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**New Rec: IMPATH, Inc. (IMPH: \$ 42.95) September 4, 2001**

**Position: Sell    Target: \$21.00    Timing: 2 (1=aggressive; 5=cautious)**

\$000	Q201a	Q301e	Q401e	Q102e	2001e	2002e	2003e
Revs	47,074	48,229	51,029	52,871	188,468	220,085	236,237
EPS	0.26	0.27	0.28	0.30	1.05	1.27	1.33
Y/Y Gro	36%	34%	24%	24%	31%	21%	4%
PE					41	34	32
PSR					3.8	3.3	3.0
Consen		0.27	0.28	n/a	1.05	1.36	1.76

**Shares Out: 16.7M**

**Mkt. Cap: \$717M**

**FYE: Dec**

Summary: IMPH is a pathology laboratory services company focused on oncology. The company derives 90% of its revenue from pathology services, which it calls Physician Services. A further 7% of revenue comes from services provided to pharmaceutical and genomics companies, which it calls IMPATH Predictive Oncology, or IPO. The remaining 3% of revenue comes from sales of tumor registry software to hospitals, which IMPH calls Information Services.

Revenue growth for IMPH has been driven primarily by Physician Services, which grew 60% year over year in 2000. "Street" models forecast growth from

this unit will slow to 36% in 2001, 17% in 2002, and 15% in 2003. Continued high growth is expected for IPO, which grew 148% year over year in 2000. Analysts expect IPO revenue to increase 80% in 2001, 88% in 2002, and 75% in 2003. "Street" models have IMPH's total EPS growing from \$0.68 in 2000 to \$1.05 in 2001, to \$1.36 in 2002, and to \$1.76 in 2003. The higher EPS growth relative to revenue growth assumes declining bad debt expense as a percent of sales, and declining depreciation and amortization expenses as a percent of sales.

Although the "street" estimates slowing growth in Physician Services, our research suggests that conditions in this business segment are even worse than current forecasts. Market saturation and pending lower payments from Medicare and other payors should be problems in 2002. Medicare payments account for about 28% of IMPATH revenue. Medicare payments for pathology services are determined by multiplying a set fee by a "physician conversion factor" which is adjusted every year according to expectations for US economic growth. In the past two years, fees from Medicare increased by 5.4% in 2000 and by 4.5% in 2001. A HCFA representative told us that the "physician conversion factor" could decline by 3% in 2002. This number could go even lower, as we explain below. This would impact not only Medicare payments, but payments from other payors who use Medicare rates as a guide to what they will pay, such as managed care payors. We project Physician Service revenue of \$168M in 2001, \$193M in 2002, and \$208M in 2003, versus "street" expectations of \$168M in 2001, \$197M in 2002, and \$226M in 2003. These lower revenue estimates for this segment alone decrease EPS by \$0.03 in 2002 and \$0.15 in 2003 versus "street" models.

"Street" analysts hope IPO will take up the slack of slowing Physician Services. However, their high expectations for the IPO business are unwarranted, in our view. This business is supposed to leverage IMPH's cancer pathology expertise into services for pharmaceutical and genomics companies. We think this business model is weak. IMPH is trying to provide many services that it has never provided before, and needs customers with whom it does not have a current relationship. The main focus of this business is GeneBank. GeneBank would provide genetic information to drug companies by collecting tissue samples of cancer patients and connecting it to data about the outcome of patient treatment. However, it appears that because IMPATH has little leverage with patients or their doctors to gain access to the samples, as well as for other reasons which we explain below, IMPATH may have trouble collecting sufficient data to make the service useful. Only three sizable drug companies have signed up for services in 2000, and only one additional customer has signed up in 2001. We doubt that revenue from this business will even come close to the expectations of the "street." We project IPO revenue of \$16M in 2001, \$22M in 2002, and \$23M in 2003, versus "street" expectations of \$17M in 2001, \$32M in 2002, and \$56M in 2003. Just these lower revenue estimates for IPO decrease estimates for total EPS by \$0.08 in 2002 and \$0.28 in 2003 versus "street" estimates.

On the expense side, we think investors should be wary of IMPH's projection that it can reduce bad debt expense (currently 17% of sales) in future periods to previous levels of 12%. We think that the cause of the high bad debt levels are not well understood. IMPH claims that it is related to computer billing,

and that it can be fixed by fixing the computer system. However, we think it is due to two other factors. The payor mix has shifted dramatically to health plans and away from hospitals. At the same time, fees have increased dramatically. Health plans may not be paying all of these higher fees, even though the fees are being billed. In many instances it appears that the balance of the billing that the health plan will not pay is sent on to the patient. In our opinion, this "co-pay" portion, which may be substantial, is probably not being well collected, nor will it be easier to collect in the future. Even without understanding the cause of the problem, the "street" has been appropriately cautious in its estimates of bad debt, reducing it from 17% in 2001 to 15.4% in 2002 and to 14.6% in 2003. However, reductions under 15% are unlikely in our view. Our bad debt estimates are in line with the "street" for 2002, and higher than the "street" in 2003. Even if IMPH were to manage to lower its bad debt expense to 12% in 2003 and realize an unexpected benefit, the very large revenue shortfall that we expect, primarily from the IPO business, would still cause IMPH to miss 2003 estimates by about \$0.21.

"Street" depreciation and amortization estimates for 2002 and 2003 appear to be too low. Analysts assume capital expenditures of \$19M in 2001 and \$23M in 2002, even though management is guiding investors to expect capex of \$25M-\$30M in both years, up from \$8.2M in 2001. We think depreciation and amortization in 2002 will be about \$1.8M higher than "street" expectations, which would reduce "street" EPS estimates by \$0.06. This shortfall is somewhat offset in our model by a higher gross margin assumption.

IMPH shares currently sell at 41 times consensus EPS of \$1.05 for 2001, and 31 times consensus EPS of \$1.38 for 2002. Its market value is **3.8** times projected 2001 revenues. We think estimates in 2002 and beyond are too high for sales in the core Physician Services business, and are even more out of line for the new IPO business. We project total revenue of \$188M in 2001, \$220M in 2002, and \$236M in 2003, versus the "street" estimates of \$190M in 2001, \$235M in 2002, and \$288M in 2003. We project EPS of \$1.05 in 2001, \$1.27 in 2002, and \$1.33 in 2003, versus "street" projections of \$1.05 in 2001, \$1.38 in 2002, and \$1.76 in 2003. Our target is \$21 per share.

#### Background:

IMPH provides pathology services for cancer (Physician Services), research and development services for pharmaceutical/biotechnology companies (IMPATH Predictive Oncology, or IPO), and tumor registry software to hospitals (Information Services). In 2000, 90% of revenue came from Physician Services. Growth for this unit has been the primary driver of IMPH revenue growth, but the "street" projects slowing growth going forward. New growth is forecast to come from IPO, which contributed 7% of revenue in 2000. The remaining 3% of revenue came from Information Services, which is growing at about 9% per year.

