

# Changes to revenue recognition in the health care industry

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## TABLE OF CONTENTS

<b>A. Introduction</b> .....	<b>1</b>
<b>B. Charity care guidance</b> .....	<b>2</b>
<b>C. New five-step revenue recognition model</b> .....	<b>2</b>
<b>C.1. Identify the contract with a customer</b> .....	<b>2</b>
<b>C.2. Identify the performance obligations in the contract</b> .....	<b>3</b>
C.2.1. Identifying promises to transfer goods or services .....	4
C.2.2. Separating promises to transfer goods or services into performance obligations .....	4
<b>C.3. Determine the transaction price</b> .....	<b>5</b>
C.3.1. Variable consideration .....	5
C.3.2. Significant financing component.....	6
<b>C.4. Allocate the transaction price to the performance obligations</b> .....	<b>7</b>
<b>C.5. Recognize revenue when (or as) each performance obligation is satisfied</b> .....	<b>8</b>
C.5.1. Transfer of control.....	8
C.5.2. Satisfaction of performance obligation over time or at a point in time.....	8
<b>D. New contract costs guidance</b> .....	<b>9</b>
<b>E. Health care services provided to insured and uninsured patients</b> .....	<b>10</b>
<b>E.1. Legacy GAAP</b> .....	<b>10</b>
<b>E.2. New guidance</b> .....	<b>11</b>
E.2.1. Identifying the contract with the customer (including evaluating collectibility)...	11
E.2.2. Accounting for variable consideration (e.g., price concessions) .....	12
E.2.3. Identifying significant financing components when there are deferred and advance payments .....	16
<b>F. Third-party settlement adjustments</b> .....	<b>16</b>
<b>F.1. Variable consideration</b> .....	<b>17</b>

<b>F.2. Significant financing component</b> .....	<b>18</b>
<b>F.3. Modified retrospective transition method</b> .....	<b>19</b>
<b>G. CCRCs</b> .....	<b>19</b>
<b>G.1. Revenue</b> .....	<b>19</b>
G.1.1. Legacy GAAP .....	20
G.1.2. Five-step revenue recognition model .....	20
<b>G.2. Costs incurred to obtain residents</b> .....	<b>20</b>
G.2.1. Legacy GAAP .....	20
G.2.2. New guidance .....	20
<b>G.3. Liabilities related to providing future residency and services to current residents</b> .....	<b>21</b>
<b>H. Risk sharing arrangements</b> .....	<b>21</b>
<b>H.1. Identifying the contract with the customer (including evaluating collectibility)</b> .....	<b>22</b>
<b>H.2. Identifying the performance obligations</b> .....	<b>22</b>
<b>H.3. Determining the transaction price</b> .....	<b>23</b>
H.3.1. Variable consideration .....	23
H.3.2. Significant financing component .....	25
<b>I. Applying a portfolio approach</b> .....	<b>25</b>
<b>J. Presentation and disclosure</b> .....	<b>27</b>
<b>J.1. Presentation</b> .....	<b>27</b>
<b>J.2. Disclosure</b> .....	<b>28</b>
J.2.1. Disaggregation of revenue .....	28
J.2.2. Contract balances .....	29
J.2.3. Performance obligations .....	29
J.2.4. Transaction price allocated to remaining performance obligations .....	30
J.2.5. Significant judgments .....	30
J.2.6. Practical expedients .....	31
J.2.7. Contract costs .....	32
J.2.8. Disclosure examples .....	32
<b>K. Conclusion</b> .....	<b>32</b>

## A. Introduction

In May 2014, the Financial Accounting Standards Board (FASB) and International Accounting Standards Board issued substantially converged final standards on revenue recognition. These final standards were the culmination of a joint project between the Boards that spanned many years. FASB Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*, provides a robust framework for addressing revenue recognition issues and replaces almost all pre-existing revenue recognition guidance in current U.S. generally accepted accounting principles (GAAP) (i.e., legacy GAAP), including industry-specific guidance and SEC Staff Accounting Bulletin Topic 13 (which is also part of legacy GAAP for public entities).

Implementation of the robust framework provided by ASU 2014-09 will result in improved comparability of revenue recognition practices across entities, industries, jurisdictions and capital markets. For public business entities (PBEs) and certain not-for-profit entities, implementation was required no later than annual reporting periods beginning after December 15, 2017, and the interim periods therein. However, if an entity is a PBE solely because its financial statements or financial information is included in a filing with the SEC pursuant to certain SEC rules and regulations (e.g., an acquired private company when its financial statements must be included in the acquirer's filing with the SEC), it may choose to adopt the new guidance in accordance with either: (a) the effective date otherwise applicable to PBEs or (b) the effective date applicable to private companies, which is annual reporting periods beginning after December 15, 2018, and interim periods thereafter.

The FASB has amended the new guidance included in ASU 2014-09 several times since its issuance. The new guidance primarily is included within the following sections of the FASB's Accounting Standards Codification (ASC):

- Topic 606, "Revenue from Contracts with Customers"
- Subtopic 340-40, "Other Assets and Deferred Costs – Contracts with Customers"

For a detailed discussion of the new guidance (as amended), refer to [A guide to revenue recognition](#). Additional information is available in our [Revenue Recognition Resource Center](#).

The American Institute of Certified Public Accountants (AICPA) organized several industry-specific task forces to identify and provide guidance on implementation issues, including the Health Care Entities Revenue Recognition Task Force. The culmination of the AICPA task forces' activities was the issuance of a final comprehensive nonauthoritative revenue recognition guide in 2019, the AICPA Audit and Accounting Guide, *Revenue Recognition* (the Revenue Recognition AAG), which provides helpful discussion and illustrative examples on how to apply the new guidance. Chapter 7 of the Revenue Recognition AAG includes discussion of the following topics a health care entity may encounter in its application of the new guidance (and which are discussed in this white paper as noted parenthetically):

- Identifying performance obligations (see Section C.2)
- Determining the timing of satisfaction of performance obligations (see Section C.5)
- Accounting for contract costs (see Section D)
- Arrangements for health care services provided to uninsured and insured patients with self-pay balances, including co-payments and deductibles (see Section E)
- Consideration of ASC 606 for third-party settlement estimates (see Section F)
- Application of the five-step revenue recognition model to the contracts of a continuing care retirement community (CCRC) (see Section G)
- Risk sharing arrangements (see Section H)

- Application of the portfolio approach (see Section I)
- Presentation and disclosure (see Section J)

To facilitate understanding the implementation issues included in the Revenue Recognition AAG, we also provide overviews of the charity care guidance (Section B) and the new five-step revenue recognition model (Section C).

## B. Charity care guidance

When a health care entity provides health care services to an uninsured patient, it must determine whether the patient qualifies for charity care (to the extent the health care entity has a charity care policy). The guidance applied to account for charity care provided by a health care entity was not changed by the new guidance. As such, a health care entity continues to account for charity care only on an internal basis as charity care does not qualify for revenue recognition (i.e., charity care is not reflected as a line item on the face of the income statement). Health care entities are expected to continue to use their internal processes for identifying charity care and distinguishing it from price concessions or bad debt expense. In addition, the disclosure requirements related to the costs of providing charity care continue to apply.

## C. New five-step revenue recognition model

The new guidance includes the following five-step revenue recognition model:



An overview of each step is provided in this section of the white paper. For a comprehensive discussion of the five-step revenue recognition model and other aspects of the new guidance, refer to [A guide to revenue recognition](#).

### C.1. Identify the contract with a customer

While the discussion in this section primarily is focused on a single contract, it may be appropriate to apply the concepts using a portfolio approach, which is discussed in Section I.

A contract is defined in ASC 606-10-25-2 as “an agreement between two or more parties that creates enforceable rights and obligations.” To account for a contract in accordance with the new guidance, the following five criteria (the contract existence criteria) must be met:

- Commercial substance exists
- Approvals have been obtained and a commitment to perform exists on the part of both parties
- Rights of both parties are identifiable
- Payment terms are identifiable
- Collection of substantially all of the amount to which the entity will be entitled in exchange for the goods or services that will be transferred to the customer is probable (i.e., likely to occur) (the collectibility criterion)

To meet the collectibility criterion, an entity must be able to conclude that collection of substantially all of the amount to which it will be entitled in exchange for the goods or services that will be transferred to the customer is probable. Before an entity can determine whether the collectibility criterion is met, it must determine the amount that should be evaluated for collectibility. To do so, there are two primary considerations:

- *Transaction price.* The transaction price is the amount ultimately recognized as revenue under the new guidance. Additional information about determining the transaction price is provided in Section C.3.
- *Mitigating credit risk.* An entity should take into consideration its ability to mitigate credit risk related to the transaction price (and, if so, to what extent). Doing so could result in the amount evaluated for collectibility being an amount less than the transaction price.

Once the entity has determined the amount that should be evaluated for collectibility, it then determines whether collectibility of that amount is probable. Making this determination requires significant judgment.

When all of the contract existence criteria are met, the remaining steps in the five-step revenue recognition model are applied to the contract. When all of the contract existence criteria are not met, revenue is deferred and the contract existence criteria continue to be evaluated to determine whether they are subsequently met. Absent meeting the contract existence criteria, revenue is only recognized when the amounts paid by the customer (or by another party on the customer's behalf) are nonrefundable and at least one of the following applies:

- The entity has no remaining performance obligations and it has received all or substantially all of the amounts promised by the customer.
- The contract has been terminated.
- The entity has both: (a) transferred control of the goods or services to which the nonrefundable consideration relates and (b) stopped transferring additional goods or services to the customer and is under no obligation to transfer any additional goods or services to the customer.

Application of this guidance (the deferral guidance) when one of the contract existence criteria has not been met could result in the initial deferral of revenue for what may be a significant period of time, even if nonrefundable cash has been received.

Refer to Section E.2.1 for discussion of applying this guidance when health care services are provided to insured and uninsured patients. Refer to Section H.1 for discussion of applying this guidance to risk sharing arrangements.

## **C.2. Identify the performance obligations in the contract**

Identifying the performance obligations in the contract establishes the units of account to which the transaction price should be allocated and for which revenue is recognized. The first step in identifying the performance obligations in the contract is to identify all of the promises to provide goods or services in the contract. Once that step is complete, criteria are applied to determine whether the promises to provide goods or services should be treated as performance obligations and accounted for separately.

It may be appropriate to apply the remaining steps in the new five-step revenue recognition model to a portfolio of similar performance obligations across multiple contracts. Applying the portfolio approach is discussed in Section I.

Refer to Section H.2 for discussion of applying this guidance to risk sharing arrangements. Refer to Section G.1 for discussion of issues that may arise when a CCRC applies this guidance. In addition, paragraphs 7.2.01 through 7.2.09 of the Revenue Recognition AAG address implementation issues that may arise when other health care entities apply this guidance.

### C.2.1. Identifying promises to transfer goods or services

An entity should scrutinize its contracts and identify all of the promises to transfer goods or services to the customer. Consideration also needs to be given to whether there are promises to transfer goods or services that arise out of an entity's customary business practices instead of an explicit contract provision.

Not all activities performed by the entity in connection with the contract transfer a good or service to the customer. For example, setup activities do not transfer a good or service to the customer. Instead, those activities are necessary for the entity to fulfill the contract and do not themselves represent a good or service transferred to the customer. As a result, they cannot represent a performance obligation. However, depending on the facts and circumstances, the entity may be required to capitalize the costs to perform these activities (which is discussed in Section D).

