

RESEARCH PAPER

THE CURRENT RECESSION AND U.S. HOSPITALS

MARCH 2009

DENNIS DUNN, PHD
DAVID KOEPKE, PHD
GARY PICKENS, PHD

CENTER FOR HEALTHCARE IMPROVEMENT



TABLE OF CONTENTS

Introduction	3
Hospital Operation, Revenues, and Profitability.....	4
Hospital Employment and Mass Layoffs.....	10
Hospital Closures.....	12
Hospital Patient Volume	14
Hospital Payer Mix	21
Summary.....	21
Data Sources and Methodology	22

LIST OF FIGURES

Figure 1: Hospitals Total and Operating Margins, Q2 2005–Q3 2008	4
Figure 2: Percentage of Hospitals with Negative Margins, Q2 2005–Q3 2008	5
Figure 3: Change in Hospital Restricted Investments, Q2 2005–Q3 2008	5
Figure 4: Change in Hospital Reimbursement Rates, January 2007–December 2008	6
Figure 5: Hospital Days Cash on Hand, All Sources, Q2 2005–Q3 2008	7
Figure 6: Hospital Bad Debt and Charity Expenses, Q2 2005–Q3 2008.....	8
Figure 7: Hospital Capital Expenditures and Interest Expense, Q2 2005–Q3 2008	8
Figure 8: Expense per Discharge and Patient Day, Q2 2005–Q3 2008	9
Figure 9: Percentage of Licensed Beds in Operation, Q2 2005–Q3 2008.....	9
Figure 10: Hospital Industry Employment, January 2007–January 2009	10
Figure 11: Hospital Industry Mass Layoffs, January 2005–December 2008	11
Figure 12: Hospital Industry Mass Layoffs, January 2007–December 2008.....	12
Figure 13: Hospital Closures, Q1 2005–Q3 2008.....	13
Figure 14: Total and Elective Inpatient Admissions, January 2007–December 2008.....	14
Figure 15: Change in Total and Elective Admissions, January, 2007–December 2008.....	15
Figure 16: Cardiovascular Services Admissions, January 2007–December 2008	16
Figure 17: Orthopedic Surgery Admissions, January 2007–December 2008.....	16
Figure 18: Hospital Outpatient Major Procedure Group Volumes, January 2006–December 2008.....	17
Figure 19: Hospital Outpatient Key Procedure Volumes, January 2006–December 2008	17
Figure 20: Changes in Hospital Outpatient Major Procedure Group Volumes, January 2007–December 2008 ...	18
Figure 21: Changes in Hospital Outpatient Key Procedure Volumes, January 2007–December 2008	18
Figure 22: Physician Service Volumes, Major Procedure Groups, February 2007–January 2009	19
Figure 23: Physician Service Volumes, Elective Procedures, February 2007–January 2009.....	20
Figure 24: Inpatient Admissions by Principal Payer, January 2006–December 2008	21

INTRODUCTION

The hospital industry has long been viewed as recession-proof, which is largely supported by historical data. However, this recession presents some unprecedented challenges for hospitals' operations. This variance raises questions about the value of historical information as a guide for understanding the present.

In researching this brief, the Healthcare business of Thomson Reuters examined current data and recent trends on:

- Hospital finances and operations
- Hospital employment
- Hospital closures
- Patient volumes
- Hospital payer mix

Our research shows that although the hospital industry is not recession-proof, it appears to be recession-resistant. Following is what we know as of January 2009 (all conclusions are based on national data).

Observed impacts that appear related to the recession:

- Hospital nonoperating and total margins have decreased dramatically, especially in Q3 2008. Total margins are at historically unprecedented lows.
- Approximately 50 percent of hospitals are operating in the red.
- Number of hospital days cash on hand has decreased significantly, mirroring a prerecession trend.
- Restricted investment assets have shrunk substantially for major teaching hospitals. These are nonrealized losses that are not reflected in total margin declines.
- Hospital reimbursement rate increases appear to be shrinking—with possible negative impacts on net patient revenue in 2009.
- Inpatient total admission volumes may be falling below expectation. Note that our trend data are not yet conclusive.

Possible recession impacts that we have not observed:

- Rising hospital unemployment rates or declining payrolls
- Bed closures
- Increases in hospital bad debt or interest expense
- Decreases in hospital capital expenditures
- Deferral of elective procedures (in hospital and nonhospital settings)
- Decreases in private pay or increases in Medicaid/uninsured patients for hospitals

HOSPITAL OPERATION, REVENUES, AND PROFITABILITY

The Thomson Reuters ACTION O-I® database provides an array of financial and operational indicators for a large sample of general acute-care hospitals.

In this sample, total margins declined for every class of hospital in 2008. Total margin consists of excess revenue derived from operations as well as nonoperating margins derived primarily from investments.

These hospitals maintained consistent operating margins through the third quarter of 2008—but their nonoperating margins began to decline in the third quarter of 2007 and accelerated their decline in the second and third quarters of 2008. This dragged down the median total margin to near zero and left approximately 50 percent of hospitals in the red (Figures 1 and 2). When we compare these total margin statistics with historic data, we find that medians this low have not been observed before.¹

Although the median total margin is near zero, there is substantial variation among hospitals. The bottom quartile of hospitals is operating with total margins lower than minus 7 percent, while the top quartile has total margins exceeding 4.5 percent.

FIGURE 1: HOSPITALS TOTAL AND OPERATING MARGINS, Q2 2005–Q3 2008

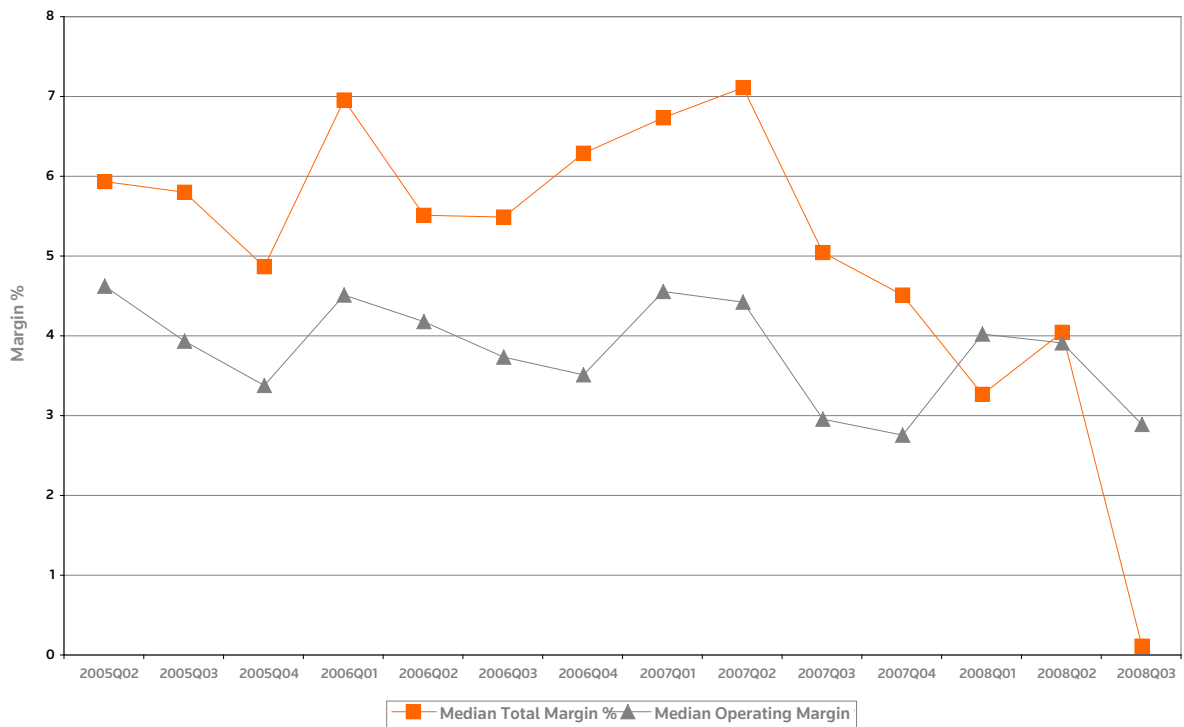
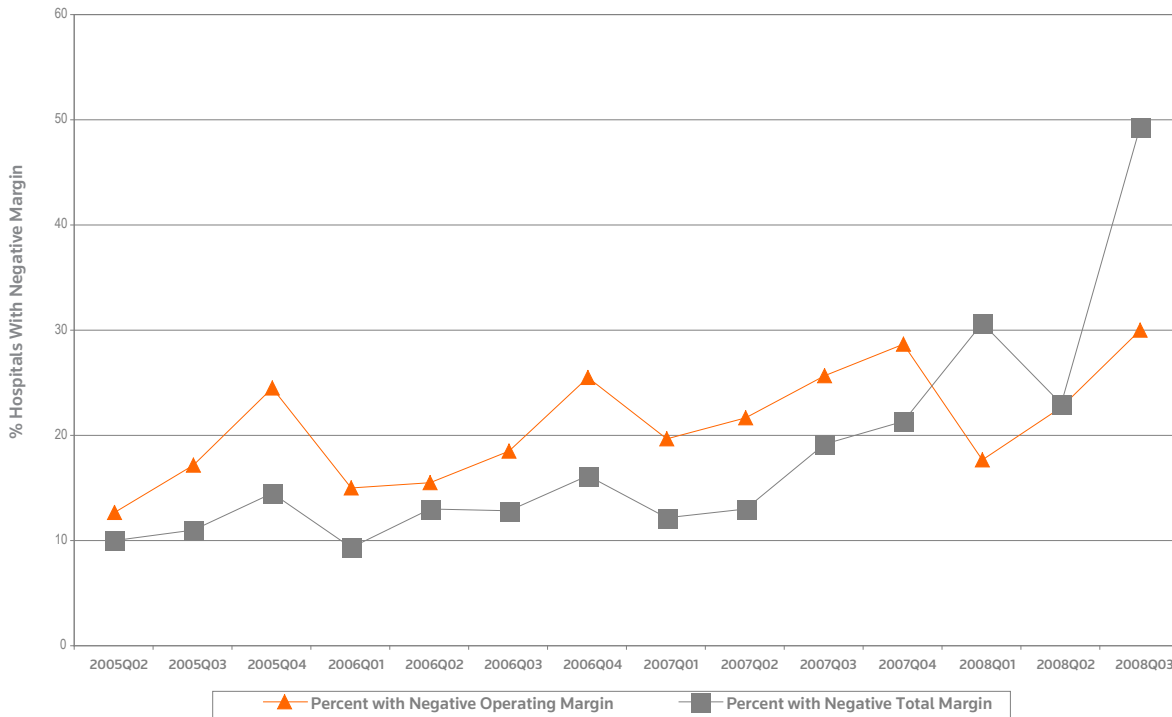
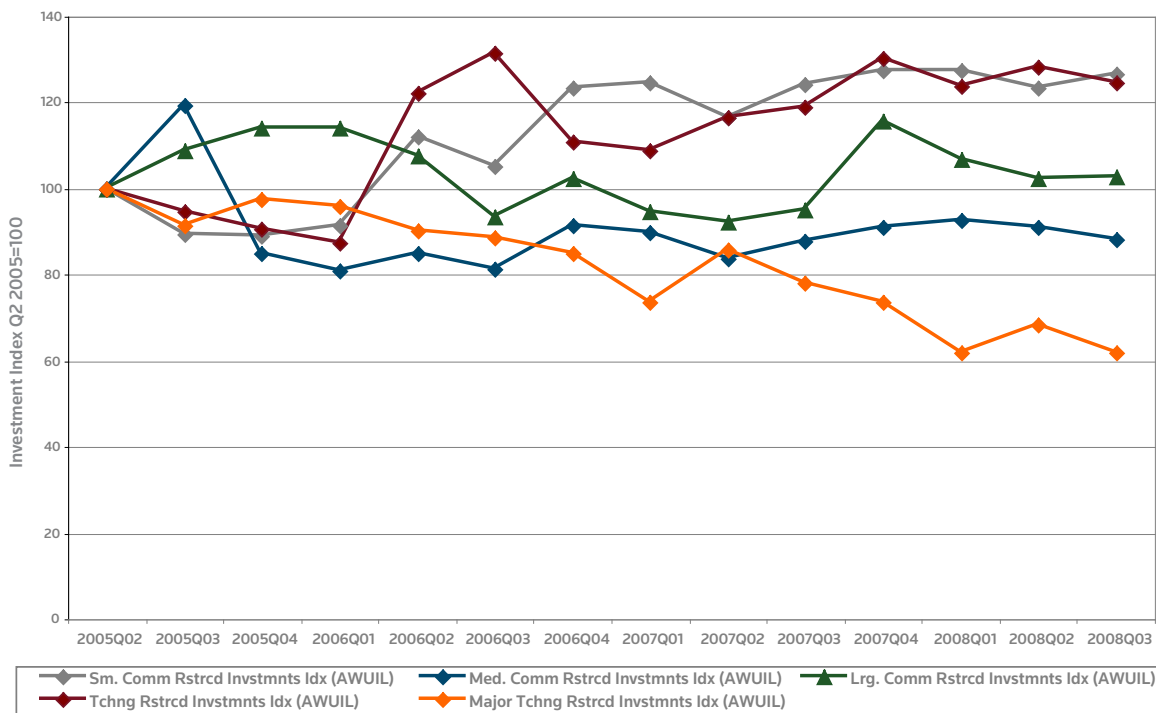


