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LABORATORY INDUSTRY REPORT®

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Vol. XI, No. 8/August 2007

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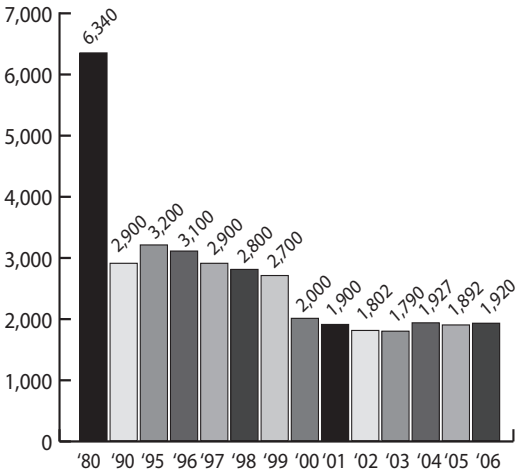
WASHINGTON G-2 REPORTS

Med Tech Shortage Stifles Lab Growth

Clinical laboratories nationwide are struggling to recruit and hire qualified medical personnel. The pool of job candidates is shrinking, while the job descriptions are getting longer and more complex. The retirement of the baby-boomer generation will continue to create vacancies that are becoming increasingly difficult to fill. Over the next decade, a shortage of approximately 5,000 medical technologists per year is projected. "Hiring gets more and more difficult every year for us," the director of human resources at a large commercial laboratory tells *LIR*. "We have many more positions than we do qualified candidates to fill them."

In a 2005/2006 survey conducted by the American Society for Clinical Pathology (ASCP; Chicago, IL), 44% of laboratories reported they were experiencing difficulties in recruiting or hiring medical personnel. That survey also indicated a 6% vacancy rate among medical technologist staff, a 7% vacancy rate among histotechnology staff, and a 7% vacancy rate among phlebotomists.

Number of Certified Medical Technologist Graduates: 1980-2006



Source: American Society for Clinical Pathology

For an in-depth look at the med tech shortage and some suggestions on how to address it, see *Inside the Laboratory Industry*, pp. 5-8.

Lab Competitive Bidding Demo Project Proceeds

The Centers for Medicare and Medicaid Services (CMS) hosted a special open door forum on July 16, before proceeding to the next step of the Medicare clinical laboratory services competitive bidding demonstration project. This followed the publication of the project's draft bidder's package. Over 400 people participated via conference call, with approximately 60 in attendance.

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"Some of the reference labs may not even know they have to bid because they may not know how much business they're doing in that zip code," says Mertz.

Lab Competitive Bidding Demo, *from page 1*

The first hour of the open door forum was an overview of the draft bidder package presented by representatives of CMS and RTI, the consulting firm that helped create the demonstration project's structure. One hour was scheduled for questions and answers, but due to demand by participants, it ran 95 minutes and could easily have gone on longer.

The draft bidder's package, available on the CMS Web site [*www.cms.hhs.gov/DemoProjectsEvalRpts/01_Overview.asp*] runs 75 pages and outlines the requirements and procedures for participating laboratories. Approximately 360 laboratory tests will be included in the demonstration project, and CMS states that to-date 22 metropolitan statistical areas (MSAs) meet the criteria to be considered competitive bid areas (CBAs).

Numerous professional organizations offered formal statements in opposition to the demonstration project, including the American Clinical Laboratory Association (ACLA), the College of American Pathologists (CAP), the American Society of Clinical Pathologists (ASCP), the Clinical Laboratory Management Association (CLMA), and the American Association of Bioanalysts (AAB).

In a prepared statement, ACLA President Alan Mertz noted that laboratory services account for only 1.6% of Medicare spending and that Medicare payment amounts for clinical laboratory services have already been reduced by about 40% in real, inflation-adjusted terms between 1984 and 2004. "This program will create a substantial and cumbersome administrative burden on CMS and the affected laboratories," said Mertz. "CMS should report to Congress that competitive bidding for laboratory services is unworkable."