	2000	% of Total	1999-2000 Growth	"Street" Est.Growth 2001	"Street" Est.Growth 2002	"Street" Est.Growth 2003
Physician Serv Rev	\$124.2M	90%	60%	36%	17%	15%
IPO Rev	\$9.5M	7%	149%	80%	88%	75%
Info Services Rev	\$4.5M	3%	9%	9%	12%	8%
Total Revenue	\$138.2	100%	62%	38%	23%	23%
EPS	\$0.68	--	35%	54%	29%	29%

IMPH was founded in 1988 by a group of pathologists associated with Memorial Sloan-Kettering Cancer Center in New York. It began by focusing on breast cancer testing, and now also conducts testing for leukemia/lymphoma, and difficult-to-diagnose tumors.

Certain tests used to diagnose and treat cancer require equipment, technicians and reagents that make low volume testing in small hospitals or independent pathology laboratories cost-prohibitive. Instead, these tests are usually done at large, high volume academic hospital labs or at specialized contract labs. IMPH has capitalized on this market need, targeting 100-500 bed hospitals that lack the volume to do these tests cost-effectively. The company also gets business from large oncology practices, which send it samples directly. Finally, IMPH does a limited amount of very specialized testing for large academic hospitals. IMPH offers fast turnaround, often providing results in 48 hours that might take a week or more to get from a smaller lab.

IMPH has tried to leverage its experience in cancer testing into services for pharmaceutical/biotechnology companies developing cancer drugs. Its IPO unit provides a variety of different services tied together by their relationship to cancer drug research. Services include GeneBank, a database of tumor tissues and outcomes data that can be used to find drug targets, OptimArray, a procedure that can be applied to GeneBank tissues to validate and qualify drug targets, a drug resistance assay to assess the activity of drug compounds, and clinical trial design and implementation services.

IPO was built primarily by acquiring two small companies. In 1998, the company acquired Physician Choice, Inc. for \$1M. This company provided post-clinical, pre-marketing, and cost-benefit analyses to pharmaceutical and biotechnology companies developing new oncology drugs. In 1999, IMPH acquired BioClinical Partners for \$8.5M in cash and stock. This company was creating a tissue repository to support the development of oncology drugs. In 2000, IMPH renamed its Biopharmaceutical services division IMPATH Predictive Oncology, and began describing its potential in more detail to investors. This unit is now the primary source of future growth expected by the "street," with GeneBank as its centerpiece.

The final source of revenue for IMPH is Information Services. This unit resulted from IMPH's 1998 acquisition of Medical Registry Services, Inc. for \$13.8M in stock. It provides software for hospitals to use to collect and manage information about cancer cases managed at their hospitals.

## Discussion:

### 1. Physician Services

IMPH's Physician Services customers are pathologists and oncologists who refer tests to IMPH. Hospitals, health plans, Medicare, and individual patients pay for IMPH's services. Typically, a local pathologist will first review a blood or tissue sample and make an initial diagnosis. In the case of leukemia, the pathologist may stain the sample, or test it for the presence of certain antibodies. Similarly, a pathologist will review tissue samples from biopsies of suspected breast cancer, and make an initial cancer diagnosis. The pathologist then sends the sample to IMPH for further testing.

IMPH conducts both diagnostic and prognostic tests. While a diagnostic test determines if a sample is cancerous, a prognostic test determines the cancer subtype. These tests guide the type of treatment a patient will receive. For example, a breast tumor biopsy will be tested for the presence of HER2/neu, a marker that indicates the tumor will be susceptible to treatment with Herceptin.

The company uses a number of techniques to test samples. These include immunohistochemistry, used to identify disease-specific cellular antigens, flow cytometry, used to examine the DNA and RNA of a sample and test for the presence of antibodies, cytogenetic analysis, used to evaluate the genetic changes that occur at the chromosome level, and molecular pathology techniques such as fluorescence in situ hybridization (FISH), used to locate and identify nucleic acid sequences within cells.

IMPH's reimbursement amount for its services differs by payor. Fees for services provided to hospitals are set by contract. Those provided to Medicare patients are paid according to the government's reimbursement schedule. Fees for patients in health plans are handled quite differently. Since IMPH is an out-of-network provider, it bills the health plan at a rate determined by IMPH alone, as it notes in its 10K: "With respect to third-party payors, management has elected, to date, not to accept reimbursement rates set by such non-governmental third-party payors as payment in full." As a result, it appears that IMPH sends a bill, and the health plan then typically reimburses whatever it deems to be the "usual and customary" fee. IMPH must try to collect the balance from the patient. The benefit of this strategy, according to IMPH, is that it can bill a higher fee than it would have negotiated with the health plan. The disadvantage is that collection rates on the patient portion appear to be lower than from other payors. We describe this problem at length below in the section concerning bad debt and accounts receivable.

### 2. Physician Services targets a \$600M market growing at 8%-10% per year

IMPH is a small player in the \$3.5B esoteric testing market. Its niche within this market is testing for difficult to diagnose cancers. IMPH defines this market as worth \$600M. "Street" reports on the clinical laboratory market agree with this

estimate, and put growth at 8%-10% per year. While these growth estimates seem reasonable to us, we doubt the entire market is accessible to IMPH, as we explain later.

IMPH describes its market as being in three segments: breast cancer prognostic analyses, lymphoma/leukemia analyses, and diagnostic analyses. As shown in the table below, the company defines each segment in terms of the number of new "cases" generated each year. A case refers to the battery of tests done on a particular patient sample.

Potential Market for IMPH, 2000

Type of Case	
Breast Cancer Prognostic Analyses	192,200
Lymphoma/leukemia (new cases and monitoring)	409,500
Diagnostic Analyses (tumors, other)	253,600
Total Cases	855,300
Average revenue per case	\$700
Potential annual revenue	\$600M

Source: IMPATH

The "street" likes to tout IMPH's focus on the cancer market as a strength of the company. Analysts suggest that the cancer market is growing very rapidly, stating that "the estimated number of cancer cases diagnosed annually in the US (excluding certain skin cancers) grew 126% from 1963 to 2000." This is fuzzy math, even for sell-side analysts. What matters, of course, is recent growth. As shown below, the number of new cases of cancers targeted by IMPH is increasing by only 1%-3% per year. New cases of cancer in all other sites has actually shown little change over the past few years.

Type of Cancer	Estimated New cases 2001e	1998-2001 CAGR
Breast	193,700	2.4%
Lymphoma	63,600	0.6%
Leukemia	31,500	3.2%
All Other Sites*	979,200	0.8%

\*Excludes basal and squamous cell skin cancers, noninvasive carcinomas except urinary bladder.  
Source: American Cancer Society

The market for cancer testing is growing faster than the incidence of cancer due to an increase in the number of tests done per patient sample, more tests to monitor the patient after the initial diagnosis, and higher reimbursement per test.

More tests per sample: Over the past few years, a number of new tests have been developed to more precisely define the type of cancer a patient has in order to guide treatment. For example, breast tumor cells are now routinely tested for the overexpression of a protein called HER2/neu to determine if the tumor will be susceptible to treatment with Herceptin. In leukemia, blood or bone marrow is analyzed with flow cytometry and cytogenetics to precisely characterize the leukemia type, and to appropriately tailor treatment.

More monitoring after initial leukemia diagnosis: The advent of new treatments for leukemia has led to increased monitoring of patients following the

initial diagnosis. Patients' bone marrow and blood may be analyzed as frequently as 6-10 times during the year after diagnosis to monitor the effect of therapy. In subsequent years, monitoring may be done once or twice per year.