FIGURE 2: PERCENTAGE OF HOSPITALS WITH NEGATIVE MARGINS, Q2 2005–Q3 2008



The recession has also had an impact on other hospital assets. Nonoperating losses reflect only realized or permanent investment losses. Hospital balance sheets indicate much larger unrealized investment losses, concentrated almost entirely in major teaching hospitals. These hospitals showed significant decreases in both unrestricted and restricted assets through the third quarter of 2008. In major teaching hospitals, restricted assets have declined by a median \$60 million in the past three years, whereas in other hospitals, these investments are largely unchanged. Major teaching hospitals have also given up a median \$10 million of their gains in unrestricted assets in the past year. Other hospitals have, on average, maintained or even increased their unrestricted assets (see Figure 3).

FIGURE 3: CHANGE IN HOSPITAL RESTRICTED INVESTMENTS, Q2 2005–Q3 2008



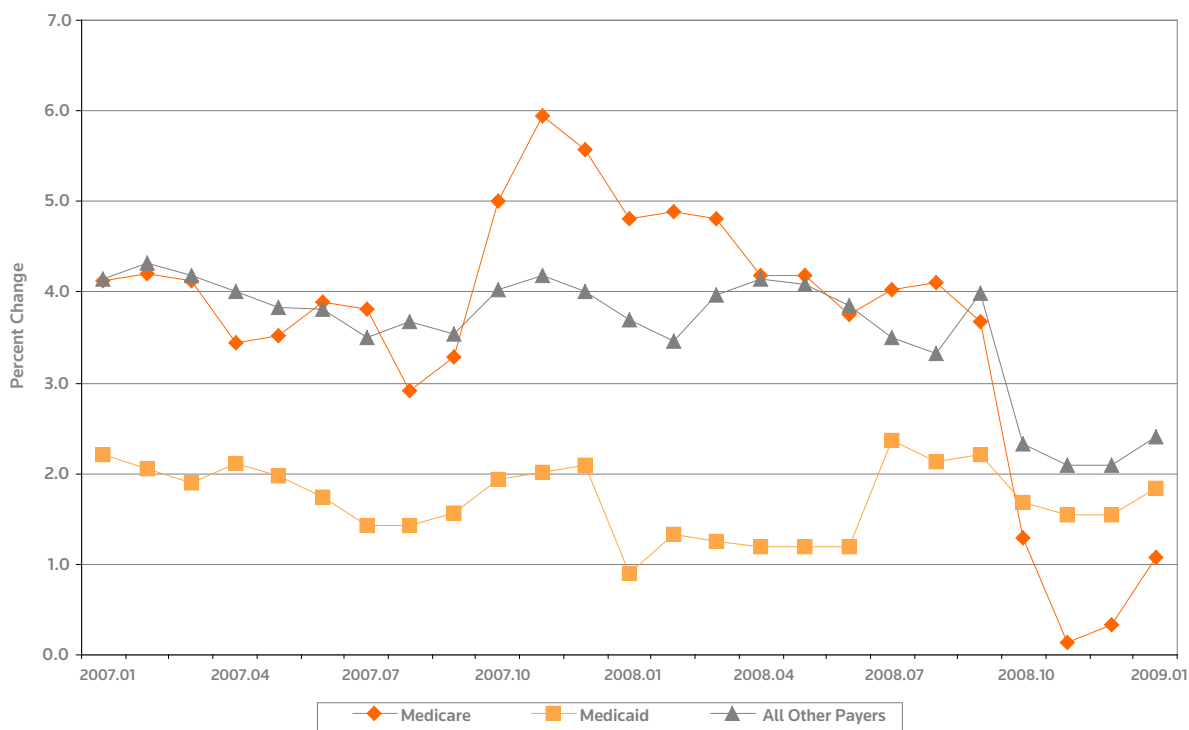
The asset decreases observed in major teaching hospitals do represent investment losses, as these hospitals did not shift assets to shorter-term assets, reduce debt, or increase capital expenditures during this period. These losses have been substantial, reducing the hospitals' capacity for capital expenditures both directly (having fewer resources available to spend) and indirectly (by rendering these hospitals less creditworthy).

The fact that hospital operating margins have remained stable implies that net patient revenues remained on historical trend through the third quarter of 2008. What can be said about hospital revenues moving into 2009?

We turned to the hospital producer price index (PPI) from the Bureau of Labor Statistics to answer this question. The hospital PPI represents the reimbursement hospitals receive for a standard market basket of inpatient and outpatient services. Thus, changes in this index over time provide estimates of hospital reimbursement increases or, equivalently, hospital price inflation.

Figure 4 displays year-over-year changes in the hospital PPI, disaggregated into three payer classes: Medicare, Medicaid, and Other (mostly private payers). All three payer classes exhibit declines in reimbursement growth in the fourth quarter of 2008 versus 2007. Note that private pay increases are roughly 2 percent, half of the historical increase, and Medicare reimbursement increases are close to zero. This decrease could be problematic moving into 2009 because private payers help many hospitals maintain positive operating margins.

FIGURE 4: CHANGE IN HOSPITAL REIMBURSEMENT RATES, JANUARY 2007–DECEMBER 2008



The credit crisis that developed in the summer of 2008 may have had an impact on the liquidity of hospitals. Figure 5 provides estimates of median days of cash on hand from the Thomson Reuters ACTION O-I database. Median days cash on hand fell throughout the series, and reached a historic low in the third quarter of 2008. There is a lot of variability around the median value of 110 days, with a quarter of hospitals having less than 57 days' cash on hand, and another quarter having 203 days' or more cash on hand.

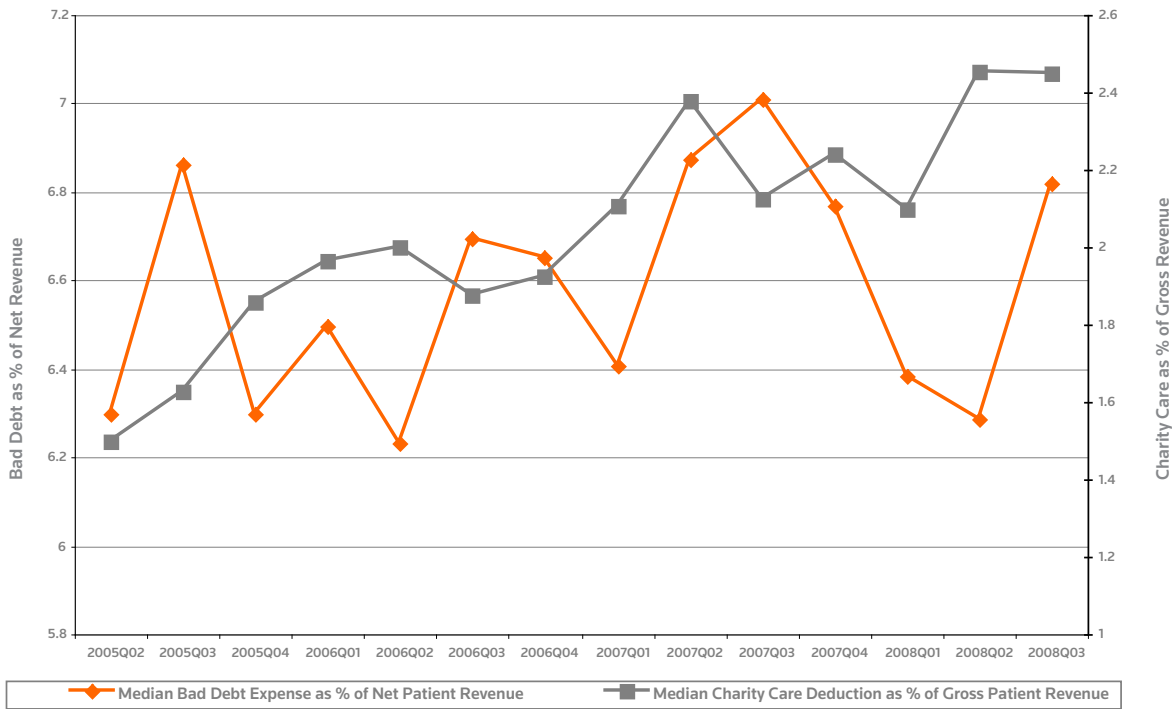
FIGURE 5: HOSPITAL DAYS CASH ON HAND, ALL SOURCES, Q2 2005–Q3 2008



It is difficult to attribute all of the decrease to recessionary effects, since the trend preceded the start of the recession by many quarters. It is possible that part of the trend is due to general changes in cash management policies by hospital finance officers.

