HEALTHWAYS, INC
Form 10-K
March 16, 2010

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

[X] Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the Fiscal Year Ended December 31, 2009

or

[ ] Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Commission file number 000-19364

HEALTHWAYS, INC.
(Exact name of registrant as specified in its charter)

Delaware	62-1117144
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

701 Cool Springs Boulevard, Franklin, TN 37067
(Address of principal executive offices) (Zip code)

(615) 614-4929
(Registrant's telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common Stock - $.001 par value, and related Preferred Stock Purchase Rights	The NASDAQ Stock Market LLC

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
Yes ¨ No x

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act.
Yes ¨ No x

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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 such 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 ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Yes ¨ No ¨

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 the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non- accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ¨ Accelerated filer x Non-accelerated filer ¨ Smaller reporting company ¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).

Yes ¨ No x

As of June 30, 2009, the last business day of the registrant's most recently completed second fiscal quarter, the aggregate market value of the shares held by non-affiliates of the registrant was approximately $443.0 million based on the price at which the shares were last sold for such date on The NASDAQ Stock Market.

As of March 5, 2010, 34,023,510 shares of Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the Annual Meeting of Stockholders to be held May 28, 2010 are incorporated by reference into Part III of this Form 10-K.

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PART I.

Item 1. Business

Founded in 1981, Healthways, Inc. provides specialized, comprehensive solutions to help people improve physical, emotional and social well-being, reducing both direct healthcare costs and costs associated with the loss of health-related employee productivity.

We provide highly specific and personalized interventions for each individual in a population, irrespective of health status, age or payor. Our evidence-based health, prevention and well-being services are made available to consumers via phone, direct mail, the Internet, face-to-face consultations and venue-based interactions.

In North America, our customers include health plans, governments, employers, pharmacy benefit managers, and hospitals in all 50 states, the District of Columbia and Puerto Rico. We also provide health improvement programs and services in Germany, Brazil and Australia. We operate care enhancement and coaching centers worldwide staffed with licensed health professionals. Our fitness center network encompasses more than 15,000 U.S. locations. We also maintain an extensive network of over 37,000 complementary and alternative medicine and chiropractic practitioners, which offers convenient access to the significant number of individuals who seek health services outside of the traditional healthcare system.

Our guiding philosophy and approach to market is predicated on the fundamental belief that healthier people cost less and are more productive. As described more fully below, our programs are designed to help keep healthy individuals healthy, mitigate and delay the progression to disease associated with family or lifestyle risk factors, and optimize care for those who are already affected by health conditions or disease.

First, our programs are designed to help keep healthy people healthy by:

- fostering wellness and disease prevention through total population screening, health risk assessments and supportive interventions; and
- providing access to health improvement programs, such as fitness, weight management, and complementary and alternative medicine.

Our prevention programs focus on education, physical fitness, health coaching, behavior change techniques and support, and evidence-based interventions to drive adherence to proven standards of care, medication regimens and physicians' plans of care. We believe this approach optimizes the health status of member populations and reduces the short- and long-term direct healthcare costs for participants, including costs associated with the loss of health-related employee productivity.

Second, our programs are designed to drive healthy behaviors and mitigate lifestyle risk by:

- promoting the reduction of lifestyle behaviors that lead to poor health or chronic conditions; and
- providing educational materials and personal interactions with highly trained nurses and other healthcare professionals to create and sustain healthier behaviors for those individuals at-risk or in the early stages of chronic conditions.

We enable our customers to engage everyone in their covered populations through specific interventions that are sensitive to each individual's health risks and needs. Our products are designed to motivate people to make positive lifestyle changes and accomplish individual goals, such as increasing physical activity for seniors through the Healthways SilverSneakers® fitness program or overcoming nicotine addiction through the QuitNet® on-line smoking cessation community.

Finally, our programs are designed to optimize care for those with existing conditions or disease by:

- incorporating the latest, evidence-based clinical guidelines into interventions to optimize patient health outcomes;
- developing care support plans and motivating members to set attainable goals for themselves;
- providing local market resources to address acute episodic interventions;
- coordinating members' care with their healthcare providers;
- providing software licensing and management consulting in support of well-being improvement services; and
- providing high-risk care management for members at risk for hospitalization due to complex conditions.

Our approach is to use proprietary, analytic models to identify individuals who are likely to incur future high costs without intervention, including those who have specific gaps in care that can be addressed to reduce disease progression and medical spending.

We recognize that each individual plays a variety of roles in his or her pursuit of health, often simultaneously. By providing the full spectrum of services to meet each individual's needs, we believe our interventions can be delivered at scale and in a manner that reflects those unique needs over time. We believe creating real and sustainable behavior change generates measurable, long-term cost savings and improved business performance.

