Working Draft:

Health Care Entities Revenue Recognition Implementation Issue

Issue #8-6– Presentation and Disclosure

Expected Overall Level of Impact to Industry Accounting:

Moderate

Wording to be Included in the Revenue Recognition Guide:

Disclosure—Background

1. It is critical that the discussions and conclusions reached in this issue be read in conjunction with the discussions and conclusions reached in the following issues:

    a. 8-1, “Application of step 1 (determine if there is a contract) and step 3 (determine the transaction price) for healthcare services provided to self-pay patients, including uninsured patient balances and self-pay patient balances arising from co-payments and deductibles”

    b. 8-2, “Application of the Portfolio Approach to Contracts with Patients”

    c. 8-3, “Identifying and satisfying the performance obligation(s) and recognizing the monthly/periodic fees and nonrefundable entrance fees under Type A or “life care” contracts for continuing care retirement communities”

    d. 8-4, “Recognizing a CCRC’s performance obligation(s) to provide future services and use of facilities to residents”

    e. 8-5, “Significant Financing Component – Continuing-Care Retirement Community (CCRC) Contracts, and patient and third-party payor amounts in arrears”

    f. 8-7, “Accounting for Contract Costs”

g. 8-8, “Consideration of FASB ASC 606, *Revenue from Contracts with Customers*, for third-party settlement estimates"

h. 8-9, “Bundled Payments”

i. 8-10, “Performance Obligations “

Disclosure Requirements

2. FASB ASC 606-10-50-1 states,

   “The objective of the disclosure requirements in this Topic is for an entity to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. To achieve that objective, an entity shall disclose qualitative and quantitative information about all of the following:

   a. Its contracts with customers (see paragraphs 606-10-50-4 through 50-16)

   b. The significant judgments, and changes in the judgments, made in applying the guidance in this Topic to those contracts (see paragraphs 606-105-50-17 through 50-21)

   c. Any assets recognized from the costs to obtain or fulfill a contract with a customer in accordance with paragraph 340-40-25-1 or 340-40-25-5 (see paragraphs 340-40-50-1 through 50-6).”

3. FASB ASC 606-10-50-2 states, “An entity shall consider the level of detail necessary to satisfy the disclosure objective and how much emphasis to place on each of the various requirements. An entity shall aggregate or disaggregate disclosures so that useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items that have substantially different characteristics.”

4. FASB ASC 606-10-50-3 states, “Amounts disclosed are for each reporting period for which a statement of comprehensive income (statement of activities) is presented and as of each reporting period for which a statement of financial position is presented. An entity need not disclose information in accordance with the guidance in this Topic if it has provided the information in accordance with another Topic.”

5. A health care entity that is neither a public business entity nor a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market (that is, a nonpublic entity) is not required to make certain of the disclosures required of public entities. These differences are described further in each of the sections below.

Contracts with Customers

<u>Disaggregation of Revenue</u>

6. In addition, FASB ASC 606-10-50-5 states, “An entity shall disaggregate revenue recognized from contracts with customers into categories that depict how the nature, amount, timing, and uncertainty of revenue and cash flows are affected by economic factors.”

7. In accordance with FASB ASC 606-10-50-6, if the health care entity applies FASB ASC 280, *Segment Reporting*, the health care entity should also disclose sufficient information to enable users of its financial statements to understand the relationship between the disclosure of disaggregated revenue (in accordance with FASB ASC 606-10-50-5) and revenue information that is disclosed for each reportable segment. Based on the guidance in paragraphs 1 and 5 of FASB ASC 606-10-50, a health care entity may consider evaluating the guidance in paragraphs 89–91 of FASB ASC 606-10-55 when selecting the categories to disaggregate revenue by.