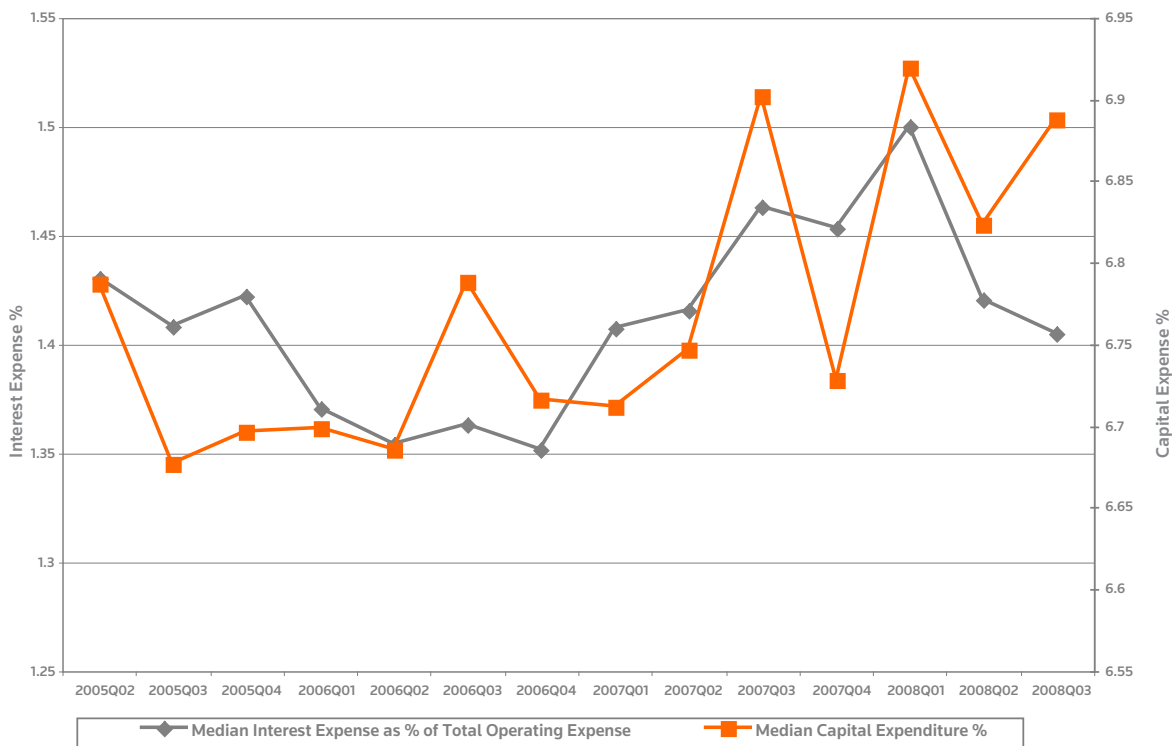
The recession also may have had an impact on hospital expenses. Two expenses that might be expected to increase are bad debt and charity care. To study this, we turned again to the ACTION O-I database. Figure 6 contains estimates of median bad debt expense (as a percent of net patient revenue) and charity care expenses (as a percent of gross patient revenue). The median bad debt percentage is within historic range, while the charity care percentage shows a consistent upward trend. It is tempting to attribute the upward trend in charity care to the recession, but this movement started well before the fourth quarter of 2007 and possibly reflects more thorough implementation of accounting standards by hospitals in response to inquiries by state attorneys general.

FIGURE 6: HOSPITAL BAD DEBT AND CHARITY EXPENSES, Q2 2005–Q3 2008



Other expenses that might be impacted by the recession are capital expenditures and interest expenses. Figure 7 displays estimates of capital and interest expense as a percentage of total operating expense based on the ACTION O-I database. We observe generally increasing trends in both metrics, but no abrupt changes after the start of the recession in the fourth quarter of 2007. In fact, the interest expense metric actually declines in the second and third quarter of 2008.

FIGURE 7: HOSPITAL CAPITAL EXPENDITURES AND INTEREST EXPENSE, Q2 2005–Q3 2008



We suspect that the full impact of the credit crisis will be felt by hospitals in the fourth quarter of 2008 and beyond. The third quarter of 2008 may be too early to provide a complete understanding of the impact of the recession on capital and interest expenses.

We also examined other operating expense metrics to determine if hospitals were beginning to reduce costs through reduction in controllable costs. The operating expense metrics we analyzed in the ACTION O-I database showed no signs of such expense reduction. Figure 8 contains estimates of median expense per discharge and patient day (case mix and area wage index adjusted), and shows no abrupt departure for historical inflation trends. Figure 9, also from the ACTION O-I database, displays the median percentage of licensed beds in operation. Also, there is no evidence that hospitals started closing beds after the beginning of the recession.

FIGURE 8: EXPENSE PER DISCHARGE AND PATIENT DAY, Q2 2005–Q3 2008

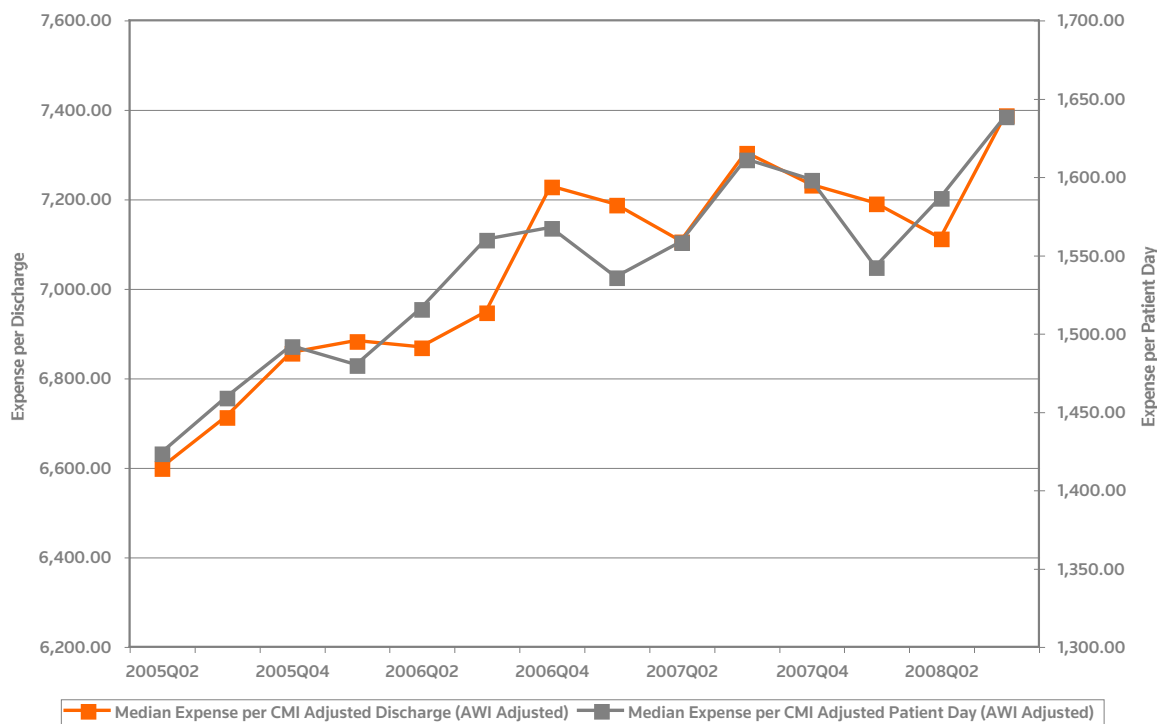
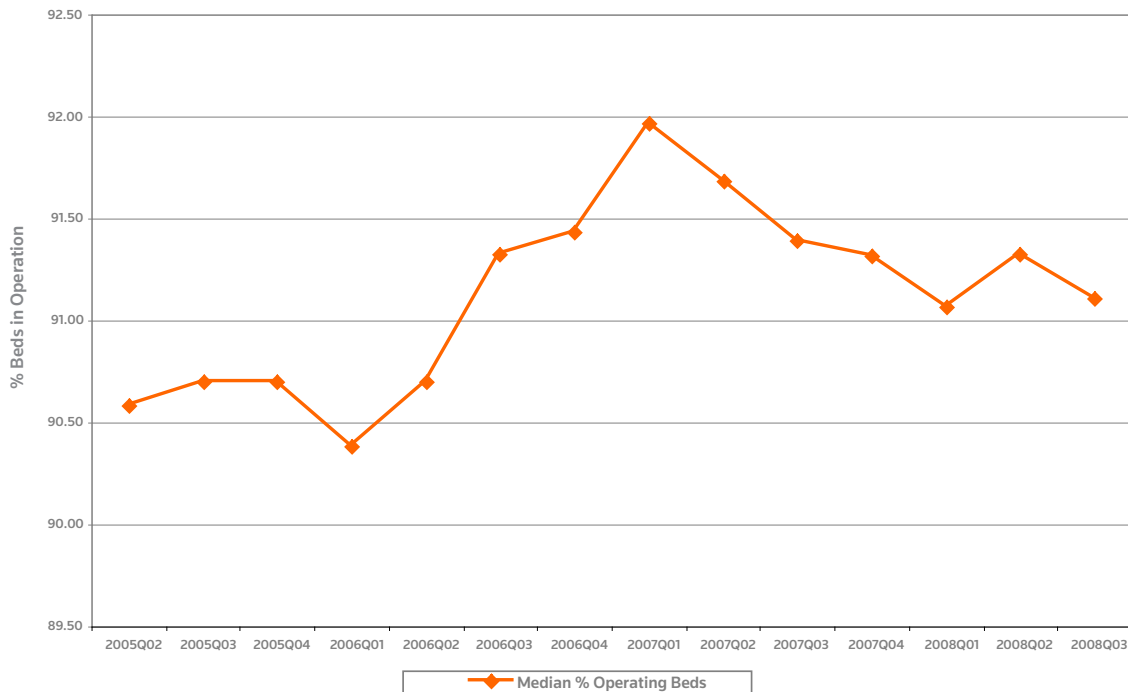