Change in Fiscal Year

In August 2008, our Board of Directors approved a change in our fiscal year-end from August 31 to December 31. Accordingly, our 2009 fiscal year began on January 1, 2009 following a four-month transition period ended December 31, 2008. References herein to fiscal 2009 refer to the year ended December 31, 2009; references herein to fiscal 2008 and fiscal 2007 refer to the years ended August 31, 2008 and 2007, respectively.

Customer Contracts

Contract Terms

We generally determine our contract fees by multiplying a contractually negotiated rate per member per month ("PMPM") by the number of members covered by our services during the month. We typically set the PMPM rates during contract negotiations with customers based on the value we expect our programs to create and a sharing of that value between the customer and the Company. In addition, some of our services, such as the SilverSneakers fitness program, are billed on a fee for service basis.

Our contracts with health plans generally range from three to five years with provisions for subsequent renewal; contracts with self-insured employers, either directly or through their health plans or pharmacy benefit manager, typically have one to three-year terms. Some of our contracts allow the customer to terminate early.

Some of our contracts provide that a portion (up to 100%) of our fees may be refundable to the customer ("performance-based") if our programs do not achieve, when compared to a baseline year, a targeted percentage reduction in the customer's healthcare costs and selected clinical and/or other criteria that focus on improving the health of the members. Approximately 4% of revenues recorded during fiscal 2009 were performance-based and were subject to final reconciliation as of December 31, 2009. We anticipate that this percentage will fluctuate due to the level of performance-based fees in new contracts and the timing and amount of revenue recognition associated with performance-based fees. Some contracts also provide opportunities for us to receive incentive bonuses in excess of the contractual PMPM rate if we exceed contractual performance targets.

Technology

Our solutions require sophisticated analytical, data management, Internet and computer-telephony solutions based on state-of-the-art technology. These solutions help us deliver our services to large populations within our customer base. Our predictive modeling capabilities allow us to identify and stratify those participants who are most at risk for an adverse health event. We incorporate behavior-change science with consumer-friendly interactions such as face-to-face, telephonic, print materials and web portals to facilitate consumer preferences for engagement and convenience. We use sophisticated data analytical and reporting solutions to validate the impact of our programs on clinical and financial outcomes. We continue to invest heavily in technology and are continually expanding and improving our proprietary clinical, data management, and reporting systems to continue to meet the information management requirements of our services. The behavior change techniques incorporated in our technology identify an individual's readiness to change and provide personalized support through appropriate messaging and convenient venues to motivate and sustain healthy behaviors.

Domestic Commercial Billed Lives and Domestic Commercial Available Lives

The number of domestic commercial available lives and domestic commercial billed lives as of December 31, 2009 and August 31, 2008 were as follows:

(In 000s)	December 31, 2009	August 31, 2008
Available lives(1)	196,700	192,500
Billed lives	36,000	31,700

(1) Estimated based on the Atlantic Information Services, Inc. (AIS) Directory of Health Plans and publicly available information.

Backlog

Backlog represents the estimated annualized revenue at target performance for business awarded but not yet started at December 31, 2009. Annualized revenue in backlog as of December 31, 2009 and August 31, 2008 was as follows:

(In 000s)	December 31, 2009	August 31, 2008
Annualized revenue in backlog	$ 32,400	$ 13,600

Demand for our services from self-insured employer accounts, which generally begin their benefit year on January 1, has historically resulted in a disproportionate amount of our new business beginning on this date.

Business Strategy

The World Health Organization defines health as "…not only the absence of infirmity and disease, but also a state of physical, mental, and social well-being."

Our business strategy reflects our passion to enhance health and well-being, and as a result, reduce overall costs and improve workforce engagement, yielding better business performance for our customers. Our programs are designed to:

- keep healthy individuals healthy;
- mitigate and delay the progression of disease associated with family or lifestyle risk factors; and
- optimize care for those who are already affected by health conditions or disease.

Through our solutions, we work to optimize the health and well-being of entire populations, one person at a time, domestically and internationally, thereby creating value by reducing overall costs and improving productivity for individuals, families, health plans, governments and employers.

We believe it is critical to impact an entire population's underlying health status and well-being in a long-term, cost effective way. Believing that what gets measured gets acted upon, in January 2008, we entered into an exclusive, 25-year relationship with Gallup to provide a national, daily pulse of individual and collective well-being. The Gallup-Healthways Well-Being IndexTM is the result of a unique partnership in well-being measurement and research that is based on surveys of 1,000 Americans every day, seven days a week. Under the agreement, Gallup evaluates and reports on the well-being of individuals of countries, states and communities; Healthways provides similar services for companies, families and individuals.

