QUEST DIAGNOSTICS INC
Form 10-K405
March 04, 2002

UNITED STATES SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-K

[LOGO] Quest Diagnostics

Annual Report Pursuant to Section 13 or 15(d) of
the Securities Exchange Act of 1934
For the Fiscal Year Ended December 31, 2001
Commission File Number 1-12215

Quest Diagnostics Incorporated
One Malcolm Avenue, Teterboro, NJ 07608
(201) 393-5000

Delaware
(State of Incorporation)

16-1387862
(I.R.S. Employer Identification Number)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Regi
Common Stock with attached Preferred Share Purchase Right	New York Stock Exchange

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Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes X No
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Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K. [x]

As of February 22, 2002, the aggregate market value of the approximately 73.5 million shares of voting and non-voting common equity held by non-affiliates of the registrant was approximately $5.3 billion, based on the closing price on

such date of the Company's Common Stock on the New York Stock Exchange.

As of February 22, 2002, there were outstanding 96,293,091 shares of Common Stock, $.01 par value.

Documents Incorporated by Reference

Document	Part of For which inc
Portions of the Registrant's Proxy Statement to be filed by April 30, 2002.....	Part

Such Proxy Statement, except for portions thereof which have been specifically incorporated by reference, shall not be deemed "filed" as part of this report on Form 10-K.

PART I

Item 1. Business

Overview

We are the nation's leading provider of diagnostic testing, information and related services for the healthcare industry, with annual net revenues in excess of $3.6 billion. We offer a broad range of clinical laboratory testing services used by physicians in the detection, diagnosis, evaluation, monitoring and treatment of diseases and other medical conditions. We have a more extensive national network of laboratories and patient service centers than our competitors and for the year ended December 31, 2001 our revenues were sixty five percent greater than those of our nearest competitor. We have the leading market share in clinical laboratory testing and esoteric testing, including molecular diagnostics, as well as non hospital-based anatomic pathology services and testing for drugs of abuse.

We currently process over 105 million requisitions each year. Each requisition form accompanies a patient specimen, indicating the tests to be performed and the party to be billed for the tests. Our customers include physicians, hospitals, managed care organizations, employers, governmental institutions and other independent clinical laboratories.

We have a nationwide network of approximately 1,350 patient service centers, 30 principal laboratories located in major metropolitan areas throughout the United States, and 100 smaller "rapid response" laboratories (including, in each case, facilities operated at our joint ventures). We also operate a leading esoteric testing laboratory and development facility known as Nichols Institute located in San Juan Capistrano, California as well as laboratory facilities in Mexico City, Mexico and near London, England.

In addition to our laboratory testing business, our clinical trials business is one of the leading providers of testing to support clinical trials of new pharmaceuticals worldwide. We also collect and analyze laboratory,

pharmaceutical and other data to help pharmaceutical companies with their marketing and disease management efforts, and to help healthcare customers better manage the health of their patients.

We are a Delaware corporation. We sometimes refer to ourselves and our subsidiaries as the "Company". We are the successor to MetPath Inc., a New York corporation that was organized in 1967. From 1982 to 1996, we were a subsidiary of Corning Incorporated ("Corning"). On December 31, 1996, Corning distributed all of the outstanding shares of our common stock to the stockholders of Corning. Our principal executive offices are located at One Malcolm Avenue, Teterboro, New Jersey 07608, telephone number: (201) 393-5000.

The United States Clinical Laboratory Testing Market

Clinical laboratory testing is an essential element in the delivery of healthcare services. Physicians use laboratory tests to assist in the detection, diagnosis, evaluation, monitoring and treatment of diseases and other medical conditions. Clinical laboratory testing is generally categorized as clinical testing and anatomical pathology testing. Clinical testing is performed on body fluids, such as blood and urine. Anatomical pathology testing is performed on tissues and other samples, such as human cells. Most clinical laboratory tests are considered routine and can be performed by most independent clinical laboratories. Tests that are not routine and that require more sophisticated equipment and highly skilled personnel are considered esoteric tests. Esoteric tests are generally referred to laboratories that specialize in performing those tests.

We believe that the United States diagnostics testing industry had approximately $35 billion in annual revenues in 2001. Most laboratory tests are performed by one of three types of laboratories: independent clinical laboratories; hospital-affiliated laboratories; and physician-office laboratories. In 2001, we believe that hospital-affiliated laboratories performed over one half of the clinical laboratory tests in the United States, independent clinical laboratories performed approximately one-third of those tests, and physician-office laboratories performed the balance.

During the last several years, the underlying fundamentals of the diagnostics testing industry have improved. During the early 1990s, the industry was negatively impacted by significant government regulation and investigations into various billing practices. In addition, the rapid growth of managed care and excess laboratory testing capacity led to revenue and profit declines within the diagnostics testing industry, which in turn led to industry consolidation, particularly among commercial laboratories. As a result of these dynamics, fewer but larger commercial laboratories have emerged which have greater economies of scale, rigorous programs designed to assure compliance with government billing regulations and other laws, and a more disciplined approach to pricing services. These changes have resulted in improved profitability and a reduced risk of non-compliance with complex government regulations. At the same time, a slowdown in the growth of managed care and decreasing influence by managed care organizations on the ordering of clinical laboratory testing by physicians has led to renewed growth in testing volumes and further improvements in profitability since 1999.

We believe that during the next several years, the industry will continue to experience moderate growth in testing volume due to the following factors:

- general expansion and aging of the United States population;
- increasing focus on early detection and prevention as a means to reduce the overall cost of healthcare and development of more sophisticated and specialized tests for early detection of disease and disease management;
- continuing research and development in the area of genomics, which is expected to yield new genetic tests and techniques;
- increasing volume of tests for diagnosis and monitoring of infectious diseases such as AIDS and hepatitis C;
- increasing affordability of tests due to advances in technology and cost efficiencies; and
- increasing awareness by consumers of the value of clinical laboratory testing and increasing willingness of consumers to pay for tests that may not be covered by third party payers.

Business Strategy

Our mission is to be recognized by our customers and employees as the best provider of comprehensive and innovative diagnostic testing, information and related services. The principal components of this strategy are to

- Capitalize on Our Leading Position Within the Laboratory Testing Market: We are the leader in our core clinical laboratory testing business offering the broadest national access to clinical laboratory testing services, with facilities in substantially all of the major metropolitan areas in the United States. Our network of approximately 1,350 patient service centers, 30 principal laboratories and 100 rapid response laboratories enable us to serve managed care organizations, hospitals, physicians, employers and other healthcare providers and their patients throughout the United States. We believe that customers will increasingly seek to utilize laboratory testing companies that have a nationwide presence and offer a comprehensive range of services and that, as a result, we will be able to profitably enhance our market position.
- Compete Through Providing the Highest Quality Services: We intend to become recognized as the quality leader in the healthcare services industry. We are implementing a Six Sigma initiative throughout our organization. Six Sigma is a management approach that requires a thorough understanding of customer needs and requirements, process discipline, rigorous tracking and measuring of services, and training of employees in methodologies so that they can be held accountable for improving results. During the second half of 2001, we began to integrate our Six Sigma initiative with our initiative to standardize operations and processes across all of Quest Diagnostics by adopting identified company best practices. We plan to continue these initiatives during the next several years and expect that successful implementation of these initiatives will result in measurable improvements in customer satisfaction and generate at least $150 million in annual net benefits by the end of 2004. Our Nichols Institute was the first clinical laboratory in North America to achieve ISO-9001 certification. Two of our clinical trials laboratories, our diagnostic kits facility and our informatics business have also achieved ISO-9001 certification. In addition, five of our laboratories, including a forensic toxicology laboratory, have achieved ISO-9002 certification. These certifications are

international standards for quality management systems. Several additional regional laboratories are currently pursuing ISO-9002 certification.

- Continue to Lead Innovation: We intend to build upon our reputation as a leading innovator in the clinical laboratory industry by continuing to introduce new tests, technology and services. As the industry leader with the largest and broadest network and the leading provider of esoteric tests, including gene-based tests, we believe that we are the best channel for developers of new technology and tests to introduce their products to the marketplace. Through our relationship with members of the academic community and pharmaceutical and biotechnology firms, we believe that we are one of the leaders in transferring technical innovation to the market. For example, we recently developed and introduced a new ultra-sensitive Heptimax'TM' viral load test for hepatitis C, using Bayer Corp.'s branched DNA technology. This test enables physicians to monitor their patients' response to pegylated interferon and combination therapy with a test that is much more sensitive than other commercially available tests. During 2001, we established a research and development, marketing and

commercial alliance with Roche Diagnostics to develop and market gene-based medical tests based primarily on Roche's polymerase chain reaction (PCR) technology. We expect this collaboration to focus initially on the commercialization of gene-based markers to assess an individual's risk for stroke and asthma and on applications in pharmacogenomics and predictive medicine. We are expanding DNA based testing in the clinical laboratory to provide enhanced sensitivity, accuracy and reliability of this next generation technology. We also intend to continue to collaborate with emerging medical technology companies that develop and commercialize novel diagnostics, pharmaceutical and device technologies. For instance, during 2001 we became the first laboratory to obtain from Orchid BioSciences, Inc. commercial rights to its proprietary SNP-IT'TM' technology for gene-based diagnostic testing services. We also exercised an option under our agreement with diaDexus to acquire an exclusive license to develop and commercialize proprietary genomics-based diagnostic tests for osteoporosis and colon cancer. We will continue to introduce new tests that we develop at Nichols Institute, one of the leading esoteric testing laboratories in the world and the largest provider of molecular diagnostics testing in the United States. We believe that, with the unveiling of the human genome, new genes and the linkages of genes with disease will continue to be discovered at an accelerating pace, leading to research that will result in ever more complex and thorough predictive, diagnostic and therapeutic testing. We believe that we are well positioned to capture much of this growth.

- Pursue Strategic Growth Opportunities: We intend to continue to leverage our network in order to capitalize on targeted strategic growth opportunities both inside and outside our core clinical laboratory testing business. These opportunities are more fully described under "Strategic Growth Opportunities" and include

continuing to make selective regional acquisitions, capturing the growth in the areas of genomics and specialty testing, expanding our direct-to-consumer business and expanding our clinical trials testing and other services to the pharmaceutical and biotechnology industries.

- Leverage Our Satisfaction Model: Our approach to conducting business states that satisfied employees lead to satisfied customers, which in turn benefits our stockholders. We regularly survey our employees and customers and follow up on their concerns. We emphasize skills training for all employees and leadership training for our supervisory employees, which also includes Six Sigma training to manage high-impact quality improvement projects throughout our organization, and annual compliance training. Most importantly, we are committed to engaging each employee with dignity and respect and trust them to treat our customers the same way. We believe that our treatment and training of employees, together with our competitive pay and benefits, helps increase employee satisfaction and performance, thereby enabling us to provide better services to our customers.

