CARESCIENCE INC
Form 10-K
March 26, 2002

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SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

ý **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2001,

or

o **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act Of 1934**
Commission file number: 0-30859

CareScience, Inc.

(Exact Name of Registrant as Specified in its Charter)

Pennsylvania	**23-2703715**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
3600 Market Street, Philadelphia, PA	**19104**
(Address of Principal Executive Offices)	(Zip Code)

(215) 387-9401
(Registrant's Telephone Number, Including Area Code)

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

None

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

Common Stock, no par value

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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. / /

The aggregate market value of voting Common Stock held by non-affiliates of the registrant based on the closing price for the Common Stock on the Nasdaq National Market on March 20, 2002 was approximately $6,214,285. As of March 20, 2002, 13,300,391 shares of Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain sections of the Proxy Statement to be filed in connection with the 2002 Annual Meeting of Shareholders are incorporated by reference into Part III of this Form 10-K Report where indicated.

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PART I

ITEM 1. BUSINESS

Overview

CareScience, Inc. is a provider of online care management services. Our mission is to transform the quality and efficiency of care delivery by providing innovative clinical information technology to the health care industry. We market our solutions to hospitals, health systems and pharmaceutical and biotechnology manufacturers, and support more than 150 customers in 40 states.

We work with health care providers to manage clinical processes surrounding the point of care so that fundamental reductions in errors and operating costs can be achieved. We collect, share, store and analyze clinical data generated by widely used health information systems. We allow customers to apply this data to enhance patient safety and to the management of care, including quality monitoring, practice improvement, credentialing, profiling, error tracking, case management and clinical guidelines. We also provide consulting services to health care providers that support strategic planning and clinical operations.

For the pharmaceutical and biotechnology industry, we provide tools and services that help to shorten the drug development cycle and improve development yield. Our offerings include a suite of Internet-based data analysis tools, consulting services, customized research and strategic development support. These tools and services are aimed at the specialized drug development needs of pharmaceutical industry clinicians, product managers, market strategists, health economists, and outcomes researchers.

We have pioneered and commercialized numerous clinical information technologies. We have developed one of the nation's first online quality measurement and management tools, one of the first clinically based outcome risk assessment algorithms, one of the first health care application service providers, and, most recently, the first peer-to-peer clinical data sharing technology. We have developed these tools in collaboration with leading public organizations, including the Wharton School of Business at the University of Pennsylvania, the National Library of Medicine, Los Alamos National Laboratory and The California HealthCare Foundation.

CareScience was incorporated in 1992 with the purpose of commercializing intellectual property that was developed at the University of Pennsylvania School of Medicine and The Wharton School of Business. In 1993, we exclusively licensed the intellectual property underlying our core technology in a 30-year agreement with the University of Pennsylvania. In 1996, we launched our first Internet-based commercial solution based on this proprietary technology under our Care Management System . In 1999, we initiated our Care Data Exchange™, as well as our Lifecycle Decision System™, which is aimed at the pharmaceutical and biotechnology industries. On March 7, 2000, we changed our name from Care Management Science Corporation to CareScience, Inc.

Industry Background

Clinical Costs are Large and Growing

According to the Centers for Medicare and Medicaid Services, or CMS, annual health care spending in the United States exceeds $1.2 trillion, or 14% of the country's gross domestic product, and is expected to grow to $2.2 trillion by 2008. Current online efforts are primarily seeking to change administrative and financial processes, reduce systems costs, improve cash flow or speed billing and purchasing. Even if successful, these efforts do not address the significant majority of health care spending that results from the cost of clinical diagnosis and treatment. These costs arise from the process of medical decision-making, treatment choice and therapeutic efficacy, and comprise the largest portion of spending in the health care industry. Furthermore, we estimate that hospitals and

pharmaceutical companies spend billions annually to manage treatment decisions and attempt to control clinical costs. As inefficiencies within the health care system consume enormous resources, as well as pose medical risks to consumers, constituents across the health care industry are seeking cost-effective information and tools to improve the quality and efficiency of care delivery.

Concerns about Clinical Quality and Medical Errors are Increasing

The delivery of clinical care usually involves complex procedures, multiple treatments and subjective judgments. Even appropriate clinical decisions are often difficult to implement and analyze because of uncontrolled operational systems. Hospitals and health plans have been seeking to gain control of and measure clinical processes to increase accountability and improve care.

Problems with quality in the health care industry have recently gained attention because of advances in the ability to measure medical errors and complications and increasing concern about clinical care among policy-makers and the public. In addition to being the eighth-leading cause of death in the United States according to the Institute of Medicine's 1999 report "To Err is Human," medical errors add substantial costs to and drive consumer dissatisfaction with the delivery of care. Medical errors and complications result in unnecessary events including emergency room visits, hospitalizations, specialist referrals and laboratory studies, all of which are used to evaluate the errors and manage the consequences they create. We believe that many of the current efforts to reduce administrative waste and improve financial performance do not address the processes that result in clinical inefficiencies. Health care delivery systems, physicians, health plans, the government and employers are seeking information regarding clinical quality and medical errors as well as tools to enhance clinical efficiency. Recently, the Institute of Medicine's 2001 report "Crossing the Quality Chasm: A New Health System for the 21st Century" called for widespread adoption of technology and managerial methods to substantially reduce the occurrence of medical errors and complications.

Health Care Constituents Remain Highly Fragmented

Health care is delivered locally in hundreds of thousands of locations through a complex and fragmented mix of constituents, including:

hospitals, health systems, medical practice groups and other provider organizations;

physicians in solo or small-group practices;

payors, such as insurance companies, managed care organizations, Medicare, Medicaid and employers; and

suppliers, such as clinical laboratories, pharmaceutical companies and other groups that provide tests, drugs, x-rays and other medical supplies and services.

Historically, many of these organizations have tried to improve efficiency, accountability and clinical-process control by horizontally or vertically integrating with other constituents. For example, hospitals acquired physician practices in order to create integrated delivery systems. These efforts have lost favor because these systems were unable to integrate clinical services and establish common goals. Additionally, these efforts highlighted the importance of being able to share clinical, operational and administrative information.

Technological Fragmentation Leads to Inefficient Use of Clinical Data

In order to efficiently deliver care, information must flow within and between health care constituents. For example, to diagnose and treat a patient properly, physicians need access to clinical information such as medical history data, laboratory results, x-rays and prescriptions from various

hospitals, laboratories and other providers. Health care constituents have not historically coordinated their information technology investments due to:

the large number of constituents;

the complexity of health care encounters and transactions;

the cost of deploying technology; and

pervasive concerns about confidentiality of patient information.

