HEALTHWAYS, INC
Form 10-Q
July 10, 2008
UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

x Quarterly Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the Quarterly Period Ended May 31, 2008

or

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

For the transition period from _____ to _____

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)

3841 Green Hills Village Drive, Nashville, TN 37215
(Former name, former address and former fiscal year, if changed since last report)

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 o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer x Accelerated filer o Non-accelerated filer o

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

Yes o No x

As of July 3, 2008 there were outstanding 33,587,978 shares of the Registrant's Common Stock, par value $.001 per share.

Healthways, Inc.

Form 10-Q

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Part I

Item 1. Financial Statements

HEALTHWAYS, INC.

CONSOLIDATED BALANCE SHEETS

(In thousands)

(Unaudited)

ASSETS

	May 31, 2008	August 31, 2007
Current assets:		
Cash and cash equivalents	$ 17,836	$ 47,655
Accounts receivable, net	121,412	80,201
Prepaid expenses	9,115	10,370
Other current assets	4,813	4,319
Income taxes receivable	—	1,741
Deferred tax asset	7,554	7,145
Total current assets	160,730	151,431
Property and equipment:		
Leasehold improvements	34,422	19,268
Computer equipment and related software	127,909	87,843
Furniture and office equipment	28,036	20,435
Capital projects in process	14,266	12,336
	204,633	139,882
Less accumulated depreciation	(94,952)	(81,160)
	109,681	58,722
Long-term deferred tax asset	8,045	—
Other assets	17,995	15,609
Customer contracts, net	36,333	41,777
Other intangible assets, net	73,635	77,722
Goodwill, net	484,178	483,584

Total assets	$ 890,597	$ 828,845

See accompanying notes to the consolidated financial statements.

HEALTHWAYS, INC.

CONSOLIDATED BALANCE SHEETS

(In thousands, except share and per share data)

(Unaudited)

LIABILITIES AND STOCKHOLDERS' EQUITY

	May 31, 2008	August 31, 2007
Current liabilities:		
Accounts payable	$ 13,942	$ 13,630
Accrued salaries and benefits	27,616	18,960
Accrued liabilities	23,499	22,146
Deferred revenue	8,032	7,918
Contract billings in excess of earned revenue	74,873	72,829
Income taxes payable	17,692	—
Current portion of long-term debt	3,446	2,213
Current portion of long-term liabilities	3,901	2,943
Total current liabilities	173,001	140,639
Long-term debt	350,905	297,059
Long-term deferred tax liability	—	14,009
Other long-term liabilities	33,973	14,388
Stockholders' equity:		
Preferred stock		
$.001 par value, 5,000,000 shares		
authorized, none outstanding	—	—
Common stock		
$.001 par value, 120,000,000 and 75,000,000 shares authorized,		
33,571,928 and 35,606,482 shares outstanding	34	35
Additional paid-in capital	202,884	188,126
Retained earnings	130,568	174,641
Accumulated other comprehensive loss	(768)	(52)
Total stockholders' equity	332,718	362,750
Total liabilities and stockholders' equity	$ 890,597	$ 828,845

See accompanying notes to the consolidated financial statements.

HEALTHWAYS, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except earnings per share data)
(Unaudited)

	Three Months Ended May 31,		Nine Months Ended May 31,	
	2008	**2007**	**2008**	**2007**
Revenues	$ 191,439	$ 167,900	$ 546,225	$ 445,236
Cost of services (exclusive of depreciation and amortization of $9,290, $7,330, $24,575, and $20,423, respectively, included below)	129,014	115,697	378,557	302,266
Selling, general & administrative expenses	20,474	18,931	54,168	47,990
Depreciation and amortization	12,990	10,139	34,053	27,225
Operating income	28,961	23,133	79,447	67,755
Interest expense	5,237	5,988	15,572	12,534
Income before income taxes	23,724	17,145	63,875	55,221
Income tax expense	9,750	6,353	26,264	21,571
Net income	$ 13,974	$ 10,792	$ 37,611	$ 33,650
Earnings per share:				
Basic	$ 0.40	$ 0.31	$ 1.06	$ 0. 96
Diluted	$ 0.39	$ 0.29	$ 1.01	$ 0.91
Weighted average common shares and equivalents:				
Basic	34,593	35,133	35,444	34,907
Diluted	35,971	37,070	37,196	36,855

See accompanying notes to the consolidated financial statements.

HEALTHWAYS, INC.

CONSOLIDATED STATEMENT OF CHANGES IN STOCKHOLDERS' EQUITY

For the Nine Months Ended May 31, 2008

(In thousands)

(Unaudited)

	Preferred Stock	Common Stock	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total
Balance, August 31, 2007	$—	$35	$188,126	$174,641	$(52)	$362,750
Cumulative effect of change in accounting principle – adoption of FIN 48	—	—	—	(687)	—	(687)
Comprehensive income:						
Net income	—	—	—	37,611	—	37,611
Net change in fair value of interest rate swaps, net of income taxes of $845	—	—	—	—	(1,203)	(1,203)
Foreign currency translation adjustment	—	—	—	—	487	487
Total comprehensive income						36,895
Exercise of stock options	—	1	6,151	—	—	6,152
Repurchases of common stock	—	(2)	(13,341)	(80,997)	—	(94,340)
Tax benefit of option exercises	—	—	9,747	—	—	9,747
Share-based employee compensation expense	—	—	12,201	—	—	12,201
Balance, May 31, 2008	$—	$34	$202,884	$130,568	$(768)	$332,718

See accompanying notes to the consolidated financial statements.

