Revenue Recognition: A Comprehensive Review for Health Care Entities
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Introduction

The revenue recognition landscape dramatically changed with the May 2014 release of Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers* (Topic 606). This ASU superseded health care industry-specific guidance and substantially all existing revenue recognition guidance and added significant interim and annual disclosures. Implementation and documentation thereof will be a significant undertaking for entities in all industries. Health care entities may face more challenges than other industries in implementation due to evolving payment and reimbursement models, legislative updates to the Affordable Care Act and ongoing changes in insurance practices, e.g., the availability of high-deductible plans. The effect on each health care organization will vary depending on existing revenue streams, patient base and estimation methodologies. Even if the amount or timing of revenue recognition does not change, presentation and disclosure will. In addition, health care organizations will have to redraft accounting policies under the new principles and update internal controls for the increases in management’s judgments (see Appendix A for additional internal controls that may be needed).

The new revenue recognition model is now effective for public entities\(^1\) (see BKD’s white paper “*Revenue Recognition: An Updated Look at the Guidance*”). This paper focuses on those items in the new model that will have the greatest effect on health care entities and includes all subsequent amendments, Transition Resource Group (TRG) clarifications, finalized and exposed guidance from the American Institute of CPAs Health Care Entities Revenue Recognition Task Force (Task Force) and U.S. Securities and Exchange Commission (SEC) views gathered from official speeches (see Appendix B for the status of the Task Force’s issues).

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**Effective Dates**

<table>
<thead>
<tr>
<th>ASU 2014-09</th>
<th>Revenue Recognition</th>
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<tbody>
<tr>
<td>Public Entities(^1)</td>
<td>Annual and interim reporting periods beginning after December 15, 2017</td>
</tr>
<tr>
<td>All Others</td>
<td>Annual reporting periods beginning after December 15, 2018</td>
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A robust implementation plan will ensure a smooth transition. This includes evaluating existing revenue contracts and revenue recognition accounting policies to identify potential changes that will result from adopting the new standard. Management judgment will be required to determine the existence of a patient contract, identification of the contract’s performance obligations, estimation of the transaction price and its allocation to separate performance obligations and the satisfaction of each performance obligation for recognition. The model requires an increased level of management judgment that will necessitate new documentation requirements and internal controls to support recognition, measurement, presentation and disclosure decisions. See Appendix A for sample internal control considerations. Even for contracts in which no change in accounting is expected, going through the process of proving that can be tedious and documentation-intensive.

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\(^1\) The new revenue standard defines a public entity as any one of these:
- A public business entity
- An NFP entity that has issued—or is a conduit bond obligor for—securities traded, listed or quoted on an exchange or over-the-counter market
- An employee benefit plan that files or furnishes financial statements to the SEC
Management also should consider the general ledger structure during implementation, including reporting needs outside of the financial statements, e.g., cost reports, tax returns, etc. Care should be taken to ensure all reporting needs continue to be met even if certain items are now netted for external financial reporting.

The Model

The revenue recognition model’s core principle is that an entity would recognize as revenue the amount that reflects the consideration to which it expects to be entitled in exchange for goods or services when (or as) it transfers control to the customer, i.e., the patient (customer and patient will be used interchangeably in the remainder of this document). To achieve that core principle, an entity will apply a five-step model:

- Identify the contract(s) with a patient
- Identify the separate performance obligations
- Determine the transaction price
- Allocate the transaction price to the separate performance obligations
- Recognize revenue when or as a performance obligation is satisfied

Scope

The new revenue standard applies to all contracts with customers, except for those within the scope of other standards, e.g., lease and insurance contracts, financing arrangements, financial instruments, guarantees (other than product or service warranties) and certain nonmonetary exchanges between vendors. A contract may be partially in the new standard’s scope and partially in the scope of other accounting guidance. If the other accounting guidance specifies how to separate and/or initially measure one or more parts of a contract, an entity should first apply those requirements before applying this ASU. For example, some life plan community (CCRC) contracts that provide guaranteed housing with maintenance services may fall under the new lease standard.

Contracts to provide health care administrative services are within the new revenue standard’s scope.

Contributions/Grants

The standard does not explicitly exclude contributions, resulting in a lengthy discussion at the TRG’s March 2015 meeting (see BKD’s article “Clarification: Contributions Excluded from Revenue Standard”). TRG members concluded contributions are outside the new standard’s scope if not given in exchange for goods or services that are an output of the entity’s ordinary activities, i.e., if they represent nonexchange transactions. The Financial Accounting Standards Board (FASB) determined no standard setting was required for a specific scope exclusion in the new revenue rules in Accounting Standards Codification (ASC) 606. FASB’s NFP Advisory Committee continued to press the issue due to the current diversity in practice in distinguishing between a conditional promise of financial support (nonexchange transaction) and a transaction where the resource provider receives commensurate value in return (exchange transaction). In August 2017, FASB issued an exposure draft to clarify existing guidance in ASC 958, Not-for-Profit Entities, on determining whether the receipt of funds under a government grant or contract is a contribution or an exchange transaction (see BKD’s article “Guidance Proposed on Accounting for Contributions”). The proposed guidance requires all organizations to evaluate whether the resource provider is receiving commensurate value in a transfer of assets transaction and whether contributions are conditional or unconditional. FASB’s current project plan indicates issuance of a final standard in the second quarter of 2018.

Other sources of NFP income not affected by the new revenue standard include rental and investment income and in-kind contributions.
Collaborative Arrangements

The new revenue standard applies to contracts with a customer defined as “a party that has contracted with an entity to obtain goods or services that are an output of the entity’s ordinary activities in exchange for consideration.” For some contracts, the counterparty may not be a customer but rather a collaborator or partner that shares with the entity the risks and benefits resulting from the activity and, therefore, would not be in the new standard’s scope. Joint operating activities may involve the joint development and ultimate commercialization of intellectual property related to a potential new drug candidate, research and development, marketing (including promotional activities and physician detailing), general and administrative activities and manufacturing and distribution activities. Common examples include:

- Co-development and co-marketing arrangements — Joint operating agreements in which both parties to the agreement assume roles and responsibilities
- Co-promotion arrangements — Agreements in which companies partner together and use each company’s commercial capabilities and experience to promote a product (owned by one of the parties) in various markets

These arrangements are most common in the biotech and pharmaceutical sectors but also may include hospitals.

In November 2017, FASB added a project to its agenda to make targeted improvements to the guidance in Topic 808, Collaborative Arrangements, to clarify when transactions between participants in a collaborative arrangement are within the revenue guidance’s scope. FASB has hosted several workshops and plans to issue an exposure draft in the second quarter of 2018; a final standard is expected by year-end.

Transactions among partners in collaboration arrangements within the scope of ASC 808 are out of scope of ASC 606. ASC 808 notes that when payments between parties in a collaboration are not within the scope of other authoritative guidance, an entity would determine income statement classification based on analogy to other authoritative accounting literature. Lacking an appropriate analogy, an entity may make an accounting policy election for a reasonable, rational and consistently applied classification. Therefore, an entity could apply the revenue recognition guidance by analogy to these types of arrangements, if that is the policy it has elected.

Charity Care

ASU 2014-09 does not change the accounting or disclosure for charity care. Charity care represents the cost of health care services for which the entity never expects to receive payment and is excluded from patient service revenue and receivables in the financial statements. Disclosure is required for management’s policy regarding charity care and the level of charity care provided. Any funds received to offset or subsidize charity services should be separately disclosed.

Portfolio Approach

FASB recognized the challenges of applying the new revenue rules on a contract-by-contract basis and provided a practical expedient for entities with a large volume of similar contracts or with similar customer classes. Health care entities can apply the practical expedient if the portfolio has similar characteristics and the entity reasonably expects that the effects will not differ materially from applying the guidance to individual contracts. Because this is a practical expedient and not a requirement, an entity can choose to apply it to certain classes of patients and use on an individual contract basis for others. The expedient is available for all aspects of the model or only to certain steps, e.g., the collectibility threshold or the evaluation of implicit price concessions (both of these concepts are new and discussed further below). Large organizations can adopt a portfolio approach on a systemwide or entity basis.

In establishing portfolios, a health care entity will need to use judgment to determine the size, composition and number of portfolios. Each organization is unique, and portfolios will depend on the customer base and
Accounting system capabilities. Entities should consider the experience with and homogeneity of the portfolio to ensure the data is useful to predict an expected outcome. Entities should have documentation to support judgments and assumptions in determining portfolios. Portfolio groupings may include:

- Type of service – inpatient, outpatient, skilled nursing, elective or emergency department
- Type of payor – insurance contract, governmental or uninsured self-pay
- Type of patient responsibility – uninsured self-pay, deductible/copay or size of deductible or copay
- Contracts entered into at or near the same time
- Geography of service locations or networks
- Patient demographics – age cohort or health condition (for CCRCs)

To ensure a portfolio’s homogeneity, an entity may need multiple subcategories within the above examples. For self-pay patients, a health care entity might begin the evaluation process by identifying categories, e.g., type of service and type of patient responsibility, and then may consider more detailed subcategories to define its portfolios. Health care entities will need to determine whether self-pay patients constitute a single customer class that share similar characteristics. For example, health care entities will need to consider whether they should distinguish between self-pay patients with insurance, i.e., deductibles and copayments, and self-pay patients without insurance. This distinction will become more important as patient deductibles and copayments increase.