Recent Acquisitions

On August 16, 1999, we completed the acquisition of SmithKline Beecham Clinical Laboratories, Inc. ("SBCL"), which operated the clinical laboratory business of SmithKline Beecham plc, or SmithKline Beecham. After taking into account a purchase price adjustment that was finalized in October 2000 and our two for one stock split in May 2001, the purchase price consisted of $930 million in cash and approximately 25.1 million shares of our common stock, which represented approximately 29% of our then outstanding common stock. During the second quarter of 2001, we completed the process of reducing redundant facilities and infrastructure and redirecting testing volume to provide more local testing and improve customer service. We continue to expect that the SBCL integration will result in approximately $150 million of annual synergies and that we will achieve this annual rate of synergies by the end of 2002. During 2001, we estimate that we realized approximately $120 million of these synergies driven by cost reductions, and at the end of 2001, we estimate we had achieved an annualized rate of synergies of approximately $140 million.

On February 7, 2002, we executed a definitive agreement to acquire American Medical Laboratories, Incorporated, or AML, in an all-cash transaction valued at $500 million, which includes the assumption of approximately $160 million in debt. AML is a national provider of esoteric testing to hospitals and specialty physicians and is a leading provider of diagnostics testing services in the Nevada and metropolitan Washington, D.C. markets. AML, established in 1959, has approximately 3,000 employees and in 2001 generated annual revenues of approximately $300 million. It has reference testing relationships with almost 500 hospitals, 150 clinical laboratories and 7,000 physician offices. AML has two full-service laboratories, located in Chantilly, Virginia and Las Vegas, Nevada, and 51 patient service centers, most of which are located in the Nevada and metropolitan Washington, D.C. markets. Following the acquisition, the Virginia reference laboratory will complement our Nichols Institute reference laboratory on the west coast. We believe that the acquisition will strengthen our leadership position in the delivery of esoteric testing services to hospitals and specialty physicians throughout the country. AML also has an anatomic pathology business served by approximately 30 board-certified specialty pathologists, which will expand the consultative capabilities and capacity of our anatomic pathology

services. As part of the acquisition, we will also acquire LabPortal, Inc., a provider of electronic connectivity products. AML also is a national provider of drugs of abuse testing, and pioneered the use of hair samples for testing. The acquisition is expected to close during the first quarter of 2002 and will be funded by cash on hand and our existing revolving credit facilities.

In December 2001, we acquired Clinical Diagnostics Services, Inc., a clinical laboratory based in Englewood, New Jersey with approximately 50 patient service centers in the New York City metropolitan area, for approximately $62 million in cash. Also in December 2001, we acquired the assets of Las Marias Reference Lab Corp and Laboratorio Clinico Las Marias, Inc., a clinical laboratory based in San Juan, Puerto Rico for $18.5 million in cash. In November 2001, we acquired the outstanding voting shares of MedPlus, Inc. ("MedPlus"), a leading developer and integrator of clinical connectivity and data management solutions for healthcare organizations and clinicians for approximately $18 million in cash. In February 2001 we also acquired the assets of Clinical Laboratories of Colorado, a clinical laboratory based in Denver, Colorado for approximately $47 million in cash.

Following an acquisition, the integration process requires the dedication of significant management resources, which could result in a loss of momentum in the activities of our business and may cause an interruption of or deterioration in our services. Since most of our clinical laboratory testing is performed under arrangements that are terminable at will or on short notice, any interruption of, or deterioration in, our services may also result in a customer's decision to stop using us for clinical laboratory testing. These events could have a material adverse impact on our business. However, management believes that the successful implementation of our integration plans and our value proposition based on expanded patient access, our broad testing capabilities and most importantly, the quality of the services we provide, will mitigate customer attrition.

Our Services

Our laboratory testing business consists of routine testing, esoteric testing, and clinical trials testing. Routine testing generates approximately 83% of our net revenues, esoteric testing generates approximately 13% of our net revenues, and clinical trials testing generates less than 3% of our net revenues. We derive less than 2% of our net revenues from foreign operations.

Routine Testing

Routine tests measure various important bodily health parameters such as the functions of the kidney, heart, liver, thyroid and other organs. Commonly ordered tests include:

- blood cholesterol level tests;
- complete blood cell counts;
- pap smears;
- HIV-related tests;
- urinalyses;
- pregnancy and other prenatal tests; and

- alcohol and other substance-abuse tests.

We perform routine testing through our network of major laboratories, rapid response laboratories, or "stat" labs, and patient service centers. We also perform routine testing at the hospital laboratories we manage. Major laboratories offer a full line of routine clinical tests. Rapid response laboratories are local facilities where we can quickly perform an abbreviated line of routine tests for customers that require rapid turnaround. Patient service centers are facilities where specimens are collected. These centers are typically located in or near a building used by medical professionals.

We operate 24 hours a day, 365 days a year. We perform and report most routine procedures within 24 hours. Most test results are delivered electronically.

Esoteric Testing

Esoteric tests are those tests that are performed less frequently than routine tests and require more sophisticated equipment and materials, professional "hands-on" attention and more highly skilled personnel. Because it is not cost-effective for most clinical laboratories to perform the low volume of esoteric tests in-house, they generally refer many esoteric tests to an esoteric clinical testing laboratory. Esoteric tests are generally priced higher than routine tests.

Our Nichols Institute is one of the leading esoteric clinical testing laboratories in the world. In 1998, Nichols Institute, located in San Juan Capistrano, California, became the first clinical laboratory in North America to achieve ISO-9001 certification. Nichols Institute performs hundreds of types of esoteric tests that are not routinely performed by our regional laboratories. These esoteric tests are generally in the following fields:

- endocrinology (the study of glands, their hormone secretions and their effects on body growth and metabolism);
- genetics (the study of chromosomes, genes, and their protein products and effects);
- immunology (the study of the immune system including antibodies, immune system cells and their effects);
- microbiology (the study of microscopic forms of life including bacteria, viruses, fungi and other infectious agents);
- oncology (the study of abnormal cell growth including benign tumors and cancer);
- serology (a science dealing with the body fluids and their analysis, including antibodies, proteins and other characteristics);
- special chemistry (more sophisticated testing requiring special expertise and technology); and

- o toxicology (the study of chemicals and drugs and their effects on the body's metabolism).

Through our relationship with members of the academic community and pharmaceutical and biotechnology firms, we believe that we are one of the leaders in transferring technical innovation to the market. Nichols Institute was the first private reference laboratory to introduce a number of new tests, including tests to measure circulating hormone levels and breast cancer prognostic markers. We continue to develop new and more sophisticated testing to monitor the success of therapy for cancer, AIDS and hepatitis C, and to detect other diseases and disorders. In addition to our recent introduction of the Heptimax'TM' test (discussed in "Business Strategy-Continue to Lead Innovation"), we recently developed and introduced an HIV genotyping test which predicts the drug resistance of HIV infected patients. To improve specificity of cervical cancer screening, we recently introduced automatic reflex high-risk DNA human papillomavirus testing for borderline ThinPrep'TM' Pap Tests'TM', using the original specimen. In addition, we recently introduced HCV DupliType'TM' testing to provide subtyping for a broader range of hepatitis C viral specimens improving the predictability of drug responsiveness.

Through our Academic Associates program, leading academics and biotechnology firms work directly with our staff scientists to monitor and consult on existing test procedures and develop new esoteric test methods. In addition, we have entered into licensing arrangements and co-development agreements with biotechnology companies and academic medical centers (see "Business Strategy-Continue to Lead Innovation").

Clinical Trials Testing

We believe that we are one of the world's three largest providers of clinical laboratory testing performed in connection with clinical research trials on new drugs. Clinical research trials are required by the FDA to assess the safety and efficacy of new drugs. We have clinical trials testing centers in the United States and in England. We also provide clinical trials testing in Australia and South Africa through arrangements with third parties. Clinical trials involving new drugs are increasingly being performed both inside and outside the United States. Approximately 31% of our net revenues from clinical trials testing in 2001 represented testing for GlaxoSmithKline plc.

Other Services and Products

We manufacture and market diagnostic test kits and systems primarily for esoteric testing under the Nichols Institute Diagnostics brand name. These are sold principally to hospital and clinical laboratories, both domestically and internationally. Our MedPlus subsidiary, which we acquired in November 2001, is a developer and integrator for clinical connectivity and data management solutions for healthcare organizations and clinicians primarily through its ChartMaxx'r' electronic medical record system; and provides workflow and content management solutions to customers in a variety of industries.

Payers and Customers

We provide testing services to a broad range of healthcare providers.

We consider a "payer" as the party that pays for the test. Depending on the billing arrangement and applicable law, the payer may be (1) the physician or other party (such as another laboratory or an employer) who referred the testing to us, (2) the patient, or (3) a third party who pays the bill for the patient, such as an insurance company, Medicare or Medicaid. Some states, including New York, New Jersey and Rhode Island, prohibit us from billing physician clients. We generally consider a "customer" to be the party who refers tests to us. We also consider a managed care organization as both our customer and a payer, when it contracts with us on an exclusive or semi-exclusive basis on behalf of its patients.

During 2001, only two customers accounted for more than 5% of our net revenues, and no single customer accounted for more than 7% of our net revenues. We believe that the loss of any one of our customers would not have a material adverse effect on our financial condition, results of operations, or cash flow.

Payers

The following table shows current estimates of the breakdown of the percentage of our total volume of requisitions and total clinical laboratory revenues during 2001 applicable to each payer group:

	Requisition Volume as % of Total Volume	Reven as % Tota Clinical La Reven
Patient	2%-- 5%	5%-
Medicare and Medicaid	10%--15%	10%-
Physicians, Hospitals, Employers and Other Monthly-Billed Payers	30%--35%	25%-
Third Party Fee-for-Service	30%--35%	40%-
Managed Care-Capitated	15%--20%	5%-

Customers

Physicians

Physicians requiring testing for patients whose tests are not covered by a managed care contract are one of the primary sources of our clinical laboratory testing volume. We typically bill physician accounts on a fee-for-service basis. Fees billed to physicians are based on the laboratory's client fee schedule and are typically negotiated. Fees billed to patients and third parties are based on the laboratory's patient fee schedule, which may be subject to limitations on fees imposed by third-party payers and negotiation by physicians on behalf of their patients. Medicare and Medicaid reimbursements are based on fee schedules set by governmental authorities.