HEALTHWAYS, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)

(Unaudited)

	Nine Months Ended May 31,	
	2008	**2007**
Cash flows from operating activities:		
Net income	**$** 37,611	$ 33,650
Adjustments to reconcile net income to net cash provided by operating activities, net of business acquisitions:		
Depreciation and amortization	34,053	27,225
Amortization of deferred loan costs	874	697
Share-based employee compensation expense	12,201	12,546
Excess tax benefits from share-based payment arrangements	(9,367)	(7,257)
Increase in accounts receivable, net	(41,230)	(7,641)
Decrease (increase) in other current assets	4,266	(4,841)
Decrease in accounts payable	(1,869)	(212)
Increase (decrease) in accrued salaries and benefits	8,656	(18,007)
Increase in other current liabilities	24,568	37,690
Deferred income taxes	(11,068)	(8,157)
Other	13,902	4,071
(Increase) decrease in other assets	(1,356)	1,732
Payments on other long-term liabilities	(1,972)	(1, 247)
Net cash flows provided by operating activities	69,269	70,249
Cash flows from investing activities:		
Acquisition of property and equipment	(70,682)	(19,864)
Acquisitions, net of cash acquired	(358)	(466,979)
Purchase of investment	—	(9,047)
Other, net	(2,439)	(13)
Net cash flows used in investing activities	(73,479)	(495,903)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	85,420	350,000
Deferred loan costs	—	(4,357)
Proceeds from sale of unregistered common stock	—	5,000
Repurchases of common stock	(94,340)	—
Excess tax benefits from share-based payment arrangements	9,367	7,257
Payments of long-term debt	(32,208)	(30,641)
Exercise of stock options	6,152	5,224
Net cash flows (used in) provided by financing activities	(25,609)	332,483
Net decrease in cash and cash equivalents	(29,819)	(93,171)

Cash and cash equivalents, beginning of period	47,655	154,792
Cash and cash equivalents, end of period	$ 17,836	$ 61,621

See accompanying notes to the consolidated financial statements.

HEALTHWAYS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

(1) Interim Financial Reporting

The accompanying consolidated financial statements of Healthways, Inc. and its wholly-owned subsidiaries for the three and nine months ended May 31, 2008 and 2007 are unaudited. However, in our opinion, the consolidated financial statements reflect all adjustments consisting of normal, recurring accruals necessary for a fair presentation. We have reclassified certain items in prior periods to conform to current classifications.

We have omitted certain financial information that is normally included in financial statements prepared in accordance with accounting principles generally accepted in the United States but that is not required for interim reporting purposes. You should read the accompanying consolidated financial statements in conjunction with the financial statements and notes thereto included in our Annual Report on Form 10-K for the fiscal year ended August 31, 2007.

(2) Recently Issued Accounting Standards

Fair Value Measurement

In September 2006 the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards ("SFAS") No. 157, "Fair Value Measurement," which provides guidance for using fair value to measure assets and liabilities, including a fair value hierarchy that prioritizes the information used to develop fair value assumptions. It also requires expanded disclosure about the extent to which companies measure assets and liabilities at fair value, the information used to measure fair value, and the effect of fair value measurements on earnings. The standard applies whenever other standards require (or permit) assets or liabilities to be measured at fair value and does not expand the use of fair value in any new circumstances. SFAS No. 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years.

In February 2008, the FASB issued FASB Staff Position ("FSP") FAS No. 157-2, "Effective Date of FASB Statement No. 157", which defers by one year the effective date of the provisions of SFAS No. 157 for non-recurring, nonfinancial assets and nonfinancial liabilities to fiscal years beginning after November 15, 2008. We do not expect the adoption of SFAS No. 157 to have a material impact on our financial position or results of operations.

Business Combinations

In December 2007, the FASB issued SFAS No. 141(R), "Business Combinations". This statement expands the definition of a business and a business combination and generally requires the acquiring entity to recognize all of the assets and liabilities of the acquired business, regardless of the percentage ownership acquired, at their fair values. It also requires that contingent consideration and certain acquired contingencies be recorded at fair value on the acquisition date and that acquisition costs generally be expensed as incurred.

SFAS No. 141(R) is effective for fiscal years beginning after December 15, 2008. We have not yet completed our analysis of the impact that the implementation of SFAS No. 141(R) will have on our results of operations or financial condition.

Accounting for Uncertainty in Income Taxes

On September 1, 2007, we adopted the provisions of FASB Interpretation ("FIN") No. 48, "Accounting for Uncertainty in Income Taxes - an interpretation of FASB Statement No. 109". FIN No. 48 creates a single model to address uncertainty in income tax positions by prescribing the minimum recognition threshold a tax position is required to meet before being recognized in the financial statements. It also provides guidance on derecognition of income tax assets and liabilities, classification of current and deferred income tax assets and liabilities, accounting for interest and penalties associated with tax positions, and income tax disclosures. See Note 4 for further discussion of the impact of the adoption of FIN No. 48.

(3) Share-Based Compensation

We have several shareholder-approved stock incentive plans for employees and directors. We currently have three types of share-based awards outstanding under these plans: stock options, restricted stock, and restricted stock units. We believe that such awards align the interests of our employees and directors with those of our stockholders. We account for share-based compensation in accordance with SFAS No. 123(R), "Share-Based Payment." For the three and nine months ended May 31, 2008, we recognized share-based compensation costs of $4.2 million and $12.2 million, respectively. For the three and nine months ended May 31, 2007, we recognized share-based compensation costs of $4.3 million and $12.5 million, respectively.

In October 2007, we granted annual equity awards, including stock options and restricted stock units, for fiscal 2007 performance. A summary of our stock options as of May 31, 2008 and changes during the nine months then ended is presented below:

Options	Shares (000s)	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term	Aggregate Intrinsic Value ($000s)
Outstanding at September 1, 2007	5,245	$ 22.46		
Granted	592	49.96		
Exercised	(580)	10.98		
Forfeited or expired	(148)	38.71		
Outstanding at May 31, 2008	5,109	$ 26.49	5.06	$ 53,837
Exercisable at May 31, 2008	2,563	$ 13.29	4.40	$ 49,158

The weighted-average grant-date fair value of options granted during the three and nine months ended May 31, 2008 was $14.89 and $23.12, respectively.

The following table shows a summary of our restricted stock and restricted stock units ("nonvested shares") as of May 31, 2008 as well as activity during the nine months then ended:

Nonvested Shares	Shares (000s)	Weighted-Average Grant Date Fair Value
Nonvested at September 1, 2007	364	$ 43.76
Granted	168	51.81
Vested	(1)	34.84
Forfeited	(31)	46.73
Nonvested at May 31, 2008	500	$ 46.31

(4) Income Taxes

We adopted the provisions of FIN No. 48 on September 1, 2007. FIN No. 48 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. FIN No. 48 also provides guidance on derecognition, classification, interest and penalties, accounting for interim periods, disclosure and transition.