This was a message echoed by organization representatives and laboratory leaders. "For reasons of safety and quality, ASCP remains opposed to the demonstration project," said Jeff Jacobs, vice president of public policy for ASCP. "At a minimum, ASCP calls for a delay until Health and Human Services can certify that the project will not be detrimental to the U.S. healthcare system."

Proposed Timeline for Competitive Bidding Demo Project

- Summer 2007: Finalize Bidder's Package
- Summer 2007: Announce CBA
- Late Summer 2007: Bidder's Conference
- Fall 2007: Bids Due
- Winter 2008: Labs Notified
- Spring 2008: Demonstration Begins

Although participants brought up many issues with the proposed project design, including how "winning" labs will be paid, quality control, double billing, continuity of care for patients, continuity of patient medical records, and market impact, two areas seem to be of greatest concern. According to Mertz, those are the impact on patients served by smaller laboratories and reference laboratory involvement.

"I think it was well-articulated at the open forum that the demonstration project is going to drive a lot of the smaller labs out of business. And those tend to be the labs that provide services to nursing homes," Mertz tells *LIR*. "It doesn't matter how stringent CMS is about the terms and conditions of this, if you drive out the labs that specialize in taking care of nursing homes, the elderly, and people in homecare and otherwise, it's going to have a detrimental effect on them."

Mertz also emphasizes the project's potential effect on reference laboratories, which tend to have very complex arrangements with local labs. "There are only

about 350 tests on the menu for this demonstration project, but some of the smaller labs said they have to send out the majority of those tests. How this is going to work in terms of setting up subcontractors and so forth is very complicated," he says. "Some of the reference labs may not even know they have to bid because they may not know how much business they're doing in that zip code. The tests are sent to them, they do them, but they don't know exactly how many beneficiaries are in those zip codes because they're just billing the labs."

Breaking News

Lab Groups Urge Congress To Scrap Project At House Hearing

At the July 25 House hearing on the competitive bidding demonstration for clinical laboratory services, representatives from both small and large labs asked lawmakers to scrap the project, saying the demo would put many labs out of business, ultimately diminishing patient access and stifling life-saving innovation.

Tod Schild, senior vice president of Shiel Medical Laboratory (Brooklyn, NY), told members of the House Small Business Committee that his lab, which operates at a margin of only 5% to 7%, would not survive beyond a year if it was required to submit a bid under the demonstration and did not win. Labs that bid and do not win will be ineligible for Medicare payments for the demonstration tests for the duration of the demo.

While the large national labs can discount their bids in the demonstration zone and compensate for these temporary discounts through their work in other parts of the country, small labs like Shiel will not have that advantage, Schild testified.

Witnesses at the hearing were almost universal in their criticism of CMS's requirement that all labs receiving at least $100,000 in revenue from Part B Medicare reimbursement in the competitive bid area will be required to bid. Mary Jo Bonifas, manager of laboratory services for United Clinical Laboratories (Dubuque, Iowa), testified that, if Dubuque were in the CBA, her lab would be the only laboratory in the city that would have to bid.

"What is concerning to me is that there will be drastic consequences if I am a 'bid loser' and also significant consequences even if I am a 'bid winner,'" she said. "If I am not a bid winner and local physicians and clinics can't use my laboratory for Medicare testing, I will also lose their non-Medicare testing." The demo could also potentially hurt UCL's 30-year relationship with Mayo Medical Labs, its reference lab.

Several witnesses expressed concern about the impact of the demo on nursing home residents, noting that small local labs often are the only ones to send phlebotomists to nursing homes to draw blood. Tom Bejgrowicz, a client account manager for Aculabs, a laboratory that primarily serves nursing homes in New Jersey, testified that there is no guarantee in the draft bidder's package that the competitive bidding "winner" will be forced to provide any level of testing to the long-term care setting.

Even Quest Diagnostics opposes the project. In a statement submitted to the committee, Quest said it has "serious concerns regarding the negative impact competitive bidding will have on small businesses, including those that compete with Quest Diagnostics, such as small laboratories and hospital laboratories." The company also noted its concern about the issue of servicing nursing homes if local laboratories are not winners.

