



November 5, 2010

Financial Accounting Standards Board
Technical Director
401 Merritt 7
P.O. Box 5116
Norwalk, Connecticut 06856-5116

RE: Proposed Accounting Standards Update, *Health Care Entities (Topic 954), Disclosures about Net Revenue and Allowance for Doubtful Accounts (a consensus of the FASB Emerging Issues Task Force)*

(File Reference No. EITF090H)

Dear FASB Technical Director:

Northwestern Memorial HealthCare (NMHC) appreciates the opportunity to comment on the Financial Accounting Standards Board's (FASB's) Proposed Accounting Standards Update, *Health Care Entities (Topic 954), Disclosures about Net Revenue and Allowance for Doubtful Accounts (a consensus of the FASB Emerging Issues Task Force)*.

NMHC serves as the sole corporate member of Northwestern Memorial Hospital (NMH) and Northwestern Lake Forest Hospital (NLFH). NMH is a major academic medical center hospital located in the Streeterville neighborhood of Chicago, providing a complete range of adult inpatient and outpatient services, primarily to residents of Chicago and surrounding areas, in an educational and research environment. It is licensed for 894 beds and is the largest single hospital in Chicago. NMH, whose origins date back to 1849, is the primary teaching center for Northwestern University's Feinberg School of Medicine. NLFH joined NMHC in February 2010 through an affiliation agreement between the two organizations. NLFH is a community hospital located in Lake Forest, Illinois. It is licensed for 117 acute care beds and 88 skilled nursing care beds.

Question 1: *Do you agree that the proposed disclosures would allow users of the financial statements to better understand and assess the net revenue recognized by a health care entity and changes in its allowance for doubtful accounts? Why or why not? If not, what changes would you suggest to the proposed amendments?*

We believe that disclosures pertaining to an entity's policies and procedures for assessing accounts for bad debts are beneficial to users of the financial statements. However, we do not believe a tabular reconciliation of the allowance for doubtful accounts by major payor source is

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necessary since most of the provision for bad debts is attributed to self-pay account balances, including accounts that are fully self-pay and the self-pay balance of accounts with a third-party primary payor (e.g., co-pay and deductibles). A provision for bad debts for third-party payor account balances could be necessary, but the need for such a provision would be infrequent and most likely not significant to the total provision.

We believe the bad debt policy and procedure disclosures that would be required should be disclosed with the entity's policies and procedures for determining patient eligibility for charity care because these assessments generally involve the same group of patients and because of the contemporaneous occurrence of these assessments. The distinction between charity care and bad debts has become less clear. We believe the similarities in the accounts and assessment processes provide a strong argument for presenting these adjustments collectively as a reduction of patient revenue in a health care entity's statement of operations. Current accounting guidance requires health care entities to present the bad debt provision in operating expense rather than a reduction of patient revenue. We believe this has and will continue to cause confusion to users of the financial statements.

Most health care entities have established and published policies for determining charity care eligibility for their patients. Many of these policies are subject to regulatory oversight, as noted further below. The timing for determining such eligibility is dependent on the cooperation of the patients. Efforts to obtain patient information to support a charity care adjustment may not be initially obtained by the health care entity, so the account may be sent to a collection agency, at which time the account is categorized as a bad debt. If the agency is successful in obtaining documentation from the patient that supports charity care eligibility, the provision is reclassified from bad debt to charity care. If this process crosses reporting periods, the presentation of the operating expenses and patient revenue can be affected under current presentation requirements. Consistent reporting of these adjustments as a reduction of patient revenue would eliminate this reporting issue.

As a not-for-profit health care system, NMHC provides care to patients regardless of a patient's ability to pay. NMHC currently publishes an Annual Nonprofit Hospital Community Benefit Plan Report, compliant with the requirements of the Illinois Attorney General. The information required includes amounts for both bad debts and charity care.

We believe the reclassification of the provision for bad debts from operating expense to a reduction of patient revenue would improve the interpretation of results for a financial statement user. This reclassification would require minimal effort to apply retrospectively for comparability purposes.

Question 2: *The Task Force considered requiring disclosure of net revenue by type of service (that is, emergency care, elective services, and so forth). Do you believe that disclosure would be more useful than the proposal to provide disclosure by major payor type? Why?*

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We believe many health care entities would have difficulty in providing disclosure of net revenue by type of service due to existing system limitations. NMHC's patient accounting system (and we believe systems of most other entities) collects and reports revenue information by primary payor. We also believe that users of the financial statements are provided more value with revenue by payor rather than service type. Concentration of credit risk by primary payor is already disclosed in our financial statements. Disclosure by primary payor allows for more comparability among health care entities. Service mix disclosures could vary among health care entities due to how revenue is captured in the patient accounting and/or cost accounting systems and a lack of standard definitions, resulting in a lack of comparability. Finally, as we look to the future of the industry and the probability that healthcare reform will move reimbursement towards a "bundled payment" methodology, net revenue by service type would be even more difficult to determine.

Question 3: *Do you agree that the amendments in this proposed Update should be applied retrospectively?*

Based on our responses to the first two questions, we disagree on retrospective application as it pertains to the proposed disclosures by major payor and/or service level. If, however, the Task Force decides to reclassify the provision for bad debts, we believe such retrospective application should be required and could be done with little effort.

Question 4: *Do you anticipate the need for significant changes in the accounting systems or information gathering to implement the proposed amendments?*

We believe to meet all the disclosure requirements as proposed by the Task Force, most health care entities would need to make considerable changes to their patient accounting systems, especially for reporting the reconciliation of the allowance for doubtful accounts by payor. We also believe many entities would need to implement and/or change cost accounting systems (primarily for reporting the service mix data).

As noted above, we do not believe the benefit that users might gain from this disclosure requirement is sufficient to justify the cost for compliance.

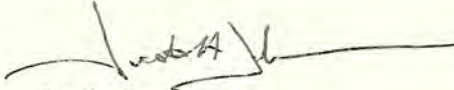
Question 5: *How much time do you believe would be necessary to efficiently implement the proposed amendments?*

While we did not specifically scope out the actual hours that would be needed, it is certain that to implement such changes prospectively would be in the hundreds or even thousands of hours as well as significant dollars for each reporting system impacted. If the requirements were also retrospective, the hours and dollars required would increase significantly.

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NMHC again thanks you for the opportunity to comment on this proposal. I am happy to make myself available to the Task Force members to answer any questions or discuss further. If desired, please contact me at (312) 926-1599 or jusjohns@nmh.org.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Justin A. Johnson", with a long horizontal flourish extending to the right.

Justin A. Johnson
Director, Accounting & Corporate Controller
Northwestern Memorial Hospital