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**File Reference No. 2011-230 Exposure Draft of a Proposed Accounting Standard Update -  
*Revenue from Contracts with Customers***

The accounting standards team of the American Institute of Certified Public Accountants (AICPA) appreciates the opportunity to offer the attached observations we have obtained from our Health Care Expert Panel and Investment Companies Expert Panel on the Exposure Draft of the Proposed Accounting Standards Update, *Revenue from Contracts with Customers* (the Exposure Draft).

This information was obtained outside of the official AICPA Financial Reporting Executive Committee (FinREC) process, and was not approved or reviewed by the members of FinREC. FinREC has submitted a separate comment letter on the Exposure Draft.

We appreciate your efforts with outreach to many industries to understand any concerns or issues as the Board works towards a final standard. Our industry expert panels stand ready to assist the staff and board with that effort.

We would be happy to discuss any aspect of this letter with the Board's members or staff.

Yours truly,

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## APPENDIX A

### Issues identified by the Health Care Expert Panel - Exposure Draft on Revenue from Contracts with Customers

#### a. Recognition of revenue for indigent self-pay patients

The FASB and EITF invested significant time in developing ASU 2011-07, *Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. This ASU was intended to be an interim step in addressing revenue recognition for uninsured self-pay patients who do not qualify for charity care until the Board's joint project on revenue recognition could be completed (ASU 2011-07, BC4). Despite the time and attention focused on the indigent self-pay revenue recognition issue at that interim point in the joint revenue recognition project, the Exposure Draft (ED) is unclear on whether or how health care entities should recognize revenue associated with services provided to those patients. For example:

- One health care organization (HCO) might conclude that the contract criteria of paragraph 14 are met and that the amount of consideration to which the entity expects to be entitled would be based on the HCO's policy for pricing services to uninsured patients, with collectability concerns addressed by reflecting contra-revenue (bad debt). That view is consistent with the ASU 2011-07 model.
- Another concludes that the contract criteria of paragraph 14 have been met, but interprets the transaction price requirements differently. For example, it might conclude that the amount of consideration to which it expects to be entitled should be estimated in the aggregate for a portfolio of self-pay patients with similar characteristics using the provisions for estimating variable consideration (i.e., reflecting either the expected value of the portfolio or the most likely amount for the portfolio), since it typically does not know which specific patient will pay or how much they will pay.
- A third HCO might conclude that the contract criteria in paragraph 14 cannot be met with respect to this class of patient, because the significant doubt at contract inception about the collectability of consideration from the patient would indicate that the patient is not committed to perform his/her obligations to pay or that the contract does not have commercial substance. That HCO presumably would report revenue from this class of patient on a cash basis.

As a result, for a hypothetical group of self-pay patients that in the aggregate has gross charges of \$10,000 and a collection history of 5%, the first HCO would accrue revenue of \$10,000 and recognize contra-revenue of \$9,500; the second HCO would accrue revenue of \$500 and recognize little or no bad debt expense/contra revenue; and the third HCO

would accrue zero revenue at the time of service and instead, recognize \$500 of revenue in the periods the cash payments are received.

#### **b. Use of "most likely amount" in estimating variable consideration**

In the health care industry, the amount of revenue earned under arrangements with government programs (for example, Medicare or Medicaid) is determined under complex rules and regulations that subject the health care entity to the potential for retrospective adjustments in future years. Several years may elapse before all potential adjustments related to a particular fiscal year are known and before the amount of revenue to which the health care entity is entitled is known with certainty. As a result, revenue from contracts with government payers typically contains a variable element that requires providers to estimate the cash flows ultimately expected to be received for services provided during a contract period. Under current GAAP (ASC 954), management generally makes its "best estimate" of the third-party settlement adjustments required based on its knowledge and experience about past and current events.

Paragraph 55 of the ED indicates that when an element of consideration is variable, an entity's estimates shall either be based on the expected value (derived from a probability-weighted calculation) or the most likely amount (derived from the "best estimate"). An entity should select the method that it expects to provide the best prediction of the amount of variable consideration. Paragraph 55 goes on to state that "an expected value may be an appropriate estimate of the transaction price if an entity has a large number of contracts with similar characteristics," and that "the most likely amount may be an appropriate estimate of the transaction price if the contract has only two possible outcomes (for example, an entity either achieves a performance bonus or does not)."

A health care entity's contracts with government programs such as Medicare or Medicaid—the largest purchasers of health care in the United States—typically are for a single year, with many years of renewals. In many cases, institutional providers' experience in estimating settlements associated with these contracts extend back more than 40 years.