Committee chairwoman Nydia Velazquez expressed sympathy with those testifying, saying that CMS "ignored congressional intent and moved forward with a project that creates a cumbersome bureaucracy" that will make it impossible for small labs to survive. She acknowledged that there are compelling arguments against competitive bidding and pledged to monitor implementation of the demonstration.

Sonic To Acquire Sunrise Medical Labs For $148M

The buying spree continues for Sonic Healthcare (Sydney, Australia). The company recently announced that it has signed an agreement to acquire 100% of Sunrise Medical Laboratories (Hauppauge, NY) for $148 million plus up to $20 million under an earn-out arrangement based on growth and EBITDA benchmarks.

The debt-funded deal, which is expected to close early next month, would give Sonic a valuable presence in the northeast United States less than two years after it entered the U.S. laboratory market with its 2005 acquisition of Clinical Pathology Laboratories (Austin, TX).

Founded in 1972 by CEO Larry Siedlick and President Pat Lanza, Sunrise has annual revenues of approximately $75 million and more than 360 employees. In keeping with Sonic's "federation model," which calls for retention of the acquired company's management, name, and "local flavor," Sunrise's management team will continue to operate the business after the acquisition closes.

Other recent acquisitions for the Australian lab giant include American Esoteric Laboratories (recently relocated to Austin, TX), the Medica Laboratory Group (Zurich, Switzerland), and Mullins Pathology & Cytology (Augusta, GA). Sonic also owns Muskogee Clinical Laboratory (Muskogee, OK), Cognoscenti Health Institute (East Orlando, FL), and Lookadoo Skyline Laboratories (Port St. Lucie, FL).

Hawaii-Based Diagnostic Laboratory Services Readies First Mainland Lab

Diagnostic Laboratory Services (DLS; Honolulu, HI) has established its first lab in the continental United States, a 4,500-square-foot facility at Memorial Hospital of South Bend (MHSB) in Indiana. This will serve as a temporary lab while DLS awaits completion of the 8,500-square-foot permanent lab on the first floor of MHSB's Heart and Vascular Center. The permanent facility is expected to be completed in January of 2008.

DLS contracted MHSB to build and manage the new lab, including providing management services, staffing, supplies, equipment, intellectual property, and operating systems. The temporary lab offers a range of core services and a menu of 340 tests. Upon moving to the permanent facility, more than 150 tests will be added to the lab's offerings. MHSB's pathology and reference lab work will continue to be provided by the hospital's previous laboratory services provider, South Bend Medical Foundation.

"Some 90% of all U.S. hospitals operate in-house laboratories, and we believe this is an important way to stabilize costs, maintain high quality, and produce quick turnaround time for results," says Kreg Gruber, chief operating officer of MHSB.

Sixteen staff members from Honolulu-headquartered DLS, led by Patrick Monahan and Jonn Ragle, have been on-site, working with a team from MHSB. Full-time employees have been hired to run the facility, which is led by lab manager Kathy Braniff.

Founded in 1985 as a joint venture of two Hawaii-based hospital systems (Queen's Health Systems and Kuakini Health Systems), DLS offers routine and esoteric testing services as well as forensic toxicology and substance abuse testing services. The company has locations throughout Hawaii, Saipan, and Guam.

Facing The Medical Technologist Shortage

While the clinical laboratory industry focuses on mergers and acquisitions, negotiating with Medicare, and organizing against the Medicare competitive bidding demonstration project, a serious crisis has been creeping up behind it, recognized but underestimated. A medical technologist shortage has become widespread and threatens to change the industry in a fundamental way.

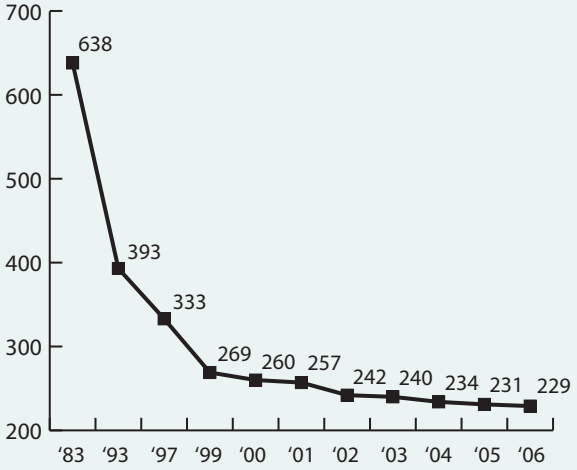
"I get calls almost daily for students that are not graduating yet. They say, 'As soon as they get out, give us a call, please tell them about us, we have so many openings right now,'" says Betty White, program director of the clinical laboratory science program at the University of Tennessee (Knoxville, TN). "And now the baby boomers are retiring. We've lost several techs just in the last few months to retirement, and we're not able to replace them."

