Note: Since issuing the new revenue standard in May 2014, the FASB and IASB have proposed various amendments to the guidance. This In depth supplement has not been updated to reflect all of the proposed changes. See In transition US2015-08, The new revenue standard — changes on the horizon, for a summary of the changes, their impact, and the areas where the FASB and IASB have taken different approaches.

Revenue from contracts with customers
The revenue standard is final – A comprehensive look at the new revenue model

Health care services industry supplement

At a glance
In May of 2014, the FASB and IASB issued their long-awaited converged standard on revenue recognition. Almost all entities will be affected to some extent by the significant increase in required disclosures. But the changes extend beyond disclosures, and the effect on entities will vary depending on the industry and current accounting practices.

In depth US2014-01 is a comprehensive analysis of the new standard. This supplement highlights some of the areas that could create the most significant challenges for health care services entities as they transition to the new standard.

Overview
In certain countries, health care is a service that is government-operated and government-funded. In contrast, the U.S. health care system resides primarily within the private sector, with the government serving as the largest purchaser of health care services. As a result, U.S. GAAP contains specific guidance and information relating to industry-specific revenue recognition principles for hospitals and other health care provider organizations, as well as for health plans, such as health maintenance organizations that arrange for health care services to be provided to their members.

Health care services revenue transactions may have certain characteristics that are atypical for commercial revenue transactions. For example, a significant portion of services is usually paid by third parties such as government programs or health insurance carriers, under arrangements that provide for the payment of amounts that are frequently less than the entity’s established rates. Revenue arising from services paid for
by government programs may be subject to retroactive adjustment as a result of examination by government agencies or contractors. And some providers may provide services to patients who lack third-party coverage, whose financial circumstances may make it doubtful that the entity will ever collect the consideration to which it would normally be entitled. As a result, a significant body of industry-specific revenue guidance developed over time.¹

The new revenue guidance will replace almost all of this industry-specific guidance. However, a portion has been retained, including the guidance related to the presentation and measurement of charity care services, which is not affected by the new standard, and certain guidance for nonprofit health care organizations related to contribution accounting, which is outside the scope of the new standard.

This supplement focuses on how the five-step model for revenue recognition described in detail in In depth US2014-01 will impact non-governmental entities in the health care industry. The examples and related discussions are intended to provide areas of focus to assist entities in evaluating the implications of the new standard.

At present, the new standard is effective for public business entities and not-for-profit conduit bond obligors in the first interim period within annual reporting periods beginning after December 15, 2016. All other entities have an additional year to adopt, although they may elect to early-adopt the standard using the public entities’ effective date. Recently, the FASB proposed to defer the effective date for one year, but allow for early adoption as of the original effective date. Comments on the proposal are due May 29.

**PwC observation:**

For some providers, the standard will result in a significant shift in how certain types of revenue are recognized and measured. Management may need to change existing IT systems and internal controls in order to capture different information than in the past. The effect could extend to other functions, such as tax (including both income tax and Form 990 information reporting) and third-party reimbursement. Changes in the timing or amount of revenue recognized may affect long-term compensation arrangements, debt covenants, and key financial ratios.

All providers, even those whose recognition and measurement are not significantly affected, will likely be affected by more expansive disclosure requirements and by the need to update revenue systems and processes and related controls to capture the information necessary to comply with the new guidance.

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**Identifying the contract with the customer**

A unique aspect of health care is the involvement of multiple parties in health care services transactions. In addition to the patient and the service provider, there is often a third-party (an insurer, managed care company, or government program) involved in paying for some or all of the services on the patient’s behalf. In these situations, there is a question as to whether the patient or the third-party payer is the “customer.”

For purposes of the new standard, the “contract with the customer” refers to the arrangement between the health care provider and the patient. However, we believe that if a separate contractual arrangement exists between the provider and a third-party payer (for example, if the provider belongs to a health plan’s network of participating providers), the terms of that separate arrangement will impact certain aspects of the contracts with patients covered by that health plan (this is explained further in the “Performance obligations” and “Transaction price” sections below).

