Hospital /Healthcare Accounting GLOSSARY

Accounts Payable (A/P)	short-term debt, obligation, or liability owed by the organization to other persons or companies for goods or services furnished
Accounts Receivable (A/R)	money owed to an organization for goods or services furnished
Accounts Receivable Collection Period	number of days in the accounting period divided by accounts receivable turnover; this ratio indicates on average, how long it takes to collect amounts due
Accounts Receivable Turnover	ratio indicates how many times accounts receivable is collected in a given cycle
Accrual Basis of Accounting	system of accounting that recognizes revenues when earned and expenses when resources used
Adjusted Discharge	for adjusted discharges or patient days: Adjusted Discharges (days) = Inpatient Discharges (days) X (1 + [Gross Outpatient Revenue/Gross Inpatient Revenue])
Adjusted Patient Days	estimate of utilization by inpatient, outpatient and newborn based on total gross revenue
Aging	process wherein accounts receivable or accounts payable are scheduled, listed, or arranged based on elapsed time from date of service or transaction
Allowance for Bad Debts	an estimate of the amount of accounts receivable that a health care provider will be unable to collect; it reduces the value of accounts receivable
Ambulatory Patient Group (APG), Ambulatory Payment Classification (APC)	institutional outpatient reimbursement system based on the methodology developed by CMS; APCs/APGs are to outpatient visits/services what DRGs are to inpatient hospital admissions; the payments are based on categories or groupings of like or similar services requiring like or similar professional services and supply utilization
Amortization	the systematic allocation of an item to revenue or expense over a number of accounting periods such as repayment of a loan on an installment basis

Hospital /Healthcare Accounting GLOSSARY

Annual Debt Service	used to determine how much a hospital or health system is leveraged
Assets	resources owned by the organization; one of the three major categories on the balance sheet
Assignment	agreement in which a patient transfers to a provider the right to receive payment from a third party for the service the patient has received
Average Age of Plant	a measure of the average age in years of a hospitals fixed assets; a lower value indicates less of a need for replacement and a higher age indicates the need for more capital spending; accumulated depreciation divided by depreciation expense is the ratio formula
Average Daily Census (ADC)	average number of inpatients, excluding newborns, receiving care each day during a reported period
Average Length of Stay (ALOS)	average stay counted by days of all or a class of inpatients discharged over a given period, calculated by dividing the number of inpatient days by the number of discharges
Bad Debt	amount not recoverable from a patient following exhaustion of all collection efforts
Balance Billing	practice of a provider billing a patient for balances not paid by a third party
Balance Sheet	financial statement that presents a snapshot of the financial condition of a health care organization at a specific point in time; statement that lists the financial resources (assets), financial obligations (liabilities), and ownership rights (equity/fund balance) within the organization
Base Capitation	stipulated dollar amount to cover the cost of total health care per covered person, carried-out services; usually stated in a monthly dollar amount
Bed Days/1000	an aggregate measure reflecting both admissions and lengths of stay as well as a global measure of inpatient management; number of inpatient days per 1000 covered health plan members
Bed Turnover Rate	number of times a facility bed, on average, changes occupants during a given period of time

Hospital /Healthcare Accounting GLOSSARY

Benchmarks	industry standards for specific tasks or performance normally set by surveying groups and comparing data across groups
Bond	long-term debt issued by a business or government unit whereby the issuer receives cash and in return issues a note; the issuer agrees to make principal and interest payments on specific dates to holders of the bond
Bond Rating	assignment or grading of the likelihood that an organization will not default on its bond obligation
Book Value	cost of an asset less its accumulated depreciation
Break-Even Point	the price at which a transaction produces neither a gain nor loss; this occurs when income matches expenditures; this definition can apply to a product, investment or the entire company's operations
Budget	comprehensive management plan of operation that formally expresses both broad and specific objectives and sets standards for the evaluation of performance
Capital	fixed or durable non-labor inputs or factors used in the production of goods and services, the value of such factors, or the money specifically allocated for their acquisition or development
Capital Asset	depreciable property of a fixed or permanent nature, including buildings or equipment not for sale in the regular course of business
Capital Budget	plan that outlines the organization's future expected expenditures on new fixed assets (e.g., land, building and equipment)
Capital Cost	cost of investing in the development of new facilities, services, or equipment, excluding operational costs
Capital Expenditure	outlay for capital assets such as facilities and equipment, excluding outlay for operation or maintenance
Capital Expenditure Growth Rate	a gauge indicating how aggressive a hospital invests in its plant and equipment; a high value indicates an active capital expenditure program of additions and replacements; measured as a percentage of the organizations total gross property, plant, and equipment added in a given year