A Shortage of Accredited Training Programs

The decrease in medical technology graduates—people with a four-year baccalaureate and eventual American Society for Clinical Pathology (ASCP) certification—appears to be directly linked to a long and steady decrease in the number of accredited training programs. In 1983 there were 638 accredited medical technology programs in the United States. This dropped steadily to an all-time low of 229 in 2006. But it's a classic chicken-or-egg question: Which comes first, the lack of students or the lack of programs?

Abraham Furman, Ph.D., assistant professor at the Oregon Health Science University Laboratory Science Program (Portland, OR) thinks it's a combination of both. "The number of programs going down made it harder for any interested student to find a place to go to. They say, 'Well, there's nothing close to home, there's nothing I can afford to go to, so I'll go into something else.' I think accessibility is a factor."

Medical Technologist Programs



Source: National Accrediting Agency for Clinical Laboratory Sciences

White suggests a historical linkage. In the early to mid-1980s, HIV and AIDS were just breaking into the media, and the public was reacting out of fear and ignorance. "It made people scared to come into the profession because there was so much misinformation about the disease. A lot of students we talked to said, 'I'm not going to do that, I'll get AIDS.'"

When student numbers drop in a medical technologist program, the program is typically not going to continue. "They're very expensive programs," says Jan Tompkins, director of distance education for the School of Allied Health Professions at the University of Nebraska Medical Center (Lincoln, NE). "We went through the stage where there were many options available to people who were interested in the sciences or interested in the laboratory. We lost a few people in that regard."

Furman agrees. "A lot of programs were axed because they cost a lot," he says. "You have to have low faculty-to-student ratios because a lot of lab work is hands-on, plus reagents and lab fees, so they end up being expensive programs. They tend to be the ones that pop up when program cuts need to be made."

Salary, Working Conditions, and Degree Requirements

Salary

A number of issues crop up in terms of how to bring more people into the field. At the very top of the list is salary. In general, medical laboratory jobs are not considered to be terribly lucrative and have also failed to keep up with similar fields, such as nursing, and similar job functions, such as pharmacy technologists and radiology technicians. "We've lagged behind, especially considering the years of training you need to go through in order to even enter the program," says Furman. "We're entering a race with heavy weights on our feet when it comes to salary. We're just not keeping up at all."

Median Hourly Pay Rates (2000-2005)

Position	2000	2002	2003	2005	5-Year CAGR*
Medical Technologist—Staff	$17.95	$19.32	$20.00	$21.52	3.69
Medical Technologist—Superv	21.50	23.00	24.50	25.96	3.84
Medical Technologist—Manager	27.00	28.50	30.00	31.99	3.45
Cytotechnologist—Staff	21.30	24.00	24.70	26.17	4.20
Histotechnologist—Staff	18.00	19.77	19.67	21.63	3.74
Medical Lab. Technician	14.00	15.35	15.96	17.23	4.24
Phlebotomist	9.90	10.55	11.03	11.74	3.47

*CAGR=compound annual growth rate
Source: American Society for Clinical Pathology

Working Conditions

Although there are undoubtedly many people interested in laboratory science, it's useful to remind both recruiters and would-be applicants to the field that one of the field's legitimate downsides is that in all likelihood at some point in your career you will be working afternoons or midnights. Working holidays and weekends on a regular basis are also a part of the job.

"I do believe it's a factor. I've had many students call, and I've told them what's involved, that they will probably start out working nights and they will always have to work weekends and holidays," says White. "And you know what? I don't hear from them again. They do not want that type of job."