**Disaggregating self-pay accounts receivable into multiple subcategories may be a significant change for some health care entities. Corresponding changes to systems, processes and methodologies may be required to accurately estimate the transaction price.**

**Assessment**

The standard does not mandate a specific approach in assessing materiality if using the portfolio approach will produce a different outcome than applying the guidance on an individual contract basis. An entity must demonstrate—in a reasonable manner, using some form of objective and identifiable information—why it expects the two approaches will not differ materially. This can include, but is not limited to, performing data analytics using information related to the portfolio, a sensitivity analysis to determine a range of potential differences between the two approaches or a qualitative assessment of disaggregating and aggregating the portfolio.

**Portfolio Changes**

Regular monitoring of portfolios is required. An entity should remove contracts from a portfolio when they no longer have similar characteristics with other contracts in the portfolio. A health care entity should review changes in collection patterns/reimbursement rates of different classes of patients, implementation of state insurance exchanges and changes to Medicaid and other state or local plans.

It may take several weeks after a patient’s treatment to determine the contract’s payor, e.g., Medicaid, charity care or uninsured. The 2017 American Institute of CPAs (AICPA) guide, *Revenue Recognition*, notes that health care entities may initially classify a patient as pending Medicaid and subsequently reclassify the patient to Medicaid, self-pay or charity care once eligibility has occurred.
Step 1 – Identify the Contract with a Customer

In the retail industry, the customer is easily identifiable. The health care industry is unique due to the involvement of multiple parties. In addition to the patient and health care provider, often a third party—an insurer, managed care company or government program—will pay for some or all of the patient’s services. The Task Force concluded that the “contract with the customer” refers to the arrangement between the health care provider and patient. A separate contractual arrangement exists between health care providers and third-party payors that establishes payment amounts on behalf of a patient for covered services rendered. These separate contractual agreements are not considered “contracts with customers” but must be considered in determining the transaction price in Step 3.

The new revenue standard defines a contract as “an agreement between two or more parties that creates enforceable rights and obligations.” Accounting for contracts with customers under the new model begins only when all the following criteria are met:

For patient arrangements that do not meet one or more of the contract criteria, a health care entity should continually reassess the arrangement as facts and circumstances change. For partial payments received when the contract criteria are not met, revenue recognition only is allowable when the consideration received is nonrefundable and one of the following has occurred:

- The entity has no remaining performance obligation and all consideration promised by the customer has been received
- The contract is terminated – this is a legal matter and may require involvement of legal counsel
- The entity has transferred control of the goods or services to which the consideration that has been received relates; the entity has stopped transferring goods and services to the customer and has no obligation under the contract to transfer additional goods or services

Entities should recognize a liability for any customer consideration received until the contract criteria are met and revenue can be recognized.
Contract Approval

The first criterion is met when the contract’s parties have approved the contract—in writing, orally or in accordance with other customary business practices—and are committed to perform their respective obligations. The AICPA revenue guide notes a patient contract exists when the patient signs a patient responsibility form (a written contract) or schedules services in advance (an oral or implied contract). If a patient does not sign a patient responsibility or treatment consent form or schedule services in advance, an entity should consider all the facts and circumstances to determine contract existence. Typically, customary business practices in the health care industry will be sufficient to conclude on contract approval by the patient, e.g., by seeking medical services, the patient implicitly acknowledges his or her responsibility to pay for those services. There are some cases where this determination may be questionable, such as a patient’s admittance to the emergency room while unconscious or unstable—a subsequent acknowledgment of a patient’s responsibility may only result in delayed recognition of revenue.

Identifiable Rights, Obligations & Payment Terms

This step is straightforward for the health care industry. In most cases, it is clear the entity will provide health care services to the patient in exchange for consideration from the patient and/or a third-party payor on the patient’s behalf. In general, payment terms are clearly identifiable upon patient admission and signing the patient responsibility or treatment consent form. Any deviations from standard payment terms, such as extended payment plans, should have terms documented in writing.

Commercial Substance

With the exception of charity care where the entity does not intend to pursue collection of any consideration for the account, all patient accounts will have commercial substance as the entity expects to send bills and pursue collection of some amount of consideration for services provided.

Collectibility

Under the new revenue model, the evaluation of collectibility is now a threshold for determining contract existence. For health care entities, the standard accelerates the assessment’s timing in the revenue cycle—current practice is to assess collectibility during the evaluation of accounts receivable and overall reserve establishment. The new rules also will change the presentation of bad debt expense.

Collectibility is an explicit threshold for determining contract existence before applying the revenue recognition model. A health care organization must evaluate customer credit risk and conclude it is “probable” that it will collect the consideration due in exchange for the services promised to the customer. Entities should evaluate both the customer’s ability and intent to pay as amounts become due.

The collectibility assessment relates to the amount of consideration to which an entity expects to be entitled, i.e., the transaction price, not the stated contract price. For example, for Medicare beneficiaries, the consideration includes both amounts due from Medicare and deductibles and copays from patients. The transaction price may be less than the contract price because an entity intends to offer a price concession. Therefore, before determining if a customer contract exists, an entity will first need to estimate the transaction price so the appropriate values can be assessed for collectibility (see Step 3).

Entities may need to gather and track additional data to make this assessment. Simple aging schedules to calculate an allowance for doubtful accounts may no longer be adequate. See Appendix D for extensive work by Community Health Systems in this area.
Pending Medicaid Considerations

The 2017 AICPA guide, Revenue Recognition, notes that a health care entity may use historical information for pending Medicaid patients to conclude that a contract exists, either on an individual or a portfolio basis. The health care entity may have historical information to determine the percentage of contracts it estimates will qualify for Medicaid or charity care or become uninsured self-pay. A health care entity can use the historical data to estimate if a patient or other payor is committed to perform his or her obligation and if it is probable the entity will collect the consideration to which it is entitled.

Example – ASU 2014-09

A hospital provides medical services to an uninsured patient in the emergency room. The hospital has never previously provided services to the patient. Because of the patient’s condition upon arrival at the hospital, immediate care is provided before the hospital can determine whether the patient is committed to perform his or her obligations under the contract in exchange for medical services provided. At this point the contract does not meet all the criteria for recognition.

The hospital obtains additional information about the patient, including a review of the services provided, standard rates and the patient’s ability and intention to pay the hospital for the medical services. The standard rate for the emergency procedures is $10,000. The hospital determines the services are not charity care based on the hospital’s policy and the patient’s income level. The patient does not qualify for any governmental subsidies. The hospital expects to accept a lower amount of consideration for the care provided. The hospital reviews its historical cash collections from this customer class and other relevant information and concludes it expects to be entitled to $1,000.

Example – TRG Issue Paper #13

An entity has a large volume of homogenous contracts with billing done monthly in arrears. Before accepting a customer, the entity performs procedures designed to ensure that it is probable the customer will pay the amounts owed. If these procedures result in the entity concluding it is not probable the customer will pay the amounts owed, the entity does not accept him or her as a customer. Because these procedures only are designed to determine whether collection is probable (and thus not a certainty), the entity anticipates some customers will not pay all amounts owed. While the entity collects the entire amount due from most customers on average, the entity’s historical evidence indicates collection of only 98 percent of the amounts billed.

TRG members discussed two possible outcomes. One view is that the entity should recognize revenue of $100 and bad debt expense of $2, while the other view is that the entity should recognize revenue of $98 (that is, zero bad debt expense).

TRG members concluded only the first outcome is consistent with ASC 606’s principals. Because the entity concluded that, due to customer acceptance procedures, it is probable the customers will pay the amounts owed, the contracts meet the collectibility threshold in Step 1. When the entity satisfies the contract’s performance obligations, it would recognize revenue of $100 and a corresponding receivable representing its unconditional right to consideration. The entity would then evaluate the receivable for impairment. The new revenue standard does not change the accounting for receivables in Topic 310. Upon initial recognition of a receivable from a customer contract, any difference between the measurement of the receivable and the corresponding revenue previously recognized shall be presented as an expense.
Step 2 – Identify Separate Performance Obligations

As soon as a health care entity has identified its contracts, it should identify the separate performance obligations within those contracts. A performance obligation is a promise to transfer goods or services to a customer and can be identified explicitly in a contract or implied by customary business practices, published policies or specific statements.