Hospital /Healthcare Accounting GLOSSARY

Capital Financing	institutional funding for facilities and equipment that become part of the capital assets of the institution
Capital Lease	leasing arrangement where the lessee seeks a long-term commitment to use the asset with or without the eventual opportunity to purchase the asset
Capital Structure	structure of the liabilities and the net assets section of the organization's balance sheet
Capitation	method under which selected health services are paid for on the basis of a fixed rate per eligible member without regard to the actual number or nature of services provided to each enrollee; typically paid per member per month (PMPM). Payment system in which providers receive a specific amount in advance to care for specific health care needs of a defined population over a specific time period. Capitated provider assumes the risk of caring for covered population for the PMPM amount.
Carve-Out	set of health plan benefits that are contracted separately from the standard benefits package
Case Management	method of managing the provision of health care with the goal of improving continuity and quality of care while lowering cost
Case Manager	clinical professional who works with patients, providers, families, and insurers to coordinate all the services deemed necessary to care for the patient in the best and lowest cost medically appropriate setting
Case Mix	clinical composition of a provider's population among various diagnoses used as a factor in determining cost of service and rate setting; mix of patients who have different third party payers for their medical bills (i.e., Medicare, private insurance, workers' compensation)
Case Mix Index (CMI)	measure of the relative costliness/acuity of patients treated in each hospital or group of hospitals
Case Rate	Fixed reimbursement amount depending on the type of case; typically includes both physician and hospital charges, limits the liability of the payer and shifts some of the financial risk to the provider
Cash	also called currency; is used to determine liquidity ratios and transact financial business; considered the most liquid of all assets

Hospital /Healthcare Accounting GLOSSARY

Census	count of patients who at the time counted were duly registered in a provider's care, normally on an inpatient basis; count of all the people in the United States taken every ten years by the federal government; listing of all eligible members who are to be covered by a plan
Centers for Medicare and Medicaid Services (CMS)	formerly Health Care Financing Administration (HCFA); government agency and division of the U. S. Department of Health and Human Services (HHS) that is responsible for administering Medicare, Medicaid and the Children's Health Insurance Program (CHIP); is also the contracting agency for third-party payers who seek direct contractor/provider status for administration of the Medicare benefit package to its enrollees
Charges	prices assigned to units of medical services, such as a visit to a physician or an inpatient day at a health care facility; gross prices charged for health care services considering any discounts to insurers, government payers, uninsured patients, patients who qualify for financial assistance or discounts for any other reasons
Chargemaster	provider's official list of charges (prices) for goods and services rendered
Charity Care	care rendered to patients without the expectation of compensation for such services
Chart of Accounts	listing of an organization's account numbers and titles within a general ledger system
Claim	request to an insurer by an insured person or assignee for payment of benefits under an insurance policy
Claims Adjudication	in health insurance, this refers to the determination of a member's payment, or financial responsibility, after a medical claim is applied to the member's insurance benefits
Claims Billed	submission of a claim for payment for services rendered by a health care provider to the insured or to the patient
Claims Incurred	insurance company's actual liability for all claims which have been incurred meaning that the covered individual has received services or supplies and those services have yet been paid by the insurance company
Claims Paid	actual amount paid to either individuals or providers to satisfy the contractual liability of a benefit plan; does not include member liability for copayments, coinsurances, deductibles, etc.

Claims Review	retrospective or prospective review by government, medical foundations, insurers, or others responsible for payment to determine the financial liability of the payer, eligibility of the beneficiary and the provider, appropriateness of the service provided, amount requested under an insurance or prepayment contract, and utilization rates for specific plans
Clean Claim	claim that can be processed without additional information from the provider or third party
Clearinghouse	third party used for centralizing the sending and receiving of electronic messages, claims, documents, claims and other remittance advices between organizations
Contract	legal arrangement between two parties; legal arrangement between an insurer and a provider under which a provider agrees to certain terms such as specified reimbursement rates for health care services provided and the insurer agrees to certain terms such as timely payment
Contractual Adjustment / Deductions	accounting adjustment required to reflect uncollectible differences between established charges for services rendered to insured persons and rates payable for those services under contracts with third-party payers
Contribution Margin	revenue from services minus all variable expenses; difference between per unit of revenue and per unit cost (variable cost rate) and thus the amount that each unit of output contributes to cover the fixed costs
Coordination of Benefits (COB)	claims review procedure by which a claim covered by two or more carriers is identified and the liability of each is determined for the purpose of avoiding duplication of payments
Copayment	a type of cost sharing arrangement under which the insured pays a predetermined dollar amount per episode of service, with the insurer paying the remainder
Cost	expenses incurred
Cost Accounting	process used to calculate the expense associated with delivery of an individual unit of service
Cost Allocation	assignment to each of several organizational departments or services an equitable proportion of the costs of activities that serve them all
Cost Center	the grouping of all related costs attributable to a "financial center" within an institution, e.g., department or program, segregated for accounting or reimbursement purposes