Adopting FIN No. 48 had the following impact on our financial statements: increased other long-term liabilities by $11.9 million; decreased our income taxes payable by $0.2 million; decreased long-term deferred tax liabilities by $11.0 million; and decreased our retained earnings by $0.7 million. As of September 1, 2007, we had $11.1 million of unrecognized tax benefits of which $0.4 million, if recognized, would affect our effective tax rate. Our policy is to include interest and penalties related to unrecognized tax benefits in income tax expense. As of September 1, 2007, we had accrued interest related to uncertain tax positions of $0.8 million on our balance sheet. During the nine months ended May 31, 2008, we included approximately $0.4 million of interest as a component of income tax expense.

As a result of an amendment to our Cooperative Agreement with the Centers for Medicare & Medicaid Services (“CMS”), during the quarter ended May 31, 2008 we changed our expectation for the timing of the recognition into taxable income of certain funds received from CMS. Based upon this change, we have reclassified approximately $8.0 million of the long-term liability established upon adoption of FIN No. 48 to a current tax liability and expect it to be paid in fiscal 2008.

We file income tax returns in the U.S. Federal jurisdiction and in various state and foreign jurisdictions. Tax years remaining subject to examination in these jurisdictions include 2004 to present. We are currently under audit by the Internal Revenue Service for our 2005 tax year.

(5) Derivative Investments and Hedging Activities

SFAS No. 133, “Accounting for Derivative Investments and Hedging Activities,” as amended, establishes accounting and reporting standards for derivative instruments, including certain derivative instruments embedded in other contracts, and for hedging activities. It requires companies to record all derivatives at estimated fair value as either assets or liabilities on the balance sheet and to recognize the unrealized gains and losses, the treatment of which depends on whether the derivative is designated as a hedging instrument.

As a result of our international initiatives, we are exposed to foreign currency exchange rate risks. A significant portion of these risks is economically hedged with currency options and forward contracts in order to minimize our exposure to fluctuations in foreign currency exchange rates. Principal currencies hedged include the Euro and British pound. These derivative instruments serve as economic hedges and

do not qualify for hedge accounting treatment under SFAS No. 133. Accordingly, they require current period mark-to-market accounting, with any change in fair value being recorded each period in the statement of operations. We record the fair market value of our foreign currency derivatives as other current assets or accrued liabilities. We routinely monitor our foreign currency exposures to maximize the overall effectiveness of our foreign currency hedge positions.

We currently maintain six interest rate swap agreements to reduce our exposure to interest rate fluctuations on our floating rate debt commitments. Under these interest rate swap agreements, the interest rate is fixed with respect to specified amounts of notional principal. The swaps are accounted for in accordance with SFAS No. 133 and were designated at their inception as qualifying cash flow hedges; thus, they are recorded at estimated fair value in the balance sheet, with changes in fair value being reported in other comprehensive income. The fair values of the swaps at May 31, 2008 of $1.9 million and ($4.3) million have been reported in other assets and other long-term liabilities, respectively, with an offset, net of tax, included in accumulated other comprehensive loss in the consolidated balance sheet.

(6) Long-Term Debt

On December 1, 2006, we entered into a Third Amended and Restated Revolving Credit and Term Loan Agreement (the “Third Amended Credit Agreement”). The Third Amended Credit Agreement provides us with a $400.0 million revolving credit facility, including a swingline sub facility of $10.0 million and a $75.0 million sub facility for letters of credit, a $200.0 million term loan facility, and an uncommitted incremental accordion facility of $200.0 million. As of May 31, 2008, availability under our revolving credit facility totaled $242.9 million.

Revolving advances under the Third Amended Credit Agreement generally bear interest, at our option, at 1) LIBOR plus a spread of 0.875% to 1.750% or 2) the greater of the federal funds rate plus 0.5%, or the prime rate, plus a spread of 0.000% to 0.250%. Term loan borrowings bear interest, at our option, at 1) LIBOR plus 1.50% or 2) the greater of the federal funds rate plus 0.5%, or the prime rate. The Third Amended Credit Agreement also provides for a fee ranging between 0.150% and 0.300% of unused commitments. The Third Amended Credit Agreement is secured by guarantees from most of the Company’s domestic subsidiaries and by security interests in substantially all of the Company’s and such subsidiaries’ assets.

We are required to repay outstanding revolving loans on the revolving commitment termination date, which is December 1, 2011. We are required to repay term loans in quarterly principal installments aggregating $0.5 million each, which commenced on March 31, 2007, and the entire unpaid principal balance of the term loans is due and payable at maturity on December 1, 2013.

The Third Amended Credit Agreement contains various financial covenants, which require us to maintain, as defined, ratios or levels of (i) total funded debt to EBITDA, (ii) fixed charge coverage, and (iii) net worth. It also restricts the payment of dividends and limits the amount of repurchases of the Company’s common stock. As of May 31, 2008, we are currently a party to the following interest rate swap agreements for which we receive a variable rate of interest based on the three-month LIBOR and for which we pay the following fixed rates of interest plus a spread of 0.875% to 1.750% on revolving advances and a spread of 1.50% on term loan borrowings:

Swap #	Notional Amount in ($000's)	Fixed Interest Rate	Termination Date	
1	$230,000	4.995%	March 31, 2010	(1)
2	40,000	3.987%	December 31, 2009	
3	40,000	3.433%	December 30, 2011	
4	50,000	3.688%	December 30, 2011	(2)
5	40,000	3.855%	December 30, 2011	(3)
6	30,000	3.760%	March 30, 2011	(4)

(1) The principal value of this swap agreement amortizes over a 39-month period.

(2) This swap agreement becomes effective April 1, 2009.

(3) This swap agreement becomes effective October 1, 2009.

(4) This swap agreement becomes effective January 2, 2010.

We currently believe that we meet the hedge accounting criteria under SFAS No. 133 in accounting for these interest rate swap agreements.