Managed Care Organizations and Other Insurance Providers

Managed care organizations and other insurance providers, which typically contract with a limited number of clinical laboratories for their members, represent approximately one half of our total testing volumes and one half of our consolidated testing revenues. Larger managed care organizations and other insurance providers typically prefer to use large independent clinical laboratories because they can provide services on a national or regional basis and can manage networks of local or regional laboratories. In addition, larger

laboratories are better able to achieve the low-cost

structures necessary to profitably service large managed care organizations and can provide test utilization data across their various plans.

While the growth in the number of patients participating in managed care plans has slowed in recent years, over the last decade, the managed care industry has been consolidating, resulting in fewer but larger managed care organizations with significant bargaining power in negotiating fee arrangements with healthcare providers, including clinical laboratories. Managed care organizations demand that clinical laboratory service providers accept discounted fee structures or assume all or a portion of the financial risk associated with providing testing services to their members through capitated payment contracts. Under capitated payment contracts, clinical laboratories receive a fixed monthly fee per individual enrolled with the managed care organization for all laboratory tests performed during the month regardless of the number or cost of the tests actually performed. Some services, such as various esoteric tests, new technologies and anatomic pathology services, may be carved out from a capitated rate and, if carved out, are charged on a fee-for-service basis. In 2001, we derived approximately 9% of our revenues from capitated payment contracts with managed care organizations.

Recently, there has been a shift in the way major managed care organizations contract with clinical laboratories. Managed care organizations have begun to offer more freedom of choice to their affiliated physicians, including greater freedom to determine which laboratory to use and which tests to order. Accordingly, our agreements with most managed care organizations are generally not exclusive arrangements, allowing us to compete for physician business more on the basis of service and quality rather than price alone. As a result of this emphasis on greater freedom of choice as well as our enhanced service network and capabilities, and our focus on ensuring that overall arrangements are profitable, pricing of managed care agreements has generally improved over the last several years. Also, managed care organizations have recently been giving patients greater freedom of choice and patients have increasingly been selecting plans (such as preferred provider organizations) that offer a greater choice of providers. Pricing for these preferred provider organizations is typically negotiated on a fee-for-service basis, which generally results in higher revenue per requisition than under a capitated fee arrangement. Despite these trends, managed care organizations continue to seek to reduce their costs in order to keep their premiums to their customers competitive. If we are unable to agree on pricing with a managed care organization, we would become a "non participating" provider and could then only bill the ordering physician or the patient rather than the managed care organization. This "non participating" status could lead to loss of business since the physician is likely to refer testing to a participating provider whose testing is covered by the patient's managed care benefit plan. We cannot assure investors that we will continue to be successful in negotiating contracts with major managed care organizations. Loss of major managed care agreements could have a material adverse effect on our financial condition, results of operations and cash flow.

Hospitals

We provide services to hospitals throughout the United States that

vary from esoteric testing to helping manage their laboratories. We believe that we are the industry's market leader in servicing hospitals. Testing for hospitals accounts for approximately 11% of our net revenues. Hospitals generally maintain an on-site laboratory to perform testing on patients and refer less frequently needed and highly specialized procedures to outside laboratories, which typically charge the hospitals on a negotiated fee-for-service basis. We believe that most hospital laboratories perform approximately 95% to 97% of their patients' clinical laboratory tests. Many hospitals compete with independent clinical laboratories for outreach (non-hospital patients) testing. Most physicians have admitting privileges or other relationships with hospitals as part of their medical practice. Many hospitals leverage their relationships with community physicians and encourage the physicians to send their outreach testing to the hospital's laboratory. In addition, hospitals that own physician practices generally require the physicians to refer tests to the hospital's affiliated laboratory. As a result, hospital-affiliated laboratories can be both customers and competitors for independent clinical laboratories.

We have joint venture arrangements with leading integrated health delivery networks in several metropolitan areas. These joint venture arrangements, which provide testing for affiliated hospitals as well as for unaffiliated physicians and other healthcare providers in their geographic areas, serve as our principal laboratory facilities in their service areas. Typically, we have either a majority ownership interest in, or day-to-day management responsibilities for, our hospital joint venture relationships. We also manage the laboratories at a number of other hospitals.

Employers, Governmental Institutions and Other Clinical Laboratories

We provide testing services to governmental agencies, including the Department of Defense and state and federal prison systems, and to large employers. We believe we are the leader in the clinical laboratory industry in providing testing to employers for substance abuse, occupational exposures, and comprehensive wellness programs.

Wellness programs enable employers to take an active role in lowering their overall healthcare costs. Testing services for employers account for approximately 4% of our net revenues. The volume of testing services for employers, which generally have relatively low profit margins, declined significantly during 2001, driven by a general slowing of the economy and a corresponding slowdown in hiring. We also perform esoteric testing services for other independent clinical laboratories that do not have the full range of our testing capabilities. All of these customers are charged on a fee-for-service basis.

Sales and Marketing

We market to and service our customers through our direct sales force sales representatives, customer service and patient service representatives and couriers.

We focus our sales efforts on pursuing and keeping profitable accounts that generate an acceptable return. We have an active account management process to evaluate the profitability of all of our accounts. Where

appropriate, we change the service levels, terminate accounts that are not profitable, or adjust pricing.

Most sales representatives market routine laboratory services primarily to physicians and hospitals. Some sales representatives focus on particular market segments or on testing niches. For example, some representatives concentrate on market segments such as hospitals or managed care organizations, and others concentrate on testing niches such as substance-abuse testing. During 2001, we created a team of sales representatives who concentrate on gene-based and other esoteric testing.

Customer service representatives perform a number of services for patients and customers. They monitor services, answer questions and help resolve problems. Our couriers pick up specimens from most clients daily.

Strategic Growth Opportunities

In addition to expanding our core clinical laboratory business through internal growth and pursuing our strategy to become a leading provider of medical information, we intend to continue to leverage our network in order to capitalize on targeted growth opportunities both inside and outside our core laboratory testing business.

- Selective Regional Acquisitions: The clinical laboratory industry is still highly fragmented. Historically, regional acquisitions fueled our growth. We expect to focus future clinical laboratory acquisition efforts on laboratories that can be integrated into our existing laboratories such as our acquisition of the assets of Clinical Laboratories of Colorado in February 2001 and the acquisition of Clinical Diagnostics Services in the New York City metropolitan area in December 2001. This strategy enables us to reduce costs and improve efficiencies through the elimination of redundant facilities and equipment, and reductions in personnel. On February 7, 2002, we executed a definitive agreement to acquire American Medical Laboratories, Incorporated (see "Recent Acquisitions"). We may also consider acquisitions of ancillary businesses as part of our overall growth strategy, such as our November 2001 acquisition of MedPlus Inc., which develops clinical connectivity products designed to enhance patient care (see "Information Systems").

- Anatomic Pathology: While we are the leading provider of non hospital-based anatomic pathology services in the United States, we have traditionally been strongest in cytology, and specifically in the analysis of pap smears to detect cervical cancer. During the last several years, we have led the industry in converting approximately 60% of our pap smear business to ThinPrep'TM', a higher quality, and more profitable product offering. During 2001, we began placing greater strategic and tactical emphasis on the growth of our physician-based histology (tissue pathology) business. We intend to continue to expand our anatomic pathology business into higher growth segments . We estimate that the current United States market for anatomic pathology services is approximately $6 billion per year. We estimate that cytology, which represents about $1 billion per year of this market, is growing about 5% per year; and that tissue pathology, which represents about $5 billion per year of this market, is growing more than 10% each year fueled by the aging of the population. We perform approximately $350 million of such services each year, representing a market position significantly less than our share of the entire clinical laboratory market.

- Genomics and Esoteric Testing: We intend to remain a leading innovator in the clinical laboratory industry by continuing to introduce new tests, technology and services. We estimate that the current United States market in gene based testing is in excess of $1 billion per year. We believe that we have the largest gene based testing business in the United States, with approximately $275 million in annual revenues, and that this business is growing by more than 20% per year. We believe that the unveiling of the human genome, the discovery of new genes and the linkages of these genes with disease will result in more complex and thorough predictive, diagnostic and therapeutic testing. We believe that we are well positioned to realize this growth. We intend to focus on commercializing diagnostic applications of discoveries in the areas of functional genomics (the analysis of genes and their functions), and proteomics (the discovery of new proteins made possible by the human genome project).

- Consumer Health: Consumers are becoming increasingly interested in managing their own health and health records. Currently, almost all the testing we perform is ordered directly by a physician, who then receives the test results. However, we believe that consumers will increasingly want to order clinical laboratory tests themselves through the Internet or our network of patient service centers, which already service about 80,000 patients each day, or through third-party retailers, even if the consumers are responsible for paying for the tests themselves. Tests particularly well suited for direct-to-consumer delivery include tests that measure levels of cholesterol, PSA (prostate specific antigen), glucose, hemoglobin A1c (diabetes monitoring), and TSH (thyroid disorders). We have launched a consumer health website, questest.com'TM', that provides easy-to-understand information about health testing. We are currently conducting proof-of-concept pilots by providing direct testing access to consumers in several markets. In those states that restrict the ability of consumers to order tests and receive results directly, we are utilizing a physician network to facilitate the ordering of tests and reporting of results.

- Pharmaceutical Services, including Clinical Trials and Commercial Services (Informatics): Among our strengths are our service relationships with physicians and our clinical laboratory results database, which we believe to be the largest private database of its kind in the world. This database continues to grow as we perform tests related to over 105 million requisitions each year. We believe that this database has substantial value since a significant portion of all healthcare decisions and spending are impacted by laboratory testing results. We believe that we can leverage our strengths to assist the pharmaceutical and biotechnology industries in the development and commercialization of their products. Large customers of clinical laboratories, including pharmaceutical companies, are increasingly interested in integrating our clinical laboratory data with other healthcare information to address quality, marketing and financial related questions. We also provide customized services for pharmaceutical and other health product companies to support the development and implementation of their products and services. We

maintain the security and confidentiality of individual patient results. Beyond our current clinical trials business and informatics database, profitable growth opportunities with pharmaceutical companies also exist in: post-marketing (Phase IV) research, patient recruitment, genomics (drug discovery), over-the-counter drug testing and pharmaceutical sales and product detailing.

Information Systems

Information systems are used extensively in virtually all aspects of our business, including laboratory testing, billing, customer service, logistics, and management of medical data. Our success depends, in part, on the continued and uninterrupted performance of our information technology (IT) systems. Our computer systems are vulnerable to damage from a variety of sources, including telecommunications failures, malicious human acts and natural disasters. Moreover, despite network security measures, some of our servers are potentially vulnerable to physical or electronic break-ins, computer viruses and similar disruptive problems. Despite the precautions we have taken, unanticipated problems affecting our systems could cause failures in our IT systems. Sustained or repeated system failures that interrupt our ability to process test orders, deliver test results or perform tests in a timely manner would adversely affect our reputation and result in a loss of customers and net revenues.