Higher reimbursement per test: Reimbursement rates for pathology services paid for by Medicare are based on a resource-based relative value scale (RBRVS). Reimbursement is calculated by multiplying the total relative value units (RVUs) associated with a test by a physician conversion factor set each year by HCFA. This physician conversion factor increased 5.4% in 2000 and 4.5% in 2001, due in part to the rapid expansion of the US economy. Higher reimbursement from Medicare also leads to higher reimbursement from health plans that use Medicare rates to guide their own rates. This trend may be about to reverse itself, however. As we discuss later in this report, HCFA estimates project at least a 3% year over year decline for the physician conversion factor for 2002.

### 3. IMPH estimates it had a 21% share of its \$600M market in 2000

IMPH has succeeded in rapidly growing its market share, and estimates it analyzed about 21% of cases in its target markets in 2000. Using company information, we arrive at the following market share estimates for each market segment.

IMPH Market Share

	1997	1998	1999	2000
Breast Cancer Cases	20%	28%	29%	30%
Leukemia/Lymphoma	3%	5%	8%	10%
Other Diagnoses	15%	23%	26%	32%
Total	10%	15%	17%	21%

Source: IMPH

IMPH estimates that it provided prognostic information in over 30% of breast cancer cases in 2000, up from 20% in 1997. This segment was the first targeted by IMPH when it was founded in 1988. Revenue per case is about \$550.

In 1996, the company began targeting lymphoma/leukemia diagnosis and monitoring, which generates higher reimbursement than other types of cancer diagnoses. According to company market size estimates, IMPH's share of this market is about 10%. However, as we discuss below, we think only about 44% of these cases are actually available to IMPH, putting its true market share in 2000 at 24%. IMPH says revenue per lymphoma/leukemia diagnosis is about \$1,500. Monitoring after diagnosis generates lower revenue.

"Other Diagnoses" includes all other cases analyzed by IMPH, including difficult to diagnoses tumors, micrometastases detection, drug resistance assays, and morphology/serum analyses. This catch-all category makes it impossible to determine IMPH's market share in more lucrative subgroups such as difficult to diagnose tumors. Revenue from these analyses ranges from \$550-\$1,000 per case.

### 4. Increasing market share and higher revenue per case has allowed IMPH to increase diagnostic revenue much faster than the 8%-10% growth rate of its

market.

IMPH has increased its diagnostic services revenue by 44%-68% year over year since 1997. As shown in the table below, in 1997 and 1998, most of the revenue increase was driven by the higher case volume that resulted from higher market share. In 1999 and 2000, case volume growth began to slow, and was replaced by growth in revenue per case.

Physician Services Revenue, Case Volume, and Revenue per Case

	1997	1998	1999	2000
Physician Services Rev	\$36.8	\$53.2M	\$77.4M	\$124.2M
Y-Y % Change	68%	44%	46%	60%
IMPH Case Volume	87,884	129,081	148,302	175,587
Y-Y % Change	58%	47%	15%	18%
Revenue per case	\$419	\$412	\$522	\$707
Y-Y % Change	6%	-2%	27%	35%

Management says revenue per case has benefited from a shift in product mix to more lucrative lymphoma/leukemia cases. However, this change in product mix does not appear to explain all of the increase in revenue per case, especially in 2000. We think that revenue per case has benefited from a shift in the payor mix from hospitals to health plans, which has allowed IMPH to raise fees per case. Remember, hospital fees are set by contract, but health plans fees are set by IMPATH. We discuss this interesting issue later in the section on bad debt and accounts receivable.

Physician Services Case Mix

	1997	1998	1999	2000
Breast Cancer Cases	41%	38%	35%	31%
Lymph/Leuk Analyses	14%	16%	21%	24%
Other Diagnoses	45%	46%	44%	45%
Total	100%	100%	100%	100%

IMPH has also increased revenue per case with savvy sales and marketing. The company's sales representatives call on both the pathologists who send samples to IMPH, and the oncologists who are ordering the tests. Representatives inform oncologists about the full range of tests available, and encourage them to order more tests. Several pathologists with whom we spoke think that IMPH's marketing results in a significant amount of unnecessary testing. But since IMPH is an out-of-network provider with no testing restriction imposed by health plans, and since doctors tend to prefer more information to less, oncologists can be easily persuaded to order the maximum number of tests.

IMPH's growing emphasis on marketing can be seen in the expansion of its sales force. As shown below, each representative now calls on only 40 accounts, versus 62 in 1997.

## Sales Force Analysis

	1997	1998	1999	2000
Hospitals/Onc Practices	1,811	2,030	2,197	2,421
Sales Reps	29	36	45	60
Reps per Hosp/Onc Practice	62	56	49	40

Source: IMPATH

5. Case volume growth in recent quarters is slowing, suggesting that IMPH is reaching saturation of its target markets

The company's quarterly disclosures of case volume growth in its target markets, shown in the table below, suggest that IMPH has reached market saturation of the breast cancer market, and is nearing saturation of the lymphoma/leukemia market. The breast cancer market is seeing only single digit increases in volume, while volume growth in the lymphoma/leukemia market has slowed from 26% in 2Q00 to 18% in 2Q01. Diagnosis of Tumors (a sub-category in the Other Diagnoses segment discussed above) continues to see high growth, but has slowed in the past year.

### Y-Y changes in Case Volume

	1Q00	2Q00	3Q00	4Q00	1Q01	2Q01
Therapeutic/Prognostic (Breast)	5%	2%	n/d	n/d	n/d	4%
Lymphoma/Leukemia	76%	26%	29%	18%	n/d	18%
Diagnosis of Tumors	13%	54%	n/a	45%	n/d	32%
Total Case Volume	16%	20%	24%	17%	11%	16%

Source: IMPATH; n/d=not disclosed

6. Understanding why IMPH should have difficulty penetrating more of the market

Penetration of the breast cancer market appears stalled at about 30%. We think this share may represent about the maximum IMPH can achieve in any of its market segments. Most of the remaining breast cancer pathology market share is held by academic hospital labs, which have a captive market in the oncologists associated with their hospitals and affiliated community hospitals. Also, these pathology labs are high volume, making it profitable for them to keep testing in house. Moreover, the teaching mission of the academic hospitals demands that they continue to do these tests. Finally, these labs are likely to view IMPH's work as inferior to their own. Several academic center pathologists with whom we spoke commented that they regard the pathologists employed by IMPH as substandard, commenting that many of the staff did not attend US medical schools. These pathologists also cited anecdotal cases were IMPH missed cancer diagnoses that they later picked up.

7. Lymphoma/leukemia closer to saturation than the "street" suspects

While IMPH presents data suggesting that it has penetrated only 10% of the lymphoma/leukemia market, we think that much of this market is unavailable to the company. We think IMPH has actually penetrated about 24% of the available market, and so is coming close to the 30% penetration "ceiling" seen with breast cancer.

IMPH estimates the lymphoma/leukemia market at 409,500 cases per year. A closer look at the market reveals that many of these tests are unavailable to IMPH. The table below summarizes our estimate of the lymphoma/leukemia market actually available to IMPH.