Hospital /Healthcare Accounting GLOSSARY

Cost of Capital	rate of return required to undertake a project; the discount rate that reflects the overall average risk of the project or business
Cost Outlier	patient whose cost of treatment exceeds the predefined cost threshold established for DRG payments assigned
Cost Plus	insurance contractual arrangement whereby the subcontracted payer of claims for a group health plan is paid the actual cost of the claim settlement plus a fixed amount for providing claims processing services
Cost-Based Reimbursement	method of Medicare reimbursement for critical access hospitals and other cost report based payments
Cost Sharing	method by which part of the cost of medical services is shared between the plan and the patient
Cost Shifting	the practice of charging certain patients higher rates to recoup losses sustained when a third-party payer reimburses at a lower rate for other patients
Covered Person	individual who meets plan eligibility requirements and for whom current premium payments are paid
Covered Service	service supplied by a provider to a patient, which is included in the scope of insurance benefits
Current Assets	asset that is expected to be converted into cash within one accounting period (often a year)
Current Liabilities	financial obligations that are paid within one year
Days Cash on Hand	cash plus short and long-term investments divided by total expenses less depreciation divided by 365; measures the number of days of average cash expense that a hospital maintains in cash or marketable securities; a measure of short and long-term liquidity; a higher value indicates better debt repayment ability
Days in Accounts Receivable	net accounts receivable divided by (net patient revenue/365); ratio indicates how quickly a hospital is converting its receivables into cash

Hospital /Healthcare Accounting GLOSSARY

Days per 1000	for a stated population of 1,000 individuals, the estimated number of hospital inpatient days per year
Debt Service Coverage	measures total debt service coverage, including interest plus principal, against annual funds available to pay debt service; does not take into account positive or negative cash flow associated with balance sheet changes; higher value indicates better debt repayment ability
Deductible	expense that the insured must incur before an insurer will assume any liability for all or part of the remaining cost of covered services
Deferred Revenues	accounting treatment applied to the receipt or accrual of revenue before it is earned; monies received that have not been yet earned, such as capitation receipts on the basis of PMPM
Depreciation	the systematic allocation of the cost of a capital asset over a predetermined timeframe
Diagnosis Related Groups (DRGs)	patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed; provides a framework for specifying hospital case mix; identifies a number of classifications of illnesses and injuries for which Medicare payment is made under the prospective pricing system
Direct Contracting	single or multi-employer health care alliances that contract directly with providers for health care services with no insurance company or managed care plan involvement
Direct Cost	cost that is clearly and directly associated with rendering services
Discharge Planning	coordination by provider personnel with external sources to provide the necessary care to the patient when the patient is discharged
Discount Rate	interest rate used to adjust a future cash flow to its present value
Discounted Fee For Service (FFS)	a contractual arrangement between a provider and a payer where the provider agrees to accept less than the normal charge for providing a service; usually specified as a fixed percent such as 90%, 85%, 80%, etc. of the normal charge
Disproportionate Share Hospital (DSH)	a designation given to a hospital that meets CMS criteria for care given to indigent and/or state health care related program patients

