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SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF
THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended
August 31, 1988

Commission file number
0-15846

HEALTHCARE COMPARE CORP. DE
(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of incorporation or organization)

36-3307583
(I.R.S. Employer Identification No.)

3200 Highland Avenue
Downers Grove, Illinois
(Address of principal executive offices)

60515
(Zip Code)

RECD S.E.C.
NOV 29 1988
FEE 07

Registrant's telephone number, including area code: (312) 719-9000

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

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

Common Stock, $.01 par value
(Title of Class)

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 ___

The aggregate market value of voting stock held by non-affiliates of the registrant on November 14, 1988 was approximately $55,070,689. On that date, there were 5,762,541 shares of Common Stock issued and outstanding.

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DOCUMENTS INCORPORATED BY REFERENCE

1988 Annual Report to Stockholders . . . . . Parts I and II

Proxy Statement for the Annual Meeting of
Stockholders scheduled to be held on
January 31, 1989. . . . . Parts I and III

PART I

Item 1. Business.

General

HealthCare COMPARE Corp. (together with its subsidiary hereinafter collectively referred to as the "Registrant" or the "Company") is one of the leading independent providers of health care utilization review and cost management services. Utilization review is a system of monitoring the medical necessity and appropriateness of certain health care services prescribed for participants in health care plans, including hospital admissions, proposed length of hospital stay, use of outpatient facilities and other treatment alternatives. The Company's utilization review and cost management services are designed to control its clients' health care costs, primarily by reducing unnecessary hospital admissions and lengths of stay, without compromising the quality of care or freedom of choice available to plan participants.

The Company, which is a Delaware corporation, was organized in 1982. The Company's principal executive offices are located at 3200 Highland Avenue, Downers Grove, Illinois 60515 and its telephone number is (312) 719-9000.

Fiscal 1987 Developments

In an effort to broaden the range of health care cost management programs offered to its clients, in June 1988 the Company acquired Affordable Health Care Concepts ("Affordable"), a health care cost management consulting firm which specializes in the development and management of custom-tailored, payor-based preferred provider organizations and the collection and analysis of health care cost data. See "Recent Acquisition--Affordable Health Care Concepts" below.

In August 1988, the Company completed a public offering of 1,320,000 shares of its common stock, $.01 par value per share (the "Common Stock"). The net proceeds to the Company from the public offering (including the proceeds from the exercise of the over-allotment option granted to the underwriters) were approximately $14,281,000.

Strategy

The Company believes that there are two basic approaches to controlling health care expenditures. The first is to manage the number of hospital days or resources to a level consistent with that which is medically necessary or appropriate under the client's health care plan. This is, in effect, the management of the number of "units" of health care services provided. The second approach is to control the price per unit of health care

services provided, which is the approach taken by HMOs and PPOs in negotiating reduced provider rates, as well as by the diagnosis related group (DRG) system implemented under the Medicare program.

The Company's business strategy is to offer its clients a broad range of health care cost management programs which are designed to control both the number of health care units provided as well as the cost per unit. From its inception, the Company has sought to develop utilization review programs designed to control the number of health care units, such as its basic hospital pre-admission certification program. The Company has continued to offer additional cost management programs which are also intended to control the number of health care units provided, including those concentrating on case management, mental health services and disability management. The Company believes that the continuing offering of new programs is important to the expansion of its business and currently has under development several new cost management programs. See "Programs Under Development" below.

As a result of the recent acquisition of Affordable, the Company now offers its clients services designed to control the price per health care unit. Affordable is a cost management firm which specializes in the development of PPOs and the collection and analysis of health care cost data. Affordable's health care cost data analysis capability allows it to use a client's actual history of health care usage to structure networks of providers custom-tailored to the client's needs. See "Recent Acquisition--Affordable Health Care Concepts" below.

The Company believes that the general unavailability of adequate health care cost information has been a hindrance in the development of comprehensive cost management programs. The acquisition of Affordable will enable the Company to employ Affordable's proprietary health care cost data programs and PPOs, in conjunction with its utilization review programs, to offer comprehensive data driven cost management programs.

Health Care Expenditures and Managed Care

According to data derived from the Health Care Financing Administration of the Department of Health and Human Services, health care expenditures have increased from $75 billion in 1970 (7.4% of GNP) to an estimated $500 billion in 1987 (11.1% of GNP). In an effort to control health care costs, the federal government has implemented a review system to monitor and assess the appropriateness and quality of medical care rendered to Medicare beneficiaries. Employers, who paid an estimated $116 billion in health care costs for their employees in 1987, have also taken steps to control their rapidly escalating health care costs. Many have modified their traditional insurance coverage

or made available to their employees the opportunity to participate in HMOs and PPOs. Many employers have also elected to self-insure the cost of providing health care benefits to their employees, thereby providing an opportunity to reduce costs. This has also enabled them to take a more active role in managing health care benefits and costs. In response to the trend towards self-insurance and increasing competition from HMOs and PPOs, group insurance carriers have sought to control premium increases through the adoption of cost containment programs.

Independent utilization review and cost management firms offer numerous programs designed to meet these collective objectives. Unlike HMOs, utilization review typically does not involve the underwriting of health insurance or the assumption of related risks. Utilization review has only recently been offered on a commercially significant scale by independent firms which are engaged primarily in the utilization review and cost management business. The industry is currently highly fragmented with numerous independent firms providing utilization review services, the vast majority of which provide such services on a regional or local level. In addition, a small number of health insurance carriers have established internal utilization review departments which typically service only certain policy holders of the carrier.

The emergence of independent utilization review and cost management firms demonstrates the increased recognition of utilization review as an effective cost containment technique. For self-insured employers, utilization review and cost management provide an objective oversight function that enables them to directly monitor and manage their health care expenditures. In the case of health insurance carriers, the cost savings resulting from utilization review enable them to offer more competitively priced indemnity products. For third party administrators, utilization review is another service which may be offered to clients. For HMOs and PPOs, utilization review provides opportunities to manage costs by employing the services of an independent third party.

Method of Operation

The Company provides centralized utilization review and cost management services from its headquarters in Downers Grove, Illinois through an internal staff consisting primarily of registered nurses and physicians. The Company also has a nationwide network of conferring physicians in various specialties. For many of its services, the Company charges its clients a "capitated fee," i.e. a fixed monthly fee for each participant (excluding covered dependants) in a client-sponsored health care plan. The amount of this fee varies depending on the number and type of review programs selected by the client. For other services, including case management, the

Company charges fees on an hourly rather than a capitated basis. See "Programs" and "Recent Acquisition--Affordable Health Care Concepts" below and "Management's Discussion and Analysis of Financial Condition and Results of Operation." The Company's utilization review services are designed to operate in two stages. The first stage review is performed by a nurse reviewer and the second stage review, if deemed necessary by the nurse reviewer, is performed by a Company-employed or-retained physician. Unlike many of its competitors, the Company's operations emphasize a high degree of interaction between the Company's physicians and the participants' attending physicians. See "Physician Resources" below.

To utilize the Company's pre-admission hospital review services, a participant or his or her attending physician calls one of the Company's nurse reviewers on the Company's toll-free telephone number prior to hospitalization or within two days after an emergency admission. The phone lines at the Company's headquarters are presently operational five days a week, eleven and one-half hours a day. From these calls, the nurse reviewer gathers information (solely to enable the Company to perform its review services) on the participant's medical condition, the attending physician's proposed treatment plan and the proposed length of hospital stay. The nurse reviewer inputs this information into the Company's proprietary computer system and determines, based upon established national norms whether the proposed hospitalization and length of stay are certifiable as medically necessary and appropriate under the participant's health care plan.

In approximately 60% of all cases, as a result of this initial screening, the nurse reviewer determines that the proposed hospitalization and length of stay are medically necessary and appropriate under the benefit plan, and a letter is then sent to the patient, the attending physician, the hospital and the plan administrator advising them that the hospitalization has been certified as such. In the remaining 40% of all cases, a second stage review of the case is conducted in which a Company-employed or -retained physician communicates with the attending physician concerning a more cost effective treatment plan. In approximately 97% of all cases which are referred for a second stage review, the attending physician and the Company's physician agree upon a treatment plan which is certifiable as being medically necessary and appropriate. Upon completion of its review, the Company notifies its client as to whether the proposed hospitalization and length of stay are medically necessary and appropriate under the client's health care benefit plan. If after consultation between the attending physician and the Company's physician the Company determines that the proposed hospitalization is not certifiable as such, the client's health care benefit plan typically reduces the payment of benefits for the proposed hospitalization. The Company's services are

advisory in nature, and all determinations as to the payment or denial of benefits are made by the third-party payor, not by the Company. In addition, all decisions as to the patient's medical treatment are made by the patient and the attending physician, not by the Company.

Nurse reviewers also review, on a regular basis, the continued stay of hospitalized patients in order to monitor the length of their hospital stay and to gather information on treatments and procedures, as well as to identify as early as possible potential large claim cases, such as chronic, serious and catastrophic illnesses. This review enables the Company, if authorized by its client, to evaluate cost-effective alternatives to hospitalization and other prescribed treatment plans for these large cases. The attending physician is advised of these possible alternatives and, if the patient and his attending physician elect to proceed with them, the Company will certify coverage under the patient's health care plan.

Members of the Company's customer service department, through seminars and written materials, seek to educate its clients' employees about the Company's services in order to ensure that they are aware of the procedures which must be followed to obtain maximum health care benefits and avoid the imposition of benefit reductions or limitations for failing to follow these procedures. In addition, participants or their physicians can call the Company on a toll-free telephone number if they have questions regarding the Company's services.

The Company provides its clients with standardized reports, on a regular basis, which contain information that enables them to analyze the effectiveness of the Company's services.

Programs

The Company offers several utilization review and cost management [illegible]ams from which its clients may select. Most of the Compa[illegible] lients subscribe to its Pre-admission and/or Continued [illegible]rograms, which serve as the base to which the Company's [illegible] programs may be added. Approximately 90% of the Company's clients subscribe to at least one additional program offered by the Company. During the last year, the Company began to offer its programs on a stand-alone basis, without requiring subscription to one of its Pre-admission and/or Continued Stay Programs. The following is a summary of the programs currently offered by the Company.

Pre-Admission and Continued Stay. The Company's Pre-admission and/or Continued Stay Programs are designed to reduce a client's hospitalization costs by identifying (for the purposes of benefit plan coverage only) hospital admissions and lengths of stay which are unnecessary or excessive compared to established

national norms. The Company's pre-admission review program involves a review by Company personnel of the medical necessity and appropriateness under the participant's benefit plan of proposed hospital admissions, as well as the proposed length of the patient's stay. Under the Company's Continued Stay Program, the Company remains actively involved during the hospitalization period in reviewing and monitoring the patient's progress, prescribed treatment plan and length of stay. The Company's utilization review services presently do not involve the monitoring of primary care by physicians prior to a request for hospital admission. See "Programs Under Development" below.

Case Management. The Case Management Program is designed to provide clients with a careful review of all cases which involve high cost diseases, conditions and/or procedures, including chronic, serious and catastrophic illnesses. Through daily reviews, the Company's nurse reviewers and physicians identify and inform benefit plan administrators of potential large claim cases. If requested to do so by the plan administrator, the Company renders ongoing case management services for an hourly fee. These services consist primarily of conferring with the attending physician in order to identify cost-effective treatment alternatives. Such alternatives may include moving a patient from an acute care hospital to less expensive settings--often the home--as soon as the patient's physician determines that it is safe and medically feasible. If such a move requires a home nursing service or medical equipment, the Company serves as a referral for alternative available services, provides recommendations regarding continued usage of these services and negotiates discounts in many cases with the providers. In all cases, the decision as to whether to proceed with the course of treatment initially prescribed by the attending physician or the more cost-efficient alternative recommended by the Company is made by the patient and his physician.

Clients which select stand-alone case management independently identify those cases which involve potentially high cost diseases, conditions and/or procedures and refer such cases to the Company to identify cost-effective treatment alternatives.

Second Surgical Opinion. The Second Surgical Opinion Program is designed to reduce health care costs by avoiding unnecessary surgery. The program requires a participant to obtain a second opinion from a physician selected by the participant or a specialist participating in a network of Company-recommended physicians before undergoing specified surgical procedures. In many cases, this requirement is waived by the Company if, after comparing the individual facts of the case to nationally accepted guidelines, it is determined that a second opinion is not necessary. The requirement that a patient obtain a second opinion is intended solely to provide the patient with sufficient information to enable him or her to make an

informed decision concerning the advisability of proceeding with surgery. In each case, the decision whether to undergo surgery is made by the patient, and patients who elect to undergo surgery receive their full health care benefits, regardless of the second physician's recommendation.

Mental Health Services Review. The Company's Mental Health Services Review Program involves the review by Company-employed or -retained psychiatrists and psychologists of the medical necessity and appropriateness under a participant's benefit plan of the type, frequency and location of prescribed psychiatric or substance abuse care. This program, which provides a review of proposed in-patient and out-patient mental health services, is designed to furnish information to patients and their psychiatrists or psychologists in order to encourage them to use their mental health benefits in a cost-effective manner. In certain other cases, psychiatric case management may be advisable, in which event the Company's physician and case management specialist and the attending physician develop an alternative treatment plan which identifies a more suitable, more cost-efficient setting for delivery of appropriate medical/psychiatric care.