Although the first step in the evaluation is to identify the contract, the arrangement with the patient does not have to be written; it can be oral or evidenced through established business practices. However, in order for revenue to be recognized, the contract must have commercial substance, and both parties must have the intent and ability to uphold their respective obligations.

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¹ This guidance is included in ASC Subtopic 954-605, Health Care Entities – Revenue Recognition. Once the ASU is effective, this Subtopic will be renamed Health Care Entities – Revenue Recognition – Charity Care and Related Fundraising Entities, to reflect its significantly narrowed focus.
Five criteria are specified which, collectively, require an entity to assess whether the contract is valid and represents a genuine transaction. For example:

- The provider will first need to conclude that it is probable that it will collect the consideration to which it will ultimately be entitled, based on an assessment of the customer’s ability and intent to pay as amounts become due. This may impact the revenue that can be recognized for patients that are uninsured or underinsured, as discussed further below.

- If the provider is unable to evaluate a patient’s intent and ability to pay at the time services are provided (for example, in an emergency situation), the provider must defer recognizing revenue pending completion of that evaluation. Until that can occur, the arrangement is one-sided – the provider has fulfilled its obligation, but is unable to assess whether the patient can pay.

**Performance obligations**

Under existing guidance, revenue is earned when an entity has substantially accomplished what it must do to be entitled to the revenue, as set forth in the contract. Under the new guidance, the actions or deliverables that must be performed are referred to as “performance obligations.” Sometimes a contract with a patient entails a single performance obligation (for example, a routine office visit to a physician). Other contracts may embody multiple performance obligations—for example, lifecare agreements between a continuing-care retirement community (CCRC) and its residents. The new standard requires that the provider evaluate how many distinct goods or services have been promised under the contract, and then to recognize revenue when or as each performance obligation is satisfied.

As indicated previously, if a separate contractual arrangement also exists between the provider and a third-party payer (hereafter, the “provider contract”), the terms of that arrangement can affect the nature of the performance obligation in a contract with a customer covered by that payer. The AICPA health care guide provides examples of common methodologies by which insurers, managed care companies, and government programs may pay providers (see box). If the provider contract indicates that payment will be made on a fee-for-service basis, the health care entity earns revenue as it provides services to the patient. If the provider will be paid a predetermined amount for services to be provided during a stipulated period of time (an episodic payment), revenue might be earned ratably over that period. If the arrangement involves capitation,\(^2\) then revenue is earned as a result of standing ready to provide services during a stipulated time period, not as a result of actually providing the care. “Stand ready” obligations are often recognized based on the passage of time.

**Transaction price**

The transaction price is the amount of consideration that the health care provider expects to be entitled to in exchange for providing the services (or in the case of capitation arrangements, for standing ready to provide services). Sometimes a transaction price is fixed, but in many cases the amount will vary based on uncertainties. This could be the case where some or all of the contract revenue:

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\(^2\) Capitation is a payment methodology under which a provider receives a fixed amount per person to provide health care services to a specified population of patients (for example, a managed care company’s subscribers in a particular area) during a specified time period. The provider is paid the fixed amount per person regardless of whether that person receives services or not.
• is subject to potential refunds or “clawbacks”—for example, under Medicare/Medicaid provider agreements subject to potential retrospective adjustments, or under CCRC resident agreements where the refundability of entrance fees declines over time,

• is based on uncertain events that may or may not occur (e.g., a performance bonus earned under a risk-sharing arrangement), or

• involves an implied price concession (discussed further under “services to uninsured patients”).

When consideration is variable, it must be estimated. The new guidance standardizes estimation techniques used by specifying use of either a probability-weighted technique or a most likely amount technique, whichever is the best predictor of future results. The estimate will also incorporate a “constraint,” which is illustrated in an example on pages 5 and 6.

**Services to uninsured patients**

For many years, hospitals have recognized revenues and receivables for services provided to uninsured patients. Often, this resulted in recognition of a substantial amount of revenue for which collectability was doubtful, followed by recognition of bad debt expense. Unlike other industries, health care providers were not required to assess whether collectability was reasonably assured before recognizing patient service revenue.