Hospital /Healthcare Accounting GLOSSARY

EBIDA	earnings before interest, depreciation, and amortization; used by not-for-profit as a measure of operational efficiency; a measure of operating success before the costs of long-lived assets
EBITDA	earnings before interest, taxes, depreciation, and amortization; used for-profits
Electronic Health Record (EHR)	a global computerized record containing storage and retrieval of patient health information in a digital format. Usually contains patients demographics, medical history, medications, allergy list, lab test results, radiology images and advance directives
Exempt Financing	financing transactions or debt for tax-exempt organizations
Expense	Measure of the resource used to generate revenue and or provide a service
FASB	Financial Accounting Standards Board a private organization whose mission is to establish and improve the standards of financial accounting and reporting requirements for private businesses
Fee For Service (FFS)	traditional means of billing by health providers for each service performed; requesting payment in specific amounts for specific services rendered
Fee Schedule	listing of fees or payments for specific provider services or supplies
Financing	refers to source of resources used in funding a project or an investment
Fiscal Intermediary (FI)	public or private insurer agency selected by CMS to pay institutional claims under Medicare
Fiscal Year	accounting or reporting year adopted by an entity
Fixed Asset	business' long term assets such as land, building and equipment

Fixed Asset Turnover	an indicator of operating efficiency; the number of operating revenue dollars generated per dollar of fixed asset investment is the ratio formula
Fixed Budget	provides for specified expenditures that do not vary with activity levels
Fixed Cost	cost that remains constant over a period of time or level of activity and is not affected by changes in volume
Flexible Budget	budget that, when prepared, recognizes that expenditures are a function of activity levels and are adjusted accordingly
Forecast	estimate of the most probable future financial position
Form 990	name of IRS form applicable to not-for-profit organizations for reporting their activities for a fiscal period
Foundation	a fund raising entity, often affiliated with a health care system or provider
Full-Time Equivalent (FTE)	workforce equivalent of one full-time individual or several part-time workers for a specific period
Gatekeeper	primary care physician responsible for monitoring a patient's utilization of health care services; a type of health insurance plan requiring covered persons to select a primary care physician or the plan's participating providers. The patient is required to see the selected primary care physician for care and referrals to other health care providers within the plan. HMOs use this type of health plan.
Generally Accepted Accounting Principles (GAAP)	the overall conventions, rules, and procedures that define accepted accounting practice in the US
Global Capitation	form of capitation that covers all medical expenses, including professional and institutional charges

Hospital /Healthcare Accounting GLOSSARY

Gross Margin	net sales minus cost of goods sold; difference between sales revenues and manufacturing costs as an intermediate step in the computation of operating profits or net income
Health Maintenance Organization (HMO)	health plan that has management responsibility for providing comprehensive health care services on a prepayment basis to voluntarily enrolled persons within a designated population
Health Plan	health insurance plan, HMOs, PPOs, self-funded plans, or any other plans that pay for health care services to enrollees
Health Care System	corporate body that may own and or manage health provider facilities or health-related subsidiaries as well as non-health related facilities that are either freestanding or subsidiary corporations and may include multiple hospitals or one hospital and additional provider facilities or programs
Hospital	institutional health care provider with an organized medical and professional staff and with permanent facilities that are able to provide inpatient and outpatient services including medical, nursing, and other health-related care to patients
Hospital-Based Physician (HBP)	physician who furnishes services in a hospital through a contractual or employment relationship
Hospitalist	a physician based in a hospital setting responsible for the care and treatment of hospitalized patients; spends most of their time in a hospital and are more readily available to the patient than a doctor who spends much of the day outside the hospital in an office or clinic setting
Indemnity Insurance	standard type of health insurance where benefits are paid in a predetermined amount in the event of a covered loss
Independent Practice Association (IPA)	organizational structure through which private physicians participate in a prepaid medical plan, charge agreed-upon rates to enrolled patients, bill the association on a fee-for-service basis, and are organized as part of a health maintenance organization
Indirect Costs	costs that are incidental or not related to the direct function of treating patients
Inpatient (IP)	patient who is provided with room, board, and continuous acute nursing service in an area of a hospital where patients remain hospitalized overnight
Insurance	contract that provides reimbursement for, or indemnification from, the results of a specific event

Hospital /Healthcare Accounting GLOSSARY

Integrated Delivery System (IDS)	a system of health care providers organized to deliver a broad range of health care services; other terms include integrated health care delivery system (IHCDS), integrated delivery network (IDN), and integrated delivery and financing system (IDFN)
Internal Rate of Return (IRR)	percentage return on investment; rate of return at which the net present value equals zero
Interest	money paid for the use of money
Key Performance Indicators (KPI)	financial statement ratio and /or operating indicator that is considered by management to be critical to the business' financial performance
Length of Stay (LOS)	number of calendar days that elapse between an admission and discharge
Lessee	one who uses the asset in the leasing arrangement
Lessor	one who owns the asset in the leasing arrangement
Long-Term Debt Capitalization	formulated as long-term debt divided by long-term debt plus unrestricted net assets; higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt
Malpractice	professional misconduct or lack of ordinary skill in the performance of a professional act
Malpractice Insurance	insurance either purchased or provided for by self-funding to reimburse or compensate a provider for the adverse effects of a legal action
Managed Care	comprehensive health care plans that attempt to reduce costs through contractual agreements with providers and through care management initiatives
Marginal Cost	the next dollar spent to generate one additional unit of service
Market Value	current exchange price as of the date of the financial statement

