

Technical Line

FASB – final guidance

How the revenue standard affects health care entities

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What you need to know

- ▶ Health care entities need to make significant judgments to assess collectibility and estimate variable consideration.
- ▶ Emerging health care contract models that are partially or wholly outside the scope of this standard, such as risk arrangements, may require significant judgment to determine the appropriate authoritative guidance to be applied.

Overview

The revenue recognition standard¹ requires entities in the health care industry (e.g., hospitals, clinics, physician practices, laboratories, integrated health systems) to make judgments and estimates, such as determining the composition and size of each portfolio of contracts and estimating implicit price concessions.

This publication, which contains a summary of the standard in the appendix, highlights key aspects of applying the standard to a health care entity's contracts with its customers. It supplements our Financial reporting developments (FRD) publication, *Revenue from contracts with customers (ASC 606)*, and should be read in conjunction with it.

Health care entities should also keep in mind that, when they adopt the new credit impairment standard,² they will need to estimate full lifetime expected credit losses for their accounts receivable and contract assets. As a reminder, they will need to do this after assessing collectibility under the revenue guidance to determine whether they have a contract with a customer. Refer to our FRD publication, *Credit impairment under ASC 326*, for more information.

Contract with a customer

A contract with a customer (e.g., a patient) must create enforceable rights and obligations to fall within the scope of the model in the standard. Contracts may be written, oral or implied by a health care entity's customary business practices. For example, a signed patient treatment consent form likely represents a written contract. However, when a patient is unable or unwilling to sign a form, a health care entity needs to determine whether it has an oral or implied contract based on its customary business practice of providing patient care (e.g., admitting the patient into the emergency room) without obtaining a signed form. Health care entities may need to consider whether to involve legal counsel because contract enforceability is a matter of law.

In addition to being legally enforceable, a contract with a patient must meet five criteria to be within the scope of the model in the standard (see Step 1 in the appendix).

Collectibility

One criterion that a health care entity is required to assess is whether it is probable that it will collect substantially all of the consideration to which it will be entitled in exchange for the goods or services that will be transferred to the patient. This criterion is a key part of the assessment of whether a contract, as defined in the standard, exists and represents a valid transaction. The objective of the collectibility assessment is to evaluate whether there is a substantive transaction between the entity and the patient.

Collectibility refers to the patient's ability and intent to pay. A health care entity should assess a patient's ability to pay based on the patient's financial capacity and intention to pay considering all relevant facts and circumstances, including past experiences with that patient or patient class.

A health care entity evaluates the collectibility of the transaction price for the goods or services that will be transferred to the patient rather than that of the stated contract price or the amount billed for those items. The contract price and the transaction price most often will differ because of variable consideration (e.g., discounts, explicit or implicit price concessions). Health care entities need to first determine the transaction price before assessing the collectibility of that amount.

Evaluating the collectibility criterion may require significant judgment for health care entities that recognize revenue for goods and services provided regardless of a patient's ability and intent to pay. Health care entities may be required by law to treat emergency conditions regardless of the patient's ability and intent to pay, or they may be driven by a mission to provide goods and services to indigent patients within their communities.

The standard provides the following example to illustrate how a health care entity would perform the collectibility assessment when it concludes that it has provided an implicit price concession in a contract with a patient:

Excerpt from Accounting Standards Codification

Revenue from Contracts with Customers – Overall

Implementation Guidance and Illustrations

Example 3 – Implicit Price Concession

606-10-55-102

An entity, 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 required by law to provide medical services to all emergency room patients. Because of the patient's

Evaluating the collectibility criterion may require significant judgment for health care entities that recognize revenue for goods and services provided regardless of a patient's ability and intent to pay.

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 the criteria in paragraph 606-10-25-1, and in accordance with paragraph 606-10-25-6, the entity will continue to assess its conclusion based on updated facts and circumstances.

606-10-55-103

After providing services, the entity obtains additional information about the patient 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 entity notes its standard rate for the services provided in the emergency room is \$10,000. The entity 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 that 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.

606-10-55-104

Before reassessing whether the criteria in paragraph 606-10-25-1 have been met, the entity considers paragraphs 606-10-32-2 and 606-10-32-7(b). Although the standard rate for the services is \$10,000 (which may be the amount invoiced to the patient), the entity expects to accept a lower amount of consideration in exchange for the services. Accordingly, the entity concludes that the transaction price is not \$10,000 and, therefore, the promised consideration is variable. The entity reviews its historical cash collections from this customer class and other relevant information about the patient. The entity estimates the variable consideration and determines that it expects to be entitled to \$1,000.