The new model will dramatically lower the volume of bad debt expense historically reported in such situations, and also result in a corresponding reduction in revenues, which will be reflected at a more realistic amount. The reduction in revenues will occur in two ways, explained in more detail below. First, the ASU requires estimation of a transaction price for services provided to uninsured patients using the concept of an “implicit price concession.” Second, it imposes an explicit threshold for collectability that must be met in order to recognize (accrue) revenue related to the contract. To apply these concepts, the hospital must take the model’s steps out of sequence, estimating the transaction price (step 3) first, then using the estimated transaction price as the basis for assessing the probability of collection (step 1). The AICPA’s Health Care Entities Revenue Recognition Task Force (Health Care RRTF) is evaluating a number of implementation issues in this area. Refer to the Appendix for more information.

**Implicit price concessions.** The new guidance uses a different model than the historic assumption that the transaction price is the amount billed to the patient. Under the new guidance, the transaction price is the amount the provider “expects to be entitled to.” Where services are provided to uninsured patients, the transaction price for revenue reporting purposes is likely to be much less. In many cases, hospitals providing services to uninsured patients do so knowing that on average, they will only collect pennies on the dollar. The new guidance permits the transaction price to be estimated using a portfolio of contracts, based on an average of amounts historically collected from that patient class.

Example 3 in the new standard illustrates this concept. In the example, the hospital’s average collection rate from uninsured patients is ten cents on the dollar. Although the patient’s gross charges for services were $10,000, the example indicates that the transaction price the provider can expect to be entitled to is $1,000 ($10,000 x 10%).

**Collectability threshold.** Once the transaction price for the services has been determined, the hospital must evaluate the likelihood of collecting that amount. This will determine whether the transaction qualifies for revenue recognition.

Step 1 of the model specifies the five criteria that must be met in order for a contract to be considered under the revenue model. Among those is a stipulation that it must be probable that the entity will collect the transaction price, based on an evaluation of the patient’s ability (that is, the financial capacity) and intention to pay. Unless it is probable that the patient is committed to performing their obligation under the contract (that is, to pay for the services), revenue and receivables should not be accrued.

Example 3 also uses a portfolio approach in making that evaluation. The illustration’s fact pattern notes that the hospital does not have any prior history with the patient. Absent any negative history with this patient, the example
implies that the hospital is as likely to collect from this patient as from any other patient in the portfolio, and thus, can deem ten cents on the dollar as the estimated transaction price, and $1,000 to be “probable of collection.”

Example 3 raises many questions. For example, what if the hospital had previously treated the patient and the patient failed to pay? The new standard does not explicitly address this issue. However, the threshold is defined in a way that suggests that the parties may not be committed to a contract if collectability is not probable or if there is significant doubt about collectability at contract inception. If negative information is available regarding the history with a specific patient, that information would likely override the experience attributable to the overall portfolio’s performance, and could result in a conclusion that no revenue should be accrued. This is one of the issues under discussion by the Health Care RRTF.

PwC observation:
Providers will need to carefully consider the level and disaggregation of portfolios that they use when estimating probability of collection. For example, one portfolio might be comprised of uninsured self-pay patients with whom the provider has no previous history; another portfolio might be uninsured self-pay patients with a positive payment history. Yet another portfolio might be patients with a history of not making any payments. The Health Care RRTF is considering whether implementation suggestions or examples in this area might be helpful.

Contracts that fail the collectability threshold. Contracts that do not meet the collectability threshold are not considered bona fide for revenue recognition purposes, and thus, the five-step model would not apply. However, the standard indicates that an entity should reassess a failed contract when and if there is a change in facts and circumstances. Thus, if the patient in Example 3 was subsequently qualified for Medicaid, the facts and circumstances would have changed. The hospital could reassess the transaction price (now, the amount established by its provider contract with the Medicaid program) and recognize revenue at that amount under the model.