CareLine. CareLine is a service which allows participants in the program to obtain, through a toll-free number, information on health care topics, such as common side-effects of certain medications. In addition, this program identifies and provides information concerning support groups which specialize in certain medical conditions, current treatment plans for various illnesses and general health/medical information requested by clients. The Company adheres to a policy of not providing any assistance, advice or recommendations which could be deemed to constitute the practice of medicine through this or any other program.

Disability Management. The Company's Disability Management Program is designed to reduce the number of working days lost as a result of a patient's disability. Using data gathered by the Company with respect to the specific case and an examination by an independent specialist, the attending physician's diagnosis and prescribed treatment plan will either be certified as medically necessary and appropriate by the Company or more cost-effective alternative treatments will be identified.

Programs Under Development

In addition to enhancing its existing programs, the Company is continually developing new programs, including programs designed to review facets of medical care other than hospitalization. The following is a brief description of various programs currently under development by the Company.

Medicare Part B Review Program. The Company is currently developing a program designed to review out-patient professional services provided under Part B of Medicare. The review process will focus on the examination of claims submitted and is being designed to enhance existing fiscal intermediary screens by providing a more comprehensive review. In addition, a more complete database of individual health care provider services will be developed from these examinations. This database will enable the Company to more accurately profile providers and to review retrospectively and prospectively the services rendered by such providers. This program is expected to utilize extensively the services of Company-employed nurses and physicians. The Company has entered into a contract to provide services under Part B of Medicare through September 30, 1989.

Chiropractic Review. The Company's Chiropractic Review Program, which is expected to be introduced late in calendar 1988, is being designed to reduce costs for clients whose benefit plans offer chiropractic benefits. Under this program, the Company will review the medical necessity and appropriateness under a participant's benefit plan of prescribed chiropractic treatment prior to the commencement of the treatment plan.

Retrospective Records Review. The Company is developing, and expects to begin marketing late in calendar 1988, a program under which it will perform retrospective reviews of medical and dental records and claims to determine the appropriateness of medical and dental services rendered and the charges for such services. This program will involve a high degree of nurse and physician involvement and, in contrast to audit procedures, is being designed to identify inappropriate utilization trends as well as aberrant billing practices.

Physician Resources

The Company believes that its full-time in-house physician staff, now numbering 23, is and will be an invaluable resource in its utilization management process. The staff now includes experienced board certified physicians in such specialties as family practice, internal medicine, oncology, urology, psychiatry, pediatrics and surgery as well as its nationwide network of conferring physicians in most significant specialties. The Company also believes that the high degree of interaction between the Company's physicians and participants' attending physician enhances the sensitivity and quality of the review process and distinguishes the Company from its competitors. In addition, the Company's in-house physicians frequently initiate and serve as a key resource in the development of new cost management programs as part of the Company's efforts to broaden and supplement its current range of programs.

Customers and Marketing

The Company markets its services through group health insurance carriers and third party administrators (TPAs), organizations which provide claims processing and related administrative services to self-insured employers. In addition, the Company markets its services to direct accounts, including self-insured employers, government employee groups and multi-employer trusts. Initially, the Company's marketing efforts focused on insurance carriers and third party administrators.

Subsequently, the Company's marketing efforts have increasingly focused on direct accounts. The following is a list of selected customers of the Company.

American Consulting Engineering Council
Control Data Corporation
General American Life Insurance Co.
Hyatt Corporation
The Mail Handlers Benefit Plan
McDonald's Corporation
Montgomery Ward & Co.
Mutual of Omaha Insurance Company
Pepsico, Inc.
Southland Corporation
Tenneco Inc.
Trammel Crow Company
United Airlines, Inc.

The following table sets forth information with respect to the approximate percentage of the Company's revenues represented by each client category in fiscal 1986, 1987 and 1988.

Revenue Contribution by Category of Client

Category of Client	Fiscal Years Ended August 31, 1986	1987	1988
Insurance Carriers and TPAs. .	62%	71%	45%
Direct Accounts.	38	29	55
Total	100%	100%	100%

The Company presently has 20 group health insurance carrier clients. Typically, the Company enters into a master service agreement with an insurance carrier under which the Company agrees to provide its utilization review and other cost management services to health care plans maintained by the carrier's policyholders. The Company's services are offered not only to new policyholders, but also to existing policyholders at the time their policies are renewed. The insurance carrier's sales and marketing staff ordinarily has the responsibility for offering the Company's services to its policyholders, thus relieving the Company of a significant marketing expense. Carriers usually require policyholders to subscribe to the Company's utilization review services or, if not so required,

carriers may offer a more attractive premium structure to those who elect to subscribe. The Company markets its services through third party administrators in essentially the same manner.

The Company typically enters into standardized service contracts with its direct accounts and master service agreements with its insurance carrier and third party administrator clients. These contracts and agreements have automatically renewable successive terms of between one and three years, and are generally terminable upon one to six months' notice prior to their expiration. These contracts are generally non-exclusive and permit the client to engage the services of other utilization review firms or to provide review services on an in-house basis. Although in most cases there is no penalty for termination, the Company believes that its replacement by another firm offering utilization review services would cause the terminating party to incur substantial transition costs and administrative problems which would tend to discourage such terminations. However, one group carrier client which accounted for approximately 3% and 2% of the Company's revenues during fiscal 1987 and fiscal 1988, respectively, has notified the Company of its intent to terminate its contract, although no termination date has been set.

The Company's master service agreements with Mutual of Omaha and General American accounted for 23% and 10%, respectively, of the Company's revenues for fiscal 1987 and 20% and 4%, respectively, of its revenues for fiscal 1988. The Company's contract with The Mail Handlers Benefit Plan accounted for approximately 16% and 12% of its revenues in fiscal 1987 and fiscal 1988, respectively. The Mail Handlers Benefit Plan has advised the Company that effective January 1, 1989 it is terminating all voluntary pre-certification review services including those rendered by the Company, but that it will continue to subscribe to the Company's case management services. During fiscal 1987 and fiscal 1988, the Company derived approximately 13% and 7% of its revenues, respectively, from pre-certification review services rendered to The Mail Handlers Benefit Plan. The loss of any major clients could have a material adverse effect on the Company.

In addition, during fiscal 1988, two of the Company's 17 group health insurance carrier clients advised it of their intention to cease writing group health insurance. Consequently, such carriers will have no further need for utilization review services. It is anticipated that the Company will continue to provide utilization review services to these clients until December 1988. During fiscal 1987 and fiscal 1988, such clients accounted, in the aggregate, for approximately 10% and 6%, respectively, of the Company's revenues.

Recent Acquisition--Affordable Health Care Concepts

In June 1988, the Company acquired Affordable in exchange for 390,000 shares of Common Stock of the Company. Affordable is a health care cost management firm which has two distinct lines of business: (1) the development and management of custom-tailored, payor-based PPOs and (2) the collection and analysis of health care cost data. Affordable has established preferred provider networks throughout California, Oregon, Washington, Nevada, New Mexico, Texas and Wisconsin. The Company's data analysis clients are located nationwide.

Affordable's clients include large purchasers of health care services, such as group health insurance carriers, workers' compensation insurance carriers, Taft-Hartley Trust Funds, self-insured employers, government employee groups and multi-employer trusts. Its clients include Eastman Kodak Company, Pacific Bell, American Telephone & Telegraph Co., Safeway Stores, Incorporated, Hughes Aircraft Co., Texas Instruments Incorporated, United Food and Commercial Workers Union trust funds and Teamsters trust funds, many of which use both the PPO and data analysis services.

In connection with its PPO programs, Affordable is retained by individual payors of health care benefits to design, structure, negotiate and manage a network of health care providers which agree to provide their services for negotiated rates. These rates usually are lower than both the providers' standard charges and those which could be obtained independently. The negotiated fee arrangements for all PPOs are designed to result in cost savings for health care payors without compromising the quality of care to participants. Affordable's hospital networks are custom-tailored to fit each client's specific needs. In addition, Affordable is currently in the final stages of developing a hospital network in California that will not be custom-tailored and that will be marketed to a broad range of clients.

Extensive data analysis is required to develop a custom-tailored PPO network. Using proprietary software, Affordable collects and analyzes health care claims data from clients and other sources to profile provider charges and utilization patterns. Potential providers are invited to become a preferred provider by submitting proposed rates for services in a competitive bidding process. Affordable evaluates these proposals based on price, range of services, geographic location, community reputation and historical utilization patterns. Affordable negotiates with the providers and selects those which meet the client's objectives. After a network has been established, Affordable provides ongoing consulting services to clients, renegotiates contracts with providers and prepares annual evaluations which profiles for its clients the effectiveness of the network.

Recently, Affordable developed, and is now marketing to existing and prospective clients, a network of outpatient providers of health care services. This network consists of physicians, dentists, laboratories, radiological facilities and outpatient surgical centers throughout California. This outpatient PPO was structured by Affordable and is now being offered to user groups as a standard network which all clients can use.

Affordable's health care cost data analysis services (which are available to its clients on a stand-alone basis) provide payors of health care with in-depth customized information concerning their health care cost and utilization experience. Using its internally developed proprietary software, Affordable analyzes its clients' health care claims information and benefit plans in order to profile each client's specific health care cost problems and evaluate appropriate cost management programs. This software also allows Affordable to simulate how changes in a benefit plan's structure will change the overall cost of a benefit program. Affordable also provides clients with customized software products to allow further analysis of health care cost issues.

For its PPO programs, Affordable typically charges either a monthly fee for each participant or a percentage of savings generated. The amount of this fee varies depending on the number of enrollees and type of preferred provider networks selected by the client. For both data services and Affordable's PPO programs, Affordable charges on a project or on an hourly basis. These services are marketed directly by Affordable's sale staff.

Affordable competes with national and local firms which develop PPOs and with major insurance carriers, third party administrators and utilization review firms which have implemented their own preferred provider networks as well as with firms which specialize in the collection and analysis of health care cost data. Many of Affordable's competitors are significantly larger and have greater financial resources.

Affordable is headquartered in Sacramento, California, and has field offices in San Francisco and Los Angeles, California and Portland, Oregon. In connection with the acquisition, five-year employment agreements were entered into with each of Affordable's executive officers.

Utilization Information System

Management believes that the company's interactive, on-line computer-based information system has been a major factor in its ability to provide clients with health care utilization review and cost management services. This information system is

comprised of four parts: proprietary software, a database of hospital utilization norms and standards, a database of patient-specific information and an automated data reporting and transmission capability.

The Company's proprietary software programs record and access patient information and hospital utilization norms and standards which are part of the review process. The Company's software requires only the initial input by a nurse reviewer to activate other review programs such as Second Surgical Opinion and Case Management.

The hospital utilization norms and standards database consists of the information against which the Company compares a participant's proposed treatment plan in order to determine whether it is medically necessary and appropriate. This database has been compiled from commercially available information specifying national norms for various medical procedures. The Company has enhanced this database to include proprietary information derived from its experience in performing utilization review services.

The patient-specific database consists of data that has been collected concerning each proposed hospital admission, including patient demographics, medical history and diagnostic and procedural information. The Company's review personnel can access the current status of the patient's case during hospitalization in order to identify more cost-effective treatment alternatives.

The Company's proprietary software generates extensive internal reports to supplement the review process by informing reviewers when specific follow-up activities are required to be performed by Company personnel. In addition, the Company's proprietary software also generates extensive reports for its clients. These reports typically itemize all cases reviewed by the Company and detail the effectiveness of the review services provided. If so requested, the Company will customize these reports to fit the needs of a particular client. The Company also has the capability of sending machine-readable computer tapes or information by electronic transfer directly to the computers of third party payors and/or clients in order to expedite claims administration. Correspondance confirming the Company's recommendations with respect to a prescribed treatment plan is automatically generated and sent to the attending physician, participant, hospital and plan administrator by the system.

Competition

The Company competes in a highly fragmented market with national and local firms specializing in utilization review and

with major insurance carriers and third party administrators which have implemented their own internal utilization review services. In addition, other health care programs sponsored by the Company's clients, such as HMOs and PPOs, compete for the enrollment of benefit plan participants. The Company is subject to intense competition in each market segment in which it competes. Many of the Company's competitors are significantly larger and have greater financial and marketing resources than the Company.

The Company competes on the basis of the quality and cost-effectiveness of its programs, its proprietary computer-based information system and its emphasis on commitment to service and high degree of physician involvement. Due to the quality of the services offered, the Company tends to charge more for its services than many of its competitors.

Employees

As of August 31, 1988, the Company had 402 employees, including 23 full-time physicians, 90 employees of Affordable and 145 registered nurses engaged in utilization review and cost management. The Company also has a nationwide network of conferring physicians in various specialties, most of whom are compensated on an hourly or per visit basis when requested by the Company to render consulting services. Certain of the agreements with the Company's consulting physicians are for a minimum term of one year and the others are terminable at any time upon 60 days notice.