Lymphoma/Leukemia Market Available to IMPH

Type of Case	Cases/Year	% Potential for IMPH	Potential IMPH Cases
Hodgkin's Lymphoma	7,400	0%	0
Non-Hodgkin's Lymphoma	56,200	100%	56,200
Chronic Leuk Diagnosis	15,750	100%	15,750
Chronic Leuk Monitoring	157,200	50%	78,600
Acute Leuk Diagnosis	15,750	100%	15,750
Acute Leuk Monitoring	157,200	10%	15,720
Total Cases	409,500	44%	182,020

Source: American Cancer Society, OWS estimates

The lymphoma market includes Hodgkin's lymphoma and non-Hodgkin's lymphoma. Diagnosis of Hodgkin's lymphoma is straightforward, and can be done by a hospital pathologist looking at a cell smear under a microscope. We think IMPH sees few if any of these cases. Diagnosis of non-Hodgkin's lymphoma is more complex, and so we count these as potential IMPH cases. Monitoring of lymphomas after the initial diagnosis is done primarily with imaging technologies (e.g., CT or PET scans).

The leukemia market can be divided into chronic leukemia diagnosis and monitoring, and acute leukemia diagnosis and monitoring. Each of these initial diagnoses would be potential IMPH cases. After diagnosis, however, many leukemia cases are referred to academic centers for treatment and monitoring. Leukemia patients, especially those with acute disease, require intensive chemotherapy and other specialized treatment that is simply not available at community hospitals. Once at the academic medical center, further lab testing to monitor of these patients will most likely be done at the academic center's community lab. We estimate that 50% of chronic cases and 90% of acute cases are treated at an academic center after initial diagnosis, and so are not available to IMPH.

Thus, of the 409,500 cases IMPH estimates the market generates each year, only about 182,000, or 44% are actually available to IMPH. With 42,000 lymphoma/leukemia cases in 2000, IMPH has already penetrated 24% of its available market, not the 10% assumed by the "street." A 30% share of this available market puts IMPH at 54,600 cases, or 13% of the total available market. We think this is the maximum penetration IMPH can hope to achieve.

#### 8. Slowing growth in number of physicians served provides further evidence of market saturation

IMPH's case volume is closely correlated with the number of physicians it serves. As shown in the table below, since 1998, case volume has been 20-22 cases per physician. Growth in the number of physicians served has slowed from 30% year over year growth in 1998, to 6% year over year growth in 2000.

	1995	1996	1997	1998	1999	2000
# physicians	2,500	4,000	5,000	6,500	7,400	7,850
Y-Y% Growth	14%	60%	25%	30%	14%	6%
Cases/physician	17	14	18	20	20	22

This slowing growth suggests that IMPH is nearing saturation of its customer base. According to the American Medical Association, in 1999 there were about 19,849 pathologists and oncologists engaged in patient care. Note that IMPH tells investors that there are 23,000 pathologists and oncologists who are potential customers. This number includes physicians involved in activities other than patient care (e.g., administration) who should not be included as potential customers, in our view.

Physicians engaged in patient care, 1999

Specialty	# of Physicians
Anatomic/Clinical Pathology	12,710
Hematology/Oncology	1,578
Medical Oncology	4,529
Pediatric Hematology/Oncology	1,032
Total	19,849

Source: American Medical Association

At the end of 2000, IMPH served 40% of these physicians. Since many of the remaining doctors are likely associated with academic medical centers with high volume pathology labs, and new competition is entering the market, we think IMPH is likely to see little growth in its physician customer base going forward.

9. New growth expected from future prognostic analyses is at least five years away

IMPH has tried to assuage investor fears of high market penetration by touting the advent of many new prognostic analyses for prostate, lung, colorectal/digestive, ovarian, and pancreatic cancer. The company estimates these analyses could add 742,600 new cases a year, nearly doubling the current 855,300 case market. However, oncologists with whom we have spoken estimate that these prognostic tests are at least five years away from commercialization.

Why have prognostic tests for leukemia become available so much earlier than tests for other cancers? Oncologists tell us that the particular genetic changes being measured by prognostic tests for leukemia occur in only 5%-10% of cases, and so can be used to identify a particular leukemia subtype. With such a readily identifiable population of subtype patients, researchers have been able to measure outcomes for various therapies, thereby giving the tests prognostic value. In contrast, genetic changes identified thus far for most solid tumors occur in a large percentage of cases, and not just in isolated subtypes. Knowing the genetic change would therefore have little impact on therapy. Thus, until unusual genetic abnormalities associated with these tumors are identified, prognostic testing will not be of value.

IMPH has tried to introduce its own tests in the past, but with little success.

Its Drug Resistance Assay (DRA) was launched in 1999, and was supposed to provide a method to measure a cancer's susceptibility to various chemotherapy approaches in a laboratory dish. While the company does not break out revenue from this test, it is certainly not a subject of much discussion by IMPH or the "street" in recent days. Oncologists with whom we have spoken suggest that drug resistance assays for oncology are not useful, and are certainly not done in most academic laboratories.

#### 10. New competition threatens IMPH's core markets

Previously, IMPH competed primarily with academic labs, and was able to win business by providing much faster turnaround. Since the oncologists and pathologists it serves do not pay for the tests, the company faced no price competition. IMPH's success has not been lost on its competitors. In just the past few months, several clinical laboratory companies have announced new initiatives targeting IMPH's core markets. For example, AmeriPath (PATH) recently opened its Center for Advanced Diagnostics in Orlando, FL to provide testing for leukemia/lymphoma, and breast, colon, and prostate cancer. LabCorp (LH) has also announced plans to enter these markets.

IMPH status as an out-of-network provider may make it particularly vulnerable to these competitive efforts. If a health plan has contracted with LH for its clinical diagnostic services, we think it is likely to give its oncology testing to LH as well. This competitive pressure may force IMPH to contract with health plans itself, and to reduce its prices. The impact would be significant. One competitor with whom we spoke charges its contract clients \$550 for a leukemia diagnosis, versus the \$1,500 IMPH estimates as its revenue from this type of case.

#### 11. Federal investigation into billing practices

In January 2000, IMPH was notified that the U.S. Attorney's Office for the Southern District of New York was investigating the company's billing practices. We can think of a number of reasons why the Government may be investigating. First, as mentioned above, IMPH appears to be encouraging unnecessary testing. Is it billing Medicare for unnecessary tests? Or is the Government acting to protect the consumer, who may be getting hit with unexpectedly high "co-pays" resulting from high charges to out-of-network health plans that pass on the balance of what they will not pay to the patient? Second, one pathologist with whom we spoke said that sometimes IMPH provides an interpretation of the pathology results (called the professional component), even though the pathologist requested only the results of the analysis (the technical component). This would suggest that IMPH is billing Medicare for both components. But the local pathologist wants to bill for the professional component. Since he did not request that IMPH do the work, he goes ahead and bills also, meaning that Medicare is double billed for the professional component. Potential double billing could be part of the government's inquiry.

12. Increased revenue from health plans has been accompanied by higher DSO and by higher levels of bad debt.

Between 1996 and 2000, health plan revenue has increased from \$7.6M to \$67.1M. Health Plan revenue grew faster than total Physician Service revenue, from \$21.8M to \$124.2M.