Questions arise as to whether, absent a change in facts and circumstances, revenue can ever be recognized for a transaction that does not initially pass the collectability threshold, and how to account for partial payments. The standard states that in order for a failed contract to subsequently be recognized as revenue, one of the following events must occur:

- All or substantially all of the consideration expected has been received and is nonrefundable
- The contract has been terminated, and any consideration received from the customer is nonrefundable

The standard’s basis for conclusions explains that this is similar to the “deposit method” applied in existing GAAP for seller-financed collateralized real estate transactions. In those situations, if the customer ultimately defaults, the seller repossesses the property and terminates the transaction (in effect, unwinding the sale). However, that guidance is difficult to apply in the context of a transaction involving services. This is one of the implementation areas under consideration by the Health Care RRTF. Additionally, the FASB has decided to propose certain amendments to the collectability guidance; however, these amendments may not provide additional clarity for contracts in the health care industry.

PwC observation:
Conceptually, the process described in Example 3 appears relatively straightforward. In practice, it will be challenging to determine how it should be applied to the thousands and even millions of transactions processed by hospitals and hospital systems.

Third-party settlement estimates

The largest purchasers of health care services in the U.S. are the federal and state governments, which act as third-party payers in programs such as Medicare and Medicaid. Under those programs, payments for services provided to program beneficiaries are determined under complex government rules and regulations. Often, they may subject the provider to
the potential for retrospective adjustments; thus, the amount ultimately earned may not be known with certainty for several years. As a result of the uncertainty, amounts earned from providing services to government program beneficiaries often represent “variable consideration” under the new standard.

Currently, management makes its best estimate of the third-party settlement adjustment based on its knowledge and experience about past and current events. Under the new standard, that process will be modified to estimate consideration using either the expected value (probability-weighting of alternative outcomes) or most likely amount, whichever is the best predictor of the future outcome. The amount determined based on that estimate should be recognized only to the extent it is probable that a significant reversal of cumulative revenue will not occur. This concept is referred to as a constraint on the amount of variable consideration included in the transaction price.

While this change in how estimates are approached may not result in significantly different amounts of accruals for adjustments, in many instances, it will represent a change in the process to develop and document estimates.

Example

Hospital X participates in the Medicare program and agrees to accept Medicare’s rates as payment in full for services rendered to Medicare beneficiaries during a contract year. Typically, it takes three years from the year that services were rendered for Medicare to validate the claims and to issue a notice of final program settlement to close out that contract year. Each year, management must estimate the potential program adjustments and accrue a third-party settlement asset or liability to adjust the revenue estimate for that contract year.

After adopting the new standard, Hospital X bills and collects $50 million of net patient service revenue associated with Medicare patients. At contract inception and at the end of each reporting period, it must make a provision for estimated future program adjustments associated with services provided to Medicaid patients during that year. Historically, management has made a single best estimate of the adjustment required, which typically has been a recoupment (i.e., additional amounts were due to Medicare). However, the new standard requires use of either a probability-weighted amount or a most likely amount in making this estimate.

Management determines that a probability-weighted estimate would be the best predictor of the ultimate amount that will be earned under the contract, and identifies four possible outcomes in terms of potential program adjustments. The probability of each possible outcome is as follows:

<table>
<thead>
<tr>
<th>Possible adjustment amounts</th>
<th>Probability</th>
<th>Probability-weighted amounts</th>
<th>Total revenue recognized</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>10%</td>
<td>$0</td>
<td>$50 million</td>
</tr>
<tr>
<td>$5 million</td>
<td>45%</td>
<td>$2.3 million</td>
<td>$47.7 million</td>
</tr>
<tr>
<td>$10 million</td>
<td>30%</td>
<td>$3.0 million</td>
<td>$44.7 million</td>
</tr>
<tr>
<td>$12 million</td>
<td>15%</td>
<td>$1.8 million</td>
<td>$42.9 million</td>
</tr>
</tbody>
</table>

The amounts associated with each outcome are aggregated to arrive at the estimated adjustment amount of $7.1 million, resulting in a revenue estimate of $42.9 million. Before finalizing that estimate, management must evaluate the probability that, when the uncertainty is resolved, the amount earned will be significantly less than $42.9 million. Said another way, they must conclude that it is probable that a significant reversal of cumulative revenue will not occur. If not, the estimate must be limited to the amount that is not probable of significant reversal.