606-10-55-105

In accordance with paragraph 606-10-25-1(e), the entity evaluates the patient's ability and intention to pay (that is, the credit risk of the patient). On the basis of its collection history from patients in this customer class, the entity concludes it is probable that the entity will collect \$1,000 (which is the estimate of variable consideration). In addition, on the basis of an assessment of the contract terms and other facts and circumstances, the entity concludes that the other criteria in paragraph 606-10-25-1 also are met. Consequently, the entity accounts for the contract with the patient in accordance with the guidance in this Topic.

If a health care entity is aware of potential collection issues at contract inception but is still willing (or required) to enter into the contract with the patient, the contract may include an implicit price concession. As the above example illustrates, the implicit price concession (along with any other variable amounts of the transaction price) is incorporated into the health care entity's assessment about whether it is probable that it will collect substantially all of the consideration to which it is entitled.

When performing the collectibility assessment at contract inception, health care entities should consider collections experience on various classes of patients. For example, in determining whether a contract with a "Medicaid-pending" patient meets the collectibility criterion, a health care entity may use its historical experience with similar patients to determine the number of patients who are ultimately approved for Medicaid coverage, the number of those who qualify for the entity's charity care policy and the number of those who are uninsured because they don't qualify for financial assistance or government programs.

Portfolio approach

Under the standard, the five-step model (see appendix) is applied to individual contracts with customers. However, there may be situations in which it may be more practical for an entity to group contracts for purposes of revenue recognition rather than attempt to account for each contract separately. In order to use the portfolio approach practical expedient in the standard, a health care entity must reasonably expect the accounting result will not be materially different from the result of applying the guidance to the individual contracts.

Health care entities using the portfolio approach need to evaluate whether contracts within their payor categories (e.g., uninsured self-pay, governmental programs, insurance companies) share similar characteristics and could be grouped into portfolios. Health care entities also may consider other characteristics of contracts in establishing portfolios, including high-deductible and other types of plans, type of goods and services provided (e.g., inpatient, outpatient, skilled nursing, home health, emergency room, physician practice) and demographics of an individual facility within a health care delivery system.

A health care entity is not required to quantitatively evaluate every possible outcome when concluding that the portfolio approach is not materially different. An entity should apply a reasonable approach to determine the portfolios that would be representative of its types of customers.

How we see it

When establishing portfolios, health care entities need to exercise judgment to determine the size and composition of each portfolio, whether the results of applying the portfolio approach are not materially different from applying the standard to individual contracts and the level of documentation necessary to support their judgments and assumptions.

Health care entities need to use judgment to determine the size and composition of each portfolio.

Transaction price

The transaction price reflects a health care entity's expectations about the consideration it will be entitled to receive from the patient and from third-party payors on behalf of the patient. If an entity has rights under the present contract to amounts that are to be paid by parties other than the customer, these amounts should be included in the transaction price.³ For example, in the health care industry, an entity may be entitled under the present contract to payments from a patient, insurance companies and/or governmental organizations. If that's the case, the total to which the health care entity expects to be entitled should be included in the transaction price, regardless of the source.

Determining the transaction price is more challenging when it is variable or when payment is received at a different time from when the entity provides the promised goods or services.

Variable consideration

Variable consideration can take many forms. In addition to implicit price concessions, variable consideration can result from explicit terms in a contract that the parties agreed on. For example, health care entities generally agree to accept payment (reimbursement) from payors (e.g., insurance companies) at varying rates for different goods and services provided to patients. Health care entities also have other forms of discounts or price concessions (e.g., prompt pay discounts, uninsured discounts) provided to patients. Under the standard, contractual adjustments (i.e., the difference between the list price and the reimbursement rate) and other revenue adjustments (e.g., discounts) result in variable consideration.

In addition, health care entities often enter into contracts with patients under which some or all of the consideration paid by a third-party payor (e.g., Medicare, Medicaid) is subject to adjustments (or settlements) in subsequent reporting periods. In these situations, the settlements due from or to a third-party payor are also variable consideration in the contract with the patient (i.e., it is a component of the transaction price).

Health care entities are required to estimate variable consideration using either an “expected value” method or the “most likely amount” method. They should select the method that better predicts the amount of consideration to which they will be entitled (i.e., the method selected is not entitled to be a “free choice”).

Health care entities determine the expected value of variable consideration using the sum of probability-weighted amounts in a range of possible amounts under the contract. To do this, an entity needs to identify the possible outcomes of a contract and the probabilities of those outcomes. This method may better predict expected consideration when an entity has a large number of contracts with similar characteristics (e.g., contracts with Medicare beneficiaries subject to retroactive adjustments) or when an entity has a single contract with a large number of possible outcomes.⁴ An entity preparing an expected value calculation is not required to consider all possible outcomes, even if it has extensive data and can identify many possible outcomes.⁵ In many cases, a limited number of discrete outcomes and probabilities can provide a reasonable estimate of the expected value.