(7) Commitments and Contingencies

Pursuant to an earn-out agreement executed in connection with the acquisition of certain assets of Health IQ in June 2005, we are obligated to pay the former stockholders of Health IQ additional purchase price equal to a percentage of revenues recognized from Health IQ's programs in each of the fiscal quarters during the three-year period ending August 31, 2008.

In June 1994, a former employee whom we dismissed in February 1994 filed a "whistle blower" action on behalf of the United States government. Subsequent to its review of this case, the federal government determined not to intervene in the litigation. The employee sued Healthways, Inc. and our wholly-owned subsidiary, American Healthways Services, Inc. ("AHSI"), as well as certain named and unnamed medical directors and one named client hospital, West Paces Medical Center ("WPMC"), and other unnamed client hospitals.

Healthways, Inc. has since been dismissed as a defendant; however, the case is still pending against AHSI before the United States District Court for the District of Columbia. In addition, WPMC has settled claims filed against it as part of a larger settlement agreement that WPMC's parent organization, HCA Inc., reached with the United States government. The plaintiff has also dismissed its claims against the medical directors with prejudice, and on February 7, 2007 the court granted the plaintiff's motion and dismissed all claims against all named medical directors.

The complaint alleges that AHSI, the client hospitals and the medical directors violated the federal False Claims Act by entering into certain arrangements that allegedly violated the federal anti-kickback statute and provisions of the Social Security Act prohibiting physician self-referrals. Although no specific monetary damage has been claimed, the plaintiff, on behalf of the federal government, seeks treble damages plus civil penalties and attorneys' fees. The plaintiff also has requested an award of 30% of any judgment plus expenses.

In the action by the former employee, discovery is complete but no trial date has been set. The parties have had initial discussions regarding their respective positions in the case; however, no resolution of this case has been reached or can be assured prior to the case proceeding to trial.

In a related matter, in February 2006, WPMC filed an arbitration claim seeking indemnification from us for certain costs and expenses incurred by it in connection with the case. In the action by WPMC, initial arbitration proceedings were commenced during the third quarter of fiscal 2006. During September 2007, the parties to this matter agreed to place the arbitration on hold for an indefinite period.

We believe that we have conducted our operations in full compliance with applicable statutory requirements and that we have meritorious defenses to the claims made in the case and the related arbitration proceeding, and intend to contest the claims vigorously. Nevertheless, it is possible that resolution of these legal matters could have a material adverse effect on our consolidated results of operations in a particular financial reporting period. We believe that we will continue to incur legal expenses associated with the defense of these matters which may be material to our consolidated results of operations in a particular financial reporting period. However, we believe that any resolution of this case and all related matters will not have a material effect on our liquidity or financial condition. As these matters are subject to inherent uncertainties, management s view of these matters may change in the future.

We are also subject to other claims and suits that arise from time to time in the ordinary course of our business.

(8) Comprehensive Income

Comprehensive income, net of income taxes, was $16.2 million and $11.5 million for the three months ended May 31, 2008 and 2007, respectively, and $36.9 million and $34.3 million for the nine months ended May 31, 2008 and 2007, respectively.

(9) Share Repurchases

The following table contains information for shares of our Common Stock that we repurchased during the third quarter of fiscal 2008:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)	Maximum Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
March 1 through 31	519,743	$34.14	738,781	$71,984,005

April 1 through 30	2,002,705	$35.94	2,741,486	—
May 1 through 31	—	—	2,741,486	—
Total	2,522,448			

(1) All share repurchases between March 1, 2008 and May 31, 2008 were made pursuant to a share repurchase program authorized by the Company's Board of Directors and publicly announced on July 5, 2007, which allows for the repurchase of up to $100 million of our common stock from time to time in the open market or in privately negotiated transactions through July 5, 2009.

(10) Earnings Per Share

The following is a reconciliation of the numerator and denominator of basic and diluted earnings per share for the three and nine months ended May 31, 2008 and 2007:

(In 000s, except per share data)	**Three Months Ended May 31, 2008**	**Three Months Ended May 31, 2007**	**Nine Months Ended May 31, 2008**	**Nine Months Ended May 31, 2007**
Numerator:				
Net income - numerator for basic earnings per share	$13,974	$10,792	$37,611	$33,650
Denominator:				
Shares used for basic earnings per share	34,593	35,133	35,444	34,907
Effect of dilutive stock options and restricted stock units outstanding:				
Non-qualified stock options	1,245	1,863	1,615	1,893
Restricted stock units	133	74	137	55
Shares used for diluted earnings per share	35,971	37,070	37, 196	36,855
Earnings per share:				
Basic	$0.40	$0.31	$1.06	$0.96
Diluted	$0.39	$0.29	$1.01	$0.91
Dilutive securities outstanding not included in the computation of earnings per share because their effect is antidilutive:	1,857	1,160	909	1,113

(11) Subsequent Events

Beginning on June 5, 2008, Healthways and its Chairman, Chief Executive Officer and Chief Financial Officer (collectively, the “Class Action Defendants”) were named as defendants in two purported class actions filed in the U.S. District Court for the Middle District of Tennessee, Nashville Division (the “Class Action Complaints”). The Class Action Complaints seek monetary damages on behalf of persons who purchased the Company’s common stock between October 17, 2007 and February 26, 2008 (the “Proposed Class Period”). These suits allege claims for violations of Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 related to certain disclosures made by Healthways during the Proposed Class Period regarding its results of operations, business and prospects. Discovery in these cases has not yet commenced and no trial dates have been set.

Also, on June 27, 2008, a shareholder filed a shareholder's derivative action purportedly on behalf of Healthways in the Chancery Court for the State of Tennessee, Twentieth Judicial District, Davidson County, against all of Healthways’ directors and certain of its officers. This action is based upon substantially the same facts alleged in the Class Action Complaint described above. The plaintiff shareholder is seeking to recover damages in an unspecified amount and equitable and/or injunctive relief. Discovery in the case has not yet commenced and no trial date has been set.

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Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

Overview

Founded in 1981, Healthways, Inc. (the "Company") provides specialized, comprehensive Health and Care Support℠ solutions to help people maintain or improve their health and, as a result, reduce both direct healthcare costs and the costs of health-related lost productivity.