	1996	1997	1998	1999	2000
Total Phys Serv Rev	\$21.8	\$36.8	\$53.2	\$77.4	\$124.2
Y-Y % change	49%	69%	44%	46%	60%
Health Plan Revenue	\$7.6	\$16.2	\$26.6	\$42.6	\$67.1
Y-Y % change	80%	113%	64%	60%	58%

Higher health plan revenues were accompanied by a dramatic change in IMPH's payor mix. As shown in the table below, health plans accounted for 35% of revenue in 1996, while in 2000 they accounted for 54%. Most of the shift has come from hospital payors, who dropped from 37% of revenue in 1996 to 13% of revenue in 2000.

#### IMPH Payor Mix

	1996	1997	1998	1999	2000
Health Plans*	35%	44%	50%	55%	54%
Medicare	25%	25%	25%	23%	28%
Hospital	37%	26%	21%	17%	13%
Individual Patients	3%	5%	4%	5%	5%
Total	100%	100%	100%	100%	100%

\*Private Insurance/Managed Care; includes IMPH billing to health plan patients

Along with this change came higher DSO and higher bad debt expense. As shown below, total DSO rose from 94 days in 1996 to 117 days in 2000. Bad debt expense, which reduces DSO, has also increased during this period, from 11% of revenue in 1996 to 15% of revenue in 2000. In 2001, the company forecasts bad debt expense at 17% of revenue.

	1996	1997	1998	1999	2000
Total DSO	94	101	107	123	117
Bad Debt Exp % Rev	11%	12%	11%	12%	15%

The DSO of each payor has also changed. As shown below, Health Plan DSO increased from 100 in 1996 to 131 in 2000. Hospital DSO skyrocketed in 1999 to 180, but appears to have been brought down in 2000 to 121 days, perhaps by a bad debt write down. Similarly, individual patient DSO were an astounding 582 days in 1998, but probably write downs have reduced this DSO class to 367 days in 2000. The only payor group that does not appear to have had its DSO adjusted downward, probably by charge offs, is Health Plans, where DSO increased from 100 in 1996 to 131 in 2000.

DSO by payor

	1996	1997	1998	1999	2000
Health Plans*	100	99	108	122	131
Medicare	90	70	59	91	94
Hospital	79	95	146	180	121
Individual Patients	251	352	582	418	367
IPO/ Info Services	--	--	--	--	--
Average Revenue/case	\$395	\$419	\$412	\$522	\$707
Y-Y % change	16%	6%	-2%	27%	35%

\* Health Plan DSO includes portion of health plan billing that is patient's responsibility, per IMPH management.

13. Higher Health Plan DSO is likely due to higher fees, a larger portion of which the health plan passes on to patients. These higher patient "co-pays" are unlikely to be collected.

We think a growing proportion of the Health Plan DSO are really payments IMPH is seeking from patients to cover the balance of the fee that the health plan is unwilling to pay. We find support for this argument in the correlation between increased revenue per case and Health Plan DSO. As shown in the table above, DSO from health plans were stable at 99-108 during 1996-1998, a period during which average revenue per case saw relatively little change. In subsequent years, Health Plan DSO increased significantly, to 122 in 1999 and 131 in 2000. Average revenue per case also jumped during this period, increasing 25% year over year in 1999 and 35% year over year in 2000. We think that IMPH raised its fees to health plans, and health plans are unwilling to pay these higher fees, but instead continued to pay "customary and usual" amounts. IMPH would then try to collect the balance from patients, resulting in higher Health Plan DSO. We discussed this theory with a spokesperson at major managed care company, who told us that out-of-network patient "co-pays" have been increasing by about 15%-20% per year. More of these expenses are being passed on to patients as employers look for ways to hold down premium increases. These patient DSO, included in the Health Plan DSO total, will be hard to collect. Improving the system for attempting to collect these amounts may be part of IMPH's "computer optimization" program.

IMPH explains that its increased average revenue per case in 2000 was due to a higher proportion of lymphoma/leukemia cases in the product mix. This might make sense if we looked only at 1999, when a 29% increase in the share of lymphoma/leukemia cases in the product mix coincided with a 27% increase in average revenue per case. The correlation fails to hold, however, in 1997, 1998, or 2000. As shown in the table below, in 1997, average revenue per case increased just 6%, while lymphoma/leukemia's share of case volume increased 40%. In 1998, average revenue per case declined, even though lymphoma/ leukemia's share of case volume increased by 15%. Finally, in 2000 lymphoma/ leukemia's share of case volume increased only 13%, while average revenues increased 35%. Where did the extra revenue increase per case come from? We think it may be from higher billing rates to health plans on a number of different types of tests.

Average Case revenue growth and growth in Lymph/Leuk case share 1997 and 1998

	1997	1998	1999	2000
Y-Y change in revenue per case	6%	-2%	27%	35%
Y-Y change in Lymph/Leuk share of case volume	40%	15%	29%	13%

While this strategy would allow IMPH to show impressive revenue growth in the near term, it would also generate higher rates of bad debt since patients are now responsible for a higher portion of the bill. Not to be morbid, but we think collection rates from patients with leukemia, for whom the one year survival rate is only 64%, must be quite low.

#### 14. Bad debt expense not likely to return to historical 12% levels

Management's explanation for its high bad debt expense and DSO is collection delays associated with the implementation of a new computerized billing system. Management says that the new system is reaching full optimization, and investors should expect bad debt expense as a percent of revenue to begin to trend down toward historical 12% levels in 2002 and beyond. "Street" analysts have followed management's lead, and are modeling bad debt expense as a percent of revenue at 15.4% in 2002 and 14.6% in 2003. We think a reduction to 15% in 2002 and 2003 may be possible with the new billing system. However, we think that IMPH's apparent increased reliance on patients' willingness to pay directly the balance that is unpaid by the health plan will make it difficult to return to the 12% levels of earlier years.

Our model assumes bad debt expense of 15.2% in 2002 and 15% in 2003. Our figure for 2002 is in line with "street" expectations. Even if IMPH does succeed in lowering bad debt expense to 12% in 2003, we estimate that IMPH will still miss "street" 2003 EPS estimates by \$0.21 due to revenue shortfalls primarily associated with the IPO division.

#### 15. DSO and gross margins are much higher than peers

IMPH's collection problems are also evident in its DSO levels. DSO for IMPH runs between 117-132, while AmeriPath reports DSO of 55 and Dianon reports DSO of 77. Perhaps not coincidentally, IMPH's gross margin of 63% in 2000 was also significantly higher than these competitors. AmeriPath's gross margins in 2000 were 53%, and Dianon's were 43%. We think IMPH's margins are higher in part because of the higher fees being charged to health plans. The problem is, IMPH is experiencing difficulty collecting these billings, resulting in higher DSO.

#### 16. Medicare payments per case in 2002 will decline by at least 3% year over year

Another fundamental problem facing IMPH is a decline in reimbursement from Medicare projected by HCFA for 2002. A HCFA representative told us the latest estimates, which include the Commerce Department's July 2001 downward revision in 2000 economic growth, suggest that the Physician Conversion Factor will decline 3% year over year in 2002. A further downward adjustment could come when HCFA includes revised estimates for 2001 economic growth, currently

estimated at 1.5%. With economic growth only slightly positive so far this year, the final 2002 Physician Conversion Factor, to be set in November 2001, could be 4%-5% lower than 2001.