8. A health care entity may disclose revenue by the major type of payor (for example, Medicare, Medicaid, commercial insurance, self-pay) as each payor generally pays different rates for services, which impacts the

nature, amount, timing, and uncertainty of revenue and cash flows. A health care entity should consider the level of disaggregation based on the significance of each payor to its revenue, how its different arrangements with those payors impact the nature, amount, timing, and uncertainty of revenue and cash flows, how it internally analyzes its major payors, and how it presents its payors externally in earnings releases, annual reports or investor presentations. For example, Medicaid may be disaggregated from Medicaid managed care, commercial insurance may be disaggregated by significant commercial payors, and self-pay may be disaggregated between uninsured self-pay and copayments and deductibles.

9. A health care entity might also consider whether the nature, amount, timing, and uncertainty of revenue and cash flows are impacted by factors such as geographical considerations (for example, regions of the country of a health care system that are used for evaluating financial performance or making resource allocation decisions), market or type of customer (for example, government and nongovernment customers), type of contract (for example, percent of charges, cost, fixed or capitated), timing of transfer of goods or services (for example, inpatient and outpatient services), and whether the health care entity has different operating segments or service lines (for example, hospital, nursing home, physician, home care, health plan, assisted/independent living, and other non-health care services).

10. FASB ASC 606-10-50-7 indicates that the quantitative disaggregation disclosure guidance in FASB ASC 606-10-50-5 through 50-6 and FASB ASC 606-10-55-89 through 55-91 is not required for nonpublic entities. However, if a nonpublic entity elects not to provide those disclosures it must provide, at a minimum, revenue disaggregated according to the timing of transfer of goods or services (for example, revenue from goods or services transferred to customers at a point in time and revenue from goods or services transferred to customers over time) and qualitative information about how economic factors (such as type of customer, geographical location of customers, and type of contract) affect the nature, amount, timing, and uncertainty of revenue and cash flows.

Contract Balances

11. In accordance with FASB ASC 606-10-45-1, “when either party to a contract has performed, an entity shall present the contract in the statement of financial position as a contract asset or contract liability, depending on the relationship between the entity’s performance and the customer’s payment. An entity shall present any unconditional rights to consideration separately as a receivable.”

12. When the health care entity has an unconditional right to payment, subject only to the passage of time, the right is treated as a receivable (refer to FASB ASC 606-10-45-4). For a health care entity, patient accounts receivable, including billed accounts and unbilled accounts for which the health care entity has the unconditional right to payment, and estimated amounts due from third-party payors for retroactive adjustments, are receivables if the entity’s right to consideration is unconditional and only the passage of time is required before payment of that consideration is due.

13. FASB ASC 606-10-45-3 indicates that if an entity performs by transferring goods or services to a customer before the customer pays consideration or before payment is due, the entity shall present the contract as a contract asset, excluding any amounts presented as a receivable. A contract asset is an entity’s right to consideration in exchange for goods or services that the entity has transferred to a customer. Non-refundable advance payments by a patient to a healthcare entity before goods or services are provided (for example, long-term care residents and continuing care retirement communities (CCRC) advance fees) are contract liabilities. A contract liability does not include amounts that are expected to be refunded pursuant to, for example, rights of return, or other provisions. In those cases, a separate refund liability must be recorded (refer to FASB ASC 606-10-32-10).

14. The guidance in FASB ASC 954-310-45-1 states “Although the aggregate amount of receivables may include balances due from patients and third-party payors (including final settlements and appeals), the amounts due from third-party payors for retroactive adjustments of items such as final settlements or appeals shall be reported separately in the financial statements.”

15. FASB ASC 606-10-45-5 indicates that an entity is not prohibited from using alternative descriptions in the statement of financial position for contract assets and contract liabilities although the entity should provide sufficient information for a user of the financial statements to distinguish between receivables and contract assets.