Health care entities determine the most likely amount of variable consideration using the single most likely amount in a range of possible consideration amounts. This method may be the better predictor when an entity expects to be entitled to only one of two possible amounts (e.g., a contract in which an entity is entitled to receive all or none of a specified performance bonus, but not a portion of that bonus).⁶

When estimating variable consideration, a health care entity should consider all information (historical, current and forecasted) that is reasonably available to the entity. We believe that an entity would not be applying the portfolio approach practical expedient just because it used a portfolio of data from its historical experience with similar customers and/or contracts.⁷ Health care entities should consider their historical collection experience when estimating variable consideration regardless of whether they use a portfolio approach.

Implicit price concessions versus credit risk

As discussed above, entities need to determine at contract inception whether they expect to collect a lower amount of consideration than the amount stated in the contract. In the Basis for Conclusions of Accounting Standards Update (ASU) 2014-09⁸ the FASB acknowledged that, in some cases, it may be difficult to determine whether the entity has implicitly offered a price concession (i.e., variable consideration) or whether the entity has chosen to accept the risk of default by the customer of the contractually agreed-upon consideration (i.e., credit impairment under Accounting Standards Codification (ASC) 310, *Receivables*, or ASC 326, *Financial Instruments – Credit Losses* (if adopted)). The Financial Accounting Standards Board did not develop detailed guidance for distinguishing between price concessions (recognized as variable consideration through revenue) and credit impairment (recognized as bad debt or credit loss expense outside of revenue). Therefore, entities should consider all relevant facts and circumstances when analyzing situations in which an entity is willing to accept a lower price than the amount stated in the contract.

Health care entities should consider all information (historical, current and forecasted) that is reasonably available to them when estimating variable consideration.

We believe the following factors may suggest the entity has implicitly offered a price concession to the customer:

- ▶ The entity has an established business practice that indicates it is willing to accept consideration less than contractually stated prices. For example, an entity routinely accepts reduced payments on services for which it earns high margins, indicating that it is willing to accept an amount of consideration that is less than the contract price.
- ▶ The entity has a history of not enforcing its contractual rights to promised consideration in similar contracts under similar circumstances such that customers expect the entity to offer price concessions. For example, the customer has a valid expectation that the entity is willing to accept a lower amount of consideration than the contractually stated price based on its past experiences with the entity.
- ▶ The entity is willing to enter into a contract with a customer even though facts and circumstances indicate that the customer intends to pay an amount of consideration that is less than the contractually stated price. For example, the entity willingly enters into a contract expecting that it will receive less than the stated contract price, implicitly reducing the transaction price to the expected lesser consideration.

Refer to our FRD publication, [*Credit impairment under ASC 326*](#), for more information on credit losses recorded when the entity has chosen to accept the risk of default by the customer of the contractually agreed-upon consideration.

Constraint

To include variable consideration in the estimated transaction price, a health care entity has to conclude that it is probable that a significant revenue reversal in the amount of cumulative revenue recognized for the contract will not occur in future periods once the uncertainty related to the variable consideration is resolved. An entity needs to consider both the likelihood and magnitude of a revenue reversal to apply the constraint.

Factors that may increase the likelihood and magnitude of a revenue reversal for a health care entity include decreased state funding for government programs, takebacks from cost report audits or other payor audits, and limited experience with certain payors or reimbursement programs.

In certain circumstances, it may be difficult for health care entities to assert that it is probable that a significant reversal of cumulative revenue recognized for a contract will not occur, including situations in which payments are contingent on regulatory approval.

When a health care entity determines that it cannot meet the probable threshold if it includes all of the variable consideration in the transaction price, the amount of variable consideration that must be included in the transaction price is limited to the amount that *will not* result in a significant revenue reversal. That is, the estimate of variable consideration is reduced until it reaches an amount that, if reversed when the uncertainty associated with the variable consideration is resolved, would not result in a significant reversal of cumulative revenue recognized for a contract. When there is significant uncertainty about the ultimate pricing of a contract, health care entities should not default to constraining the estimate of variable consideration to zero.