For a promised good or service to be distinct and a separate performance obligation, both of the following criteria must be met:

- Capable of being distinct because the customer can benefit from the good or service on its own or with other readily available resources
- Distinct within the context of the contract – the good or service to the customer is separately identifiable from other promises in the contract. The following indicators would be used to evaluate if a good or service is distinct within the context of the contract:
  - Significant integration services are not provided
  - The customer was able to purchase—or not purchase—the good or service without significantly affecting other promised goods or services in the contract
  - The good or service does not significantly modify or customize another good or service promised in the contract

In general, most health care contracts have a single performance obligation, i.e., a bundle of health care services to treat the patient’s diagnosis. While a patient may receive benefit from individual services provided during the continuum of care, those services generally are integrated and represent inputs into a bundle of services that represents the combined output for which the patient has contracted.

Frequently, hospitals may perform certain additional care coordination activities or case management services not spelled out in a contract that may include:

- Providing notification to the patient that the patient is a participant in a bundled payment arrangement
- Providing coordination of the post-acute care plan
- Calling the patient to ensure the patient is taking prescribed medications

The Task Force believes that, in general, these types of care coordination activities do not transfer an additional good or service to the patient, are administrative in nature and would not be considered separate performance obligations. However, hospitals should consider if there are implied promises to the patient to provide post-acute transitional services or coordination of care with other post-acute providers. These implied promises could be considered performance obligations if the promises are considered distinct. Based on each hospital’s facts and circumstances regarding arrangements in place, a hospital should evaluate if care coordination activities should be considered separate performance obligations in its customer contracts.

In some instances, such as inpatient stay, all of the goods or services performed are interrelated and bundled specifically to meet the patient’s needs. Other instances, such as goods or services performed on an outpatient basis, may not be interrelated. In addition, some goods or services provided on an outpatient basis are regularly sold and patients can benefit from an individual good or service provided. The standard provides a basic example noted below. The Task Force’s exposure draft provides more subtle examples.
Stand-Ready Obligations

The new standard notes that a contract may include “a service of standing ready to provide goods or services or of making goods or services available for a customer to use as and when the customer decides.” TRG members generally agreed that the promise in a stand-ready obligation is the assurance the customer will have access to the good or service, not the delivery of the underlying good or service. This conclusion determines the pattern of revenue recognition in Step 5. The Task Force concluded that for CCRC Type A contracts, the promised good or service is a stand-ready obligation to prove a service such that the resident can continue to live in the CCRC and access the appropriate level of care. CCRCs should assess other goods or services offered separately that are not included in the monthly fees to determine if any additional performance obligations exist.

Material Rights

A contract may contain an option to acquire additional goods or services. A separate performance obligation could exist if the option provides a material right to the customer that it would not receive without entering into that contract. Material right obligations must be separately valued to allocate part of the transaction price to those specific performance obligations. This conclusion affects the number of performance obligations identified and the pattern of revenue recognition in Step 5. This topic generated a large number of implementation questions, and TRG members generally agreed on the following:

- Entities should consider accumulating incentive programs, e.g., loyalty rewards, when determining whether an option represented a material right.
- The material right evaluation should consider both qualitative and quantitative factors.
- It would be reasonable for an entity to apply the guidance on contract modifications to the exercise of a material right. The exercise of a material right also may be treated as a continuation of the existing contract. The decision will require management’s judgment based on the facts and circumstances of each arrangement.
- Entities should assess a material right to determine if a significant financing component exists. If the customer can choose when to exercise the option, there likely is not a significant financing component.
The period over which a nonrefundable upfront fee will be recognized depends on whether the fee provides the customer with a material right to future contract renewals. If the entity concludes the upfront fee does not provide a material right, the fee would be recognized over the contract term.

Usage-based fees will require judgment.

The Task Force noted that, in general, the monthly fees paid by a new CCRC resident are comparable to monthly fees paid by existing customers. Therefore, the monthly renewal options included in the resident agreement for a Type A life care resident would not provide a material right to the resident in addition to the material right provided by the nonrefundable entrance fee.

### Step 3 – Determine the Transaction Price

The transaction price is the amount of consideration to which an entity expects to be entitled in exchange for transferring promised goods or services to a customer. To determine the transaction price, an entity would consider the terms of the contract, its customary business practices and the effects of the time value of money, noncash consideration and consideration payable to the customer. Consideration may include fixed amounts, variable amounts or both. Health care entities would include amounts to which the entity has right under the contract paid by any party—patient, insurance company and/or Medicare/Medicaid, including third-party settlement adjustments.

An entity should recognize a liability if some or all of the consideration received from a customer is expected to be refunded. For example, refundable CCRC advance fees should be recorded as a liability at the inception of the resident agreement and not included in the transaction price because the CCRC expects to refund these amounts when the resident agreement is terminated.

<table>
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<tr>
<th>Transaction Price</th>
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<tr>
<td><strong>Total amount of consideration to which an entity expects to be entitled</strong></td>
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<tr>
<td>Variable consideration</td>
</tr>
<tr>
<td>Constraining estimates of variable consideration</td>
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<tr>
<td>Significant financing</td>
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<tr>
<td>Noncash consideration</td>
</tr>
<tr>
<td>Consideration payable to a customer</td>
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### Variable Consideration & Constraining Estimates

Variable consideration is anything that causes the consideration to vary. For health care entities, this includes contractual allowances, discounts, concessions and contingent payments. Pricing also varies depending on the party financially responsible for payment—patient, private insurer, Medicare, etc.

Variable consideration can be explicitly stated (single service agreements or cash-pay schedules) or implicit from an entity’s customary business practices. For example:

- Not performing a credit assessment prior to providing services
- Continuing to provide services to a patient class, e.g., self-pay, when experience indicates collection is not probable
Revenue Recognition: A Comprehensive Review for Health Care Entities

A price concession can be implicit even if the health care organization continues to attempt to collect the full amount of charges. In some cases, it may be difficult to determine if an entity has implicitly offered a price concession or accepted the customer’s risk of default on the contractually agreed consideration. FASB declined to develop detailed guidance for differentiating between a price concession and impairment losses. Documentation will be required to support management’s judgment in making this determination.

An estimate, including some or all of the variable consideration, could be included in the transaction price if it is “probable” the amount would not result in a significant revenue reversal. The AICPA guide, Revenue Recognition, provides the following factors health care entities should consider when assessing the probability of a significant revenue reversal:

- Factors outside an entity’s control – a health care entity may consider the current economic conditions in its service area
- Long period of time before final amount determined
- Limited experience with contract type
- Wide range of historical price concessions
- An entity’s practice of offering price concessions or changing payment terms

Health care entities must estimate the transaction price using either the “expected value” or the “most likely amount” approach, depending on which is expected to most accurately predict the consideration to which the entity will be entitled:

- Expected value – the sum of probability-weighted amounts in a range of possible consideration amounts; an expected value may be an appropriate estimate of the amount of variable consideration if an entity has a large number of contracts with similar characteristics
- Most likely amount – the single most likely amount in a range of possible consideration amounts, i.e., the single most likely outcome of the contract; the most likely amount may be an appropriate estimate of the amount of variable consideration if the contract only has two possible outcomes, e.g., an entity achieves or doesn’t achieve a performance bonus

Under current guidance, a health care entity generally makes its “best estimate” of the revenue it will collect from third-party payors. While these estimates may not change under the new revenue standard, health care entities will have to review their processes to make sure they properly address the new guidance on estimating variable consideration and appropriately document their conclusions.

Changes in the Estimate of the Transaction Price

Each reporting period, management must reassess its transaction price estimates, including any constrained variable consideration. Factors that may change the transaction price estimate prior to payment include receipt of additional information about the insured patient’s deductible, copayment, coinsurance coverage or the patient’s personal financial situation, e.g., an uninsured patient qualifies for Medicaid or charity care.

For implicit price concessions, AICPA believes subsequent changes to the variable consideration estimate should generally be accounted for as adjustments to patient service revenue. Because the price concession assessment inherently considers the expected patient collections, AICPA believes changes in the entity’s expectation of the amount of customer payments will be recorded in revenue—unless there is a patient-specific event, e.g., a bankruptcy filing, that suggests the patient no longer has the ability and intent to pay the amount due and, therefore, the changes in estimate better represent an impairment (bad debt).

Entities with frequent subsequent adjustments should reassess the appropriateness of their estimation process, including the constraint.
Entities should not wait for subsequent cash collections before updating transaction price estimates.