To improve measurements like the Well-Being Index and thus enhance health and well-being within their respective populations, our current and prospective customers require solutions that focus on the underlying drivers of healthcare demand, address worsening health status, reverse or slow unsustainable cost trends, foster healthy behaviors, mitigate health risks, and manage chronic conditions. Our strategy is to deliver programs that engage individuals and help them enhance their health status and well-being regardless of their starting point. We believe we can achieve health and well-being improvements in a population and generate significant cost savings and increases in productivity by providing effective programs that support the individual throughout his or her health journey.

We are adding and enhancing solutions to extend our reach and effectiveness and to meet increasing demand for integrated solutions. The flexibility of our programs allows customers to provide those services they deem appropriate for their organizations. Customers may select from certain single program options up to a total-population approach, in which all members of a customer's population are eligible to receive benefits.

Our strategy includes as a priority the ongoing development of an order-of-magnitude increase in our value proposition through, most recently, the introduction of our WholeHealth solution. This solution, in addition to improving health and reducing direct healthcare costs, targets a much larger improvement in employer profitability by lowering the costs of lost productivity due to health-related reasons. With the success of our WholeHealth solution, we expect to gain an even greater competitive advantage in responding to employers' needs for a healthier, higher-performing and less costly workforce.

Our strategy also includes the further enhancement of our proprietary next generation technology platform known as Embrace. This platform, which is essential to our WholeHealth solution, enables us to integrate data from all the healthcare and other entities interacting with an individual. Embrace enables the

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delivery of our integrated solutions and ongoing communications between the individual and his/her medical and health experts, using any method desired, including venue-based face-to-face; print; phone; mobile and remote devices; on-line; emerging modalities; and any combination thereof.

We plan to increase our competitive advantage in delivering our services by leveraging our scalable, state-of-the-art call centers, medical information content, behavior change processes and techniques, strategic relationships, health provider networks, fitness center relationships, and proprietary technologies and techniques. We anticipate we will continue to enhance, expand and further integrate capabilities, pursue opportunities in domestic government and international markets, and enhance our information technology support. We may add some of these new capabilities and technologies through internal development, strategic alliances with other entities and/or through selective acquisitions or investments.

Segment and Major Customer Information

We have one reportable segment, well-being improvement services. During fiscal 2009, CIGNA HealthCare, Inc. comprised approximately 19% of our revenues. No other customer accounted for 10% or more of our revenues in fiscal 2009.

Competition

The healthcare industry is highly competitive and subject to continual change in the manner in which services are provided. Other entities, whose financial, research, staff, and marketing resources may exceed our resources, are marketing a variety of well-being improvement services and other services to health plans and self-insured employers, or have announced an intention to offer such services. These entities include disease management companies, health and wellness companies, retail drug stores, major pharmaceutical companies, health plans, healthcare organizations, providers, pharmacy benefit management companies, medical device and diagnostic companies, healthcare information technology companies, web-based medical content companies, and other entities that provide services to health plans and self-insured employers.

We believe we have advantages over our competitors because of the breadth and depth of our well-being improvement capabilities, state-of-the-art call center technology linked to our proprietary information technology, predictive modeling capabilities, behavior-change techniques, the comprehensive recruitment, pre-testing and training of our clinical colleagues, our experienced management team, the comprehensive clinical nature of our product offerings, our established reputation for providing well-being improvement services to members with health risks or chronic diseases, and the proven financial and clinical outcomes of our programs; however, we cannot assure you that we can compete effectively with other companies such as those noted above.

Consolidation has been, and may continue to be, an important factor in all aspects of the healthcare industry, including the well-being and health management sector. While we believe the size of our membership base provides us with the economies of scale to compete even in a consolidating market, we cannot assure you that we can effectively compete with companies formed as a result of industry consolidation or that we can retain existing health plan customers if they are acquired by other health plans which already have or are not interested in our programs.

Governmental Regulation

Governmental regulation impacts us in a number of ways in addition to those regulatory risks presented under the “Risk Factors” below.

While many of the governmental and regulatory requirements affecting healthcare delivery generally do not directly affect us, our customers must comply with a variety of regulations including the licensing and

reimbursement requirements of federal, state and local agencies and the requirements of municipal building codes and health codes. Certain of our services, including health service utilization management and certain claims payment functions, require licensure by government agencies. We are subject to a variety of legal requirements in order to obtain and maintain such licenses.