### C.2.2. Separating promises to transfer goods or services into performance obligations

If there is more than one promise to transfer goods or services in a contract, consideration must be given to whether the promises to transfer goods or services should each be considered performance obligations and treated separately for accounting purposes. The determining factor in this analysis is whether each promised good or service is distinct. If a promised good or service meets both of the following criteria, it is considered distinct and accounted for separately as a performance obligation unless the series exception applies:

- *Capable of being distinct.* If a customer can benefit from the promised good or service (or a bundle of goods or services) on its own or by combining it with other resources readily available to the customer, then the good or service is capable of being distinct. A promised good or service is capable of being distinct when the entity regularly sells that good or service separately or when the customer can generate an economic benefit either on its own or when combined with other readily available resources. The ability to sell the good or service for scrap value only would not, in and of itself, support a conclusion that the promised good or service is capable of being distinct. For a resource to be readily available to the customer, it must be sold separately either by the entity or another party or it must be a good or service that the customer already has obtained as a result of either a contract with the entity (including the contract under evaluation) or another transaction or event.
- *Distinct within the context of the contract.* If the promised good or service is separately identifiable from other promised goods or services in the contract, it is distinct within the context of the contract. To determine whether a promised good or service is distinct within the context of the contract, the entity must ascertain which of the following best describes its promise within the context of the specific contract:
  - *The promise within the context of the specific contract is to transfer the promised good or service individually.* If this best describes the entity's promise within the context of the specific contract, the promised good or service is distinct within the context of the contract.
  - *The promise within the context of the specific contract is to transfer a combined item or items to which the promised good or service is an input.* If this best describes the entity's promise within the context of the specific contract, the promised good or service is not distinct within the context of the contract.

Indicators are provided to assist in determining whether a promised good or service is distinct within the context of the contract. Answering yes to any of the following questions is an indication that the promised good or service is *not* distinct within the contract:

- Is the entity providing a significant service of integrating the promised good or service with one or more of the other promised goods or services in the contract, with the result of that integration being one or more of the combined outputs contracted for by the customer?

- Does the promised good or service significantly modify or customize one or more of the other promised goods or services in the contract, or is the promised good or service significantly modified or customized by one or more of the other promised goods or services in the contract?
- Is the promised good or service highly interdependent or highly interrelated with one or more of the other promised goods or services in the contract, such that each of the promised goods or services is significantly affected by one or more of the other promised goods or services?

If a promised good or service is distinct, it is considered a performance obligation and accounted for separately. However, a series of distinct promised goods or services that are substantially the same should be considered a *single* performance obligation and accounted for as one unit of account if each of the goods or services has the same pattern of transfer to the customer as a result of: (a) each of the goods or services otherwise being considered satisfied over time and (b) the entity otherwise having to use the same method of measuring progress toward completion for each of the goods or services.

Promised goods or services that are not distinct are combined with the other promised goods or services until the group of promised goods or services is considered distinct, at which point that group is considered a performance obligation and accounted for separately. It is possible that all of the promised goods or services in the contract might have to be accounted for as a single performance obligation. This happens when none of the promised goods or services are considered distinct on their own or together with less than all of the other promised goods or services in the contract.

### **C.3. Determine the transaction price**

Transaction price, which is the amount ultimately recognized as revenue under the new guidance, is defined in ASC 606-10-32-2 as “the amount of consideration to which an entity expects to be entitled in exchange for transferring promised goods or services to a customer, excluding amounts collected on behalf of third parties (for example, some sales taxes).” The transaction price includes or could be affected by one or more of the following:

- Fixed cash consideration
- Variable consideration
- Noncash consideration
- Significant financing component
- Consideration payable to the customer

Issues encountered by health care entities in determining the transaction price typically involve variable consideration and significant financing components. Overviews of the guidance applicable to each are provided in Sections C.3.1 and C.3.2.

#### **C.3.1. Variable consideration**

Discounts, price concessions and contractual allowances the entity intends to offer and (or) the customer expects to receive based on the entity’s customary business practices, published policies or specific statements are examples of variable consideration. Additionally, as discussed further in Section F.1, while contracts between third-party payors (such as governmental entities) and health care entities often include terms indicating the amounts third-party payors will remit for the services provided to the covered patient, the contracts are also quite complex and implicitly or explicitly allow for retrospective third-party adjustments, which results in variable consideration. For variable consideration other than a sales or usage-based royalty for which the only or predominant item to which the royalty relates is the license of intellectual property, determining the amount of variable consideration that should be included in the transaction price typically involves two steps: (a) estimating the variable consideration to which the entity expects to be entitled and (b) including the estimated variable consideration in the transaction price to the

extent it is probable that its inclusion will not result in a significant reversal of cumulative revenue recognized when the uncertainty giving rise to the variability is resolved.

One of two methods must be used to estimate the variable consideration to which the entity expects to be entitled: (a) the most likely amount method or (b) the expected value method. The entity must use the method that is expected to better predict the amount to which the entity expects to be entitled. In applying either one of these methods (as appropriate), the entity should consider all reasonably available information. In addition, the same estimation method should be used when accounting for contracts with similar characteristics in similar circumstances. If a contract is subject to more than one type of uncertainty, it may be appropriate to use the most likely amount method to estimate the amount to which the entity expects to be entitled when one (or more) of the uncertainties is resolved and to use the expected value method to estimate the amount to which the entity expects to be entitled when the other uncertainties are resolved. For example, if a contract includes two variable payments and each is based on the resolution of a different uncertainty, it may be appropriate, depending on the facts and circumstances, to use the expected value method to estimate the variable consideration related to one uncertainty and the most likely amount method to estimate the variable consideration related to the other uncertainty.

Once the entity has estimated the amount to which it expects to be entitled, it then applies the variable consideration constraint to determine whether it is probable that inclusion of the variable consideration in the transaction price will not result in a significant reversal of cumulative revenue recognized when the uncertainty giving rise to the variability in the transaction price is resolved. If it is probable that a significant reversal of cumulative revenue recognized will not occur with respect to: (a) all of the variable consideration, then no adjustment is made to the variable consideration included in the transaction price or (b) some of the variable consideration, then only that portion of the variable consideration is included in the transaction price. If it is less than probable that a significant reversal of cumulative revenue recognized will not occur with respect to all of the variable consideration, then none of the variable consideration is included in the transaction price.

The estimated variable consideration must be reassessed each reporting period until the underlying uncertainty is resolved. The method used to initially estimate the variable consideration also should be used when the estimate is reassessed each reporting period.

Refer to the following sections of this white paper for further information:

- Section E.2.2 for discussion of applying this guidance when health care services are provided to insured and uninsured patients
- Section F.1 for discussion of applying this guidance to third-party settlement adjustments
- Section H.3.1 for discussion of applying this guidance to risk sharing arrangements

### **C.3.2. Significant financing component**

When a contract includes a significant implicit or explicit benefit of financing to either the entity or the customer (i.e., a significant financing component), it is taken into consideration in determining the transaction price, unless the entity qualifies for and elects to apply a practical expedient. A significant financing component could exist with respect to deferred or advance payment terms, which means it could result in the entity recognizing interest income or expense.

All of the relevant facts and circumstances related to the contract need to be considered in determining whether it includes a significant financing component. For example, an entity should consider whether there is a difference between the amount the customer would have had to (i.e., hypothetically) pay for the goods or services in cash at the time they were provided and the amount the customer is paying for those goods or services based on the deferred payment terms. An entity also should consider the amount of

time that will pass between when the goods or services are provided to the customer and when the customer pays for those goods or services, along with the relevant prevailing interest rates.

The new guidance specifically indicates that a significant financing component does *not* exist in any of the following situations:

- The customer makes an advance payment, and the timing of transferring the promised goods or services to the customer is at the customer's discretion.
- There is substantial variable consideration, and payment of that consideration is contingent on the resolution of an uncertainty that is not substantially in the entity's or customer's control.
- There are reasons not related to financing that justify the nature and amount of the difference between the cash selling prices of the goods or services and the promised consideration.

If an entity concludes there is a significant financing component in its contract with the customer, it may elect a practical expedient to ignore that financing component when estimating the transaction price if the entity expects the difference between the following two events to be one year or less at contract inception: (a) the entity's transfer of the goods or services to the customer and (b) the customer's payment for those goods or services. When assessing whether the practical expedient can be applied, it is important to focus on these two events and not the duration of the contract in its totality.

If an entity chooses not to consider the practical expedient or concludes that the practical expedient cannot be applied in its facts and circumstances, the significant financing component must be taken into consideration in estimating the transaction price. The objective of doing so is to recognize revenue in an amount consistent with what the customer would have paid in cash upon the transfer of the promised goods or services.

To adjust the promised consideration for the significant financing component, the entity should use a discount rate consistent with the rate that would be present in a separate financing transaction between the entity and the customer at contract inception. Such discount rate should take into consideration: (a) the credit risk of the entity (when advance payments are involved) or the customer (when deferred payments are involved) and (b) any collateral or other security provided by either the entity or the customer. The discount rate is not adjusted after contract inception.

Refer to the following sections of this white paper for further information:

- Section E.2.3 for discussion of identifying significant financing components when there are deferred or advance payments related to health care services provided to insured and uninsured patients
- Section F.2 for discussion of applying this guidance to third-party settlement adjustments
- Section G.1.2 for discussion of issues that may arise when a CCRC applies this guidance
- Section H.3.2 for discussion of applying this guidance to risk sharing arrangements

#### **C.4. Allocate the transaction price to the performance obligations**

If a contract has more than one performance obligation, the transaction price should generally be allocated to each performance obligation based on the standalone selling prices of each performance obligation in relation to the total of those standalone selling prices (i.e., on a relative standalone selling price basis). Exceptions to the relative standalone selling price method are provided for certain situations involving discounts and (or) variable consideration that can be shown to be related to one or more (but less than all) performance obligations.

The standalone selling price of a performance obligation is the amount the entity charges (or would charge) when the distinct goods or services that make up the performance obligation (i.e., the underlying

distinct goods or services) are sold on their own to a customer. Standalone selling prices are determined at contract inception and are not subsequently adjusted for changes in facts and circumstances.

The best evidence of the standalone selling price of the underlying goods or services is the observable price charged by the entity for those goods or services when they are sold separately in similar circumstances to similar customers. Absent evidence of a directly observable standalone selling price, the entity is required to estimate a standalone selling price. In making this estimate, the entity should maximize observable inputs and consider all reasonably available and relevant information, which includes both entity-specific and market-specific information.

Refer to Section G.1.2 for discussion of issues that may arise when a CCRC applies this guidance.

### **C.5. Recognize revenue when (or as) each performance obligation is satisfied**

Revenue is recognized when (or as) a performance obligation is satisfied, which is when control of the underlying distinct goods or services is transferred to the customer. The amount of revenue recognized when the performance obligation is satisfied is the amount of the transaction price allocated to it.

Refer to Section G.1.2 for discussion of issues that may arise when a CCRC applies this guidance. In addition, paragraphs 7.5.01 through 7.5.08 of the Revenue Recognition AAG provide guidance on the implementation issues that may arise when health care entities other than CCRCs apply this guidance.

#### **C.5.1. Transfer of control**

Control has been transferred to a customer when the customer has the ability to direct the use of the good or service and receive substantially all of the related remaining benefits, which includes the customer being able to stop others from directing the use of the good or service and receiving substantially all of the related remaining benefits. For this purpose, benefits are considered in terms of the potential cash flows the customer can obtain (directly or indirectly) as a result of having control of the good or service. The new guidance provides a number of indicators that should be considered in assessing whether control has transferred, including indicators focused on the customer's obligation to pay, customer acceptance and the transfer of legal title, physical possession and the significant risks and rewards of ownership.