An entity is not required to strictly follow a two-step process to determine the transaction price (i.e., first estimate the variable consideration, then apply the constraint to that estimate) if its internal processes incorporate the principles of both steps in a single step.⁹ For example, if a health care entity already has a single process to estimate the amount of consideration it expects to collect from patients and third-party payors in a manner consistent with the objectives of applying the constraint, it would not need to estimate the transaction price and

then separately apply the constraint. Applying the expected value method for estimating variable consideration, which requires an entity to consider probability-weighted amounts, sometimes can achieve the objective of the constraint on variable consideration.¹⁰

When a portfolio approach is used to estimate variable consideration, the constraint should be applied at the portfolio level. That is, the assessment of whether a significant revenue reversal in the amount of cumulative revenue recognized is probable of occurring should be performed for each portfolio.

Subsequent changes in the transaction price

When a contract includes variable consideration (e.g., an implicit price concession), an entity needs to update its estimate of the transaction price to depict conditions that exist at each reporting date. This involves updating the estimate of the variable consideration (including any amounts that are constrained) to reflect the health care entity's revised expectations about the amount of consideration to which it expects to be entitled considering uncertainties that are resolved or new information that is gained about remaining uncertainties. For example, if a health care entity subsequently determines that it will collect more consideration than it originally estimated for a contract with a patient (e.g., if the constraint no longer exists due to an uncertainty being resolved), it will account for the change as an increase in the estimate of the transaction price (i.e., an upward revenue adjustment).

If a health care entity subsequently determines that the amount it expects to collect from a patient and/or third-party payor is less than it originally estimated (e.g., if new information is obtained that indicates the original estimate of variable consideration needs to be decreased), it will generally account for the change as a decrease in the estimate of the transaction price (i.e., a downward revenue adjustment). However, due to the application of the constraint, we don't expect health care entities will experience downward adjustments that result in a significant reversal of cumulative revenue recognized for a contract (or a portfolio of contracts, if the portfolio approach practical expedient has been applied).

If the entity becomes aware of a change in the specific facts and circumstances about the patient's ability and intent to pay (e.g., loss of employment), it may conclude that the change in the entity's expectation of the amount it will collect is an impairment loss.

Health care entities that apply a portfolio approach to estimate variable consideration need to evaluate information about patients in each portfolio when determining how to account for subsequent changes in the transaction price.

How we see it

Health care entities need to carefully evaluate all facts and circumstances known at contract inception, as well as any subsequent events that may affect the ability and intent of a patient (or third-party payor on behalf of a patient) to pay, to distinguish between a change in the estimate of the transaction price and an impairment loss (i.e., bad debt).

Arrangements that do not meet the definition of a contract

In cases in which an arrangement does not meet the definition of a contract under the standard (and continues not to meet the criteria required for a contract), a health care entity should recognize nonrefundable consideration received as revenue only when one of the following events has occurred: (1) the entity has fully performed and substantially all of the consideration has been received, (2) the contract has been terminated or (3) the entity has transferred control of the goods or services and has stopped transferring (and has no obligation under the contract to transfer) additional goods or services to the patient.

Changes in the estimate of the transaction price are recognized in revenue, while impairment losses are recognized in bad debt expense.

The third event in this alternative recognition model is not the equivalent of a “cash basis” of accounting.¹¹ Therefore, under this model, a health care entity should not presume to be able to recognize revenue when cash is received from the patient or third-party payor if collectibility is not probable at contract inception. Under the standard, an entity would only meet the requirements of this event if it has transferred control of the goods or services and has stopped transferring (and has no obligation under the contract to transfer) additional goods or services to the patient. This assessment requires judgment about the specific facts and circumstances of the contract.

Arrangements partially or wholly outside of the scope of the standard

Charity care

Charity care does not qualify for revenue recognition. However, distinguishing charity care from implicit price concessions and bad debt expense requires judgment.¹²

Health care entities are still required to make disclosures about charity care and may elect to use a ratio of cost-to-gross charges to estimate the cost of charity care.

Contributions

The standard does not apply to contributions because they are nonreciprocal transfers.¹³ That is, contributions generally do not represent consideration given in exchange for goods or services that are an output of the entity's ordinary activities. As a result, health care entities account for contributions received under the guidance for not-for-profit entities.¹⁴

Insurance contracts

The revenue standard does not apply to contracts within the scope of ASC 944, *Financial Services – Insurance* (e.g., health insurance contracts). However, an entity that has contracts within the scope of ASC 944 may also have contracts that are outside the scope of ASC 944. For example, some health care entities may enter into contracts to provide health care administrative services, generally referred to as administrative services only (ASO) plans or arrangements, to employers, governmental agencies, unions and other groups sponsoring self-insured plans. These contracts are within the scope of the revenue standard.