FIGURE 9: PERCENTAGE OF LICENSED BEDS IN OPERATION, Q2 2005–Q3 2008



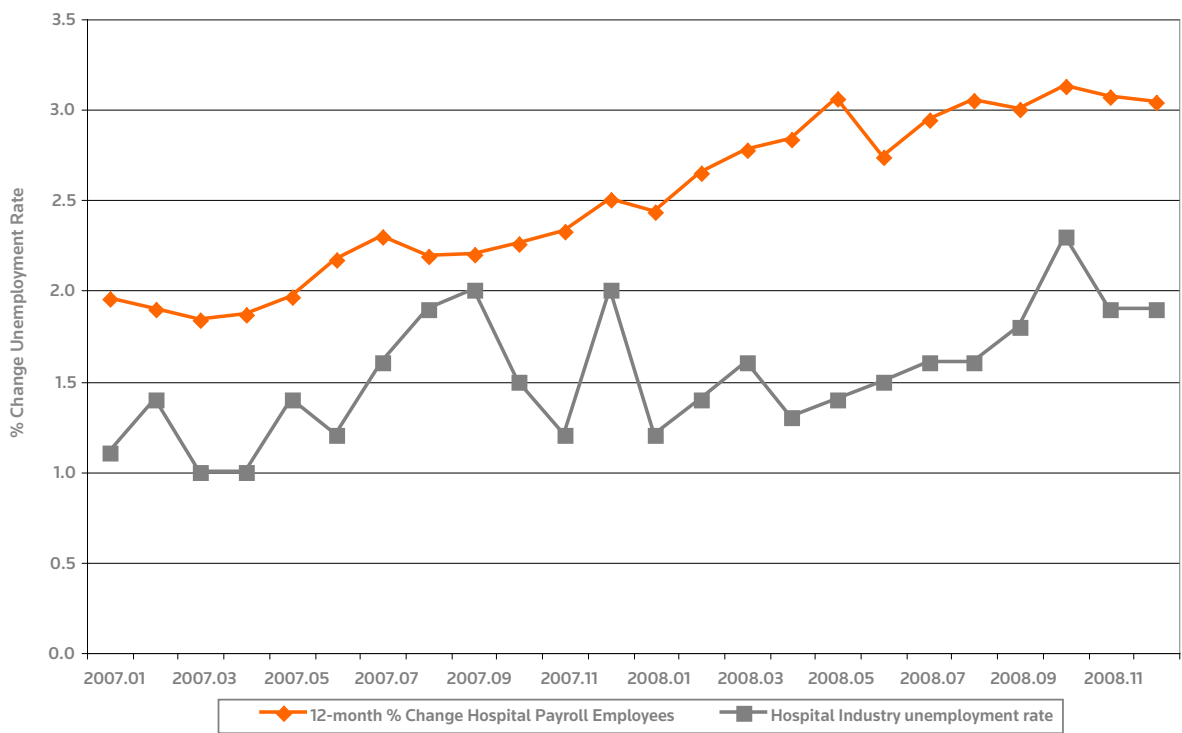
HOSPITAL EMPLOYMENT AND MASS LAYOFFS

Historical analysis of economic cycles and hospital employment shows that hospitals reduce workforce in response to recessions; they also reduce workforce in nonrecessionary periods.¹

The Bureau of Labor Statistics tracks employment through two surveys. The first, the Current Economic Survey (CES), is a monthly sample of business payrolls and includes a hospital industry subsample. The second survey is the Current Population Survey (CPS), a household sample used in part to produce monthly employment and unemployment estimates. From CPS, we can also obtain estimates of unemployment by industry, including the hospital industry.

Figure 10 displays hospital unemployment and year-over-year payroll changes for the hospital industry. Year-over-year increase in payroll employees appears to be leveling off while the unemployment rate is down slightly in the last three months, but still well within historical range. Note that both of these employment estimates for the hospital industry are much more favorable than they are for the general economy.

FIGURE 10: HOSPITAL INDUSTRY EMPLOYMENT, JANUARY 2007–JANUARY 2009



Another source of information on hospital industry employment is mass layoff data compiled by the Bureau of Labor Statistics. Mass layoffs provide information about economic stress that is somewhat different than unemployment. Unemployment may fluctuate up and down due to hospital demand conditions and decisions to allow open positions to remain unfilled. Mass layoffs affect a large number of employees in specific organizations that are significantly reducing operations. Figure 11 displays a historical series of mass layoffs (number of claimants) for the hospital industry from January 2005 through December 2008. We show the older history to provide insight into effects of a major industry event: hospital closures and layoffs due to Hurricane Katrina in August 2005.

FIGURE 11: HOSPITAL INDUSTRY MASS LAYOFFS, JANUARY 2005–DECEMBER 2008

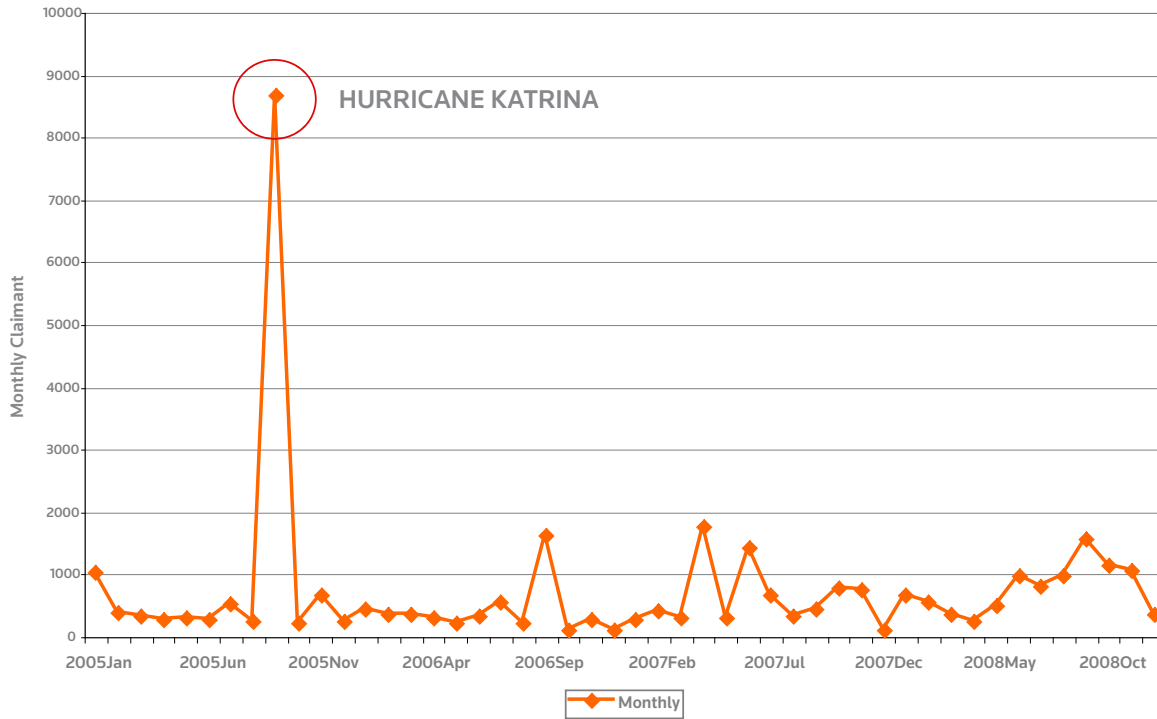
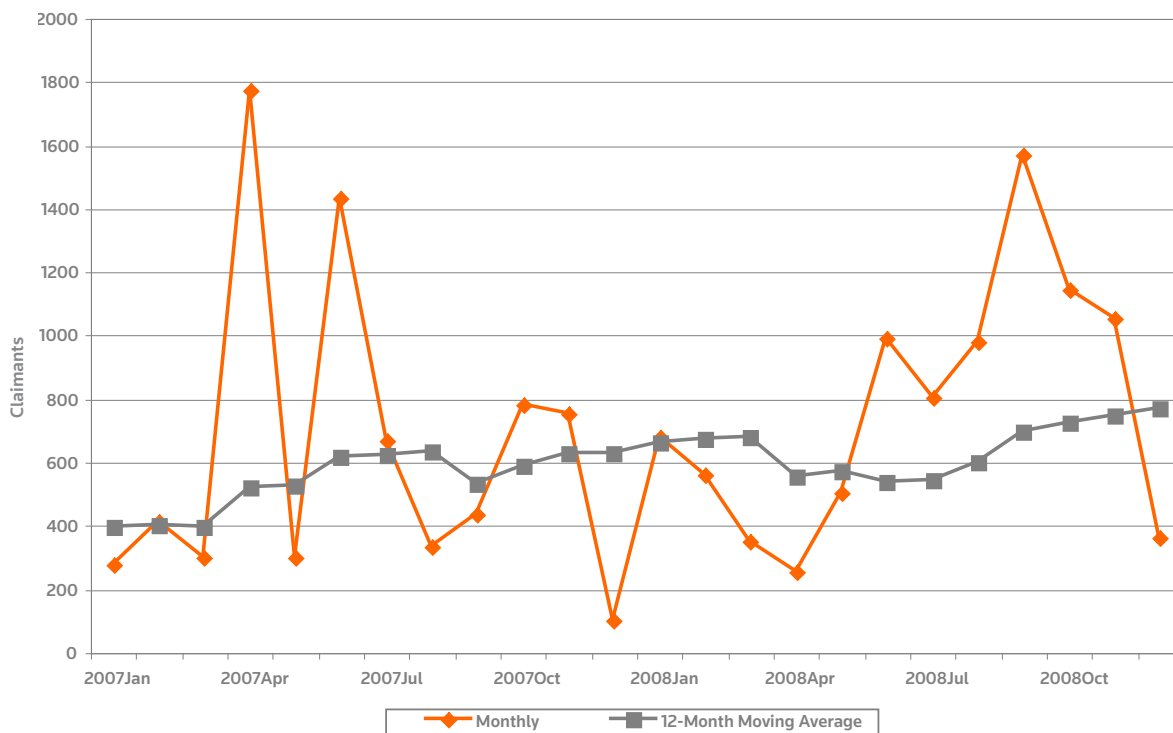


Figure 12 displays the mass layoff data from the same source, showing information from 2007 forward on monthly claimants and a 12-month moving average. There is some evidence of gradual increase in the total number of claimants based on the moving average, and December 2008 is a recent high of the mass layoff moving average series.