Typical Pay for Medical Professionals

Title	Average Annual Salary
Clinical Pharmacist	$87,523
Physical Therapist	$59,401
Occupational Therapist	$57,523
Ultrasound Technologist	$56,138
Genetic Counselor	$53,800
Medical Technologist	$47,630
Radiologic Technologist	$43,911
Histotechnologist	$41,122

Source: Diversity Allied Health Careers and Salary.com

It's clear that little can be done about this except, perhaps, to make it financially worth going into the field.

Degree Requirements

A medical technology Bachelor of Science degree program typically runs four to five years. This program is then followed by a year-long intern-

ship, usually unpaid, before the technologist can become ASCP certified. A number of programs have been developed that include the internship in the program, so instead of a four-plus-one program, it's a five-year program. They are then called medical technologists (Not technicians. This is an important semantic point for people outside the field. A technologist has at least a bachelor's degree. A technician has an associate degree from a two- or three-year program).

A MLT, or medical laboratory technician, is typically a graduate of a two- or three-year program. One of the things that the industry has been doing to deal with the shortage of medical technologists is to hire more MLTs to fill the needed positions.

Tompkins feels that this has also backfired on the industry. "There is a little bit of effort in the industry to go with the associate degree person because they don't have to pay them as much money," he says. "I see that beginning to backfire because there aren't enough baccalaureate-trained individuals to meet the demands, particularly the supervisory, management capacity that is required."

Furman is careful not to discount the importance of the MLTs and CLTs, but sees only problems with MLTs and CLTS doing the work of medical technologists while still being paid MLT wages. "I tend to think the MLTs and CLTs have their place, but by putting the onus on the average MLT to do all the things that are expected of them, they're eventually going to be a group that's going to be used," he says. "People will suddenly say, 'I've got to do this and this and this and for the amount of money I'm getting, what am I doing all this for?' I think the turnover's going to end up increasing."

The clinical laboratory industry also seems to be going in the opposite direction of the rest of the healthcare industry in this regard. Furman gives the examples of pharmacy and occupational therapy as fields that once demanded only B.Sc. degrees but are now requiring master's, Pharm.D., or Ph.D. qualifications. "We're one of the very few fields that seem to be going in the other direction, and it makes no sense to me," he adds.

Meanwhile, the industry is moving toward more complex testing. "The technology, whether it's information technology or molecular, is all getting more difficult," says Furman. "The automation is not easier, and new regulations are always coming on board. You have to understand method validation procedures and all of these kinds of information that people don't think about. You need well-trained individuals to do that."

Average Vacancy Rates for Key Laboratory Positions (2005)

Position	*1996*	*1998*	*2000*	*2005*
Medical Technologist—Staff	8.2%	10.2%	11.1%	6.0%
Medical Technologist—Supervisor	8.6	9.3	12.5	4.0
Medical Technologist—Manager	7.7	15.4	13.3	4.0
Cytotechnologist—Staff	7.1	10.5	20.6	3.0
Histotechnologist—Staff	5.3	10.3	22.3	7.0
Medical Laboratory Technician	9.4	11.1	14.3	6.0
Phlebotomist	12.5	12.3	18.1	7.0

Source: American Society for Clinical Pathology

Five Potential Steps For A Solution

1. Increase salaries.
Every person interviewed for this article felt that salaries for medical technologists were not high enough given the complexity and importance of the work and the education and training required of those in the field. "I don't think the level of education is appreciated," says Tompkins. "Most clinical lab scientists are baccalaureate-trained and a lot of laboratories won't hire people who aren't. They tend to be the better labs—they have reputations. There's certainly been a period of time where the salary increases did not measure up with other professions, such as nursing."

2. Raise the field's profile.
The laboratories, the industry, and the various professional organizations involving medical technologists need to make a concerted effort to bring their field to the attention of the general public. "Laboratory medicine is not highly visible—and I mean both in the hospital and externally," says Jamieson. "We don't do a very good job of self-promotion."

3. Educate students about the field earlier.
Early education is part of creating a higher profile. White notes that one of their successes has been to create a basic college course that would introduce potential students to the field. "Anybody can take it. It's not a prerequisite to the program, but it gets the word out," says White. "A lot of students liked it, and they tell other people about it."