#### **C.5.2. Satisfaction of performance obligation over time or at a point in time**

To identify the appropriate timing and pattern of revenue recognition, an entity must perform an evaluation at contract inception focused on whether the performance obligation is satisfied (and control of the underlying good or service is transferred) over time or at a point in time. If a performance obligation meets one or more of the following criteria, it is considered satisfied over time:

- *Customer simultaneously receives and consumes benefits as entity performs.* A performance obligation is satisfied over time if the customer consumes the benefits of the entity's performance at the same time as: (a) the customer receives those benefits and (b) the entity performs and creates those benefits. If it is not readily apparent whether this is the case in a particular set of facts and circumstances, then a performance obligation is satisfied over time if another entity could step in and fulfill the remaining performance obligation without having to substantially reperform the work already performed by the entity.
- *Control passes as the entity performs.* A performance obligation is satisfied over time if the customer controls the asset (which encompasses the underlying goods and [or] services) as it is created or enhanced by the entity's performance. An entity will need to carefully consider the indicators of control discussed previously in assessing whether control of the asset passes to the customer as the entity performs.
- *No alternative use and an enforceable right to payment.* A performance obligation is satisfied over time if: (a) the asset created by the entity's performance does not have an alternative use to the entity

upon its completion and (b) the entity's right to payment for its performance to date is enforceable. In making the alternative use assessment, an entity needs to determine the nature and substance of any legal or practical limitations on its ability to redirect (e.g., sell to another customer) the completed asset created by its performance.

If a performance obligation does not meet any of these three criteria, it is considered satisfied at a point in time and revenue is recognized at the point in time that the customer obtains control over the underlying good or service.

If the performance obligation is considered satisfied over time, the related revenue is recognized over time. In these situations, the entity must identify a single method by which to measure the progress toward complete satisfaction of the performance obligation. Important considerations in identifying that single method include:

- The nature of the underlying promised good or service should be taken into consideration in identifying an appropriate measure of progress toward complete satisfaction of the performance obligation.
- The method identified should provide a reasonable and reliable estimate of the measure of progress toward complete satisfaction of the performance obligation.
- The method identified should be consistent with how control of the underlying goods or services is transferred to the customer.
- The method of measuring progress toward the complete satisfaction of a performance obligation should be applied consistently to similar performance obligations in similar circumstances.

If an entity is unable to reasonably and reliably measure the progress toward complete satisfaction of the performance obligation, it should recognize revenue to the extent of the costs incurred to satisfy the performance obligation, but only if it expects to recover those costs. This approach is used only until the entity is able to reasonably and reliably measure the outcome of a performance obligation.

Output methods or input methods can be used to measure progress toward complete satisfaction of performance obligations. Output methods rely on the value of the underlying goods or services transferred to the customer (e.g., appraisals of results achieved, units produced). Input methods rely on the efforts put forth by the entity to satisfy the performance obligation (e.g., labor hours, costs incurred).

Progress toward complete satisfaction of a performance obligation is based on the amount of outputs or inputs to date and the estimated total amount of outputs or inputs necessary to satisfy the performance obligation. Progress toward completion is calculated at the end of each reporting period and used in determining the appropriate amount of revenue to recognize.

## D. New contract costs guidance

The new guidance addresses the circumstances under which the following costs should be capitalized.

- *Costs to fulfill a contract.* If there is other guidance in the ASC that applies to the costs incurred to fulfill a contract (e.g., inventory costs), that other guidance should be applied. If there is no specific guidance in the ASC that applies to costs incurred to fulfill a contract, the new guidance should be applied, which requires capitalization of those costs if all of the following criteria are met:
  - The costs incurred by the entity are directly related to a specific contract or anticipated contract (e.g., direct labor related to setup activities).
  - The costs generate or enhance resources that the entity will use in satisfying its future performance obligations under the contract (e.g., the activities giving rise to the costs are not a performance obligation in and of themselves).

- The entity expects to recover the costs (e.g., based on net cash flows from the contract and expected contract renewals).

If these criteria are met, the fulfillment costs must be capitalized. In other words, there is no option to expense fulfillment costs for which these criteria are met.

- *Costs of obtaining a contract.* The incremental costs of obtaining a contract (i.e., those costs related to obtaining the contract that would not have been incurred if the contract was not obtained), such as a sales commission, should be capitalized if the entity expects to recover those costs (e.g., based on net cash flows from the contract and expected contract renewals). However, an entity may elect a practical expedient under which the incremental costs of obtaining a contract are expensed if the amortization period would otherwise be one year or less. Costs of obtaining a contract that are not incremental (i.e., costs related to obtaining the contract that would have been incurred regardless of whether the contract had been obtained) should only be capitalized if those costs are explicitly chargeable to the customer regardless of whether the entity enters into a contract with the customer. Otherwise, such costs are expensed as incurred.

Capitalized contract costs should be amortized in a manner that is consistent with how the related goods or services are transferred to the customer. For example, if the related services are transferred to the customer continuously and evenly over the amortization period, straight-line amortization of the capitalized costs would typically be appropriate.

Capitalized contract costs are tested for impairment by comparing the carrying amount of the capitalized costs to an amount that considers all of the following: (a) the contract consideration an entity expects to receive in the future, (b) the contract consideration the entity already has received but has not yet recognized as revenue and (c) the costs that remain to be recognized under the contract. The time period reflected in the impairment test should take into consideration expected contract renewals and extensions with the same customer. Once an impairment loss is recognized, it is not reversed under any circumstance.

Refer to Section G.2 for discussion of issues that may arise when a CCRC applies this guidance. In addition, paragraphs 7.7.61 through 7.7.73 of the Revenue Recognition AAG provide guidance on implementation issues that may arise when other health care entities apply this guidance.

## **E. Health care services provided to insured and uninsured patients**

### **E.1. Legacy GAAP**

Under the legacy GAAP in ASC 954-605, “Health Care Entities – Revenue Recognition,” revenue for health care services is recognized when it is earned and realized or realizable, which is usually when services are provided to the patient or when coverage is provided to an enrollee in a prepaid health care plan (e.g., a plan subscriber or one of its eligible dependents). Gross service revenue generally is based on the standard rates charged by a health care entity. In other words, gross service revenue does not reflect any contractual allowances provided to third-party payors or discounts provided to patients. When revenue is recognized, contractual allowances and discounts also are recognized on an accrual basis and are deducted from gross service revenue to arrive at net service revenue.

An allowance for uncollectible amounts also should be recognized when revenue is recognized by the health care entity. The income statement presentation of the related provision for bad debts depends on whether the health care entity recognizes significant amounts of patient service revenue before it is able to evaluate the patient’s ability and intent to pay. If so, the provision for bad debts is deducted from patient service revenue (which is gross patient service revenue less contractual allowances and discounts) to arrive at net patient service revenue less the provision for bad debts. Bad debts related to receivables from patient service revenue are presented as an operating expense if the health care entity only recognizes revenue to the extent it expects to collect that amount.

## E.2. New guidance

The discussion in this section primarily is based on the guidance in paragraphs 7.6.01 to 7.6.43 of the Revenue Recognition AAG, which focus on issues that arise in applying the following aspects of the new guidance to health care services provided to insured and uninsured patients:

- Identifying the contract with the customer (including evaluating collectibility)
- Accounting for variable consideration (e.g., price concessions)
- Identifying significant financing components when there are deferred and advance payments

While the discussion in this section primarily is focused on a single contract, it may be appropriate to apply the concepts using a portfolio approach, which is discussed in Section I.

### E.2.1. Identifying the contract with the customer (including evaluating collectibility)

While in many cases it will be relatively straightforward for a health care entity to determine whether a contract exists for accounting purposes, in some cases doing so may be more complex. The degree of complexity depends on the nature of the health care entity's practice with respect to establishing contracts with its patients and whether this practice varies depending on the nature of the services provided or other factors, such as whether there is a third-party payor involved. A less complex determination may be involved, for example, when a health care entity requires a patient to complete and sign a patient responsibility form prior to providing that patient with any services. When completed and approved, such a form (depending on its contents) may evidence the payment terms and each party's performance commitments and rights and obligations. A more complex determination may be involved, for example, when the health care entity enters into oral contracts or implied contracts with patients based on its customary business practices (e.g., scheduling elective surgery in advance).

When oral or implied contracts are the basis for providing services to a patient, the health care entity must exercise judgment in determining whether such a contract identifies the payment terms and each party's performance commitments, rights and obligations. Ultimately, determining whether an oral or implied contract legally exists and understanding the terms of such a contract may require the entity to consult with its legal counsel. It is important to note, however, that reaching a conclusion that an oral or implied contract exists for legal purposes does not automatically result in the conclusion that a contract exists for accounting purposes. To reach the latter conclusion, all of the contract existence criteria discussed in Section C.1 must be met. For example, an oral or implied contract may exist for legal purposes, but not for accounting purposes because the collectibility criterion (one of the contract existence criteria) has not been met.

A particularly complex determination as to whether a contract exists for accounting purposes arises when the patient is unable to make a commitment to perform under a contract before the health care entity provides services to the patient. Consider a situation in which a patient is brought to the emergency room in need of immediate medical attention. Certain health care entities may be required by law, regulation or their own charity care policy to provide emergency or other necessary services to patients without regard to whether the patient is insured or has the ability to pay. In addition, health care entities that are charitable organizations under Section 501(c)(3) of the Internal Revenue Code must have written policies that limit the amount the health care entity may charge for emergency or other medically necessary services provided to qualifying individuals. In these types of situations, the specific facts and circumstances must be carefully analyzed to determine if and when there is a basis to conclude that the health care entity and patient have entered into a contract for accounting purposes. Example 3 in ASC 606-10-55 illustrates a situation in which the patient cannot commit to perform its obligations when brought to the emergency room for immediate medical attention due to his or her condition. In addition, the health care entity is unable to ascertain whether the patient qualifies for charity care or government subsidies. As a result, a contract with that patient does not exist for accounting purposes when the services are provided, which results in the recognition of no revenue at that point in time. Only after

providing the services and gathering additional information is the health care entity in that example able to conclude a contract exists for accounting purposes (i.e., that all of the contract existence criteria are met).

Concluding that a contract exists for accounting purposes also requires the collectibility criterion to be met. Before a health care entity can determine whether the collectibility criterion is met, it must determine the amount that should be evaluated for collectibility. As discussed in Section C.1, there are two primary considerations in doing so: (a) determining the transaction price (see Sections C.3 and E.2.2) and (b) determining whether the health care entity can mitigate its credit risk.

Taking into consideration the health care entity's ability to mitigate credit risk related to the transaction price (and, if so, to what extent) could result in the amount evaluated for collectibility being an amount less than the transaction price. For example, the health care entity and patient may enter into a contract for medical services that will be provided over six monthly appointments. The health care entity in this situation may be able to mitigate its credit risk by having the contractual and practical ability to stop providing the patient with services if the patient does not fulfill its obligation to pay for each medical procedure within 30 days of when the procedure was performed (which would be prior to the patient's next appointment). If the health care entity mitigates its credit risk in this manner and, in practice, discontinues providing patients with services if they do not pay within 30 days, the amount evaluated for collectibility is the fee for each monthly appointment. Another way in which a health care entity may be able to mitigate its credit risk is by requiring its patients to pay for health care services in advance. For example, a health care entity may require a patient to make a nonrefundable prepayment for a portion of the estimated fees for an elective surgical procedure. While the health care entity has mitigated some of its credit risk in this situation, the amount evaluated for collectibility still includes the portion of the transaction price prepaid. However, when evaluating whether collection of that amount is probable, the health care entity takes the nonrefundable prepayment into consideration (i.e., collection of at least the amount prepaid is probable).

Once the health care entity has determined the amount that should be evaluated for collectibility, it then determines whether collectibility of that amount is probable. Making this determination could involve the health care entity considering its history with that patient and (or) assigning the patient to a particular customer class based on the patient's information. If the health care entity has patient-specific history indicating no consideration was collected from the patient for services provided in the past, such history may be strong evidence that the collectibility criterion is not met.

When all of the contract existence criteria are not met, application of certain elements of the deferral guidance discussed in Section C.1, such as determining whether a contract has been terminated or whether the health care entity is under no obligation to transfer any additional goods or services, may require involvement of the health care entity's legal counsel.

