



**Association of
American Medical Colleges**

2450 N Street, N.W., Washington, D.C. 20037-1127

T 202 828 0400 **F** 202 828 1125

www.aamc.org

September 12, 2007

Mr. Ron Schultz
Senior Technical Advisor
Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Dear Mr. Schultz:

The Association of American Medical Colleges (AAMC) is a nonprofit association representing all 126 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians. The AAMC welcomes the opportunity to provide the Internal Revenue Service (IRS or “the Service”) with comments on proposed revisions to Form 990 (the “core form”) and the new Schedule H.

The AAMC appreciates the willingness of IRS staff to meet with us and other hospital associations to discuss issues of particular concern to our members. The discussions provided a useful exchange of information. We hope that the final Form 990 and associated schedules will reflect these discussions and the written comments about the many changes that should be made before the IRS finalizes these new requirements.

Transition Period

In June 2006 the Advisory Committee on Tax Exempt and Government Entities (ACT) issued a Report of Recommendations related to Form 990. Among the recommendations were the following:

- Form 990 should be designed primarily to assess whether the filer is complying with federal tax requirements
- Form 990 and its instructions should be as understandable to a person unschooled in the law of tax-exempt organizations as possible without compromising its primary purpose

The current IRS effort does not fully reflect these recommendations. On both draft Form 990 and Schedule H the Service poses questions that go well beyond any current federal

tax requirements. Completion of the forms will require a high level of specialized knowledge, significant financial resources and staff time, and will likely prove to be extremely burdensome, especially in the initial years. The AAMC suggests that revisions of the magnitude proposed would benefit from a process that embraces the goals of the ACT report and may require more time to finalize than has been suggested by the Service.

The AAMC believes that the substantial changes needed to the draft Form 990 will necessitate a longer transition period than what has been proposed. Given that under the proposed implementation schedule the forms will not be final until later this year, and instructions are not expected to be issued until the middle of next year, it is unrealistic to expect hospitals to be prepared to file these new forms, particularly Schedule H, for the 2008 tax year. Far more reasonable would be to not require that Schedule H be used until the 2010 tax year. This would allow for a more reasonable transition period for hospitals. Those not familiar with reporting community benefit will then have ample time to prepare with full knowledge of the IRS requirements. Even those hospitals that have been reporting community benefit will need to make modifications in their systems to comply with IRS requirements and would benefit from this additional time. As the ACT recommendations suggest, the goal should be to adopt a comprehensible, uniform system for entities to accurately report information that directly relates to their tax status. Giving hospitals and other entities that complete the Form 990 and Schedule H adequate time to adapt to numerous new requirements will enhance the process and help achieve this goal.

Comments on Schedule H

The AAMC endorses the comments submitted by the American Hospital Association. We also endorse the Catholic Health Association's comments about the importance of recognizing that community building is a community benefit and should be a separate category under the Community Benefit Report.

After providing some background regarding the characteristics and activities of teaching hospitals, the AAMC's comments focus on 4 areas:

- Education
- Research
- Allowing hospitals that are closely affiliated with other organizations with separate employer identification numbers (EINs) to be viewed as a whole for the purpose of understanding the extent of the organization's total community benefit commitment.
- Recognizing that some portion of bad debt should be classified as community benefit

I. What Are Teaching Hospitals and Which of Their Activities Support Their Tax Exempt Purposes?

The AAMC is pleased that the IRS continues to recognize the essential contributions made by teaching hospitals by providing space on the proposed Schedule H Community Benefit Report for health professions education (line 6) and research (line 8).

When Rev. Rul. 69-545 was issued nearly 40 years ago, the IRS recognized that “[b]y using its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training, education, and research programs [a hospital] is operating in furtherance of its exempt purpose.” While the 21st century teaching hospital has changed in many ways from its progenitors, the commitments to education, research, and patient care remain just as strong and continue to reaffirm that it merits its tax exempt status.