Medicaid (Title XIX)	federally aided, state-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care; benefits, program eligibility, rates of payment for providers, and methods of administering determined by the state subject to federal guidelines
Medical Foundation Model	a tax-exempt entity, usually a hospital or clinic that provides health care to patients. Physicians ally with foundations via professional service agreements. The foundation, not the doctor, holds the managed care contracts.
Medical Group Model	competitive entity that offers a high degree of integration of health care delivery; is usually made up of a large multi-specialty medical group operating under one tax ID that owns and operates one or more clinics that may also include ancillary services such as laboratory and imaging, as well as ambulatory surgery; generally the medical group contracts with payers separately from any hospital
Medical Record	record of a patient maintained by a hospital or a physician for the purpose of documenting clinical data on diagnosis, treatment, and outcome
Medicare (Title XVIII)	U.S. health insurance program generally for people aged 65 and over, consists primarily of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B)
Medicare Advantage	Medicare Prescription Drug, Improvement and Modernization Act (MMA) replaced the Medicare+Choice program with Medicare Advantage, allowing Medicare beneficiaries to enroll in a managed care plan
Medicare Part A	hospital insurance program portion of Medicare, which automatically enrolls all persons aged 65 and over entitled to benefits under the Old Age, Survivors, Disability and Health Insurance Program or railroad retirement; generally pays for inpatient care
Medicare Part B	voluntary portion of Medicare, which generally covers physician services; requires enrollment and the payment of a monthly premium
Medicare Part C	a program known as Medicare Advantage; if you are entitled to Medicare Part A and enrolled in Part B, you are eligible to switch to a Medicare Advantage plan provided by Medicare approved managed care plans, provided one or more plans are available in your service area
Medicare Part D	Medicare prescription drug plan for Medicare beneficiaries

Medicare Payment Advisory Commission (MedPAC)	independent advisory group appointed by Congress to review and make recommendations to the HHS Secretary on issues affecting the Medicare program including normal increases in Medicare payment rates; mandated by the Balanced Budget Act as a consolidation of the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC)
Medicare Provider Analysis and Review File (MedPAR)	database containing clinical and financial claims data for Medicare beneficiaries, in which data elements are defined by Medicare billing requirements and are maintained by CMS
Medigap Insurance	supplemental insurance sold by private insurance companies to pay for medical expenses not covered by Medicare
Member	any individual enrolled in a health care benefit plan
Member Month	unit of volume measurement calculated regardless of whether or not the member actually received services during the month
MS-DRG	Medicare Severity Adjusted DRG; system implemented by CMS October 1, 2007 and used in the inpatient prospective payment system. The number of DRGs was expanded to745.
Net Accounts Receivable	accounts receivable reduced by all contractual allowances covered in government participation agreement and third-party managed care contracts
Net Assets	in not-for-profit organizations, net assets often is used in place of "equity"; residual amount from total assets less total liabilities
Net Fixed Assets	value of assets after deducting depreciation
Net Income	net of revenues, expenses, gains, and losses over a specified period of time
Net Operating Income	net revenue less operating expenses but before all non-operating income and expenses as well as taxes that result in a profit.

Hospital /Healthcare Accounting GLOSSARY

Net Working Capital	current assets minus current liabilities
Net Operation Loss	net revenue less operation expenses but before other income and expense and taxes that result in a loss
Net Operation Revenue	total revenue less contractual allowance reductions
Net Patient Service Revenue	represents revenue actually collected after all contractual adjustments and bad debts are removed
Net Present Value	the sum of the present values (PVs) of the individual cash flows. NPV is a central tool in discounted cash flow (DCF) analysis, and is a standard method for using the time value of money to appraise long-term projects. Used for capital budgeting, it measures the excess or shortfall of cash flows, in present value terms, once financing charges are met.
Not-For-Profit Organization (NFP)	tax-exempt organization chartered for a charitable purpose; entity organized under any state's not-for-profit corporation enabling statute for purposes such as charity, education, research, religion, or other purposes in which private persons are not permitted to receive distributions of assets
Observation	23 hour or less stay in hospital setting
Occupancy Rate	measure of percentage of beds occupied in a hospital over a period of time
One-Time Revenue	amount of money received from a non-repeating source or event, such as a sale of an asset
Operating Budget	budget that combines both revenue and expense budgets
Operating Costs	costs and expenses directly attributable to operations of business activities