During the 1980s and early 1990s when we acquired many of our laboratory facilities, our regional laboratories were operated as local, decentralized units. When the laboratories were acquired, we did not make significant changes in their method of operations and we did not standardize their billing, laboratory, and some of their other information systems. As a result, by the end of 1995 we had many different information systems for billing, test results reporting, and other transactions. Over time, the growth in the size and network of our customers and the increasing complexity of billing demonstrated a greater need for standardized systems.

Prior to the acquisition of SBCL, we had chosen our proprietary SYS system as our standard billing system and our QuestLab system (which is licensed from a third party) as our standard laboratory information system, and had begun to convert our laboratories to these standard systems. SBCL had standardized billing and laboratory information systems throughout its laboratory network that were different from our existing systems. During 2002, we plan to begin to develop and implement a standard laboratory information system and a standard billing system. We expect that the implementation of the standardized systems will take several years to complete and will result in significantly more centralized systems than we have today. We expect the integration of these systems will improve operating efficiency and provide management with more timely and comprehensive information with which to make management decisions. However, failure to properly implement this standardization process could materially adversely impact us. During system conversions of this type, workflow may be temporarily interrupted, which may cause backlogs. In addition, the implementation process, including the transfer of databases and master files to new data centers, presents significant conversion risks which could cause failures in our IT systems and disrupt our operations.

We continue to invest in the development and improvement of our

connectivity products for customers and providers by developing differentiated products that will provide friendlier, easier access to information. We have expanded our Internet capabilities with the enhanced Quest on Demand'TM' website offering tests orders and results online for physicians and hospitals customers. This service will allow us to replace desktop products that we currently provide to most physicians. In November 2001, we acquired MedPlus, Inc. Their ChartMaxx'TM' and E. Maxx'TM' patient record systems support the creation and management of an electronic patient record, by bringing together in one patient-centric view information from various sources, including the physician's records and laboratory and hospital data. We intend to consider other strategic arrangements that will enhance our ability to introduce electronic services to a broader variety of healthcare customers.

Billing

Billing for laboratory services is complicated. Laboratories must bill various payers, such as patients, insurance companies, Medicare, Medicaid, doctors and employer groups, all of which have different requirements. Additionally, auditing for compliance with applicable laws and regulations as well as internal compliance policies and procedures adds further complexity to the billing process. Among many other factors complicating billing are:

- pricing differences between our fee schedules and the reimbursement rates of the payers;
- disputes with payers as to which party is responsible for payment; and
- disparity in coverage and information requirements among various carriers.

We believe that most of our bad debt expense, which was 6% of our net revenues in 2001, is the result of issues that are not credit-related, primarily missing or incorrect billing information on requisitions received from healthcare providers. In general, we perform the requested tests and report test results regardless of whether the billing information is incorrect or missing. We subsequently attempt to contact the provider to obtain any missing information and rectify incorrect billing information. Missing or incorrect information on requisitions adds complexity to and slows the billing process, creates backlogs of unbilled requisitions, and generally increases the aging of accounts receivable. When all issues relating to the missing or incorrect information are not resolved in a timely manner, the related receivables are written-off to the allowance for doubtful accounts.

We have implemented "best practices" for billing that have significantly reduced the percentage of requisitions with missing billing information from approximately 16% at the beginning of 1996 to approximately 5.5% immediately prior to the acquisition of SBCL. These initiatives, together with progress in dealing with Medicare medical necessity documentation requirements and standardizing billing systems, have significantly reduced bad debt expense since 1996. During the twelve months ended July 31, 1999 (immediately prior to the acquisition of SBCL), our bad debt expense was about 6% of net revenues (adjusted to exclude the effect of testing performed by third parties under our laboratory network management arrangements), while SBCL, which had not implemented procedures similar to ours, had bad debt expense of about 10% of net revenues (adjusted to exclude the effect of testing performed by third parties under SBCL's laboratory network management arrangements). Since the acquisition, we have begun implementing our pre-acquisition billing practices at the former SBCL facilities, which we believe should enable us to lower overall bad debt expense (including that of SBCL) to or below the levels immediately prior to the acquisition. As a result of implementing these billing practices, bad debt expense improved to about 6% of net revenues during 2001,

from about 7% of net revenues in 2000, and about 8% of net revenues (adjusted to exclude the effect of testing performed by third parties under our laboratory network management arrangements) just after completion of the SBCL acquisition. We believe that in the

longer term, with a continuing focus on process discipline, bad debt as a percentage of revenues can be reduced to 4% or less (see "Regulation of Reimbursement for Clinical Laboratory Services"). Changes in laws and regulations could negatively impact our ability to bill our clients. The Center for Medicare and Medicaid Services, or CMS (formerly the Health Care Financing Administration) establishes procedures and continuously evaluates and implements changes in the reimbursement process.

Competition

The clinical laboratory testing business is fragmented and highly competitive. We compete with three types of providers: hospital-affiliated laboratories, other independent clinical laboratories, and physician-office laboratories. We are the leading clinical laboratory provider in the United States, with net revenues greater than $3.6 billion during 2001, and facilities in substantially all of the country's major metropolitan areas. Our largest competitor is Laboratory Corporation of America Holdings, or LabCorp, which had net revenues of approximately $2.2 billion during 2001. In addition, we compete with many smaller regional and local independent clinical laboratories, as well as with laboratories owned by physicians and hospitals (see "Customers-Hospitals").

We believe that healthcare providers consider a number of factors when selecting a laboratory, including:

- service capability and quality;
- accuracy, timeliness and consistency in reporting test results;
- number and type of tests performed by the laboratory;
- number, convenience and geographic coverage of patient service centers;
- reputation in the medical community; and
- pricing.

We believe that we compete favorably in each of these areas.

We believe that large independent clinical laboratories may be able to increase their share of the overall clinical laboratory testing market due to their large service networks and lower cost structures. These advantages should enable larger clinical laboratories to more effectively serve large customers, including managed care organizations. In addition, we believe that consolidation in the clinical laboratory testing business will continue. However, a majority of the clinical laboratory testing is likely to continue to be performed by hospitals, which generally have affiliations with community physicians that refer testing to us (see "Customers-Hospitals"). As a result of these

affiliations, we compete against hospital-affiliated laboratories primarily on the basis of service capability and quality as well as other non-pricing factors. Our failure to provide service superior to hospital-affiliated laboratories and other laboratories could negatively impact our net revenues.

Advances in technology may lead to the development of more cost-effective tests that can be performed outside of an independent clinical laboratory such as (1) point-of-care tests that can be performed by physicians in their offices and (2) home testing that can be performed by patients or by physicians in their offices. Development of such technology and its use by our customers would reduce the demand for our laboratory testing services and negatively impact our revenues (see "Regulation of Clinical Laboratory Operations").

Quality Assurance

Our goal is to continually improve the processes for collection, storage and transportation of patient specimens, as well as the precision and accuracy of analysis and result reporting. Our quality assurance efforts focus on proficiency testing, process audits, statistical process control and personnel training for all of our laboratories and patient service centers. We are implementing the Six Sigma approach to help achieve our goal of becoming recognized as the undisputed quality leader in the healthcare services industry.

Internal Proficiency Testing, Quality Control and Audits. Quality control samples are processed in parallel with the analysis of patient specimens. The results of tests on quality control samples are then monitored to identify drift, shift or imprecision in the analytical processes. In addition, we administer an internal proficiency testing program, where proficiency testing samples are processed through our systems as routine patient samples and reported. We also perform internal process audits as part of our comprehensive quality assurance program.

External Proficiency Testing and Accreditation. All our laboratories participate in various quality surveillance programs conducted externally. These programs supplement all other quality assurance procedures. They include proficiency testing programs administered by the College of American Pathologists, or CAP, as well as some state agencies.

CAP is an independent non-governmental organization of board certified pathologists. CAP is approved by the CMS to inspect clinical laboratories to determine compliance with the standards required by the Clinical Laboratory Improvement Amendments of 1988. CAP offers an accreditation program to which laboratories may voluntarily subscribe. All of the Company's major regional laboratories are accredited by the CAP. Accreditation includes on-site inspections and participation in the CAP (or equivalent) proficiency testing program.

Regulation of Clinical Laboratory Operations

The clinical laboratory industry is subject to significant federal and state regulation, including inspections and audits by governmental agencies. Governmental authorities may impose fines or criminal penalties or take other enforcement actions to enforce laws and regulations, including revoking a

clinical laboratory's right to conduct business. Changes in regulation may increase the costs of performing clinical laboratory tests or increase the administrative requirements of claims.

CLIA. All of our laboratories and patient service centers are licensed and accredited by applicable federal and state agencies. The Clinical Laboratory Improvement Amendments of 1988, or CLIA, regulates virtually all clinical laboratories by requiring they be certified by the federal government to ensure that all clinical laboratory testing services are uniformly accurate, reliable and timely. CLIA permits states to adopt regulations that are more stringent than federal law. For example, state laws may require additional personnel qualifications, quality control, record maintenance and proficiency testing.

Currently, most of our clinical laboratory testing is categorized as "high" or "moderate" complexity, and therefore subject to extensive and costly regulation under CLIA. The cost of compliance with CLIA makes it cost prohibitive for many physicians to operate clinical laboratories in their offices; other laws limit the ability of physicians to have ownership in a laboratory and refer tests to such laboratory. However, manufacturers of laboratory equipment and test kits could seek to increase their sales by marketing point-of-care laboratory equipment to physicians and by selling test kits approved for home use to both physicians and patients. Diagnostic tests approved or cleared by FDA for home use are automatically deemed to be "waived" tests under CLIA and may then be performed in physician office laboratories as well as by patients in their homes with minimal regulatory oversight.

Drug Testing. The Substance Abuse and Mental Health Services Administration, or SAMHSA, regulates drug testing for public sector employees and employees of certain federally regulated businesses. SAMHSA has established detailed performance and quality standards that laboratories must meet to perform drug testing on federal employees and contractors and other regulated entities. All laboratories that perform such testing must be certified as meeting SAMHSA standards.

Controlled Substances. The federal Drug Enforcement Administration, or DEA, regulates access to controlled substances used to perform drugs of abuse testing. Laboratories that use controlled substances are licensed by the DEA.

Medical Waste, Hazardous Waste and Radioactive Materials. Clinical laboratories are also subject to federal, state and local regulations relating to the handling and disposal of regulated medical waste, hazardous waste and radioactive materials. We generally use outside vendors to dispose of specimens.