	1999	2000	2001	2002e
Physician Conversion Factor	\$34.73	\$36.61	\$38.26	\$37.11
Y-Y % Change	n/a*	5.4%	4.5%	(3.0%)

\*1999 was the first year this system was in place

Source: HCFA

This decline would cut Medicare reimbursements (28% of 2000 Physician Service revenue) to IMPH. In 2000, if Medicare payments had declined 4% instead of increasing 5.4%, Physician Services revenue would have been reduced by \$3.2M. However, the effects may not be limited to Medicare revenue. Many health plans use Medicare reimbursement to guide their own reimbursement levels. If many followed Medicare's lead, the impact on IMPH would be more significant.

#### 16. IMPATH Predictive Oncology (IPO) business model is poor, faces significant competition

With a decline in growth of Physician Services revenue widely expected by "street" analysts, IMPH has had to come up with another way to grow revenue. Its response has been to start IPO, a business unit charged with providing services to pharmaceutical and genomics companies.

To date, only three companies have signed up for IPO's services: Millennium, Bristol-Myers, GlaxoSmithKline, and Abgenix. The company has announced no new relationships since March 2001.

IMPH has focused investor attention on GeneBank as the most important of the services offered by IPO. IMPH is trying to collect 50,000 tumor specimens linked to data about the outcome of treatment. The company does not disclose how many samples it has collected thus far, but says it has contracted for more than 25% of the specimens. As we explain below, collecting these samples is not a simple exercise. IMPH has yet to prove it can do this, or that the resulting database will be of value to pharmaceutical companies. In the meantime, it plans to make capital expenditures of \$25M-\$35M in both 2001 and 2002, largely to develop GeneBank.

IMPH tells investors that its position as a high volume cancer pathology lab puts it in a unique position to gather large numbers of tumor samples for its database. IMPH faces several collection problems, however. First, it must compete with other groups, both for-profit and non-profit, who want access to the tissue. We think it is also competing with its potential pharmaceutical company customers, who likely control tissue samples from patients involved in their clinical trials. Then, it must obtain informed consent from the patient to use the tissue. Since it does not directly interact with the patient, the company must rely on the pathologist or oncologist to make the extra effort to obtain the informed consent. Moreover, the tissue sample alone is of limited value. IMPH must also collect patient outcome data to make the sample useful. Again, it must somehow

convince the doctor to pass the outcome data along.

What incentive can IMPH give to hospitals to convince them to part with their tumor samples? In May 2001, IMPH announced a deal with the University of Pennsylvania Cancer Center that may indicate its approach. IMPH expects this agreement to generate 4,000 samples in 3 years. Under this agreement, the Cancer Center will "offer" the GeneBank program to the 28 community hospitals in its Cancer Network. We think IMPH is paying the Cancer Center for access to these hospitals, and then is perhaps paying each hospital for the samples.

This agreement is the only tissue access deal IMPH has announced to date. Will IMPH be able to win enough contracts to meet its 50,000 sample goal? Given the competition it faces, we think this will be difficult. For example, the Genomics Collaborative and Aradis, both private companies, are competing for the same tissue targeted by IMPH. The Genomic Collaborative launched its 100,000 tissue database (including cancer and other types of samples) in June 2001, and has signed up partners such as Pharmacia, GlaxoSmithKline, and Exelexis. Aradis is gathering samples from academic medical centers to develop its database, and is presently collaborating with Beth Israel Deaconess Hospital in Boston and Duke University.

In September 2001, IMPH announced that it acquired an oncology clinical studies network from Innovative Clinical Solutions (ICSL). Though IMPH did not disclose the terms of the agreement, ICSL's most recent 10-K, filed in August 2001, discloses that it had entered into a definitive agreement to sell its oncology and hematology operations for \$2.5M. This business, with annualized revenues of \$2M, provides clinical trial support services to pharmaceutical and biotechnology companies.

In announcing the acquisition, IMPH focused on its ability to enhance IPO's patient recruitment services for clinical trials. Thus, its may contribute to IMPH's attempts to become more active in clinical trial services, but will do nothing for IMPH's gathering of tissue samples for GeneBank.

We wonder if IMPH will be any more successful with this business than the previous owners. ICSL recently emerged from bankruptcy protection, and is selling off assets in order to try to stay afloat. We think the primary benefit of the acquisition is really its \$2M in annualized revenue, which may have been necessary for IMPH to make its guidance of \$1.05 EPS in 2001.

#### 17. IPO growth is not very profitable

While the "street" has been cheered by the growth in IMPH's IPO business, with revenue growth of 148% year over year in 2000, a look at the unit's financial performance should dampen their enthusiasm. Here we look at EBITDA, since the company says it is making significant capital investments in the unit. As shown in the table below, IPO's EBITDA was (\$1.4M) in 2000 on revenues of \$9.5M. Things improved somewhat in the first half of 2001, with the unit generating EBITDA of \$838,000. In our view, this poor performance does not bode well for

the unit's ability to contribute earnings growth to make up for declining growth in the core Physician Services unit.

#### IPO Financial Performance

	1998	1999	2000	1H01
Revenue	\$1.6	\$3.8	\$9.5	\$6.5
Y-Y Growth	n/a	137%	150%	63%
EBITDA	0.9	1.4	(1.4)	0.8
Y-Y growth	n/a	56%	-200%	n/a

#### 18. Information services (Tumor Registry) business not profitable, growing slowly

The final piece of IMPH revenue comes from its Information Services unit, which provides software for hospitals to track tumor cases and their outcomes. This business is growing slowly, with only 5% year over year growth in 1H01. Moreover, the business is losing money. As shown in the table below, EBITDA for 1H01 was \$0.4M, and in 1H01 the segment has already lost as much money as in all of 2000.

#### Information Services Financial Performance

	1998	1999*	2000	1H01
Revenue	\$1.4	\$4.1	\$4.5	\$2.3
Y-Y Growth	n/a	193%	10%	5%
EBITDA	0.9	1.2	(0.4)	(0.4)

\* This business was acquired in August 1998

#### 19. High valuation relative to most peers

IMPH shares currently sell at 41 times consensus EPS of \$1.05 for 2001, and 31 times consensus EPS of \$1.38 for 2002. As shown below, this valuation is much higher than any awarded to other laboratory services companies such as AmeriPath, LabCorp, and Quest Diagnostics. Only Dianon and Specialty Labs have richer P/Es.

#### Peer Valuation Analysis

Company	Share Price (9/4/01)	2001 P/E	2002 P/E
IMPH	\$42.95	41	31
DIAN	\$49.35	42	33
SP	\$32.25	52	43
PATH	\$33.22	24	20
DGX	\$64.01	34	26
LH	\$80.60	32	25

#### 20. Financial Projections:

We assume Physician Services revenue increases 35% in 2001, and 15% in 2002. In 2003, we project growth of 8%, in line with growth of the overall cancer pathology testing market. We assume growth slows as a result of saturation of the lymphoma/leukemia market and lower payments from Medicare and other payors. If IMPH is forced to contract with health plans due to increasing competition, our growth rate projections may prove conservative. We assume IPO revenue grows

63% in 2001, 42% in 2002, and 3% in 2003. We expect Information Services revenue to increase 5% per year for 2001-2003.