Risk arrangements

Health care entities, including managed care entities, may enter into arrangements with other parties (e.g., health plans, Medicare) that obligate them to provide, and/or become financially responsible for, health care services to specified, qualified beneficiaries. When the arrangement exposes the health care entity to the uncertainty of financial gain or loss, it is generally referred to as a risk arrangement. The form and structure of these risk arrangements may vary significantly from contract to contract. The accounting framework that may apply to a risk arrangement is dependent upon various factors, including the terms and conditions of the arrangement, the activities performed by the health care entity, and the financial risk assumed. For example, ASC 944, ASC 815, *Derivatives and Hedging*, ASC 460, *Guarantees* and the revenue standard are all accounting frameworks to consider when determining the appropriate authoritative guidance to be applied to a risk arrangement.

How we see it

Health care entities should carefully evaluate whether their contracts, or portions of their contracts, are within the scope of other authoritative guidance (e.g., ASC 944, ASC 815, ASC 460) and outside the scope of the revenue standard.

Disclosure requirements

Health care entities are required to provide a comprehensive and coherent set of disclosures about revenue from contracts with customers. Public entities, including not-for-profit conduit bond obligors, are required to provide qualitative and quantitative information about: (1) contracts with customers, (2) significant judgments made in applying the standard and (3) assets recognized from the costs to obtain or fulfill a contract. Nonpublic entities can choose to provide the same or streamlined disclosures; however, certain disclosures are required for nonpublic entities.

The majority of the standard's disclosure requirements relate to an entity's contracts with customers. These disclosures include disaggregation of revenue, information about contract asset and liability balances, and information about an entity's performance obligations.

Disaggregated revenue disclosures should illustrate how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors. When determining how to disaggregate revenue, a health care entity should consider how information is presented for other purposes, including information presented outside the financial statements (e.g., investor presentations), information reviewed by the chief operating decision maker to evaluate operating segments and other similar information used to evaluate the entity's financial performance. This information may include type of services (e.g., inpatient, outpatient), type of customer (e.g., self-pay, insured) and geographical location.

The guidance also requires disclosure of significant accounting estimates and judgments made in determining the transaction price. For health care entities, this may include information about how they determined their contract portfolios and the methodology and data used (e.g., collection history) to estimate variable consideration.

Endnotes:

- ¹ ASC 606, *Revenue from Contracts with Customers*.
- ² ASU 2016-13, *Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*.
- ³ Paragraph BC187 of ASU 2014-09, *Revenue from Contracts with Customers*.
- ⁴ Paragraph BC200 of ASU 2014-09.
- ⁵ Paragraph BC201 of ASU 2014-09.
- ⁶ Paragraph BC200 of ASU 2014-09.
- ⁷ 13 July 2015 Transition Resource Group for Revenue Recognition (TRG) meeting; agenda paper no. 38.
- ⁸ Paragraph BC194 of ASU 2014-09.
- ⁹ Paragraph BC215 of ASU 2014-09.
- ¹⁰ 13 July 2015 TRG meeting; agenda paper no. 38.
- ¹¹ Paragraph BC24 of ASU 2016-12, *Narrow-Scope Improvements and Practical Expedients*.
- ¹² ASC 954-605-25-10, *Health Care Entities – Revenue Recognition*.
- ¹³ 30 March 2015 TRG meeting; agenda paper no. 26.
- ¹⁴ ASC 958-605, *Not-for-Profit Entities – Revenue Recognition*.

Health care entities have to disclose significant judgments made when applying the standard.

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Appendix: The five-step revenue model and contract costs

The standard's core principle is that an entity recognizes revenue at an amount that reflects the consideration to which the entity expects to be entitled in exchange for transferring goods or services to a customer. That principle is applied using five steps that require entities to exercise judgment when considering the terms of their contract(s) and all relevant facts and circumstances. Entities have to apply the requirements of the standard consistently to contracts with similar characteristics and in similar circumstances. This table summarizes the new revenue model and the guidance for contract costs.