Hospital /Healthcare Accounting GLOSSARY

Operating Lease	a lease with no transfer of ownership interest; annual rent commitments are recorded as rental expense in the current period as they occur
Operating Margin	defined in the health care industry as total operating revenues minus total operating expenses. Operating margin percentage is a measure of operating success in controlling costs per dollar of revenue
Out-Of-Pocket (OOP) Cost	portion of payment for health services required to be paid by the participating member in the health plan
Outpatient (OP)	a person who receives health care services without being admitted to a hospital
Outpatient Service	hospital health care service provided to patients who do not require admission as inpatients
Overhead Expenses	excludes the economic costs of the physicians time in delivering the services but includes shared expenses such as office rent, utilities, and insurance; physician groups may share these expenses equally but they may also share them according to other allocation methods
Patient Day	unit of measure depicting lodging in a facility between two consecutive census taking periods; unit of time (days) inpatient services of the health care facility are utilized by a patient
Patient Financial Obligation	the amount the patient owes for health care services, after payment from other sources and after any discounts have been considered; includes co-payments, deductibles, coinsurance, and amounts due for services not covered by insurance
Patient Mix	numbers and types of patients served by provider or insurer, classified according to their home, socioeconomic characteristics, diagnosis, or severity of illness
Pay for Performance (P4P)	uses incentives to encourage and reinforce the delivery of evidence-based practices to improve the health care quality and services as efficiently as possible; also available to hospitals in certain markets
Payers	insurance companies or other financing vehicles, employers, or government entities (Medicare, Medicaid) that pays a provider for the delivery of health care services on behalf of their clients, employees, or other covered lives

Peer Review (PR)	concurrent or retrospective review by practicing physicians or other health professionals of the quality and efficiency of patient care practices or services ordered or performed by other physicians or other professionals
Per Diem Rate	established daily rate of payment regardless of services of rendered; set amount that a payer pays for one day of care
Per Diem Reimbursement	payment based on a negotiated rate which can be varied by service
Per Member Per Month (PMPM)	payment for each plan's member for one month
Per Thousand Members Per Year (PTMPY)	provider utilization expressed as hospital inpatient days per thousand members per year
Point of Service (POS)	health care insurance plan that allows the member to select to use providers either in network or out of network; beneficiaries are enrolled in an HMO but have the option to go outside of the network for an additional cost
Precertification (Pre-Admission Certification, Pre-Admission Review, or Precert)	process of obtaining authorization from the health benefit plan for routine hospital admissions (inpatient or outpatient) or other high cost services prior to service delivery
Preferred Provider Organization (PPO)	an arrangement whereby a third- party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return guarantees of a certain volume of patients
Premium	periodic payment, usually monthly, made to a health benefit plan in return for providing health benefits coverage to members under the contract
Prepaid	incidence of an expenditure before the benefits are received

Present Value	value today of an amount to be received or paid later at an assumed discount or interest rate
Pricing Transparency	making hospital prices widely available to patients who may want to shop around for certain services; usually applicable to elective services where the patient can afford to take the time to shop around; empowers patient with high deductible health plan as well as consumers to find value and quality when comparing health care procedures and services
Primary Care	routine medical care, normally provided in a doctor's office or professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in ambulatory setting, with referral to secondary care specialists as necessary
Primary Care Physician (PCP)	family physicians, general practitioners, internists, pediatricians, and, occasionally OB-GYNS, who act as a patient's principal or first contact for health care services
Prospective Payment System (PPS)	method of payment by which rates of payment to providers for services to patients are established in advance for the coming fiscal year; providers are paid these rates for services delivered regardless of the costs actually incurred in providing these services
Provider	health care professional, a group of health care professionals, a hospital, or some other facility that provides health care services to patients
Quick Ratio	Cash, short-term investments, and receivables divided by current liabilities
Ratio Analysis	a significant component of financial statement analysis; summarizes financial statement relationships among the financial statement elements
Reimbursement	process by which health care providers receive payment for their services
Reinsurance	insurance purchased by a health benefits plan to protect it against extremely high cost cases (specific reinsurance) or against extremely high claims cost in total (aggregate reinsurance)
Return on Assets (ROA)	net income divided by total assets; a useful gauge of profitability by measuring the size of the surplus generated in relation to the amount of assets needed to achieve the surplus