Given the implications of reaching the appropriate conclusions with respect to whether a contract exists (including whether collectibility is probable) and appropriately estimating the transaction price, health care entities should make sure they have the processes in place to determine whether: (a) all of the contract existence criteria in the new guidance are met and (b) all of the discounts and price concessions have been identified and taken into consideration in estimating the transaction price. This could be a significant undertaking for some health care entities given that the applicable legacy GAAP did not incorporate all of the same criteria and (or) concepts.

### **E.2.2. Accounting for variable consideration (e.g., price concessions)**

For health care entities, the transaction price will often be less than the stated price (e.g., standard rate or gross charges) because of the industry practice to provide discounts, price concessions and contractual allowances to the patient based in part on whether the patient has insurance coverage from a third-party payor and the nature of that coverage. Essentially, any portion of the standard rate or gross charges that could eventually be affected by discounts, price concessions or contractual allowances makes that portion of the standard rate or gross charges variable consideration.

Discounts, price concessions and contractual allowances may be explicit or implicit. An example of an explicit price concession is when the health care entity maintains a policy to provide uninsured self-pay patients a 70 percent discount off its standard rates or gross charges for the services. An example of an implicit price concession is when the health care entity places an uninsured self-pay patient in a billing and collection category for which it expects to only collect 10 percent of the discounted rate (the standard rate less the 70 percent discount). Based on paragraph 7.6.24 of the Revenue Recognition AAG, the following two questions may be considered by a health care entity when determining whether it intends to offer an implicit price concession:

- Are health care services typically provided to a patient (or patient class) without first performing a credit assessment (e.g., the health care entity is required by law to provide emergency health care services regardless of the patient's intent and ability to pay)?
- Does the health care entity continue to provide health care services to a patient (or patient class) despite historical evidence that shows it is not probable the patient will pay substantially all of the discounted charges?

Based on Paragraph 7.6.25 of the Revenue Recognition AAG, if one or both of these questions is answered in the affirmative, an implicit price concession exists even if the health care entity intends to bill, and tries to collect, the full amount of the discounted charges. Many of the examples at the end of Section 7.6 of the Revenue Recognition AAG illustrate how to identify and account for implicit price concessions.

While many health care entities provide implicit price concessions that reflect the patient's credit risk, some do not. The accounting for both situations is discussed next.

#### *Implicit price concessions exist*

It may take a health care entity some time to estimate the variable consideration to which it expects to be entitled (e.g., the extent of any discounts or price concessions it expects to provide to a patient) because, as discussed previously, it may provide emergency services to the patient without knowing whether the patient is insured, has the ability to pay or qualifies for charity care. Depending on the facts and circumstances, it may be appropriate to use historical evidence (e.g., the likelihood of different discounts ultimately being offered to similarly situated patients) to estimate the discounts or price concessions that will ultimately be provided to patients in these situations. The discussion in paragraph 7.6.10 of the Revenue Recognition AAG indicates that historical evidence will generally be used in practice to estimate the implicit discounts or price concessions for a portfolio of contracts. Each health care entity should take its own facts and circumstances into consideration when identifying the evidence to be used in estimating the implicit discounts or price concessions for a portfolio of contracts. As discussed in Section C.3.1, the health care entity should ensure that it is using either the most likely amount method or expected value method to estimate the effects of implicit discounts or price concessions on the transaction price.

Also as discussed in Section C.3.1, the health care entity must apply the variable consideration constraint to the portion of the transaction price estimate that could be affected by implicit discounts or price concessions. If the method used by the health care entity to estimate the effects of the implicit discounts and price concessions on the transaction price is consistent with the objective of the variable consideration constraint (i.e., it is probable that there will not be a significant reversal of cumulative revenue recognized), separate application of the variable consideration constraint may not be necessary.

Paragraph 7.6.27 of the Revenue Recognition AAG includes the following factors a health care entity should consider when explicitly applying the variable consideration constraint and assessing whether it is probable that a significant reversal of cumulative revenue recognized will not occur:

- *To what extent is the amount collected from the patient affected by factors not within the health care entity's control?* The greater the extent to which the amount collected from the patient is affected by factors not within the health care entity's control, the more likely it is that a significant reversal of cumulative revenue recognized could occur.

- *How much experience does the health care entity have with collecting amounts from similar patients?* The less experience the health care entity has, the more likely it is that a significant reversal of cumulative revenue recognized could occur.
- *How long does it take the health care entity to collect the amounts owed by its patients?* The longer it takes the health care entity to collect, the more likely it is that a significant reversal of cumulative revenue recognized could occur.
- *To what extent does the health care entity change the discounts and price concessions offered to patients?* The greater the extent to which the health care entity changes the discounts and price concessions offered to patients, the more likely it is that a significant reversal of cumulative revenue recognized could occur.
- *How broad is the range of possible payment amounts captured in the health care entity's historical information for similar patients?* The broader the range of possible payment amounts, the more likely it is that a significant reversal of cumulative revenue recognized could occur.

If sufficient historical evidence does not exist with respect to the health care entity's ability to qualify patients for charity care or a government subsidy or with respect to its ability to estimate the extent of implicit discounts or price concessions, it ultimately may conclude that the contract existence criteria discussed in Section C.1 are not met. When those criteria are not met, revenue is deferred until the criteria are met (at which point the remainder of the new five-step revenue recognition model is applied) or until one of three specific situations discussed in Section C.1 arises.

To illustrate how the variable consideration guidance should be applied by a health care entity, consider the following example.

**Example**

Health Care Entity (HCE) provides emergency health care services to Patient, who is an uninsured self-pay patient. The standard rate for the services provided is \$50,000. Upon gathering the necessary information from Patient (including information necessary to assess Patient's ability and intent to pay), HCE determines that Patient should be placed in category C1 of its uninsured self-pay patient population for billing and collection purposes. For all uninsured self-pay patients, HCE's policy is to discount its standard rates by 70 percent, which means Patient receives a \$35,000 discount (\$50,000 x 70 percent) under this policy. In addition, for uninsured self-pay patients assigned to category C1, HCE estimates that it will collect 10 percent of the discounted amount, which means HCE estimates that it will collect \$1,500  $[(\$50,000 - \$35,000) \times 10 \text{ percent}]$  from Patient. For purposes of its billing and collection efforts, however, HCE bills and attempts to collect \$15,000  $(\$50,000 - \$35,000)$  from Patient. HCE evaluates the estimated variable consideration of \$1,500 and concludes that it is probable that a significant reversal of cumulative revenue recognized will not occur. Based on the guidance in paragraphs 7.6.24 and 7.6.25 of the Revenue Recognition AAG, HCE intends to offer an implicit discount of \$13,500  $(\$15,000 - \$1,500)$ .

The health care entity estimates the transaction price (and net patient service revenue [NPSR]) for its contract with Patient in this situation as follows:

<b>Standard rate</b>	\$50,000
<b>Explicit discount</b>	(35,000)
<b>Implicit discount</b>	(13,500)
<b>Transaction price (NPSR)</b>	\$1,500

As discussed in paragraph 7.6.33 and further explained in Examples 7-6-1 and 7-6-3 in the Revenue Recognition AAG, while each health care entity should make this determination based on its own facts and circumstances, when the transaction price includes variable consideration as a result of implicit price concessions, changes in the amount expected to be collected from a patient generally should be reflected as a change in that variable consideration (which is discussed later in this section). However, if the change in the amount expected to be collected can be attributed to a patient-specific event that has occurred since the patient's credit risk was initially assessed (e.g., the patient loses his or her job or files for bankruptcy), the change is reflected as bad debt expense. When accounting for variable consideration on a portfolio basis for a particular patient class, the health care entity should be monitoring information about the implicit price concessions provided to patients in the portfolio and the collection rate for the portfolio to determine whether the estimated variable consideration for the portfolio requires adjustment or whether bad debt expense should be recorded (which is further explained in Example 7-6-3 of the Revenue Recognition AAG).

Changes in variable consideration not caused by a contract modification (such as a change in the estimated amount of an implicit price concession) or that cannot be attributed to a patient-specific event occurring after the initial assessment of the patient's credit risk (as discussed in the preceding paragraph) should be allocated to the performance obligations in the contract on the same basis that was used to allocate the transaction price at contract inception (with limited exceptions). When this is the case and there is only one performance obligation and that performance obligation has been satisfied when the change in variable consideration occurs, the adjustment to the transaction price should be reflected as an increase or decrease to revenue, as appropriate, in the period the variable consideration changed. For example, if the only performance obligation is an outpatient surgical procedure and that procedure has been completed and the related transaction price has been recognized as revenue, when the health care entity appropriately determines that an adjustment to decrease the implicit price concession (i.e., increase the transaction price) is necessary, it should recognize that adjustment as an increase to revenue at that point in time.

To the extent a health care entity's estimates of the amounts it expects to collect change frequently and (or) change to a significant extent, it should reassess the estimation process it has in place for variable consideration, including the assessment of whether it is probable that there will not be a significant reversal of cumulative revenue recognized when final collections are made.

#### *No implicit price concessions exist*

Some health care entities may not provide an implicit price concession based on the patient's ability and intent to pay. For example, a health care entity specializing in elective surgical procedures may not permit credit-related discounts from its standard rates. To manage its risk of default, the health care entity assesses the patient's ability and intent to pay prior to performing the procedures.

If the health care entity has appropriate policies and procedures in place to determine whether the patient (or patient class) has the ability and intent to pay the standard rates for the procedures to be performed and concludes that the patient (or patient class) has the requisite ability and intent to pay after applying and performing those policies and procedures, the health care entity is concluding that it is probable that it will collect substantially all (e.g., 97 percent) of the consideration to which it expects to be entitled. As a result, there is no implicit price concession that reflects the patient's (or patient class') credit risk and, if the historical evidence the health care entity has for this patient class shows that it collects 97 percent of the amounts billed to its patients, the health care entity recognizes revenue for 100 percent of the billed amount (i.e., its standard rates) and bad debt expense for 3 percent of the billed amount (provided the remainder of the new five-step revenue recognition model would otherwise result in the health care entity recognizing revenue). To the extent there is a subsequent change in circumstances that affects a patient's (or a patient class') ability and intent to pay (e.g., the patient loses his or her job, the patient class' ability to pay is affected by an economic downturn), the health care entity recognizes the effects of a credit loss in accordance with the applicable guidance in the ASC on accounts receivable and presents

the credit loss as bad debt expense (which is further explained in Example 7-6-6 of the Revenue Recognition AAG).

If the health care entity does not have appropriate policies and procedures in place to determine whether the patient has the ability and intent to pay the standard rates for the procedures to be performed, or if the health care entity concludes that the patient does not have the requisite ability and intent to pay after applying and performing those policies and procedures, the health care entity is concluding it is not probable that it will collect substantially all of the consideration to which it expects to be entitled. As a result, the contract existence criteria are not met and revenue recognition is deferred until the contract existence criteria are met or one of the situations in the deferral guidance discussed in Section C.1 arises.

### **E.2.3. Identifying significant financing components when there are deferred and advance payments**

It is not uncommon for health care entities to receive payments on a deferred basis. For example, as discussed in Sections F.2 and H.3.2, health care entities typically receive third-party settlement adjustments months (and sometimes even more than a year) after the services have been provided to the patients. A health care entity may also offer payment plans to uninsured self-pay patients that span months or years. It is also not uncommon for certain types of health care entities to receive advance payments from their customers. To the extent a health care entity receives payments on a deferred or advance basis, it should consider the guidance on significant financing components discussed in Section C.3.2 to determine whether there is a significant financing component that should be reflected in the transaction price.

## **F. Third-party settlement adjustments**

Third-party payors, such as Medicare, Medicaid or an insurance company, often are involved in paying health care entities for services provided to patients. Paragraphs 7.6.44 through 7.6.72 of the Revenue Recognition AAG include discussion of issues that arise when a health care entity applies the new guidance to situations in which a third-party payor is involved.