This has resulted in the current technology infrastructure in health care being characterized by numerous incompatible and proprietary mainframe and client/server systems that store information in isolated databases using non-standardized formats. Thus, providers must typically request information by phone, fax or patient survey and those requests are frequently delayed due to disparate paper-based systems maintained by most constituents. Furthermore, the lack of timely access to accurate clinical information, particularly in an urgent-care situation, may lead to poor clinical outcomes and excess costs through:

inaccurate diagnoses;

redundant tests; and

enhanced potential for medical errors and clinical complications.

As a result of geographic, organizational and technological fragmentation, current information exchange is often incomplete or redundant, thus creating the need for a comprehensive technology solution.

The Growth of the Internet is Impacting Health Care

The Internet has emerged as the fastest growing communication medium in history. International Data Corporation, an independent research firm, estimates that nearly 1 billion people, about 15% of the world's population, will be using the Internet by the year 2005. The Internet is currently being used to speed and streamline a variety of business transactions. The Internet's open architecture, platform and location independence, scalability and growing acceptance make it an increasingly important medium for the information-intensive and highly transactional health care industry. We believe that many existing solutions fail to provide tools to monitor the care delivery process or improve clinical efficiency. Additional improvements in the ability to search, store, structure, integrate and filter vast amounts of disparate data and to dynamically analyze, customize and display information in contexts relevant to particular users will further increase the usefulness of Internet-based applications to the health care market.

Pharmaceutical and Biotechnology Companies Need Better Information Closer to the Point of Decision

According to a 1994 study by Duke University, seven out of ten commercialized pharmaceutical solutions fail to recoup their development costs. In order to reduce the failures of the drug development and commercialization process better decisions about discovery, research and marketing need to be made. We believe that pharmaceutical and biotechnology companies need access to better clinical information closer to the point of their drug development decisions. Moreover, additional improvements in the ability to analyze and apply information in contexts relevant to pharmaceutical and biotechnology users will further increase the usefulness of Internet-based applications to the health care market.

The CareScience Solution

We are a clinical knowledge company with a mission to inform health care professionals at the point of decision for better quality at the point of care. For providers, we offer care management solutions, data sharing technologies and consulting services. For pharmaceutical and biotechnology companies, we specialize in data analysis, research support, and consulting.

Our range of Internet-based tools for care management, clinical analysis and data exchange are designed with a single goal to improve the quality and efficiency of health care delivery. They help health care professionals:

Access Comprehensive Patient Data More Efficiently. Our technologies provide information to influence diagnostic and treatment decisions by enabling secure information sharing among authorized health care constituents. We believe that health care providers who can access clinical information immediately and securely at the point of care will become the standard-bearers of informed care. Since much information is not currently available at the point of care, we are developing an Internet-based peer-to-peer technology that allows health care organizations to share patient information across locations allowing providers direct access to patient data when and where it is most needed at the point of care. This peer-to-peer technology will provide secure, real-time Internet access to clinical results, patient demographics, medical records and other critical data from the original source.

Analyze Comprehensive Patient Data More Efficiently. Our proprietary scientific methodologies were developed at the University of Pennsylvania School of Medicine and The Wharton School. Our algorithms allow us to normalize clinical information across thousands of parameters using sophisticated statistical analysis and, in conjunction with our online analytic processing technology, provide retrospective as well as predictive evaluation of clinical performance. Unlike benchmarking, which compares performance to designed protocols or averages of broad populations across a limited number of criteria, our algorithms allow users to understand the underlying basis of their clinical performance. For example, when a patient experiences a clinical complication, we can help determine the likelihood that the complication was attributable to the patient's condition, the physician's decisions or the hospital's operations, and for any of these, which specific factors likely contributed to the complication. We believe our solutions provide health care constituents with the most comprehensive, robust and clinically credible tools for clinical-process management.

Apply Clinical Knowledge for Better Health Quality and Reduced Medical Expenses. The collection, standardization and analysis of clinical data is complicated, time intensive and requires specialized capabilities. We believe that very few health care organizations possess these resources or capabilities. Our solutions are designed to collect and analyze comprehensive clinical data in order to improve the delivery of care. As an application service provider, we offer our customers cost-effective access to remotely hosted data supported by sophisticated processing technology and analysis methods. In addition, our consulting for health care providers complements our Internet-based solutions with services for care process improvement, management infrastructure, leadership development and more.

Our Value Proposition

Our value proposition to our customers is based on enabling them to manage their clinical operations using our data-sharing technologies, databases and proprietary clinical algorithms. Our approach identifies clinical inefficiencies and medical errors and thereby offers the opportunity to improve the quality of care and reduce costs. Additionally, we host our customers' clinical data and provide real-time access to that data, which reduces their fixed cost of information technology while increasing reporting flexibility.

Customers gain value from our solutions in three principal areas:

Improving Clinical Processes. Many tests and therapies that are performed on patients do not improve outcomes or may pose undue risk. Moreover, many patients do not receive indicated preventative therapies or are placed at risk during the treatment process. Our solutions enable our customers to strengthen their business performance by improving the quality of care they deliver and avoiding medical errors and unnecessary treatments.

Lowering the Cost of Care Delivery. In hospitals and health systems, our solutions reduce the need for manual data collection and for tracking of clinical events. Our Lifecycle Decision System databases reduce the need for pharmaceutical makers to have specialized in-house staff to manage aspects of the strategic drug development process. Because our solutions are vendor neutral and operate over the Internet, we enable our customers to realize substantial value from their historical investment in legacy systems. In addition, our Care Data Exchange is expected to reduce costs by using a peer-to-peer architecture to provide secure, real-time access to clinical results, patient demographics, medical records and other clinical data from the original source.

Improving the Way Health Care Constituents Interact. Our solutions provide service integration by enabling health care constituents to share relevant clinical information. Our solutions enable hospitals and health systems to provide patient-centric clinical-data access to physicians at the point of care and to share data with other health care entities and patients.

Our Strategy

Our objective is to become the leading provider of Internet-based solutions to facilitate improvements in health care quality and efficiency. The primary components of our strategy include:

Offer Community-based Solutions. Our primary focus is at the community level, where the overwhelming majority of people receive clinical services. Our solutions and services support the key participants in local health care delivery: hospitals, health plans, pharmaceutical and biotechnology companies, physicians and consumers. We offer a comprehensive suite of Internet-based solutions and services that allow different participants in local health care systems to manage their role in care delivery while collaborating with other participants.

