Education expense. Both direct and indirect (overhead) expenses should be reported. Any tuition or fees collected also are to be reported as offsetting revenue.

Other Expenses and Revenues. As previously mentioned, hospital organizations also can report:

- Cash and in-kind contributions for Health Professions Education made by the hospital to other entities,
- Start-up and planning expenses for Health Professions Education programs that are intended to be accredited and that would be reportable as community benefit once operating,
- Scholarships provided to community members so they can participate in Health Professions Education programs, and
- Other types of expenses, including costs to operate libraries used by Health Professions Education students and facilities-related expenses for CME and other programs — if not already included in the hospital's Medicare Cost Report.

ABOUT THE CATHOLIC HEALTH ASSOCIATION

The Catholic Health Association of the United States (CHA), founded in 1915, supports the Catholic health ministry's commitment to improve the health of communities and provide quality and compassionate health care.

CHA is recognized nationally as a leader in community benefit planning and reporting. In collaboration with member hospitals, health systems and others, CHA developed the first uniform standards for community benefit reported by not-for-profit health care organizations. These standards were used by the Internal Revenue Service to develop the Form 990, Schedule H for Hospitals.

ABOUT VIZIENT

Vizient is a member-driven, health care performance improvement company committed to optimizing every interaction along the continuum of care. Vizient was founded in 2015 as the combination of VHA Inc., a national health care network of not-for-profit hospitals; University HealthSystem Consortium, an alliance of the nation's leading academic medical centers; and Novation, the care contracting company they jointly owned. In February 2016, Vizient acquired MedAssets' Spend and Clinical Resource Management (SCM) segment, which included Sg2 health care intelligence.

Vizient has a long track-record of working to ensure that community-based, not-for-profit health care is supported. Congress, the White House and federal regulatory agencies, such as the Internal Revenue Service, regularly examine the merits of tax-exemption for not-for-profit hospitals, and look to ensure that exemption is justified by activities that provide meaningful benefits to their communities. Vizient continues to work with policymakers to ensure that our members are represented in those policy discussions and are able to fully tell the full story of the essential care that they provide to the communities they serve.

ABOUT THE AUTHOR

Keith Hearle, MBA, is President of Verité Healthcare Consulting. Prior to establishing Verité in 2006, Keith led the Hospitals and Health Systems practice for The Lewin Group, Inc., served as CFO of the San Francisco Department of Public Health (Public Health Division), as a Manager at KPMG Peat Marwick and as a Senior Equity Analyst (Healthcare) for a California-based money manager.

In 1989, he developed for CHA/Vizient the first accounting framework for hospital community benefit and co-authored the CHA/Vizient Social Accountability Budget. He also authored the accounting chapters (and worksheets and other materials) in the May 2006 and December 2008 CHA/Vizient Guide to Planning and Reporting Community Benefit and in all subsequent editions. He developed a framework for determining "What Counts as Community Benefit," adopted by CHA/Vizient in 2007. In 2008, he was asked by IRS officials to draft major sections of the Instructions to IRS Form 990, Schedule H. He worked with IRS staff thereafter on refinements to the Instructions.

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A Mission to Care: A Commitment to Community

From the very beginning, civic leaders and congregations of religious women and men courageously responded to the needs of the communities they were called to serve.

Today, that same call to provide health and hope is being answered in unique and creative ways through community benefit programs.

AS COMMUNITY BENEFIT LEADERS:

We are concerned with the dignity of persons.
We are committed to improving health care access for all persons at every stage of life regardless of race, culture or economic status and to eliminating disparities in treatment and outcome.

We are concerned about the common good.
We design community benefit programs to improve health through prevention, health promotion, education and research.

We have special concern for vulnerable persons.
We put a priority on programs that address the most vulnerable in our communities and ensure that all programs reach out to persons most in need.

We are concerned about stewardship of resources.
We use resources where they are most needed and most likely to be effective.

We are called to justice.
We advocate health care for all and work to improve social conditions that lead to improved health and well-being.

We care for the whole person.
We engage partners in our communities so that together we improve health and quality of life through better jobs, housing and the natural environment.

For more information about community benefit and Catholic health care, go to www.chausa.org/communitybenefit

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