16. FASB ASC 606-10-50-8 requires a health care entity to make certain disclosures regarding contract balances. Those requirements and considerations for a health care entity are as follows:

    a. "The opening and closing balances of receivables, contract assets, and contract liabilities from contracts with customers, if not otherwise separately presented or disclosed." For many health care entities receivables (for example, patient accounts receivable or estimated amounts due from third-party payors for retroactive adjustments) are likely to be presented on their balance sheets as separate line items. Health care entities should also consider if contract assets are separately presented on their balance sheet. If it is determined that sufficient information is not presented on the balance sheet, the opening and closing balances of receivables, contract assets, and contract liabilities should be disclosed in the notes to the financial statements. CCRC and similar entities with other contract balances (for example, nonrefundable advance fees) may also need to consider disclosure of additional details.

    b. "Revenue recognized in the reporting period that was included in the contract liability balance at the beginning of the period." Health care entities will need to disclose reductions in a contract liability balance as a result of services provided during the reporting period. For example, this may apply to CCRCs and similar entities with nonrefundable advance fees recorded as contract liabilities.

17. In accordance with FASB ASC 606-10-50-9, a health care entity "shall explain how the timing of satisfaction of its performance obligations (see paragraph 606-10-50-12(a)) relates to the typical timing of payment (see paragraph 606-10-50-12(b)) and the effect that those factors have on the contract asset and the contract liability balances. The explanation provided may use qualitative information." A health care entity might explain how CCRC nonrefundable advance fees are recognized or disclose that patients and/or third-party payors are generally billed several days after services are rendered to a patient. Amounts related to services provided to patients for which the entity has not billed and which do not meet the conditions of unconditional right to payment at the end of the reporting period are presented as contract assets. Amounts billed that have not yet been collected and that meet the conditions for unconditional right to payment are presented as patient receivables, not contract assets.

18. Paragraph 10 of FASB ASC 606-10-50 states, "An entity shall provide an explanation of the significant changes in the contract asset and the contract liability balances during the reporting period. The explanation shall include qualitative and quantitative information." FASB ASC 606-10-50-10 provides examples of changes in an entity's balances of contract assets and contract liabilities such as a business combination or a cumulative catch-up adjustment to revenue, including adjustments arising from a change in the estimate of the transaction price (and any changes in the assessment of whether an estimate of variable consideration is constrained). Changes in contract liabilities of CCRCs may include changes in nonrefundable advance fees.

19. FASB ASC 606-10-50-11 indicates that the disclosure requirements in FASB ASC 606-10-50-8 through 50-10 related to contract balances and certain changes impacting revenue, timing of the satisfaction of its performance obligations and explanation of the significant changes in the contract asset and liability balances during the reporting period, are not required for nonpublic entities. However, if a nonpublic entity elects not to provide these disclosures, the entity should provide the disclosure in FASB ASC 606-10-50-8(a), which requires the disclosure of the opening and closing balances of receivables, contract assets, and contract liabilities from contracts with customers, if not otherwise separately presented or disclosed.

<u>Performance Obligations</u>

20. Paragraph 12 of FASB ASC 606-10-50 includes disclosure requirements regarding performance obligations. Those requirements and the considerations for a health care entity are as follows:

    a. "When the entity typically satisfies its performance obligations (for example, upon shipment, upon delivery, as services are rendered, or upon completion of service) including when performance obligations

are satisfied in a bill-and-hold arrangement." A health care entity may disclose that it satisfies some of its performance obligations at the time the services are provided (for example, certain outpatient visits), while other performance obligations may be satisfied over time (for example, inpatient acute care services and certain services provided by continuing care retirement communities).

b. "The significant payment terms (for example, when payment typically is due, whether the contract has a significant financing component, whether the consideration amount is variable, and whether the estimate of variable consideration is typically constrained in accordance with paragraphs 606-10-32-11 through 32-13." A health care entity may disclose that it typically enters into agreements with third-party payors (Medicare, Medicaid, commercial insurance, HMOs, and similar payors) that provide for payments at amounts different from its established charges and that the arrangement terms provide for subsequent settlement and cash flows that may occur well after the service is provided. Similarly, a health care entity may disclose that it offers uninsured patients certain discounts from charges and may include implicit price concessions in the estimate of the transaction price based on historical collection experience. Those amounts are estimated each reporting period. If applicable, a health care entity should disclose how it estimates retroactive settlements with third-party payors and whether those amounts are constrained. A CCRC may disclose payment terms (for example, monthly and advance fees) and whether advance fees are refundable or not. A CCRC may also need to disclose whether there is a significant financing component included in its payment arrangements (see issue 8-5).