Develop New Solutions Based on Our Proprietary Knowledge and Data Assets. We have developed a substantial and rapidly growing proprietary online data asset in a single location and format encompassing millions of care encounters. We maintain proprietary, rigorously validated clinical algorithms. Our data and knowledge bases are unique because of their clinical detail and linkage to ongoing relationships with active customers. We are leveraging our proprietary database to develop and introduce other Internet-based solutions. For example, in the spring of 2001, we introduced our Lifecycle Decision System Query tool to pharmaceutical and biotechnology companies to help users gain insights into and answers about diseases, treatments, outcomes and economic impact.

Cross-sell Solutions. We are developing strong relationships with hospitals, health systems and pharmaceutical companies. We intend to enhance these relationships by developing and selling additional complementary solutions to these customers. While each of our solutions is designed to satisfy the needs of a particular type of customer, customers frequently purchase more than one type of service or enhancements. For example, we believe that hospitals that use our Care Management System to manage clinical processes are more likely to use our Care Data Exchange to exchange clinical data and our Clinical Information Architecture to extract data to facilitate the development of their databases.

Leverage our Technology Platform. Our solutions benefit from a common technology platform, including the architecture, data structures, analytic processing tools, clinical algorithms and

telecommunication protocols. Additionally, our solutions frequently integrate with a variety of other vendors' products or enable direct interactions among those products. By using the Internet and serving as a centralized application service provider, our solution represents a high-value proposition for our customers. Furthermore, since our solutions are technologically intensive and connect disparate industry segments, customers cannot replicate our solutions without incurring substantial costs. For example, we recently announced the Clinical Information Architecture, a state-of-the-art data integration and communication platform that is anticipated to allow the secure transfer of clinical and administrative data from originating source systems or third parties to and from our data center. This new architecture is expected to be available for customer implementation in early 2002 and to shorten implementation times, allow for real-time reporting, more comprehensive data, and ultimately translate into better care and better return on investment for our customers.

Pursue Targeted Strategic Relationships and Acquisitions. We intend to pursue strategic relationships and acquisitions that would bolster our distribution channels in core areas or expand our service offerings to customers. For example, on January 12, 2001, we acquired Strategic Outcomes Services, Inc., a pharmacoeconomic consulting firm based in Research Triangle Park, North Carolina, to expand our consulting services to the pharmaceutical and biotechnology industries and to improve our ability to sell our pharmaceutical and biotechnology solutions and services. We plan to continue to seek targeted partnerships and acquisitions that are consistent with our objective to improve quality and efficiency in health care. In 2001, we also signed distribution agreements with two health care group purchasing organizations, AmeriNet and AllHealth, for the marketing and distribution of the Care Management System and related services.

Solutions and Services

We provide an integrated suite of Internet-based solutions designed to access, analyze and apply clinical information to improve the process of decision surrounding the point of care. Our customers use these solutions to build relationships and to improve the quality and delivery of clinical care. We also provide consulting services to compliment our solutions. To date, we have deployed solutions for both health care providers and for pharmaceutical and biotechnology companies. For health care providers, we currently offer our Care Management System, Free Benchmarking™, Care Data Exchange, National Comparatives™ and consulting services. For pharmaceutical and biotechnology companies, we offer our Lifecycle Decision System and consulting services.

An overview of our solutions and services can be seen in the table below:

Solution or Service	Target Market	Core Function
Care Management System	Hospitals and health systems	Managing clinical efficiency and reduce medical errors using clinical data
Care Data Exchange	All health care participants	Securely exchanging clinical information at the point of care via the Internet
Lifecycle Decision System	Pharmaceutical and biotechnology companies	Managing drug development processes
Free Benchmarking	Hospitals and health systems	Direct hospital-hospital performance comparisons using public data
National Comparatives	Hospitals and health systems	Hospital performance comparisons using de-identified national customer dataset
Consulting for Health Care Providers	Hospitals and health systems	Evaluating organizational processes and management infrastructure

Consulting for Pharmaceutical and Biotechnology Companies	Pharmaceutical and biotechnology companies	Analyzing clinical and economic performance of new pharmaceutical products

Care Management System

The CareScience Care Management System applies cutting-edge analysis methods to help health care provider organizations improve their clinical performance by allowing users to:

identify the underlying causes of high complication rates and clinical performance opportunities;

achieve measurable care process improvement and efficiency gains;

support initiatives for profiling, case management or physician education;

provide easy access to the outcomes information and practice patterns that guide medical management;

automate the process of data gathering, analysis and reporting; and

establish a high-validity, clinically rigorous basis for collaboration between physicians and management.

The Care Management System helps health care provider organizations take advantage of the vast data resources that often remain trapped or underutilized within organizations. The Care Management System's Internet-based interface enables medical officers, clinical analysts, physicians and health care professionals to do their jobs more effectively. In particular, the Care Management System helps:

quickly identify problem areas;

support hypothesis testing about care process or outcome improvement opportunities;

evaluate and test these hypotheses against real data; and

establish likely causes of problems before intervention.

We typically sell the Care Management System pursuant to three- to five-year contracts. Contract pricing is estimated based on a per-encounter basis. Customers typically have unlimited access to data and are supported by an array of telephone and email help, data validation and management, training classes and ad-hoc services.

Features

Some features of the Care Management System are:

Complication Identification: We apply sophisticated disease- and outcome-specific risk adjustment methodologies in the Care Management System to distinguish between new complications and pre-existing conditions.

Continuous-scale Risk Assessment: The Care Management System calculates patient-specific risks for outcomes including mortality, complication frequency, complication morbidity, length of stay, charges and cost.

Integrated Database: We construct an integrated, longitudinal clinical and financial resource detail database for the Care Management System using a health care provider's existing data from its core patient information systems.

Clinical Terminology Service: The Care Management System maps to the National Library of Medicine's Unified Medical Language System to create common coding definitions about tests, therapies, interpretations and related activities across facilities.

Ad-hoc Queries: The Care Management System includes an ad-hoc query feature that allows users to construct questions using "common language" terms.

Care Process Analysis: The Care Management System automatically applies our algorithms to daily resource data and clinical outcomes data for the identification of unique care process pathways by disease and "best practice" within each path.

