ATHENAHEALTH INC
Form 424B4
September 20, 2007

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Filed Pursuant to Rule 424(b)(4)
Registration No. 333-143998

6,286,819 Shares

Common Stock

This is an initial public offering of shares of common stock of athenahealth, Inc.

athenahealth is offering 5,000,000 shares of common stock to be sold in the offering. The selling stockholders identified in this prospectus are offering an additional 1,286,819 shares. athenahealth will not receive any of the proceeds from the sale of the shares by the selling stockholders.

Prior to this offering, there has been no public market for our common stock. The common stock has been approved for listing on the NASDAQ Global Market under the symbol ATHN.

See Risk Factors on page 8 to read about factors you should consider before buying shares of the common stock.

Neither the Securities and Exchange Commission nor any other regulatory body has approved or disapproved of these securities or passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

	Per Share	Total
Initial public offering price	$ 18.00	$ 113,162,742
Underwriting discount	$ 1.26	$ 7,921,392
Proceeds, before expenses, to athenahealth	$ 16.74	$ 83,700,000
Proceeds, before expenses, to the selling stockholders	$ 16.74	$ 21,541,350

To the extent that the underwriters sell more than 6,286,819 shares of common stock, the underwriters have the option to purchase up to an additional 943,023 shares from the selling stockholders at the initial public offering price less the underwriting discount.

The underwriters expect to deliver the shares against payment in New York, New York on September 25, 2007.

Goldman, Sachs & Co. **Merrill Lynch & Co.**

Piper Jaffray **Jefferies & Company**

Prospectus dated September 19, 2007

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You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with information different from that contained in this prospectus. We are offering to sell, and are seeking offers to buy, shares of common stock only in jurisdictions where offers and sales are permitted. The information contained in this prospectus is accurate only as of the date of this prospectus, regardless of the time of delivery of this prospectus or of any sale of our common stock.

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PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus and does not contain all of the information you should consider before buying shares of our common stock. Before deciding to invest in shares of our common stock, you should read the entire prospectus carefully, including our consolidated financial statements and the accompanying notes and the information set forth under the headings Risk Factors and Management s Discussion and Analysis of Financial Condition and Results of Operations, in each case included elsewhere in this prospectus.

athenahealth, Inc.

Overview

athenahealth is a provider of internet-based business services for physician practices. Our service offerings are based on three integrated components: our proprietary internet-based software, our continually updated database of payer reimbursement process rules and our back-office service operations that perform administrative aspects of billing and clinical data management for physician practices. Our principal offering, athenaCollector, automates and manages billing-related functions for physician practices and includes a medical practice management platform. We have also developed a service offering, athenaClinicals, that automates and manages medical record-related functions for physician practices and includes an electronic medical record, or EMR, platform. We refer to athenaCollector as our revenue cycle management service and athenaClinicals as our clinical cycle management service. Our services are designed to help our clients achieve faster reimbursement from payers, reduce error rates, increase collections, lower operating costs, improve operational workflow controls and more efficiently manage clinical and billing information.

Our services require relatively modest initial investment, are highly adaptable to changing healthcare and technology trends and are designed to generate significant financial benefit for our physician clients. Our results are directly tied to the financial performance of our clients, because the majority of our revenue is based on a percentage of their collections. Our fees are typically 2% to 8% of a practice s total collections depending upon the size, complexity and other characteristics of the practice, with other fees for implementation, patient billing statements and training services. Our services have enabled our clients, on average, to resolve 93% of their claims to payers on their first submission attempt, compared to an industry average we estimate to be 70%. Our internal studies show that we have reduced the days in accounts receivable of our client base by more than 30%. We have experienced a contract renewal rate of at least 97% in each of the last five years, and this persistent client base drives a predictable revenue stream. In 2006, we generated revenue of $75.8 million from the sale of our services, compared to $53.5 million in 2005. As of June 30, 2007, there were more than 10,500 medical providers, including more than 8,000 physicians, using our services across 32 states and 54 medical specialties.