Designed to provide highly specific and personalized interventions for each individual in a population, irrespective of health status, age, or payor, our evidence-based services are made available to consumers by phone, mail, internet, and face-to-face interactions. To expand our Health Support offerings, on December 1, 2006, we acquired Axia Health Management, Inc. ("Axia"), a national provider of health and wellness programs.

We deliver our programs to customers, which include health plans, governments, employers, and hospitals, in all 50 states, the District of Columbia, and Puerto Rico. We began delivering our Health and Care Support programs in Germany and Brazil in January 2008 and June 2008, respectively. Our services include:

- fostering wellness and disease prevention through total population screening, health risk assessments, and supportive interventions;
- providing access to health improvement programs such as fitness, weight management, complementary and alternative medicine and smoking cessation;
- promoting the reduction of lifestyle behaviors that lead to poor health or chronic conditions;
- providing educational materials and personal interactions with highly trained nurses and other healthcare professionals that are designed to create and sustain healthier behaviors to members with chronic conditions;
- incorporating current 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; and
- coordinating members' care with their healthcare providers.

Our programs focus on prevention, education, physical fitness, health coaching, behavior change and evidence-based interventions to drive adherence to proven standards of care, medication regimens and physicians' plans of care. The programs are designed to support better health and assist in providing more effective care, which we believe will optimize the health status of member populations and reduce both the short-term and long-term direct healthcare costs for participants, including the costs of health-related lost productivity.

Health and Care Support services enable health plans and employers to reach and engage everyone in their covered populations through interventions that are both sensitive to and specific to each individual's health risks and needs. Health Support products are designed to motivate people to make positive lifestyle changes and accomplish individual goals, such as becoming more physically active through the Healthways SilverSneakers® Fitness Program, staying fit using on-line tools and a vast network of fitness centers, and quitting smoking through an on-line

smoking cessation community, QuitNet®. The Care Support product line includes programs for people with chronic diseases or persistent conditions, including diabetes, coronary artery disease, heart failure, asthma, chronic obstructive pulmonary disease, end-stage renal disease, cancer, chronic kidney disease, depression, high-risk obesity, metabolic syndrome, acid-related stomach disorders, atrial fibrillation, decubitus ulcer, fibromyalgia, hepatitis C, inflammatory bowel disease, irritable bowel syndrome, low-back pain, osteoarthritis, osteoporosis, and urinary incontinence. We also provide high-risk care management through our StatusOne® product for members at risk for hospitalization due to complex conditions. We believe that creating real and sustainable behavior change generates measurable long-term cost savings.

Predicated on the fundamental belief that healthier people cost less and are more productive, Healthways' programs are designed to help keep healthy individuals healthy, mitigate and delay the progression to disease associated with family or lifestyle risk factors, and promote the best possible health habits for those who are already affected by disease. At the same time, 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 Health and Care Support services to meet each individual's needs, we believe that our interventions can be delivered both at scale and in a manner that reflects the unique needs of each consumer over time. Further, Healthways' extensive and fully accredited complementary and alternative provider network offers convenient access to the significant number of individuals who seek health services outside of the traditional healthcare system.

Highlights of Performance for the Three and Nine Months Ended May 31, 2008

- Revenues for the three months ended May 31, 2008 increased 14.0% over the three months ended May 31, 2007. Revenues for the nine months ended May 31, 2008, which included nine months of operations related to the acquisition of Axia on December 1, 2006, increased 22.7% over the nine months ended May 31, 2007.
- Net income for the three months ended May 31, 2008 increased 29.5% over the three months ended May 31, 2007. Net income for the nine months ended May 31, 2008, which included nine months of operations related to the acquisition of Axia, increased 11.8% over the nine months ended May 31, 2007.

Forward-Looking Statements

Management's Discussion and Analysis of Financial Condition and Results of Operations contains forward-looking statements, which are based upon current expectations and involve a number of risks and uncertainties. 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 like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "p "continue." In order for us to usethe "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995, we caution you that the following important factors, among others, may affect these forward-looking statements. Consequently, actual operations and results may differ materially from those expressed in the forward-looking statements. The important factors include but are not limited to:

- our ability to sign and implement new contracts for Health and Care Support solutions;
- our ability to accurately forecast performance and the timing of revenue recognition under the terms of our contracts with customers and/or our Cooperative Agreement with the CMS ahead of data collection and reconciliation in order to provide forward-looking guidance;

- the effect of any new or proposed legislation, regulations and interpretations relating to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, including the potential expansion to Phase II for Medicare Health Support programs and any legislative or regulatory changes with respect to Medicare Advantage;
- our ability to effect the financial, clinical, and satisfaction outcomes under our Cooperative Agreement with CMS and reach mutual agreement with CMS with respect to results necessary to achieve success under Phase I of Medicare Health Support;
- our ability to anticipate the rate of market acceptance of Health and Care Support solutions and the individual market dynamics in potential international markets;
- our ability to accurately forecast the costs necessary to implement our strategy of establishing a presence in international markets;
- the risks associated with foreign currency exchange rate fluctuations and our ability to hedge against such fluctuations;
- the potential adverse effects of additional regulatory requirements imposed by foreign governments and other regulatory bodies;
- our ability to effectively manage any growth that we might experience;
- our ability to retain existing health plan customers if they decide to take programs in-house or are acquired by other health plans which already have or are not interested in Health and Care Support programs;
- the risks associated with a significant concentration of our revenues with a limited number of customers;
- our ability to effect cost savings and clinical outcomes improvements under Health and Care Support contracts and reach mutual agreement with customers with respect to cost savings, or to effect such savings and improvements within the time frames contemplated by us;
- our ability to achieve estimated annualized revenue in backlog in the manner and within the timeframe we expect, which is based on certain estimates regarding the implementation of our services;
- our ability and/or the ability of our customers to enroll participants in our Health and Care Support programs in a manner and within the timeframe anticipated by us;
- our ability to collect contractually earned performance incentive bonuses;
- the ability of our customers and/or CMS to provide timely and accurate data that is essential to the operation and measurement of our performance under the terms of our contracts;
- our ability to favorably resolve contract billing and interpretation issues with our customers;
- our ability to service our debt and make principal and interest payments as those payments become due;
- our ability to integrate the operations and technology platforms of Axia and other acquired businesses or technologies into our business;
- our ability to develop new products and deliver outcomes on those products, including those anticipated from our strategic relationship with Medco, Inc.;
- our ability to effectively integrate new technologies and approaches, such as those encompassed in our Health and Care Support initiatives or otherwise licensed or acquired by us, into our Health and Care Support platform;
- our ability to renew and/or maintain contracts with our customers under existing terms or restructure these contracts on terms that would not have a material negative impact on our results of operations;