Item 2. Properties.

The Company's headquarters presently occupy approximately 80,000 square feet of leased office space in Downers Grove, Illinois under a lease which will provide the Company with 37,000 additional square feet of space in 1989. The lease expires in 2002 and is renewable at the option of the Company until 2007.

The Company is attempting to sublease the facilities which it occupied prior to the relocation of its headquarters in September 1987. No assurances can be given that the Company will be successful in subleasing such facilities, in which case the Company will be required to continue making rental payments of $21,794 per month through October 1990. See Note 8 of Notes to the Company's Financial Statements.

In May 1988, an Illinois Bell transfer station located near the Company was destroyed by fire, interrupting telephone service to the Company and approximately 35,000 other customers in the western suburbs of Chicago. The Company responded to the

situation by arranging for the re-routing of telephone calls to an alternate facility for a period of three weeks. The telephone service interruption had no material adverse effect on the Company's financial condition or results of operations.

Affordable's headquarters presently occupy approximately 15,300 square feet of leased office space in Sacramento, California. The lease expires in 1992 and is renewable at the option of Affordable until 1997. Affordable also maintains field offices in San Francisco and Los Angeles, California and Portland, Oregon.

Item 3. Legal Proceedings.

Affordable has been named as a co-defendant in a civil suit in the United States District Court, Central District of California, arising out of the establishment of a PPO, which plaintiff alleges is being operated in violation of federal antitrust and state trade regulation laws. The plaintiff, a hospital located in Hawthorne, California, alleges that it was denied an opportunity to participate in the network and that as a result it has suffered damages which are unknown but believed to exceed $90,000 per month. The Company intends to defend vigorously the suit which is currently in the preliminary discovery stage. The Company has consulted with its special legal counsel, Chadwell & Kayser, Ltd., and the Company believes that it has a reasonably good chance of prevailing in this action. In any event, the Company believes, although there can be no assurance, that the suit will not have a material adverse effect on the Company.

In April 1988, Community Care Network ("CCN"), then Affordable's largest client, terminated its contractual relationship with Affordable. The Company believes that the contract was wrongfully terminated and is seeking substantial monetary damages from CCN. As a result, the terms of the Affordable acquisition were renegotiated to reflect this occurrence. There are both arbitration proceedings and a civil suit pending in California which concern the termination of CCN's relationship with Affordable. In these proceedings, Affordable alleges that it suffered damages in excess of $20,000,000 as a result of the wrongful termination of the relationship. Daniel Brunner, Jack Scanlon and Claire Lipschultz, the former shareholders of Affordable, are also plaintiffs in the civil suit and allege that the defendants intended to interfere with the proposed acquisition of Affordable by the Company, thereby precluding them from receiving the economic benefits of the transaction. The shareholders allege that they have suffered damages in excess of $12,000,000.

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

No matters were submitted to a vote of the Company's security holders during the last quarter of the fiscal year ended August 31, 1988.

Executive Officers of the Registrant

Name	Age	Positions Held With the Company
Robert J. Becker, M.D., F.A.C.P.	66	Chairman of the Board and Chief Operating Officer
James C. Smith	47	President; Chief Executive Officer and Director
Ronald H. Galowich	52	Executive Vice President, Secretary, General Counsel and Director
Joseph E. Whitters	30	Vice President, Finance and Chief Financial Officer
Daniel Brunner	44	President of Affordable and Director

Robert J. Becker, M.D., F.A.C.P., the founder of the Company, has served as Chairman of the Board since its organization. Previously, Dr. Becker practiced internal medicine (allergy and clinical immunology) for 26 years. Dr. Becker is a Fellow of the American College of Physicians and has twice served as president of the American Association of Professional Standards Review Organization (a utilization review organization for monitoring Medicare and Medicaid costs). Additionally, Dr. Becker has served on the advisory council of the National Institute of Environmental Health Services and has authored numerous articles on utilization review and cost management.

James C. Smith joined the Company as President and Chief Executive Officer in January 1984. From January 1978 to December 1983, Mr. Smith was Chief Executive Officer and President of ARC Management, Inc., a privately-held management consulting firm. From February 1975 to December 1977, Mr. Smith was a marketing and sales manager for Texas Instruments Incorporated. Mr. Smith presently serves on the Benefit Communications and Educational Program Committees of the International Foundation of Employee Benefit Plans.

Ronald H. Galowich has served as the Executive Vice President, Secretary, General Counsel and a director of the

Company since its organization. In these capacities, Mr. Galowich spends a substantial amount but less than all of his time on Company matters. Since 1982, Mr. Galowich has also served as the President of several subsidiaries of Marmon Holdings, Inc. which are engaged in the construction, development and management of real estate, and as the director of real estate operations for the Pritzker family. From October 1960 to December 1981, Mr. Galowich was engaged in the private practice of law.

Joseph E. Whitters joined the Company as Controller in October 1986 and has served as its Vice President, Finance since August 1987 and its Chief Financial Officer since March 1988. From October 1984 to September 1986, Mr. Whitters was Controller of Charter Med, Inc., a wholly-owned subsidiary of United HealthCare, a health maintenance organization company. Prior to joining Charter Med, Inc., Mr. Whitters served from July 1983 to September 1984 as an accounting manager with Overland Express, Inc., a transportation company. From September 1980 to June 1983, Mr. Whitters was employed by Peat Marwick Main & Co. as a certified public accountant.

The Company's officers serve at the discretion of the Board of Directors.

Additional information respecting executive officers and information respecting directors will be included in the Company's definitive proxy statement to be used in connection with its annual meeting of stockholders scheduled to be held on January 31, 1989 (the "Proxy Statement"). The Company expects to file the Proxy Statement with the Securities and Exchange Commission on or prior to December 29, 1988, and reference is expressly made thereto for the information incorporated herein by the aforesaid reference.

PART II

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

The Company's Common Stock has been traded in the over-the-counter market on the National Association of Securities Dealers Automated Quotation System ("NASDAQ") under the symbol "HCCC" since the Company's initial public offering on May 29, 1987. Information concerning the range of high and low closing sales prices of the Company's Common Stock on the National Market System, as reported by NASDAQ, and the approximate number of stockholders of record of the Common Stock is set forth under "Common Stock" in the Company's 1988 Annual Report to Stockholders. Information concerning the Company's dividend policy is set forth under "Dividend Policy" in the Company's 1988 Annual Report to Stockholders. All of such information is incorporated herein by reference.

Item 6. Selected Financial Data.

Selected financial data of the Company for each of its last five fiscal years is set forth under "Selected Financial Data" in the Company's 1988 Annual Report to Stockholders. Such information is incorporated herein by reference.

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

The information required by this item is set forth under "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Company's 1988 Annual Report to Stockholders and is incorporated herein by reference.

Item 8. Financial Statements and Supplementary Data.

The financial statements required by the item are contained in the Company's 1988 Annual Report to Stockholders on the pages indicated and are incorporated herein by reference.

Financial Statements:	Page No.
Report of Independent Certified Public Accountants	18
Consolidated Balance Sheets, August 31, 1987 and 1988	19
Consolidated Statements of Operations for the Years Ended August 31, 1986, 1987 and 1988	20
Consolidated Statements of Stockholders' Equity for the Years Ended August 31, 1986, 1987 and 1988	21

Consolidated Statements of Cash Flows for the
Years Ended August 31, 1986, 1987 and 1988 22
Notes to Consolidated Financial Statements 24

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

Not applicable.

PART III

Item 10. Directors and Executive Officers of the Registrant.

Certain of the information respecting executive officers required by this Item is set forth under the caption "Executive Officers of the Registrant" in Part I. Other information respecting executive officers, as well as the required information regarding directors, will be included in the Proxy Statement and such information is incorporated herein by reference.

Item 11. Executive Compensation.

The information required by this Item will be included in the Proxy Statement and is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management.

The information required by this Item will be included in the Proxy Statement and is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions.

The information required by this Item will be included in the Proxy Statement and is incorporated herein by reference.

PART IV

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

(a) The following documents are filed as part of this report:

(1) The Index to Financial Statements is set forth on page 18 of this report.

(2) Financial Statement Schedules: Schedule XI--Supplementary Income Statement Information.

(3) The Index to Exhibits is set forth on page 25 of this report.

(b) Reports on Form 8-K: During the last quarter of fiscal 1988, the Company filed a Current Report on Form 8-K dated July 13, 1988 to report an event under Item 2. Such report included the following financial statements:

(1) Financial statements of business acquired:

Report of Independent Certified Public Accountants

Balance Sheets, August 31, 1986 and 1987 and May 31, 1988 (unaudited)

Statements of Operations and Retained Earnings (Deficiency) for the Years Ended August 31, 1985, 1986 and 1987 and for the nine months ended May 31, 1987 and 1988 (unaudited)

Statements of Changes in Financial Position for the Years Ended August 31, 1985, 1986 and 1987 and for the nine months ended May 31, 1987 and 1988 (unaudited)

Notes to Financial Statements

(2) Pro forma financial information:

Unaudited Pro Forma Combined Condensed Statement of Operations for the year ended August 31, 1987

Unaudited Pro Forma Combined Condensed Statement of Operations for the nine months ended May 31, 1988

Unaudited Pro Forma Combined Condensed Balance Sheet, May 31, 1988

Notes to Unaudited Pro Forma Combined Condensed Financial Statements

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HEALTHCARE COMPARE CORP.

By: James C. Smith, President and Chief Executive Officer

Date: November 22, 1988

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities indicated on November 22, 1988:

Signature	Title
Robert G. Becker, M.D.	Chairman of the Board and Chief Operating Officer
James C. Smith	President, Chief Executive Officer and Director (Principal Executive Officer)
Joseph E. Whitters	Chief Financial Officer (Principal Financial and Accounting Officer)
Ronald H. Galowich	Director

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HEALTHCARE COMPARE CORP.

By: _____
James C. Smith, President and
Chief Executive Officer

Date: November 22, 1988

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities indicated on November 22, 1988:

Signature	Title
_____ Robert J. Becker, M.D.	Chairman of the Board and Chief Operating Officer
_____ James C. Smith	President, Chief Executive Officer and Director (Principal Executive Officer)
_____ Joseph E. Whitters	Chief Financial Officer (Principal Financial and Accounting Officer)
_____ Ronald H. Galewich	Director

Melvin Garb — Director

Burton W. Kahter — Director

J. Patrick Foley — Director

Melvin Simon — Director

Daniel Brunner — Director

INDEX TO EXHIBITS

Exhibit No.	Description
3.1.	Restated Certificate of Incorporation of the Company. [3.1](1)
3.2.	Restated Certificate of Designation of Preferences, Rights and Limitations. [3.2](1)
3.3.	Amended and Restated By-Laws of the Company. [3.3](1)
3.4.	Agreement, dated as of May 20, 1987, to Amended and Restated By-Laws of the Company [3.4](2)
3.5.	Amendment to Amended and Restated By-Laws of the Company. [3.5](6)
3.6.	Amendment to Amended and Restated By-Laws of the Company. [3.6](6)
4.	Specimen of Stock Certificate for Common Stock. [4](2)
9.	Voting Trust Agreement, dated as of August 31, 1984, between Robert J. Becker, M.D. and Ronald H. Galowich, as trustee. [9](1)
9.1.	Resignation of Ronald H. Galowich as Trustee of Voting Trust Agreement dated August 31, 1984 and Acceptance of Trusteeship by Jerome Harris. [9.1](4)
9.2.	Termination of Voting Trust dated March 8, 1988. [9.2](6)
10.1.	Management Agreement, dated as of August 31, 1984, between the Company and Robert J. Becker, M.D. [10.1](1)
10.2.	Amendment, dated April 15, 1987, to Management Agreement, dated as of August 31, 1984. [10.2](1)
10.3.	Management Agreement, dated as of August 31, 1984, between the Company and James C. Smith. [10.3](1)

10.4. Amendment, dated April 15, 1987, to Management Agreement, dated as of August 31, 1984. [10.4](1)

10.5. Retainer Agreement, dated as of August 31, 1984, between the Company and Ronald H. Galowich. [10.5](1)

10.6. Amendment, dated April 15, 1987, to Retainer Agreement, dated as of August 31, 1984. [10.6](1)

10.7. Employment Agreement, dated October 1, 1986, by and between the Company and Joseph E. Whitters. [10.7](6)

10.8. Employment Agreement, dated June 3, 1988, by and between Affordable Health Care Concepts and Daniel Brunner. [10.8](6)

10.9. Employment Agreement, dated June 3, 1988, by and between Affordable Health Care Concepts and Jack Scanlon. [10.9](6)

10.10. Employment Agreement, dated June 3, 1988, by and between Affordable Health Care Concepts and Claire Lipschultz. [10.10](6)

10.11. HealthCare COMPARE Corp. 1987 Stock Option Plan, as amended and restated. [4](5)

10.12. Amendment No. 1 to HealthCare COMPARE Corp. Stock Option Plan, as amended and restated. [10.12](6)

10.13. The HealthCare COMPARE Corp. Retirement Savings Plan. [10.8](1)

10.14. Lease, dated as of September 7, 1984, as amended, between the Company and LaSalle National Bank, not personally, but as Trustee under Trust Agreement dated the 8th day of March, 1984, and known as Trust Number 107741. [10.9](1)