FIGURE 12: HOSPITAL INDUSTRY MASS LAYOFFS, JANUARY 2007–DECEMBER 2008



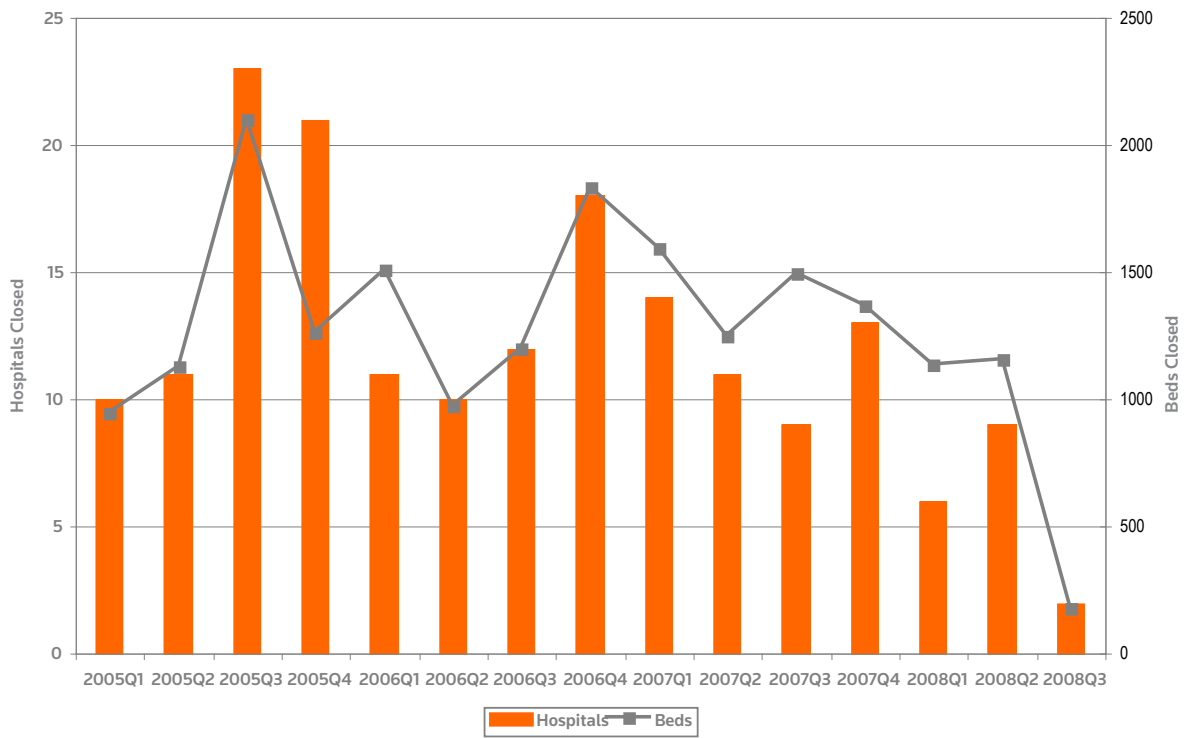
HOSPITAL CLOSURES

We observed in the first section of this report that hospital total margins were at historically unprecedented lows in the third quarter of 2008. Conceivably, this could be accompanied by an increase in hospital closures.

We examined this possibility using the Centers for Medicare and Medicaid Services (CMS) Provider of Service (POS) database and identified hospital closures from the first quarter of 2005 through the third quarter of 2008. Hospital closures were defined as termination of the hospital entity, without an acquisition, merger, or conversion to another status (such as a critical access hospital).

Figure 13 displays hospitals and beds closed by year and quarter. While Hurricane Katrina contributed to mass layoffs in late 2005, it is not completely explanatory of recent highs in last half of 2005. Hospital closures after the start of the recession in the fourth quarter of 2007 are somewhat lower than they were in recent history.

FIGURE 13: HOSPITAL CLOSURES, Q1 2005–Q3 2008



HOSPITAL PATIENT VOLUME

Our historical research found no systematic relationship between hospital patient volumes and recessionary periods. This does not prove that there is no relationship today, especially at a local level.

The MarketScan® Hospital Drug Database (HDD) contains extremely current inpatient discharge information for a nationally representative sample of hospitals. The data reported here are for a 150-hospital subset of the HDD with continuous, reliable reporting of data since January 2006.

Figure 14 displays admissions per day for the HDD subset for the period January 2007 through December 2008. Total and elective admissions are reported using 12-month moving averages.² There is some evidence of flattening of historic 1–2 percent growth rates, starting in the fourth quarter of 2007. However, there is no evidence that this is driven by elective admissions (4.6 percent of total in December 2007 and 4.5 percent of total in December 2008).

FIGURE 14: TOTAL AND ELECTIVE INPATIENT ADMISSIONS, JANUARY 2007–DECEMBER 2008

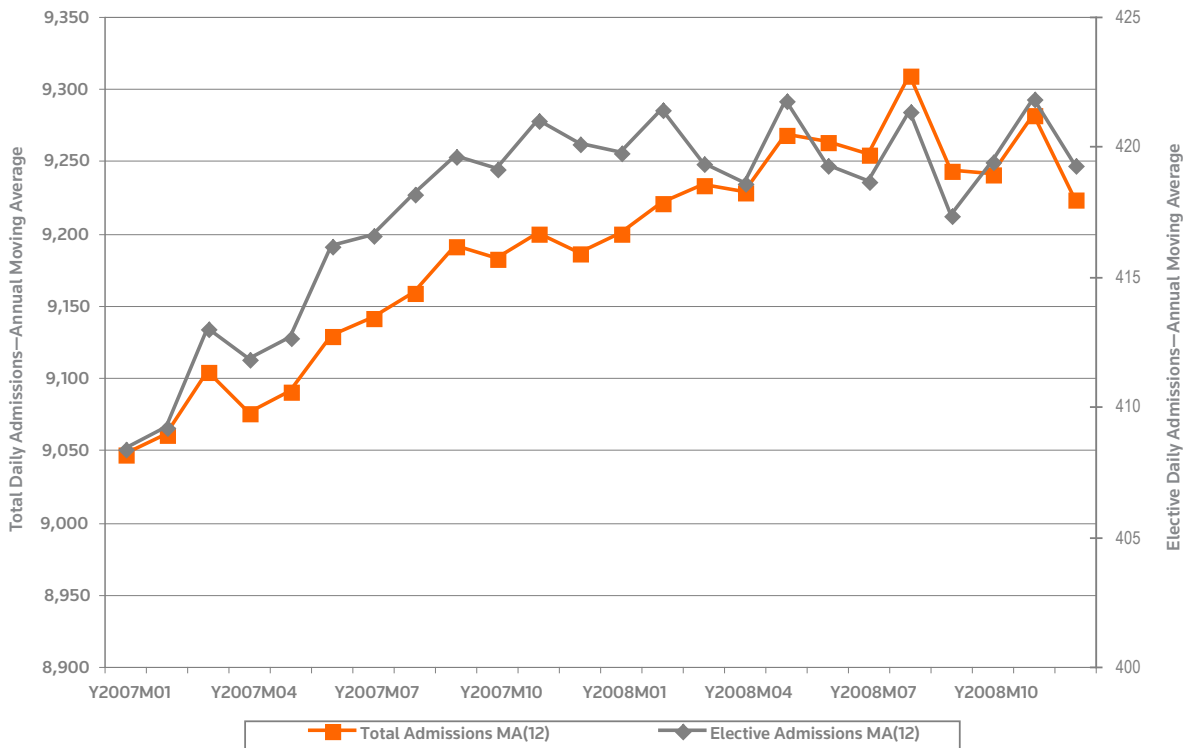


Figure 15 contains another view of the total and elective admission data, with year-over-year changes in inpatient admissions for the HDD subset displayed. There is some evidence of year-over-year volume decreases. However, the monthly variability in the admission process variance appears to increase in recent periods and makes it difficult to deduce a trend. It is notable that year-over-year variances of +/-5 percent are not unusual—and these are averages of a subset of 150 hospitals. Individual hospitals should use caution when interpreting fluctuations in their own inpatient volume data.

FIGURE 15: CHANGE IN TOTAL AND ELECTIVE ADMISSIONS, JANUARY 2007–DECEMBER 2008



We sought additional insight into possible recession impacts on hospital care by examining two key service lines for hospitals: cardiovascular care and orthopedic surgery. Figure 16 displays monthly data for cardiovascular admissions (medicine and surgery) for the HDD subset. The data plotted are moving annual average admissions per day. Cardiovascular surgery varies within historic ranges. Observed decreases in cardiovascular medicine simply continue a pattern of long-term decline that predates the recession.³

Figure 17 contains admission data for orthopedic surgery from the same HDD subset. Orthopedic inpatient admissions show no sign of decrease in this set of hospitals.