Free Benchmarking

CareScience's Free Benchmarking service on the Internet helps health care providers understand how their clinical performance compares against risk-adjusted standards drawn from Medicare and all-payor state data, where available. Currently, Free Benchmarking is offered as a service to the health care provider community to generate name awareness, and to drive requests for more information concerning our solutions and services.

Free Benchmarking enables qualified hospitals, physician groups and health systems pinpoint opportunities for improvement across diseases and compare patient mix and outcomes among institutions in a defined local or national marketplace. To better manage these processes, these health care participants need to subscribe to our Care Management System.

Free Benchmarking provides access to publicly available data: MEDPAR files of nationwide Medicare patients and certain state-sponsored inpatient databases. These databases have been risk-adjusted using CareScience's proprietary techniques and include standardized outcomes by ICD-9 principal diagnosis, DRG, MDC and ICD-9 principal procedure for facility benchmarking and comparative screening purposes. Flags highlight diseases where results are significantly better or worse than forecasted performance, to focus attention on high-impact diseases for quality or cost improvement.

National Comparatives

CareScience's soon to be released National Comparatives service on the Internet is anticipated to help health care providers understand how their clinical performance compares against risk-adjusted standards drawn from a de-identified national dataset of Care Management System customers.

National Comparatives lets our Care Management System customers pinpoint opportunities for improvement across diseases and compare patient mix and outcomes in a national marketplace. To better manage these processes, these health care participants need to use our Care Management System.

The National Comparatives database houses data generated from more than one million patient encounters captured in the Care Management System and is growing rapidly. The clinical data housed in the database has been risk-adjusted and the resource data has been standardized to allow for meaningful, accurate comparisons across multiple facilities. The database is updated regularly to provide recent data to its users, and the National Comparatives query tool accommodates very specific, user-defined clinical analyses. It gives users a valid, national patient data sample to use as a benchmark for outcomes and resource comparison at the diagnosis, DRG, and procedure level. And the module offers additional population segment views by physician specialty, admission source, payor, patient age, gender, and discharge disposition.

Care Data Exchange

The Care Data Exchange is a peer-to-peer technology being developed by us, which allows health care organizations to share patient information across locations allowing providers direct access to patient data when and where it is most needed at the point of care. The Care Data Exchange is designed to provide secure, real-time Internet access to patient-centric clinical results, patient demographics, medical records and

other critical data from the original source.

The Care Data Exchange design includes:

- neural net to support probabilistic model for unique patient indexing;
- cross-enterprise and health system participation;
- Internet-based access to indexed patient records;
- plug-and-play technology to interface with existing information systems;
- real-time peer-to-peer data sharing; and
- local control of business relationships and source data.

The Care Data Exchange gives individual health care organizations the ability to store and manage their own data while making it accessible to all authorized users within a designated network. This peer-to-peer approach reduces the cost of data sharing while minimizing the competitive issues surrounding data ownership and access privileges.

Care Data Exchange users are expected to include:

- hospitals and health systems;
- independent physician groups;
- clinics and outpatient facilities;
- labs and ancillary care providers;
- public health agencies;

- health plans and employers; and
- pharmacies.

Assuring that all necessary clinical information is available at the point of care can significantly reduce medical errors, eliminate unnecessary and redundant treatments, and improve the process of health care. Together, the elements of the Care Data Exchange help overcome the financial, competitive, and technical obstacles to building the alliances and data-sharing capabilities necessary to empower caregivers, benefit patients, and protect the autonomy of participating institutions.

We have entered into agreements with other vendors to become our Care Data Exchange partners. As a Care Data Exchange partner, a vendor's Internet solutions can be integrated into the Care Data Exchange peer-to-peer network, enabling a broader range of data-sharing capabilities. In addition, we have partners that offer implementation, integration and support services to optimize the use of the Care Data

Exchange and our other technologies.

The Care Data Exchange is currently under development in Santa Barbara County, California. The full implementation of the Santa Barbara County Care Data Exchange pilot project is expected to lead to availability of complete Care Data Exchange technologies later in 2002. This project is the result of a partnership between us and the California HealthCare Foundation, a non-profit philanthropic organization. Importantly, we are designing the Care Data Exchange to be scalable and capable of being expanded at low marginal cost. Markets for this health care information utility include both communities and health systems.

Consulting for Health Care Providers

Our consulting services complement our Internet-based Care Management System, Free Benchmarking and National Comparatives to offer winning strategies for clinical process management and quality improvement. We are helping health care leaders build customized care management infrastructures that will continuously generate the knowledge necessary to more effectively guide care decisions and meet other top-priority objectives like:

Optimizing the use of the Care Management System;

establishing a formal plan for clinical care management improvement;

discovering the root causes for specific, actual clinical outcomes;

executing a strategic plan for continuous quality and cost improvement;

reducing clinical costs by focusing on the expense of substandard clinical processes; and

planning performance improvement methods that will win the approval of those involved in the care management process.

In addition, we offer our Throughput Optimization Service to aid our customers in identifying and evaluating their care delivery processes in order to improve patient placement and flow, match bed capacity and caregiver skills to expected demand, and enable focused care within each patient unit. Our Throughput Optimization Service provides focused operations methodologies, data, and best practices for allocating clinical services and operating units built around physician, nurse and other caregiver skills.

We also offer consulting services to optimize the implementation, integration and support of the Care Data Exchange and services related to drug formulary optimization.

Lifecycle Decision System

Our Lifecycle Decision System builds upon the proprietary de-identified databases created by our other service lines, and uses this data to answer important development, market-targeting and pricing questions for pharmaceutical and biotechnology companies. The Lifecycle Decision System accelerates organizational decision-making, helping pharmaceutical and biotechnology companies create medications that perform better for patients and the marketplace.

The Lifecycle Decision System provides a combination of proprietary, risk-adjusted data and Internet applications to help pharmaceutical and biotech companies optimize their market access. Customers use our Lifecycle Decision System to help:

identify unmet therapeutic needs;

quantify the efficacy of therapeutic options;

improve the design and execution of clinical trials;

reduce risks and expenses;

analyze clinical data more efficiently;

determine optimal product differentiation and positioning; and

increase the likelihood of achieving economic targets.

We strictly adhere to federal, state and local privacy regulations, identifiable information about patients, physicians and facilities is not available through the Lifecycle Decision System.