The threshold question addressed in the Revenue Recognition AAG is whether a third-party payor's involvement should be considered when applying the new five-step revenue recognition model. While paragraph 7.6.46 of the Revenue Recognition AAG acknowledges that the new guidance should be used to account for the contract between the patient and the health care entity, it goes on to indicate that a third-party payor's involvement should be considered when estimating the transaction price for the contract.

Accounting for the contracts between third-party payors and health care entities typically involves consideration of the following aspects of the new guidance on determining the transaction price:

- *Variable consideration.* While contracts between third-party payors and health care entities often include terms indicating the amounts third-party payors will remit for the services provided to the covered patient, the contracts are also quite complex and implicitly or explicitly allow for retrospective third-party settlement adjustments, which results in variable consideration. Applying the variable consideration guidance to third-party settlement adjustments is discussed in Section F.1.
- *Significant financing component.* The period of time between when services are provided to the covered patient and when third-party settlement adjustments related to those services are finalized could be quite extended (e.g., more than a year), which raises the question as to whether there is a significant financing component that should be reflected in the transaction price. Applying the significant financing component guidance to third-party settlement adjustments is discussed in Section F.2.

In addition, the period of time between when services are provided to the covered patient and when third-party settlement adjustments related to those services are finalized may give rise to an issue in applying the modified retrospective transition method, which is discussed in Section F.3.

### F.1. Variable consideration

Based on the guidance discussed in Section C.3.1, the health care entity should use whichever of the following two methods provides the better estimate of the third-party settlement adjustment: (a) the most likely amount method or (b) the expected value method. While ASC 606-10-32-8(b) indicates that the most likely amount method may provide an appropriate estimate in situations with two potential outcomes, paragraph 7.6.52 of the Revenue Recognition AAG points out that ASC 606-10-32-8(b) does not prohibit use of the most likely amount method when there are more than two potential outcomes. In addition, paragraph 7.6.52 of the Revenue Recognition AAG goes on to indicate that the most likely amount method may be used by health care entities to estimate third-party settlement adjustments when there are more than two different outcomes, provided that method better predicts the amount to which the health care entities expect to be entitled. Regardless of whether the portfolio approach (see Section I) is used to estimate the third-party settlement adjustment, current and historical information related to third-party settlements (e.g., information about reimbursements, charges, allowable costs, patient statistics and experience with any fiscal intermediaries) should be taken into consideration as appropriate in applying either method.

In general, once a health care entity estimates the third-party settlement adjustment using either the most likely amount method or expected value method, it should then apply the variable consideration constraint to determine whether it is probable that inclusion of that estimate in the transaction price will not result in a significant reversal of cumulative revenue recognized when the third-party settlement adjustment is finalized. However, if the health care entity's estimate of the third-party settlement adjustment is consistent with the objective of the variable consideration constraint (i.e., it is probable that there will not be a significant reversal of cumulative revenue recognized), separate application of the variable consideration constraint may not be necessary.

Paragraph 7.6.56 of the Revenue Recognition AAG discusses the following factors a health care entity should consider when explicitly applying the variable consideration constraint and assessing whether it is probable that a significant reversal of cumulative revenue recognized will not occur:

- *To what extent is the third-party settlement affected by factors not within the health care entity's control?* Typically, the greater the extent to which the amount collected from the third-party payor is affected by factors not within the health care entity's control, the more likely it is that a significant reversal of cumulative revenue recognized could occur. The health care entity typically has very little (if any) control over the finalized third-party settlement adjustment when the third-party payor is a governmental entity, such as Medicare or Medicaid.
- *How much experience does the health care entity have with the third-party payor?* The nature and extent of the experience, which could vary significantly depending on the third-party payor, should be taken into consideration when evaluating the likelihood that a significant reversal of cumulative revenue recognized could occur. For example, a health care entity may have significant experience with Medicare and Medicaid, but less experience with an insurance company new to the geographic region in which the health care entity operates. When a health care entity does not have sufficient historical experience with a third-party payor, applying the variable consideration constraint could result in certain components of a third-party settlement adjustment being partially or fully constrained. As the health care entity builds sufficient experience with the third-party payor, the uncertainty related to the settlement adjustments with that third-party payor likely will decrease, which may, over time, result in a smaller portion of the third-party settlement adjustment being constrained.

- *How long does it take for the third-party settlement adjustment to be finalized?* It is not uncommon for one or more years to pass before a third-party settlement adjustment is finalized. Typically, the longer it takes, the more likely it is that a significant reversal of cumulative revenue recognized could occur.
- *To what extent does the health care entity offer price concessions to the third-party payor or otherwise change the payment terms?* Typically, when the third-party payor is not Medicare or Medicaid, the greater the extent to which the health care entity offers price concessions or otherwise changes the payment terms, the more likely it is that a significant reversal of cumulative revenue recognized could occur. When the third-party payor is Medicare or Medicaid, the health care entity does not offer price concessions or otherwise change the payment terms because Medicare or Medicaid dictates the prices and payment terms.
- *How broad is the range of possible third-party settlement adjustments captured in the health care entity's historical information for the third-party payor?* Typically, the broader the range of third-party settlement adjustments, the more likely it is that a significant reversal of cumulative revenue recognized could occur.

In most cases, a third-party settlement adjustment encompasses contracts between the health care entity and many of its patients. As noted in paragraph 7.6.58 of the Revenue Recognition AAG, for purposes of evaluating the likelihood and significance of a third-party settlement adjustment when applying or considering the variable consideration constraint, the health care entity should look at the third-party settlement adjustment in relation to all of the reimbursements from the third-party payor to the health care entity for all of the contracts covered by the third-party settlement adjustment.

Paragraph 7.6.70 of the Revenue Recognition AAG includes examples illustrating the application of the variable consideration guidance to revenue related to or affected by the Medicare program in the following ways:

- Medicare sends a notice of final program settlement to close out a cost report year.
- Medicare subjects certain claims to the Recovery Audit Contractor Program.
- Medicare determines the final payment under the Disproportionate Share Hospital Program.

## **F.2. Significant financing component**

In applying the significant financing component guidance (which is discussed in Section C.3.2) to third-party settlement adjustments, the health care entity should first determine whether a significant financing component exists. In doing so, the health care entity should understand all of the relevant facts and circumstances, including: (a) the factors giving rise to the third-party settlement adjustment and the length of time it takes to finalize the adjustment and (b) the process by which the third-party settlement adjustment is finalized.

The significant financing component guidance specifically indicates that a significant financing component does not exist in three situations. Paragraph 7.6.66 of the Revenue Recognition AAG indicates how the three indicators typically apply to third-party settlements:

- Consideration generally is not paid in advance.
- Such adjustments usually involve substantial variable consideration (as discussed in Section F.1) and the timing of consideration is outside the control of the health care entity.
- The amount of the third-party settlement adjustment arises due to the normal course of cost report settlements and not as a result of a financing arrangement.

While each health care entity should make this determination based on its own facts and circumstances, paragraph 7.6.67 of the Revenue Recognition AAG indicates that it is likely that a significant financing

component should not be reflected in the accounting for the third-party settlements because the timing of the payment is at the discretion of the third-party payor and does not involve the patient.

### **F.3. Modified retrospective transition method**

An entity may choose to transition to the new guidance using either the full retrospective transition method or the modified retrospective transition method. The modified retrospective transition method involves application of the new guidance to either: (a) all contracts at the date of initial application or (b) only contracts that are not completed at the date of initial application. For this purpose, a completed contract is one for which all or substantially all of the revenue has been recognized under legacy GAAP as of the date of initial application. If a health care entity elects to apply the modified retrospective transition method to only contracts that are not completed at the date of initial application, it must take third-party settlement adjustments into consideration in determining whether all or substantially all of the revenue related to a particular patient contract has been recognized under legacy GAAP. In other words, if any future third-party settlement adjustments related to the patient contract are expected to result in less than substantially all of the revenue related to the contract having been recognized under legacy GAAP as of the date of initial application, the health care entity should not conclude that the contract is completed at the date of initial application. For example, if there is a significant third-party settlement adjustment related to a patient contract that the health care entity expects to receive after the date of initial application and that adjustment was not recognized under legacy GAAP as of the date of initial application, the patient contract would not be considered completed at the date of initial application.

Additional information about the full retrospective transition method and the modified retrospective transition method can be found in Chapter 17 of [A guide to revenue recognition](#).

## **G. CCRCs**

### **G.1. Revenue**

Contracts entered into by CCRCs with their residents can vary significantly across CCRCs and even within one CCRC. A common type of contract entered into by CCRCs is a Type A life care contract (Type A contract). At the core of contracts entered into by CCRCs, including Type A contracts, is the CCRC providing specific services (including limited health care services) and use of its facilities (e.g., residency) to residents until the end of their lives. In many cases, the nature of the residency and services provided to a resident may change over time. For example, Type A contracts start with the resident in an independent-living setting (which entitles the resident to a certain type of residency and services), with the expectation that the resident will progress over his or her remaining life span through the assisted-living and skilled-nursing settings (each of which entitle the resident to a different type of residency and services).

While payment terms in CCRC contracts may vary, it is not uncommon for residents to pay an initial entrance fee and monthly fees. In many CCRC contracts, including Type A contracts, residents have the right to leave the facility with no obligation to pay any future monthly fees. The initial entrance fee may be fully refundable or fully nonrefundable, or the amount that is refundable may decrease over time. The contract may provide for the monthly fees to change over time for inflation and (or) when the type of residency and services provided to the resident change (e.g., when the resident progresses from the independent-living setting to the assisted-living setting). Payment terms in Type A contracts typically include an initial entrance fee and monthly fees that start at a base amount that only changes over time to reflect an inflation factor. In other words, the monthly fee is not increased to reflect the changes in the nature of the residency and services provided to the resident when he or she moves from the independent living setting to either the assisted living or skilled nursing setting. In addition, CCRC contracts may provide for only certain types of services to be covered by the monthly fee and for other types of services to be paid for separately.

### G.1.1. Legacy GAAP

Legacy GAAP provides guidance on how a CCRC should recognize revenue for its contracts with residents in ASC 954-605 and ASC 954-430, “Health Care Entities – Deferred Revenue.” In general, this guidance requires the recognition of a liability for the portion of an advance fee the CCRC expects to refund to a resident or its estate. The remaining amount of the advance fee is deferred by the CCRC and amortized into revenue over the shorter of the estimated life of the resident or the contract term. In addition, ASC 954-605 provides general guidance related to the accounting for health care services revenue, which is discussed in Section E.1.

### G.1.2. Five-step revenue recognition model

Paragraphs 7.6.109 through 7.6.162 of the Revenue Recognition AAG discuss application of the five-step revenue recognition model to a CCRC contract (e.g., Type A contract) and address the following issues:

- What is the term of a CCRC contract given that it typically has an unspecified end date (i.e., resident’s end of life)?
- How should a CCRC identify performance obligations in a resident agreement in which the level of care will change over the resident’s life span (i.e., are there multiple performance obligations or a single stand-ready performance obligation)?
- Does the resident’s ability to in effect renew a CCRC contract each month by staying at the facility affect the identification of the promised goods or services and performance obligations (i.e., are there renewal options that should be accounted for separately)?
- Does a CCRC contract that includes a nonrefundable entrance fee provide the customer with a material right? If so, when should revenue related to the material right be recognized?
- When a CCRC contract includes an advance fee that is refundable, how is the refund right taken into consideration in estimating the transaction price?
- Does a CCRC contract that includes an advance fee include a significant financing component that should be reflected in the transaction price?

## G.2. Costs incurred to obtain residents

CCRCs incur a variety of costs to obtain residents—from paying a commission to the salesperson responsible for obtaining a contract with a new resident to the costs of processing the contract with a new resident to the costs of soliciting potential new residents, just to name a few.