FDA. The Food and Drug Administration, or FDA, has regulatory responsibility over instruments, test kits, reagents and other devices used by clinical laboratories and has taken responsibility from the Centers for Disease Control and Prevention, or CDC, for test classification. In 1998 a final rule issued by the FDA became effective clarifying that certain reagents used in many tests internally developed and performed by clinical laboratories do not require FDA clearance or approval. However, the FDA is considering whether to regulate laboratory developed genetic tests and

certain laboratory developed genotyping tests for HIV resistance. In 2001, the FDA also issued a final rule requiring clinical laboratories that perform blood

bank testing or confirmatory tests to register with the FDA.

Occupational Safety. The federal Occupational Safety and Health Administration, or OSHA, has established extensive requirements relating specifically to workplace safety for healthcare employers. This includes protecting workers from exposure to blood-borne pathogens, such as HIV and hepatitis B and C. OSHA amended its regulations effective in 2001 to require employers to develop a program to reduce or eliminate needle stick injuries. During the fourth quarter of 2000, we began to provide to our employees safety needles, which are more expensive than regular needles, throughout our patient service center network. During the fourth quarter of 2001, we began to provide safety needles to clients who request the same safety needles we use for the purpose of drawing specimens referred to us for testing.

Specimen Transportation. Transportation of infectious substances such as clinical laboratory specimens is subject to regulation by the Department of Transportation, the Public Health Service, or PHS, the United States Postal Service and the International Civil Aviation Organization.

Corporate Practice of Medicine. Many states, including several in which our principal laboratories are located, prohibit corporations from engaging in the practice of medicine. The corporate practice of medicine doctrine has been interpreted to prohibit corporations from employing licensed healthcare professionals to provide services on the corporation's behalf. These restrictions may affect our ability to provide services directly to consumers.

Confidentiality of Health Information

Pursuant to the Health Insurance Portability and Accountability Act of 1996, or HIPAA, on December 28, 2000, the Secretary of the Department of Health and Human Services, or HHS, issued final regulations that would establish comprehensive federal privacy standards with respect to the use and disclosure of protected health information by a health plan, healthcare provider or healthcare data clearinghouse. The regulations establish a complex regulatory framework on a variety of subjects, including:

- the circumstances under which uses and disclosures of protected health information require a general patient consent, specific authorization by the patient, or no patient consent or authorization;
- patients' rights to access, amend and receive an accounting of the disclosures and uses of protected health information;
- the content of notices of privacy practices for protected health information; and
- administrative, technical and physical safeguards required of entities that use or receive protected health information.

The federal healthcare privacy regulations establish a "floor" and do not supersede state laws that are more stringent. Therefore, we are required to comply with both federal privacy standards and varying state privacy laws. In addition, for healthcare data transfers relating to citizens of other countries, we will need to comply with the laws of other countries. The federal privacy regulations became effective in April 2001 for healthcare providers, who have until April 2003 to comply. In addition, final standards for electronic transactions were issued in August 2000 and will become effective in October 2002, although covered entities are eligible to obtain a one year extension if approved through an application to the Secretary of Health and Human Services, that includes a plan for achieving compliance by October 16, 2003. These regulations provide uniform standards for code sets (codes representing medical procedures and laboratory tests and diagnosis codes, which are used, among

others, in connection with the identification and billing of medical procedures and laboratory tests), electronic claims, remittance advice, enrollment, eligibility and other electronic transactions. Finally, the proposed security and electronic signature regulations issued by the Secretary of HHS in August 1998 pursuant to HIPAA are expected to be finalized this year and will not be effective until two years later. HIPAA provides for significant fines and other penalties for wrongful disclosure of protected health information. Compliance with the HIPAA requirements, when finalized, will require significant capital and personnel resources from all healthcare organizations, including Quest Diagnostics. However, we will not be able to estimate the cost of complying with all of these regulations, which we expect to be significant, until after all the regulations are finalized. These regulations, when finalized and effective, will likely restrict our ability to use our laboratory database to provide medical information for purposes other than payment, treatment or healthcare operations (as defined by HIPAA), except for information that does not identify a patient.

Regulation of Reimbursement for Clinical Laboratory Services

Overview. The healthcare industry has experienced significant changes in reimbursement practices during the past several years. Governmental payers, such as Medicare (which principally serves patients 65 years and older) and Medicaid (which principally serves indigent patients), as well as private insurers and large employers, have taken steps to control the cost, utilization and delivery of healthcare services. Principally as a result of reimbursement reductions and measures adopted by CMS to reduce utilization described below, the percentage of our aggregate net revenues derived from Medicare and Medicaid programs declined from 20% in 1995 to 14% in 2001. We believe that our other business may significantly depend on continued participation in the Medicare and Medicaid programs, because many customers may want a single laboratory to perform all of their clinical laboratory testing services, regardless of whether reimbursements are ultimately made by themselves, Medicare, Medicaid or other payers.

Billing and reimbursement for clinical laboratory testing is subject to significant and complex federal and state regulation. Penalties for violations of laws relating to billing federal healthcare programs and for violations of federal fraud and abuse laws include: (1) exclusion from participation in Medicare/Medicaid programs; (2) asset forfeitures; (3) civil and criminal penalties and fines; and (4) the loss of various licenses, certificates and authorizations necessary to operate some or all of a clinical laboratory's business. Civil monetary penalties for a wide range of violations are not more than $10,000 per violation plus three times the amount claimed and, in the case of kickback violations, not more than $50,000 per violation plus up to three times the amount of remuneration involved. A parallel civil remedy under the federal False Claims Act provides for damages not more than $11,000 per violation plus up to three times the amount claimed.

Reduced Reimbursements. In 1984, Congress established a Medicare fee schedule payment methodology for clinical laboratory services performed for patients covered under Part B of the Medicare program. Congress then imposed a national ceiling on the amount that carriers could pay under their local Medicare fee schedules. Since then, Congress has periodically reduced the national ceilings. The Medicare national fee schedule limitations were reduced in 1996 to 76% of the 1984 national median of the local fee schedules and in

1998 to 74% of the 1984 national median. In addition, Congress also eliminated the provision for annual fee schedule increases based on the consumer price index through 2002. Effective January 2001, however, the limitation amount for new clinical laboratory tests as determined by the Secretary of HHS, for which no limitation amount has previously been established, is 100% of the median of all the fee schedules established for that test.

Laboratories must bill the Medicare program directly and must accept the carrier's fee schedule amount as payment in full for most tests performed on behalf of Medicare beneficiaries. In addition, state Medicaid programs are prohibited from paying more (and in most instances, pay significantly less) than Medicare. Major clinical laboratories, including Quest Diagnostics, typically use two fee schedules:

- "Client" fees charged to physicians, hospitals, and institutions to which a laboratory supplies services on a wholesale basis and which are billed on a monthly basis. These fees are generally subject to negotiation or discount.

- "Patient" fees charged to individual patients and third-party payers, like Medicare and Medicaid. These generally require separate bills for each requisition.

The fee schedule amounts established by Medicare are typically substantially lower than patient fees otherwise charged by us, but are sometimes higher than our fees actually charged to certain other clients. During 1992, the Office of the Inspector General, or OIG, of the HHS issued final regulations that prohibited charging Medicare fees substantially in excess of a provider's usual charges. The OIG, however, declined to provide any guidance concerning interpretation of these rules, including whether or not discounts to non-governmental clients and payers or the dual-fee structure might be inconsistent with these rules.

A proposed rule released in September 1997 would have authorized the OIG to exclude providers from participation in the Medicare program, including clinical laboratories, that charge Medicare and other programs fees that are "substantially in excess of . . . usual charges . . . to any of [their] customers, clients or patients." This proposal was withdrawn by the OIG in 1998. However, the 1997 Balanced Budget Act permits CMS to adjust statutorily prescribed fees for some medical services, including clinical laboratory services, if the fees are "grossly excessive." In January 1998, CMS issued an interim final rule setting forth criteria to be used by CMS in determining whether to exercise this power. Among the factors listed in the rule are whether the statutorily prescribed fees are "grossly higher or lower than the payment made for the . . . services by other purchasers in the same locality." In November 1999, the OIG issued an

advisory opinion which indicated that a clinical laboratory offering discounts on client bills may violate the "usual charges" regulation if the "charge to Medicare substantially exceeds the amount the laboratory most frequently charges or has contractually agreed to accept from non-Federal payors." The OIG subsequently issued a letter clarifying that the usual charges regulation is not a blanket prohibition on discounts to private pay customers. We cannot provide any assurances to investors that fees payable by Medicare could not be reduced

as a result of the application of this rule or that the government might not assert claims for reimbursement by purporting to apply this rule retroactively.

Currently, there are no Medicare co-insurance or co-payments required for clinical laboratory testing. When co-insurance was last in effect in 1984, clinical laboratories received from Medicare carriers only 80% of the Medicare allowed amount and were required to bill Medicare beneficiaries for the unpaid balance of the Medicare allowed amount. If enacted, a co-insurance proposal could adversely affect the revenues of the clinical laboratory industry, including us, by exposing the testing laboratory to the credit of individuals and by increasing the number of bills. In addition, a laboratory could be subject to potential fraud and abuse violations if adequate procedures to bill and collect the co-insurance payments are not established and followed. Co-payments were not part of the Bush Administration's recent budget proposal for fiscal year 2002.

Reduced Utilization of Clinical Laboratory Testing. In recent years, CMS has taken several steps to reduce utilization of clinical laboratory testing. Since 1995, Medicare carriers have adopted policies under which they do not pay for many commonly ordered clinical tests unless the ordering physician has provided an appropriate diagnostic code supporting the medical necessity of the test. Physicians are required by law to provide diagnostic information when they order clinical tests for Medicare and Medicaid patients. However, CMS has not prescribed any penalty for physicians who fail to provide diagnostic information to laboratories.

We are generally permitted to bill patients directly for some statutorily excluded clinical laboratory services. We are also generally permitted to bill patients for clinical laboratory tests that Medicare does not pay for due to "medical necessity" limitations (these tests include limited coverage tests for which a carrier-approved diagnosis code is not provided by the ordering physician) if the patient signs an advance beneficiary notice (ABN) under which the patient makes an informed decision as to whether to personally assume financial liability for laboratory tests which are likely to be not covered by Medicare because they are deemed to be not medically necessary. We do not have any direct contact with most of these patients and, in such cases, cannot control the proper use of the ABN by the physician or the physician's office staff. If the ABN is not timely completed or is not completed properly, we end up performing tests that we cannot subsequently bill to the patient if they are not reimbursable by Medicare. Currently CMS is considering the adoption of a CMS-approved ABN. Adoption of the new ABN form could result in even fewer valid ABNs and consequently prevent us from billing additional beneficiaries for services denied by Medicare for lack of medical necessity.

