



Gary L. Gephart
AVP and Controller

1301 Central Street
Evanston, IL 60201
www.northshore.org
(847) 570-5053
(847) 570-5240 fax

November 5, 2010

Technical Director
Financial Accounting Standards Board

Email: director@fasb.org

RE: File Reference EITF090H
Proposed Accounting Standards Update, Health Care Entities (Topic 954)
Disclosure about Net Revenues and Allowance for Doubtful Accounts

Dear Director:

NorthShore University HealthSystem welcomes the opportunity to comment on proposed disclosures for hospital net revenues and allowance for doubtful accounts.

NorthShore is a not-for-profit integrated healthcare delivery system operating in the near north suburbs of Chicago, Illinois. In our fiscal year ended September 30, 2010, our four acute care hospitals (with over 900 licensed beds) provided care for over 62,000 cases, had approximately 118,000 emergency room visits, and over 1 million outpatient visits. Our operations also include a multi-specialty physician group (with over 650 physicians), a research institute, and home health care.

We believe our information systems technology is state of the art. We have been recognized by *Hospital and Health Networks* as one of the "Top 100 Most Wired Hospitals" eight years in a row. Three of our hospitals were among the first 15 hospitals honored for reaching "Stage 7" of HIMMS EMR Adoption Model. Our CEO has been honored by *Modern Healthcare* and HIMMS for demonstrating superior levels of leadership and commitment to using information technology for the advancement of NorthShore's strategic goals. Despite these capabilities, our organization will be hard-pressed, as noted below, to track the information to accommodate the proposed disclosures.

Comments on the Proposed Standards:

Question 1 –

We do not believe that the proposed standards will allow users of the financial statements to *better understand and assess* the net revenue of our healthcare organization. We do believe

the current disclosure in our audited financial statements provides sufficient detail to assess our revenues and receivables. These current disclosures include revenue percentages by major payors and accounts receivable balances by major payor. We believe this sufficiently allows the user to assess the quality of such accounts.

The major source of our uncollectible (bad debt) accounts arise from self-pay receivables. Thus, to delineate any other payor sources would not be meaningful. We would also find it difficult to determine which classification to give the account since many of these receivables are determined after the primary payor (generally a third party or government payor) has made payment. Would these still be a self-pay classification? We believe that it would be difficult to standardize this classification among all hospitals which would not result in better comparability.

We believe one of the major obstacles in comparing organizations is in the methodologies and practices used to determine an account that is bad debt and that which is charity care. Thus, we believe, the combination of these two deductions would be a more beneficial method than the current proposal. In addition, combining both types of write-offs to arrive at net patient revenue would add more clarity to the users of the statements.

Question 2 -

We do not believe disclosure of net revenue by type of service would be useful. This type of presentation does not align with how we manage our business nor in how we receive payment for our services. Most patients receive services from a multitude of departments in one visit. We are paid one fee for the duration of a patient's stay or for an entire day at a time. Thus, our systems are not designed to record net pay for particular services. There is no efficient manner to determine how a bundled payment should be applied to each area since such payments will be determined after the services have been provided. If possible to do, it would still be a very costly endeavor to redesign our systems to do so.

Question 3 -

We do not believe the amendments, if adopted, should be applied retroactively. Again, we have no current systems in place to collect this data and it will take time and effort to do this. In addition, patients account payor status may change over time depending on their circumstances and our systems retain current status only.

Question 4 -

We would anticipate major changes to our current accounting systems in order to tabulate the proposed disclosures. As noted previously, our systems cannot currently track changes in components of a patient's service by expected payment from a primary insurance, then a secondary insurance, until finally the balance to be paid by the person themselves.

Question 5 -

It would take countless thousands of hours to implement changes to our information systems from the point of patient access to the billing of accounts to the final interface to the general ledger to track data as proposed. The cost could be in the millions of dollars.

In summary, NorthShore University HealthSystem is of the opinion that current disclosures do allow the financial statement users to adequately assess the quality of our revenues and receivables. If there is a need for a change, we would rather see the provision for doubtful accounts be combined with charity care as a deduction from revenue. This would have the benefit of achieving more uniformity amongst healthcare organizations and better assessment of actual net revenues for services provided.

Sincerely,

Gary L. Gephart, CPA
Controller, NorthShore University HealthSystem