### G.2.1. Legacy GAAP

Under legacy GAAP, certain costs incurred related to the initial occupation of a CCRC facility are capitalized and amortized on a straight-line basis over the shorter of the average expected remaining lives of the residents or the contract term. Capitalization of such costs ceases upon the earlier of: (a) the CCRC facility becoming substantially occupied or (b) a year passing since completion of the CCRC facility. As a result, costs incurred with respect to entering into contracts to fill units in the CCRC facility vacated by a resident (often referred to as second-generation contracts) typically are not capitalized under legacy GAAP.

### G.2.2. New guidance

Paragraphs 7.7.64 and 7.7.66 of the Revenue Recognition AAG discuss the application of the new contract costs guidance (see Section D of this white paper) to the costs incurred by a CCRC to obtain contracts with residents. While commission costs, if significant, could be capitalized under the new guidance, costs to solicit potential new residents and process new contracts generally are not incremental to obtaining a specific contract and should be expensed.

For those costs capitalized under the new guidance, paragraphs 7.7.70 through 7.7.73 of the Revenue Recognition AAG also address the considerations involved in identifying the appropriate amortization period and method.

### **G.3. Liabilities related to providing future residency and services to current residents**

Legacy GAAP provides guidance in ASC 954-440-35 related to recognizing a liability for the CCRC's obligation to provide future residency and services to current residents (i.e., a future service obligation). ASC 954-440-35 was retained with only minor changes to conform it to the new guidance. As a result, after the effective date of the new guidance, a CCRC continues to record a future service obligation if the advance fees and periodic fees to be recognized as revenue in the future are less than the costs of providing the resident with residency and services in the future.

Paragraph 7.6.161 of the Revenue Recognition AAG addresses how a contract liability arising from advance fees and (or) capitalized contract costs recognized under the new guidance should be reflected in a CCRC's calculation of the obligation to provide future residency and services.

## **H. Risk sharing arrangements**

Paragraphs 7.6.73 through 7.6.108 of the Revenue Recognition AAG provide guidance addressing issues that arise when a health care entity applies the new guidance to risk sharing arrangements, specifically those related to The Comprehensive Care for Joint Replacement (CCJR) model.

Under the CCJR model, a hospital is subject to a bonus or penalty payable by or to Medicare (the CCJR bonus or penalty) that is based on the entire spend related to a patient episode, which begins with the Medicare patient's admittance to the hospital for the joint replacement surgery and ends 90 days after the patient is discharged from the hospital. As a result, the entire spend includes the costs associated with the joint replacement surgery and hospital stay, as well as any health care services provided within 90 days of discharge, which are referred to as post-acute services and may include, for example, a nursing home stay, a rehabilitation center stay, physical therapy visits and (or) home health care visits. Some or all of the post-acute services may be provided by health care entities not related to the hospital. While the purpose of the CCJR model is to encourage all of the health care service providers involved in a patient episode to provide effective and efficient care throughout the entire patient episode, the CCJR bonus or penalty is payable to or by the hospital. As a result, the hospital may undertake care coordination activities across health care service providers involved in the patient episode to help manage the effectiveness and efficiency of care provided throughout the entire patient episode. The discussion in the Revenue Recognition AAG (and, therefore, this section) focuses solely on the hospital's accounting for the CCJR bonus or penalty and does not address either: (a) the hospital's accounting for any arrangements it has with the post-acute service providers or (b) the post-acute service provider's accounting for the services it provides to the patient.

The CCJR bonus or penalty is based on a performance year, which is a calendar year. Patient episodes included in a performance year are those that end within that year. The CCJR bonus or penalty is calculated based on the actual amount spent by Medicare on the patient episodes included in a performance year compared to the total target price for those episodes, which is adjusted to reflect both: (a) the hospital's quality score as determined by Medicare and (b) the effects of potential overlaps between the CCJR model and other Medicare payment models, such as the shared savings program. In addition, a stop-gain or stop-loss percentage limits the amount of a CCJR bonus or penalty.

Medicare typically notifies the hospital of its quality score four to six months after the performance year ends. In addition, Medicare sends two reconciliation reports related to each performance year. The first reconciliation report typically is received by the hospital two months after the performance year ends and includes information available at that time about claims received for patient episodes ending in the performance year and information about the target price per patient. This report may result in an interim

CCJR bonus or penalty. The second reconciliation report typically is received some time after the first reconciliation report (e.g., 14 months after the performance year ends) and includes the final amount of any CCJR bonus or penalty.

Accounting for a CCJR bonus or penalty typically raises issues in applying the first three steps of the new five-step revenue recognition model. Those issues are discussed in the remainder of this section. For additional information related to Steps 4 and 5, refer to Sections C.4 and C.5, respectively.

### **H.1. Identifying the contract with the customer (including evaluating collectibility)**

While paragraph 7.6.79 of the Revenue Recognition AAG indicates that the new guidance should be used to account for the contract between the patient and the health care entity, paragraph 7.6.80 goes on to indicate that a third-party payor's involvement (such as Medicare's involvement in the CCJR bonus or penalty) should be considered when estimating the transaction price for the contract. This is similar to the discussion in Section F of this white paper related to third-party settlement adjustments.

As discussed in Sections C.1 and E.2.1, the contract existence criteria must be met to move on to Step 2 of the new five-step revenue recognition model. As indicated in paragraph 7.6.81 of the Revenue Recognition AAG, the following should be considered in applying these criteria when a hospital provides patient services that are subject to the CCJR model:

- If, prior to performing the joint replacement surgery, the hospital has not obtained signed forms from the patient that constitute a written contract (e.g., a patient responsibility form), it should consider whether the patient's scheduling of the surgery in advance creates an oral or implied contract.
- The hospital should consider whether the contract with the patient (whether written, oral or implied) gives it the right to payment for the services provided to the patient.
- The hospital should consider whether the payment terms can be identified, including those payment terms applicable to both Medicare and the patient (in the form of a co-pay or deductible).
- The hospital should consider whether its contract with the patient has commercial substance in that its future cash flows are expected to change as a result of providing services to the patient.
- The hospital should consider whether collection of substantially all of the amount to which it will be entitled in exchange for the services that will be transferred to the patient is probable (i.e., likely to occur). Additional discussion of the considerations involved in applying this criterion to situations involving third-party payors is provided in Sections E.2.1 and F.1.

When the contract existence criteria are not met, revenue recognition is deferred until the contract existence criteria are met or one of the situations in the deferral guidance discussed in Section C.1 arises.

### **H.2. Identifying the performance obligations**

As discussed in Section C.2.2, the first step in identifying the performance obligations in a contract is identifying the promised goods or services in the contract. Once that step is complete, criteria are applied to determine whether the promises to provide goods or services should be treated as performance obligations and accounted for separately. While each hospital should make this determination based on its own facts and circumstances related to the services it provides in connection with a patient episode under the CCJR model, paragraph 7.6.84 of the Revenue Recognition AAG indicates that such services generally will be considered a single combined performance obligation for inpatient health care services.

With respect to identifying the promised goods or services in the contract, Section C.2.2 notes that not all activities performed by the entity in connection with the contract transfer a good or service to the customer. One issue that arises in identifying the promised goods or services in a contract with a patient subject to the CCJR model involves whether any care coordination activities undertaken by the hospital across the patient episode represent a promised good or service. While each health care entity should

make this determination based on its own facts and circumstances, paragraph 7.6.85 of the Revenue Recognition AAG indicates that such care coordination activities generally do not transfer a promised good or service to the patient. As a result, they generally do not represent a performance obligation to which part of the transaction price is allocated. However, paragraph 7.6.85 of the Revenue Recognition AAG goes on to indicate that a hospital should consider whether it has made any implied promises to provide the patient with either: (a) post-acute transitional services or (b) coordination of care across post-acute service providers. If the hospital has made any such promises, it should evaluate whether the underlying services are distinct. Those services that are distinct should be considered performance obligations.

### H.3. Determining the transaction price

Hospitals may apply Step 3 of the new five-step revenue recognition model using a portfolio approach, which is discussed in Section I. In doing so, a hospital typically will group together in one portfolio the individual patient contracts subject to the CCJR model that have patient episodes ending in the same performance year. This approach is consistent with the basis on which the CCJR bonus or penalty is determined. The remainder of the discussion in this section is based on the assumption that the CCJR bonus or penalty is accounted for on a portfolio basis.

Issues that arise in applying the new guidance on determining the transaction price to a patient contract subject to the CCJR model include those related to:

- *Variable consideration.* Given how the CCJR bonus or penalty is calculated, the uncertainties that exist with respect to many of the inputs used in the calculation and the amount of time it takes to resolve many of these uncertainties (e.g., 14 months after the end of the performance year), a patient contract subject to the CCJR model includes variable consideration (see Section H.3.1 for additional discussion).
- *Significant financing component.* Given the period of time between when the hospital provides services to the patient and when the final CCJR bonus or penalty is determined, the question arises as to whether there is a significant financing component that should be reflected in the transaction price (see Section H.3.2 for additional discussion).

#### H.3.1. Variable consideration

A hospital that enters into patient contracts subject to the CCJR model should recognize revenue for the normal Medicare Severity-Diagnosis Related Group payments in its customary manner, which is discussed in Section E. The effects on the transaction price of the CCJR bonus or penalty is evaluated separately by applying the variable consideration guidance to the portfolio of contracts for a performance year. Applying that guidance may result in the hospital recognizing an adjustment to the transaction price for that portfolio (due to an estimated CCJR bonus or penalty) and recognizing or adjusting a receivable or payable to Medicare for CCJR program settlements.

Based on the guidance discussed in Section C.3.1, the amount a hospital should reflect in the transaction price for the CCJR bonus (as an increase to the transaction price) or penalty (as a reduction to the transaction price) (if any) should be determined by: (a) estimating the expected CCJR bonus or penalty and (b) applying the variable consideration constraint such that the transaction price is limited to the amount for which it is probable that a significant reversal of cumulative revenue recognized will not occur when the final amount of the bonus or penalty is communicated in the second reconciliation report. To the extent the hospital is not able to conclude that it is probable that a significant reversal of cumulative revenue recognized will not occur when the CCJR bonus or penalty is finalized, it should reflect the maximum CCJR penalty that could be assessed by Medicare in the transaction price.

Based on the guidance discussed in Section C.3.1, when estimating the CCJR bonus or penalty for a portfolio of contracts, a hospital should use whichever of the following two methods provides the better estimate in its facts and circumstances: (a) the most likely amount method or (b) the expected value

method. Determining whether this estimate should be constrained as a result of applying the variable consideration constraint requires the hospital to consider a number of factors, including:

- *To what extent is the CCJR bonus or penalty affected by factors not within the hospital's control?* Paragraph 7.6.96 of the Revenue Recognition AAG indicates that whether a hospital receives a CCJR bonus or penalty is mostly not within its own control because of the involvement of other post-acute service providers. As a result, this factor coupled with the remaining factors may cause a hospital to conclude that the estimate should be constrained.
- *How many possible CCJR bonus and penalty amounts are there and how broad is the range of possible CCJR bonus and penalty amounts?* The larger the number of CCJR bonus and penalty amounts and the broader the range of those amounts, the more likely it is that the estimate should be constrained.
- *How long does it take for the hospital to obtain information about the amounts charged by the post-acute service providers?* The longer it takes for the hospital to obtain this information, the more likely it is that the estimate should be constrained. The analysis of this factor may be affected by whether the post-acute service providers are within the same health system as the hospital or if the hospital has collaboration agreements under which the post-acute service providers must supply the hospital with certain information.
- *How much history does the hospital have with the CCJR model?* Given that the CCJR model was effective on April 1, 2016, there currently is not much history on which a hospital can base its estimate, which increases the likelihood that the estimate should be constrained.
- *How uncertain are the individual inputs used in the calculation of the estimated CCJR bonus or penalty?* The greater the degree of uncertainty, the more likely it is that the estimated CCJR bonus or penalty should be constrained. For example, a hospital must consider how likely it is that its quality score will be different than expected or how likely it is that its estimate of complications or readmissions across an entire portfolio will be different than expected. The greater the likelihood of the actual outcomes for these uncertainties being different than what the hospital expected, the greater the likelihood the estimate should be constrained.