White also does not think that recruitment efforts at the high-school level are terribly effective. "They listen to you, but it doesn't seem to stay with them. I think you need to get them in the first couple years of college."

4. Employ dedicated program recruiters.
The clinical laboratory industry is going to be in serious trouble if the number of accredited clinical laboratory programs continues to decline. "Recruiting efforts seem to be a little bit better, but I think there's still confusion about who's responsible for recruiting," says Tompkins. "In some disciplines they feel it's the responsibility of the professional organization. In others they feel it's the college or the school that have the program. I think it takes everybody because everyone approaches it from a different perspective."

Tompkins also notes that individual clinical laboratory programs would benefit from a dedicated recruiter, rather than relying on the university's career counselors or recruiters.

5. Secure federal and commercial funding for medical technology programs.
As noted earlier, accredited medical technology programs are very expensive to run. Furman says, "I think one of the things that should be done is federal moneys should be coming in to help more students get accessibility—scholarships, grants, fellowships—and have moneys come in to enlarge the programs and generate more faculty."

In addition, however, those companies and institutions that rely heavily on medical technologists—after all, clinical laboratory tests are responsible for 70% to 80% of medical decisions—need to seriously consider underwriting programs and offering scholarships to encourage people into the field. Or pretty soon they're going to find it difficult to operate their businesses.

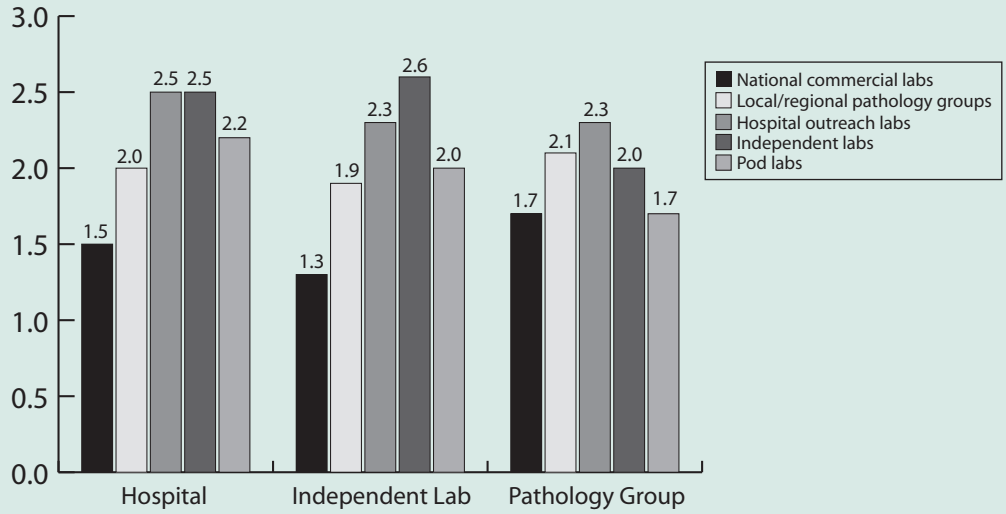
AP Labs Feel Pressure From Aggressive Commercial Labs

Anatomic pathology laboratories are feeling the competitive pressure of commercial labs, a new survey finds. Washington G-2 Reports canvassed 190 anatomic pathology labs from hospitals, independent labs, and pathology groups across the United States. Of the respondents, 72% were located at hospitals, 12% pathology groups, and 11% independent labs—with considerable overlap in the types of practices identified either as independent or as a pathology group. The respondents ranked national commercial laboratories as their top competitor, followed by local or regional pathology groups and by pod laboratories.

A review of financial data from the national commercial laboratories supports the identification of the commercial labs as the top competitor. Quest Diagnostics, the largest of the national laboratories, reported an increase in net income of 9.2% in 2006 compared to 2005. LabCorp reported an increase in net earnings of 11.8% between 2006 and 2005. For 2006, Quest reported net income of $626 million and LabCorp reported net earnings of $431.6 million. The magnitude of earnings for the national labs allows them to provide a broad scope of services, in virtually all areas of anatomic pathology, across not just the United States, but also in the international healthcare market.