10.15. Lease, dated as of March 27, 1987, between the Company and American National Bank and Trust Company of Chicago, not personally, but as Trustee under Trust Agreement dated August 22, 1985 and known as Trust Number 65303 and TCS-Highland Limited Partnership. [10.10](1)

10.16.	Amendment, dated as of May 1, 1987, to Lease, dated March 27, 1987. [10.24](4)
10.17.	First Amendment to TGS-Highland Limited Partnership Agreement and Certificate of Limited Partnership. [10.25](4)
10.18.	Utilization Review Agreement, dated November 1, 1985, between the Company and the Hyatt Corporation Welfare Benefit Plan. [10.12](1)
10.19.	Form of Utilization Review Agreement between the Company and The Marmon Group, Inc. and certain of its subsidiaries. [10.14](1)
10.20.	Preferred Stock Purchase Agreement, dated as of August 31, 1984, by and among the Company and the persons named therein. [10.22](2)
10.21.	Utilization Review Agreement, dated May 1, 1985, between the Company and Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company. [10.23](3)
10.22.	Amendment, dated January 27, 1988, to Utilization Review Agreement, dated May 1, 1985. [10.22](6)
10.23.	Subcontract Agreement, dated October 25, 1984, as amended, between the Company and General American Life Insurance Company. [10.24](3)
10.24.	Total Care Service Agreement, dated as of September 25, 1985, between the Company and Claims Administration Corporation. [10.25](3)
10.25.	Form of Consulting Physician Agreement. [10.20](2)
10.26.	Form of Consulting Specialist Agreement. [10.21](2)
10.27.	Registration Agreement, dated as of August 31, 1984, between the Company and the signatories thereto. [10.15](1)
10.28.	Amended Registration Agreement. dated as of April 15, 1987. [10.16](2)

10.29.	Amendment No. 1 to Amended Registration Agreement dated as of April 15, 1987. [10.29](6)
10.30.	Registration Rights Agreement, dated June 3, 1988, by and among the Company, Daniel Brunner, Jack Scanlon and Claire Lipschultz. [10.30](6)
10.31.	Agreement and Plan of Reorganization, dated as of May 12, 1988, by and among the Company, Affordable Acquisition Corp., Affordable Health Care Concepts and Daniel Brunner, Jack Scanlon and Claire Lipschultz. [10.31](6)
10.32.	Agreement of Merger, dated as of May 12, 1988, by and among the Company, Affordable Acquisition Corp. and Affordable Health Care Concepts. [10.32](6)
10.33.	Revolving Note, dated February 3, 1988, from the Company to The Exchange National Bank of Chicago. [10.33](6)
10.34.	Amendment, dated February 22, 1988, to Total Care Service Agreement, dated as of September 25, 1986, between the Company and Claims Administration Corporation. [10.34](6)
10.35.	First Amendment to the Company's Retirement Savings Plan. [10.35](6)
11.	Statement of computation of earnings per share. Page 35
13.	1988 Annual Report to Stockholders. Page 36
22.	Subsidiaries of the Company. [22](6)

[ ] Exhibits so marked have been previously filed with the Securities and Exchange Commission as exhibits to the filings shown below under the exhibit numbers indicated following the respective document description and are incorporated herein by reference.

(1) Registration Statement on Form S-1 ("Registration Statement"), as filed with the Securities and Exchange Commission on April 17, 1987.

(2) Amendment No. 2 to Registration Statement, as filed with the Securities and Exchange Commission on May 22, 1987.

(3) Amendment No. 3 to Registration Statement, as filed with the Securities and Exchange Commission on May 29, 1987.

(4) Annual Report on Form 10-K for the fiscal year ended August 31, 1987, as filed with the Securities and Exchange Commission on November 27, 1987.

(5) Registration Statement on Form S-8, as filed with the Securities and Exchange Commission on January 22, 1988.

(6) Registration Statement on Form S-1, as filed with the Securities and Exchange Commission on July 12, 1988.

Independent Auditors' Report on Financial Statement Schedules

Board of Directors and Stockholders'
HealthCare COMPARE Corp.
Downers Grove, Illinois

We have audited the consolidated financial statements of HealthCare COMPARE Corp. as of August 31, 1987 and 1988, and for each of the three years in the period ended August 31, 1988, and our report thereon dated October 18, 1988 is incorporated by reference. In connection with our audit of these financial statements, we audited the financial statement schedule listed under Item 14(a). In our opinion, this financial statement schedule presents fairly, in all material respects, the information stated therein, when considered in relation to the financial statements taken as a whole.

Laventhol & Horwath
LAVENTHOL & HORWATH

Chicago, Illinois
October 18, 1988

HealthCare COMPARE Corp. and Subsidiary

Schedule XI--Supplementary Income Statement Information
Years Ended August 31, 1988, 1987 and 1986

Item	Charged to costs and expenses
Year Ended August 31, 1988:	
Advertising cost	$325,000
Year Ended August 31, 1987:	
Advertising cost	$443,000
Year Ended August 31, 1986:	
Advertising cost	$596,000

EXHIBIT 11

Health Care COMPARE Corp.

Computation of Earnings Per Common Share (Unaudited)

	1988	1987	1986
Income before extraordinary item . .	$2,299,000	$1,167,000	$ 299,000
Extraordinary item--utilization of net operating loss carryforward . .	--	60,000	277,000
Net income	2,299,000	1,227,000	576,000
Preferred stock dividends.	(75,000)	(23,000)	--
Earnings for common share computations.	$2,224,000	$1,204,000	$ 576,000
Weighted average number of common shares outstanding:			
Shares outstanding from beginning of period.	4,226,000	1,489,000	1,489,000
Conversion of convertible preferred stock into common stock retroactive to the beginning of the period.		1,430,000	--
Other issuances of common stock .	189,000	311,000	--
Common share equivalents:			
Additional share equivalents from assumed exercise of convertible preferred stock. . .		--	1,430,000
Weighted average common and common share equivalents	4,415,000	3,230,000	2,919,000
Net income per common share			
Income before extraordinary item	$ .50	$ .15	$ .10
Extraordinary item--utilization of net operating loss carry-forward.	--	.02	.10
Net income per share	$ .50	$ .17	$ .20

A treatment site for the 1990's

HealthCare COMPARE

1988 ANNUAL REPORT

FINANCIAL HIGHLIGHTS

	Fiscal Year Ended August 31,		
	1986	1987	1988
	(In thousands, except per share data)		
Revenues	$5,535	$11,603	$20,829
Income before income taxes and extraordinary item	576	1,988	3,794
Income before extraordinary item	299	1,167	2,299
Extraordinary item - utilization of net operating loss carryforward	277	60	--
Net income	576	1,227	2,299
Earnings for common share computations	576	1,204	2,224
Net income per share before extraordinary item	10	.35	50
Net income per share	20	.37	50
Total assets	2,622	17,274	33,990
Stockholders' equity (deficiency)	(220)	13,322	33,679

CONTENTS

Letter to Stockholders	5
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Corporate and Investor Information	30
Directors and Corporate Officers	31

THE COMPARE MISSION:

The Company's objective is to be pre-eminent in developing and implementing innovative, effective and comprehensive health care cost management services, on at least a national basis, at a profit level which sustains the dynamic growth of the Company.

To achieve profitable growth, COMPARE will: (1) Develop services that shall be implementable in a broad range of payer environments, anticipate and be responsive to the needs of respective constituents and communities, and be of high caliber and of demonstrable benefit. (2) Develop services that shall be easy to replicate and modify in response to changes in the health care market in order to promote continuity of client relationships. (3) Develop long-term relationships with all types of health care payers under fee arrangements that produce a profit for the Company and a demonstrable cost/benefit for the client. (4) Develop clients that shall be of such size, visibility, diversity and geographic location so as to promote the continued and orderly growth of the Company.

COMPARE CORPORATE PROFILE:

HealthCare COMPARE Corp. is the largest independent provider of health care utilization review and cost management services. Utilization review is a system of monitoring the medical necessity and appropriateness of certain health care services prescribed for participants in health care plans, including hospital admissions, proposed length of stay, use of outpatient facilities and other treatment alternatives.

The Company's utilization review and cost management services are designed to control its clients' health care costs, primarily by reducing unnecessary hospital admissions and lengths of stay, without compromising the quality of care or freedom of choice available to health care plan participants. In an effort to broaden the range of health care cost management programs offered to its clients, in June 1988 the Company acquired Affordable Health Care Concepts, a health care cost management consulting firm which specializes in the development and management of custom-tailored, payer-based preferred provider organizations and the collection and analysis of health care cost data. Management believes that the Company is one of a limited number of independent health care cost management firms which provide these services on a nationwide basis.

The Company's clients include group health insurance carriers, third party administrators (organizations which provide claims processing and related services to self-insured employers), self-insured employers, government employee groups, multi-employer trusts and Taft-Hartley Trusts.

HealthCare COMPARE Corp. was founded in 1982 by Robert J. Becker, M.D., its Chairman. It is headquartered in Downers Grove, Illinois, a Chicago suburb.

The Company's common stock is traded on the NASDAQ national market system under the symbol HCCC.

ROBERT J BOOKER M D

JAMES C SMITH

LETTER TO STOCKHOLDERS

HealthCare COMPARE is pleased to present its annual report to stockholders.

With the completion of our second public offering in the fourth quarter, your Company raised net proceeds of $14,281,000 through the sale of 1,134,000 common shares.

Fiscal 1988 was highlighted by continued strong growth in revenues, earnings and earnings per share. Revenues for the year increased 80 percent to $20,829,000 from $11,603,000 in fiscal year 1987. Earnings for the year were $2,299,000 or $.50 per share, compared to net income of $1,227,000 or $.37 per share in fiscal 1987.

The significant growth in revenues and earnings resulted primarily from an increase in the number of participants we cover with review services.

With the acquisition of AFFORDABLE Health Care Concepts in the fourth quarter, COMPARE added to the health care cost management services that your Company can offer payers.

AFFORDABLE is a leading developer of payer-based Preferred Provider Organizations (PPO's) and services more than 100 clients with a proprietary database of health care price information.

As health care costs continue to increase, we believe that more payers will want the Company to provide total cost management services by negotiating provider prices for each unit of care as well as reviewing each unit of care for medical necessity.

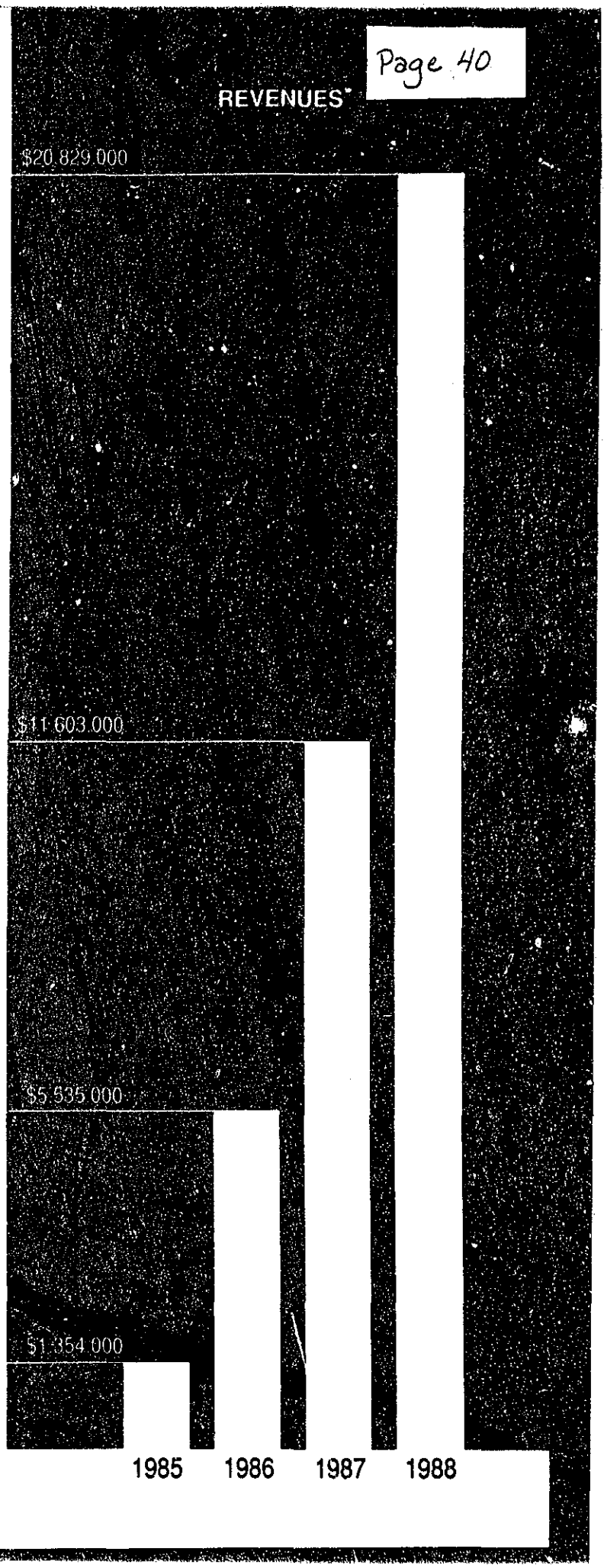
Your Company's account management has built a reputation for reliability and responsiveness with our services and client reporting systems. Our nurses and staff physicians watch health care trends to identify the changes in medical services that can lead to changes in practice patterns. And our confident and courteous professionalism has earned the respect of health care providers.