We assume gross margins of 65%, higher than "street" estimates of 64% in both years. We estimate SG&A (less bad debt expense) of 23% of revenue for 2001-2003. We project bad debt expense will decline from 17% of revenue in 2001 to 15.2% of revenue in 2002 and to 15% in 2003. We project depreciation and amortization of \$15M in 2001, \$18M in 2002, and \$19.5M in 2003. We project operating income as a percent of revenue of 17% in 2001, and 18% in 2002 and 19% in 2003. Our tax rate of 43% is based on historical rates. Our EPS of \$1.05 for 2001 is in line with "street" consensus. Going forward, we estimate EPS of \$1.27 in 2002, and \$1.33 in 2003, versus "street" consensus of \$1.38 in 2002 and \$1.76 in 2003.

Income Statement	1999	2000	2001e	2002e	2003e
Physician Services	77,433	124,224	168,216	193,055	208,260
IPO	3,838	9,539	15,557	22,100	22,800
Information Services	4,095	4,458	4,695	4,930	5,176
Total Revenue	85,366	138,221	188,468	220,085	236,237
Salaries/Other Costs	32,323	51,330	65,920	77,030	82,683
SG&A less Bad Debt exp	23,568	31,316	43,165	50,900	54,900
Bad Debt Expense	10,434	21,324	31,516	33,541	35,435
Legal Settlement	-	3,273	-	-	-
Depreciation/Amort.	6,960	10,730	15,342	17,996	19,496
Total Expenses	73,285	117,973	155,943	179,467	192,514
Operating Income	12,081	23,521	32,525	40,618	43,722
Interest Expense	(960)	(2,541)	(3,233)	(3,209)	(3,382)
Interest Income	2,603	1,820	1,475	1,080	1,080
Gains on mkt securities	-	3,144	-	-	-
Income Before Taxes	13,724	22,671	30,767	38,488	41,420
Income Taxes	5,490	9,721	13,231	16,550	17,811
Income After Taxes	8,235	12,950	17,536	21,938	23,609
Dilutd EPS Excl XOrd	0.51	0.80	1.05	1.27	1.33
Diluted Average Shs.	16,306	16,278	16,764	17,267	17,785

Y-Y % change	1999	2000	2001e	2002e	2003e
Physician Services	46%	60%	35%	15%	8%
IPO	128%	149%	63%	42%	3%
Information Services	195%	9%	5%	5%	5%
Total Revenue	52%	62%	36%	17%	7%
Salaries/Other Costs	50%	59%	28%	17%	7%
SG&A less Bad Debt exp	42%	33%	38%	18%	8%
Bad Debt Expense	70%	104%	48%	6%	6%
Legal Settlement	n/a	n/a	n/a	n/a	n/a
Depreciation/Amort.	99%	54%	43%	17%	8%
Total Expenses	54%	61%	32%	15%	7%
Operating Income	42%	95%	38%	25%	8%
Interest Expense	46%	165%	27%	-1%	5%
Interest Income	-29%	-30%	-19%	-27%	0%
Gains on mkt securities	n/a	n/a	n/a	n/a	n/a
Income Before Taxes	19%	65%	36%	25%	8%
Income Taxes	20%	77%	36%	25%	8%
Income After Taxes	19%	57%	35%	25%	8%
Dilutd EPS Excl XOrd	16%	58%	31%	21%	4%
Diluted Average Shs.	2%	0%	3%	3%	3%
<b>% Total Revenue</b>	<b>1999</b>	<b>2000</b>	<b>2001e</b>	<b>2002e</b>	<b>2003e</b>
Physician Services	91%	90%	89%	88%	88%
IPO	4%	7%	8%	10%	10%
Information Services	5%	3%	2%	2%	2%
Total Revenue	100%	100%	100%	100%	100%
Salaries/Other Costs	38%	37%	35%	35%	35%
SG&A less Bad Debt exp	28%	23%	23%	23%	23%
Bad Debt Expense	12%	15%	17%	15%	15%
Legal Settlement	0%	2%	0%	0%	0%
Depreciation/Amort.	8%	8%	8%	8%	8%
Total Expenses	86%	85%	83%	82%	81%
Operating Income	14%	17%	17%	18%	19%
Interest Expense	-1%	-2%	-2%	-1%	-1%
Interest Income	3%	1%	1%	0%	0%
Gains on mkt securities	0%	2%	0%	0%	0%
Income Before Taxes	16%	16%	16%	17%	18%
Income Taxes	6%	7%	7%	8%	8%
Income After Taxes	10%	9%	9%	10%	10%

Income Statement	1Q99	2Q99	3Q99	4Q99	1Q00	2Q00	3Q00	4Q00
Physician Services	15,734	19,588	19,182	22,929	27,436	30,309	31,596	34,883
IPO	252	300	1,364	1,922	1,945	2,047	2,692	2,855
Information Services	984	958	997	1,156	1,182	1,008	1,117	1,151
Total Revenue	16,970	20,846	21,543	26,007	30,563	33,364	35,405	38,889
Salaries/Other Costs	6,727	7,835	8,035	9,726	12,112	12,835	13,132	13,251
SG&A less Bad Debt exp	4,612	5,770	5,504	7,682	7,191	7,765	7,556	8,804
Bad Debt Expense	1,745	2,348	2,483	3,858	4,076	4,609	5,906	6,733
Legal Settlement	-	-	-	-	-	-	-	3,273
Depreciation/Amort.	1,362	1,612	1,865	2,121	2,375	2,549	2,732	3,074
Total Expenses	14,446	17,565	17,887	23,387	25,754	27,758	29,326	35,135
Operating Income	2,524	3,281	3,656	2,620	4,809	5,606	6,079	3,754
Interest Expense	(171)	(243)	(290)	(256)	(381)	(702)	(754)	(704)
Interest Income	671	792	644	496	474	480	474	392
Gains on mkt securities	-	-	-	-	-	-	-	3,144
Income Before Taxes	3,024	3,830	4,010	2,860	4,902	5,384	5,799	6,586
Income Taxes	1,233	1,532	1,604	1,121	2,080	2,315	2,494	2,832
Income After Taxes	1,791	2,298	2,406	1,739	2,822	3,069	3,305	3,754
Dilutd EPS Excl XOrd	0.11	0.14	0.15	0.11	0.18	0.19	0.20	0.23
Diluted Average Shs.	16,556	16,312	16,282	16,060	15,808	16,208	16,499	16,684
Y-Y % change	1Q99	2Q99	3Q99	4Q99	1Q00	2Q00	3Q00	4Q00
Physician Services	36%	47%	38%	59%	74%	55%	65%	52%
IPO	131%	114%	289%	77%	672%	582%	97%	49%
Information Services	n/a	n/a	191%	10%	20%	5%	12%	0%
Total Revenue	45%	55%	48%	57%	80%	60%	64%	50%
Salaries/Other Costs	42%	45%	51%	60%	80%	64%	63%	36%
SG&A less Bad Debt exp	29%	54%	28%	55%	56%	35%	37%	15%
Bad Debt Expense	50%	50%	55%	113%	134%	96%	138%	75%
Legal Settlement	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Depreciation/Amort.	146%	130%	101%	62%	74%	58%	46%	45%
Total Expenses	44%	54%	47%	65%	78%	58%	64%	50%
Operating Income	48%	62%	53%	9%	91%	71%	66%	43%
Interest Expense	51%	106%	77%	-3%	123%	189%	160%	175%
Interest Income	97%	-24%	-41%	-58%	-29%	-39%	-26%	-21%
Gains on mkt securities	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Income Before Taxes	57%	30%	21%	-14%	62%	41%	45%	130%
Income Taxes	48%	32%	28%	-15%	69%	51%	55%	153%
Income After Taxes	63%	29%	16%	-13%	58%	34%	37%	116%
Dilutd EPS Excl XOrd	19%	24%	20%	-9%	65%	34%	36%	108%
Diluted Average Shs.	38%	3%	-3%	-4%	-5%	-1%	1%	4%

