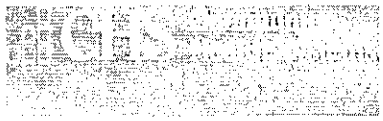

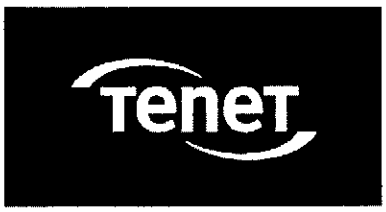

March 15, 2010

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Gentlemen:

Re: Revenue Recognition in Healthcare Organizations

We appreciate the opportunity to share with the Financial Accounting Standards Board (the "FASB") our views related to the Emerging Issues Task Force's (the "EITF" or the "Task Force") ongoing discussions regarding revenue recognition in health care organizations (HCOs). We are five of the larger, investor owned hospital companies in the United States: Community Health Systems, Inc., Health Management Associates, Inc., IASIS Healthcare LLC, Lifepoint Hospitals, Inc., and Tenet Healthcare Corporation.

The U.S. hospital industry is broadly defined to include acute care, rehabilitation, and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 5,800 inpatient hospitals in the U.S. which are not-for-profit owned, investor owned, or state or local government owned.

As a group, we provide health care services through approximately 300 hospitals, along with other health care facilities that we operate. These hospitals are geographically diversified across approximately 32 states, with an approximately 48,000 licensed beds, representing approximately 5% of the licensed beds in the United States. We generate revenues by providing a broad range of general and specialized

hospital healthcare services to patients in the communities in which we are located. Services provided by our hospitals include general acute care services, emergency room services, general and specialty surgery, critical care, internal medicine, obstetrics, and other related services. Collectively, we reported annual net patient service revenue of approximately $31 billion in 2009.

We have been monitoring the Task Force's deliberations on revenue recognition in health care organizations and we appreciate the opportunity to share our perspective on certain aspects of the deliberations.

Revenue Recognition in Healthcare Organizations

Revenue Recognition for Pure Self Pay Patients – As noted in Issue No. 09-H, *Selected Healthcare Organization Issues*, Issue Summary No. 1 (dated February 22, 2010) (the "Issue Summary"), HCOs may perform services for which the ultimate collection of all or a certain portion of the amount billed or billable is not expected at all, is doubtful, or cannot be determined at the time the services are rendered. Empirical evidence in our hospitals indicates that the vast majority of services performed, where collectability is uncertain, relate to "pure self pay" patients (uninsured patients who pay out of pocket for services). We believe HCOs across the United States share similar experience. The largest source of self pay revenue in most HCOs results from services provided in emergency departments, which are subject to the federal Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires hospitals to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay, when a patient presents to an emergency room for attention to an emergency medical condition. Emergency services are inherently more expensive to provide than services in a non-emergency setting, resulting in higher billings, which for pure self pay patients are the least collectible of all accounts.

Currently, nearly all HCOs report revenue related to pure self pay patients at various discounted rates (some of which are state regulated) and report bad debt expense as the amount of the discounted rates not expected to be realized (resulting in a substantially high provision for bad debt). The amount ultimately collected for services provided to pure self pay patients in many hospitals is a small portion of the discounted rates (for example, collections of only 4% to 8% of reimbursable amounts are common).

Additionally, current industry practice of recording revenue related to pure self pay patients does not give sufficient consideration to whether persuasive evidence of an arrangement exists between the HCO and the patient. Staff Accounting Bulletin (SAB) Topic 13 – *Revenue Recognition* (SAB Topic 13) requires that evidence of an exchange arrangement must exist to determine if the accounting treatment represents faithfully the transaction. The use of the term 'arrangement' is meant to identify the final understanding between the parties as to the specific nature and terms of the agreed-upon transaction.[1]

Revenue Recognition for Insured Patients – HCOs also provide services to insured patients under contractual arrangements with governmental programs such as Medicare and Medicaid, and other third party payors. Medicare is a federal program that provides medical insurance benefits to persons age 65 and over, certain disabled persons, and persons with end-stage renal disease. Medicaid is a federal-state funded program, administered by the states, which provides medical benefits to individuals who are unable to afford healthcare. In certain areas in which we operate, government agencies contract directly with private companies to manage the care of the Medicare and Medicaid beneficiaries. In addition to government programs, HCOs are paid under contractual relationships with private payors, which include insurance companies, HMOs, PPOs, other managed care companies, and employers (collectively referred to as "other third party payors"). Under these programs, HCOs can demonstrate persuasive evidence of