Consulting for Pharmaceutical and Biotechnology Companies

Our Consulting Services complement our Internet-based Lifecycle Decision System to deliver the expertise of our clinicians, economists, researchers, programmers and statisticians to help pharmaceutical and biotechnology companies find answers to critical business questions.

Through our consulting services, we:

conduct custom pharmacoeconomic, outcomes and clinical research projects;

perform economic and pricing analyses for internal decision-making and pricing strategies;

develop targeted health outcomes strategies to achieve optimal market access; and

optimize clinical trial design for greater efficiency and effectiveness.

Customers

We have entered into long term relationships with over 150 major hospitals, health systems, health plans and pharmaceutical and biotechnology companies. Representative customers for our solutions and services includes:

Ascension Health;

Borgess Health Alliance;

GlaxoSmithKline plc;

Pharmacia Corp.;

Providence Health System;

Rush System for Health;

Sansum-Santa Barbara Medical Foundation Clinic;

Santa Barbara Regional Health Authority;

Sisters of Mercy Health System;

Tenet Brookwood Medical Center;

The Health Alliance of Greater Cincinnati;

University of Pennsylvania Health System; and

Washington Hospital Center.

The Company's operations are conducted in one business segment and sales are primarily made to health care payors and providers. During the years ended December 31, 2001, 2000 and 1999, we generated 12%, 20% and 21%, respectively, of our revenue from our development partner, the California HealthCare Foundation.

The Company had one and two customers as of December 31, 2001 and 2000, respectively, which accounted for 12% and 29% of total accounts receivable.

Technology

We have developed a core set of shared technologies that underlie all of our solutions. The four major components of these technologies are:

web hosting;

the clinical information architecture; and

clinical data access, analysis and reporting applications.

Each component is briefly described below.

Web Hosting

We operate our own web-hosting technology that provides a complete set of security, monitoring, high-availability servers and large-scale disk storage. Given that our web hosting supports our applications, we operate as an application service provider so that we can rapidly implement and upgrade our solutions at low cost. We provide our customers with an Internet-based environment where computation intensive functions are supported with high security, performance, availability and scalability. All of our applications are accessible through a standard Internet browser. Customer-specific databases are integrated by an analysis layer and a communications layer using a multi-tier server architecture. We maintain security through formal policies and procedures as well as technologies used to protect the integrity of the systems and the confidentiality of the sensitive data they contain. Performance and availability are maintained through a redundant design that allows for

continued operation in the event of failure of individual critical components, as well as automated monitoring to detect failures.

Clinical Information Architecture

We have developed a strategy and supporting technologies that enable the acquisition of data from different source systems. This technology, called the Clinical Information Architecture, is a computer-to-computer interface that uses standard internet protocols, such as HTTPS. The Clinical Information Architecture enables the secure transfer of clinical and administrative data from originating systems to us. The Clinical Information Architecture supports interfacing to a wide variety

of systems that can provide real-time or batch updates to the Care Management System and Care Data Exchange.

The Clinical Information Architecture can collect all required data in an automated, electronic fashion. The Clinical Information Architecture can be customized to fit a particular organization's infrastructure needs by being deployed in one of three primary methods:

Hosted Relay Model A relay interface installed at a customer's site collects the data directly from an integration engine. It then sends the information, via the Internet, to our data center. A secure server validates the inbound data and adds it to the Care Management System database.

Client Software Model A customer integrates the Clinical Information Architecture software into its information systems. This approach is useful in the absence of a fully deployed integration engine. The Clinical Information Architecture software runs on a customer's system, collecting data through a private port. The data is then encrypted and transported via the Internet to us, where a secure server validates it and populates the Care Management System database.

Secure Transfer Model A secure staging server, installed in our data center, accepts the transmission of data files in a batch format. This is useful if a batch extract of data is more practical than a message-based interface.

The Clinical Information Architecture also has a data management utility, which applies a data validation process to all incoming data. As the data is fed through the Clinical Information Architecture, the data management utility checks data for format, content errors, and omissions. The data management utility reports any data issues back to the customer. The data management utility also allows the customer to correct any data errors using a browser-based interface.

Clinical Data Access, Analysis and Reporting Applications

We provide a number of technologies to enable the use of our Care Data Exchange and Care Management System. Each is briefly described below:

Identity Correlation System. The Identity Correlation System is used to identify person-specific identities across an enterprise or community. It consists of a set of neural network algorithms that use a blend of multivariate analysis and weighted values to create new person objects or to match person identities to an existing object. This engine underlies the peer-to-peer tools that support clinical data sharing and can be used to create a single identity for the patients treated in a care management customer.

Clinical Terminology Service. The Clinical Terminology Service assigns all incoming clinical terms to a standard clinical vocabulary based on the National Library of Medicine Unified Medical Language System. This engine allows comparisons of tests and therapies across facilities and application of treatment-specific rules. This engine also supports outbound queries by matching syntactical variants and substitute terms to requested search terms.

Clinical Analysis Service. The Clinical Analysis Service applies the company's statistical and knowledge-base analytic methods to validated clinical data. Examples include: the identification of medical and surgical complications, the assignment of patient-level risk scores for various clinical and economic outcomes, the calculation of treatment norms for resources used in patient care and measurement of the severity of complications that patients incur.

Information Locator Service. The Information Locator Service enables the secure exchange of clinical data between cooperating health-care organizations. This engine stores and accesses metadata, which identifies the location of patient-specific health care data. This

engine manages the requesting,

directing and security process for data sharing. It is designed to be used by or incorporated into authorized third party applications.

Access Control Service. The Access Control Service manages the security and access rules for accessing data from the Care Data Exchange. This engine creates and manages policies determining which users get to see which data for which patient at what time. This engine will be operated in compliance with security regulations required in the Health Insurance Portability and Accountability Act of 1996, as they become known with certainty.

Users and authorized system administrators can access data from our data warehouses or from the Care Data Exchange by using several data access and reporting applications. These are all designed, implemented and operated by us. Each is briefly described below:

Query Applications. Query applications allow health system and pharmaceutical users to access and analyze data stored in our data warehouses. Using our query applications, users perform a variety of operations and tasks on data, including population analysis, time trending, benchmarking, hypothesis testing and performance evaluation.

Workflow Applications. Workflow applications will be used by customers to manage the business processes of patient care. These applications can allow these users to interact with data, merge outside information such as strategy, business process, decision goals, and to progress along pre-determined or customized decision processes.