c. "The nature of the goods or services that the entity has promised to transfer, highlighting any performance obligations to arrange for another party to transfer goods or services (that is, if the entity is acting as an agent)." A health care entity may disclose the different services it provides (for example, inpatient, outpatient, long-term care, home health, and so on).

d. "Obligations for returns, refunds, and other similar obligations." A hospital will disclose credit balances that represent refunds owed to patients and third-party payors and CCRCs will disclose if it has advance fees that are refundable and the related terms.

e. "Types of warranties and related obligations." A health entity will need to determine if it has provided material warranties or has related obligations and disclose these if applicable.

21. FASB ASC 606-10-50-12A states "An entity shall disclose revenue recognized in the reporting period from performance obligations satisfied (or partially satisfied) in previous periods (for example, changes in transaction price)." If a health care entity determined that the implicit price concessions, discounts and/or contractual adjustments, or third-party settlements that it estimated in a previous reporting period changed, it will need to disclose the impact that this change in the estimate of the transaction price had on revenue in the reporting period.

Transaction Price Allocated to the Remaining Performance Obligations

22. An entity should disclose information about its remaining performance obligations, in accordance with FASB ASC 606-10-50-13 subject to certain exceptions in FASB ASC 606-10-50-14 and 14A. Certain types of health care providers may have remaining performance obligations at the end of the reporting period, including hospitals with in-house patients, CCRCs, providers with multi-visit procedures, entities that offer prepaid services, and those with bundled payments. They are required to disclose a description of the following:

    a. The aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied (or partially unsatisfied) as of the end of the reporting period.

    b. An explanation of when the entity expects to recognize as revenue the amount disclosed in accordance with FASB ASC 606-10-50-13(a), which the entity should disclose in either of the following ways:

(1) On a quantitative basis using the time bands that would be most appropriate for the duration of the remaining performance obligations.

(2) By using qualitative information.

23. FASB ASC 606-10-50-14 states "An entity need not disclose the information in paragraph 606-10-50-13 for a performance obligation if either of the following conditions is met:

    a. The performance obligation is part of a contract that has an original expected duration of one year or less.

    b. The entity recognizes revenue from the satisfaction of the performance obligation in accordance with paragraph 606-10-55-18." FASB ASC 606-10-55-18 states that "if an entity has a right to consideration from a customer in an amount that corresponds directly with the value to the customer of the entity's performance completed to date (for example, a service contract in which an entity bills a fixed amount for each hour of service provided), the entity may recognize revenue in the amount to which the entity has a right to invoice."

24. FASB ASC 606-10-50-14A states "An entity need not disclose the information in paragraph 606-10-50-13 for a performance obligation if either of the following conditions is met:

    a. The variable consideration is a sales-based or usage-based royalty promised in exchange for a license of intellectual property accounted for in accordance with paragraphs 606-10-55-65 through 55-65B

    b. The variable consideration is allocated entirely to a wholly unsatisfied performance obligation or to a wholly unsatisfied promise to transfer a distinct good or service that forms part of a single performance obligation in accordance with paragraph 606-10-25-14(b), for which the criteria in paragraph 606-10-32-40 have been met."

25. FASB ASC 606-10-50-14B indicates that the optional exemptions in FASB ASC 606-10-50-14(b) and 14A should not be applied to fixed consideration.