Step 1: Identify the contract(s) with the customer
<p>Definition of a contract</p> <p>An entity must first identify the contract, or contracts, to provide goods and services to customers. A contract must create enforceable rights and obligations to fall within the scope of the model in the standard. Such contracts may be written, oral or implied by an entity's customary business practices but must meet the following criteria:</p> <ul style="list-style-type: none"> ▶ The parties to the contract have approved the contract (in writing, orally or based on their customary business practices) and are committed to perform their respective obligations ▶ The entity can identify each party's rights regarding the goods or services to be transferred ▶ The entity can identify the payment terms for the goods or services to be transferred ▶ The contract has commercial substance (i.e., the risk, timing or amount of the entity's future cash flows is expected to change as a result of the contract) ▶ It is probable that the entity will collect substantially all of the consideration to which it will be entitled in exchange for the goods or services that will be transferred to the customer <p>If these criteria are not met, an entity would not account for the arrangement using the model in the standard and would recognize any nonrefundable consideration received as revenue only when certain events have occurred.</p> <p>Contract combination</p> <p>The standard requires entities to combine contracts entered into at or near the same time with the same customer (or related parties of the customer) if they meet any of the following criteria:</p> <ul style="list-style-type: none"> ▶ The contracts are negotiated as a package with a single commercial objective ▶ The amount of consideration to be paid in one contract depends on the price or performance of another contract ▶ The goods or services promised in the contracts (or some goods or services promised in each of the contracts) are a single performance obligation <p>Contract modifications</p> <p>A contract modification is a change in the scope and/or price of a contract. A contract modification is accounted for as a new contract separate from the original contract if the modification adds distinct goods or services at a price that reflects the standalone selling prices of those goods or services. Contract modifications that are not accounted for as separate contracts are considered changes to the original contract and are accounted for as follows:</p> <ul style="list-style-type: none"> ▶ If the goods and services to be transferred after the contract modification are distinct from the goods or services transferred on or before the contract modification, the entity should account for the modification as if it were the termination of the old contract and the creation of a new contract ▶ If the goods and services to be transferred after the contract modification are not distinct from the goods and services already provided and, therefore, form part of a single performance obligation that is partially satisfied at the date of modification, the entity should account for the contract modification as if it were part of the original contract ▶ A combination of the two approaches above: a modification of the existing contract for the partially satisfied performance obligations and the creation of a new contract for the distinct goods and services

Step 2: Identify the performance obligation(s) in the contract

An entity must identify the promised goods and services within the contract and determine which of those goods and services (or bundles of goods and services) are separate performance obligations (i.e., the unit of accounting for purposes of applying the standard). An entity is not required to assess whether promised goods or services are performance obligations if they are immaterial in the context of the contract.

A promised good or service represents a performance obligation if (1) the good or service is distinct (by itself or as part of a bundle of goods or services) or (2) the good or service is part of a series of distinct goods or services that are substantially the same and have the same pattern of transfer to the customer.

A good or service (or bundle of goods or services) is distinct if both of the following criteria are met:

- ▶ The customer can benefit from the good or service either on its own or together with other resources that are readily available to the customer (i.e., the good or service is capable of being distinct)
- ▶ The entity's promise to transfer the good or service to the customer is separately identifiable from other promises in the contract (i.e., the promise to transfer the good or service is distinct within the context of the contract)

In assessing whether an entity's promise to transfer a good or service is separately identifiable from other promises in the contract, entities need to consider whether the nature of the promise is to transfer each of those goods or services individually or to transfer a combined item or items to which the promised goods or services are inputs. Factors that indicate two or more promises to transfer goods or services are not separately identifiable include, but are not limited to, the following:

- ▶ The entity provides a significant service of integrating the goods or services with other goods or services promised in the contract into a bundle of goods or services that represent the combined output or outputs for which the customer has contracted
- ▶ One or more of the goods or services significantly modify or customize, or are significantly modified or customized by, one or more of the other goods or services promised in the contract
- ▶ The goods or services are highly interdependent or highly interrelated. In other words, each of the goods or services is significantly affected by one or more of the other goods or services in the contract

If a promised good or service is not distinct, an entity is required to combine that good or service with other promised goods or services until it identifies a bundle of goods or services that is distinct.

Series guidance

Goods or services that are part of a series of distinct goods or services that are substantially the same and have the same pattern of transfer to the customer must be combined into one performance obligation. To meet the same pattern of transfer criterion, each distinct good or service in the series must represent a performance obligation that would be satisfied over time and would have the same measure of progress toward satisfaction of the performance obligation (both discussed in Step 5), if accounted for separately.

Customer options for additional goods or services

A customer's option to acquire additional goods or services (e.g., an option for free or discounted goods or services) is accounted for as a separate performance obligation if it provides a material right to the customer that the customer would not receive without entering into the contract (e.g., a discount that exceeds the range of discounts typically given for those goods or services to that class of customer in that geographical area or market).