Based on current practice, many health care entities are likely to conclude that the best predictor of the variable consideration is continued use of their best estimate. However, it is unclear whether paragraph 55 is intended to effectively create a rebuttable presumption that the best estimate method should be used only when outcomes are binary.

#### **c. Revenue transactions involving multiple contractual relationships**

A unique aspect of health care operations is that revenue transactions primarily involve more parties than the traditional "buyer" and "seller." As many as four parties may be associated with a revenue transaction involving an institutional health care entity such as a hospital. These include: (1) the individual who receives the medical care; (2) the physician who orders the required services on behalf of the patient; (3) the hospital that

provides the setting or administers the treatment; and (4) a third-party payer that pays the hospital on behalf of the patient (for example, Medicare, Medicaid, or a managed care plan).

As a result, the provision of services to the patient may involve a network of contractual relationships, illustrated as follows. A hospital admits a Medicare patient. The hospital will have an overall contract with Medicare (the primary payer) setting forth the terms and conditions of payment for services provided to any Medicare beneficiaries treated by the hospital, and will also execute a contract with the patient related to his or her specific admission. The contract with Medicare will indicate the services that are covered or not covered, the amount that can be charged for the services, and the amount of the patient's responsibility for the services provided. Historically, the contract with the primary payer has driven the timing and amount of revenue recognized. Other contractual relationships will affect the hospital's ability to collect the agreed-upon sales price from among the various parties. These include the portion payable by Medicare (as the primary payor), the portion due from one or more secondary payors (for example, an AARP Medicare supplement policy that pay certain costs that otherwise would be the responsibility of the patient, based on a contract between the patient and AARP), and the remaining patient responsibility. Each contract referenced above would have been entered into at different times and on different terms.

Paragraphs 13–15 of the proposed ASU would indicate that all of these arrangements are "contracts," as they are in writing, have commercial substance, and identify each party's rights and payment terms. However, guidance in ASC 954-280-45-1 states that third-party payors are not "customers" of a health care organization for purposes of providing disclosures by segment and provides the following rationale:

“When providing information about major customers pursuant to paragraph 280-10-50-42, an insuring entity shall not be considered the customer of a health care facility. The fact that an insuring entity is a paying agent for the patient does not make the insuring entity the customer of the health care facility because the insuring entity does not decide which services to purchase and from which health care facility to purchase the services. The latter two factors are important in determining the customer.”

As a result of the guidance in ASC 954-280, different conclusions could be reached regarding whether third-party payer contracts can be considered "contracts with customers" for purposes of applying the ED. Differences in interpretation would result in differences in applying the revenue recognition process described in the ED as well as in applying the onerous contract provisions.

In addition, the ED's provisions around combining of contracts—which apparently did not contemplate the health care situation—are likely to present challenges to health care providers attempting to interpret and apply the guidance in light of the transaction structures described above. Similar challenges are likely to arise with respect to accounting for the effects of a customer's credit risk on a contract asset (because multiple

payers are involved) as well as on grouping of performance obligations for evaluation of onerous contracts.

#### **d. NFP-specific exclusion pertaining to onerous performance obligations**

Paragraph 90 of the ED exempts not-for-profit entities from the requirements to report onerous performance obligations "if the purpose of the contract is to provide a social or charitable benefit." No further elaboration is provided, and the Board's intention regarding the scope exception is unclear. Many not-for-profit organizations (including all Internal Revenue Code sec. 501(c)(3) not-for-profit organizations) have a stated mission of providing some form of social or charitable benefit. Thus, organizations might interpret paragraph 90 as applying to any contract executed in carrying out their mission, even if that contract is entered into on normal commercial terms (for example, a contract between a not-for-profit HMO and an employer).

According to BC353, the exception was intended to apply to contracts whose purpose is to provide a social or charitable benefit because those types of contracts may not always have a profit-making objective, and recording a liability for future losses under such contracts would be "inconsistent with the objective of financial reporting for not-for-profit entities." This explanation also is too ambiguous to be of use in consistent application of the guidance. Paragraph 8 of Concepts Statement No. 4, *Objectives of Financial Reporting by Nonbusiness Organizations*, states that

"Some [not-for-profit] organizations have no ownership interests but are essentially self-sustaining from fees they charge for goods and services. Examples are those private nonprofit hospitals and nonprofit schools that may receive relatively small amounts of contributions and grants but finance their capital needs largely from the proceeds of debt issues and their operating needs largely from service charges rather than from private philanthropy or governmental grants.....[T]he objectives of Concepts Statement 1 [objectives of financial reporting by business organizations] may be more appropriate for those organizations."