Certain of our professional healthcare employees, such as nurses, must comply with individual licensing requirements. All of our healthcare professionals who are subject to licensing requirements are licensed in the state in which they are physically present, such as the professionals located at a call center. Multiple state licensing requirements for healthcare professionals who provide services telephonically over state lines may require some of our healthcare professionals to be licensed in more than one state. We continually monitor legislative, regulatory and judicial developments in telemedicine in order to stay in compliance with state and federal laws; however, new agency interpretations, federal or state legislation or regulations, or judicial decisions could increase the requirement for multi-state licensing of all call center health professionals, which would increase our costs of services.

Changes in laws governing reimbursement to health plans providing services under governmental programs such as Medicare and Medicaid may affect us. Legislative and regulatory bodies may continue to reduce the funding of the Medicare and Medicaid programs in an effort to reduce overall federal healthcare spending. These changes, healthcare reform efforts, future legislative initiatives, and/or government regulation could adversely affect our operations or reduce the demand for our services.

Federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") extensively restrict the use and disclosure of individually-identifiable health information by health plans, most healthcare providers, and certain other entities (collectively, "covered entities"). Federal security regulations issued pursuant to HIPAA require covered entities to implement and maintain administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic individually-identifiable health information. We are required to comply with certain aspects of the HIPAA privacy and security regulations as a result of the American Recovery and Reinvestment Act of 2009 ("ARRA") and our customer contracts. Under ARRA we may be subject to civil and criminal penalties for violations of the regulations. In addition ARRA significantly increased the civil penalties for violations, with penalties of up to $50,000 per violation for a maximum civil penalty of $1.5 million in a calendar year for violations of the same requirement. In addition, we are contractually obligated to comply with any applicable state laws or regulations related to privacy that are more restrictive than the federal privacy regulations. We may also be directly subject to state requirements related to the confidentiality and security of confidential personal information. In the event of a data breach involving individually identifiable information, we are subject to contractual obligations and state and federal requirements that may require us to notify our customers or individuals affected by the breach. These requirements may also require us or our customers to notify regulatory agencies and the media of the data breach.

Further, the healthcare industry is highly regulated at the federal and state levels. For example, federal law contains various prohibitions related to false statements and false claims, some of which apply to private payors as well as federal programs. Actions may be brought under the federal False Claims Act by the government as well as by private individuals, known as "whistle blowers," who are permitted to share in any settlement or judgment.

When a private party brings an action under the whistleblower provisions of the False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination of whether it will intervene and take a lead in the litigation. There are many potential bases for liability under the False Claims Act. Although liability under the False Claims Act arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term "knowingly" broadly. Thus, although simple negligence generally will not give rise to liability under the False Claims Act,

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submitting a claim with reckless disregard for its truth or falsity can constitute "knowingly" submitting a claim. In some cases, whistleblowers, the federal government, and some courts have taken the position that entities who allegedly have violated other statutes, such as the "fraud and abuse" provisions of the Social Security Act, have thereby submitted false claims under the False Claims Act. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the False Claims Act by, among other things, creating liability for knowingly or improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. From time to time, participants in the healthcare industry, including our company, may be subject to actions under the False Claims Act, and it is not possible to predict the impact of such actions. As discussed under Item 3: "Legal Proceedings", we were subject to a "whistle blower" action filed in June 1994 on behalf of the United States government by a former employee whom we dismissed in February 1994. This lawsuit was settled effective April 1, 2009.

Employees

As of March 8, 2010, we had approximately 3,000 employees. Our employees are not subject to any collective bargaining agreements. We believe we have a good relationship with our employees.

Available Information

Our Internet address is www.healthways.com. We make available free of charge, on or through our Internet website, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

Item 1A. Risk Factors

In the execution of our business strategy, our operations and financial condition are subject to certain risks. A summary of certain material risks is provided below, and you should take such risks into account in evaluating any investment decision involving our company. This section does not describe all risks applicable to us and is intended only as a summary of certain material factors that could impact our operations in the industry in which we operate. Other sections of this Annual Report on Form 10-K contain additional information concerning these and other risks.

We depend on payments from customers, and cost reduction pressure on these entities may adversely affect our business and results of operations.

The healthcare industry in which we operate currently faces significant cost reduction pressures as a result of increased competition, constrained revenues from governmental and private revenue sources, increasing underlying medical care costs, and general economic conditions. We believe that these pressures will continue and possibly intensify.

We believe that our solutions, which are geared to foster wellness and disease prevention and provide access to health improvement programs, specifically assist our customers in controlling the high costs of healthcare; however, the pressures to reduce costs in the short term may negatively affect our ability to sign and/or retain contracts under existing terms or to restructure these contracts on terms that would not have a material negative impact on our results of operations. These financial pressures could have a negative impact on our results of operations.