Inconsistent Practices. Currently, many different local carriers administer Medicare. They have inconsistent policies on matters such as: (1) test coverage; (2) automated chemistry panels; (3) diagnosis coding; (4) claims documentation; and (5) fee schedules (subject to the national limitations). Inconsistent regulation has increased the complexity of the billing process for clinical laboratories. As part of the 1997 Balanced Budget Act, HHS was required to adopt uniform policies on the above matters by January 1, 1999, and replace the current local carriers with no more than five regional carriers. Although HHS has finalized a number of uniform policies, it has not taken any final action to replace the local carriers with five regional carriers. However, in November 2000, CMS published a solicitation in the Commerce Business Daily seeking two contractors to process Part B clinical laboratory claims. In the solicitation, CMS stated that the Secretary has decided to limit the number of carriers processing clinical diagnostic laboratory test claims to two contractors. The solicitation indicated that the Request for Proposal (RFP) would be released on or before December 31, 2000 but as of February 2002, it had not been issued; the solicitation did not indicate the effective date for a final transition to the regional carrier model.

CMS plans to achieve standardization in part through implementing a single claims processing system for all carriers. This initiative, however, was suspended due to CMS's Year 2000 compliance priorities.

Competitive Bidding. The 1997 Balanced Budget Act requires CMS to conduct five Medicare bidding demonstrations involving various types of medical services and complete them by 2002. CMS is expected to include a clinical laboratory demonstration project in a metropolitan statistical area as part of the legislative mandate. Florida has issued a proposal for competitive bidding for its Medicaid program. If competitive bidding were implemented on a regional or national basis for clinical laboratory testing, it could materially adversely affect the clinical laboratory industry and us.

Future Legislation. Future changes in federal, state and local regulations (or in the interpretation of current regulations) affecting governmental reimbursement for clinical laboratory testing could adversely affect us. We cannot predict, however, whether and what type of legislative proposals will be enacted into law or what regulations will be adopted by regulatory authorities.

Fraud and Abuse Regulations. Medicare and Medicaid anti-kickback laws prohibit clinical laboratories from making payments or furnishing other benefits to influence the referral of tests billed to Medicare, Medicaid or other federal programs. As noted above, the penalties for violation of these laws may include criminal and civil fines and penalties and/or suspension or exclusion from participation in federal programs. Many of the anti-fraud statutes and regulations, including those relating to joint ventures and alliances, are vague or indefinite and have not been interpreted by the courts. We cannot predict if some of the fraud and abuse rules will be interpreted contrary to our practices.

In November 1999, the OIG issued an advisory opinion concluding that the industry practice of discounting client bills may constitute a kickback if the discounted price is below a laboratory's overall cost (including overhead) and below the amounts reimbursed by Medicare. Advisory opinions are not binding but may be indicative of the position that prosecutors may take in enforcement actions. The OIG's opinion, if enforced, could result in fines and possible exclusion and could require us to eliminate offering discounts to clients below the rates reimbursed by Medicare. The OIG subsequently issued a letter clarifying that it did not intend to imply that discounts are a per se violation of the federal anti-kickback statute, but may merit further investigation depending on the facts and circumstances presented.

In addition, since 1992, a federal anti-"self-referral" law, commonly known as the "Stark" law, prohibits, with certain exceptions, Medicare payments for laboratory tests referred by physicians who have, personally or through a family member, an investment interest in, or a compensation arrangement with, the testing laboratory. Since January 1995, these restrictions have also applied to Medicaid-covered services. Many states have similar anti-"self-referral" and other laws that also affect investment and compensation arrangements with physicians who refer other than government-reimbursed laboratory testing to us. We cannot predict if some of the state laws will be interpreted contrary to our practices.

Government Investigations and Related Claims

We are subject to extensive and frequently changing federal, state and local laws and regulations. We believe that, based on our experience with government settlements and public announcements by various government officials, the federal government continues to strengthen its position on healthcare fraud. In addition, legislative provisions relating to healthcare fraud and abuse give federal enforcement personnel substantially increased funding, powers and remedies to pursue suspected fraud and abuse. While we believe that we are in material compliance with all applicable laws, many of the regulations applicable to us, including those relating to billing and reimbursement of tests and those relating to relationships with physicians and hospitals, are vague or indefinite and have not been interpreted by the courts. They may be interpreted or applied by a prosecutorial, regulatory or judicial authority in a manner that could require us to make changes in our operations, including our billing practices. If we fail to comply with applicable laws and regulations, we could suffer civil and criminal penalties, including the loss of licenses or our ability to participate in Medicare, Medicaid and other federal and state healthcare programs.

During the mid-1990s, Quest Diagnostics and SBCL settled government claims that primarily involved industry-wide billing and marketing practices that both companies believed to be lawful. The aggregate amount of the settlements for these claims exceeded $500 million. The federal or state governments may bring additional claims based on new theories as to our practices that we believe to be in compliance with law. The federal government has substantial leverage in negotiating settlements since the amount of potential fines far exceeds the rates at which we are reimbursed, and the government has the remedy of excluding a non-compliant provider from participation in the Medicare and Medicaid programs, which represented approximately 14% of our consolidated net revenues during 2001.

At December 31, 2001 recorded reserves, relating primarily to billing claims, including those indemnified by SmithKline Beecham, approximated $21 million. Note 17 to the Consolidated Financial Statements describes the indemnification from SmithKline Beecham against certain claims. SmithKline Beecham has also agreed to indemnify Quest Diagnostics with respect to pending actions relating to a former SBCL employee that at times reused certain needles when drawing blood from patients. Although management believes that established reserves for both indemnified and non-indemnified claims are sufficient, it is possible that additional information may become available that may cause the final resolution of these matters to exceed established reserves by an amount which could be material to our results of operations and cash flows in the period in which such claims are settled. We do not believe that these issues will have a material adverse effect on our overall financial condition. However, we understand that there may be

pending qui tam claims brought by former employees or other "whistle blowers" as to which we have not been provided with a copy of the complaint and accordingly cannot determine the extent of any potential liability.

As an integral part of our compliance program discussed below, we investigate all reported or suspected failures to comply with federal healthcare reimbursement requirements. Any non-compliance that results in Medicare or

Medicaid overpayments is reported to the government and reimbursed by us. As a result of these efforts, we have periodically identified and reported overpayments. While we have reimbursed these overpayments and have taken corrective action where appropriate, we cannot assure investors that in each instance the government will necessarily accept these actions as sufficient.

Compliance Program

Compliance with all government rules and regulations has become a significant concern throughout the clinical laboratory industry because of evolving interpretations of regulations and the national debate over healthcare. We began a compliance program early in 1993.

We emphasize the development of training programs intended to ensure the strict implementation and observance of all applicable laws, regulations and company policies. Further, we conduct in-depth reviews of procedures, personnel and facilities to assure regulatory compliance throughout our operations. The Quality, Safety and Compliance Committee of the Board of Directors requires periodic reporting of compliance operations from management. Government officials have publicly cited our program as a model for the industry. In October 1996, we signed a five-year corporate integrity agreement with the OIG that expired in October 2001.

We believe we comply in all material respects with all applicable statutes and regulations. However, we cannot assure you that no statutes or regulations will be interpreted or applied by a prosecutorial, regulatory or judicial authority in a manner that would adversely affect us. Potential sanctions for violation of these statutes include significant damages, penalties, and fines, exclusion from participation in governmental healthcare programs and the loss of various licenses, certificates and authorization necessary to operate some or all of our business.

Insurance

As a general matter, providers of clinical laboratory testing services may be subject to lawsuits alleging negligence or other similar legal claims. These suits could involve claims for substantial damages. Any professional liability litigation could also have an adverse impact on our client base and reputation. We maintain various liability and property insurance programs for claims that could result from providing or failing to provide clinical laboratory testing services, including inaccurate testing results and other exposures but we are essentially self-insured for most of these claims. We do maintain coverage which caps our exposure on individual claims. The basis for our insurance reserves is the actuarially determined projected losses based upon our historical loss experience. Management believes that present insurance coverage and reserves are sufficient to cover currently estimated exposures, but we cannot assure you that we will not incur liabilities in excess of recorded reserves. Similarly, although we believe that we will be able to obtain adequate insurance coverage in the future at acceptable costs, we cannot assure you that we will be able to do so.

Employees

At December 31, 2001 and 2000, we employed approximately 29,000 and 27,000 people, respectively. Approximately 27,000 of our employees were full-time at December 31, 2001. These totals exclude employees of the joint ventures where we do not have a majority interest. We have no collective bargaining agreements with any unions, and we believe that our overall relations with our employees are good.

CAUTIONARY STATEMENT FOR PURPOSES OF THE "SAFE HARBOR" PROVISIONS OF THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995

Some statements and disclosures in this document are forward-looking statements. Forward-looking statements include all statements that do not relate solely to historical or current facts and can be identified by the use of words such as "may", "believe", "will", "expect", "project", "estimate", "anticipate", "plan" or "continue". These forward-looking statements are based on our current plans and expectations and are subject to a number of risks and uncertainties that could significantly cause our plans and expectations, including actual results, to differ materially from the forward-looking statements. The Private Securities Litigation Reform Act of 1995 provides a "safe harbor" for forward-looking statements to encourage companies to provide prospective information about their companies without fear of litigation.

We would like to take advantage of the "safe harbor" provisions of the Litigation Reform Act in connection with the forward-looking statements included in this document. Investors are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this document. The following important factors could cause our actual financial results to differ materially from those projected, forecasted or estimated by us in forward-looking statements:

(a) Heightened competition, including increased pricing pressure, competition from hospitals for testing for non-patients and competition from physicians. See "Business - Competition."

(b) Impact of changes in payer mix, including any shift from traditional, fee-for-service medicine to capitated managed-cost healthcare. See "Business - Payers and Customers - Customers - Managed Care Organizations."

(c) Adverse actions by government or other third-party payers, including unilateral reduction of fee schedules payable to us and an increase in the practice of negotiating for exclusive contracts that involve aggressively priced capitated payments by managed care organizations. See "Business - Regulation of Reimbursement for Clinical Laboratory Services" and "Business - Payers and Customers - Customers - Managed Care Organizations."

(d) The impact upon our volume and collected revenue or general or administrative expenses resulting from our compliance with Medicare and Medicaid administrative policies and requirements of third-party payers. These include:

(1) the requirements of Medicare carriers to provide diagnosis codes for many commonly ordered tests and the likelihood that third-party payers will increasingly adopt similar requirements;

(2) the policy of CMS to limit Medicare reimbursement for tests contained in automated chemistry panels to the amount that would have been paid if only the covered tests, determined on the basis of demonstrable "medical necessity", had been ordered;

(3) continued inconsistent practices among the different local carriers administering Medicare; and

(4) proposed changes by CMS to the ABN form.

