August 31, 2010

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

File Reference No. EITF090H
RE: Issue No. 09-H - Health Care Entities: Revenue Recognition

Dear FASB Technical Director:

HCA Inc. (HCA) appreciates the opportunity to comment on the Financial Accounting Standards Board's (FASB's) Issue No. 09-H, Health Care Entities: Revenue Recognition.

HCA is the largest non-governmental hospital operator in the U.S. and a leading provider of health care and related services. As of June 30, 2010, we operated a portfolio of 162 hospitals (with approximately 41,000 beds) and 106 freestanding surgery centers across 20 states throughout the U.S. and in England. For the year ended December 31, 2009, we generated revenues of $30.052 billion and net income attributable to HCA Inc. of $1.054 billion.

Comments on Issue No. 09-H

We understand the EITF did not reach a consensus on Issue No. 09-H at the July 29, 2010 meeting and further discussions are expected for future EITF meetings.

It appears the EITF is considering alternatives that include:

1. HCOs would maintain their current revenue recognition practices, but bad debt expense would be presented as a revenue deduction rather than an operating expense. Consideration will be given to presenting bad debt expense on a separate line, as a deduction from revenues.

   A possible concern with this revenue deduction presentation for bad debt expense (either presenting bad debt as a separate line item or not) is compliance with Article 5-03 of Regulation S-X.

2. HCOs would maintain their current revenue recognition practices, including maintaining bad debt expense as a separate operating expense line item in the income statement, and would be required to provide disclosures regarding their policies for self-pay revenue deductions and bad debt expense.

We believe the strong similarities underlying the provision for doubtful accounts, uninsured discounts and charity care would best be communicated to users of healthcare organizations' (HCO's) financial statements by accounting for all three consistently, as revenue deductions in the income statement. We believe the best income statement presentation would be to treat the three components of uncompensated care as direct revenue deductions, with no separate line items being presented for any of the three uncompensated care components. The alternative being considered which would require HCOs to present bad debt expense as a revenue deduction on a separate line would not eliminate the current inconsistencies and HCO financial statement user confusion, it would merely move these inconsistencies and confusion from one position on the income statement to another.

Each of the three components of uncompensated care relate primarily to uninsured amounts due from patients receiving services in the HCO's facilities. Each of these items are recorded based upon the HCO's gross charges, which are generally, significantly in excess of the HCO's costs of providing the healthcare services. The current inconsistency of accounting for two of these items (charity care and uninsured discounts) as revenue deductions and the third item (provision for doubtful accounts) as an operating expense leads to inconsistencies in comparing HCO's income statements and is a source of confusion to HCO investors and users of HCO financial statements.

The following table presents actual information for HCA for the years ended December 31, 2009, 2008, and 2007 and for the six months ended June 30, 2010 and 2009 (dollars in millions):

	Years Ended December 31,			Six Months Ended June 30,	
	2009	2008	2007	2010	2009
Provision for doubtful accounts	$ 3,276	$ 3,409	$ 3,130	$ 1,352	1,673
Uninsured discounts	2,935	1,853	1,474	2,107	1,222
Charity care	2,151	1,747	1,530	1,144	1,076
Total uncompensated care	$ 8,362	$ 7,009	$ 6,134	$ 4,603	$ 3,971
Gross patient service charges	$115,682	$102,843	$92,429	$61,785	$ 57,242
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation)	22,975	22,030	20,768	11,737	11,227
Cost-to-charges ratio	19.86 %	21.42 %	22.47 %	19.00 %	19.61 %
Estimated cost of total uncompensated care	$ 1,661	$ 1,501	$ 1,378	$ 875	$ 779

You can note from our trends on the three components of uncompensated care that our decision to increase our uninsured discounts during 2009 has resulted in the provision for doubtful accounts declining from 51% of total uncompensated care for the year ended 2007 to 29% of total uncompensated care for the six months

ended June 30, 2010, and uninsured discounts have increased from 32% of total uncompensated care for the year ended 2007 to 46% of total uncompensated care for the six months ended June 30, 2010. The recent EITF consensus on Issue 09-2 will result in disclosure of the estimated cost of one component (charity care) of total uncompensated care, but the other two components of total uncompensated care (uninsured discounts and the provision for doubtful accounts) will continue to be based on gross charges, which for HCA are approximately five times our underlying cost. We believe consideration should be given to requiring HCOs to make a presentation (in a format similar to the preceding table) that addresses disclosure of the three components of uncompensated care and the related estimated costs rather than only providing the estimated cost disclosures for charity care and leaving the provision for doubtful accounts and uninsured discounts based upon gross charges.

The majority of our uninsured patient volume originates through the emergency departments in our hospital facilities. Hospital facilities participating in the Medicare program are required to conduct an appropriate medical screening examination of every person who presents to the emergency department and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition, regardless of their ability to pay for the healthcare service provided. We are not making a credit decision on some of these patients and failing to make a credit decision on others; we aren't making a credit decision on any of these individuals who present to our emergency departments.

Our position is that it would appear to make sense to account for the three uncompensated care adjustments consistently, as revenue adjustments. They each relate to the same general patient group (the uninsured and underinsured), they are each based upon each HCO's gross charges (which significantly exceed the HCO's costs) and there is little underlying differentiation among the three adjustments. The patient receiving charity care may have more financial resources than an uninsured patient who doesn't receive the qualification for charity care, simply because such patient will not provide us the financial information to determine whether they meet our guidelines to qualify for charity care.

We believe the inconsistencies among HCOs in both their setting of gross charges (gross charges can vary significantly among HCOs) and their policies for determining charity care, uninsured discounts and the provision for doubtful accounts lead to investor and financial statement user confusion in trying to determine the estimated cost of total uncompensated care and understanding and comparing uncompensated care among HCO's. We believe the reclassification of the provision for doubtful accounts from operating expense to a revenue deduction (without separate line item presentation of the provision for doubtful accounts as a revenue deduction) would significantly help investors and financial statement users by eliminating these inconsistencies.

We believe one alternative to address concerns related to the reclass of the HCO's provision for doubtful accounts, to present it as a revenue deduction, and compliance with Article 5-03 of Regulation, would be to bifurcate the HCO's provision for doubtful accounts and reclass only the bad debt expense related to self-pay patient amounts (uninsured) as a revenue deduction and retain the presentation of other bad debt expense (primarily related to bankrupt/ in receivership insurers or managed care companies) as an operating expense. The bifurcation of our bad debt expense would be easy to accomplish as we record the patient-related and insurer-related bad debt amounts in separate general ledger accounts.

Thank you for the opportunity to comment. I am available to provide additional comments, or meet with you or members of your board to discuss this matter further. If I can provide additional material or perspective on this issue, please contact me at (615) 344-5900 or by email at don.street@hcahealthcare.com.

Don Street

Don Street
Vice President & Chief Accounting Officer