Principal versus agent considerations

When more than one party is involved in providing goods or services to a customer, an entity must determine whether it is a principal or an agent in these transactions by evaluating the nature of its promise to the customer. An entity is a principal and therefore records revenue on a gross basis if it controls the specified good or service before transferring that good or service to the customer. An entity is an agent and records as revenue the net amount it retains for its agency services if its role is to arrange for another entity to provide the specified goods or services. Because it is not always clear whether an entity controls a specified good or service in some contracts (e.g., those involving intangible goods and/or services), the standard also provides indicators of when an entity may control the specified good or service as follows:

- ▶ The entity is primarily responsible for fulfilling the promise to provide the specified good or service
- ▶ The entity has inventory risk before the specified good or service has been transferred to a customer or after transfer of control to the customer (e.g., if the customer has a right of return)
- ▶ The entity has discretion in establishing the price for the specified good or service

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. When determining the transaction price, entities need to consider the effects of all of the following:

Variable consideration

An entity needs to estimate any variable consideration (e.g., amounts that vary due to discounts, rebates, refunds, price concessions, bonuses) using either the expected value method (i.e., a probability-weighted amount method) or the most likely amount method (i.e., a method to choose the single most likely amount in a range of possible amounts). An entity's method selection is not a "free choice" and must be based on which method better predicts the amount of consideration to which the entity will be entitled. To include variable consideration in the estimated transaction price, the entity has to conclude that it is probable that a significant revenue reversal will not occur in future periods. This "constraint" on variable consideration is based on the probability of a reversal of an amount that is significant relative to cumulative revenue recognized for the contract. The standard provides factors that increase the likelihood or magnitude of a revenue reversal, including the following: the amount of consideration is highly susceptible to factors outside the entity's influence, the entity's experience with similar types of contracts is limited or that experience has limited predictive value, or the contract has a large number and broad range of possible outcomes. The standard requires an entity to estimate variable consideration, including the application of the constraint, at contract inception and update that estimate at each reporting date.

Significant financing component

An entity needs to adjust the transaction price for the effects of the time value of money if the timing of payments agreed to by the parties to the contract provides the customer or the entity with a significant financing benefit. As a practical expedient, an entity can elect not to adjust the transaction price for the effects of a significant financing component if the entity expects at contract inception that the period between payment and performance will be one year or less.

Noncash consideration

When an entity receives, or expects to receive, noncash consideration (e.g., property, plant or equipment, a financial instrument), the fair value of the noncash consideration at contract inception is included in the transaction price.

Consideration paid or payable to the customer

Consideration payable to the customer includes cash amounts that an entity pays, or expects to pay, to the customer, credits or other items (vouchers or coupons) that can be applied against amounts owed to the entity or equity instruments granted in conjunction with selling goods or services. An entity should account for consideration paid or payable to the customer as a reduction of the transaction price and, therefore, of revenue unless the payment to the customer is in exchange for a distinct good or service. However, if the payment to the customer exceeds the fair value of the distinct good or service received, the entity should account for the excess amount as a reduction of the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract

For contracts that have multiple performance obligations, the standard generally requires an entity to allocate the transaction price to the performance obligations in proportion to their standalone selling prices (i.e., on a relative standalone selling price basis). When allocating on a relative standalone selling price basis, any discount within the contract generally is allocated proportionately to all of the performance obligations in the contract. However, there are two exceptions.

One exception requires variable consideration to be allocated entirely to a specific part of a contract, such as one or more (but not all) performance obligations or one or more (but not all) distinct goods or services promised in a series of distinct goods or services that forms part of a single performance obligation, if both of the following criteria are met:

- ▶ The terms of a variable payment relate specifically to the entity's efforts to satisfy the performance obligation or transfer the distinct good or service
- ▶ Allocating the variable consideration entirely to the performance obligation or the distinct good or service is consistent with the objective of allocating consideration in an amount that depicts the consideration to which the entity expects to be entitled in exchange for transferring the promised goods or services to the customer

The other exception requires an entity to allocate a contract's entire discount to only those goods or services to which it relates if certain criteria are met.

To allocate the transaction price on a relative standalone selling price basis, an entity must first determine the standalone selling price of the distinct good or service underlying each performance obligation. The standalone selling price is the price at which an entity would sell a good or service on a standalone (or separate) basis at contract inception. Under the model, the observable price of a good or service sold separately in similar circumstances to similar customers provides the best evidence of standalone selling price. However, in many situations, standalone selling prices will not be readily observable. In those cases, the entity must estimate the standalone selling price by considering all information that is reasonably available to it, maximizing the use of observable inputs and applying estimation methods consistently in similar circumstances. The standard states that suitable estimation methods include, but are not limited to, an adjusted market assessment approach, an expected cost plus a margin approach or a residual approach (if certain conditions are met).

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation

An entity recognizes revenue only when (or as) it satisfies a performance obligation by transferring control of the promised good(s) or service(s) to a customer. The transfer of control can occur over time or at a point in time.