[1] Staff Accounting Bulletin Topic 13 – Revenue Recognition, Section A.1. Revenue Recognition – general, inclusive of footnote 3 thereto.

an arrangement via their contractual relationship with the governmental program or other third party payor. This is a distinctive difference between pure self pay patients and insured patients. Under arrangements with governmental programs and other third party payors, reimbursable amounts are generally significantly less than a hospital's standard charges for the services provided. The difference between the reimbursable amounts and standard charges are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at net operating revenues. These net operating revenues are an estimate of the reimbursable amounts pursuant to arrangements with these payors. As a group, we receive a substantial portion of our revenue from the Medicare and Medicaid programs and from other third party payors.

Under these contractual arrangements, patients are generally not responsible for any differences between standard charges and reimbursable amounts pursuant to arrangements with governmental programs and other third party payors. Pursuant to these arrangements, patients are responsible, however, for services not covered by these programs, as well as for the deductibles and co-insurance obligations ("co-pays") of their coverage[2]. While the collection of amounts due from individuals for deductibles and co-pays is typically more difficult than collection of amounts due from governmental programs or other third party payors, HCOs collect substantially all of reimbursable amounts under these arrangements and, accordingly, believe collectability is reasonably assured.

Because HCOs have performed services under contractual relationships with governmental programs and other third party payors under pre-defined payment rates for many years, most HCOs generally have reliable information systems or other source data with which to demonstrate reasonable assurance as to amounts that will ultimately be collected. Importantly, substantially all of the reimbursable amounts are ultimately collected for services provided to patients under the Medicare and Medicaid programs and other third party payor relationships. The collectability rates under these revenue streams are drastically different from, and should be contrasted with, the pure self pay patients described above.

Our Conclusions on Revenue Recognition in Healthcare Organizations

Accounting and Reporting

We believe collectability should be reasonably assured before revenue can be recognized and support View A as described in the Issue Summary. We agree with the Staff's recommendation that there should be no industry exceptions to the revenue recognition guidance on collectability; accordingly, we reject View B as described in the Issue Summary. We believe View A improves financial reporting for the following reasons:

- View A eliminates distortions to operating margins caused by higher reported net revenue and bad debt expense related to pure self pay patients. Currently, reported net revenue is impacted and bad debt expense is dominated by pure self pay amounts for which the HCOs know there is no reasonable assurance of collection. In addition, these net revenue and bad debt expense amounts can be arbitrarily impacted based on adjustments to discounting policies or reimbursable amounts to pure self pay patients. View A eliminates this variability by requiring HCOs to record revenue on pure self pay patients once collectability is reasonably assured (e.g., when the cash is received).
- View A eliminates variability that may exist in the methodologies for estimating bad debts. Variability creates a lack of comparability, which has been a point of frustration for investors and analysts.

[2] Generally, governmental programs do not permit HCOs to collect any amounts from patients covered under Medicaid.

- View A eliminates the high degree of subjectivity introduced into financial statements under current practices. Management of HCOs currently spends significant time and resources estimating the provision for bad debt of pure self pay patients. View A eliminates this subjectivity.
- View A clarifies existing guidance which can be interpreted to require HCOs to assess collectability. Paragraph 954-605-25-4 of the FASB Accounting Standards Codification (the Codification) states, "The provision for contractual adjustments (that is, the difference between established rates and third-party payor payments) and discounts (that is, the difference between established rates and the amount collectible) are recognized on an accrual basis and deducted from gross service revenue to determine net service revenue." We believe this paragraph, as originally contemplated, indicates that collectability should be reasonably assured before the initial measurement of net revenue.

The following examples demonstrate the application of View A to three specific payor types. These reflect individual patient encounters and do not reflect our overall experience by payor type.

Example A – Pure Self Pay

Patient presents to the Emergency Department with complications from chest pain resulting in coronary bypass surgery. Pursuant to EMTALA, the HCO admits the patient and provides examination and needed stabilizing treatment. No consideration is given, at the date of service, as to insurance coverage or ability to pay. Subsequent to the date of service, the HCO learns that the patient is uninsured (i.e., resulting in a pure self pay account).