The Health Care Expert Panel (EP) encourages the Board to clarify the situations to which the exception was intended to apply. Does the Board intend it to apply solely to some or all organizations that are organized as not-for-profit (for example, to all entities that meet the definition of a not-for-profit organization in the ASC Glossary; or only to "nonbusiness" not-for-profit entities with the objectives of financial reporting described in CON Statement 4)? Or was the Board's intent more transaction-focused (for example, part-exchange-part-contribution transactions that are structured with charitable intent; transactions involving a price that is established with an expectation that it will be supplemented by charitable gifts or endowment income)?

#### **e. Elimination of "prepaid health care plan" definition in Master Glossary**

The EP is concerned that the definition of "prepaid health care plan" is being eliminated from the Master Glossary and would no longer be referenced in ASC 954. Without a clear indication that prepaid health care plans are healthcare entities (within the scope of ASC 954), health care entities may apply the guidance in Topic 944, *Insurance Entities*, to these arrangements, instead of the guidance in Subtopic 605-10. This concern applies to both general revenue recognition for premiums received by prepaid health care plans and the guidance for onerous performance obligations.

#### **Continuing-care retirement communities**

#### **f. CCRC advance fees refundable only from proceeds of reoccupancy**

Continuing-care retirement communities (CCRCs) provide services and the use of facilities to individuals over their remaining lives. The contract between a CCRC and a resident will stipulate the services to be provided and the fees associated with those services. The contract provisions generally stipulate the amount of the advance fee (a significant one-time fee, typically paid at or prior to occupancy as a condition of admission), the amount and timing of additional periodic fees or use fees payable (if required), and the CCRC's refund policies (if applicable).

If some or all of the advance fee is refundable upon termination of the arrangement, the timing of the refund payment typically is contingent on receipt of a new entrance fee from a subsequent resident ("reoccupancy proceeds"). Some contracts will further restrict the *amount* of refund payable to the amount of reoccupancy proceeds received. In those situations, the CCRC's own funds will never be used to make the refunds to the prior resident; instead, the CCRC is effectively facilitating the transfer of cash between the successor resident and the prior resident. If a restriction on the amount of the refund is explicitly stated in the contract and it is the entity's policy or practice to enforce the restriction, ASC 954-430-25-1 and 954-430-35-4 (as clarified by the proposed Technical Corrections ED) permit the refundable entrance fee paid by the unit's initial resident to be deferred and amortized into income over the life of the facility (reflecting that it is in essence capital financing). If fees received from subsequent occupants of the unit increase, the incremental increases are added to the original deferred amount and amortized over the remaining period.

Par. 57 of the Revenue Recognition ED states, "If an entity receives consideration from a customer and expects to refund some or all of that consideration to the customer, the entity shall recognize as a refund liability the amount of consideration that the entity reasonably expects to refund to the customer." The EP is concerned that different CCRCs may reach different conclusions on whether or how par. 57 would apply to contracts where the amount of refund is limited to reoccupancy proceeds. Some may conclude that the guidance is not applicable, believing that the refund is paid by the successor resident (rather than from the consideration provided by the customer). Those

CCRCs would report the refundable amount as revenue, while CCRCs that conclude otherwise would report the refundable amount as a liability.

### **g. Scope**

Some CCRC contracts do not provide any health services but instead, provide a guaranteed place to live with some maintenance services. (Presumably, health care services, meals etc. would be purchased *a la carte*). Would such arrangements be within the scope of this ED, or the Proposed Accounting Standards Update, *Leases*?

### **h. Time value of money**

Under the CCRC business model, new residents typically must pay an up-front entrance fee in order to join a community. The purpose of charging entrance fees is to allow the CCRC to offer lower monthly fees (which also are typically part of the financial arrangement), because in part, they are invested to help pay for the future expenses of housing and care for the resident. Entrance fees also can be used to finance development of new facilities (for example, paying construction loans) or in the case of refundable fees, as a source of financing refund payments.

Under the proposal, an entity must adjust the consideration received under a contract to reflect the time value of money if the contract has a financing component that is significant to the contract. The EP is concerned that different CCRCs will reach different conclusions on whether this guidance applies to entrance fees. Paragraph 58 and BC 144 specify that a financing component exists when "the promised consideration differs from the cash selling price of the goods or services." This is consistent with the stated objective of the guidance, which is to adjust the contract revenue to reflect the "cash and carry" amount. Under the CCRC business model, there typically is no "cash selling price" to compare to, since most CCRCs require payment of the entrance fee in order to gain access to the use of facilities/services. Because there is no cash selling price to compare to the promised consideration, some CCRCs may conclude that the time value of money requirements do not apply.