Portfolio Expedient Versus Portfolio Data

Health care entities should consider all information—historical, current and forecast—that is reasonably available to estimate variable consideration when determining the transaction price regardless of whether ASC 606 is applied on a portfolio or individual contract basis. Entities commonly use a portfolio of data to develop estimates to account for customer contracts, most frequently historical cash collections and reimbursement rates. TRG members clarified the use of portfolio data is not the same as applying the portfolio practical expedient. An entity is not required to apply the portfolio practical expedient when considering evidence from other similar contracts to develop an estimate of variable consideration. An entity could choose to apply the portfolio practical expedient, but it is not required to do so.

Example – Implicit Price Concession (ASU 2014-09)

A hospital provides medical services to an uninsured patient in the emergency room. The entity has not previously provided medical services to this patient but is legally required to provide medical services to all emergency room patients. Because of the patient’s condition upon arrival at the hospital, the entity provides the services immediately and, therefore, before the entity can determine whether the patient is committed to perform its obligations under the contract in exchange for the medical services provided. Consequently, the contract does not meet all the criteria for a contract, and the entity will continue to assess its conclusion based on updated facts and circumstances.

After providing services, the hospital obtains additional patient information, including a review of the services provided, standard rates for such services and the patient’s ability and intention to pay the entity for the services provided. During the review, the hospital notes its standard rate for the services provided in the emergency room is $10,000. The hospital also reviews the patient’s information and, to be consistent with its policies, designates the patient to a customer class based on the entity’s assessment of the patient’s ability and intention to pay. The entity determines the services provided are not charity care based on the entity’s internal policy and the patient’s income level. In addition, the patient does not qualify for governmental subsidies.

Before reassessing the contract criteria, the entity considers the variable consideration guidance. Although the standard service rate is $10,000, the hospital expects to accept a lower amount. The entity concludes the transaction price is not $10,000, but rather, the promised consideration is variable. The entity reviews its historical cash collections from this customer class and other relevant patient information. The entity estimates the variable consideration and determines that it expects to be entitled to $1,000.

The entity evaluates the patient’s ability and intent to pay. Based on its collection history from patients in this customer class, the hospital concludes it is probable the entity will collect $1,000 (the estimate of variable consideration). In addition, based on the contract terms and other facts and circumstances, the entity concludes the other contract criteria also are met. Consequently, the entity accounts for the contract with the patient in accordance with ASC 606.
Significant Financing Component

Contract terms may provide explicit or implicit favorable financing terms to an entity or its customer. An entity is required to adjust the transaction price to reflect the time value of money if the financing component is significant. The transaction price should reflect a selling price as though the customer had paid cash at the time of transfer. To determine if a contract contains a significant financing component, an entity would consider:

- Whether the consideration would differ substantially if the customer paid cash promptly under typical credit terms
- Expected length of time between delivery of goods or services and receipt of payment
- The interest rate in the contract and prevailing market interest rates

TRG discussions clarified that an entity only should consider the significance of a financing component at a contract level rather than consider whether the financing is material at a portfolio level. As a practical expedient, an entity would not reflect the time value of money if the period between customer payment and transfer of goods or services is one year or less. Disclosure is required if this expedient is elected.

The Task Force concluded a significant financing component likely does not exist for third-party settlements because the timing of the payment is at the discretion of the third-party payor and does not involve the patient.

A significant financing component is most likely to exist in CCRC contracts. As noted above, a CCRC’s refundable entrance fees are not part of the transaction price and, therefore, no financing analysis is required. If the CCRC’s nonrefundable entrance fee arrangement contains a financing component, a CCRC should apply judgment to determine whether the financing component is significant. This assessment will be based upon individual facts and circumstances for each entity. If an entity concludes the financing component is not significant, the entity does not need to adjust the transaction price. If a CCRC determines a significant financing component exists and adjusts the transaction price, the entity would continue to use the same assumed discount rate at contract inception unless there is a contract modification.

Step 4 – Allocate Transaction Price to Separate Performance Obligations

As discussed in Step 2, health care entities generally have a single performance obligation. However, if a contract includes separate performance obligations, an entity would allocate the transaction price to performance obligations based on the relative standalone selling price of separate performance obligations. The best evidence of standalone selling price would be the observable price for which the entity sells goods or services separately. If an entity does not have separately observable sales, it should estimate the standalone selling price by using observable inputs and considering all information reasonably available to the entity. The objective would be to allocate the transaction price to each performance obligation in an amount that represents the consideration the entity expects to receive for its goods or services. Several approaches are available:

- Adjusted market assessment – An entity would evaluate the market and estimate the price customers would pay. Competitors’ price information might be used and adjusted for an entity’s cost and margins.
- Cost-plus margin – An entity would forecast its expected cost to provide goods or services and add an appropriate margin to the estimated selling price.
Residual value – An entity would subtract the sum of observable standalone selling prices for other goods and services promised in the contract from the total transaction price to find an estimated selling price for a performance obligation. The residual value approach would be appropriate only if the selling price is highly variable or uncertain, e.g., a new product.

Step 5 – Recognize Revenue When (or as) Performance Obligations Are Satisfied

An entity would recognize revenue when (or as) the entity satisfies a performance obligation by transferring a promised good or service to a customer. If the performance obligations are satisfied at a point in time, the associated revenue would be recognized at that point in time. Entities would recognize revenue for a performance obligation satisfied over time using a method that best depicts the transfer of goods or services. If an entity has a right to invoice a customer in an amount that directly corresponds with the value to the customer of the entity’s performance to date, the entity could recognize revenue equal to the amount the entity has a right to invoice, unless another measure better depicts the entity’s performance.

For hospitals and similar health care entities, if a good or service is distinct, the satisfaction of that performance obligation (and revenue recognition) generally occurs at a point in time for goods, e.g., retail, pharmacy, equipment, etc., and over time for services. Health care entities also could determine that bundled performance obligations in a patient encounter are satisfied over time (length of stay). In most situations, health care entities would recognize revenue over time in the same manner they do under existing U.S. generally accepted accounting principles (GAAP).

In general, the timing of revenue recognition will not change for most patient encounters as a result of point-in-time or over-time designation, since the transfer of goods or services generally occurs over a matter of hours or days. An entity’s conclusion on point in time versus over time will affect disclosure requirements.

Nonrefundable Upfront Fees

Certain contracts charge a nonrefundable upfront fee to customers, e.g., health club memberships. Such fees may cover costs incurred in setting up a contract or may represent a separate performance obligation. If the upfront fee is an advance payment for future goods or services, revenue would be recognized when those goods or services are delivered to the customer. If the fees are compensation for setup activities and do not transfer a
service to a customer, they are not a performance obligation. Management would need to evaluate if these costs have resulted in a capitalized asset.

CCRC Considerations

The Task Force concluded that a CCRC should recognize monthly fees as revenues when the services for the month are performed. More management judgment will be required to determine the pattern of recognition for nonrefundable entrance fees. The Task Force concluded that a nonrefundable entrance fee including a material right should be allocated to optional future periods covering a resident’s life expectancy. The standard is nonprescriptive. Health care entities can choose among various allocation methods to allocate the nonrefundable upfront fees to the material right:

- Time-based measure that results in an equal amount allocated to each month
- Cost-to-cost measure based on when the future estimated costs are transferred to a CCRC resident
- Allocate the transaction price to the option periods by reference to the goods or services expected to be provided and the corresponding expected monthly fee

TRG members generally agreed that the promise in a stand-ready obligation is the assurance the customer will have access to the good or service—not the delivery of the underlying good or service—and that an entity should not default to a straight-line revenue attribution model. A ratable recognition may not be appropriate if the benefits are not spread evenly over the contract period. However, if an entity expects the customer to receive and consume the benefits of its promise throughout the contract period, a time-based measure of progress, e.g., straight line, could be appropriate. This allocation will be a significant judgment requiring supporting documentation and disclosure in the financial statement notes. The AICPA’s working draft contains examples of the three approaches applied to a CCRC.

A CCRC may need to consider updating relevant assumptions at the end of each reporting period if the updates would have a material effect on the determination of revenue recognized during each reporting period, i.e., change in life expectancies. CCRCs should apply judgment to determine the appropriate accounting for a change in an assumption that could affect the amortization of the contract liability balance (the nonrefundable entrance fees). The Task Force believes an acceptable approach to account for changes in estimates is to apply the changes prospectively.