FIGURE 16: CARDIOVASCULAR SERVICES ADMISSIONS, JANUARY 2007–DECEMBER 2008

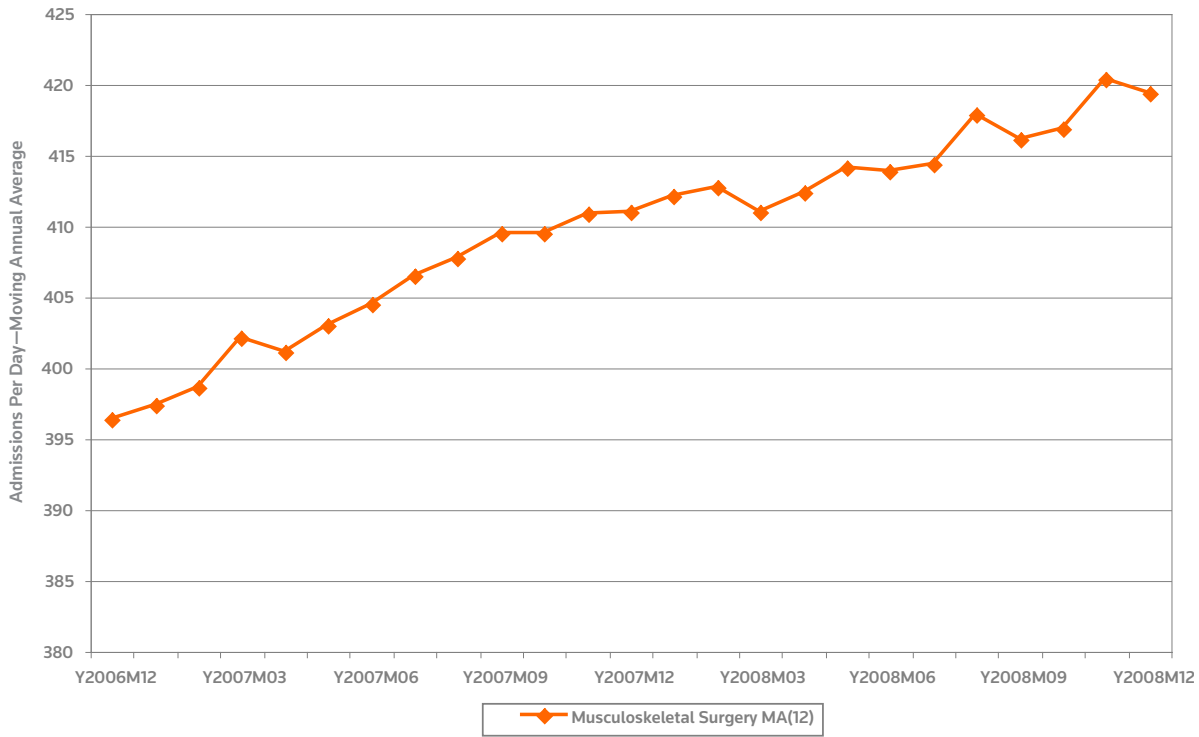
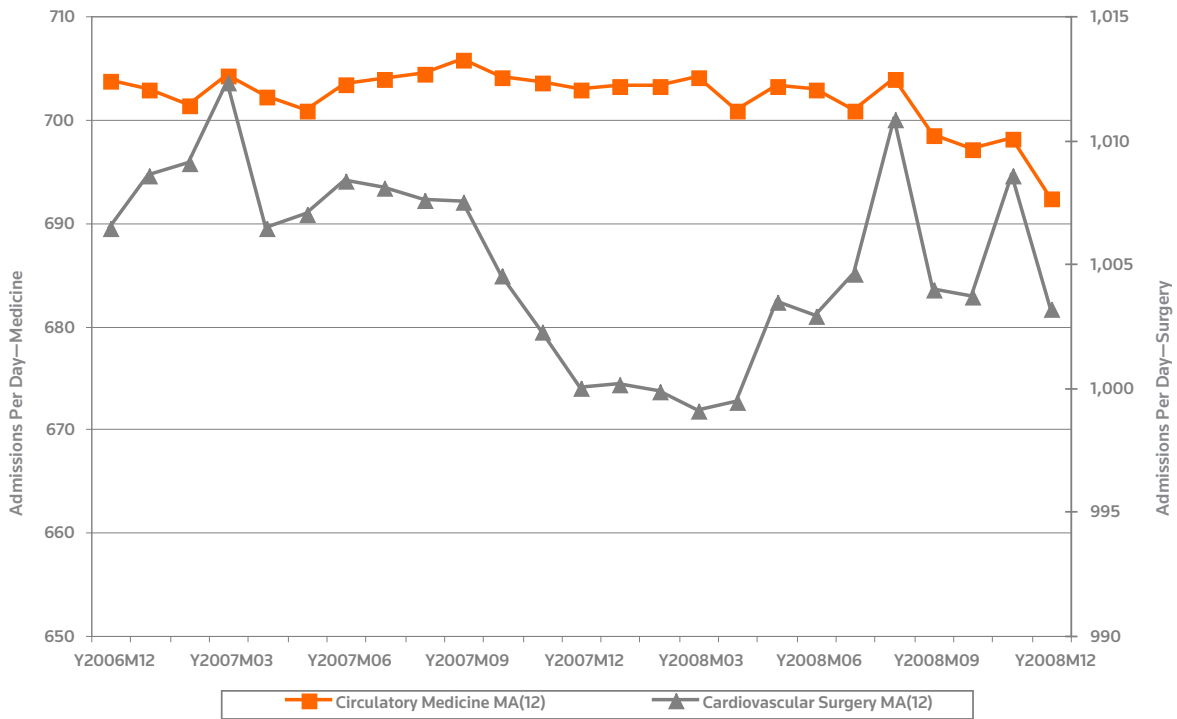


FIGURE 17: ORTHOPEDIC SURGERY ADMISSIONS, JANUARY 2007–DECEMBER 2008



Hospital inpatient admissions may not be sensitive to the recession, but is this true for hospital outpatient care? Figure 18 contains estimates of procedures per day for the HDD hospital cohort. We display information for major invasive diagnostic, major outpatient surgery, and major imaging procedure groups, since these are of key business importance to most hospitals.⁴ We find no evidence of volume trend breaks following the start of the recession in the fourth quarter of 2007.

FIGURE 18: HOSPITAL OUTPATIENT MAJOR PROCEDURE GROUP VOLUMES, JANUARY 2006–DECEMBER 2008

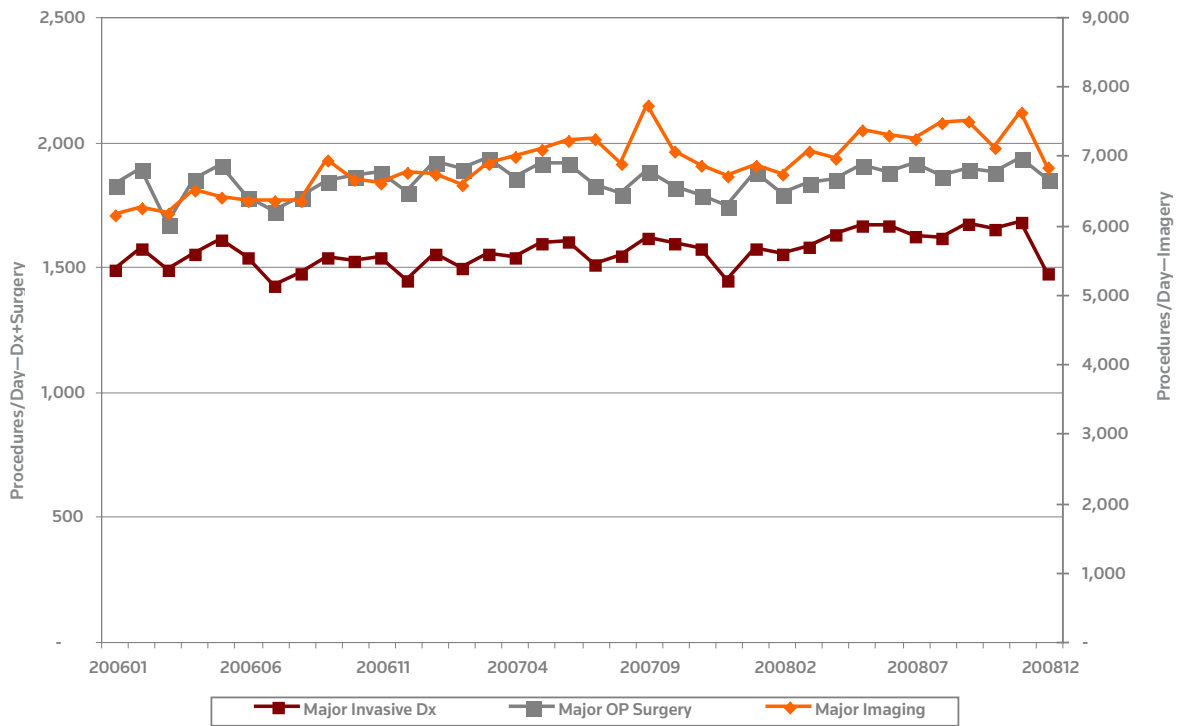
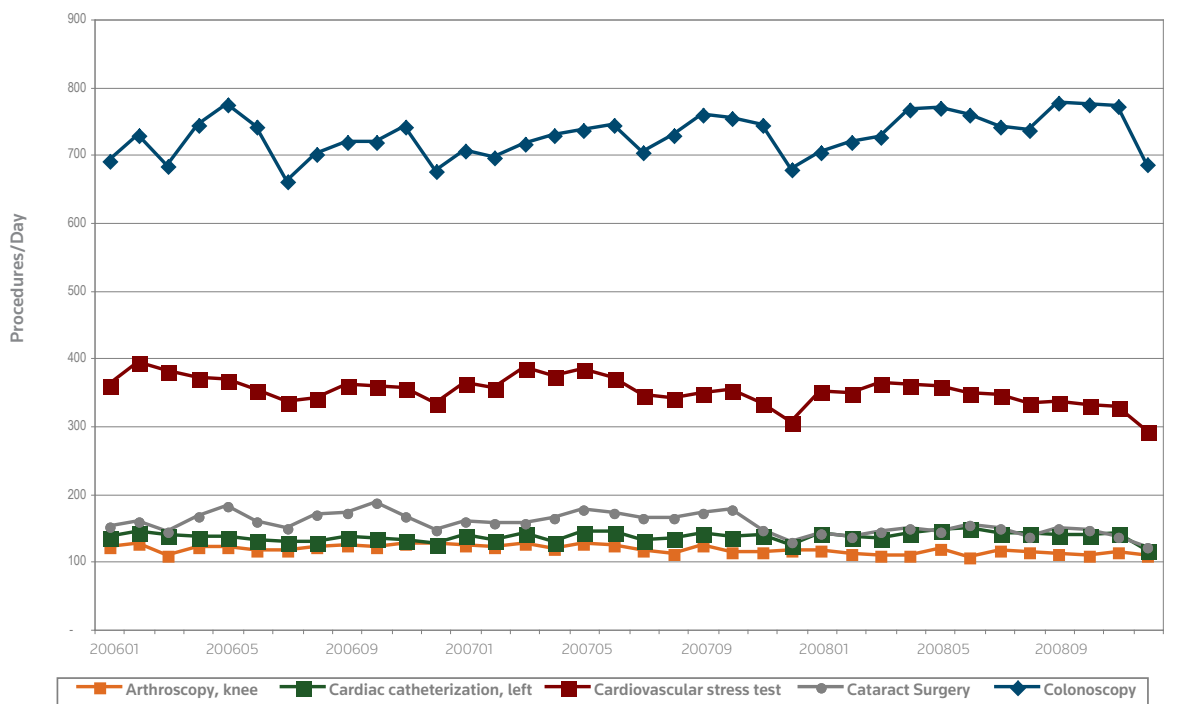


Figure 19 also displays hospital outpatient data from the HDD subset, but focuses on specific procedures important for hospital outpatient revenues.