See "Business - Regulation of Reimbursement for Clinical Laboratory Services" and "Business - Billing".

(e) Adverse results from pending or future government investigations or private actions. These include, in particular:

(1) significant monetary damages and/or exclusion from the Medicare and Medicaid programs and/or other significant litigation matters;

(2) the absence of indemnification from SmithKline Beecham for:

(a) governmental claims against SBCL that arise after August 16, 1999; and

(b) private claims unrelated to the indemnified governmental claims or investigations; and

(3) the absence of indemnification for consequential damages from SmithKline Beecham.

(f) Failure to obtain new customers at profitable pricing or failure to retain existing customers, and reduction in tests ordered or specimens submitted by existing customers.

(g) Failure to efficiently integrate acquired clinical laboratory businesses, or to efficiently integrate clinical laboratory businesses from joint ventures and alliances with hospitals, and the costs related to any such integration, or to retain key technical and management personnel.

(h) Inability to obtain professional liability insurance coverage or a material increase in premiums for such coverage. See "Business - Insurance."

(i) Denial of CLIA certification or other license for any of Quest Diagnostics' clinical laboratories under the CLIA standards, by CMS for Medicare and Medicaid programs or other federal, state and local agencies. See "Business - Regulation of Clinical Laboratory Operations."

(j) Increased federal or state regulation of independent clinical laboratories, including regulation by the FDA.

(k) Adverse publicity and news coverage about us or the clinical laboratory industry.

(l) Computer or other system failures that affect our ability to

perform tests, report test results or properly bill customers, including potential failures resulting from systems conversions, including from the integration of the systems of Quest Diagnostics and SBCL, telecommunications failures, malicious human acts (such as electronic break-ins or computer viruses) or natural disasters. See "Business - Information Systems" and "Business - Billing."

(m) Development of technologies that substantially alter the practice of laboratory medicine, including technology changes that lead to the development of more cost-effective tests such as (1) point-of-care tests that can be performed by physicians in their offices and (2) home testing that can be carried out without requiring the services of clinical laboratories. See "Competition" and "Regulation of Clinical Laboratory Operations."

(n) Issuance of patents or other property rights to our competitors or others that could prevent, limit or interfere with our ability to develop, perform or sell our tests or operate our business. See "Business - The United States Clinical Laboratory Testing Market."

(o) Development of tests by our competitors or others which we may not be able to license, or usage of our technology or similar technologies or our trade secrets by competitors, any of which could negatively affect our competitive position.

(p) Development of an Internet based electronic commerce business model that does not require an extensive logistics and laboratory network.

(q) The impact of the privacy and security regulations issued under HIPAA on our operations (including its medical information services) as well as the cost to comply with the regulations. See "Business - Confidentiality of Health Information."

(r) Changes in interest rates and changes in our credit ratings from Standard & Poor's and Moody's Investor Services causing a substantial increase in our effective borrowing rate.

(s) An ability to hire and retain qualified personnel or the loss of the services of one or more of our key senior management personnel.

(t) Terrorist and other criminal activities, which could affect our customers, transportation or power systems, or our facilities, and for which insurance may not adequately reimburse us for.

(u) Changes in our credit ratings from Standard & Poor's and Moody's Investor Services causing an unfavorable impact on our cost of and access to capital.

Item 2. Properties

Our principal laboratories (listed alphabetically by state) are located in or near the following metropolitan areas. In certain areas (indicated by the number (2)), we have two principal laboratories as a result of recent acquisitions.

Location	Leased or Owned
Phoenix, Arizona	Leased by Joint Venture
Los Angeles, California	Owned
San Diego, California	Leased
San Francisco, California	Owned
San Juan Capistrano, California	Owned
Denver, Colorado	Leased
New Haven, Connecticut	Owned
Miami, Florida (2)	Leased
Tampa, Florida	Owned
Atlanta, Georgia	Owned
Chicago, Illinois (2)	One owned, one leased
Indianapolis, Indiana	Leased by Joint Venture
Lexington, Kentucky	Owned
New Orleans, Louisiana	Owned
Baltimore, Maryland	Owned
Boston, Massachusetts	Leased
Detroit, Michigan	Leased
St. Louis, Missouri	Owned
New York, New York (Teterboro, New Jersey)(2)	One owned, one leased
Long Island, New York	Leased
Oklahoma City, Oklahoma	Leased by Joint Venture
Portland, Oregon	Leased
Philadelphia, Pennsylvania	Leased
Pittsburgh, Pennsylvania	Leased
Nashville, Tennessee	Leased
Dallas, Texas	Leased
Houston, Texas	Leased
Seattle, Washington	Leased

Our executive offices are located in Teterboro, New Jersey, at the facility that also serves as our regional laboratory serving the New York City metropolitan area. We lease an administrative office in Lyndhurst, New Jersey, near our executive offices and lease a site in Norristown, Pennsylvania, that serves as a billing center. We also lease under a capital lease an administrative office in Collegeville, Pennsylvania. We own our laboratory facility in Mexico City and lease a laboratory facility near London, England. We believe that, in general, our laboratory facilities are suitable and adequate for our current and anticipated future levels of operation. We believe that if we were unable to renew a lease on any of our testing facilities, we could find alternative space at competitive market rates and relocate our operations to such new location.

Item 3. Legal Proceedings

In addition to the investigations described in "Business-Government Investigations and Related Claims," we are involved in various legal proceedings arising in the ordinary course of business. Some of the proceedings against us involve claims that are substantial in amount. Some of these claims involve contracts of SBCL that were terminated following our acquisition of SBCL. Although we cannot predict the outcome of such proceedings or any claims made

against us, we do not anticipate that the ultimate outcome of the various proceedings or claims will have a material adverse effect on our financial position.

Item 4. Submission of Matters to a Vote of Security Holders

None.

PART II

Item 5. Market for Registrant's Common Stock and Related Stockholder Matters

Our common stock is listed and traded on the New York Stock Exchange under the symbol "DGX." The following table sets forth, for the periods indicated, the high and low sales price per share as reported on the New York Stock Exchange Consolidated Tape (all prices have been restated to reflect the two-for-one stock split effected on May 31, 2001 - See Note 2 to the Consolidated Financial Statements):

	High	Low
1999		
First Quarter	$11.41	$ 8.87
Second Quarter	13.75	10.75
Third Quarter	14.07	11.87
Fourth Quarter	16.47	11.28
2000		
First Quarter	20.19	14.57
Second Quarter	37.37	18.50
Third Quarter	70.50	36.63
Fourth Quarter	73.13	41.37
2001		
First Quarter	70.47	36.60
Second Quarter	75.75	42.15
Third Quarter	75.50	48.10
Fourth Quarter	72.27	55.02

As of February 22, 2002, we had approximately 6,200 record holders of our common stock.

We have never declared or paid cash dividends on our common stock and do not anticipate paying any dividends on our common stock in the foreseeable future. We currently intend to retain all available funds and any future earnings to fund the development and growth of our business.

Item 6. Selected Financial Data

See page 28.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

See page 31.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

See Management's Discussion and Analysis of Financial Condition and Results of Operations.

Item 8. Financial Statements and Supplementary Data

See Item 14 (a) 1 and 2.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

PART III

Item 10. Directors and Executive Officers of the Registrant

Information concerning the directors of the Company is incorporated by reference to the information in the Company's Proxy Statement to be filed on or before April 30, 2002 (the "Proxy Statement") appearing under the caption "Election of Directors."

Executive Officers of the Registrant

Officers of the Company are elected annually by the Board of Directors and hold office at the discretion of the Board of Directors. The following persons serve as executive officers of the Company:

Kenneth W. Freeman (51) is Chairman of the Board and Chief Executive Officer of the Company. Mr. Freeman joined the Company in May 1995 as President and Chief Executive Officer, was elected a director in July 1995 and was elected Chairman of the Board in December 1996. Prior to 1995, he served in a variety of financial and managerial positions at Corning, which he joined in 1972. He was elected Controller and a Vice President of Corning in 1985, Senior Vice President in 1987, General Manager of the Science Products Division in 1989 and Executive Vice President in 1993. He was appointed President and Chief Executive

Officer of Corning Asahi Video Products Company in 1990.

Surya N. Mohapatra, Ph.D. (52) is President and Chief Operating Officer. Prior to joining the Company in February 1999 as Senior Vice President and Chief Operating Officer, he was Senior Vice President of Picker International, a worldwide leader in advanced medical imaging technologies, where he served in various executive positions during his 18-year tenure.

Lucia L. Quinn (49) is Senior Vice President for Advanced Diagnostics. Ms. Quinn has overall responsibility for Science and Innovation, Business Development, Pharmaceutical Services and Consumer Health. Ms. Quinn joined the Company in April 2001 as Vice President, Developing Businesses. From 1999 through April 2001 she was with Allied Signal/Honeywell, serving most recently as Vice President Strategic Marketing. From 1989 through 1999, Ms. Quinn was employed by Digital Equipment Corporation/Compaq, most recently serving as Vice President- Corporate Strategy. She assumed her current responsibilities in October 2001.

Richard L. Bevan (42) is Vice President for Human Resources. From 1982 until August 1999, Mr. Bevan served in a variety of human resources positions for SmithKline Beecham's pharmaceutical and clinical laboratory businesses, most recently serving as Vice President and Director of Human Resources-Operations for SBCL. Mr. Bevan was appointed Corporate Vice President for Human Resource Strategy and Development in August 1999, and to his present position in January 2001.

Catherine Doherty (39) is Vice President for Communications and Public Affairs. Ms. Doherty has overall responsibility for internal and external communications and government affairs. Ms. Doherty has been employed by the Company since 1990. She served as Chief Accounting Officer from 1996 until July 2000, when she became Vice President Investor Relations. Ms. Doherty assumed her current responsibilities in November 2001.

Robert A. Hagemann (45) is Vice President and Chief Financial Officer. He joined Corning Life Sciences, Inc., in 1992, where he held a variety of senior financial positions before being named Vice President and Corporate Controller of the Company in 1996. Prior to joining the Company, Mr. Hagemann was employed by Prime Hospitality, Inc. and Crompton & Knowles, Inc. in senior financial positions. He was also previously associated with Ernst & Young. Mr. Hagemann assumed his present responsibilities in August 1998.