Assuming management concludes that no part of the $42.9 million should be constrained, Hospital X would accrue an estimated third-party settlement liability of $7.1 million to adjust Medicare revenue for the contract year to $42.9 million.
Continuing care retirement communities

CCRCs are senior living communities that provide residential services in various settings, depending on a resident’s needs. Contracts between a CCRC and its residents—“resident agreements”—typically span several years and, considering the promises of care and use of facilities contained in their agreements, include a variety of performance obligations. Given the complex, long-term nature of continuing care contracts, CCRCs are expected to be among the health care organizations whose revenue recognition is most significantly affected by the new guidance.

Typically, the resident’s financial obligation involves payment of monthly fees plus a one-time upfront entrance fee. Under existing industry-specific guidance, CCRCs account for monthly fees as they become due and amortize the upfront fees into income over the estimated residency period, generally on a straight-line basis. The new standard’s requirement that revenue be recognized in a pattern which “reflects the pattern of transfer of benefit from the seller to the buyer” will likely trigger a significant change. CCRC contracts that include an obligation to provide health care services would typically be expected to have a back-end loaded pattern of transfer, providing more services as the resident ages. Thus, the new standard would require that more revenue to be recognized in the later years of the contract (when the resident may require skilled nursing facility care) than in the earlier years (when the resident is living independently).

Performance obligations. The starting point for evaluating the pattern of transfer is to identify the individual performance obligations within the resident agreement. This can be challenging. CCRC contracts are a complex bundle of rights and obligations that can combine aspects of leasing, hospitality, and health care. A single contract might be viewed as embodying thousands of individual performance obligations over the multi-year term. Because of the interrelated nature of the various goods and services provided by the CCRC, the challenge arises in determining how the individual obligations should be grouped so that the pattern of transfer of the services is appropriately captured.

Although the new standard provides guidance to help entities develop an approach to identifying performance obligations that best reflects the economic substance of a transaction, constituents have asked the FASB and IASB to provide additional implementation guidance in this area. Issues related to the separation criteria were recently discussed by the joint Transition Resource Group, and the FASB has tentatively agreed to make certain clarifications to the guidance, which were proposed in May. The Health Care RRTF is also discussing this matter and is expected to provide some ideas on best practices for identifying the performance obligations in the context of CCRC contracts. Refer to the Appendix for more information about the topics identified by the Health Care RRTF.

Transaction price. The ASU’s requirements for determining a contract’s “transaction price” may impact CCRCs in several ways.

- **Aggregation of fees.** Under the new standard, the CCRC will likely need to aggregate the entrance fee and monthly fees together when estimating the transaction price. This will be a change from current practice where those components are accounted for separately.

- **Contracts with declining refunds.** The guidance for estimating variable consideration must be considered for contracts where the refundability of entrance fees diminishes over time. Under both existing GAAP and the new standard, the refund liability reported in the financial statements is the amount that the facility estimates it will actually be called upon to refund based on historical experience, and is typically estimated using a portfolio basis. However, the facility must estimate the liability using either the expected value or most likely amount (whichever is the best predictor of future results). The estimate will also be subject to the constraint discussed above, which precludes recognizing revenue if it is probable a change in estimate would result in a significant reversal in future years.

- **Fees refundable only from proceeds of reoccupancy.** Existing GAAP allows CCRCs to treat refundable fees that meet certain contractual conditions as if they were nonrefundable. That is, they are permitted to be deferred and amortized into income over the contract’s term. The new standard eliminates that specialized guidance.

3 These were the subject of ASU 2012-01.
Going forward, such amounts will be reported as a liability. As a result, revenue reported by affected CCRCs will be lower under the new model than under the old.