The analysis of many of these factors may change over time as a hospital gets more experience with the CCJR model.

Until the final CCJR bonus or penalty amount is communicated in the second reconciliation report, the hospital must revisit the estimated CCJR bonus or penalty included in the transaction price at the end of each reporting period to determine whether an adjustment is necessary. Given that the CCJR bonus or penalty is calculated based on a performance year and that the final CCJR bonus or penalty may not be known until 14 months after the performance year ends, the likelihood of an adjustment may vary depending where in the CCJR bonus or penalty payment timeline the end of the reporting period falls. For example, as the timeline progresses and more information becomes available (e.g., the hospital's quality score becomes known, more information about the claims submitted by post-acute service providers becomes known), the effects of applying the variable consideration constraint may change and give rise to an adjustment.

For interim reporting purposes, paragraph 7.6.101 of the Revenue Recognition AAG indicates that the hospital should estimate the CCJR bonus or penalty for the performance year at the end of an interim period and recognize a pro-rata portion of the bonus or penalty in the interim period based on the interim period's proportionate share of the total performance year. The objective is to have each interim period reflect a reasonable portion of the estimated bonus or penalty for the performance year such that the hospital is recognizing revenue as it is transferring services to the patient.

The fact that the CCJR bonus or penalty is calculated based on a performance year and that the final CCJR bonus or penalty may not be known until 14 months after the performance year ends creates the

potential for a hospital to have three performance years open at the end of any given financial reporting period. In those situations, the hospital must separately evaluate the CCJR bonus or penalty for each of the open performance years and separately determine the accounting effects of each of those evaluations on the current financial reporting period.

A comprehensive example illustrating the complexities associated with accounting for the CCJR bonus or penalty for multiple performance years in one financial reporting period is provided in paragraph 7.6.108 of the Revenue Recognition AAG.

### **H.3.2. Significant financing component**

Given the amount of time that may pass before a CCJR bonus or penalty is finalized, the hospital should determine whether a significant financing component exists (which is generally discussed in Section C.3.2).

The significant financing component guidance specifically indicates that a significant financing component does not exist in three situations. One of those situations is when there is substantial variable consideration and payment of that consideration is contingent on the resolution of an uncertainty that is not substantially in the entity's or customer's control. While each hospital should make this determination based on its own facts and circumstances, paragraph 7.6.105 of the Revenue Recognition AAG indicates that a CCJR bonus or penalty does not give rise to a significant financing component because the timing of the payment is determined by Medicare and is not determined by the patient.

## **I. Applying a portfolio approach**

The discussion in this section is based primarily on the guidance in paragraphs 7.7.01 to 7.7.15 of the Revenue Recognition AAG.

The new guidance includes a practical expedient that allows an entity to apply the guidance to a portfolio of similar contracts (or performance obligations) if doing so is not reasonably expected to result in materially different outcomes compared to individually accounting for the contracts (or performance obligations).

The practical expedient may be applied to none, some or all of a health care entity's contracts (or performance obligations). In other words, the practical expedient is optional. In addition, the practical expedient to account for a portfolio of contracts does not have to be applied to all groups of similar contracts. For example, a health care entity may elect to account for one group of similar contracts as a portfolio of contracts and another group of similar contracts as individual contracts.

Electing the practical expedient to account for a portfolio of contracts is not the same as using a portfolio of data to make an estimate for an individual contract. For example, a health care entity may account for its contracts individually (i.e., not elect the practical expedient), but use a portfolio of historical data for similar contracts to estimate the price concessions for an individual contract. When using a portfolio of historical data to make an estimate for an individual contract, it is important to monitor contracts in that portfolio to ensure they continue to be representative of the individual contract.

As discussed in paragraph 7.7.04 of the Revenue Recognition AAG, for purposes of determining whether accounting for a portfolio of contracts is not reasonably expected to result in materially different outcomes compared to individually accounting for the contracts, a health care entity should consider whether it has a sufficient amount of homogeneous patient data on which to base its determination.

Questions for a health care entity to consider when determining if contracts within a group are similar include:

- *What type of service(s) do the contracts cover?* For example, a contract for inpatient services likely would not be considered similar to a contract for outpatient services, and a contract for elective services likely would not be considered similar to a contract for services that are not elective.
- *Who is the payor?* For example, a contract for which the payor is a government entity (e.g., Medicare, Medicaid) likely would not be considered similar to a contract for which the payor is an insurance company, which likely would not be considered similar to a contract for which the payor is an uninsured self-pay patient.
- *To what extent is the patient responsible for payment?* For example, a contract for an insured patient with a low deductible amount likely would not be considered similar to a contract for an insured patient with a high deductible amount, which likely would not be considered similar to a contract for an uninsured self-pay patient.
- *During what timeframe were services provided under the contract?* For example, contracts entered into six months apart from each other likely would not be considered similar, while contracts entered into within one month of each other may be considered similar depending on the degree of similarity they possess with respect to other important characteristics.
- *Are the contracts related to services provided at different facilities of the health care entity?* For example, contracts entered into by the health care entity at Facility A in City X may not be considered similar to contracts entered into by the entity at Facility B in City Z.
- *Are the contracts processed using different billing systems?* For example, a contract for the health care services entered into by Facility A in City X may not be considered similar to a contract for the same services entered into by Facility B in City X when different billing systems are used by each facility. In this situation, the health care entity needs to understand the nature and extent of any differences between the two billing systems and the related processes before concluding whether the contracts are similar.
- *Do the contracts have similar collection or reimbursement rates?* For example, a contract with a patient that is assigned a satisfactory credit and collection rating by the health care entity should not be considered similar to a contract with a patient assigned an unsatisfactory credit and collection rating.
- *Is the payor for the contracts unknown because, for example, the health care entity is attempting to qualify the patients for Medicaid?* As discussed in Section E.2, certain health care entities are required by law or regulation to provide emergency services to patients without regard to whether the patient is insured or whether the patient is a credit risk. Health care entities in this situation often have processes in place to attempt qualifying such patients for Medicaid. Given the amount of time it can take to work through the Medicaid qualification process, these health care entities may consider whether it is appropriate to have a temporary “pending-Medicaid” portfolio. If having such a portfolio is appropriate, it is important to ensure that patients are transferred out of the portfolio on a timely basis to another portfolio (e.g., Medicaid, self-pay, charity care) or accounted for on an individual contract basis.

Only after considering these and other characteristics relevant to its facts and circumstances will the health care entity be in a position to exercise appropriate discretion and judgment in identifying portfolios of similar contracts for which accounting for them as a portfolio is not reasonably expected to result in materially different outcomes compared to accounting for them individually. To the extent a health care entity expects to apply the practical expedient to account for a portfolio of contracts, it should ensure it has documented the analysis showing that the portfolio approach is not reasonably expected to result in materially different outcomes compared to individually accounting for the contracts. In addition, if the health care entity prepares audited financial statements, we strongly encourage the health care entity to share this analysis with its auditor early in the process of implementing the new guidance.

Once a health care entity identifies a portfolio of contracts to which the practical expedient will be applied, it should monitor the portfolio to determine whether any changes or unexpected trends develop that draw into question whether the contracts in the portfolio continue to be similar. As discussed in paragraph 7.7.10 of the Revenue Recognition AAG, during this monitoring, the health care entity: (a) can add a contract with similar characteristics to the portfolio and (or) (b) should remove a contract that develops dissimilar characteristics from the portfolio. For example, consider a health care entity that has three contract portfolios, each of which includes patients with similar credit ratings. If a patient's credit rating changes between when the health care services are provided and when the health care entity completes its collection efforts related to those services (e.g., the patient's credit rating worsens because he or she lost a job), the contract may need to be moved from one portfolio to another. For another example, consider a situation in which one of the similarities a portfolio of contracts shares relates to the amount of the co-payment or deductible the patient is responsible for paying. After the insurance company makes its required payments for the contracts in this portfolio, the health care entity may consider whether it is appropriate to transfer these contracts to a portfolio that includes only self-pay contracts.

## **J. Presentation and disclosure**

Presentation and disclosure issues that arise when a health care entity applies the related requirements in the new guidance are addressed in paragraphs 7.7.16 through 7.7.59 of the Revenue Recognition AAG, which is the primary basis for the discussion in this section.

### **J.1. Presentation**

Application of the new guidance may result in the recognition and presentation on the balance sheet of a contract asset or liability for the difference between the health care entity's performance (i.e., the goods or services transferred to the customer) and the customer's performance (i.e., the consideration paid by, or unconditionally due from, the customer).

When determining the amount of the contract asset or liability to be recognized (if any), a health care entity should first determine whether it has an unconditional and noncancellable right to any consideration from the customer (and a third-party payor paying on the customer's behalf). If the contract is cancellable by the customer and the health care entity has not yet performed, it cannot have an unconditional right to payment. An unconditional right exists when only the passage of time is required before payment. If the health care entity has an unconditional and noncancellable right to consideration, it should recognize a receivable, even if the amount to which it has an unconditional and noncancellable right has not yet been billed. For example, if a hospital has an unconditional and noncancellable right to payment from a patient or third-party payor (including amounts due for third-party settlement adjustments), but has not yet billed the patient or third-party payor, the hospital should recognize those rights as patient or third-party payor unbilled receivables, respectively. In addition, a health care entity is still required by ASC 954-310-45-1 to separately present on the face of the balance sheet the receivable due from third-party payors related to third-party settlement adjustments and other retroactive adjustments.

A contract asset arises if the health care entity's performance is greater than that of the customer, which is when the revenue recognized by the health care entity is greater than the consideration paid by and unconditionally due from the customer. In other words, the contract asset does not include amounts paid by or unconditionally due from the customer. The contract asset represents the health care entity's conditional right to consideration in exchange for the goods or services it has transferred to a customer, but for which: (a) the customer has not paid, (b) payment is not yet due (e.g., for goods or services provided to a patient that has been admitted to, but not yet discharged from, a hospital) and (c) the health care entity cannot yet bill the customer.

Conversely, a contract liability arises if the customer's performance is greater than that of the health care entity (i.e., the consideration paid or recognized as a receivable is greater than the revenue recognized). This liability represents the health care entity's obligation to perform with respect to the contract. For

example, if a resident in a CCRC makes an upfront nonrefundable payment and doing so results in the resident's performance being greater than that of the CCRC (at least early in the CCRC contract), the CCRC recognizes a contract liability. This liability represents at least part of the CCRC's obligation to perform with respect to the contract with the resident.

A refund liability to the customer (which may arise, for example, when the customer has the right of return or refund) should not be included with the contract liability for presentation purposes.

"Contract liability" and "contract asset" are not required descriptors for the related asset or liability in the balance sheet. However, if a descriptor other than contract asset is used, it needs to clearly indicate that the asset represents something other than a receivable.

Once recognized: (a) a receivable is accounted for in accordance with the accounts receivable guidance in the ASC and (b) a contract asset is evaluated for impairment in accordance with the accounts receivable guidance in the ASC.

## J.2. Disclosure

The new guidance includes many new qualitative and quantitative disclosure requirements. The objective of the disclosure requirements is to help financial statement users understand the nature, amount, timing and uncertainty of revenue and related cash flows. In general, health care entities are required to disclose a variety of information about the contracts they have with customers and significant judgments used in the application of the new guidance.

A health care entity should review its systems, processes, procedures and controls to determine whether it is capable of providing the information necessary to satisfy the new disclosure requirements discussed in the remainder of this section, and if not, what changes it must make to enable it to provide the necessary information.