There is no uniformly recognized definition of a teaching hospital, though at a minimum a teaching hospital participates in the education of interns and residents. AAMC member teaching hospitals do far more than that. While accounting for 6% of all hospitals and 22% of all inpatient admissions, they provide 43% of all hospital charity care. In 2005, the latest year for which data are available, the median charity care costs for an AAMC member hospital was \$8.89 million (not including bad debt). Charity care represents only a fraction of the total community benefit that teaching hospitals provide. Teaching hospitals serve local, regional, and in many cases national populations. Through education, research, patient care, and community building, a teaching hospital provides community benefits that extend well beyond the geographic area where most of its patients reside.

II. Education as a Community Benefit

Non-profit teaching hospitals are the backbone of the graduate medical education system. In FY2004, the latest year for which complete data are available, non-government, non-profit teaching hospitals trained nearly 80% of all medical residents; government hospitals (such as the VA) trained nearly 17%; and investor owned, for-profit hospitals which comprise 10 percent of all teaching hospitals, trained the remaining 3 percent¹.

Educating medical students; physicians during residency and fellowship; nurses and other health care professionals requires teaching hospitals to make a large commitment of financial resources and personnel. After graduating from medical school, future physicians enroll in a residency program that typically is sponsored by a teaching hospital. These physicians generally do not pay tuition when they enroll in a residency program, but instead receive a stipend to support them during this educational period.

Medicare---and in some states Medicaid programs---provides the only uniform explicit support to non-governmental hospitals for resident education costs through

¹ Most of these teaching hospitals were established as tax-exempt entities, but were acquired by for-profit hospital firms within the past several decades.

reimbursements that are provided only to teaching hospitals. The Medicare payment received by teaching hospitals to support graduate medical education is based on historic costs from 1983-4 that have been updated for inflation. Medicare does not pay this amount but rather only its “share” based on the percentage of Medicare patients treated in the hospital. Over the years Congress has made changes in the payment formula for direct graduate medical education, but it has never been modified to reflect actual graduate medical education costs. Medicaid support for GME is subject to each state’s varied policies and the needs of the population in relation to budgetary constraints. Consequently, the reimbursement teaching hospitals receive falls short of the actual costs teaching hospitals incur to train the next generation of physicians. For this reason, health professions education can be among the largest community benefit expenditures for teaching hospitals.

No physician can obtain a state license to practice medicine without having completed at least one year in a residency program. Most hospitals require a physician to be board certified before gaining privileges, meaning that the residency program must be completed (at least three years) and an examination in the physician’s specialty must be passed.

Residency programs require teaching hospitals to organize and support an array of resources. Among the requirements for educating a resident physician are supervising (or teaching) physicians, larger patient and operating rooms to accommodate trainees, and the ordering of more laboratory and other tests as young physicians learn how to practice medicine. Supporting an educational program also requires a hospital to have access to a sufficient number of patients for the residents. Additionally, conducting residency training programs requires GME administrative support to prepare and oversee resident rotation schedules and other required educational activities of the resident that extend beyond direct patient care. The educational experience for each medical specialty are established and monitored under the umbrella of the Accreditation Council of Graduate Medical Education (ACGME), the accrediting body that is recognized by the Medicare program.²

Educating physicians is of vital importance to the entire country. By analyzing trends in the physician workforce (e.g., the number of retirements and new graduates) and carefully assessing future needs, the AAMC has demonstrated that in some specialties and some geographic areas, physician shortages currently exist; for physicians in general, future shortages are projected. In response, the Association has called for a 30 percent increase in medical school enrollees by 2015. To ensure that all U.S. medical school graduates receive residency training, it is vital that teaching hospitals be able to continue, and in some cases increase, their commitment to educating residents to accommodate larger numbers of graduates.

² Osteopathic residency programs are accredited by the American Osteopathic Association which also is recognized by the Medicare program.

A. Education Worksheet

Included at the end of this comment letter is a revised worksheet, renamed “Net Costs Associated with Health Professions Education.” While many of these revisions are self-explanatory; others are not and will be discussed below.

1. Indirect Medical Education (IME) Is Patient Care Revenue, Not Educational Funding

The Medicare Indirect Medical Education (IME) payment carries a "medical education" label, but its purpose, as stated by Congress when it created the prospective payment system (PPS) in 1983, is much broader:

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Rept, No. 98-25, March 4, 1983 and Senate Finance Committee Rept, No. 98-23, March 11, 1983).