26. In accordance with FASB ASC 606-10-50-15, an entity "shall disclose which optional exemptions in paragraphs 606-10-50-14 through 50-14A it is applying. In addition, an entity applying the optional exemptions in paragraphs 606-10-50-14 through 50-14A shall disclose the nature of the performance obligations, the remaining duration (see paragraph 606-10-25-3), and a description of the variable consideration (for example, the nature of the variability and how that variability will be resolved) that has been excluded from the information disclosed in accordance with paragraph 606-10-50-13. This information shall include sufficient detail to enable users of financial statements to understand the remaining performance obligations that the entity excluded from the information disclosed in accordance with paragraph 606-10-50-13. In addition, an entity shall explain whether any consideration from contracts with customers is not included in the transaction price and, therefore, not included in the information disclosed in accordance with paragraph 606-10-50-13. For example, an estimate of the transaction price would not include any estimated amounts of variable consideration that are constrained (see paragraphs 606-10-32-11 through 32-13)." For health care entities, an example of performance obligations that are recognized over time may relate to those services provided to acute care patients in a hospital at period end (in-house patients) that have not yet been billed. However, because the in-house patient is typically discharged within the following fiscal year, a health care entity may elect to apply the optional exemption in FASB ASC 606-10-50-14a and would only make the required qualitative disclosures. Other health care entities may have other types of performance obligations remaining at the end of the reporting period and they would need to determine if they meet the other optional exceptions provided in FASB ASC 606-10-50-14(b) and 50-14A and, if not, make the disclosures required in FASB ASC 606-10-50-13.

27. The descriptive disclosures of an entity's performance obligations of FASB ASC 606-10-50-12 are required for nonpublic entities, but FASB ASC 606-10-50-16 indicates that the disclosure requirements of FASB ASC 606-10-50-13 through 50-15 related to remaining performance obligations are not required for nonpublic entities.

Significant Judgments in the Application of the Guidance

28. FASB ASC 606-10-50-17 states:

    "An entity shall disclose the judgments, and changes in the judgments, made in applying the guidance in this Topic that significantly affect the determination of the amount and timing of revenue from contracts with customers. In particular, an entity shall explain the judgments, and changes in the judgments, used in determining both of the following:

    a. The timing of satisfaction of performance obligations (see paragraphs 606-10-50-18 through 50-19).

    b. The transaction price and the amounts allocated to performance obligations (see paragraph 606-10-50-20)."

29. A health care entity will provide disclosure of the judgments, and any significant changes, that it makes in the determination of the amount and timing of revenue recognized. This might include how the entity determines explicit and implicit price concessions for uninsured self-pay patients and insured patients with co-payments and deductibles, and any constraints on revenue. A hospital may describe when it satisfies performance obligations for the services it provides (for example, inpatient and outpatient services). A CCRC may describe when it satisfies its performance obligations, how the transaction price is determined including entrance fees and monthly fees, and how the transaction price is allocated. A medical practice that performs multi-visit procedures may describe when it satisfies its performance obligations, how it determines the transaction price, and how it allocates the transaction price to each performance obligation or visit.

30. Determining the amount of implicit price concessions for contracts to provide health care services to uninsured and insured patients with co-payments and deductibles will likely involve significant judgments for many health care entities (see issue 8-1). While not required by FASB ASC 606, a health care entity may consider disclosing the amount of implicit price concessions included in estimating the transaction price each reporting period. This disclosure may provide meaningful information to users of financial statements in evaluating the judgments made by management in estimating the transaction price.

Determining the Timing of Satisfaction of Performance Obligations

31. If a health care entity has performance obligations that are satisfied over time, the health care entity should disclose both of the following, in accordance with FASB ASC 606-10-50-18:

    a. The methods used to recognize revenue (for example, a description of the output methods or input methods used and how those methods are applied). For example, a health care entity might apply the input method of measuring progress toward the complete satisfaction of the performance obligation by measuring costs incurred relative to the total expected costs or charges incurred relative to the total expected charges.

    b. An explanation of why the methods used provide a faithful depiction of the transfer of goods or services. For example, a health care entity might indicate that costs or charges incurred to date are a faithful depiction of the entity's performance (that is, transfer of goods or services to the patient).