<table>
<thead>
<tr>
<th>CCRC Entrance Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current U.S. GAAP</strong></td>
</tr>
<tr>
<td><strong>Nonrefundable</strong> – Deferred revenue from advance fees should be amortized into income over future periods based on the estimated life of the resident or contract term, if shorter. Annual updates are required. Unamortized deferred revenue from nonrefundable advance fees should be recorded as revenue upon a resident’s death or contract termination.</td>
</tr>
<tr>
<td><strong>Refundable</strong> – The portion of the refundable advance fees that will be paid to current residents or their designees, only to the extent of the reoccupancy proceeds. Deferred revenue should be amortized into income over future periods based on the remaining useful life of the facility.</td>
</tr>
</tbody>
</table>

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Contract Costs

In conjunction with the new revenue model, FASB also amended ASC 340, *Other Assets and Deferred Costs*, superseding existing guidance in ASC 954-720 for contract acquisition cost related to prepaid health care services and continuing care contracts. The ASU contains criteria for determining when to capitalize costs associated with obtaining and fulfilling a contract. Health care entities are required to recognize an asset for the incremental costs of obtaining a contract, e.g., sales commissions or legal fees, when those costs are expected to be recovered. A practical expedient allows expense recognition if the amortization period is less than a year; if elected, this must be disclosed in the financial statement notes.

**Health care entities that issue one-year prepaid health contracts would be able to take advantage of the practical expedient and could continue to expense contract acquisition costs. This expedient generally would not be available for CCRC entrance fees because the contract is for the resident’s life expectancy, which is generally greater than one year.**

The costs of fulfilling a contract that are not covered by other standards, e.g., inventory, property, plant and equipment or capitalized software, only would be capitalized when they meet all the following criteria:

- Directly relate to a contract
- Generate or enhance resources that will be used to satisfy performance obligations
- Are expected to be recovered

In assessing recoverability, a health care entity should consider the contract’s pricing and the recoverability of the incremental costs through direct reimbursement or the contract’s inherent margin.

Sales commissions directly related to sales achieved during a time period typically represent incremental costs that would require capitalization. In general, costs incurred regardless of whether a contract is signed should be expensed unless they are explicitly chargeable to the customer, regardless of whether the contract is obtained. The Task Force notes that some bonuses and other compensation based on other quantitative or qualitative metrics (profitability or performance evaluations) typically do not meet the criteria for capitalization because they are not directly related to contract acquisition.

An entity would amortize capitalized costs in a manner consistent with the pattern of transfer of the goods or services to which the asset is related. The amortization period also should take into consideration any expected contract renewals. Impairment of any recorded asset also will be subject to an ongoing assessment.

Health care entities may be required to capitalize qualifying costs and will need to use judgment in determining:

- Which acquisition costs are incremental, e.g., complex commission structures
- The amortization period
- Monitoring capitalized costs for impairment
Revenue Recognition: A Comprehensive Review for Health Care Entities

### Contract Acquisition Costs

<table>
<thead>
<tr>
<th>Current U.S. GAAP – ASC 894-720</th>
<th>New Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>The costs of acquiring a continuing care contract after a continuing care retirement community is substantially occupied or one year following completion shall be expensed when incurred</td>
<td>An entity shall recognize as an asset the incremental costs of obtaining a contract with a customer if the entity expects to recover those costs</td>
</tr>
<tr>
<td>Although there is theoretical support for deferring certain acquisition costs, the acquisition cost of providers of prepaid health care services other than the costs of advertising shall be expensed as incurred</td>
<td></td>
</tr>
</tbody>
</table>

### Onerous Contract

ASU 2014-09 does not include specific guidance on accounting for onerous revenue contracts or other contract losses. Instead, FASB carried forward existing industry and contract-specific guidance, as noted in the table below. A health care entity not covered by onerous guidance generally is precluded from accruing contract losses.

CCRCs would continue to recognize a liability if the advance fees and periodic fees charged are insufficient to meet the costs of providing future services and the use of facilities based on actuarial assumptions, e.g., mortality and morbidity rates, estimates of future costs and revenues and the specific CCRC’s historical experience and statistical data.

For prepaid health care services, contract losses will continue to be recognized when it is probable that expected future health costs will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts.

### Onerous Contract Guidance

<table>
<thead>
<tr>
<th>Reference</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC 605-20, Revenue Recognition—Services</td>
<td>Separately priced extended warranty and product maintenance</td>
</tr>
<tr>
<td>ASC 605-35, Revenue Recognition—Construction-Type and Production-Type Contracts</td>
<td>Construction- and production-type contracts</td>
</tr>
<tr>
<td>ASC paragraph 954-450-30-3 to ASC paragraph 954-450-30-4</td>
<td>Prepaid health care services</td>
</tr>
<tr>
<td>ASC paragraph 954-440-35-1 to ASC paragraph 954-440-35-3</td>
<td>CCRC contracts</td>
</tr>
<tr>
<td>ASC paragraph 912-20-45-5</td>
<td>Certain federal government contracts</td>
</tr>
</tbody>
</table>

### Presentation

For health care entities, the most noticeable change will be income statement presentation. The provision for doubtful accounts will no longer be separately reported as a reduction from revenue, and patient service revenue will be presented in a single line on the income statement at the total amount expected to be collected. If an entity evaluates collectibility prior to providing health care services, then bad debt expense, if any, will be reported as an operating expense. Entities will have to be able to separately track and report bad debt expense from implicit price concessions. Patient service revenue will include estimated price concessions as well as updates to collection estimates. Only changes in a patient’s specific facts and circumstances will result in bad debt expense.
Although the aggregate amount of receivables may include balances due from patients and third-party payors (including final settlements and appeals), the amount due from third-party payors for retroactive adjustments of items such as final settlements or appeals shall be separately reported in the financial statements.

Disclosures

BKD has prepared a separate white paper on the new required disclosures that is applicable for all industries, “Revenue Recognition: New Disclosures.” FASB provided significant relief to entities that do not meet the definition of a public entity (see Appendix C for a summary of requirements for public and nonpublic entities). The Task Force will incorporate its finalized conclusions on disclosure requirements into a future edition of the AICPA guide, Revenue Recognition.

Companies that have early adopted the standard have found this area to be more challenging than initially anticipated. The standard provides significant relief for nonpublic entities and less focus on quantitative disclosures. FASB retained all current health care-specific disclosure requirements regarding patient service revenue and receivables. Health care entities should ensure they have systems, internal controls and procedures in place to accumulate the information required to satisfy these new presentation and disclosure requirements. The objective of the disclosure requirements is to enable financial statement users to understand the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers.

Health care entities may voluntarily disclose implicit price concessions in addition to charity care in order to disclose all uncompensated care.
Disaggregation

When determining how to disaggregate revenue for disclosure purposes, an entity should consider how investors, regulators and lenders use the information to evaluate the entity’s financial performance. **Public entities** must disaggregate revenue in meaningful categories. Factors to consider in disaggregation include:

- Payors – Medicare, Medicaid, commercial insurance and self-pay
- Geography
- Market or type of customer – governmental and nongovernmental customers
- Contract type – percent of charges, cost, fixed and capitated
- Timing of transfer of goods or services – over time versus point in time
- Operating segments or service lines – hospital, nursing home

The ASU provides some relief to nonpublic entities on this requirement; at a minimum, revenue must be disaggregated according to the timing of transfer of goods or services (point-in-time versus over-time revenue recognition) and should include qualitative information about how economic factors affect the nature, timing and uncertainty of revenue and cash flows.

Contract Balances

Health care entities must report contract assets separately from patient accounts receivable on the balance sheet. A contract asset is an unbilled amount for patient services, while a receivable is a billed but not collected payment for services rendered. The Task Force noted “for a health care entity, patient accounts receivable, including billed accounts and unbilled accounts for which the 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.” The amounts due from third-party payors for retroactive adjustments, *e.g.*, final settlements or appeals, also should be reported separately in the financial statements.

Under Topic 606, reclassification from a contract asset to a receivable is contingent on fulfilling performance obligations—not on invoicing a client. As a result, the point at which a contract asset is reclassified as a receivable may be different than the time of invoicing.

A contract liability is generated when the patient performs its obligation under the contract (prepayment) before the health care entity completes all its obligations. A contract liability does not include amounts that are expected to be refunded. CCRCs will need to disclose details regarding nonrefundable advance fees and how they are recognized. A CCRC also will need to disclose whether there is a financing component included in its payment arrangements and how it is estimated.

All health care entities must present opening and closing balances of receivables, contract assets and liabilities on the balance sheet or in the notes to the financial statements. FASB again provides significant relief for nonpublic entities. Only public entities are required to explain significant changes in the contract asset and liability balances during the reporting period. Public health care entities will need to disclose reductions in a contract liability balance for services provided during the reporting period, *i.e.*, CCRCs’ nonrefundable advance fees. The explanation will be required to include both qualitative and quantitative information. Public entities must disclose how the timing of satisfaction of its performance obligations relates to the typical timing of payment and the effect those factors have on the contract asset and liability balances. An entity can use qualitative information.

Entities can use different descriptions of contract assets, contract liabilities and receivables and could use additional line items to present those assets and liabilities if the entity also provides sufficient information for financial statement users to distinguish them.
Performance Obligations

All entities must disclose how performance obligations are satisfied, i.e., at a point in time or over time, significant payment terms, if the consideration is variable and if the estimate of variable consideration is constrained. All entities must describe the nature of goods or services provided, highlighting if an entity is acting as an agent.