Medicare provides the IME payment as an adjustment to the per case payment each time a Medicare beneficiary is discharged from a teaching hospital. Therefore, our members appropriately consider the IME to be a patient care payment. We believe it is more logical for teaching hospitals to include their IME payments as part of their Medicare revenue rather than as revenue associated with education. The revised education worksheet eliminates all references to Indirect Medical Education. Although the original worksheets developed by the CHA and subsequently proposed by the IRS include IME on the education worksheet, the updated worksheets that will be submitted by CHA are in agreement with the AAMC’s recommendation.

2. Nursing Should Be Mentioned Separately From Other Allied Health Professions

We have suggested that, consistent with the Medicare terminology, nursing should be mentioned separately from other allied health professions.

3. All A&G Should Be Included As Costs

We also believe that it is important that all costs include related Administrative and General costs as they are necessary support for the educational programs. These costs are allowable by the Medicare program as direct graduate medical education.

4. Medicaid Direct GME Should Be Counted As A Source of Education Funding, Not As Medicaid Revenue; Indirect Should be Counted as Patient Care

Finally we suggest that Medicaid GME payments, when available, be counted as a funding source for education. For those states that make allotments for GME, the money is analogous to that provided by the Medicare program and should be counted in the same way. Therefore, it should not be counted as Medicaid revenue elsewhere on either Schedule H or Form 990 (Part IV, line 2a). Similarly, if Medicaid programs provide for IME, then those dollars should be counted as Medicaid patient care revenue, as was suggested for Medicare IME.

III. Research as a Community Benefit

Just as teaching institutions are committed to education, they also are committed to supporting research as one of their core missions. There are many different types of research that occur within an academic medical center, some within the four walls of the teaching hospital, others elsewhere such as at a related medical school or in the local community with financial support from the hospital.

Examples of various types of research are research that: involves patient care (“clinical research”); occurs in a laboratory (“bench research”); involves data analysis that looks at disease or other trends in given populations (epidemiologic research); or focuses on how to best implement new treatments or tests to make them most effective in improving health, and restructuring of health care delivery (health services research). Many residency programs require that residents engage in research, and research funds help teaching hospitals build a high-quality health sciences faculty, many of whom supervise resident training in the teaching hospital. The hospital or its affiliated organizations must have the ability to support this residency requirement.

There are multiple sources of research funding. Some clinical research that occurs in hospitals is sponsored by for-profit pharmaceutical or medical device companies while other research is funded by grants from federal agencies such as the National Institutes of Health and the National Science Foundation; and grants and contracts from nonprofit entities, such as the Howard Hughes Medical Institute. Teaching hospitals themselves devote resources to research, and thus incur net costs that are counted as community benefit.

Most research that is funded by nonprofit or governmental entities is conducted at a financial loss to the teaching hospital, as the government considers these grants or contracts to be assistance mechanisms and the awards for the research do not cover the full costs. Nonetheless, the research mission compels teaching hospitals and their affiliated organizations to support research.

In contrast, research that is sponsored by for-profit companies involves a negotiation of terms, including payment for the research so it is anticipated that an institution generally will not incur a loss for this type of research.

Research benefits the health and well being of our citizens by producing knowledge that leads to improvements in diagnosis, treatment and prevention of disease, or that may result in improvements in the health care delivery system. The benefits from research may be localized, such as a study that identifies high rates of asthma among children in a nearby community, or they may extend beyond the United States to provide a new cure for a disease that is prevalent both in this country and elsewhere.

A. Research Worksheet

Included with this letter are recommended revisions to Worksheet 7, that we propose be renamed “Net Costs of Research.” We are proposing that the research that should count as community benefit be limited to research that is funded by a grant or contract from a governmental or nonprofit entity or self-funded by the institution. When research is funded by a for-profit entity, the process entails a negotiation between the two parties, and should result in a contract that covers the costs of that research. Grants and funding from nonprofit entities are never intended to cover the full costs of the research so are expected to result in a loss to the institution. They also provide ample evidence that research is a community benefit.