Quest's recent acquisition of AmeriPath will also increase competition for pathology groups. AmeriPath operates two divisions that offer a substantial amount of anatomic pathology services. Dermpath Diagnostics employs more than 80 board-certified dermatopathologists who interpret 2.4 million biopsies annually. AmeriPath's general anatomic pathology division provides surgical pathology services in gastroenterology, urology, oncology, and women's health. The growth of national commercial laboratories and their acquisitions of anatomic pathology services will continue to intensify competition for local pathologists.

Top Three Competitors, by Type of Lab



Source: Washington G-2 Reports Anatomic Pathology Survey (2007), n=190

Effects Of National Pathology Firms On Local Practices

Of the 174 people who responded to this question, 71 (41%) stated that the national anatomic pathology firms have had little or no effect on their practices. Two pathologists stated that they worked for a national pathology company, and one of the two added that this national practice "provided a venue for business" in a geographic area with increased competition.

The pathologists who described an effect by the national anatomic pathology practices encountered the loss of work, usually outpatient, because of the marketing practices of the national firms. The most commonly cited areas of lost work include small biopsy specimens, urology biopsies, gastrointestinal specimens, gynecologic cytology, hematopathology outpatient specimens, breast biopsies, and dermatopathology samples.

Respondents attributed the loss of work to exclusive contracts by national laboratories with insurers, competitive pricing, more aggressive marketing, better information technology services (including interfaces with electronic medical records), willingness to enter into fee-splitting/mark-up arrangements in a particular state that has yet to pass anti-markup legislation, "apathy on the part of pathologists," and a larger menu of tests (including clinical pathology testing) provided by the national laboratories that creates convenience and efficiency for physician-office staff members.

Response To Possible Discontinuation Of Payment For Clinical Pathology Services

Another issue that could dramatically alter the competitive landscape for anatomic pathology is attempts by Medicare/Medicaid, managed care plans, and private health insurers to discontinue payments for clinical pathology services. This topic drew an array of survey responses. Thirteen respondents felt that payments will stop or have already stopped, and 18 felt that payments definitely will not stop for clinical pathology services. Some individuals noted that they do not provide this service and, thus, would experience no change in practice or income if payments for clinical pathology stopped.

Other respondents who anticipate a reduction in payment for clinical pathology services expressed the need to negotiate for an increase in hospital-based reimbursements from Part A billings. One respondent felt that the hospital would not be willing to increase Part A payments to the pathology group, which would result either in a reduction of the number of pathologists or a reduction in income for the pathologists.

Many individuals expect to work with professional societies and legislators to preserve payments for clinical pathology services and consultations. One person asked, "What can I do?" and another opined, "It's out of my hands." Another observed that "hospital pathology as we know it may be a thing of the past."

Lab Stocks Up 1% Led By Genomic Health

The G-2 Laboratory Stock Index rose 1% in the four weeks ended July 20, with seven stocks up in price and four down. Year to date, the G-2 Index is up 22%, while the Nasdaq is up 11% and the S&P 500 is up 8%.

Genomic Health (Redwood City, CA) climbed 16% to $20.68 per share for a market cap of $486 million. The company recently announced the BlueCross BlueShield Association (BCBSA) medical advisory panel's conclusion that use of Genomic Health's Oncotype DX breast cancer assay to inform decision making about adjuvant chemotherapy meets the BCBSA technology evaluation center criteria for women with estrogen receptor-positive, node-negative, tamoxifen-treated breast cancer.