Access Applications. Access applications are used to support patient care needs by providing patient-specific data access from our clinical data repositories or the Care Data Exchange Information Locator. These applications are platform independent and could also be incorporated into third-party applications. Access applications for patients to review their own data are under development.

Strategic Relationships

We have developed strategic relationships with organizations that supply important inputs into our solutions. We have a long-standing technology transfer relationship with the University of Pennsylvania, from which we have licensed intellectual property and methods. The University and management began this relationship in 1987 and it has grown over time as new methods and properties have been added to our portfolio. From time to time, faculty of the University of Pennsylvania provide informal advice and consultation regarding refinement of our existing methodologies and/or advice regarding potential areas of new development. This informal advice is not material to our results of operations. Dr. David J. Brailer, our Chairman, Chief Executive Officer and a member of our Board of Directors, is an adjunct faculty member of the University of Pennsylvania. The University of Pennsylvania Health System is also a non-material customer of CareScience. Also, the University owns less than one percent of our common stock. The University does not have the ability to direct or influence our operations, except as licensor under the license agreement. We are not aware of any agreements among the University and any other parties, such as other shareholders, to influence our management or operations. We have no agreements with the University, informal or formal, other than a non-material customer agreement and the license agreement.

We entered into our license agreement with the University on July 1, 1993 and amended it effective on April 1, 1995 and May 1, 1997. That agreement expires on March 31, 2025, unless sooner terminated by the University upon our default or sooner terminated by us upon 90 days' notice to the University. Under the license agreement, the University grants a royalty-bearing, worldwide, exclusive license to us for the use of the software code which forms the basis for our technology and the proprietary analytic routines which were used to create the software, as well as the right to sublicense the software, to create derivative works from the software and to enter into end-user agreements with our customers. We pay the University royalties for the license in an amount equal to a percentage of

fees we receive for allowing others to use or to sublicense the technology. We are obligated to pay the University a minimum level of $75,000 per year in royalties, regardless of the fees we collect. If we fail to pay the minimum level of royalty fees every year, the University has the option to convert our exclusive license to a non-exclusive license. The University retains the right to publish the material we license, although the University must notify us in advance of their intention to publish in order that a filing for intellectual property protection of such material may be made. In the event of such publication, to the extent that intellectual property protection is not available for such material, the University

agrees to negotiate with us in good faith as to whether the disclosure can be appropriately modified or withheld, although we do not have a right to prevent any such disclosure. The University has not disclosed any information about the licensed material and, to our knowledge, the University has no plans to do so. Pursuant to the license agreement, we agree to indemnify and hold the University harmless against claims which arise out of the use of the licensed material by us or parties with which we contract.

We have entered into a consulting agreement with California HealthCare Foundation for a term beginning October 1, 1999 until the earlier of September 30, 2002, or the completion of an extensive work plan, unless sooner terminated. The work plan includes the production of a local business model for the Internet-based cooperative sharing of clinical health information that may then be replicated in other localities. The purpose of the agreement is to establish a management office to facilitate the development and maintenance of a care data exchange for the sharing of clinical health care data in Santa Barbara County. Under the terms of the agreement, the Foundation is required to make payments to us upon various milestones, including the receipt and approval of narrative and financial reports, work plans, deliverables and budget projections, which may not exceed a total of approximately $4.6 million. The Foundation owns all intellectual property rights with respect to the project, subject to a license between us and the Foundation described below. Either party may terminate the agreement due to the other's breach that is not cured within 45 days of written notice from the non-breaching party.

We also entered into a license agreement with the Foundation on October 2, 2000. That agreement expires on October 2, 2030, unless sooner terminated by the Foundation upon our default or sooner terminated by us upon 90 days' notice to the Foundation. Under the license agreement, the Foundation grants a royalty-bearing, worldwide, exclusive license to us for the use of the software code which forms the basis for the Care Data Exchange, as well as the right to sublicense the software, to create derivative works from the software and to enter into end-user agreements with our customers. We pay the Foundation royalties for the license in an amount equal to a percentage of fees we receive for allowing others to use or to sublicense the technology. We are obligated to pay the Foundation a minimum level of $41,250, $57,500, $73,750 and $90,000 per year in royalties for the year 2002, 2003, 2004 and 2005 and each year after 2005, respectively, regardless of the fees we collect. If we fail to pay the minimum level of royalty fees every year, the Foundation has the option to convert our exclusive license to a non-exclusive license. Pursuant to the license agreement, we agree to indemnify and hold the Foundation harmless against claims which arise out of the use of the licensed material by us or parties with which we contract.

Marketing and Sales

We sell our solutions and services through a geographically distributed sales force in the health care provider and pharmaceutical and biotechnology markets. We have positioned ourselves as a leader in the provision of Internet-based solutions to improve the quality and efficiency of health care. We market our solutions and services by:

conducting executive education programs aimed at health industry executives;

providing consulting activities aimed at solving important management problems faced by health system executives;

publishing in academic journals and speaking regularly at conferences attended by health industry leaders;

developing a customer service and consulting staff with strong clinical, management and analytic expertise;

leading research about clinical-decision support and other important methodological frontiers; and

advertising in trade publications aimed at health industry executives, clinicians and technicians.

By following this strategy, we have become a preeminent vendor of Internet-based tools designed to improve the quality and efficiency of health care to chief medical officers and other key decision-makers in health systems. These individuals are becoming increasingly prominent in senior management positions and are gaining accountability as medical management becomes essential to health system operations.

We have supplemented our brand awareness with the free distribution of Free Benchmarking. This tool is used by more than 6,000 registrants generating tens of thousands of reports on a monthly basis. Also, we began publicizing the launch of the Santa Barbara Care Data Exchange demonstration project in Santa Barbara County, California, our Clinical Information Architecture and our Lifecycle Decision System

Query tool. These efforts will continue our positioning as an innovator of Internet-based clinical and data exchange solutions.

We have used the Care Management System to build a distribution channel to health care systems and our pharmaceutical consulting services for pharmaceutical makers and biotechnology firms and to leverage our ability to cross-sell our solutions and services in multiple markets. We sell our solutions and services into these sectors through a national sales force of experienced sales executives who manage all aspects of sales and also generate cross selling referrals to other services.