The AAMC also suggests that research be defined as follows:

Any effort of which the goal is to generate generalizable knowledge, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

IV. Bad Debt As Community Benefit

As currently drafted, the IRS worksheets do not allow hospitals to count any of their bad debt as community benefit. This fails to recognize the reality that for many hospitals some portion of bad debt is, in fact, charity care and should be counted as such when quantifying community benefit.

It is not uncommon for individuals to come to emergency departments with no insurance, or with health savings accounts or high deductible policies that require large out-of-pocket expenses that they cannot afford. It also is not uncommon for these individuals, some of whom may be in this country illegally, to provide incorrect or incomplete

information to the hospital at the time the service is rendered, meaning that it is not until some point in the future—perhaps even into the next tax reporting year—that it is clear that this individual is uninsured or underinsured and could have qualified for charity care. Hospitals do not have the option of refusing to screen an individual who comes to the emergency department or, except in very limited circumstances prescribed by law, failing to treat an emergency condition.

HFMA’s Statement 15, *Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers* is considered by some to be the solution to the bad debt problem. They contend that hospitals merely need to adopt a more accurate and flexible system to determine if a patient should be classified under “charity care” or “bad debt.” Unfortunately, this view fails to recognize that accomplishing this goal is an extremely complex undertaking. While the IRS may want to encourage hospitals to revise their policies and comply with Statement 15, the Service should acknowledge that it will take considerable time and effort to do so and that there may be other reasonable methodologies that should be considered. As with other requirements, a change of this magnitude would necessitate a transition period. In the interim, one possibility is for the IRS to allow hospitals to report their total bad debt and then to use a proxy to estimate the portion of that amount that should be classified as charity care. To allow no portion of bad debt to be counted as charity care is to unreasonably and arbitrarily penalize hospitals for the services that they are providing for no payment or, in the case of large deductibles and co-payments, incomplete payment.

The AAMC and our member hospitals would welcome the opportunity to work with the IRS to develop a methodology that allows hospitals to more precisely classify patients and, during a transition period, to determine the portion of bad debt that should be counted as charity care.

V. Need For Some Hospitals and Other Affiliated Entities to Aggregate Their Community Benefit Activities

It is not unusual for a teaching hospital—and even for some non-teaching hospitals—to have related entities, such as a foundation or medical school, each of which has its own EIN, and each of which works in combination to provide community benefit. Academic Medical Centers have adopted different organizational structures, and the tax code played a minor or inconsequential role in how these structures have evolved. For example, one academic medical center operates a medical school and a teaching hospital together under one EIN. Another has one EIN for the medical school and another for the teaching hospital. Some academic medical centers have established separately incorporated divisions to house education activities; others operate the programs within departments of the teaching hospital. Academic medical centers thus represent a collection of entities working together to carry out a mission to which each is committed, and that cannot be accomplished without this joint effort.

For certain teaching hospitals, it is important that the IRS consider the hospital’s community benefit in the context of the all of the entities with which it is affiliated and

that work as a whole to provide community benefits through patient care, education, research, and community building. As currently drafted, Schedule H only allows the hospital to report on its own activities, and not those of its affiliated partners. The AAMC strongly urges that, at a minimum, the IRS allow hospitals to provide the EINs of all other organizations that it considers to be partners in its community benefits activities, and further, to consider the extent of the hospital's community benefit contributions in the full context of the other organizations with which it is affiliated. Another possibility is for the IRS to allow use of a system analogous to that of taxable corporate filers in which the parent of a consolidated group files a tax return based on the consolidated financials of the parent and its controlled subsidiaries, all prepared in accordance with GAAP.

Comments on the Core Form (Form 990)

Although the AAMC recognizes that Form 990 would benefit from extensive changes, we have selected only a few items for comment.

I. Who Should Complete Schedule H?

Form 990 opens the door to the completion of Schedule H. The IRS has proposed that a determination about which entities should complete that schedule depends on whether an organization “operates, or maintains a facility to provide hospital or medical care.” The answer to that question lies in the definition of “medical or hospital care” found in the Glossary. The AAMC urges the IRS to revise both the question and the definition to ensure that Schedule H is completed only by those entities that consider themselves to be hospitals, are looked at by their communities as hospitals, and are licensed as such by their states.