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A significant percentage of our revenues is derived from health plan customers.

A significant percentage of our revenues is derived from health plan customers. The health plan industry continues to undergo a period of consolidation, and we cannot assure you that we will be able to retain health plan customers if they are acquired by other health plans which already have or are not interested in our programs. In addition, a reduction in the number of covered lives enrolled with our health plan customers or a decision by our health plan customers to take programs in-house could adversely affect our results of operations. As discussed below, the uncertainty surrounding healthcare reform may cause our health plan customers or prospective customers to reduce or delay the purchase of our services.

We currently derive a large percentage of our revenues from one customer. The loss of, or the restructuring of a contract with, this or other large customers could have a material adverse effect on our business and results of operations.

Because of the size of its membership and the number of programs purchased from us, CIGNA HealthCare, Inc. comprised approximately 19% of our revenues in fiscal 2009. Our contract with CIGNA continues into 2013. No other customer accounted for 10% or more of our revenues in fiscal 2009.

Our industry is a continually evolving segment of the healthcare industry.

The rapidly growing industry in which we operate is a continually evolving segment of the overall healthcare industry with many entrants marketing various services and products labeled as wellness and prevention, disease management, health management, health support and care support. Companies have used the generic labels of wellness, prevention, disease management and/or health management to characterize a wide range of activities, from the sale of medical supplies and drugs to demand management services. Because the industry is continually evolving, purchasers of these services have not had significant experience purchasing, evaluating or monitoring the new products and services which are being developed, which generally results in a lengthy sales cycle for new contracts. As the industry matures, the number of programs that customers have been purchasing has generally expanded from one or two programs to a more comprehensive suite of programs. These changes result in a sizable contract commitment that generally requires approval from the customer’s executive management, thus elongating the sales process in some cases.

Our business strategy is dependent in part on developing new and additional products to complement our existing services, as well as establishing additional distribution channels through which we may offer our products and services.

Our strategy focuses on keeping healthy people healthy, mitigating and delaying the progression of disease associated with family or lifestyle risk factors, and optimizing care for those who are already affected by health conditions or disease. While we have considerable experience in solutions with a broad range of medical conditions, any new or modified programs will involve inherent risks of execution, such as our ability to implement our programs within expected timelines or cost estimates; our ability to obtain adequate financing to provide the capital that may be necessary to support our operations and to support or guarantee our performance under new contracts; and our ability to deliver outcomes on any new products or services. In addition, as part of our business strategy, we may enter into relationships, such as our strategic relationship with Medco Health Solutions, Inc., to establish additional distribution channels through which we may offer our products and services. As we offer products through new or alternative distribution channels, we may face difficulties, such as potential customer overlap that may lead to pricing conflicts, which may adversely affect our business.

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Our inability to meet or exceed the targets under our customer contracts could have a material adverse effect on our business and results of operations.

Our ability to grow and expand our business is contingent upon our ability to achieve desired financial savings, clinical performance targets, and productivity improvement under our existing contracts and to favorably resolve contract billing and interpretation issues with our customers. Unusual and unforeseen patterns of healthcare utilization by individuals with diabetes, cardiac, respiratory and/or other diseases or conditions for which we provide services could adversely affect our ability to achieve desired financial savings and clinical outcomes.

We depend on the timely receipt of accurate data from our customers and our accurate analysis of such data.

Identifying which members are eligible to receive our services and measuring our performance under our contracts are highly dependent upon the timely receipt of accurate data from our customers and our accurate analysis of such data. Data acquisition, data quality control and data analysis are complex processes that carry a risk of untimely, incomplete or inaccurate data from our customers or flawed analysis of such data, which could have a material adverse impact on our ability to recognize revenues.

Certain customer contracts are performance-based, and all or a portion of our fees may be refundable if certain performance targets are not achieved.

Certain customer contracts provide that all or a portion of our fees may be refundable to the customer if our programs do not achieve targeted savings performance. There is no guarantee that we will effect the necessary cost savings and clinical outcomes improvements under our contracts within the time frames contemplated and reach mutual agreement with customers with respect to cost savings. In addition, our ability to provide financial guidance with respect to performance-based contracts is contingent upon our ability to accurately forecast performance and the timing of revenue recognition under the terms of our contracts ahead of data collection and reconciliation.

Our ability to recognize estimated annualized revenue in backlog is based on certain estimates.

Our ability to recognize estimated annualized revenue in backlog in the manner and within the timeframe we expect is based on certain estimates regarding the implementation of our services. We cannot assure you that the amounts in backlog will ultimately result in revenues in the manner and within the timeframe we expect.