### J.2.1. Disaggregation of revenue

#### ***Disclosures required for public health care entities and elective for nonpublic health care entities.***

Quantitative disaggregation of revenue based on how economic factors affect the nature, amount, timing and uncertainty of revenue recognition and cash flows should be disclosed by public health care entities and may be disclosed by nonpublic health care entities. Given that the amount of revenue recognized for a particular service often depends on the type of payor (e.g., Medicare, commercial insurers, self-pay), it may be appropriate for a health care entity to disaggregate revenue by payor. In considering various factors with respect to the level of disaggregation, a health care entity may conclude that it is appropriate to disaggregate: (a) revenue related to Medicare from revenue related to Medicaid, (b) revenue related to one (or a group of) commercial insurer(s) from another (or different group of) commercial insurer(s) and (or) (c) revenue related to self-pay payors that are uninsured from self-pay payors that are responsible for a copayment or deductible. Other attributes that it may be appropriate for a health care entity to use in disaggregating revenue for disclosure include:

- The geographic regions of its operations
- The types of patients it serves
- The types of markets it serves
- The types of contracts into which it enters
- The timing (e.g., inpatient vs. outpatient) of the services provided
- The types of services it provides
- The operating segments it uses

**Disclosures required for nonpublic health care entities that do not elect to provide the disclosures required for public health care entities.** Such nonpublic health care entities should disaggregate revenue based on when control of the goods or services transfers to the patient (e.g., over time or at a point in time). In addition, such nonpublic health care entities should provide qualitative discussion about how economic factors (such as those that might otherwise serve as the basis for quantitative disaggregation) affect the nature, amount, timing and uncertainty of revenue recognition and cash flows.

### J.2.2. Contract balances

**Disclosures required for all health care entities.** The opening and closing balances of accounts receivable, contract assets and contract liabilities should be disclosed or presented separately on the face of the balance sheet by all health care entities.

**Additional disclosures required for public health care entities and elective for nonpublic health care entities.** The following information should be disclosed by public health care entities and may be disclosed by nonpublic health care entities:

- *The amount of revenue recognized in the current reporting period that was included in the contract liability balance at the end of the previous reporting period.* For example, when a CCRC has a contract liability as a result of receiving upfront nonrefundable payments, it should disclose the amount of that liability that was recognized as revenue in the current reporting period.
- *An explanation of the timing of the health care entity's satisfaction of its performance obligations in contrast to the timing of when it typically receives payment for providing the underlying goods or services and how the contract asset and contract liability balances are affected by these factors.* For example, when a health care entity provides services to Medicare patients, it should disclose the timing of providing services to those patients in contrast to the timing of when it receives payment from Medicare (including any third-party settlement adjustments) and how those two factors affect the contract asset and contract liability balances.
- *A qualitative and quantitative explanation of what caused significant changes in the contract assets or contract liabilities during the reporting period.* For example, if a health care entity acquires another health care entity during the reporting period, the effects of the acquisition on the contract assets or contract liabilities should be explained. For another example, any significant changes in the estimates of third-party settlements affecting contract assets should also be explained.

### J.2.3. Performance obligations

**Disclosures required for all health care entities.** The following information should be disclosed about a health care entity's performance obligations:

- *When its performance obligations are typically satisfied.* For example, a rehabilitation center may disclose that its performance obligations are satisfied over time as it provides services.
- *Significant payment terms.* For example:
  - A health care entity that provides services to Medicare patients may disclose the following about its payment terms with Medicare: (a) the amount Medicare pays for services differs from the health care entity's standard charges for those services and (b) the nature of the third-party settlement adjustment process in place with respect to Medicare patients and the uncertainty it creates with respect to the timing and amount of payments received from Medicare, including how the health care entity estimates the effects of the adjustment process.
  - A health care entity that provides implicit price concessions to uninsured patients may disclose the nature and basis for those concessions (e.g., based on historical collection experience).
  - A CCRC may disclose whether it charges advance fees and (or) monthly fees and whether those fees are refundable.

- *Nature of the goods or services provided to customers.* For example, a hospital may disclose that it provides both inpatient and outpatient services.
- *Obligations related to contracts, such as rights of return or refund.* For example, a CCRC may disclose the circumstances under which an advance fee is refundable.
- *Warranties and related obligations.* For example, a surgical eye center may disclose that it provides a warranty on its laser vision correction surgeries.
- *Revenue recognized in the current reporting period related to performance obligations satisfied in the prior reporting period.* For example, a health care entity that provides services to Medicare patients may disclose the revenue it recognized in the current reporting period related to services provided to Medicare patients in a prior reporting period resulting from the estimated third-party settlement adjustment recognized in the prior period being less than the final third-party settlement adjustment received in the current period.

#### **J.2.4. Transaction price allocated to remaining performance obligations**

Remaining performance obligations are those performance obligations identified in a contract entered into before the end of the reporting period for which some or all of the underlying goods or services have not been transferred to the customer at the end of the reporting period.

##### ***Disclosures required for public health care entities and elective for nonpublic health care entities.***

With certain exceptions, the following information should be disclosed by public health care entities and may be disclosed by nonpublic health care entities about their remaining performance obligations at the end of the reporting period:

- *The total amount of the transaction price allocated to those performance obligations.* For example, a CCRC may disclose the amount of the transaction price allocated to the remaining performance obligations it has under its open CCRC contracts at the end of the reporting period.
- *An explanation of when the health care entity expects to recognize the transaction price allocated to those performance obligations as revenue.* This disclosure can be satisfied either quantitatively (using appropriate time bands for when the allocated transaction price is expected to be recognized as revenue) or qualitatively. For example, a CCRC may disclose the time bands related to when it expects to recognize the transaction price allocated to the remaining performance obligations it has under its open CCRC contracts at the end of the reporting period.

As described further in ASC 606-10-50-14 to 50-14B, a public health care entity may be optionally exempt from disclosing this information for certain performance obligations. A public health care entity should disclose the optional exemptions it has elected as well as the following information about the related remaining performance obligations: (a) their nature, (b) their remaining duration and (c) a description of any variable consideration excluded from the disclosures as a result of the optional exemptions elected.

In addition, public health care entities should and nonpublic health care entities may disclose whether there is any consideration not included in the transaction price that has been allocated to the remaining performance obligations. For example, a health care entity that provides services to Medicare patients may disclose that the transaction price related to these services was subject to the variable consideration constraint, which means some of the consideration has not been included in the transaction price.

#### **J.2.5. Significant judgments**

A health care entity should disclose those judgments (and the changes to those judgments) it makes in applying the new guidance that have a significant effect on when and how much revenue is recognized related to its contracts, including those judgments (and changes in judgments) involved in: (a) determining when its performance obligations are satisfied and (b) determining the transaction price and allocating it to the performance obligations.

**Disclosures required for all health care entities.** The following information should be disclosed by all health care entities:

- *For performance obligations satisfied over time, the method (e.g., input or output) used to recognize revenue over time.* For example, if a CCRC recognizes revenue ratably for the residency and related services it provides to residents, it may disclose that fact.
- *The judgments involved in identifying the methods, inputs and assumptions used in the application of the variable consideration constraint.* For example, if a health care entity provides its patients with implicit price concessions or is subject to third-party settlement adjustments as a result of providing services to Medicare patients, it should disclose the methods, inputs and assumptions reflected in the application of the variable consideration constraint (e.g., historical experience, range of potential outcomes). While disclosing the amount of any implicit price concessions offered by a health care entity is not required, paragraph 7.7.47 of the Revenue Recognition AAG indicates that a health care entity should consider disclosing the amount to the extent the information would be meaningful to users of the financial statements.

**Additional disclosures required for public health care entities and elective for nonpublic health care entities.** The following information should be disclosed by public health care entities and may be disclosed by nonpublic health care entities:

- *For performance obligations satisfied over time, an explanation about why the method (e.g., input or output method) used to recognize revenue over time provides a faithful depiction of how the health care entity transfers goods or services.* For example, if a CCRC recognizes revenue ratably for the residency and related services it provides to residents, it should explain why that method is a faithful depiction of how it transfers goods or services.
- *For performance obligations satisfied at a point time, when control of the goods or services transfers to the health care entity's patients.* For example, a retail pharmacy may disclose that control of the prescription drugs transfers to the customer at the point of sale.
- *The judgments involved in identifying the methods, inputs and assumptions used to determine and allocate the transaction price and measure any obligations related to the contract.* For example:
  - If there is variable consideration (e.g., implicit price concessions, third-party settlement adjustments), the health care entity should explain how it estimates the variable consideration (e.g., the most likely amount method or the expected value method).
  - If there is a significant financing component included in the contract (e.g., long-term payment plans for uninsured self-pay patients), the health care entity should disclose how it was reflected in the transaction price.
  - If there is more than one performance obligation in the contract (e.g., health care services and renewal options), the health care entity should disclose how it estimated the standalone selling price of each performance obligation. In addition, if the contract includes a discount or variable consideration, the health care entity should disclose how the discount or variable consideration was allocated.
  - If the health care entity offers the right of return or refund (e.g., right of refund related to some or all of an advance payment made to a CCRC), it should disclose how it estimated the related obligation.

#### **J.2.6. Practical expedients**

**Disclosures required for public health care entities and elective for nonpublic health care entities.**

If a public health care entity has elected either of the following practical expedients, it should disclose that fact: (a) the practical expedient that results in not reflecting a significant financing component in the

transaction price (See Section C.3.2) or (b) the practical expedient that results in not capitalizing certain incremental costs related to obtaining a contract (see Section D). As applicable, nonpublic health care entities may elect to make this disclosure.

### **J.2.7. Contract costs**

#### ***Disclosures required for public health care entities and elective for nonpublic health care entities.***

The following information related to the costs incurred to obtain or fulfill a contract should be disclosed by public health care entities and may be disclosed by nonpublic health care entities:

- A description of the judgments made in identifying the costs that should be capitalized
- A description of the method used each reporting period to amortize the capitalized costs and the amount of amortization recognized for the reporting period
- The closing balances of capitalized costs, broken out by main category of asset (e.g., costs incurred to obtain a contract, fulfillment costs)
- The amount of any impairment loss recognized related to the capitalized costs

In addition, as mentioned previously, if a public health care entity has elected the practical expedient that would result in not capitalizing certain incremental costs related to obtaining a contract, it should disclose that fact. As applicable, nonpublic healthcare entities may elect to make this disclosure.

### **J.2.8. Disclosure examples**

Paragraph 7.7.59 of the Revenue Recognition AAG provides an example of the disclosures provided by a public health care entity and an example of the disclosures provided by a nonpublic health care entity.

## **K. Conclusion**

This white paper provides an overview of the new five-step revenue recognition model and contract cost guidance and only discusses in more detail certain implementation issues addressed in the Revenue Recognition AAG. Refer to [A guide to revenue recognition](#) for a comprehensive discussion about the new guidance, including its scope, core principle and key steps, implementation guidance, presentation and disclosure requirements and effective date and transition provisions.

All health care entities whose financial statements are prepared in accordance with GAAP will be affected by the new guidance because their accounting policies for revenue recognition will need to change to reflect the five-step revenue recognition model. In addition, every health care entity will be significantly affected by the disclosure requirements in the new guidance because they substantially increase the volume of revenue-related information disclosed in the financial statements, particularly for public health care entities. The new guidance will require health care entities to evaluate whether any changes are needed to their current revenue and financial reporting processes, systems and procedures. This undoubtedly will require substantive involvement by persons beyond those involved in the accounting function. If you have questions about the new guidance or need implementation assistance, do not hesitate to contact your RSM representative, Dan Vandenberghe (+1 612 376 9267), Pat Kitchen (+1 312 634 7109), Jay Adkisson (+1 312 634 3310) or Karen Pinkstaff (+1 972 421 9932).

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