The definition proposed by the IRS casts too broad a net and would require many health care organizations not commonly considered to be hospitals to complete the Schedule. The AAMC suggests that the IRS adopt the definition of a hospital below. The examples of what is and is not a hospital should be considered illustrative only and are not meant to be an exhaustive list.

A hospital is a health care organization that has a governing body, an organized medical staff and professional staff, and inpatient facilities and provides medical, nursing, and related services for ill and injured patients 24 hours per day, seven day per week. A hospital is a facility (and all of its components) that is licensed or recognized in its state as a hospital.

Some examples of hospitals are:

- General hospital
- Rehabilitation hospital
- Acute long term care hospital
- Children's hospital
- Psychiatric hospital
- Hospital for treating certain disease categories

Some examples of facilities that are not hospitals are:

- A nursing facility (including a skilled nursing facility, convalescent home, or home for the aged)
- Free-standing outpatient clinic
- Community mental health or drug treatment center
- Physician group practices/faculty practice plans
- Physician offices
- Facility for mentally retarded/developmentally disabled
- Facility for treating alcohol and drug abuse
- Hospital wing of a school, prison, or convent

Adopting this definition will require a revision to Part VII, Question 9. We suggest that the question be changed to: Does the organization operate a hospital? If yes, complete Schedule H.

II. Executive Compensation (Core Form, Part II)

Parallel with the fact that many teaching hospitals should have their community benefit activities considered together with those entities with which they are affiliated, so too should executive compensation be considered in its totality. It is not unusual for the CEO and other key employees of a teaching hospital to receive a paycheck from multiple organizations (for example, the hospital and a foundation) and to divide his or her time among them. When entities with separate EINs share a CEO and other key employees, they must be allowed to report together regarding salary from each organization, the title given to the individual by each organization, and the percentage of time the individual devotes to each. This will provide a complete picture of salary and responsibilities, which is far more constructive information than if each entity reports on a separate schedule. The AAMC urges the IRS to adopt as an option the use of a consolidated compensation schedule for affiliated organizations with shared officers, directors, trustees, and key employees.

III. Statements Regarding Governance, Management, and Financial Reporting (Core Form, Part III)

This section asks if an organization has a written conflicts of interest policy and the number of transactions reviewed (lines 3a and b); a written whistleblower policy (line 4); and a written document retention and destruction policy (line 5). In the accompanying instructions, the following tip is provided:

Sarbanes-Oxley requires certain tax-exempt organizations to adopt whistleblower protection and document retention and destruction policies.

This is not a requirement of Sarbanes-Oxley so this tip should be deleted.

Of concern to the AAMC is that the questions about conflicts of interest policies, whistleblowers, and document retention and destruction are unrelated to tax status. The AAMC recognizes the importance of conflicts of interest (COI) policies in a health care setting and has been a leader in developing guidelines to aid members in drafting and implementing such policies. Nonetheless, the Association questions the utility of including these policies in this context. Also, it is unclear what information is revealed by the number of transactions reviewed under a COI (Line 3b). Does a large number mean that the policy is working well since many COIs are being reviewed? Does a small number mean that the policy is ineffective in identifying possible COIs; or that few COIs exist? If the IRS decides that it will collect information on COIs, it may be more useful to ask: does the entity have in place a policy for identifying and managing conflicts of interest?

A typical AAMC member has a robust compliance program that includes a whistleblower policy, and many members also have document destruction and retention policies that reflect state law and other requirements. Despite the existence of the three types of policies singled out in this section of the Core Form, the AAMC urges the IRS to delete these questions. It is important that Form 990 be limited to collecting information that relates directly to an organization's tax status.

IV. Reporting Program Service Revenue (Core Form, Part IV, lines 2a-g)

Line 2a aggregates Medicare and Medicaid payments. The AAMC strongly urges the IRS to allow Medicare and Medicaid revenues be reported on separate lines. The programs are intended to cover very different populations and the payment rates for each are structured very differently. Hospitals should have the opportunity to clearly demonstrate the extent to which each of these Federal programs provides revenue or is operated at a loss.

We also would appreciate a clarification about whether "fees and contracts from government agencies" (line 2b) includes TRICARE and other government payers.