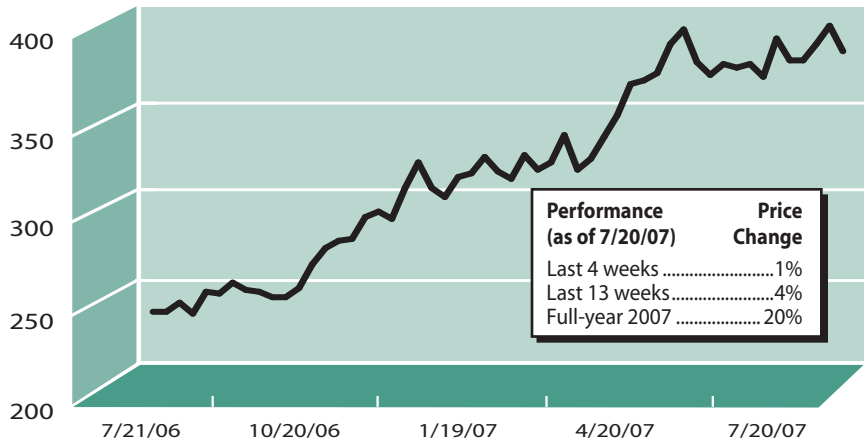
Further bolstering Genomic Health shares were the BCBSA panel's additional decisions that neither breast cancer gene expression ratio-based profiling nor Agendia's MammaPrint gene expression profiling meet their evaluation criteria at this time.

After a run-up over the past several months, **Medtox** (St. Paul, MN) floundered on lower than expected results for the second quarter. Shares in the lab company plummeted 25% to $20.61 per share for a market capitalization of $161 million. The company pointed to increased selling, general and administrative expenses, and the cost of implementing new client relationships.

Medtox's revenue for the quarter was up 19% to $20.8 million compared to $17.4 million in the prior-year period. The company posted second-quarter earnings of $1.8 million, or 20 cents a share, compared with $1.3 million, or 15 cents a share, in the same period last year. The numbers fell below some analysts' estimates.

Meanwhile, among seven selected lab stocks, **Bio-Reference** and **Quest Diagnostics** have the lowest market price-to-sales ratio at 1.7 times; Medtox is next lowest at 2.1 times. Both **LabCorp** and **Orchid Cellmark** are currently priced at 2.5 times their annual revenues.

G-2 Laboratory Stock Index



Source: The G-2 Laboratory Stock Index is tabulated weekly by *Laboratory Industry Report* from the average percentage change in the price of 11 laboratory testing service stocks.

% price change, 4 weeks ended 7/20/07

UP	Price	% Chg
Genomic Health	$20.68	16%
LabCorp	79.81	1
Myriad	38.94	7
Monogram	1.73	4
Orchid	5.15	13
Psychemedics	20.44	3
Quest	54.02	6
DOWN		
Bio-Reference	26.31	-1
Clarient	2.02	-1
Enzo Biochem	14.20	-7
Medtox	20.61	-25

INDUSTRY buzz

Don't miss the silver anniversary edition of Lab Institute! Registration is now open for the 25th Annual Lab Institute: *What's Next Now!* Oct. 10-13, 2007, at the Crystal Gateway Marriott in Arlington, Virginia. Sponsored by Washington G-2 Reports and the American Pathology Foundation, this year's Institute features some of the laboratory industry's most influential business and government leaders tackling a range of key issues, including these blockbuster keynote sessions:

- ❑ **Colin Goldschmidt**, CEO and managing director of Sonic Healthcare, will assess the state and direction of the U.S. laboratory market and provide an international perspective on the industry.
- ❑ **Dave King**, chairman and CEO of LabCorp, will discuss how the nation's second largest commercial lab does business in today's evolving healthcare market.
- ❑ Urban Institute fellow **Robert Berenson, M.D.**, will survey the challenges of reforming the U.S. healthcare system and weigh in on whether Medicare should lead the way in the reform process.
- ❑ Genzyme Genetics President **Mara Aspinall** will address the exploding market for molecular testing, including the "brave new world" of personalized medicine and the marriage of diagnostics and therapeutics.

Other must-see sessions will focus on issues such as national contracting trends, the intersection of pathology and imaging, competitive bidding, outsourcing U.S. lab testing, and the outlook from Capitol Hill on lab reimbursement and oversight. For a complete Lab Institute program go to *www.g2reports.com* or call 1-800-401-5937, ext. 2.

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AAB 314-241-1449

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 Laboratory Industry Report (ISSN 1060-5118) is published by Washington G-2 Reports, 3 Park Avenue, 30th Floor, New York, NY 10016-5902. Tel: 212-244-0360. Fax: 212-564-0465. Order line: 212-629-3679. Web site: www.g2reports.com.

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