Your Company's management and staff is proud of our accomplishments and we thank you, our fellow stockholders, for your support.

Sincerely,

Robert J. Becker, M.D.
Chairman

James C. Smith
President and Chief
Executive Officer



COMPANY ACCOUNT SERVICES OFFER CLIENTS THE BEST SYSTEM OF ADMINISTRATIVE SUPPORT.

Payers come to COMPARE and AFFORDABLE to get the most out of their health care dollars. Clients stay with the Company because they respect the customized services that help them manage their benefits programs more effectively as well as more efficiently.

The Company now provides total medical cost management for Government Employee Groups, Group Health Insurance Carriers, HMO's, Multi-Employer Trusts, Self-Insured Employers, Taft-Hartley Trusts, Third Party Administrators and Worker's Compensation Carriers.

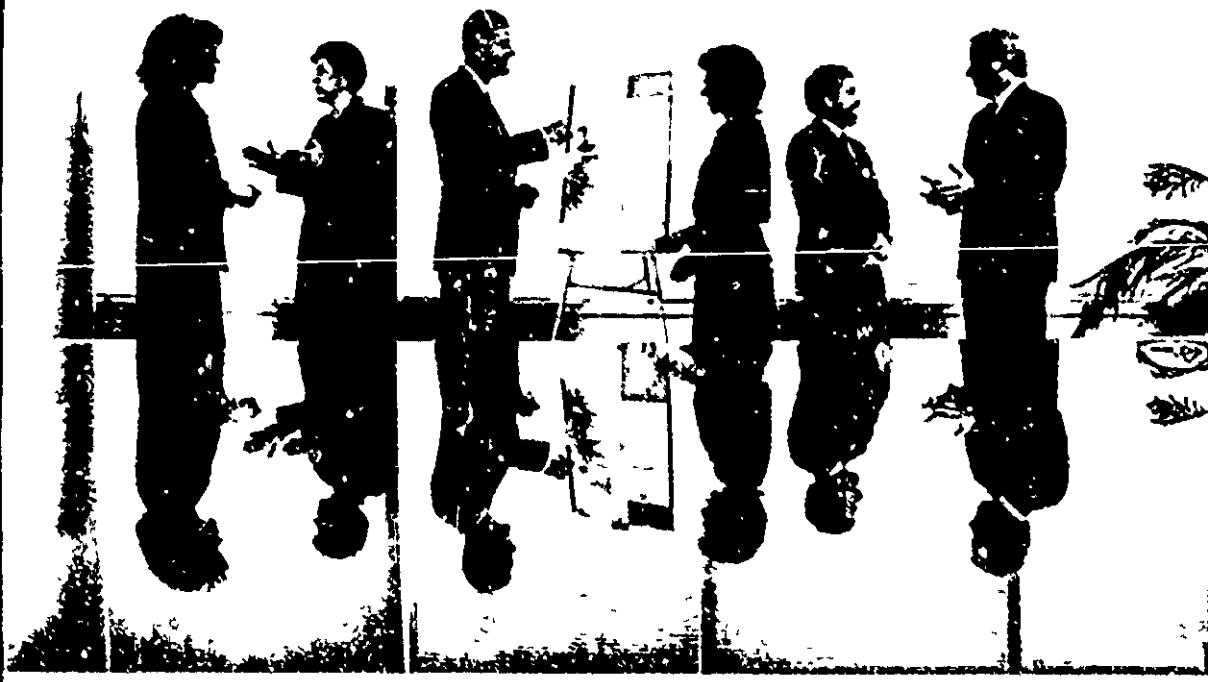
Staff assignments are made to fit each client's needs for counsel and services. Account representatives who know the client's market, report to a specialized management team.

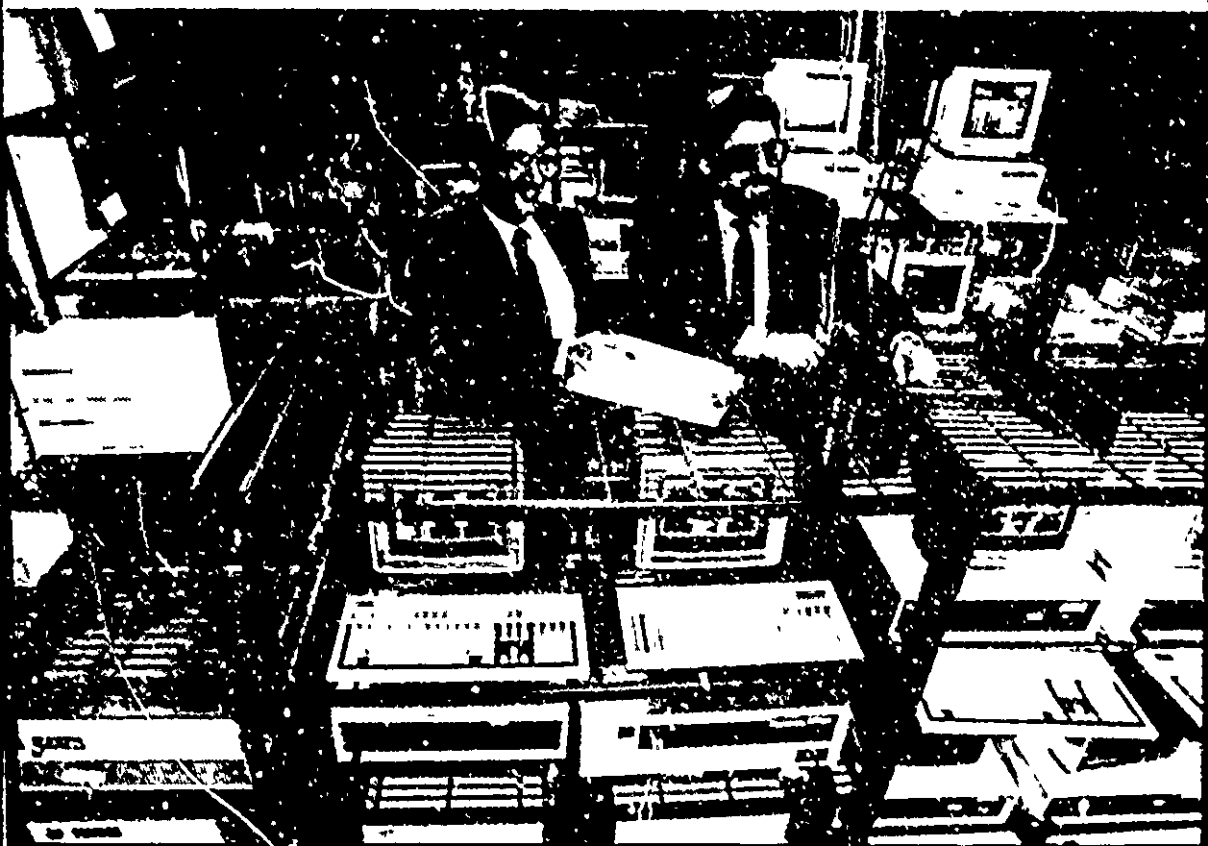
Activity reports for each program are generated at regular intervals for each account. These reports keep clients up to date on the savings they accrue on health care resources managed by COMPARE and on provider charges negotiated by AFFORDABLE.

The computer programs that produce client reports interact with review software at COMPARE. At AFFORDABLE, client reporting is linked with the claims payment database. As a result, clients can monitor progress and track their return on investment for the Company's services.

(Facing page top left to right)
SHARON COX AND LOTTIE KURTZ, NATIONAL ACCOUNT DIRECTOR FOR GOVERNMENT EMPLOYERS AND CORPORATE ACCOUNTS; PATRICK DILLS, SENIOR DIRECTOR, SALES AND MARKETING; MARGARET DEENEY, DIRECTOR OF OPERATIONS; LYN FOX AND MAE MORAN, NATIONAL ACCOUNT DIRECTORS, INSURANCE CARRIERS AND TRUSTS)

(Facing page bottom)
DR. MATTHEW KUONSO, RESEARCH DIRECTOR AND LOTTIE DEER, VICE PRESIDENT OF INFORMATION SYSTEMS, ARE SHOWN IN THE HEALTHCARE COMPARE COMPUTER CENTER. COMPARE CONTINUES ITS SYSTEMS LEADERSHIP WITH THE COUNTRY'S LARGEST LOCAL AREA NETWORK (LAN). THE SYSTEM PLANNED UNLIMITED GROWTH AND INTERACTS WITH ALL CLIENT REPORTING SYSTEMS.)





AFFORDABLE DATA MANAGEMENT OFFERS CLIENTS THE BEST SYSTEM TO MANAGE THE PRICE OF CARE.

AFFORDABLE Health Care Concepts is one of America's leading developers of Preferred Provider Organizations (PPO's) and manages client-based provider networks that experience 25% to 50% savings from billed charges.

To achieve these kinds of results, AFFORDABLE has created a unique system of claims data management

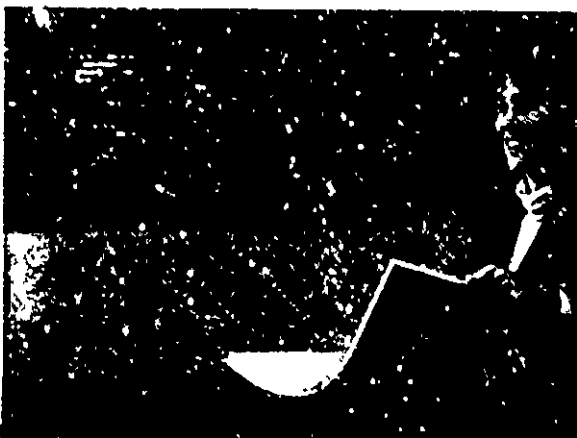
Each year, millions of claims payment records (from all regions of the country) are read into AFFORDABLE computers for clients. With this national perspective, AFFORDABLE can establish a target price to negotiate with any provider in any region covered by any group.

A client's own claims payment data are also read into AFFORDABLE computers to target the hospitals, physicians, and ancillary services that the network must include in order to insure a high level of participation by the client's group.

As these [illegible] with group activity [illegible] the client's claims process, AFFORDABLE audits claims and [illegible] utilization and provider [illegible]

AFFORDABLE uses this highly effective data-based management system to establish and operate these five types of networks:

- *Hospital-based PPO networks.*
- *Physician/ancillary services*
  Adult/adolescent substance abuse.
- *Dental and specialty providers*
- *Worker's compensation networks.*



(Above: JIM SMITH, PRESIDENT, HEALTHCARE COMPARE; DANIEL BRUNNER, PRESIDENT, AND JACK SCANLON, SENIOR VICE PRESIDENT, AFFORDABLE HEALTH CARE CONCEPTS.)

(Right: CLAIRE UPSCHULTZ, SENIOR VICE PRESIDENT, AFFORDABLE HEALTH CARE CONCEPTS, IS THE CHIEF NEGOTIATOR FOR PPO NETWORK CONTRACTS.)

COMPARE TWO-STAGE REVIEW OFFERS CLIENTS THE BEST SYSTEM TO MANAGE UNITS OF CARE.

HealthCare COMPARE now reviews the medical necessity of many types of inpatient and outpatient care.

To achieve measurable savings for clients and a unique sensitivity to patients, the Company established its group practice of physicians specializing in managed care.

COMPARE review programs are all based on a two-stage system:

In stage-one screening, nurses use review criteria that anticipate physicians practicing cost-effective medicine in efficient hospitals on patients who have no unusual problems.

When a patient has unusual problems, or when a physician has practice habits that are not cost-efficient, a COMPARE physician initiates second-stage review with a telephone call to the patient's physician.

Discussions between COMPARE staff physicians (who know their client's philosophy for the application of benefits) and attending physicians (who know their patient's medical condition) result in patient-sensitive care as well as savings for clients

(Below: COMPARE CONTINUOUSLY RECRUITS EXPERIENCED NURSES AND GIVES THEM AN INTENSIVE ONE-MONTH TRAINING PROGRAM FOR STAGE-ONE REVIEW BEFORE THEY ARE ASSIGNED TO ONE OF THE PROFESSIONAL REVIEW GROUPS. HERE, MARY ANNE CARPENTER, VICE PRESIDENT OF REVIEW PROGRAMS, ADDRESSES A CLASS.)

Stage-two reviews, conducted by the COMPARE physicians shown here, are a continuing source of data for up-dating these COMPARE programs.