Gerald C. Marrone (59) is Senior Vice President, Administration and Chief Information Officer. Mr. Marrone joined the Company in November 1997 as Chief Information Officer, after 12 years with Citibank, N.A. While at Citibank, he was most recently Vice President, Division Executive for Citibank's Global Production Support Division, and was also the Chief Information Officer of Citibank's Global Cash Management business. Prior to joining Citibank, he was the Chief Information Officer for Memorial Sloan-Kettering Cancer Center in New York for five years.

Michael E. Prevoznik (40) is Vice President for Legal and Compliance and General Counsel. Prior to joining SBCL in 1994 as its Chief Legal Compliance Officer, Mr. Prevoznik was with Dechert Price & Rhodes. In 1996, he became Vice President and Chief Legal Compliance Officer for SmithKline Beecham Healthcare Services. In 1998, he

was appointed Vice President, Compliance for SmithKline Beecham, assuming additional responsibilities for coordinating all compliance activities within SmithKline Beecham worldwide. Mr. Prevoznik assumed his current responsibilities with the Company in August 1999.

Item 11. Executive Compensation

The information called for by this Item is incorporated by reference to the information under the caption "Executive Compensation" appearing in the Proxy Statement. The information contained in the Proxy Statement under the captions "Compensation Committee Report on Executive Compensation" and "Performance Graph" is not incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management

The information called for by this Item is incorporated by reference to the information under the caption "Security Ownership of Certain Beneficial Owners and Management" appearing in the Proxy Statement.

Item 13. Certain Relationships and Related Transactions

The information called for by this Item is incorporated by reference to the information under the caption "Certain Relationships and Related Transactions" appearing in the Proxy Statement.

PART IV

Item 14. Exhibits, Financial Statement Schedules and Reports on Form 8-K

(a) Documents filed as part of this report:

1. Index to financial statements and supplementary data filed as part of this report:

Item	Page
Report of Independent Accountants	F-1
Consolidated Balance Sheets	F-2
Consolidated Statements of Operations	F-3
Consolidated Statements of Cash Flows	F-4
Consolidated Statements of Stockholders' Equity	F-5
Notes to Consolidated Financial Statements	F-6
Supplementary Data: Quarterly Operating Results (unaudited)	F-33

2. Financial Statement Schedule:

Item	Page
Schedule II - Valuation Accounts and Reserves.....	F-34

3. Exhibits filed as part of this report:

See (c) below.

(b) Reports on Form 8-K filed during the last quarter of 2001:

On November 14, 2001, the Company filed a current report on Form 8-K to update all investors on its outlook, which remained unchanged from the guidance we provided during the Third Quarter 2001 financial conference call on October 19, 2001.

On November 27, 2001, the Company filed a current report on Form 8-K with respect to its completion, on November 26, 2001, of its previously announced public offering of $250 million of 1.75% contingent convertible debentures due 2021 (the "Debentures Offering").

On November 29, 2001, the Company filed a current report on Form 8-K containing an opinion by Shearman & Sterling as to certain tax matters in connection with the Debentures Offering.

(c) Exhibits filed as part of this report:

Exhibit Number	Description
3.1	Restated Certificate of Incorporation (filed as an exhibit to the Company report on Form 8-K (Date of Report: May 31, 2001) and incorporated herein
3.2	Amended and Restated By-Laws of the Registrant (filed as an Exhibit to th annual report on Form 10-K and incorporated herein by reference)
4.1	Form of Rights Agreement dated December 31, 1996 (the "Rights Agreement") Clinical Laboratories Inc. and Harris Trust and Savings Bank as Rights Ag

(filed as an Exhibit to the Company's Registration Statement on Form 10 (and incorporated herein by reference)

4.2	Form of Amendment No. 1 effective as of July 1, 1999 to the Rights Agreem exhibit to the Company's current report on Form 8-K (Date of Report: Augu incorporated herein by reference)
4.3	Form of Amendment No. 2 to the Rights Agreement (filed as an Exhibit to t 1999 annual report on Form 10-K and incorporated herein by reference)
4.4	Form of Amendment No. 3 to the Rights Agreement (filed as an Exhibit to t 2000 annual report on Form 10-K and incorporated herein by reference)
10.1	Form of 6 3/4% Senior Notes due 2006, including the form of guarantee end (filed as an exhibit to the Company's current report on Form 8-K (Date of 27, 2001) and incorporated herein by reference)
10.2	Form of 7 1/2% Senior Notes due 2011, including the form of guarantee end (filed as an exhibit to the Company's current report on Form 8-K (Date of 27, 2001) and incorporated herein by reference)
10.3	Form of 1.75% Contingent Convertible Debentures due 2021, including the f endorsed thereon (filed as an exhibit to the Company's current report on of Report: November 26, 2001) and incorporated herein by reference)
10.4	Indenture dated as of June 27, 2001, among the Company, the Subsidiary Gu the Trustee (filed as an exhibit to the Company's current report on Form Report: June 27, 2001) and incorporated herein by reference)
10.5	First Supplemental Indenture, dated as of June 27, 2001, among the Compan Subsidiary Guarantors, and the Trustee to the Indenture referred to in Ex (filed as an exhibit to the Company's current report on Form 8-K (Date of 27, 2001) and incorporated herein by reference)
10.6	Second Supplemental Indenture, dated as of November 26, 2001, among the C Subsidiary Guarantors, and the Trustee to the Indenture referred to in Ex (filed as an exhibit to the Company's current report on Form 8-K (Date of November 26, 2001) and incorporated herein by reference)
10.7	Credit Agreement, dated as of June 27, 2001, among the Company, the Subsi and the Banks (filed as an exhibit to the Company's current report on For Report: June 27, 2001) and incorporated herein by reference)
10.8	Amended and Restated Credit and Security Agreement, dated as of September Quest Diagnostics Receivables Inc., as Borrower, the Company, as Initial the Lenders party thereto and Wachovia Bank, N.A., as Administrative Agen exhibit to the Company's quarterly report on Form 10-Q for the quarter en 2001 and incorporated herein by reference)
10.9	Amendment No. 1 to the Amended and Restated Credit and Security Agreement October 30, 2001, among Quest Diagnostics Receivables Inc., as Borrower, Initial Servicer, each of the Lenders party thereto and Wachovia Bank, N. Administrative Agent (filed as an exhibit to the Company's quarterly repo for the quarter ended September 30, 2001 and incorporated herein by refer
10.10	Amendment No. 2 to the Amended and Restated Credit and Security Agreement January 14, 2002, among Quest Diagnostics Receivables Inc., as Borrower, Initial Servicer, each of the Lenders party thereto and Wachovia Bank, N. Administrative Agent
10.11	Receivables Sale Agreement dated as of July 21, 2000 between the Company, subsidiary sellers party thereto and Quest Diagnostics Receivables Inc. (to the Company's quarterly report on Form 10-Q for the quarter ended June incorporated herein by reference)
10.12	Stock and Asset Purchase Agreement dated as of February 9, 1999 among Smi SmithKline Beecham Corporation and the Company (the "Stock and Asset Purc as Appendix A of the Company's Definitive Proxy Statement dated May 11, 1 by reference)
10.13	Amendment No. 1 dated August 6, 1999 to the Stock and Asset Purchase Agre an exhibit to the Company's current report on Form 8-K (Date of Report: A and incorporated herein by reference)
10.14	Non-Competition Agreement dated as of August 16, 1999 between SmithKline Company (filed as an exhibit to the Company's current report on Form 8-K

	(Date of Report: August 16, 1999) and incorporated herein by reference)
10.15	Stockholders Agreement dated as of August 16, 1999 between SmithKline Bee and the Company (filed as an exhibit to the Company's current report on F (Date of Report: August 16, 1999) and incorporated herein by reference)
10.16	Category One Data Access Agreement dated as of August 16, 1999 between Sm Beecham plc and the Company (filed as an exhibit to the Company's current Form 8-K (Date of Report: August 16, 1999) and incorporated herein by ref
10.17	Global Clinical Trials Agreement dated as of August 16, 1999 between Smit Beecham plc and the Company (filed as an exhibit to the Company's current Form 8-K (Date of Report: August 16, 1999) and incorporated herein by ref
10.18	First Amendment to Global Clinical Trials Agreement, dated January 18, 20 effective date of January 1, 2000 between SmithKline Beecham plc and the
10.19	Form of Employees Stock Purchase Plan (filed as an Exhibit to the Company Statement on Form 10 (File No. 1-12215) and incorporated herein by refere
10.20	Form of 1996 Employee Equity Participation Program (filed as an Exhibit t Registration Statement on Form 10 (File No. 1-12215) and incorporated her
10.21	Form of 1999 Employee Equity Participation Program (filed as an Exhibit t proxy statement for the 1999 annual meeting of shareholders and incorpora reference)
10.22	Form of Stock Option Plan for Non-Employee Directors (filed as an exhibit proxy statement for the 1998 annual meeting of shareholders and incorpora reference)
10.23	Employment Agreement between the Company and Kenneth W. Freeman (filed as the Company's 1999 annual report on Form 10-K and incorporated herein by
10.24	Amendment to the Employment Agreement between the Company and Kenneth W. as an exhibit to the Company's quarterly report on Form 10-Q for the quar 30, 2000 and incorporated herein by reference)
10.25	Form of Supplemental Deferred Compensation Plan (filed as an exhibit to t annual report on Form 10-K for the year ended December 31, 1998 and incor by reference)
10.26	Form of Executive Retirement Supplemental Plan (filed as an Exhibit to th Registration Statement on Form 10 (File No. 1-12215) and incorporated her
12.27	Form of Variable Compensation Plan (filed as an Exhibit to the Company's Statement on Form 10 (File No. 1-12215) and incorporated herein by refere
21	Subsidiaries of Quest Diagnostics Incorporated
23.1	Consent of PricewaterhouseCoopers LLP
23.2	Consent of PricewaterhouseCoopers LLP
99.1	Quest Diagnostics Incorporated and Subsidiaries Selected Historical Finan to Reflect the Two-for-one Stock Split Effective May 31, 2001 (filed as a Company's current report on Form 8-K (Date of Report: May 31, 2001) and i by reference)

Signatures

Pursuant to the requirements of Sections 13 or 15(d) of the Securities

Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Quest Diagnostics Incorporated

By /s/ Kenneth W. Freeman

Kenneth W. Freeman	Chairman of the Board and Chief Executive Officer	February

By /s/ Robert A. Hagemann

Robert A. Hagemann	Vice President and Chief Financial Officer	February

By /s/ Thomas F. Bongiorno

Thomas F. Bongiorno	Vice President Controller and Chief Accounting Officer	February

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and on the dates indicated.

	Capacity	Da
/s/ Kenneth W. Freeman		
Kenneth W. Freeman	Chairman of the Board and Chief Executive Officer	February
/s/ Kenneth D. Brody		
Kenneth D. Brody	Direc	