- our ability to implement our Health and Care Support strategy within expected cost estimates;
- our ability to obtain adequate financing to provide the capital that may be necessary to support the growth of our operations and to support or guarantee our performance under new contracts;
- unusual and unforeseen patterns of healthcare utilization by individuals with diabetes, cardiac, respiratory and/or other diseases or conditions for which we provide services;
- the ability of our customers to maintain the number of covered lives enrolled in the plans during the terms of our agreements;
- our ability to attract and/or retain and effectively manage the employees required to implement our agreements;
- the impact of litigation involving us and/or our subsidiaries;
- the impact of future state, federal and international health care and other applicable legislation and regulations on our ability to deliver our services and on the financial health of our customers and their willingness to purchase our services;
- current geopolitical turmoil and the continuing threat of domestic or international terrorism;
- general worldwide and domestic economic conditions and stock market volatility; and
- other risks detailed in our other filings with the Securities and Exchange Commission.

We undertake no obligation to update or revise any such forward-looking statements.

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 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, typically have one-year terms. Some 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 the nine months ended May 31, 2008 were performance-based and were subject to final reconciliation as of May 31, 2008. We anticipate that this percentage will fluctuate due to the level of performance-based fees in new contracts, revenue recognition associated with performance-based fees, and the timing of data reconciliation, which varies according to contract terms. A limited number of contracts also provide opportunities for us to receive incentive bonuses in excess of the contractual PMPM rate if we exceed contractual performance targets.

We are currently participating in a Medicare Health Support pilot awarded under the Chronic Care Improvement Program authorized by the Medicare Modernization Act of 2003. The

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pilot is scheduled to terminate on July 31, 2008. We began operating this pilot in August 2005 to serve 20,000 Medicare fee-for-service beneficiaries in Maryland and the District of Columbia. All fees under this pilot are performance-based. The pilot is for complex diabetes and congestive heart failure disease management services and, while operationally similar to our programs for commercial and Medicare Advantage health plan populations, has been modified for the special needs and conditions of this population. In addition, we began serving 20,000 beneficiaries in Georgia in September 2005 in collaboration with CIGNA HealthCare, Inc ("CIGNA"). CIGNA terminated its Chronic Care Improvement Program Cooperative Agreement with CMS effective January 14, 2008. The majority of our fees under our contract with CIGNA were performance-based.

In June 2006, we signed an amendment to our cooperative agreement with CMS for our Medicare Health Support stand-alone pilot in Maryland and the District of Columbia, which, among other things, enabled us to provide congestive heart failure programs to approximately 4,500 additional Medicare fee-for-service beneficiaries for two years beginning on August 1, 2006 (the "refresh population"). All fees for the refresh population are performance-based.

Technology

Our customer contracts require sophisticated analytical, data management, Internet and computer-telephony solutions based on state-of-the-art technology. These solutions help us deliver Health and Care Support 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 Health and Care Support services.

Contract Revenues

Our contract revenues depend on the contractual terms we establish and maintain with customers to provide Health and Care Support services to their members. Some contracts allow the customer to terminate early. Restructurings and possible terminations at, or prior to, renewal could have a material negative impact on our results of operations and financial condition.

Approximately 19% and 20% of our revenues for the three and nine months ended May 31, 2008 were derived from one customer. The loss of this customer or any other large customer or a reduction in the profitability of a contract with any large customer would have a material negative impact on our results of operations, cash flows, and financial condition.

Domestic Commercial Billed Lives and Domestic Commercial Available Lives

The number of domestic commercial available lives and domestic commercial billed lives as of May 31, 2008 and 2007 were as follows:

(In 000s)	May 31, 2008	May 31, 2007
Domestic commercial available lives[1]	189,400	187,400
Domestic commercial billed lives	28,900	27,100

[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 May 31, 2008. Annualized revenue in backlog as of May 31, 2008 and 2007 was as follows:

(In 000s)	May 31, 2008	May 31, 2007
Annualized revenue in backlog	$ 13,774	$ 22,871

Our Health and Care support services with self-insured employer accounts are primarily contracted through the Administrative Services Only (ASO) line of business with our health plan customers, in which our health plan customers do not assume medical cost risk but provide, among other services, administrative claim and health network access services. Signed contracts between these self-insured employers and our health plan customers are incorporated in our contracts with our health plan customers, and these program-eligible members are included in the domestic commercial available and billed lives or in the annualized revenue in backlog reported in the table above, as appropriate.

Business Strategy

Our primary strategy is to optimize the health of entire populations, as well as the quality and affordability of healthcare, through our Health and Care Support solutions both domestically and internationally, thereby creating value for individuals, health plans, governments, and employers. We plan to continue using our scalable state-of-the-art call centers, medical information content, behavior change processes and techniques, strategic relationships, health provider networks and proprietary technologies to gain a competitive advantage in delivering our Health and Care Support services.

We continue to see increasing demand for integrated Health and Care Support solutions from self-insured employers. As a result, we expect to continue adding and enhancing solutions to extend our reach and effectiveness for entire populations. The flexibility of our programs allows customers to enter the Health and Care Support market at the level of services that they deem appropriate for their organization. Customers may select from a single Health or Care Support program to a total-population approach, in which all members of the customer’s population are eligible to receive the benefit of our programs.

We deliver programs that engage consumers in their health. We believe that we can achieve health improvements and generate significant cost savings and productivity improvements by addressing consumer and customer needs for effective programs that support the individual throughout his or her lifetime.