- *CareLine (medical information hotline)*
- *Case Management and Review*
- *Chiropractic Review*
- *Dental Review*
- *Disability Management*
- *Fraud and Abuse Investigations*
- *Hospital Bill Auditing*
- *Managed Surgical Opinion*
- *Medical/Surgical Hospital Review*
- *Outpatient Review*
- *Psychiatric & Substance Abuse Review*
- *Worker's Compensation Review*

(Above, left to right
HARTMUT KANNEGIESSER, M.D., DALE KOA, M.D.
JAMES GEIST, M.D., ROBERT J. BUCKLER, M.D.)

(Facing page top, left to right
CLIFFORD MARBUT, M.D., CARMEN HERNANDEZ, M.D.
JEANNE MENCER, M.D., ROBERT FRUHL, M.D.
DEAN GREESON, M.D.)

(Facing page bottom left, left to right
LESTER RUDY, M.D., HAROLD NELSON, M.D.
ALEX BRADONI, M.D.)

(Facing page bottom right, left to right
MARIANNE PAVACH, M.D., ROBERT BABICK, M.D.
BRUCE RAYMOND, M.D.)

(Not shown: GEORGE COLLENTINE, M.D.
SIDNEY GOLDMAN, M.D., ROBERT GIBBS, M.D.
JANAN LANE, D.O., MARK SANDERS, D.C.)

HealthCare COMPARE Corp. and Subsidiary

SELECTED FINANCIAL DATA

	Fiscal Year Ended August 31				
	1984	1985	1986	1987	1988
Income Statement Data	(In thousands except per share data)				
Revenues	$ 39	$ 1,354	$ 5,525	$ 11,603	$ 20,829
Operating expenses:					
Cost of Services	199	1,006	2,621	5,743	10,452
Selling and marketing	259	693	1,5[illegible]	2,485	4,374
General and administrative	204	396	563	[illegible]	1,802
Depreciation and amortization	11	60	203	561	1,082
Interest, net	30	27	40	(72)	(675)
Total operating expenses	703	2,182	4,059	9,615	17,035
Income (loss) before income taxes and extraordinary item	(664)	(828)	576	1,988	3,794
Income taxes	--	--	(277)	(821)	(1,495)
Income (loss) before extraordinary item	(664)	(828)	299	1,167	2,299
Extraordinary item-utilization of net operating loss carryforward(1)	--	--	277	60	--
Net income (loss)	(664)	(828)	576	1,227	2,299
Preferred stock dividends	--	--	--	(23)	(75)
Earnings (loss) for common share computation	$ (664)	$ (828)	$ 576	$ 1,204	$ 2,224
Net income (loss) per common share					
Income (loss) before extraordinary item	$ (46)	$ (58)	$ 10	$ .35	$ .50
Extraordinary item-utilization of net operating loss carryforward(1)	--	--	.10	.02	--
Net income (loss) per share	$ (46)	$ (58)	$ .20	$ .37	$ .50
Weighted average common and common share equivalents(2)	1,420	1,436	2,913	3,230	4,415
Balance Sheet Data					
Working capital (deficit)	$ (1,007)	$ (59)	$ (263)	$ 11,907	$ 23,052
Total assets	6	1,123	2,632	17,274	38,990
Long-term debt	--	--	--	--	260
Redeemable preferred stock	--	1,000	1,000	1,500	--
Stockholders' equity (deficit)	(927)	(788)	(220)	12,322	33,679

(1) Tax reductions from use of net operating loss carryforward. During the first quarter of 1987 the Company utilized the remaining portion of net operating loss carryforward.

(2) For the years ended August 31, 1984 and 1985 the Company's common share equivalents were antidilutive since the Company had a net loss and, accordingly, have not been included in the computation of net loss per common share.

HealthCare COMPARE Corp. and Subsidiary

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

From its organization in May 1982 through August 1984 the Company was principally engaged in the development of its health care utilization review and cost management programs and the proprietary software designed to implement those programs. The Company had no revenues in fiscal 1982 or 1983 and had insignificant revenues in fiscal 1984. Operating expenses during this period consisted of costs associated with the development and enhancement of the Company's review programs and proprietary software, recruitment of personnel and employee salaries.

On June 3, 1988, the Company completed its acquisition of Affordable Health Care Concepts (Affordable). The Affordable acquisition has been accounted for as a purchase, and accordingly the Company's consolidated financial statements contain results of Affordable's operations from June 3, 1988 to August 31, 1988.

Results of Operations

The following table presents the percentages of the Company's revenue represented by certain income statement items and compares the percentage change in dollar amount of these items to the indicated prior period.

	Year Ended August 31			Period to Period Change Increase	
	1986	1987	1988	1987 vs 1986	1988 vs 1987
Revenues	100%	100%	100%	110%	80%
Expenses					
Cost of Services	47	50	50	119	82
Selling & Marketing	28	22	21	63	76
General and administrative	10	8	9	71	87
Depreciation and amortization	4	4	5	147	116
Interest, net	1	(1)	(3)	*	777
	90	83	82	84	77
Income before income taxes and extraordinary item	10	17	18	285	91
Net income	10%	10%	11%	113%	87%

*Not Meaningful

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Revenues. The Company's revenues consist of fees for utilization review and cost management services provided under contracts which typically require clients to pay a fixed monthly charge for each participant, excluding covered dependents (capitated revenue), in a client sponsored health care plan. To a lesser extent, the Company derives revenues from case management and other specialized services on an hourly basis (fee-based revenue). Fee-based revenue has increased significantly from August 1987 to the present.

Total revenues increased by $6,069,000 (110%) and $9,226,000 (80%) from fiscal 1986 to fiscal 1987 and from fiscal 1987 to 1988, respectively. This growth is primarily attributable to increased sales and marketing efforts, the addition of new programs, the unbundling of existing programs, and, in management's opinion, a growing recognition of utilization review services as an effective means of controlling health care costs. Price increases have not been an important factor in the Company's revenue growth. There can be no assurance that the Company will continue to experience revenue growth comparable to prior periods.

The following table sets forth unaudited information with respect to the Company's capitated and fee-based revenue for the years ended August 31, 1986, 1987 and 1988 and the percentage of total revenues represented by such revenue.

	For the Year Ended August 31					
	1986	%	1987	%	1988	%
	(000 omitted)					
Capitated Revenue	$5,145	93%	$10,533	91%	$15,524	75%
Fee-Based Revenue	390	7	1,070	9	5,305	25
Total	$5,535	100%	$11,603	100%	$20,829	100%

Cost of Services. Cost of services, which consists primarily of nurse reviewer and physician salaries, telephone expenses and facility expenses and information processing costs has increased significantly as the Company has expanded its review staff and telephone and computer systems to enable it to serve a larger revenue base. As a percentage of revenues, however, cost of services were 47% in fiscal 1986, 50% in fiscal 1987 and 50% in fiscal 1988.

Selling and Marketing. Selling and marketing expenses have increased primarily due to the hiring of additional sales and marketing personnel and increased advertising, promotional and travel expenditures. As a percentage of revenues, however, selling and marketing expenses decreased from 28% in fiscal 1986 to 22% in fiscal 1987 and to 21% in fiscal 1988. The decrease from fiscal 1986 to 1987 primarily resulted from the effectiveness of prior marketing efforts and because revenues increased more rapidly than selling and marketing expenses.

General and Administrative. General and administrative costs increased for fiscal 1986, 1987 and 1988 primarily due to the hiring of additional executive and administrative personnel. As a percentage of revenues, however, these costs decreased from 10% in fiscal 1986 to 8% in fiscal 1987 and increased to 9% in 1988. The decreases from 1986 to 1987 occurred primarily because general and administrative costs increased less rapidly than revenues due to greater operating efficiencies realized as a result of the Company serving a larger revenue base. The increase from 1987 to 1988 was primarily due to various general and administrative expenses associated with the Affordable acquisition.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Depreciation and Amortization. As a percentage of revenues, depreciation and amortization expenses remained relatively constant at approximately 4% in each of fiscal 1986 and 1987, and increased to 5% in fiscal 1988. These expenses have increased as a result of the purchase of additional computer hardware and software, telephone and office equipment, the amortization of leasehold improvements in connection with the Company's relocation into a new and significantly larger corporate headquarters in September 1987 and costs in excess of net assets acquired in connection with the Affordable acquisition.

Interest, Net. The Company incurred interest expense representing 1% of revenues in fiscal 1986. The Company has invested a significant portion of the net proceeds from its public offerings in May 1987 and July 1988 in various interest bearing instruments and, as a result, the Company generated net interest income that represented 1% of revenues in fiscal 1987 and 3% of revenues in fiscal 1988.

Income taxes. For fiscal 1986, a net operating loss carryforward offset income tax expenses. During the first quarter of fiscal 1987, the Company utilized the remaining portion of its net operating loss carryforward. The Tax Reform Act of 1986 eliminates all investment tax [illegible] that would otherwise be available to the Company and reduced the federal statutory corporate income tax rate applicable to the Company to 44% in fiscal 1987 and to 34% thereafter. See note 4 of the Notes to Consolidated Financial Statements.

Seasonality. The Company has historically experienced significant salary and related training costs for nurse reviewers and physicians as well as associated equipment costs during its first and second fiscal quarters in anticipation of an increase in the number of new participants during the open enrollment period. Since health care plans typically have an open enrollment period for new participants during January of each year, the Company anticipates that its future first and second quarters will continue to reflect cost increases resulting from the addition of nurses and physicians and related expenditures. Future earnings could be adversely affected if the Company incurs costs in excess of those necessary to service the actual number of new participants resulting from open enrollment.

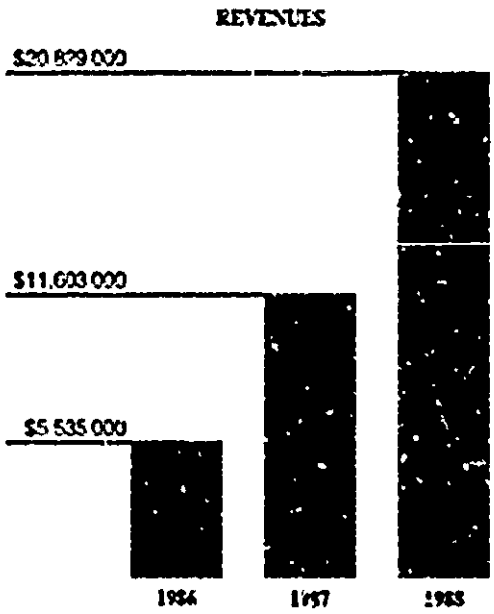
Inflation. Although inflation has not had a significant effect on the Company's operations to date, management believes that the rate at which health care costs have increased has contributed significantly to the demand for utilization review and cost management services such as those provided by the Company.

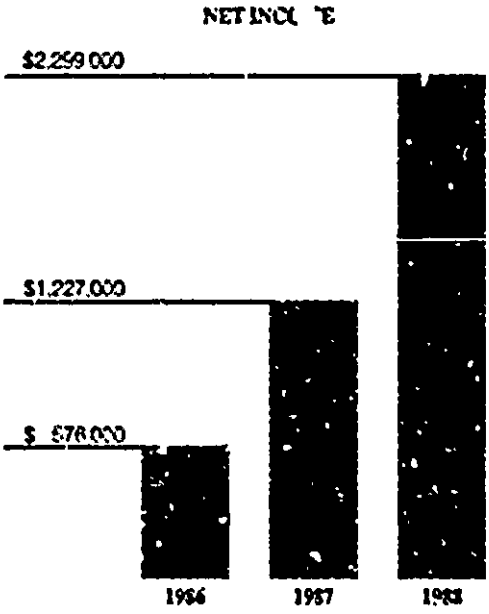
Liquidity and Capital Resources

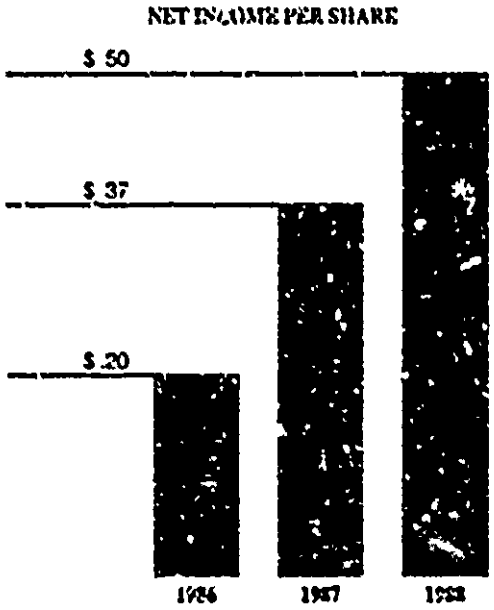
The Company had $23,082,000 of working capital at August 31, 1988, as compared with $11,907,000 of working capital at August 31, 1987. The Company's primary source of liquidity in fiscal 1987 and 1988 was the net proceeds of $12,818,000 and $12,747,000 from the issuance of common stock in two public stock offerings. Additionally, $1,534,000 was received in September 1988 through the Underwriters exercise of their over-allotment option. The significant uses of working capital included additions of property and equipment and other assets to support the Company's expanded base of business.