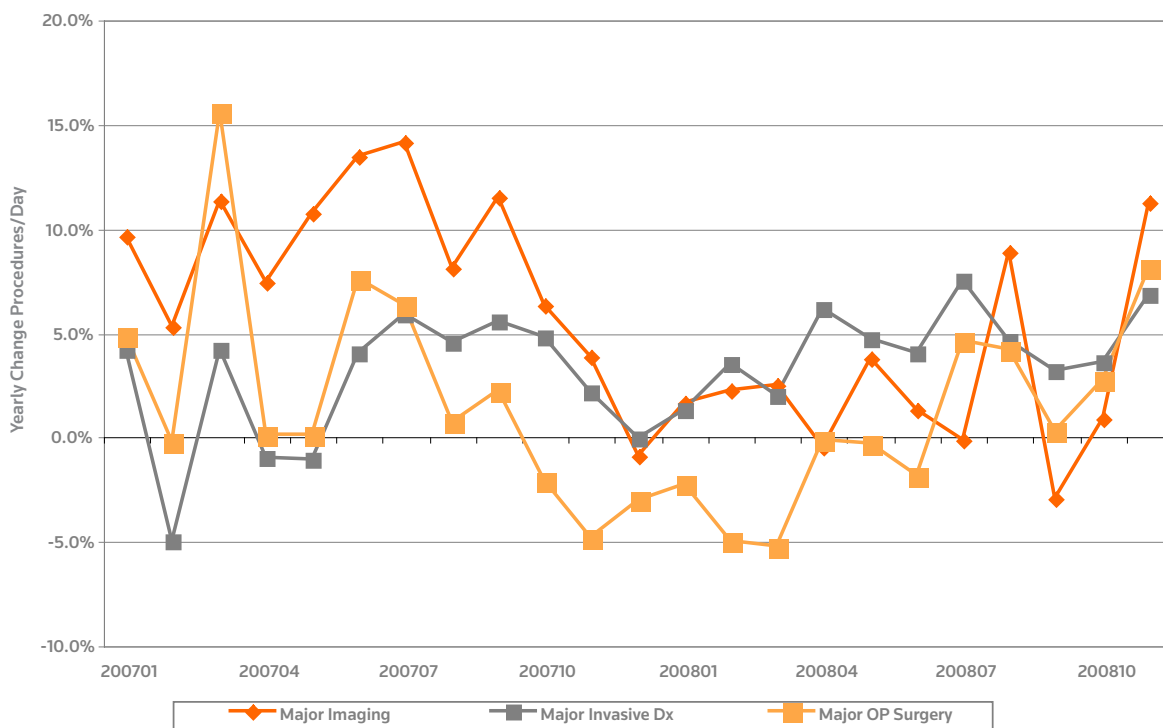
FIGURE 19: HOSPITAL OUTPATIENT KEY PROCEDURE VOLUMES, JANUARY 2006–DECEMBER 2008



Figures 20 and 21 contain the same outpatient volume data as in the previous charts, restated as year-over-year volume change.

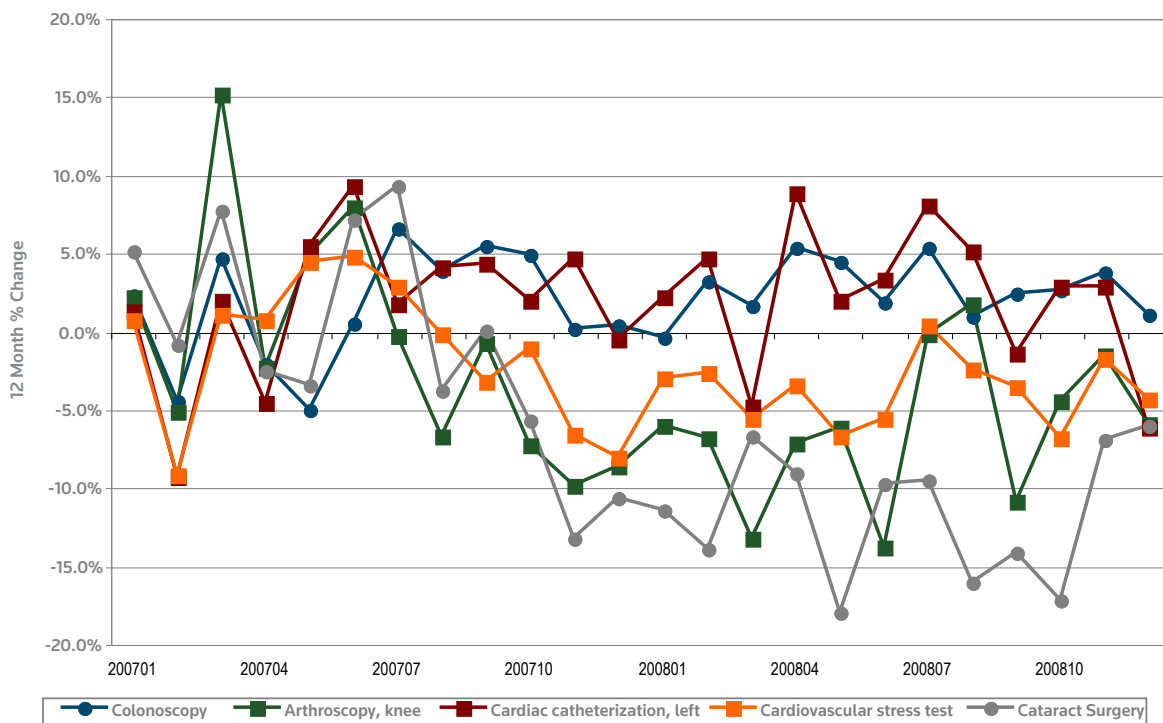
Annual percentage changes in major invasive diagnostics, major imaging procedures, and major surgeries vary within historic range (Figure 20).

FIGURE 20: CHANGES IN HOSPITAL OUTPATIENT MAJOR PROCEDURE GROUP VOLUMES, JANUARY 2007–DECEMBER 2008



There is some evidence of downward trends in cataract surgery, stress tests, and knee arthroscopies (Figure 21). However, these trends are consistent with movement of key procedures to nonhospital outpatient settings.

FIGURE 21: CHANGES IN HOSPITAL OUTPATIENT KEY PROCEDURE VOLUMES, JANUARY 2007–DECEMBER 2008



Hospital outpatient volume estimates do not account for shifts of care to nonhospital sites. The Thomson Reuters Physician Activity Database (PADB) contains information on physician procedural activity across all settings of care for a large sample of physicians. We are tracking a subset group of the PADB, containing approximately 17,000 physicians, who provide consistent and reliable reporting of data from February 2007 through January 2009. Figure 22 displays estimates of mean procedures per working day for the PADB subset, using the major procedure groups used to track hospital outpatient volumes.⁴ All series are following historic trend lines or are within range of historic variation (visits and consultations have been displayed on a second axis for clarity).

FIGURE 22: PHYSICIAN SERVICE VOLUMES, MAJOR PROCEDURE GROUPS, FEBRUARY 2007–JANUARY 2009

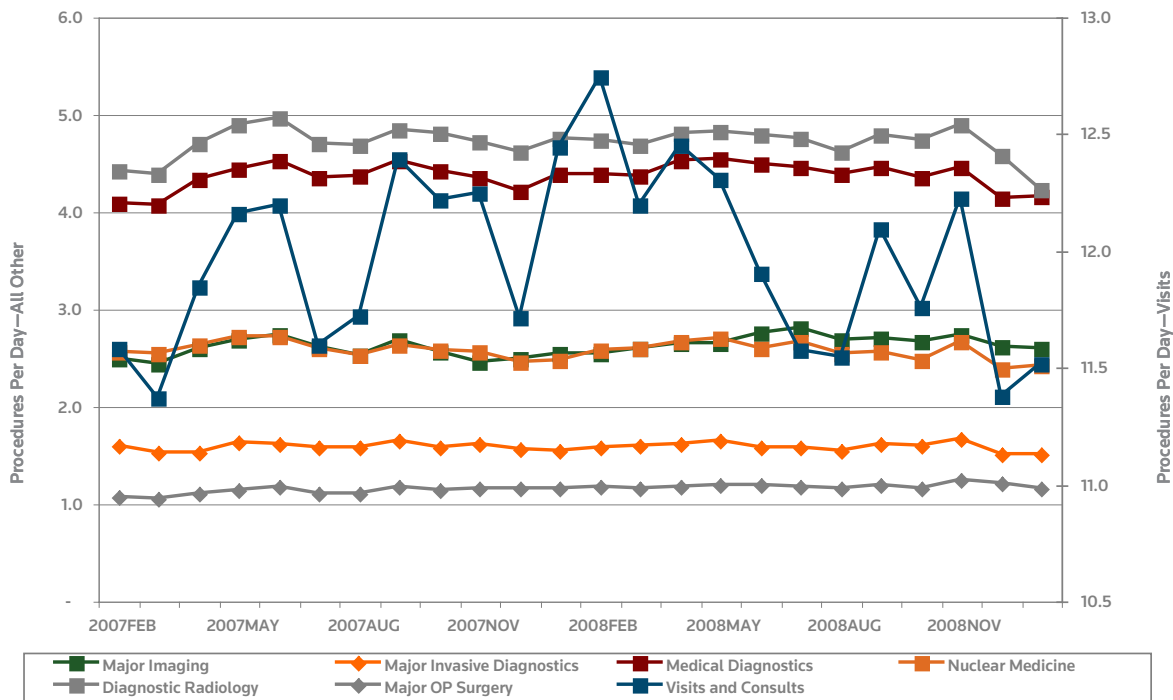
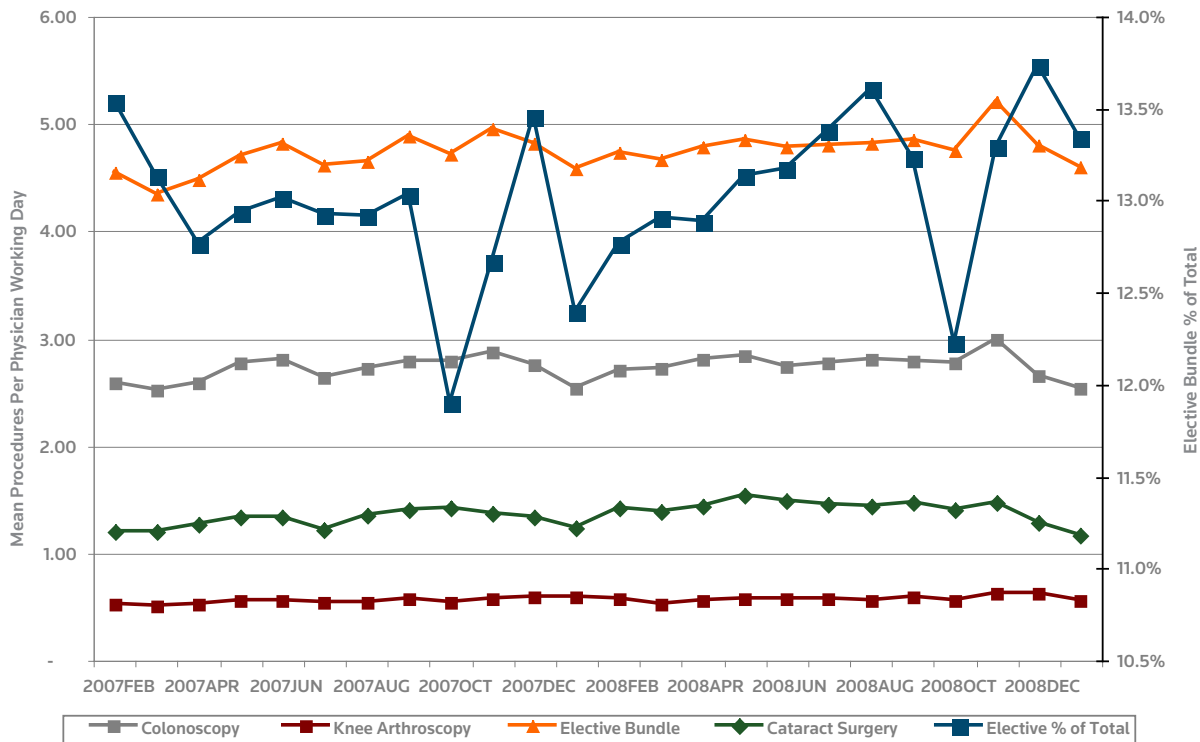


Figure 23 provides another view of the PADB subset activity, namely elective procedure volume.⁵ The bundle of elective procedures and other key elective procedures follows standard patterns of seasonal variation. Knee arthroscopy and cataract surgery volumes are stable, affirming that volume declines for these procedures in the hospital setting really represent a shift in site of care.