32. For performance obligations satisfied at a point in time, a health care entity should disclose, in accordance with FASB ASC 606-10-50-19, the significant judgments made in evaluating when a customer obtains control of promised goods or services. A health care entity might consider the indicators of transfer of control from FASB ASC 606-10-25-30 in determining its disclosure.

Determining the Transaction Price and Amounts Allocated to Performance Obligations

33. Refer to issue 8-1, issue 8-3, and issue 8-5 for discussion on determining the transaction price.

34. Paragraph 20 of FASB ASC 606-10-50 requires health care entities to disclose information about the methods, inputs, and assumptions used for all of the following:

    a. "Determining the transaction price, which includes, but is not limited to, estimating variable consideration, adjusting the consideration for the effects of the time value of money, and measuring noncash consideration." A health care entity may disclose that implicit price concessions included in the estimate of the transaction price are based on historical collection experience. A health care entity also may disclose how it estimates retroactive settlements with third-party payors. If applicable, a CCRC may disclose how it estimates the significant financing component included in its payment arrangements (see issue 8-5).

    b. "Assessing whether an estimate of variable consideration is constrained." A health care entity may disclose that its historical experience and range of potential outcomes take into account the constraint in the estimate of variable consideration or the factors considered in constraining the transaction price.

    c. "Allocating the transaction price, including estimating standalone selling prices of promised goods or services and allocating discounts and variable consideration to a specific part of the contract (if applicable)."

    d. "Measuring obligations for returns, refunds, and other similar obligations." A CCRC may disclose that it estimates its refundable advance fee each reporting period based on its historical experience.

35. FASB ASC 606-10-50-21 indicates that the following disclosure requirements are not required for nonpublic entities:

    a. FASB ASC 606-10-50-18(b), which states that an entity should disclose, for performance obligations satisfied over time, an explanation of why the methods used to recognize revenue provide a faithful depiction of the transfer of goods or services to a customer

    b. FASB ASC 606-10-50-19, which states that an entity should disclose, for performance obligations satisfied at a point in time, the significant judgments made in evaluating when a customer obtains control of promised goods or services

    c. FASB ASC 606-10-50-20, which states that an entity should disclose the methods, inputs, and assumptions used to determine the transaction price and to allocate the transaction price. However, if a nonpublic entity elects not to provide these disclosures, the entity should provide the disclosure in FASB ASC 606-10-50-20(b), which states that an entity should disclose the methods, inputs, and assumptions used to assess whether an estimate of variable consideration is constrained.

Practical Expedients

36. Based on the guidance in FASB ASC 606-10-50-22, a health care entity should disclose its policy for electing either of the following:

    a. the practical expedient provided by FASB ASC 606-10-32-18 about the existence of a significant financing component

    b. the practical expedient provided by FASB ASC 340-40-25-4 about incremental costs of obtaining a contract.

37. FASB ASC 606-10-50-23 indicates that the disclosure requirements of FASB ASC 606-10-50-22 related to election of the practical expedients for existence of a significant financing component and incremental costs of obtaining a contract, respectively, are not required for a nonpublic entity.

Assets Recognized from the Costs to Obtain or Fulfill a Contract with a Customer

38. Refer to issue 8-7 for discussion on this topic.

39. If a health care entity capitalized costs to obtain or fulfill a contract with a customer in accordance with FASB ASC 340-40-25-1 or 25-5, it is required to make the following disclosures:

    a. A health care entity should describe both of the following in accordance with FASB ASC 340-40-50-2:

        (1) The judgments made in determining the amount of the costs incurred to obtain or fulfil a contract with a customer in accordance with FASB ASC 340-40-25-1 or 25-5

        (2) The method it uses to determine the amortization for each reporting period.

    b. A health care entity should disclose all of the following in accordance with FASB ASC 340-40-50-3:

        (1) The closing balances of assets recognized from the costs incurred to obtain or fulfil a contract with a customer (in accordance with FASB ASC 340-40-25-1 or 25-5), by main category of asset (for example, costs to obtain contracts with customers, precontract costs, and setup costs)

        (2) The amount of amortization and any impairment losses recognized in the reporting period.

    c. Health care entities may apply the practical expedient provided in FASB ASC 340-40-25-4, which allows the health care entity to recognize the incremental costs of obtaining a contract as an expense when incurred if the amortization period of the asset that the entity otherwise would have recognized is one year or less and will not capitalize these costs. In accordance with FASB ASC 340-40-50-5, health care entities that have elected the practical expedient provided in FASB ASC 340-40-25-4 should disclose that fact. Certain other health care entities (for example, CCRCs) may incur material costs to obtain customer contracts and if so they should provide the disclosures described above (see issue 8-7).