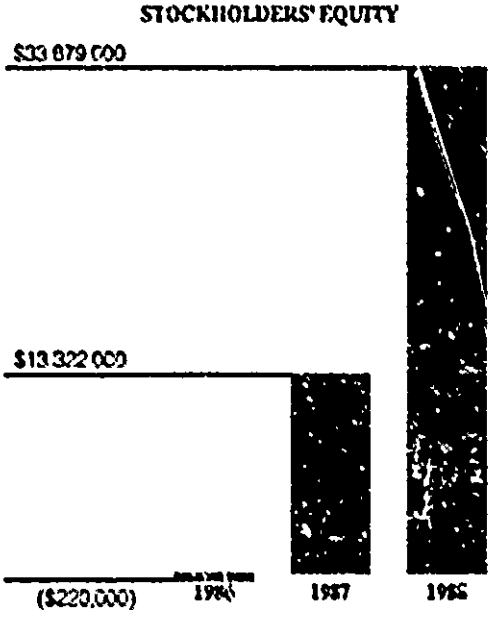
The Company believes that cash generated from future operations, the proceeds of its public offerings, and the Company's currently unused $5,000,000 bank line of credit, will be sufficient to fund the Company's operations and its anticipated expansion for the next 12 to 24 months depending upon the level of business expansion.

IBM









(On facing page ALLAN LORN, M.D.
DIRECTOR OF THE COMPANY MEDICAL DEPARTMENT
CONDUCTS A REVIEW WITH A PATIENT'S PHYSICIAN
CAUSE A WATS LINE, HIS COMPUTER SCREEN
COMPARES BENEFITS PLAN COVERAGE WITH
THE PHYSICIAN'S TREATMENT PLAN.)

HealthCare COMPARE Corp. and Subsidiary

FINANCIAL REPORT

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Consolidated Statements of Operations	[illegible]
Consolidated Statements of Stockholders' Equity	21
Consolidated Statements of Cash Flows	22
Notes to Consolidated Financial Statements	24

REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS

Board of Directors and Stockholders
HealthCare COMPARE Corp
Downers Grove, Illinois

We have audited the accompanying consolidated balance sheets of HealthCare COMPARE Corp and Subsidiary as of August 31, 1987 and 1988, and the related consolidated statements of operations, stockholders' equity and cash flows for each of the three years in the period ended August 31, 1988. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HealthCare COMPARE Corp and Subsidiary as of August 31, 1987 and 1988, and the results of its operations and its cash flows for each of the three years in the period ended August 31, 1988, in conformity with generally accepted accounting principles.

Laventhol & Horwath
LAVENTHOL & HORWATH

Chicago, Illinois
October 18, 1988

HealthCare COMPARE Corp. and Subsidiary

CONSOLIDATED BALANCE SHEETS

ASSETS

	August 31	
	1997	1996
Current Assets		
Cash and cash equivalents	$ 12,667,000	$ 23,104,000
Accounts receivable, net	1,353,000	3,306,000
Supplies inventory	229,000	205,000
Prepaid expenses	89,000	220,000
Total current assets	14,337,000	26,835,000
Property and Equipment		
Computer equipment and software	1,625,000	3,344,000
Office furniture and equipment	1,350,000	3,073,000
Leasehold improvements	382,000	1,517,000
	3,357,000	7,934,000
Less accumulated depreciation and amortization	(427,000)	(1,484,000)
Total property and equipment	2,930,000	6,454,000
Cost in excess of net assets acquired net of accumulated amortization of $71,000 in 1996	-	5,600,000
Other assets, net of accumulated amortization of $108,000 in 1997 and $270,000 in 1996	247,000	101,000
	$ 17,274,000	$ 38,990,000

LIABILITIES AND STOCKHOLDERS' EQUITY

	August 31	
	1997	1996
Current Liabilities		
Current portion of long-term obligations	$ -	$ 38,000
Accounts payable	980,000	2,010,000
Accrued expenses	689,000	1,155,000
Income taxes payable	761,000	550,000
Total current liabilities	2,430,000	3,753,000
Deferred Compensation	22,000	-
Long-Term Obligations, Net of Current Portion		269,000
Deferred Income Taxes	-	762,000
Deferred Rent	-	637,000
Total liabilities	2,452,000	5,111,000
Commitments		
Redeemable Preferred Stock	1,500,000	
Stockholders' Equity		
Common stock	42,000	56,000
Additional paid-in capital	13,350,000	31,649,000
Retained earnings (deficiency)	(70,000)	2,154,000
Total stockholders' equity	13,322,000	33,879,000
	$ 17,274,000	$ 39,990,000

See notes to consolidated financial statements.

HealthCare COMPARE Corp. and Subsidiary

CONSOLIDATED STATEMENTS OF OPERATIONS

	Years Ended August 31,		
	1988	1987	1986
Revenues	$ 5,535,000	$ 11,603,000	$ 20,829,000
Operating expenses			
Cost of services	2,624,000	5,743,000	10,452,000
Selling and marketing	1,523,000	2,485,000	4,374,000
General and administrative	563,000	963,000	1,802,000
Depreciation and amortization	203,000	501,000	1,082,000
Interest, net	46,000	(77,000)	(675,000)
	4,959,000	9,615,000	17,035,000
Income before income taxes and extraordinary item	576,000	1,988,000	3,794,000
Income taxes	(277,000)	(861,000)	(1,495,000)
Income before extraordinary item	299,000	1,127,000	2,299,000
Extraordinary item - utilization of net operating loss carryforward	277,000	80,000	--
Net income	576,000	1,207,000	2,299,000
Preferred stock dividends	--	(23,000)	(75,000)
Earnings for common share computations	$ 576,000	$ 1,204,000	$ 2,224,000
Weighted average common and common share equivalents	2,919,000	3,230,000	4,415,000
Net income per common share			
Income before extraordinary item	$ .10	$ .35	$ .50
Extraordinary item - utilization of net operating loss carryforward	.10	.02	-
Net income per common share	$ .20	$ .37	$ .50

See notes to consolidated financial statements

HealthCare COMPARE Corp. and Subsidiary

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Shares		Amount		Common Stock		Paid-in capital	Retained Earnings (Deficiency)
			Series A	Series C	Shares	Amount		
Balance, August 31, 1985			[illegible]	$500,000	1,430,000	$14,000	$ 38,000	$(1,850,000)
Issuance of common stock	--	-		-	59,000	1,000	1,000	--
Net income	-	--		-	--	--	--	576,000
Balance, August 31, 1986	700	500	500,000		1,489,000	15,000	39,000	(1,274,000)
Issuance of common stock	--	--	-		1,307,000	13,000	12,825,000	-
Conversion of preferred stock into redeemable preferred stock	(500)	-	(500,000)	--	--	--	--	--
Common stock issued upon conversion of convertible preferred stock	--	(500)	--	(500,000)	1,430,000	14,000	486,000	--
Preferred stock dividends	--	--	--	--	-	--	--	(23,000)
Net income	--	--	--	-	--	--	--	1,227,000
Balance, August 31, 1987	--	--	--	--	4,226,000	42,000	13,350,000	(70,000)
Issuance of common stock	--	-	--	--	1,415,000	14,000	18,319,000	-
Preferred stock dividends	--	--	--	--	--	--	--	(76,000)
Net income	--	--	-		--	--	--	2,299,000
Balance, August 31, 1988	--	-	$ -	$ --	5,641,000	$56,000	$31,669,000	$2,154,000

See notes to consolidated financial statements

HealthCare COMPARE Corp. and Subsidiary

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Years Ended August 31		
	1988	1987	1986
Cash flows from operating activities:			
Cash received from customers	$ 4,626,000	$ 11,364,000	$ 18,908,000
Cash paid to suppliers and employees	(4,297,000)	(8,998,000)	(14,650,000)
Interest paid	(74,000)	([illegible],000)	(24,000)
Interest received	8,000	[illegible],000	699,000
Income taxes paid	--	--	(1,254,000)
Net cash provided by operating activities	263,000	2,381,000	3,679,000
Cash flow from investing activities:			
Payment for purchase of subsidiary net of cash acquired		--	(314,000)
Purchase of property and equipment	(1,021,000)	(1,911,000)	([illegible],000)
Net cash used in investing activities	([illegible])	(1,911,000)	(4,344,000)
Cash flow from financing activities:			
Net borrowings under line-of-credit agreement	680,000	--	--
Payments under line-of-credit agreement	-	(680,000)	
Principal payment, notes payable – stockholders	(265,000)	(67,000)	
Principal payment on debt			(75,000)
Redemption of preferred stock		-	(1,500,000)
Proceeds from issuance of stock	2,000	12,839,000	12,775,000
Dividends paid	-	--	(98,000)
Net cash provided by financing activities	417,000	12,091,000	11,102,000
Net increase (decrease) in cash	(341,000)	12,561,000	10,437,000
Cash and cash equivalents, beginning of period	447,000	106,000	12,667,000
Cash and cash equivalents, end of period	$ 106,000	$ 12,667,000	$ 23,104,000

See notes to consolidated financial statements.

HealthCare COMPARE Corp. and Subsidiary

CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Years Ended August 31		
	1986	1987	1988
Reconciliation of net income to net cash provided by operating activities			
Net income	$ 576,000	$ 1,227,000	$ 2,239,000
Adjustments to reconcile net income to net cash provided by operating activities			
Depreciation and amortization	209,000	501,000	1,087,000
Deferred income taxes			452,000
Deferred rent			537,000
Changes in assets and liabilities			
Increase in accounts receivable	(909,000)	(297,000)	(1,953,000)
(Increase) decrease in supplies inventory	(89,000)	(41,000)	24,000
Increase in prepaid expenses	(24,000)	(44,000)	(132,000)
Increase in other assets		(299,000)	(16,000)
Increase in accounts payable	362,000	192,000	1,053,000
Increase in accrued expenses	128,000	524,000	466,000
Increase (decrease) in deferred compensation	16,000	(143,000)	(22,000)
Increase (decrease) in income taxes payable		761,000	(211,000)
Total adjustments	(313,000)	1,154,000	1,380,000
Net cash provided by operating activities	$ 263,000	$ 2,381,000	$ 3,619,000

Supplemental schedule of non-cash investing and financing activities

The Company issued [illegible],000 shares of common stock and assumed $452,000 of debt in connection with the acquisition of Affordable Healthcare Concepts. On the effective date of the acquisition, the closing price of the Company's common stock was $14.25 per share.

See notes to consolidated financial statements.

HealthCare COMPARE Corp. and Subsidiary

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES:

The Company:

HealthCare COMPARE Corp. provides utilization review and cost management services to various entities throughout the nation, including group health insurance carriers, third party administrators, self-insured employers, government employee groups, and multi-employer trusts.

Principles of consolidation:

The financial statements include the accounts of the Company and its wholly-owned subsidiary. Material intercompany balances and transactions have been eliminated.

Property and equipment:

Property and equipment are stated at cost. Expenditures for the maintenance and repair of property and equipment are charged to expense as incurred. Expenditures for major replacement or betterment are capitalized.

Depreciation is provided using the straight-line method over the estimated useful lives ranging from 3 to 5 years. Leasehold improvements are amortized over the shorter of the estimated useful life of the asset or the term of the lease.

Income taxes:

Income taxes are provided on income for financial reporting purposes after adjustment for income and expense items which would not enter into the computation of income taxes payable. Investment tax credits were treated as a reduction of the provision for income taxes in the year in which the credit was utilized.

Effective for 1987, the Tax Reform Act of 1986 eliminated investment tax credit, changed depreciation rates, and reduced the corporate tax rates. In 1989, the Company will adopt Statement of Financial Accounting Standards No. 96 (SFAS No. 96) Accounting for Income Taxes. Management does not expect that the changes under the Tax Reform Act of 1986 or the adoption of SFAS No. 96 will have a material impact on the Company's financial position or results of operations.

Revenue recognition:

The Company recognizes revenue based upon a fixed fee per covered participant and the fee varies depending upon the programs selected. In addition, the Company derives revenue on an hourly basis for Case Management and other specialized programs.

Net income per share:

Net income per share is based on the average number of common and common share equivalents outstanding during the period. The average number of common and common share equivalents (assuming conversion of Series C Preferred in 1986 and 1987) was 2,919,000 in 1986, 3,230,000 in 1987 and 4,415,000 in 1988. The assumed exercise of stock options would not result in a material dilution.

Cash and cash equivalents:

Cash equivalents consist principally of money market funds and are stated at cost which approximates market. Interest income was $8,000, $133,000 and $099,000 for 1986, 1987, and 1988.

Cost in excess of net assets of subsidiary:

Cost in excess of the net assets of acquired subsidiary is amortized, on a straight line basis, over a period of 20 years.

Change in basis of presentation:

To comply with Statement of Financial Accounting Standards No. 95, the prior-years statements of changes in financial position have been replaced by the statements of cash flows.