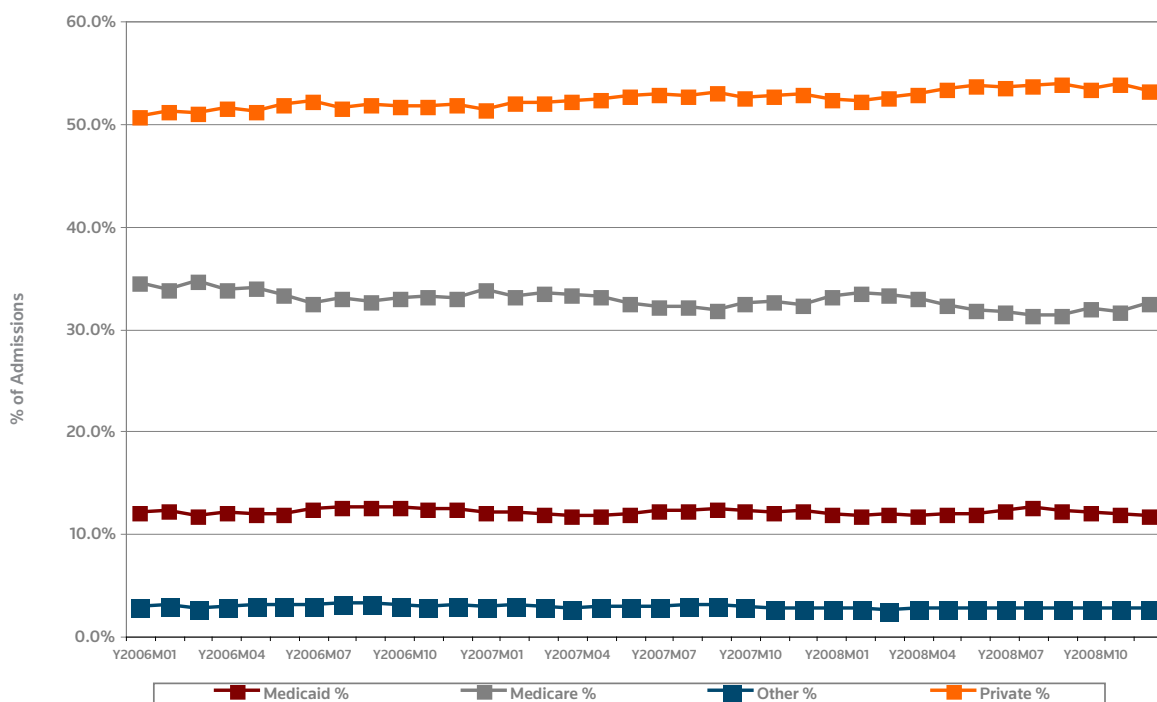
FIGURE 23: PHYSICIAN SERVICE VOLUMES, ELECTIVE PROCEDURES, FEBRUARY 2007–JANUARY 2009



HOSPITAL PAYER MIX

The most current information we possess on insurance coverage and hospital care is the principal payment source for patients who are admitted to hospitals. Looking again at the HDD subset, we recorded the expected principal source of payment for admissions from January 2007 through December 2008. We are able to classify admissions by private, Medicaid, Medicare, and other sources of payment. Figure 24 shows very little movement in the principal payer composition for inpatient in our HDD subset. Contrary to other industry information, we see a slight increase in the fraction of private-pay patients in this cohort.

FIGURE 24: INPATIENT ADMISSIONS BY PRINCIPAL PAYER, JANUARY 2006–DECEMBER 2008



SUMMARY

Observed impacts that appear related to the recession:

- Hospital nonoperating and total margins have decreased dramatically, especially in Q3 2008. Total margins are at historically unprecedented lows.
- Approximately 50 percent of hospitals are operating in the red.
- Number of hospital days cash on hand has decreased significantly, mirroring a prerecession trend.
- Restricted investment assets have shrunk substantially for major teaching hospitals. These are unrealized losses that are not reflected in total margins declines.
- Hospital reimbursement rate increases appear to be shrinking—with possible negative impacts on net patient revenue in 2009.
- Inpatient total admission volumes may be falling below expectation. Note that our trend data are not yet conclusive.

Possible recession impacts that we have not observed:

- Rising hospital unemployment rates or declining payrolls.
- Bed closures.
- Increases in hospital bad debt or interest expense.
- Decreases in hospital capital expenditures.
- Deferral of elective procedures (in hospital and nonhospital settings).
- Decreases in private pay or increases in Medicaid/uninsured patients for hospitals.

DATA SOURCES AND METHODOLOGY

- The hospital operational and financial performance data used in this study are quarterly financial data (Q2 2005 through Q3 2008) for general acute care community hospitals in the proprietary Thomson Reuters ACTION O-I database. The quarterly samples have an average 439 reporting hospitals, comprised of 76 small community hospitals (26–99 beds), 127 medium community hospitals (100–249 beds), 74 large community hospitals (250+ beds), 102 teaching hospitals, and 60 major teaching hospitals. Data have been weighted and projected to the universe of general acute care community hospitals.
- The hospital inpatient and outpatient cohorts in this research brief are constructed from the MarketScan Hospital Drug Database (HDD). This Thomson Reuters database provides monthly projections of hospital inpatient and outpatient volumes and pharmaceutical use. The projections are based on a nonrandom sample of hospitals that submit near real-time discharge and pharmaceutical information to the Hospital Drug Database. Approximately 200 of the submitting hospitals are able to send full discharge, procedural, diagnostic, and drug detail within 30 days of the close of each month. Sample data are projected to represent the universe of short-term, general, nonfederal hospitals.
- The physician subset used in this study is constructed from the Thomson Reuters Physician Activity Database (PADB). This database provides claims for all sites of care and all payers for a sample of approximately 120,000 allopathic and osteopathic physicians. Data from the sample are projected to the universe of physician activity at a national level.
- The Bureau of Labor Statistics provides estimates of hospital employment, reimbursement, mass layoffs, and the producer price index. See www.bls.gov for additional information on these estimates.
- Information on hospital closures is derived from the Centers for Medicare and Medicaid Services (CMS) hospital provider of service (POS) file. For more information on the POS, see www.cms.gov.

NOTES

- 1 *The Impact of Economic Cycles on U.S. Hospitals*, Dennis Dunn, David Koepke, Gary Pickens, Thomson Reuters, January 2009.
- 2 Information on inpatient elective procedure definitions is available from the authors.
- 3 For example, see *Recent Trends in Hospital Utilization for Acute Myocardial Infarction and Coronary Revascularization in the United States*, Brahmajee K. Nallamothu et al, *American Journal of Cardiology*, 2007.
- 4 Information on outpatient procedure group definitions is available from the authors.
- 5 Information on outpatient elective procedures is available from the authors.

ABOUT THE CENTER FOR HEALTHCARE IMPROVEMENT

The Center for Healthcare Improvement (CHI) is a knowledge creation center for the Healthcare business of Thomson Reuters. Its main focus is creating insights to guide the healthcare industry toward improved performance.

CHI performs research aimed at improving the future of healthcare. Its experts mine treatment, outcome, safety, financial, operational, market share, and patient perception data across care settings to create new knowledge for providers. The team consists of pioneers who continually find new ways to integrate and analyze disparate data streams to develop unique measures and benchmarks. CHI seeks to support performance improvement cultures in hospitals and develop new methods to increase utility, reliability, and predictability of information for improving healthcare.

The members of CHI have subject-matter expertise in hospital performance measurement, operations, statistics, epidemiology, demographics, patient care, managed care, and hospital-cost reporting.

CHI also concentrates on preproduct research and development and government and industry relations, and contributes data, analysis, and content to several annual reports and programs.

- *By the Numbers* healthcare industry annual trends report features new national trends in hospital business and clinical performance that affect providers, pharmaceutical companies, insurers, and government. It includes in-depth analysis of high-impact developments that will change healthcare as we know it today.
- The Thomson Reuters 100 Top Hospitals® program incorporates a national hospital balanced scorecard and benchmarks, with academic and industry research partnerships that investigate hospital leadership, organizational change, best practices, and performance improvement. By combining publicly available data sets and our empirical, time-tested methodologies, the 100 Top Hospitals program objectively identifies the highest performers in the nation and national rates of improvement.

ABOUT THE ECONOMIC IMPACT SERIES

This research brief continues our monthly series focusing on the impact of the current recession on hospitals. The series combines current, proprietary Thomson Reuters data with public data to deliver unprecedented insight. Thomson Reuters works with its clients to provide information solutions to ease recession impacts in local markets. Read more of our research at <http://provider.thomsonhealthcare.com/Articles/>.

Consistent with Thomson Reuters guiding principles, this series will provide insights on factors that affect hospital business performance that are unbiased, reliable, and as current as possible. We will track metrics at a national and local level that may impact hospital financial or clinical performance. In doing so, we will:

- Use quantitative data to identify significant hospital industry changes.
- Avoid reliance on opinion.
- Incorporate public and Thomson Reuters proprietary data sources to construct findings.

ABOUT THOMSON REUTERS

The Healthcare business of Thomson Reuters produces insights, information, benchmarks and analysis that enable organizations to manage costs, improve performance, and enhance the quality of healthcare. Thomson Reuters is the world's leading source of intelligent information for businesses and professionals. We combine industry expertise with innovative technology to deliver critical information to leading decision makers in the financial, legal, tax and accounting, scientific, healthcare and media markets, powered by the world's most trusted news organization. With headquarters in New York and major operations in London and Eagan, Minn., Thomson Reuters employs more than 50,000 people in 93 countries. Thomson Reuters shares are listed on the New York Stock Exchange (NYSE: TRI); Toronto Stock Exchange (TSX: TRI); London Stock Exchange (LSE: TRIL); and Nasdaq (NASDAQ: TRIN).

healthcare.thomsonreuters.com/provider

Thomson Reuters
777 E. Eisenhower Parkway
Ann Arbor, MI 48108 USA
Phone +1 800 366 7526

©2009 Thomson Reuters.
All rights reserved.
PRO-6519 03/09 JB



THOMSON REUTERS