Transaction Price Allocated to the Remaining Performance Obligations

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 multivisit procedures, entities that offer prepaid services and those with bundled payments. The following disclosures are required for public entities:

- The aggregate amount of the transaction price allocated to the unsatisfied performance obligations at the end of the reporting period
- An explanation of when the entity expects to recognize such revenue in either of the following ways:
  - Quantitatively using time bands based on the duration of the remaining performance obligations
  - Qualitatively

FASB provided two practical expedients from the above requirement:

- Disclosure is not required for remaining performance obligations if either of the following conditions is met:
  - The contract has an original expected duration of one year or less
  - The entity recognizes revenue in an amount that directly corresponds with the value of the performance completed to date, e.g., an entity bills a fixed amount for each hour of service provided
- Disclosure is not required for variable consideration within unsatisfied performance obligations if either condition is met:
  - The variable consideration is a sales- or usage-based royalty promised in exchange for a license of intellectual property
  - The variable consideration fully allocated to a wholly unsatisfied performance obligation or wholly unsatisfied promise to transfer a distinct good or service that forms part of a single performance obligation under the series provision

If an entity elects either of these practical expedients, it must disclose what exemptions it is applying, the nature of the performance obligations, remaining duration and a description of the excluded variable consideration. An entity shall explain whether any consideration is not included in the transaction price and, therefore, not included in the information disclosed, e.g., an estimate of the transaction price would not include any estimated amounts of constrained variable consideration.

Significant Judgments

All entities are required to disclose judgments and changes in judgments that significantly affect the amount and timing of revenue from customer contracts. This includes the timing of satisfaction of performance obligations and the transaction price and amounts allocated to performance obligations. All entities also must disclose the methods, inputs and assumptions made in assessing whether an estimate of variable consideration is constrained. Only public entities additionally must disclose the methods, inputs and assumptions for determining the transaction price, including estimating variable consideration, adjusting for significant financing and measuring noncash consideration and allocating the transaction price to goods and services.

For health care entities, this will include how the entity determines price concessions for uninsured self-pay patients and insured patients with copayments and deductibles, and any constraints on revenue. An entity will disclose whether estimates of transaction price are based on historical experience. 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.

An entity should disclose how it estimates retroactive settlements with third-party payors and whether those amounts are constrained. If an entity determined the revenue estimated in a previous period has changed, it will need to disclose the effect on revenue in the current period. Entities should disclose credit balances that represent refunds owed to patients and third-party payors.

For performance obligations satisfied over time, all entities should disclose the methods used to recognize revenue. 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. For public entities only, an explanation of why the methods used provide an accurate depiction of the transfer of goods or services.

For performance obligations satisfied at a point in time, public entities should disclose the significant judgments made in evaluating when a customer obtains control of the promised goods or services.

**Capitalized Contract Costs**

If a public entity capitalized costs to obtain or fulfill a contract, e.g., a CCRC, it will be required to make the following disclosures:

- Description of the judgments made in determining the amount of the costs incurred to obtain or fulfill a contract
- Description of the method to determine the amortization for each reporting period
- The closing balances of assets recognized from the costs incurred by main category of asset, e.g., costs to obtain contracts, precontract costs and setup costs
- The amount of amortization and any impairment losses recognized in the reporting period

**SEC Requirements**

The SEC currently requires a public company that retrospectively adopts an accounting standard to provide five years of comparable data based on the new accounting policies. SEC staff will not object if companies that adopt on a full retrospective basis do not restate the earliest two years in their five-year selected financial data disclosures. A company only will be required to reflect the accounting change in the summary for the three years for which it presents full financial statements elsewhere in the filing. If elected, clear disclosure about the lack of comparability would be required.

**Transition**

Entities must retrospectively apply the new revenue standard using either a full or modified retrospective approach. Each approach has relative benefits, costs and complexities. There is no “one size fits all” solution—it will depend on each entity’s specific facts and circumstances and which factors are most relevant. Some entities may consider comparability to peers or between reporting periods to be most relevant while others may prioritize the cost of implementation. In other cases, an entity may consider comparability most important but determine the retrospective method is not feasible because it cannot make the necessary system changes in the required time frame at a reasonable cost.
Full Retrospective

Under this approach, entities would apply the new guidance as if it had been in effect since the inception of all customer contracts. FASB provided several practical expedients:

- For completed contracts, an entity need not restate contracts that begin and end within the same annual reporting period.
- For completed contracts that have variable consideration, an entity may use the transaction price at the date the contract was completed rather than estimating variable consideration amounts in the comparative reporting periods.
- For all reporting periods presented before the date of initial application, an entity need not disclose the amount of the transaction price allocated to remaining performance obligations and an explanation of when the entity expects to recognize that amount as revenue.
- ASU 2016-12 added an additional expedient for contract modifications, eliminating the need to separately evaluate the effects of each contract modification when determining the transaction price upon initial adoption of the standard. An entity could elect to perform a single standalone selling price allocation (with the benefit of hindsight) to all of the contract’s satisfied and unsatisfied performance obligations.

Entities can elect any or all of these expedients and would disclose that fact as well as a qualitative assessment of the estimated effects. Entities must apply each expedient selected consistently to all contracts for all periods presented.

Modified Retrospective

Under this approach, the cumulative effect of initially applying this ASU is recognized in opening retained earnings on adoption date. ASU 2016-12 permits an entity to elect to apply the modified retrospective transition approach either to all contracts as of the adoption date or only to uncompleted contracts. Entities are required to disclose how they applied the modified retrospective method.

Comparative-year restatement is not required, but entities must disclose the following additional information in reporting periods that include the initial adoption date:

- For each financial statement line item, the amount affected in the current reporting period by the application of this ASU as compared to the guidance that was in effect before the change
- An explanation of the reasons for significant changes
Entities electing a modified retrospective approach only can use the practical expedient related to contract modifications.

As originally issued, the standard would have required an entity electing modified retrospective application to disclose the effect of the change on income from continuing operations, net income, any other affected financial statement line items and any affected per-share amounts for the current period and any prior periods retrospectively adjusted, substantially increasing transition costs. For companies applying the guidance using the modified retrospective application, ASU 2016-12 eliminates the requirement to disclose the effect of the accounting change for period of adoption. However, entities still would need to disclose the changes’ effect on any prior periods retrospectively adjusted.

Completed Contracts

ASU 2016-12 clarifies that for a contract to be considered completed at transition, all—or substantially all—of the revenue must have been recognized under legacy GAAP before the date of initial application. Accounting for contract elements that do not affect revenue under legacy GAAP would be irrelevant to the assessment of whether a contract is complete.

A health care entity that elects to apply the modified retrospective transition method only to contracts that are not completed as of the date of initial application should evaluate its contracts to determine if all or substantially all of the revenue was recognized under legacy GAAP, i.e., they are completed contracts, before the date of initial application.

For patient contracts where a third-party settlement has not been finalized for a specific cost report year as of the standard’s adoption date, the health care entity should compare the payor’s estimated settlement to the revenue recognized under legacy GAAP for patients subject to retroactive settlement to determine the amount of revenue recognized. If all or substantially all of the revenue has not been recognized, the patient contracts subject to retroactive settlement by that payor for the open cost report year would be considered open contracts and FASB ASC 606 will need to be applied to those contracts for purposes of determining the cumulative-effect adjustment at the date of initial application.

Management will need to carefully consider the cost and benefits of these two approaches, which will affect the start date and data requirements of implementation projects.

The adoption of this ASU will be complex and likely will require significant hours to implement correctly. BKD can help educate your team, provide implementation tools and assist with analysis and documentation. If you would like assistance complying with the new revenue recognition standard, contact your trusted BKD advisor. BKD has prepared a library of BKD Thoughtware® on revenue recognition issues. Visit our Hot Topics page to learn more.