CCRCs that read paragraph 58 in conjunction with BC143 may reach a different conclusion. BC 143 states that "Some contracts with customers include a financing component... [that] may be explicitly identified in the contract or may be implied by the payment terms of the contract." The focus of the commentary in BC 143-146 appears to be on whether the primary purpose of the upfront payment is for the customer to provide financing to the entity. Because a financing characteristic is inherent in the requirement to pay entrance fees, as discussed above, those CCRCs are likely to conclude that the time value of money requirements apply. However, they may disagree on how to calculate the revenue adjustment would be calculated in the absence of a cash selling price. Some may conclude that they need to develop a hypothetical pricing structure that would apply if cash sales existed. Others may simply calculate the amount of interest attributable to

the interest-free loan element (the refundable portion of the contract) and gross up revenue by that amount; however, it is unclear from the proposed standard whether that approach would be acceptable.

#### **i. Performance obligation(s) and pattern of transfer**

Under current guidance, CCRCs amortize nonrefundable entrance fees into income over the expected life of the resident, and recognize monthly fees as revenue of the period. Under the ED, CCRCs will be required to evaluate the performance obligation(s) inherent in a CCRC contract and evaluate the pattern of transfer of benefit over time. The objective is to "depict the transfer of control of goods or services to the customer." Different interpretations of these requirements are possible.

- One view might hold that while many of a CCRC's performance obligations would be considered distinct and separate under the proposed guidance (e.g., room and board, meal service, laundry, housekeeping), a practical expedient within the proposal would allow an entity to account for multiple distinct goods or services as a single performance obligation when the underlying goods and services have the same pattern of transfer. In this case, the pattern of transfer would be continuously over time (services are provided daily or weekly for life).
- A different view might hold that the obligation to provide services is likely to be more costly in the later years of a resident's tenancy of a Lifecare contract (commonly referred to as a Type A contract). In such cases, if the pattern of transfer would mirror the expected pattern of the level of effort involved in fulfilling the obligation to the resident, the revenue would be "back-end loaded." This view might involve identification of three separate performance obligations: one for the resident's expected term of residency in independent living; another for the expected term of residency in assisted living; and a third for the expected term of residency in skilled nursing.
- If contracts that are refundable only from proceeds of reoccupancy (discussed in comment (f)) are deemed to be revenue (rather than a liability), does a different pattern of transfer of benefit exist? Under the existing guidance, such contracts are amortized into income over the expected life of the facility, rather than the residents' expected tenancy.

#### **j. Obligation to provide future services**

A CCRC expects to provide services and use of facilities to individuals over their remaining lives. The nature and extent of the services depend on variables such as an individual's estimated remaining lifespan, health, sex, and economic status. If the advance and periodic fees that are charged are insufficient to meet the costs of providing future services and the use of facilities, ASC 954 requires the CCRC to report a liability



equal to the excess of the costs expected to be incurred to provide services and the use of facilities to individuals over their remaining lives over the related anticipated revenues. If CCRCs must gross up revenues as a result of factoring in the time value of money, how would that impact the calculation? For example, if a CCRC grosses up a \$300,000 entrance fee by an imputed \$100,000 of interest expense on the implied borrowing, is the transaction price used in the onerous contract calculation \$400,000 or \$300,000?

## **APPENDIX B**

### **Issue identified by the Investment Companies Expert Panel - Exposure Draft on Revenue from Contracts with Customers**

Example 13 on page 70 of the Exposure Draft (ED) includes a scenario of an entity entering into a contract with a client to provide asset management services. The definition of a “client” for these purposes and which party the investment adviser should consider as its client: the mutual fund(s) it manages or the investor that bought shares in the fund(s) is not clear. As the definition of a “client” may impact the accounting treatment, the Investment Companies Expert Panel requests that the FASB provide more clarity with respect to the definition of a “client”.

Regarding recognition of the 12b-1 fee (a fee paid by the fund out of fund assets to cover distribution expenses and sometimes shareholder service expenses), if the investor is the client, an entity may need to consider the length of time an investor is expected to be in the fund and develop an expectation of revenue throughout that period. Typically, advisers have their contracts renewed each year through their distributor, and the fund pays the distributor a fee based on average net assets. Additionally, if the investor is deemed to be the client, then the adviser may need to perform an analysis regarding the adviser’s collectability of management and other fees from individual shareholders. The Investment Companies Expert Panel members observe that internationally the client may be considered to be an investor rather than the fund, while in the United States the fund is usually viewed as the client.