40. A nonpublic entity may elect not to provide the disclosures in FASB ASC 340-40-50-2 through 50-3 and FASB ASC 340-40-50-5.

41. The following examples are illustrative only. It is important that the actual determination of the appropriate disclosures be based on a health care entity's specific facts and circumstances. These examples illustrate how the disclosure guidance in FASB ASC 606, *Revenue from Contracts with Customers*, might be applied to certain health care entities. Other presentations also may be appropriate depending on the nature of the entity, how the entity manages its business and the conclusions it makes about revenue recognition.

42. The following example is applicable to a health care entity that is either a public business entity or a not-for-profit health care entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market. This example assumes that the opening and closing balances of receivables, contract assets, and contract liabilities from contracts with customers are separately presented or disclosed on the health care entity's financial statements.

    Example I – Public Entity or Entity with Public Debt

    Patient Care Service Revenue: Patient care service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

    Performance obligations are determined based on the nature of the services provided by the Organization. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Organization believes that this method provides a faithful depiction of

the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in our hospital(s) receiving inpatient acute care services. The Organization measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided and the Organization does not believe it is required to provide additional goods or services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Organization has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy, and/or implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy(ies), and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- **Medicare:** Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic and other factors. Certain services are paid based on cost-reimbursement methodologies subject to certain limits. Physician services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates.
- **Medicaid:** Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of service, or per covered member.
- **Other:** Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Organization. In addition, the contracts the Organization has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Organization's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments

arising from a change in the transaction price, were not significant in 20x2 or 20x1. [Or, disclose the amounts and explain significant adjustments.]

Generally patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the years ended December 31, 20x2 and 20x1, additional revenue of $xxx and $xxx, respectively, was recognized due to changes in its estimates of implicit price concessions for performance obligations satisfied in prior years. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended December 31, 20x2 and 20x1 was not significant.

Consistent with the Organization's mission, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Organization expects to collect based on its collection history with those patients.

Patients who meet the Organization's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue.

The composition of patient care service revenue by payor for the years ended December 31 is as follows:

	20x2	20x1
Medicare	$ 16,000	$ 15,000
Medicaid	6,000	5,000
Managed care	11,000	10,500
Other insurers	4,000	3,500
Self-pay deductibles and coinsurance	1,000	1,000
Uninsured	800	900
Other	1,000	1,000
	$ 39,800	$ 36,900

The composition of patient care service revenue based on the regions of the country the Organization operates in, its lines of business, and timing of revenue recognition for the years ended December 31, 20x2 and 20x1 are as follows:

	20x2			
	Northeast	Central	Southeast	Total
Services lines:				
Hospital	$ 6,000	$ 4,000	$ 7,000	$ 17,000
Nursing home and senior care	4,000	-	2,000	6,000
Physician services	3,000	4,000	5,000	12,000
Home health and hospice	1,000	800	2,000	3,800
Other	400	200	400	1,000
	$ 14,400	$ 9,000	$ 16,400	$ 39,800
Timing of revenue and recognition:				
At time services are rendered	$ 5,400	$ 3,500	$ 8,400	$ 17,300
Services transferred over time	9,000	5,500	8,000	22,500

$14,400	$ 9,000	$ 16,400	$ 39,800

[Notes: 1. Although not included in this example, a similar table would be required for 20X1 for comparative purposes. 2. FASB ASC 606-10-50-6 would require a reconciliation of this information to the segment disclosures for a public business entity.]