HealthCare COMPARE Corp. and Subsidiary

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

2. LONG-TERM OBLIGATIONS:

	August 31	
	1987	1988
Note payable to former stockholders of subsidiary interest at 14% per annum with monthly principal and interest payments of $5,962 payable through October 15, 1994 (including deferred interest of $100,000 in 1988)		$ 290,000
Equipment under capital leases net of amounts representing interest		17,000
		307,000
Less current portion		39,000
	$ -	$ 268,000

Maturities on long-term obligation for each of the next five years are as follows.

Year Ended August 31	Amount
1989	$ 39,000
1990	44,000
1991	49,000
1992	50,000
1993	57,000
Thereafter	68,000
	$307,000

Interest expense was $37,000, $55,000 and $24,000 for the years ended August 31, 1986, 1987, and 1988. During 1988, the Company's revolving line of credit was increased to $5,000,000 with interest payable at the prime rate. No amounts have been borrowed on the line as of August 31, 1988.

3. AFFORDABLE HEALTH CARE CONCEPTS ACQUISITION:

On June 3, 1988 the Company acquired Affordable Health Care Concepts ("Affordable") a Sacramento, California-based health care cost management firm specializing in the development and management of custom-tailored, payer-based preferred provider organizations and the collection and analysis of health care cost data, in exchange for 390,000 shares of the Company's Common Stock. The purchase price of $6,182,000 was allocated to the acquired assets and liabilities based upon the current purchase accounting principles. The purchase price exceeded the fair market value of the net assets by $5,671,000 and is being amortized over 20 years. The operations of Affordable are included in the consolidated statement of operations from the date of acquisition.

Prior to the closing of the acquisition, Affordable's largest client, Community Care Network ("CCN"), terminated its contractual relationship with Affordable and the terms of the acquisition were renegotiated to reflect this occurrence. The following table summarizes the combined unaudited pro forma consolidated operating results as if the acquisition of Affordable had occurred on September 1, 1986 and adjusted for management's best estimates of the effect of (i) the loss of CCN, (ii) elimination of discretionary costs incurred because of the prior status of Affordable as a private company, not managed with the goal of maximizing reported net income, and (iii) the amortization of the unallocated excess of Affordable's purchase price over the net assets acquired.

	Year Ended August 31	
	1987	1988
	(unaudited)	
Revenues	$13,331,000	$22,257,000
Net income	1,267,000	1,764,000
Net income per common share		
Income before extraordinary item	.27	.36
Net income	.29	.36

The pro forma operating results do not purport to be indicative of the results that actually would have been obtained had the combined operations been conducted during the periods presented and are not intended to be a projection of future operating results.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

4. INCOME TAXES:

In 1986, pre-tax income was offset by the utilization of available loss carryforwards. During 1987, the remaining loss carryforwards were completely utilized.

Components of the provision for income taxes:

	August 31,		
	1986	1987	1988
Current			
Federal	$ ---	$ 669,000	$ 896,000
State	---	92,000	147,000
	---	761,000	1,043,000
Deferred			
Federal	---	---	367,000
State	---	---	85,000
	---	--	452,000
Tax effect of loss carryforward	277,000	60,000	---
Total	$ 277,000	$ 821,000	$1,495,000

Reconciliation of statutory to effective income tax rate:

	August 31		
	1986	1987	1988
Federal statutory rate	46%	44%	34%
State taxes, net of federal benefit	3	3	4
Expenses not deductible for income tax purposes	--	--	7
Non-taxable interest income and dividends	--	(3)	(6)
Tax benefit of credit utilization	--	(3)	--
Other	(1)	--	--
Effective income tax rate	48%	41%	39%

The sources of deferred income taxes and their tax effects are as follows:

	August 31		
	1986	1987	1988
Excess of tax over book depreciation	--	--	$207,000
Expenses for financial statements in excess of amounts deducted for tax	--	--	(128,000)
Limited partnership losses deductible for tax purposes not recognized for financial statements	--	--	373,000
	$ --	$ --	$452,000

5. EMPLOYMENT AGREEMENTS AND DEFERRED COMPENSATION:

The Company has employment agreements, expiring between 1988 and 1993, with certain officers and key employees. The agreements provide for, among other things, annual base salaries, and incentive and deferred compensation. A portion of the incentive compensation is based on achievement of certain goals; the balance is at the discretion of the Board of Directors.

At August 31, 1987, certain key employees were entitled to receive future deferred compensation payments aggregating $50,000. No payments were due at August 31, 1988.

6. REDEEMABLE PREFERRED STOCK:

At August 31, 1987, the Company had authorized, issued and outstanding 1,000 shares of Series B redeemable preferred stock, $1.00 par value ("Series B Preferred"). In April 1987, the Board of Directors amended the mandatory redemption features of the Series B Preferred to require that after May 31, 1988, if the net income of the Company for any preceding period of four consecutive fiscal quarters is at least $1,900,000, the Company must redeem within 45 days all outstanding shares of Series B Preferred at a redemption price of $1,000 per share, plus a dividend in an amount equal to 6% per annum of such redemption price computed from June 1, 1987 to the date of redemption.

At August 31, 1987, the Company had authorized, issued, and outstanding 500 shares of Series A redeemable preferred stock, $1.00 par value ("Series A Preferred"). In April, 1987, the Board of Directors adopted identical mandatory redemption provisions (as stated above for the Series B Preferred) with respect to the Series A Preferred. As a result of these changes, these shares have been classified as Redeemable Preferred Stock at August 31, 1987. The Series A Preferred and Series B Preferred were redeemed in July 1988 at the redemption price plus accrued dividends of $98,000.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

7. STOCKHOLDERS' EQUITY:

Public offerings:

In 1987 the Company completed its initial public offering of 1,300,000 shares of Common Stock and raised net proceeds of $12,818,000. During 1988 the Company completed a public offering of 1,134,000 shares of Common Stock and raised net proceeds of $14,281,000 (includes the Underwriters exercise of their over-allotment option in September 1988). The proceeds from these offerings are being used for general corporate purposes, principally to provide funds for working capital, new cost management programs and possible acquisitions.

Recapitalization:

In April 1987 the Board of Directors approved the conversion of each issued and outstanding share of Class B Common Stock, $.01 par value, into one share of Class A Common Stock, $.01 par value. The Class A Common Stock was redesignated as Common Stock, $.01 par value, and the number of authorized shares of Common Stock was increased to 20,000,000 shares. Additionally, the Board approved a two-for-three reverse stock split, effective April 10, 1987. All share per share, and stock option data has been retroactively adjusted for the stock split.

Convertible preferred stock:

Through the year ended August 31, 1986, the Company had authorized, issued and outstanding 500 shares of Series C participating convertible redeemable preferred stock, $1.00 par value ("Series C Preferred"). The Series C Preferred had a liquidation value of $1,000 per share, plus any declared but unpaid dividends. In connection with the Company's initial public offering these shares were converted into 1,430,000 shares of Common Stock.

Stock options:

In September 1985, the Company established an incentive stock option plan which provided for the issuance of a maximum of 84,667 stock options to key employees. Subsequently, the Board of Directors and Stockholders of the Company approved an increase in the number of shares subject to the plan to 250,000. In June 1988 the Board of Directors amended the plan, subject to stockholder approval, to increase to 500,000 the number of shares subject to the plan. During the year ended August 31, 1988, options to acquire 11,000 shares were exercised at prices ranging from $2.[illegible]6 to $4.50 per share. As of August 31, 1988 there were [illegible] options outstanding to purchase 341,000 shares, including 88,000 immediately exercisable options, at prices ranging from $2.25 to $14.25 per share which expire on various dates between 1996 and 1997.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

8. LEASE COMMITMENTS

The Company acquired a 50% limited partnership interest in the partnership that owns the building in which its headquarters are located. This 50% limited partnership interest is accounted for under the equity method of accounting. Under the lease, which expires in 2002, the Company is required to provide a security deposit (which secures the Company's obligations for rent and other monetary payments under the lease) of up to $500,000 in the form of bank issued letters of credit. Additionally the Company leases office space from a stockholder under the terms of an operating lease which expires in October, 1989. Rent expense, under this lease was $165,000 in 1986, $240,000 in 1987, and $244,000 in 1988. The Company's subsidiary also leases office facilities under operating leases extending through 1993. At August 31, 1988 future minimum annual rental commitments under all operating leases were as follows:

Year Ending August 31	Amount
1989	$ 527,000
1990	2,074,000
1991	2,048,000
1992	1,969,000
1993	1,722,000
Thereafter	10,[illegible]
Total	$[illegible]

Total rent expense recognized under the straight line method was $165,000 in 1986, $240,000 in 1987 and $959,000 in 1988.

The Company's subsidiary signed a lease commitment in June 1988 for new office space commencing sixty days after the landlord delivers possession of the substantially completed premises, scheduled for December 1989. The rent commitment of $63,075 per month for ten years, with one five year option to renew, commences on the lease commencement date. The subsidiary's old lease terminates on this commencement date.

9. MAJOR CUSTOMERS:

In 1986 and 1987 the Company had contracts with three customers (The Mail Handlers Benefit Plan, Mutual of Omaha Insurance Company and General American Life Insurance Company) which represented 59% and 49% of total revenues respectively. In 1988 the Company had contracts with two customers (The Mail Handlers Benefit Plan and Mutual of Omaha Insurance Company) which accounted for 50% of total revenue.

10. LITIGATION

a) In December 1987, Affordable was named a defendant in a lawsuit filed in the United States District Court, Central District of California alleging violation of federal antitrust and California State trade regulation laws. The suit is premised on the allegation that Affordable and the other named defendants conspired to boycott a certain medical center from providing services to workers' compensation patients through the establishment of a network of health care providers which did not include the plaintiff. The suit also alleges that the conduct of the defendants constituted resale price fixing.

Discovery has only recently commenced and the outcome of this action cannot be predicted at this time. Management believes that the case is without merit and it intends vigorously to defend the action.

b) In April 1986, Community Care Network ("CCN"), then Affordable's largest client, terminated its contractual relationship with Affordable. The Company believes that the contract was wrongfully terminated and is seeking substantial monetary damages from CCN. As a result of this contract termination, the terms of the Affordable acquisition were renegotiated to reflect this occurrence. There are both arbitration proceedings and a civil suit pending in California which concern the termination of CCN's relationship with Affordable. In these proceedings, Affordable alleges that it suffered damages in excess of $20,000,000 as a result of the wrongful termination of the relationship. The former shareholders of Affordable are also plaintiffs in the civil suit and allege that the defendants intended to interfere with the proposed acquisition of Affordable by the Company, thereby precluding them from receiving the economic benefits of the transaction. The former shareholders allege that they have suffered damages in excess of $12,000,000.

11. COMMITMENTS:

The Company entered into agreements with two consultants who will provide the Company with various consulting services for a period of 10 years commencing in June 1989. The consulting fees to be paid under these agreements will aggregate $500,000 payable $[illegible] quarterly commencing in June 1989.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

12. Quarterly Financial Data (Unaudited)

The following is a summary of unaudited results of operations (in thousands except per share data) for the years ended August 31, 1988 and 1987

1988	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Revenue	$3,958	$4,737	$5,131	$7,003
Net income	399	484	631	815
Net income per common share	$ .08	$ .11	$ .14	$ .16
Weighted average common and common share equivalents	4,790	4,230	4,234	4,965
1987				
Revenue	$2,330	$2,654	$3,135	$3,484
Net income	250	237	295	445
Net income per common share	$ .09	$ .08	$ .10	$ .10
Weighted average common and common share equivalents	2,906	2,906	2,906	4,153

CORPORATE AND INVESTOR INFORMATION

Independent Certified Public Accountants
Laventhol & Horwath
Chicago, Illinois

Corporate Counsel
Neal Gerber Eisenberg & Lurie
Chicago, Illinois

Transfer Agent & Registrar
The Exchange National Bank of Chicago
Chicago, Illinois

Form 10-K
The Company has filed an Annual Report on Form 10-K with the Securities and Exchange Commission. Stockholders may obtain a copy of this report, without charge, by writing: Joseph Whitters, Chief Financial Officer, HealthCare COMPARE Corp., 3200 Highland Ave., Downers Grove, IL 60515

Common Stock
HealthCare COMPARE Corp common stock is traded in the over-the-counter market on NASDAQ under the symbol HCCC.
The following table shows the quarterly range of high and low prices of the Common Stock on the National Market System since the Company's initial public offering on May 29, 1987

	High	Low
Fiscal 1987:		
Third Quarter (from May 29)	12 1/4	11 1/2
Fourth Quarter	13 1/4	10 3/4
Fiscal 1988:		
First Quarter	14 1/2	7 3/8
Second Quarter	15 1/4	7 3/4
Third Quarter	17 1/2	13
Fourth Quarter	15 1/2	13 1/8
Fiscal 1989:		
First Quarter	[illegible]	12

As of November 8, 1988, the Co[illegible]d
197 stockholders of record

Dividend Policy
The Company has not paid any dividends on its Common Stock and expects that its earnings will be retained for use in the operation and expansion of its business

Annual Meeting
The annual meeting of stockholders will be held at HealthCare COMPARE Corp. at 2 00 p m on January 31, 1989

Corporate Headquarters
HealthCare COMPARE Corp
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Downers Grove, IL 60515-1223
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