Charges related to these services are:

Standard charges - $50,000
Reimbursable amounts (after "managed care style" discount for uninsured patients[3]) - $20,000
Amount ultimately collected - $0[4]

Based on the minimal historical collection rates known to the HCO at the date of service, it is apparent that collectability of the entire reimbursable amount is not reasonably assured. Accordingly, revenue should not be recorded for such accounts until collectability is reasonably assured (e.g., when the cash is received). While these bad debt amounts may be deemed uncollectible, we will continue to pursue collection from the patients and/or attempt to qualify the patients for Medicaid or other third-party payor coverage. Our experience has been that, even after consideration of subsequent collections and payments from Medicaid and other third-party payors, collections from this patient type is not reasonably assured.

Example B - Medicare

Patient presents to the HCO for previously scheduled coronary bypass surgery. HCO obtains insurance information (in our example, assume patient presents Original Medicare eligibility and a Medigap policy[5]), admits patient, and performs bypass and related procedures.

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[3] Pursuant to state law in certain states and/or pursuant to board approved policies, most HCOs offer "managed care style" discounts for uninsured patients.

[4] Actual collection experience varies by patient. In the aggregate, HCOs collect approximately 4-8% of pure self pay accounts.

[5] A Medigap policy (also called "Medicare Supplement Insurance") is private health insurance that is designed to supplement Original Medicare. This means it helps pay some of the health care costs "gaps" that Original Medicare doesn't cover (like copayments, coinsurance, and deductibles). Medigap policies may also cover certain things that

Charges related to these services are:

Standard Charges - $50,000
Reimbursable amounts (after discounts) - $20,000
Amount ultimately collected - $20,000 (100% of reimbursable amounts)

- Medicare responsibility / amount collected – $17,500 / $17,500
- Medigap responsibility / amount collected – $2,000 / $2,000
- Patient Responsibility / amount collected – $500 / $500[6]

Based on the high historical collection rates known at the date of service and considered in the aggregate, it is apparent that collectability is reasonably assured. Accordingly, revenue should be recorded for the total net charges ($20,000).

Example C – Managed Care

Patient presents to the HCO for previously scheduled coronary bypass surgery. HCO obtains insurance information (in our example, assume patient presents proof of managed care insurance coverage), admits patient, and performs bypass and related procedures.

Charges related to these services are:

Standard Charges - $50,000
Reimbursable amounts - $20,000
Amount ultimately collected - $19,000 (95% of reimbursable amounts)

- Managed care insurance company responsibility / amount collected – $18,000 / $18,000
- Patient co-pay responsibility / amount collected – $2,000 / $1,000

Based on historical collection rates known at the date of service and considered in the aggregate, it is apparent that collectability is reasonably assured. Accordingly, revenue should be recorded for the total reimbursable amounts ($20,000).

As demonstrated by these three examples, the decision to extend credit to patients is a fundamental principle inherent in our business models. Depending upon patient financial class (e.g., pure self pay vs. governmental programs and other third party payors), HCOs are able to evaluate collectability at the individual patient level by considering the contractual terms or characteristics of the third party payor relationships the HCO typically serves. This results in a revenue recognition model whereby net revenue is recorded for amounts where collectability is reasonably assured (e.g., governmental programs and other third party payors) and revenue is not recorded where collectability is not reasonably assured (e.g., pure self pay). This model follows the foundational principles of revenue recognition which require that collectability be ascertained before amounts are recorded as revenue.

Medicare doesn't cover. For patients in Original Medicare that have a Medigap policy, Medicare will pay its share of the Medicare-approved amounts for covered health care costs, then the patients Medigap policy pays its share.

[6] At admission, the HCO makes a decision to extend credit. Generally, patients covered by insurance have a higher likelihood of payment due to their ongoing relationship with the insurer and, in many cases, a higher degree of financial wherewithal.

Disclosure

We agree with the FASB staff that no additional recurring disclosures would be required as a result of the resolution of the Issue Summary.

Transition Method

We support a transition method whereby HCOs will apply the new revenue recognition guidance prospectively from the date of adoption and would record a cumulative effect adjustment to beginning retained earnings in the year of adoption to write off the pure self pay accounts receivable and related allowance for doubtful accounts amounts as of the beginning of the year of adoption. We believe this modified approach is a practical expedient for the following reasons:

- Certain meaningful, comparative information (e.g., 'net revenue less bad debt expense' and 'operating expenses less bad debt expense') can be derived from historical and prospective financial statements.
- It avoids a re-estimation process for the purpose of restating historical financial statements, which in and of itself would be subjective and could create variability.
- Costs of re-estimating historical information, and restating historical financial statements could be avoided.
- Costs of having the restated financial statements audited could be avoided.
- The incremental benefit to users of restated financial statements would not outweigh the costs to present such information.