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317.383.4000
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## Appendix A – Internal Controls

<table>
<thead>
<tr>
<th>Five-Step Model</th>
<th>Considerations for New or Amended Controls</th>
</tr>
</thead>
</table>
| **Step 1: Identify the Contract with the Customer** | • Identifying arrangements (whether written or unwritten) that meet the contract criteria  
• Reassessing arrangements not initially meeting the contract criteria as significant changes may occur in the underlying facts and circumstances  
• Assessing management’s and the customer’s commitment and ability to perform under the contract  
• Checking that payment terms are properly considered  
• Assessing the collectibility criterion  
• Evaluating contract modifications |
| **Step 2: Identify Performance Obligations** | • Identifying performance obligations, including those explicitly stated in the contract and those that may be implied based on customary business practices  
• Evaluating whether a promised good or service is distinct, particularly within the context of the contract  
• Evaluating whether a series of goods or services should be treated as a single performance obligation |
| **Step 3: Determine the Transaction Price** | • Estimating the amount to which the entity expects to be entitled, *i.e.*, the transaction price, including any variable consideration. When valuation consultants are hired, it’s normally expected that controls are in place to help ensure their competence and objectivity  
• Evaluating whether any portion of variable consideration should be constrained  
• Determining the fair value of noncash consideration  
• Identifying and measuring whether there’s a significant financing component in the contract  
• Determining the accounting for consideration payable to a customer |
| **Step 4: Allocate the Transaction Price** | • Estimating the standalone selling price, including the increasing of observable inputs in that process  
• Determining the appropriate transaction price allocation, including variable consideration and discounts |
| **Step 5: Satisfaction of Performance Obligations** | • Determining whether performance obligations are satisfied at a point in time or over time  
• Measuring progress toward complete satisfaction of a performance obligation that’s satisfied over time, *i.e.*, the input and output methods  
• Recognizing revenue only when (or as) control is transferred to the customer |
## Appendix B – AICPA’s Health Care Revenue Recognition Task Force Issues

### Health Care Entities Revenue Recognition Task Force – Issues List (as of March 26, 2018)

<table>
<thead>
<tr>
<th>Issue #</th>
<th>Description of Implementation Issue</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determining If an Enforceable Contract Exists</td>
<td>2017 AICPA Guide Revenue Recognition</td>
</tr>
<tr>
<td>1A</td>
<td>Implicit Price Concessions</td>
<td>2017 AICPA Guide Revenue Recognition</td>
</tr>
<tr>
<td>2</td>
<td>Application of the Portfolio Approach</td>
<td>2017 AICPA Guide Revenue Recognition</td>
</tr>
<tr>
<td>3</td>
<td>CCRC: Identifying and satisfying the performance obligation(s) and recognizing the monthly/periodic fees and nonrefundable entrance fees under Type A or “life care” contracts</td>
<td>Out for exposure until April 2, 2018</td>
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<tr>
<td>4</td>
<td>CCRC: Identifying and recognizing the performance obligation(s) to provide future services and use of facilities</td>
<td>Out for exposure until April 2, 2018</td>
</tr>
<tr>
<td>5</td>
<td>Significant Financing Component – CCRC contracts and patient and third-party payor amounts in arrears</td>
<td>Out for exposure until April 2, 2018</td>
</tr>
<tr>
<td>6</td>
<td>Disclosure Requirements</td>
<td>Finalized – a future edition of the AICPA Guide Revenue Recognition</td>
</tr>
<tr>
<td>7</td>
<td>Accounting for Contract Costs</td>
<td>Out for exposure until April 2, 2018</td>
</tr>
<tr>
<td>8</td>
<td>Third-Party Settlement Estimates</td>
<td>Out for exposure until September 1, 2017</td>
</tr>
<tr>
<td>9</td>
<td>Bundled Payments</td>
<td>Out for exposure until December 1, 2017</td>
</tr>
<tr>
<td>10</td>
<td>Performance Obligations (Other Than CCRCs)</td>
<td>Out for exposure until February 1, 2018</td>
</tr>
</tbody>
</table>
Appendix C – Disclosure Requirements

<table>
<thead>
<tr>
<th>Description</th>
<th>Public¹ Entities</th>
<th>All Other Entities</th>
<th>Annual</th>
<th>Interim (Public¹ Entities Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contracts with Customers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue recognized from contracts with customers, separate from other sources of revenue</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Any impairment loss on any receivable or contract assets arising from a contract with a customer, separate from impairment losses on other contracts</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation of Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>An entity shall disclose sufficient information to enable the users of financial statements to understand the relationship between the disclosures of disaggregated revenue and revenue information that is disclosed for each reportable segment, if the entity applies Topic 280</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Disaggregation Practical Expedient for Private Companies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonpublic entities electing not to disclose the quantitative disaggregation information above shall disclose, at a minimum, revenue disaggregated according to the timing of transfer of goods or services and qualitative information about how economic factors affect the nature, amount, timing and uncertainty of revenue and cash flows</td>
<td>N/A</td>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td><strong>Contract Balances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening and closing balances of receivables, contract assets and liabilities from contracts with customers, if not otherwise separately presented or disclosed</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Revenue recognized in the reporting period that was included in the contract liability balance at the beginning of the period</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
**Revenue Recognition: A Comprehensive Review for Health Care Entities**

### Contract Balances

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate transaction price allocated to unsatisfied or partially satisfied performance obligations at the end of the reporting period</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Explanation of how the timing of satisfaction of its performance obligations related to the typical timing of payment and the effect those factors have on the contract asset and liability balances; may use qualitative information</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Explanation of significant changes in the contract asset and liability balances during the reporting period</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

### Performance Obligations – Some Practical Expedients Available

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>When an entity typically satisfies its performance obligations</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Significant payment terms (when payment is typically due, existence of significant financing component, any variable consideration, any constraints on variable consideration)</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Nature of goods or services promised, highlighting if entity is acting as an agent</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Obligations for returns, refunds and other similar obligations</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Types of warranties and related obligations</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Revenue recognized in the reporting period from performance obligations satisfied (or partially satisfied) in previous periods</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>When an entity expects to recognize as revenue the amount disclosed immediately above on either a quantitative basis using the time bands that would be most appropriate for the duration of the remaining performance obligations or using qualitative information</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

---

2 An entity need not disclose this information for a performance obligation if either condition is met:
   a. The performance obligation is part of a contract with an original expected duration of one year or less.
   b. The entity recognizes revenue in the amount to which the entity has a right to invoice.

3 An entity need not disclose this information for variable consideration if either condition is met:
   a. The variable consideration is a sales-based or usage-based royalty promised in exchange for a license of intellectual property.
   b. The variable consideration is entirely allocated to a wholly unsatisfied performance obligation or wholly unsatisfied promise to transfer a distinct good or service that forms part of a single performance obligation under the series provision.
### If Practical Expedients Are Elected for Performance Obligations

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>An entity shall disclose what optional exemptions it is applying as well as the nature of the performance obligations, the remaining duration and a description of the excluded variable consideration. An entity shall explain whether any consideration is not included in the transaction price and, therefore, not included in the information disclosed, e.g., an estimate of the transaction price would not include any estimated amounts of constrained variable consideration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An entity shall disclose if a practical expedient is elected for either the existence of a significant financing component or the incremental costs of obtaining a contract</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

### Significant Judgments

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgments and changes in judgments that significantly affect the amount and timing of revenue from customer contracts. This includes the timing of satisfaction of performance obligations and the transaction price and the amounts allocated to performance obligations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For performance obligations satisfied over time:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The method used to recognize revenue</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>• Explanation of why the methods used faithfully depict the transfer of goods or services</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>For performance obligations satisfied at a point in time, the significant judgments made in evaluating when a customer obtains control of the promised goods or services</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Methods, inputs and assumptions used for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determining the transaction price, including estimating variable consideration, adjusting the price consideration for the time value of money and measuring noncash consideration</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Assessing whether an estimate of variable consideration is constrained</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Allocating the transaction price, including estimating the standalone selling price of promised goods or services and allocating discounts and variable consideration to a specific part of a contract</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Measuring obligations for returns, refunds and similar obligations</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
### Assets Arising from Contract Costs – Practical Expedients Available

<table>
<thead>
<tr>
<th>Description</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgments made in determining the amount of cost incurred to obtain or fulfill a contract, and the method used to determine amortization for each reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closing balances of assets recognized from the cost incurred to obtain or fulfill a contract by main category of asset, e.g., cost to obtain a contract, precontract costs, setup costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of amortization and any impairment losses recognized in the reporting period</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### If Practical Expedients Are Elected for Contract Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>N/A</th>
<th>YES</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a nonpublic entity elects the practical expedient in the paragraph on the first two disclosures above, the entity shall disclose that fact</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HCA Healthcare, Inc. 2017 10-K

We believe the most significant impact of adopting the new standard will be to the presentation of our income statement where the provision for doubtful accounts will be recorded as a direct reduction to revenues and will not be presented as a separate line item. We expect to adopt the new standard using the full retrospective application, and we do not believe the adoption will have a significant impact on our recognition of net revenues or related disclosures for any period.

Community Health Systems, Inc. 2017 10-K

We adopted ASU 2014-09 on January 1, 2018 and during the fourth quarter of 2017 we completed our plan for adoption, including updating our revenue recognition policies, procedures and control framework and evaluating the resulting impact on our consolidated financial position, results of operations and cash flows. We have elected to apply the modified retrospective approach to adopting this ASU. The application of new processes and methodologies to evaluate updated collection data to determine the patient portfolios and estimate the implicit price concessions and constraints on revenue required by this new accounting standard resulted in new information that reflected a required reduction to the amount of net patient accounts receivable on our consolidated statement of financial position. As a result, we recorded a change in estimate through additional contractual allowances and allowance for doubtful accounts at December 31, 2017. We do not expect the adoption of this ASU on January 1, 2018 to have a material impact on our consolidated results of operations on a prospective basis.