- **Time value of money.** Another issue being considered by the Health Care RRTF is whether the requirement to pay an upfront entrance fee triggers the new standard’s requirements to adjust the transaction price for the time value of money. The answer hinges on whether the purpose of the upfront payment is to provide financing to the CCRC, or whether instead it is required for other reasons. If the purpose is deemed to be financing (that is, an interest-free loan made by the resident to the CCRC), the financing element is a separate performance obligation that must be carved out and accounted for separately. This will result in an upward adjustment of the transaction price, as it must be “grossed up” by the amount of the imputed interest expense associated with the “loan” from the resident to the CCRC.

**Example**

A resident with an actuarially determined remaining life of 10 years pays an upfront nonrefundable entrance fee of $100,000. If the upfront payment is, in substance, an interest-free loan from the resident to the CCRC, and if the CCRC’s normal interest cost for a 10-year loan would be $20,000, the new standard views the transaction price (and therefore the revenue to be recognized over the life of the contract) as $120,000. The CCRC would also recognize interest expense over the life of the contract of $20,000.

**Recognition of revenue.** Once the transaction price has been estimated, it must be allocated among the specific performance obligations identified. This allocation is done in proportion to the relative standalone selling prices of each performance obligation. If standalone selling prices are not directly available, the new standard describes allowable methods for estimating them.

The transaction price allocated to each performance obligation will be recognized when (or as) the performance obligation is satisfied. The performance obligation may be satisfied all at once (upon completion), or over time. The new standard states that when a customer simultaneously receives and consumes the benefit of services as the entity performs them, recognition over time is appropriate. Thus, the typical CCRC would likely be able to recognize revenue throughout the life of the contract, in the pattern over which benefits are transferred to the resident.

**Implementation considerations**

As previously mentioned, the FASB and the IASB have established a joint Transition Resource Group (TRG) to inform the Boards about broad-based interpretive issues identified as implementation efforts commence. Several recommendations from the TRG already are under consideration by the Boards as potential amendments.

Additionally, under the auspices of its Financial Reporting Executive Committee (FinREC), the AICPA has formed sixteen industry task forces to help develop a new Revenue Recognition Guide that will provide interpretive guidance for how to apply the new standard to industry-specific transactions. As FinREC identifies issues under discussion by its Task Forces that it believes warrant further consideration by the FASB, it forwards those to the TRG.

Among those AICPA industry task forces is the Health Care RRTF that has been previously mentioned. The Health Care RRTF is comprised of industry experts that are analyzing the standard and attempting to work out practical suggestions as to how it might be applied to health care services transactions. At some point, the Health Care RRTF expects to post its draft work product to the AICPA’s website for solicitation of informal comments. Ultimately, this guidance will also become part of the AICPA industry audit and accounting guide Health Care Entities. See the Appendix for a listing of the issues under consideration by the Health Care RRTF.
Appendix: AICPA Health Care Entities Revenue Recognition Task Force

The AICPA’s Health Care Entities Revenue Recognition Task Force is charged with developing suggestions and illustrative examples for how to apply the principles in the new guidance to health care services revenue transactions. Below is a list of potential implementation issues identified by the Task Force to date. The list will be updated as the Task Force continues its discussions.

1. Accounting for revenue contracts that do not meet the collectability threshold, specifically patient with uninsured self pay balances (including deductibles and co-pays), considering:
   - Application of step 1 in determining if there is a contract
   - Application of step 3 in determining the transaction price considering allowances/discounts and implicit price concessions
   - Application of the portfolio approach for self-pay balances

2. Identifying the performance obligation(s) and recognition of the monthly/periodic fees and refundable and nonrefundable entrance fees for CCRC contracts, considering:
   - Implications for the calculation of the obligation to provide future services and use of facilities (FSO)
   - Analysis related to the portfolio vs. individual contract approach to revenue recognition
   - Significant financing component considerations for refundable and nonrefundable fees

3. Scope of prepaid health services as it relates to revenue recognition and the application of FASB ASC 954 vs. ASC 944

4. Disclosure requirements as compared to ASU 2011-07

5. Contract acquisition costs for prepaid health services and CCRC entrance fees

6. Determination (estimation) of transaction price (expected value vs most likely) related to third-party settlement estimates

Source:
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