Using a cumulative effect adoption approach, 'net revenue less bad debt expense' and 'operating expenses less bad debt expense' information will be comparable for all periods presented. Because of the distorting impact of historically reported bad debt expense, many of us use the aforementioned comparative information for investor presentations. Historical balance sheet information would not be expected to change materially. The incremental benefit to users of restated financial statements would not outweigh the costs to present such information.

Because a substantial portion of the historical allowance for doubtful accounts related to pure self pay patient accounts receivable, many of our models for estimating the allowance for doubtful accounts were primarily built to estimate pure self pay accounts receivable net realizable values. This prospective change may require HCOs to change their models to focus only on realizable revenue and related receivables from third-party payor arrangements. Conversely, restatements of historical financial statements would require HCOs to re-build the historical models (removing the pure self pay components) and modify historical assumptions (focusing on new assumptions solely relating to the co-pay and deductible components of third party payor arrangements) for each period restated, and could result in inconsistency due to hindsight.

The resources needed to restate historical financial statements will impact many departments (e.g., patient accounting, information systems, and financial accounting departments) and could be significant. In some cases, historical information about patient financial class and amounts (as of certain dates or for certain periods) is not readily available or may ultimately change over time as patients qualify for third party coverage. Also, the efforts of our external auditors will be proportionate to our efforts, with increased focus on amounts and internal controls involving management estimates.

We note that the FASB has allowed similar transition methods in recently issued accounting standards where retrospective application was impractical (e.g., FIN 48). Accounting Standards Codification (ASC) Topic 250-10-45-6 states, "If the cumulative effect of applying a change in accounting principle to all prior periods can be determined, but it is impracticable to determine the period-specific effects of that change on all prior periods presented, the cumulative effect of the change to the new accounting principle

shall be applied to the carrying amounts of assets and liabilities as of the beginning of the earliest period to which the new accounting principle can be applied. An offsetting adjustment, if any, shall be made to the opening balance of retained earnings (or other appropriate components of equity or net assets in the statement of financial position) for that period." Due to the inherent estimates and significant resources involved in the process as described above, we believe that for the vast majority of HCOs it would be impracticable to apply the effects of a change in accounting principle retrospectively (pursuant to ASC Topic 250-10-45-9).

Importantly, we reject transition method View A (prospective adoption) as described in the Issue Summary. Transition method View A would confuse analysts and investors because following adoption, the majority of pure self pay cash receipts in the initial post adoption months would relate to amounts previously recognized as revenue (following the HCOs accounting policy). Conversely, cash receipts related to pure self pay services provided post-adoption would not be received (and reach "steady state") for at least several months, depending on each HCO's facts and circumstances. As a result, there would be a lag in reported revenues immediately subsequent to the date of adoption as pre-adoption cash receipts were applied to that accounts receivable. Due to differences in our billing and collection procedures and our historical methods for computing allowances for doubtful accounts, the lag effects would hinder users' ability to compare and benchmark an individual company's post-adoption revenues to the industry peer group. In addition to extreme analyst and investor confusion, the revenue lag may impact our compliance with loan covenants. Lastly, HCOs generate a large number of unique clinical encounters each day. Assuming HCOs begin recording pure self pay revenue on a cash basis prospectively, certain organizations may have information system limitations that impact their ability to segregate cash collections into "pre-" and "post-" implementation amounts for prospective financial reporting purposes. The combination of analyst and investor confusion, potential loan covenant issues and system limitations causes us to reject prospective adoption.

With our proposed method, the net realizable value of all previously recognized pure self pay revenues would be written off through beginning retained earnings. Pure self pay cash receipts subsequent to the date of adoption would be recognized consistently during the prospective adoption period.

We agree that a consensus would eliminate diversity in practice and therefore believe early adoption should be permitted.

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Thank you for your attention to our views. We trust that these perspectives are of value to the deliberation process and we hope to have the opportunity to discuss these matters with you in greater detail. If we can provide further information or clarification of our comments, please call any of the signatories listed below.

Sincerely,

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