Conclusion

The AAMC appreciates the effort that the IRS has undertaken to revise Form 990 (the "core form") and to develop Schedule H to allow hospitals to report on their community benefit activities. In meetings, staff from the Service have reiterated their commitment to finalizing the Core Form and accompanying schedules by the end of the year. While we realize that the Service would like to obtain the information from the new and revised forms as quickly as possible, we urge you to consider the benefits of taking adequate time to ensure that the forms collect uniform information that is directly related to tax-exempt status, readily comparable across entities, and provides adequate opportunities for entities to submit a complete picture of their structures and activities. Finally, the Association asks that the IRS provide sufficient lead time to allow entities to understand how to best meet the new IRS requirements.

If you have any questions or would like additional information, please feel free to contact me, or Ivy Baer from my staff. We both may be reached at 202-828-0490 or rdickler@aamc.org and ibaer@aamc.org.

Sincerely,



Robert M. Dickler
Senior Vice President
Division of Health Care Affairs

Cc: Theresa Pattara

Attachments (2):

Net Costs of Education Worksheet
Net Costs of Research Worksheet

Net Costs Associated with Health Professions Education

1. Direct costs
 - a. Medical students
 - b. Interns, Residents, and Fellows
 - c. Nursing
 - d. Other allied health professions
 - e. Continuing health professions education if open to all in community
2. **Total direct education costs** (add lines 1a-e)

Funding sources:

3. Direct medical education funding
 - a. Direct Medicare reimbursement for graduate medical education
 - b. Direct Medicaid GME
 - c. Continuing health professions education reimbursement/tuition fees
 - d. Other explicit support of education programs
4. **Total direct education revenue** (lines 3a-d)

Net costs of health education (line 2 minus line 4)

Instructions

For all direct costs include related Administrative and General. If the hospital supports the medical school library, those costs are included in the hospital's A&G. Include the following as Direct Costs (Line 1):

1. Stipends, fringe benefits of interns and residents; salaries and fringe benefits of faculty directly related to intern and resident education
2. Salaries and fringe benefits of faculty directly related to teaching of medical students (while at the hospital, or at all times?) Related overhead?
3. Salaries, fringe benefits of research trainees (PhD students, post doctoral students, MD-PhD students, others?); salaries and fringe benefits of faculty directly related to education of research trainees
4. Salaries and fringe benefits of faculty directly related to teaching of students enrolled in degree-granting nursing programs.
5. Salaries and fringe benefits of faculty directly related to teaching of students enrolled in degree-granting and/or certificate allied health professions education programs, including, but not limited to pharmacy, occupational therapy, laboratory
6. For continuing health professions education open to all in the community count salaries and fringe benefits of faculty for teaching continuing health professions education, including

payment for development of on-line or other computer-based training that is accepted as continuing health professions education by the relevant professional organization

Count as Funding Sources:

Other explicit support of education programs: examples would include grants from any source

Net Costs of Research

Note: Neither expenses nor revenues from for-profit companies for clinical trials are included

1. Costs of research that are funded by a governmental entity or a non-profit entity³:
 - a. Direct expense
 - b. Indirect expense
- 2. Total research costs (add a. and b.)**
3. Funding sources:
 - a. Grant or contract dollars received from a governmental entity or a non-profit entity source in offsetting revenue
- 4. Add total funding of research costs**
- 5. Net costs of research (line 2 minus line 4)**

Instructions

1. Define “research” to include any effort of which the goal is to generate generalizable knowledge, such as about underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).
2. Examples of costs of research (Line 1) include, but are not limited to: Salaries of researchers and staff (including stipends for research trainees—either Ph.D. candidates or fellows); Facilities (including research, data, and sample collection and storage; animal facilities); Equipment; Supplies; Tests conducted for research rather than patient care; Statistical and computer support; Compliance (e.g., accreditation for human subjects protection; biosafety; HIPAA); Dissemination of research results

³ Examples of these costs include, but are not limited to: Salaries of researchers and staff (including stipends for research trainees—either Ph.D. candidates or fellows); Facilities (including research, data, and sample collection and storage; animal facilities); Equipment; Supplies; Tests conducted for research rather than patient care; Statistical and computer support; Compliance (e.g., accreditation for human subjects protection; biosafety; HIPAA); Dissemination of research results