A performance obligation is satisfied at a point in time unless it meets one of the following criteria, in which case it is satisfied over time:

- ▶ The customer simultaneously receives and consumes the benefits provided by the entity's performance as the entity performs
- ▶ The entity's performance creates or enhances an asset that the customer controls as the asset is created or enhanced
- ▶ The entity's performance does not create an asset with an alternative use to the entity, and the entity has an enforceable right to payment for performance completed to date

The transaction price allocated to performance obligations satisfied at a point in time is recognized as revenue when control of the goods or services transfers to the customer. If the performance obligation is satisfied over time, the transaction price allocated to that performance obligation is recognized as revenue as the performance obligation is satisfied. To do this, the standard requires an entity to select a single revenue recognition method (i.e., measure of progress) that faithfully depicts the pattern of the transfer of control over time (i.e., an input method or an output method).

Licenses of intellectual property

The standard provides guidance on the recognition of revenue for licenses of intellectual property (IP) that differs from the model for other promised goods and services. The nature of the promise in granting a license of IP to a customer is either:

- ▶ A right to access the entity's IP throughout the license period (a right to access)
- ▶ A right to use the entity's IP as it exists at the point in time in which the license is granted (a right to use)

To determine whether the entity's promise is to provide a right to access its IP or a right to use its IP, the entity should consider the nature of the IP to which the customer will have rights. The standard requires entities to classify IP in one of two categories:

- ▶ **Functional:** This IP has significant standalone functionality (e.g., many types of software, completed media content such as films, television shows and music). Licenses of functional IP generally grant a right to use the entity's IP, and revenue for these licenses generally is recognized at the point in time when the IP is made available for the customer's use and benefit. This is the case if the functionality is not expected to change substantially as a result of the licensor's ongoing activities that do not transfer an additional promised good or service to the customer. If the functionality of the IP is expected to substantively change because of activities of the licensor that do not transfer additional promised goods or services, and the customer is contractually or practically required to use the latest version of the IP, revenue for the license is recognized over time. However, we expect licenses of functional IP to meet the criteria to be recognized over time infrequently, if at all.
- ▶ **Symbolic:** This IP does not have significant standalone functionality (e.g., brands, team and trade names, character images). The utility (i.e., the ability to provide benefit or value) of symbolic IP is largely derived from the licensor's ongoing or past activities (e.g., activities that support the value of character images). Licenses of symbolic IP grant a right to access an entity's IP, and revenue from these licenses is recognized over time as the performance obligation is satisfied (e.g., over the license period).

Revenue cannot be recognized from a license of IP before both (1) an entity provides (or otherwise makes available) a copy of the IP to the customer and (2) the beginning of the period during which the customer is able to use and benefit from its right to access or its right to use the IP.

The standard specifies that sales and usage-based royalties on licenses of IP are recognized when the later of the following events occurs: (1) the subsequent sales or usage occurs or (2) the performance obligation to which some or all of the sales-based or usage-based royalty has been allocated has been satisfied (or partially satisfied). This guidance must be applied to the overall royalty stream when the sole or predominant item to which the royalty relates is a license of IP (i.e., these types of arrangements are either entirely in the scope of this guidance or entirely in the scope of the general variable consideration constraint guidance).

Contract costs

ASC 340-40, *Other Assets and Deferred Costs – Contracts with Customers*, specifies the accounting for costs an entity incurs to obtain and fulfill a contract to provide goods and services to customers. The incremental costs of obtaining a contract (i.e., costs that would not have been incurred if the contract had not been obtained) are recognized as an asset if the entity expects to recover them. ASC 340-40 cites commissions as a type of incremental costs that may require capitalization. The standard provides a practical expedient that permits an entity to immediately expense contract acquisition costs when the asset that would have resulted from capitalizing these costs would have been amortized in one year or less.

An entity accounts for costs incurred to fulfill a contract with a customer that are within the scope of other authoritative guidance (e.g., inventory, property, plant and equipment, internal-use software) in accordance with that guidance. If the costs are not in the scope of other accounting guidance, an entity recognizes an asset from the costs incurred to fulfill a contract only if those costs meet all of the following criteria:

- ▶ The costs relate directly to a contract or to an anticipated contract that the entity can specifically identify
- ▶ The costs generate or enhance resources of the entity that will be used in satisfying (or in continuing to satisfy) performance obligations in the future
- ▶ The costs are expected to be recovered

Any capitalized contract costs are amortized, with the expense recognized as an entity transfers the related goods or services to the customer. Any asset recorded by the entity is subject to an impairment assessment.