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Example Footnote Disclosure for Health Care Entities Implementing the New Revenue Recognition Standard

The following example footnote disclosure was exposed by the American Institute of Certified Public Accountant's Health Care Entities Revenue Recognition Task Force on June 1, 2017. It hasn't been finalized, but still provides helpful guidance to hospitals implementing the new revenue recognition standards.

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

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

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

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Organization's policy and/or implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments

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and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on historical collection experience with this class of patients.

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

Medicare: Certain inpatient acute care services are paid at prospectively determined rates per discharge based on clinical, diagnostic or other factors. Certain services are paid based on a cost-reimbursement methodologies subject to certain limits. Physical services are paid based upon established fee schedules. Outpatient services are paid using prospectively determined rates.

Medicaid: Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of services, or per covered member.

Other: Payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

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

Settlements with third-party payers for retroactive adjustments due to audits, review or investigations are considered variable consideration and are included in the determination of estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and the Organization's historic settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews and investigations. Adjustments arising from a change in the transaction price, were not significant in 2017 or 2018. [Or, disclose the amounts and explain significant adjustments].

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Generally, patients who are covered by third-party payers are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. For the years ended December 31, 2017 and 2018, additional revenue of $xxx and $xxx, respectively, was recognized due to changes in its estimates of implicit price concessions for performance obligations satisfied in prior years. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2017 and 2018 was not significant.

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

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