Third-Party Reimbursement

By implementing new data extraction techniques and updated hindsight information on historical collection data, we are able to better estimate the net amount after contractual allowances owed by the third-party payor and what will be owed by the patient based on historical experience. Such updated information included portfolio-level data related to historical collection amounts on an individual hospital and patient level that previously had not been readily available. Using this information we created a new accounting process by which we can estimate contractual allowances on a per patient basis. In addition to this new accounting methodology, we also revised our methods of estimating contractual allowances to (1) expand the hindsight period over which we analyze payors’ historical paid claims data to estimate contractual allowances, (2) expand the basis for payor denied claims to refine the hindsight reserve for such denials, and (3) adjust the contractual allowances for certain categories of commercial payors using more precise historical experience based on recent patterns of account reimbursement. Based on these new accounting processes and methodologies, we recorded a change in estimate during the three months ended December 31, 2017 to increase contractual allowances by approximately $197 million.

Due to the complexities involved in these estimates, actual payments we receive could be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% at December 31, 2017 from our estimated reimbursement percentage, net loss for the year ended December 31, 2017 would have changed by approximately $73 million, and net accounts receivable at December 31, 2017 would have changed by $109 million. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. We account for adjustments to previous program reimbursement estimates as contractual allowance adjustments and report them in the periods that such adjustments become known. Contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net loss by an insignificant amount each of the years ended December 31, 2017, 2016, and 2015.
Allowance for Doubtful Accounts

Our historical accounting systems and processes to estimate net operating revenues from third-party payors did not have the ability to specifically identify the portion of an insured patient account that was due from the patient (e.g., deductibles and co-payments), and we did not have portfolio-level data related to historical collection amounts on an individual hospital or patient level. As part of the new accounting methodologies and processes developed in 2017 to implement the new accounting standard on revenue recognition, we changed our methodology for estimating those amounts that are recorded as part of the receivable with the primary insurance payor but will ultimately be due from the patient. While our historical estimation process for the allowance for doubtful accounts utilized historical write-off and collection information on a consolidated basis, the new processes and related data obtained from the hindsight analysis provided updated information on the ultimate collectability of all patient accounts for the amount at the date of service that will ultimately be due from the patient. Such information was evaluated at a portfolio level by payor and by hospital rather than on a consolidated basis. Based on these new accounting processes and methodologies, we recorded a change in estimate during the three months ended December 31, 2017 to increase the provision for bad debts and the allowance for doubtful accounts by approximately $394 million.

Tenet Healthcare Corporation 2017 10-K

We have completed our evaluation of the requirements of the new standard to insure that we have processes, systems and internal controls in place to collect the necessary information to implement the standard, which became effective for us on January 1, 2018, and we are drafting the new disclosures required post implementation. We used a modified retrospective method of application to adopt ASU 2014-09 on January 1, 2018. For our Hospital Operations and other and Ambulatory Care segments, we used a portfolio approach to apply the new model to classes of payers with similar characteristics and analyzed cash collection trends over an appropriate collection look-back period depending on the payer. Adoption of ASU 2014-09 will result in changes to our presentation for and disclosure of revenue related to uninsured or underinsured patients. Prior to the adoption of ASU 2014-09, a significant portion of our provision for doubtful accounts related to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance in our Hospital Operations and other segment. Under ASU 2014-09, the estimated uncollectible amounts due from these patients are generally considered a direct reduction to net operating revenues and, correspondingly, result in a material reduction in the amounts presented separately as provision for doubtful accounts. We also completed our assessment of the impact of the new standard on various reimbursement programs that represent variable consideration and concluded that accounting for these programs under the new standard is substantially consistent with our historical accounting practices. These include supplemental state Medicaid programs, disproportionate share payments and settlements with third party payers. The payment mechanisms for these types of programs vary by state. For our Conifer segment, the adoption of ASU 2014-09 will result in changes to our presentation and disclosure of customer contract assets and liabilities and the assessment of variable consideration under customer contracts. While the adoption of ASU 2014-09 will have a material effect on the presentation of net operating revenues in our Consolidated Statements of Operations and will impact certain disclosures, it will not materially impact our financial position, results of operations or cash flows. There was no cumulative effect of a change in accounting principle recorded related to the adoption of ASU 2014-09 on January 1, 2018.

Universal Health Services, Inc. 2017 10-K

We are currently in the process of assessing and analyzing the various sources of revenue and plan to use a portfolio approach as a practical expedient to account for patient contracts. We have a team in place to lead the implementation of the new standard, including the evaluation of our systems and internal controls to ensure adequacy of data and information needed for adoption, as well as assessing the potential impact of the new standard on various reimbursement programs in which our hospitals participate. The team, consisting of representatives across the organization is progressing towards the completion of their evaluation and began drafting required disclosures and updates to our policies and practices in the fourth quarter of 2017. We are planning to adopt the standard using the modified retrospective approach. We anticipate the most significant
change will be how the estimate for the allowance for doubtful accounts will be recognized under the new standards. Under the current standards, our estimate for amounts not expected to be collected based upon our historical experience have been included within net revenue. Under the new standards, our estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue. However, subsequent changes in estimate of collectability due to a change in the financial status of a payor, for example a bankruptcy, will be recognized as bad debt expense in operating charges. Although we continue to evaluate the impact of this ASU, we do not expect the adoption to have a material impact on our consolidated financial statements and related disclosures.

Brookdale Senior Living Inc. 2017 10-K

ASU 2014-09, as amended, is effective for the Company’s fiscal year beginning January 1, 2018, and the Company will adopt the new standard under the modified retrospective approach. Under the modified retrospective approach, the guidance is applied to the most current period presented, recognizing the cumulative effect of the adoption change as an adjustment to beginning retained earnings. The Company has determined that the adoption of ASU 2014-09 will not result in an adjustment to beginning retained earnings for the Company and will not result in a significant change to the amount and timing of the recognition of resident fee revenue. The Company has determined that there will not be any significant change to the annual amount of revenue recognized for management fees under the Company’s management agreements, however, the Company will recognize an estimated amount of incentive fee revenue earlier during the annual contract period. The Company has determined that there will be no significant change to the amounts presented for revenue recognized for reimbursed costs incurred on behalf of managed communities and reimbursed costs incurred on behalf of managed communities with no net impact to the amount of income from operations.

Additionally, real estate sales are within the scope of ASU 2014-09, as amended by ASU 2017-05, Other Income – Gains and Losses from the Derecognition of Nonfinancial Assets (“ASU 2017-05”). ASU 2017-05 clarifies the scope of subtopic 610-20, Other Income - Gains and Losses from Derecognition of Nonfinancial Assets, and adds guidance for partial sales of nonfinancial assets. Under ASU 2014-09 and ASU 2017-05, the income recognition for real estate sales is largely based on the transfer of control versus continuing involvement under the current guidance. As a result, more transactions may qualify as sales of real estate and gains or losses may be recognized sooner. Upon adoption, the Company will apply the five step revenue model to all future sales of real estate.

Five Star Senior Living Inc. 2017 10-K

Under the new ASUs, the income recognition for real estate sales is largely based on the transfer of control versus continuing involvement under the current guidance. As a result, more transactions may qualify as sales of real estate and gains or losses may be recognized sooner. We will adopt these ASUs as required effective January 1, 2018 and currently expect to apply the modified retrospective approach. While we are continuing to assess the impact adopting these ASUs (and related clarifying guidance issued by the FASB) will have on our consolidated financial statements, we believe its adoption will not have a material impact on the timing of our revenue recognition. We do expect the adoption will result in expanded disclosures related to the nature, amount, timing and uncertainty of revenue and cash flows arising from our contracts with customers that are included in the scope of these ASUs. A substantial portion of our revenue relates to contracts with residents that are generally short term in nature and fall under ASC Topic 840, Leases, which are specifically excluded from the scope of ASU No. 2014-09. Our contracts with residents and other customers that are included in the scope of these ASUs are also generally short term in nature and revenue is recognized when services are provided. Upon the adoption of these ASUs, we anticipate being required to separately disclose the components of our senior living revenue between lease revenue accounted for under the existing lease guidance and service revenue accounted for under the new ASUs, including non-lease components, such as certain services embedded in our base leasing fees. As we complete our evaluation of these ASUs, new information may arise that could change our current understanding of the impact to revenue recognized. Additionally, we will continue to monitor industry activities and any additional guidance provided by regulators, standards setters and the accounting profession and will adjust our assessment and implementation plans accordingly.