We anticipate that we will continue to enhance, expand and further integrate our Health and Care Support 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.

Critical Accounting Policies

We describe our accounting policies in Note 1of the Notes to the Consolidated Financial Statements included in our Annual Report on Form 10-K for the fiscal year ended August 31, 2007. We prepare the consolidated financial statements in conformity with U.S. generally accepted accounting principles, which require us to make estimates and judgments that affect the

reported amounts of assets and liabilities and related disclosures at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

We believe the following accounting policies are the most critical in understanding the estimates and judgments that are involved in preparing our financial statements and the uncertainties that could impact our results of operations, financial condition and cash flows.

Revenue Recognition

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 are billed on a fee for service basis.

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 the nine months ended May 31, 2008 were performance-based and were subject to final reconciliation as of May 31, 2008. We anticipate that this percentage will fluctuate due to the level of performance-based fees in new contracts, revenue recognition associated with performance-based fees, and the timing of data reconciliation, which varies according to contract terms. A limited number of contracts also provide opportunities for us to receive incentive bonuses in excess of the contractual PMPM rate if we exceed contractual performance targets.

We generally bill our customers each month for the entire amount of the fees contractually due for the prior month's enrollment, which typically includes the amount, if any, that is performance-based and may be subject to refund should we not meet performance targets. Deferred revenues can arise from contracts which permit upfront billing and collection of fees covering the entire contractual service period, generally 12 months. Contractually, we cannot bill for any incentive bonus until after contract settlement. Fees for service are typically billed in the month after the services are provided.

We recognize revenue as follows: 1) we recognize the fixed portion of PMPM fees and fees for service as revenue during the period we perform our services; 2) we recognizethe performance-based portion of the monthly feesbased on the most recent assessment of our performance, which represents the amount that the customer would legally be obligated to pay if the contract were terminated as of the latest balance sheet date; and 3) we recognizeadditional incentive bonuses based on the most recent assessment of ourperformance, to the extent we considersuch amounts collectible.

We assess our level of performance for our contracts based on medical claims and other data that the customer is contractually required to supply. A minimum of four to six months' of data is typically required for us to measure performance. In assessing our performance, we may include estimates such as medical claims incurred but not reported and a medical cost trend compared to a baseline year. In addition, we may also provide contractual reserves, when appropriate, for billing adjustments at contract reconciliation.

All of the fees under the Medicare Health Support pilot in which we are currently participating are performance-based. Our original cooperative agreement required that, by the end of the third year, we achieve a cumulative net savings (total savings for the intervention population as compared to the control group less fees received from CMS) of 5.0%. Under an amendment to our agreement, we began serving a "refresh population" of approximately 4,500 beneficiaries on August 1, 2006, which is measured as a separate cohort for two years, by the end of which the program is required to achieve a 2.5% cumulative net savings when compared to a new control cohort. In April 2008, we signed an amendment to our Medicare Health Support protocol with CMS, which changed the financial performance target for both the initial cohort and the refresh population to budget neutrality from 5.0% net savings and 2.5% net savings, respectively. Although we receive the medical claims and other data associated with the intervention group under these pilots on a monthly basis, we assess our performance against the control group under these pilots based on quarterly summary performance reports received from CMS' independent financial reconciliation contractor. As of May 31, 2008, contract billings in excess of earned revenue related to the Medicare Health Support pilots totaled $60.8 million.

Ifdata is insufficient or incomplete to measure performance, or interim performance measures indicate that we are not meetingperformance targets, we do not recognize performance-based fees subject to refund as revenues but instead record them in a current liability account entitled "contract billings in excess of earned revenue." Only in the event we do not meet performance levels by the end of the measurement period, typically one year, are we contractually obligated to refund some or all of the performance-based fees. We would only reverse revenues that we had already recognized if performance to date in the measurement period, previously above targeted levels, subsequently dropped below targeted levels. Historically, any such adjustments have been immaterial to our financial condition and results of operations.

During the settlement process under a contract, which generally occurs six to eight months after the end of a contract year, we settle any performance-based fees and reconcile healthcare claims and clinical data. As of May 31, 2008, performance-based fees that have not yet been settled with our customers but that have been recognized as revenue in the current and prior years totaled approximately $44.9 million. Of this amount, $5.3 million was based on calculations which include estimates such as medical claims incurred but not reported and/or the customer's medical cost trend compared to a baseline year, while $39.6 million was based entirely on actual data received from our customers. Data reconciliation differences, for which we provide contractual allowances until we reach agreement with respect to identified issues, can arise between the customer and us due to customer data deficiencies, omissions, and/or data discrepancies.

Performance-related adjustments (including any amounts recorded as revenue that were ultimately refunded), changes in estimates, data reconciliation differences, or adjustments to incentive bonuses may cause us to recognize or reverse revenue in a current fiscal year that pertains to services provided during a prior fiscal year. During the nine months ended May 31, 2008, we recognized a net increase in revenue of approximately $1.4 million that related to services provided prior to fiscal 2008.

Impairment of Intangible Assets and Goodwill

In accordance with SFAS No. 142 "Goodwill and Other Intangible Assets," we review goodwill for impairment on an annual basis or more frequently whenever events or circumstances indicate that the carrying value may not be recoverable.

If we determine that the carrying value of goodwill is impaired based upon an impairment review, we calculate any impairment using a fair-value-based goodwill impairment test as required by SFAS No. 142. Fair value is the amount at which the asset could be bought or sold in a current transaction between two willing parties. We estimate fair value using a number of techniques, including quoted market prices or valuations by third parties, present value techniques based on estimates of cash flows, or multiples of earnings or revenues performance measures.

We review intangible assets not subject to amortization on an annual basis or more frequently whenever events or circumstances indicate that the assets might be impaired. We assess the potential impairment of intangible assets subject to amortization whenever events or changes in circumstances indicate that the carrying values may not be recoverable.

If we determine that the carrying value of other identifiable intangible assets may not be recoverable, we calculateany impairmentusing an estimate of the asset's fair value based on the projected net cash flows expected to result from that asset, including eventual disposition.