Financing component:

Example A:

The Organization has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Organization's expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Example B:

The Organization has entered into contracts with patients which provide for payments ratably over 2 years with no stated interest rate. The Organization adjusts the promised amount of consideration due from these patients using discount rates ranging from x% to xx% to account for the effects of the financing component. For the years ended December 31, 20x2 and 20x1, interest income of $xx and $xx, respectively, was recognized. At December 31, 20x2 and 20x1, the unamortized discount was $xx and $xx, respectively.

Contract costs:

Example A:

The Organization has applied the practical expedient provided by FASB ASC 340-40-25-4 and all incremental customer contract acquisition costs are expensed as they are incurred as the amortization period of the asset that the Organization otherwise would have recognized is one year or less in duration.

Example B:

The Organization has elected to apply the practical expedient provided by FASB ASC 340-40-25-4, and expense as incurred the incremental customer contract acquisition costs for contracts in which the amortization period of the asset that the Organization otherwise would have recognized is one year or less. However, incremental costs incurred to obtain customer contracts for which the amortization period of the asset that the Organization otherwise would have recognized is longer than one year are capitalized and amortized over the life of the contract based on the pattern of revenue recognition from these contracts. The Organization regularly considers whether the unamortized contract acquisition costs are impaired if they are not recoverable under the contract. During the year ended December 31, 20x2, $xx of unamortized costs were expensed as a result of the impairment analysis. During the years ended December 31, 20x2 and 20x1, the Organization recognized amortization expense of $xx and $xx, respectively. At December 31, 20x2 and 20x1, the unamortized customer contract acquisition costs are $xxx and $xxx, respectively, and are presented in other assets on the accompanying balance sheets.

43. The following example is applicable to a health care entity that is other than a public business entity or a not-for-profit health care entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market (that is, nonpublic entities), that elected the disclosure exclusions of paragraphs 7, 11, 16, 21, and 23 of FASB ASC 606-10-50 and FASB ASC 340-40-50-6. This example assumes that the opening and closing balances of receivables, contract assets, and contract liabilities from contracts with customers are separately presented or disclosed on the health care entity's financial statements.

Example II—Nonpublic Entity

Patient Care Service Revenue: Patient care service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government payors), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Organization bills the patients and third-party payors several days after the services

are performed and/or the patient is discharged from the facility. Revenue is recognized as the performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Organization. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Organization believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in our hospital(s) receiving inpatient acute care services. The Organization measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when services are provided and the Organization does not believe it is required to provide additional goods or services to the patient.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy and/or implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policy(ies), and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Agreements with third-party payors provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors follows:

- **Medicare:** Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic and other factors. Certain services are paid based on cost-reimbursement methodologies subject to certain limits. Physician services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates.
- **Medicaid:** Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of service, or per covered member.
- **Other:** Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Organization. In addition, the contracts the Organization has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Organization's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in the transaction price, were not significant in 20x2 or 20x1. [Or, disclose the amounts and explain significant adjustments.]

Consistent with the Organization's mission, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and other

uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represents the difference between amounts billed to patients and the amounts the Organization expects to collect based on its collection history with those patients.

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The nature, amount, timing and uncertainty of revenue and cash flows are affected by several factors that the Organization considers in its recognition of revenue. Following are some of the factors considered:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement/payment methodologies
- Length of the patient's service/episode of care
- Geography of the service location
- Organization's line of business that provided the service (for example, hospital, nursing home, etc.)

For the years ended December 31, 20x2 and 20x1, the Organization recognized revenue of $xx and $xx, respectively at the time the services were provided and $xx and $xx, respectively from services and goods provided over time.

Comments should be received by August 1, 2017, and sent by electronic mail to Andy Mrakovcic at Andy.Mrakovcic@aicpa-cima.com, or you can send them by mail to Andy Mrakovcic, AICPA, 1211 Avenue of the Americas, NY 10036.