Product Development

We have been a leader in the management of health care quality and efficiency using the Internet by focusing on changes in the analysis and application of information to support patient care. Our technology arose from fundamental research in risk assessment, outcomes measurement, care-process analysis, medical-language processing and data integration and validation at the University of Pennsylvania, beginning in the late 1980s. Researchers have published more than eleven scientific manuscripts about the methodologies underlying our solutions and other publications are underway at this time regarding new advances, which we intend to commercialize in the future.

From this research base, we have built a track record for commercializing significant advances in clinical management and information-sharing solutions. We have accomplished this by nurturing technology transfer-relationships with scientists, from which we can acquire and commercialize new technologies. Our development is coordinated by our research center, which is staffed with our employees and by academic scientists and which can balance the academic needs of scientists with proprietary requirements. Our research center works closely with our engineers to prototype new innovations.

In addition to design of solutions in the laboratory, we refine our solutions in demonstration projects. For example, we tested our Care Management System in a group of health systems, and our consulting services for health care providers in two major health systems before commercialization. We are currently demonstrating our Care Data Exchange in Santa Barbara, California.

Competition

Each of our service lines face different competitors, although we believe that our total solution as a whole has no single competitor. We have few pure Internet-based competitors, but Internet-based competition is increasing and many off-line organizations are adding Internet capabilities. We believe that competition in our industry is based on the performance, utility, price and level of comprehensiveness of solutions and services.

Care Management System. There are no dominant care-management firms serving the hospital or health plan markets, and Internet-based entities have not established a credible base in this market. Rapid growth and the demand for a new generation of care-management tools has opened this market sector to new entrants. Therefore, most Care Management System competition arises from clinical information system companies that offer data warehousing or from benchmarking firms. These clinical information system firms offer large-scale transactional databases and applications, but their current data warehouses do not have clinical analysis methodologies or the ability to change the way that health care constituents interact with each other and with physicians or consumers. These benchmarking firms tend to be administratively oriented and focus on external comparisons rather than the internal management of care.

Care Data Exchange. The Care Data Exchange faces a diverse array of competitors, including consulting firms, technology vendors, and local efforts. Most vendors offer a within enterprise approach rather than allowing customers obtain data beyond their organization. Furthermore, most result reporting solutions mandate the use of a centralized database, which requires redundant stores of proprietary data that are costly and difficult to maintain. Additionally, these solutions and services are aimed primarily at the flow of claims and financial data, rather than clinical data. Large consulting firms have presented plans for new activities in data sharing. However, their core business model is to focus on application implementation, not data sharing. In addition, these consulting firms tend to have long-standing relationships with large hospital information system vendors that prevent them from being vendor-neutral, and they have not yet been able to adapt their value proposition to the Internet.

Lifecycle Decision System. The Lifecycle Decision System competes with contract research organizations and pharmaceutical information companies. Contract research organizations are increasingly offering pharmacoeconomic studies and outcomes research to pharmaceutical companies and directly to the health care market. Pharmaceutical information companies are the largest suppliers of information to the pharmaceutical industry. However, these firms have not focused on market economics or outcomes, and the information provided is generally limited to traditional market research data and analysis. Generally, these firms do not offer complete outsourcing of strategic analysis for drug development. Many of these groups also lack integrated patient-level clinical, laboratory and pharmacy information over time.

Government Regulation

The collection, storage and transmission of personal information about an individual, especially health care information, is extensively regulated by federal and state governmental authorities in the United States. A variety of federal and state laws protect a person's medical records and information as confidential, including the federal Health Insurance Portability and Accountability Act of 1996. In addition, several federal and state privacy laws have strict requirements governing the treatment of particularly sensitive health data, such as information regarding an individual's HIV status, mental health, or substance abuse problems. Widespread access to the Internet, and the high speed at which data is transferred over the Internet, make this medium especially vulnerable to breaches of confidentiality.

As required by the Health Insurance Portability and Accountability Act of 1996, the U.S. Department of Health and Human Services has promulgated final regulations to protect the confidentiality of individually identifiable health information that is stored or transmitted electronically. This information is referred to as "protected health information." The regulations were effective on April 14, 2001 and all affected organizations are required to be compliant by April 14, 2003. The Health Insurance Portability and Accountability Act of 1996 privacy regulation prohibits health care providers, health insurance plans and health care clearinghouses, referred to as "covered entities," from using or disclosing protected health information without the individual's authorization, except as permitted by the proposed regulations. Additionally, the regulation requires a covered entity to protect an individual's medical records from unauthorized disclosure for the life of the individual plus two years after the individual's death.

The regulation also outlines procedures and policies that covered entities must establish regarding the collection, storage and dissemination of protected health information. Finally, the privacy regulation also governs business associates of a covered entity who receive protected health information from a covered entity.

We will be subject to the Health Insurance Portability and Accountability Act of 1996 privacy regulation as a business associate of a covered entity. Over the two years following the effective date of the final regulation, we will need to ensure that our internal policies and procedures meet the requirements of the regulation. We will also need to ensure that our business relationships with persons who share information with us, and with whom we share information, meet the requirements of the regulations. Under the final regulation, in many situations our exchange of protected health information will not require a patient's authorization under the regulation. However, even in these situations we must be very careful to safeguard the information against receipt by persons other than the intended recipient. We will need to implement technical safeguards to ensure that information in our systems can only be accessed by authorized persons. We do not expect to significantly modify our solutions and services or business operations or materially increase our expenses in response to currently proposed regulations.

Two years after the final regulation becomes effective, we will be subject to periodic reviews by the federal government to verify our compliance with the regulations. If we are found not to be in compliance, we may have to pay penalties. Additionally, if we are found to have misused any protected health information, we may face substantial monetary penalties and our management or employees could face imprisonment.

Under the Health Insurance Portability and Accountability Act of 1996, the privacy regulation sets a federal standard for the privacy of protected health information; however, the Health Insurance Portability and Accountability Act of 1996 provides that state medical privacy laws will preempt the federal standard if the state law is not contrary to and is more stringent than the federal standard. Therefore, we will still be subject to provisions of state laws to the extent that they preempt the federal standard. Some state laws establish strict requirements for the maintenance and dissemination of an individual's health records, especially when those records contain particularly sensitive data such as HIV status, mental health information or substance abuse information.

Intellectual Property

We have licensed intellectual property from the University of Pennsylvania and from the California HealthCare Foundation. The intellectual property underlying our online analytic processing software is licensed exclusively to us by the University of Pennsylvania in a 30-year agreement, which include payments by us of royalties or sublicense fees. The intellectual property used in our Care Data Exchange software is licensed exclusively to us by the California HealthCare Foundation in a 30-year

agreement, which include payments by us of royalties or sublicense fees. We consider the technology we own and license to be fundamental to the success of our operations.