Future events could cause us to conclude that impairment indicators exist and that goodwill and/or other intangible assets associated with ouracquired businesses are impaired. Any resulting impairment loss could have a material adverse impact on our financial condition and results of operations.

Share-Based Compensation

In accordance with SFAS No. 123(R), we measure and recognize compensation expense for all share-based payment awards based on estimated fair values at the date of grant. Determining the fair value of share-based awards at the grant date requires judgment in developing assumptions, which involve a number of variables. These variables include, but are not limited to, the expected stock price volatility over the term of the awards and expected stock option exercise behavior. In addition, we also use judgment in estimating the number of share-based awards that are expected to be forfeited.

Results of Operations

The following table shows the components of the statements of operations for the three and nine months ended May 31, 2008 and 2007 expressed as a percentage of revenues.

	Three Months Ended May 31,		**Nine Months Ended May 31,**	
	2008	**2007**	**2008**	**2007**
Revenues	100.0 %	100.0 %	100.0 %	100.0 %
Cost of services (exclusive of depreciation and amortization included below)	67.4 %	68.9 %	69.3 %	67.9 %
Selling, general and administrative expenses	10.7 %	11.3 %	9.9 %	10.8 %
Depreciation and amortization	6.8 %	6.0 %	6.2 %	6.1 %

Operating income [1]	15.1	%	13.8	%	14.5	%	15.2	%
Interest expense	2.7	%	3.6	%	2.9	%	2.8	%
Income before income taxes [1]	12.4	%	10.2	%	11.7	%	12.4	%
Income tax expense	5.1	%	3.8	%	4.8	%	4.8	%
Net income	7.3	%	6.4	%	6.9	%	7.6	%

[1] Figures may not add due to rounding.

Revenues

Revenues for the three months ended May 31, 2008 increased $23.5 million, or 14.0%, over revenues for the three months ended May 31, 2007, primarily due to the following:

- $8.3 million due to the commencement of new contracts since the beginning of the third quarter of fiscal 2007;
- $7.0 million due to the addition of new programs or the expansion of existing programs into additional populations with existing customers since the beginning of the third quarter of fiscal 2007;
- $6.5 million due to increased membership in customers' existing programs; and
- $5.2 million from the Medicare Health Support pilot due to the signing of an amendment in April 2008 to our Medicare Health Support protocol with CMS, which changed the financial performance target for both the initial cohort and the refresh population to budget neutrality from 5.0% net savings and 2.5% net savings, respectively, and resulted in revenue recognition based on performance data.

These increases were partially offset by decreases in revenues of $6.9 million primarily due to contract terminations with certain customers as well as incentive bonus revenues related to one customer that were recognized during the three months ended May 31, 2007.

Revenues for the nine months ended May 31, 2008 increased $101.0 million, or 22.7%, over revenues for the nine months ended May 31, 2007 primarily due to the acquisition of Axia on December 1, 2006. The remainder of the increase is primarily due to the following:

- $25.5 million due to increased membership in customers' existing programs; and
- $18.7 million due to the addition of new programs or the expansion of existing programs into additional populations with existing customers since the beginning of fiscal 2007.

These increases were partially offset by decreases in revenues of $20.1 million related to the following: contract terminations with certain customers, a decline in participation associated with a change in the delivery model for one customer, and a reduction in the scope of our services with one customer.

We anticipate that, despite the aforementioned contract terminations and contract scope reductions, revenues for the remainder of fiscal 2008 will increase over fiscal 2007 revenues primarily due to contracts with new customers, additional or expanded programs with existing customers, and increased membership in customers' existing programs since the end of fiscal 2007, as noted above. We further anticipate that our ability to continue to increase revenues year over year will largely depend on our ability to add revenues in a manner and in a timeframe that will

more than offset revenue declines from any contract terminations or reductions in scope of services, such as those noted above.

Cost of Services

Cost of services (excluding depreciation and amortization) as a percentage of revenues decreased to 67.4% for the three months ended May 31, 2008 compared to 68.9% for the three months ended May 31, 2007. The decrease is primarily due to the following:

- decreased costs related to the Medicare Health Support pilot in which we participated in collaboration with CIGNA, which CIGNA terminated effective January 14, 2008;
- decreased integration costs related to the acquisition of Axia; and
- efficiencies related to certain cost management initiatives.

These decreases were partially offset by the following increases in cost of services as a percentage of revenues:

- an increased portion of our revenue growth generated by fitness center programs, which typically have a higher cost of services as a percentage of revenue than our other programs;
- severance costs related to capacity consolidation during the three months ended May 31, 2008; and
- an increase in the level of employee bonus provision during the three months ended May 31, 2008 compared to the three months ended May 31, 2007 based on the Company's year-to-date financial performance against established internal targets during these periods.

Cost of services (excluding depreciation and amortization) as a percentage of revenues for the nine months ended May 31, 2008 increased to 69.3% compared to 67.9% for the nine months ended May 31, 2007. The increase is primarily due to the following:

- an increased portion of our revenue growth generated by fitness center programs, which typically have a higher cost of services as a percentage of revenue than our other programs; and
- costs related to the opening of four new call centers, including the initial operating costs related to hiring and training, as well as the resulting lower capacity utilization during the early months of operations.

These increases were partially offset by decreases in cost of services as a percentage of revenues for the nine months ended May 31, 2008 compared to the nine months ended May 31, 2007, primarily due to decreased costs related to the Medicare Health Support pilot in which we participated in collaboration with CIGNA, which CIGNA terminated effective January 14, 2008.

We anticipate that cost of services for the remainder offiscal 2008 will increase over fiscal 2007 primarily as a result of expenses associated with increases in operating staff required for the increase in demand for our services in fiscal 2008, increases in indirect staff costs associated with the continuing development and implementation of our Health and Care Support services, and increases in information technology and other support staff and costs.

Selling, General and Administrative Expenses

Selling, general and administrative expenses as a percentage of revenues decreased to 10.7% for the three months ended May 31, 2008 compared to 11.3% for the three months ended May 31, 2007, primarily due to the following:

- efficiencies from the integration of the Axia acquisition and a decrease in the related integration costs; and
-