Return on Equity (ROE)	net income divided by book value; a financial indicator that measures a hospitals ability to add new investment in plant and equipment without adding excessive levels of new debt; the amount of net income earned per dollar of net assets or equity; an increase is a positive trend
Return on Investment (ROI)	percentage gain or loss experienced from an investment
Revenue	the income that results from the sale of goods and the rendering of services, which is measured by the charge made to patients for goods and services furnished to them; gains from the sale or exchange of assets, interest, and dividends earned on investments and unrestricted donations of resources to the hospital are also considered revenue
Revenue Cycle	all administrative and clinical functions that contribute to the capture, management, and resolution of patient service
Self-Insurance	program for providing group insurance with benefits financed and risk assumed entirely through the internal means of the policyholder, instead of through coverage purchased from a commercial carrier
Self-Insured or Self-Funded Plan	health plan where the risk for the medical costs is assumed by the employer, union, or plan administrator rather than an insurance company or managed care plan that handles the administrative functions of the plan
Self-Pay Patients	patients who are personally responsible for all or a portion of their health care bills because of factors such as health plan cost-sharing provisions (annual deductible or co-payments); services not covered by health insurance; or the lack of coverage by private insurance or governmental health care programs
Semi-Variable Costs	step costs that are fixed up to a certain level of operations; upon reaching a predetermined level, these costs become variable
Statement of Cash Flows	a financial statement that summarizes the current period business activities on a cash basis
Statement of Earnings	see Statement of Income

Hospital /Healthcare Accounting GLOSSARY

Statement of Income / Statement of Operations	a report of a company's revenues, expenses, gains, and losses that are the result of operating and non-operating activities over a specific period of time
Statement of Revenue and Expenses	see Statement of Income
Stop-Loss Insurance	reinsurance that provides protection for the expenses of medical treatment above a certain cost limit; maximum amount a plan member is required to spend for services in a given period or over a lifetime
Tax-Exempt Organization	organization determined by the IRS to be exempt from federal income tax under Internal Revenue Code section 501(a) regulations
Tax-Exempt Bonds	bonds in which the interest payments to the investor are exempt from IRS taxation; bonds must be issued by an organization that has received tax-exempt from the IRS and are used to fund projects that qualify as exempt uses; backed by the organization's revenue and offer lower interest rates than taxable bonds
Third Party Payer	entity other than the patient that pays for health care services; examples include Medicare, indemnity insurance, Medicaid and HMOs
Uncompensated Care	services absorbed by a provider in providing medical care for patients who do not pay
Uninsured Patients	self-pay patients who have no commercial health insurance or government sponsored health coverage for their health care at any given time during the year
Utilization	the frequency with which a benefit is used, for example 3,200 doctors office visits per 1,000 HMO members per year; utilization experience multiplied by the average cost per unit of service delivered equals capitated costs
Utilization Management (UM)	integration of utilization review, risk management, and quality assurance into management in order to ensure the judicious use of the facility's resources and high quality care
Utilization Review (UR)	review of appropriateness of health care services on a prospective, concurrent, and retrospective basis

Hospital /Healthcare Accounting GLOSSARY

Variable Cost	a cost whose unit value remains relatively constant but whose aggregate value changes, usually proportionately to changes in volume
Withhold	form of compensation whereby a health plan withholds payment to a provider until the end of a period at which time the plan distributes any surplus based on some measure of provider efficiency or performance
Working Capital	sum of an institution's short-term or current assets including cash, marketable (short-term) securities, accounts receivable, and inventories minus current liabilities

Glossary terms taken from the following three sources:

1) Health Care Financial Management Association Glossary
2) Understanding Healthcare Financial Management, 5th Edition, by Louis C. Gapenski, Ph.D., George H. Pink, Ph.D., Health Administration Press, November 2006
3) Essentials Of Health Care Finance, 5th Edition, by William O. Cleverley and Andrew E. Cameron, Aspen Publishers, 2002