% Total Revenue	1Q99	2Q99	3Q99	4Q99	1Q00	2Q00	3Q00	4Q00
Physician Services	93%	94%	89%	88%	90%	91%	89%	90%
IPO	1%	1%	6%	7%	6%	6%	8%	7%
Information Services	6%	5%	5%	4%	4%	3%	3%	3%
Total Revenue	100%	100%	100%	100%	100%	100%	100%	100%
Salaries/Other Costs	40%	38%	37%	37%	40%	38.5%	37.1%	34.1%
SG&A less Bad Debt exp	27%	28%	26%	30%	24%	23%	21%	23%
Bad Debt Expense	10%	11%	12%	15%	13%	14%	17%	17%
Legal Settlement	0%	0%	0%	0%	0%	0%	0%	8%
Depreciation/Amort.	8%	8%	9%	8%	8%	8%	8%	8%
Total Expenses	85%	84%	83%	90%	84%	83%	83%	90%
Operating Income	15%	16%	17%	10%	16%	17%	17%	10%
Interest Expense	-1%	-1%	-1%	-1%	-1%	-2%	-2%	-2%
Interest Income	4%	4%	3%	2%	2%	1%	1%	1%
Gains on mkt securities	0%	0%	0%	0%	0%	0%	0%	8%
Income Before Taxes	18%	18%	19%	11%	16%	16%	16%	17%
Income Taxes	7%	7%	7%	4%	7%	7%	7%	7%
Income After Taxes	11%	11%	11%	7%	9%	9%	9%	10%

Income Statement	1Q01	2Q01	3Q01e	4Q01e	1Q02e	2Q02e	3Q02e	4Q02e
Physician Services	38,004	42,420	42,863	44,929	46,395	49,462	48,607	48,591
IPO	3,012	3,479	4,166	4,900	5,300	5,500	5,600	5,700
Information Services	1,120	1,175	1,200	1,200	1,176	1,234	1,260	1,260
Total Revenue	42,136	47,074	48,229	51,029	52,871	56,195	55,467	55,551
Salaries/Other Costs	14,955	16,225	16,880	17,860	18,505	19,668	19,413	19,443
SG&A less Bad Debt exp	9,520	11,045	11,000	11,600	12,100	12,800	12,800	13,200
Bad Debt Expense	6,832	8,003	8,006	8,675	8,459	8,429	8,320	8,333
Legal Settlement	-	-	-	-	-	-	-	-
Depreciation/Amort.	3,420	3,824	3,974	4,124	4,274	4,424	4,574	4,724
Total Expenses	34,727	39,097	39,860	42,259	43,338	45,322	45,107	45,700
Operating Income	7,409	7,977	8,369	8,770	9,533	10,874	10,359	9,852
Interest Expense	(948)	(745)	(765)	(775)	(786)	(797)	(808)	(819)
Interest Income	613	322	270	270	270	270	270	270
Gains on mkt securities	-	-	-	-	-	-	-	-
Income Before Taxes	7,074	7,554	7,874	8,265	9,017	10,347	9,822	9,303
Income Taxes	3,042	3,249	3,386	3,554	3,877	4,449	4,223	4,000
Income After Taxes	4,032	4,305	4,488	4,711	5,140	5,898	5,598	5,303
Dilutd EPS Excl XOrd	0.24	0.26	0.27	0.28	0.30	0.34	0.32	0.30
Diluted Average Shs.	16,715	16,680	16,780	16,880	17,216	17,180	17,283	17,386

Y-Y % change	1Q01	2Q01	3Q01e	4Q01e	1Q02e	2Q02e	3Q02e	4Q02e
Physician Services	39%	40%	36%	29%	22%	17%	13%	8%
IPO	55%	70%	55%	72%	76%	58%	34%	16%
Information Services	-5%	17%	7%	4%	5%	5%	5%	5%
Total Revenue	38%	41%	36%	31%	25%	19%	15%	9%
Salaries/Other Costs	23%	26%	29%	35%	24%	21%	15%	9%
SG&A less Bad Debt exp	32%	42%	46%	32%	27%	16%	16%	14%
Bad Debt Expense	68%	74%	36%	29%	24%	5%	4%	-4%
Legal Settlement	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Depreciation/Amort.	44%	50%	45%	34%	25%	16%	15%	15%
Total Expenses	35%	41%	36%	20%	25%	16%	13%	8%
Operating Income	54%	42%	38%	134%	29%	36%	24%	12%
Interest Expense	149%	6%	1%	10%	-17%	7%	6%	6%
Interest Income	29%	-33%	-43%	-31%	-56%	-16%	0%	0%
Gains on mkt securities	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Income Before Taxes	44%	40%	36%	25%	27%	37%	25%	13%
Income Taxes	46%	40%	36%	25%	27%	37%	25%	13%
Income After Taxes	43%	40%	36%	25%	27%	37%	25%	13%
Dilutd EPS Excl XOrd	35%	36%	34%	24%	24%	33%	21%	9%
Diluted Average Shs.	6%	3%	2%	1%	3%	3%	3%	3%
<b>% Total Revenue</b>	<b>1Q01</b>	<b>2Q01</b>	<b>3Q01e</b>	<b>4Q01e</b>	<b>1Q02e</b>	<b>2Q02e</b>	<b>3Q02e</b>	<b>4Q02e</b>
Physician Services	90%	90%	89%	88%	88%	88%	88%	87%
IPO	7%	7%	9%	10%	10%	10%	10%	10%
Information Services	3%	2%	2%	2%	2%	2%	2%	2%
Total Revenue	100%	100%	100%	100%	100%	100%	100%	100%
Salaries/Other Costs	35.5%	34.5%	35%	35%	35%	35%	35%	35%
SG&A less Bad Debt exp	23%	23%	23%	23%	23%	23%	23%	24%
Bad Debt Expense	16%	17%	17%	17%	16%	15%	15%	15%
Legal Settlement	0%	0%	0%	0%	0%	0%	0%	0%
Depreciation/Amort.	8%	8%	8%	8%	8%	8%	8%	9%
Total Expenses	82%	83%	83%	83%	82%	81%	81%	82%
Operating Income	18%	17%	17%	17%	18%	19%	19%	18%
Interest Expense	-2%	-2%	-2%	-2%	-1%	-1%	-1%	-1%
Interest Income	1%	1%	1%	1%	1%	0%	0%	0%
Gains on mkt securities	0%	0%	0%	0%	0%	0%	0%	0%
Income Before Taxes	17%	16%	16%	16%	17%	18%	18%	17%
Income Taxes	7%	7%	7%	7%	7%	8%	8%	7%
Income After Taxes	10%	9%	9%	9%	10%	10%	10%	10%