We have spent approximately $3.9 million, $4.7 million and $1.5 million in the years ended December 31, 2001, 2000 and 1999, respectively, on research and development activities excluding stock based compensation of $39,000, $78,000 and $20,000, respectively.

We own proprietary software that we have developed and used in our operations which we consider to be trade secrets. In addition, we have filed a patent with the United States Patent and Trademark Office to protect our Care Data Exchange technology.

Employees

As of December 31, 2001, we employed 118 people, including 38 in research and development, 21 in sales and marketing, 43 in professional services and 16 in administration.

ITEM 2. PROPERTIES

Our headquarters and application service provider operations are located in Philadelphia, Pennsylvania, where we lease approximately 21,000 square feet of office space. We also lease approximately 5,000 square feet of office space in San Francisco, California, and approximately 4,000 square feet of office space in Research Triangle Park, North Carolina.

ITEM 3. LEGAL PROCEEDINGS

We and certain of our officers are defendants in a purported shareholder class action lawsuit litigation pending in the United States District Court for the Eastern District of Pennsylvania described below for alleged violations of federal securities laws. Although we cannot predict the ultimate outcome of the case or estimate the range of any potential loss that may be incurred in the litigation, we believe the lawsuits are frivolous and without merit, strenuously deny all allegations of wrongdoing asserted by plaintiffs, and believe we have meritorious defenses to plaintiffs' claims. We intend to vigorously defend the lawsuits.

The class action litigation is the result of several complaints filed with the court beginning on October 17, 2001. These actions were consolidated on November 16, 2001. The court approved the selection of the lead plaintiff in the litigation on March 12, 2002. These complaints purport to bring claims on behalf of all persons who allegedly purchased our common stock between June 29, 2000 and November 1, 2000, for alleged violations of the federal securities laws, including Sections 11, 12(a)(2) and 15 of the Securities Act of 1933 by issuing a materially false and misleading Prospectus and Registration Statement with respect to the initial public offering of our common stock. Specifically, the complaints allege, among other things, that our Prospectus and Registration Statement misrepresented and omitted to disclose material facts concerning two of our prospective products and our planned disposition of the offering proceeds. The actions seek compensatory and other damages, and costs and expenses associated with litigation.

We are not involved in any other legal proceedings that either individually or taken as a whole would have a material adverse effect on our business, financial condition or results of operations.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

No matters were submitted to a vote of security holders during the fourth quarter of the year ended December 31, 2001.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

Price Range of Common Stock

Our common stock is quoted on the Nasdaq National Market System under the symbol CARE. The following table sets forth the range of high and low closing prices of our common stock as reported by the Nasdaq National Market System for each period indicated beginning June 28, 2000, the effective date of our initial public offering:

	Low	High
2000		
Second quarter	$ 10.02	$ 10.56
Third quarter	2.25	9.97
Fourth quarter	0.59	3.13
2001		
First quarter	0.66	1.75
Second quarter	0.69	1.95
Third quarter	1.11	1.78
Fourth quarter	0.98	1.42

Dividend Policy

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund the development and growth of our business. Therefore, we do not anticipate paying any cash dividends in the foreseeable future.

Sales of Unregistered Securities

On January 12, 2001, in connection with the acquisition of Strategic Outcomes Services, Inc., we issued 250,000 shares of our common stock to the 19 shareholders of Strategic Outcomes Services, Inc. Such sales were made in reliance upon the exemption provided by Section 4(2) of the Securities Act for transactions not involving a public offering and/or Rule 701 under the Securities Act.

On June 15, 2001, we issued 259,259 shares of our common stock to seven of our executive officers and three of our directors in a private sale at a price per share equal to the closing price of our common stock on the Nasdaq National Market on that date. Such sales were made in reliance upon the exemption provided by Section 4(2) of the Securities Act for transactions not involving a public offering and/or Rule 701 under the Securities Act.

Use of Proceeds

On June 28, 2000 the Securities and Exchange Commission declared effective our Registration Statement on Form S-1 (File number 333-32376), relating to the initial public offering of our Common Stock, no par value per share. The net offering proceeds to us after total expenses were $43.4 million. As of December 31, 2001, we have used approximately $23.1 million of the net proceeds from our initial public offering of which approximately $11.9 million was used for working capital and other general corporate purposes, including expansion of our sales and marketing efforts as well as development of our solutions and services, approximately $6.5 million was used for dividends on and the redemption of preferred stock, approximately $3.6 million was used for the purchase of property plant and equipment, including technology and equipment expenditures required to support our product development infrastructure and $1.1 million was used for the acquisition of Strategic Outcomes Services, Inc.

ITEM 6. SELECTED FINANCIAL DATA

(in thousands, except per share data)

Our statement of operations data for the years ended December 31, 1999, 2000 and 2001 and the balance sheet data as of December 31, 2000 and 2001 have been derived from our financial statements, which have been audited by Arthur Andersen LLP, independent public accountants, and are included herein. Our statement of operations data for the years ended December 31, 1997 and 1998 and the balance sheet data as of December 31, 1997, 1998 and 1999 have been derived from our financial statements, which have been audited by Arthur Andersen LLP, independent public accountants, and are not included herein. You should read the data set forth below together with Management's Discussion and Analysis of Financial Condition and Results of Operations and the financial statements and related notes contained in this Form 10-K.

	Year Ended December 31,				
	1997	1998	1999	2000	2001
Statement of Operations Data:					
Revenues	$ 1,041	$ 2,552	$ 4,351	$ 7,822	$ 12,478
Cost of revenues(1)	1,494	1,904	2,509	4,645	6,081
Gross profit (loss)	(453)	648	1,842	3,177	6,397
Operating expenses:					
Research and development(2)	1,555	1,669	1,460	4,651	3,908
Selling, general and administrative(3)	2,241	3,169	3,897	9,570	10,788
Stock-based compensation			233	1,347	1,227
Total operating expenses	3,796	4,838	5,590	15,568	15,923
Operating loss	(4,249)	(4,190)	(3,748)	(12,391)	(9,526)
Interest (income) expense, net	47	418	(78)	(1,070)	(931)
Net loss(4)	(4,296)	(4,608)	(3,670)	(11,321)	(8,595)
Preference distribution on preferred stock	&n				