We believe our innovative internet-based business services model represents a significant departure from the traditional model of physicians relying upon on-site or outsourced administrative staff, using stand-alone software that is not internet-based, to run the back-office aspects of their practices. By continuously improving all three components of our services, we drive improvement in the business results of our network of clients: we typically update our centralized internet-based software every six to eight weeks; we add more than 100 rules on average each month to our database of payer rules; and we regularly improve our back-office service operations with more efficient technology and processes. Additionally, as our database of aggregated health information grows, we are able to use this information to further the strategic position of our company. For example, in June 2006 we introduced our annual PayerView rankings of health plans performance with respect to the speed and accuracy of reimbursement processes at different insurance companies, an initiative that we believe increases our profile in the provider and payer

communities.

Market Opportunity

The market opportunity for our services is driven by physician office collections in the United States. According to the U.S. Centers for Medicare and Medicaid Services, since 2000, ambulatory care spending

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increased by an average of 7.7% per year to $420 billion in 2005. As the ambulatory care market has grown, we estimate that the market for revenue and clinical cycle management solutions has grown to over $27 billion. These expenditures are primarily comprised of salary and benefits for in-house administrative staff and the cost of third-party practice management and EMR software.

In addition, growth in managed care has increased the complexity of physician practice reimbursement. Managed care plans typically create complex reimbursement structures and plan designs that place greater responsibility on physician practices to capture data and provide appropriate claims to obtain payments. As a result, physician practices must keep track of multiple plan designs and processing requirements to ensure appropriate payment for services rendered. We also believe that new initiatives by government-sponsored and private health plans will further increase the complexity of physician practice reimbursement. For example, pay-for-performance programs require submission of enhanced information to payers, and new health plan designs, known as consumer driven health plans, include provisions for increased direct payment by patients.

Physician practices are generally not well equipped to address this increasing complexity. In addition to administering typical small business functions, physician practices must invest significant time and resources in activities that are required to secure reimbursement from third-party payers or patients and to process inbound and outbound communications related to physician orders to laboratories and pharmacies. To accomplish these tasks, physician offices often use locally installed software, send and receive paper-based and fax-based communications and conduct telephone-based discussions with payers and intermediaries to resolve unpaid claims or to inquire about the status of transactions. This work is typically performed by in-house staff, although some practices hire third-party services that also use locally installed software to manage transactions.

As the complexity and number of health benefit plan payer rules have increased, the ability of physician practices or third-party billing services to use locally installed software solutions to keep up with these rules has diminished, leading to poor financial performance and decreased clinical efficiency. In addition to the time and cost of these activities, medical offices typically stop seeking reimbursement and write off associated receivables for approximately 10% of their medical claims.

Our Solution

The dynamic and increasingly complex healthcare market requires an integrated solution to effectively manage the reimbursement and clinical landscape. We believe we are the first company to integrate internet-based software, a continually updated database of payer reimbursement process rules and back-office service operations into a single internet-based business service for physician practices. We deliver these services at each critical step in the revenue and clinical cycle workflow through a combination of software, knowledge and work:

Software. athenaNet, our proprietary internet-based practice management and EMR application, is a workflow management tool used in every work step that is required to properly handle billing, collections and medical record management-related functions. All users across our client-base simultaneously use the same version of our software application, which connects them to our continually updated database of payer rules and to our services team.

Knowledge. athenaRules, our proprietary database of payer rules, enforces physician office workflow requirements, and is continually updated with payer-specific coding and documentation information. This knowledge continues to grow as a result of our years of experience managing back office service operations for hundreds of physician practices, including processing medical claims with tens of thousands of health benefit plans.

Work. The athenahealth service operations, consisting of nearly 400 people in the United States, and more than 700 people at our off-shore service provider, interact with clients at all key steps of the revenue and clinical cycle workflow. These operations include setting up medical providers for billing, checking the eligibility of scheduled patients electronically, submitting electronic and paper-based

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claims to payers directly or through intermediaries, processing clinical orders, receiving and processing checks and remittance information from payers, documenting the result of payers responses and evaluating and resubmitting claims denials.

Our Strategy

Our mission is to be the most trusted and effective provider of business services for physician practices. To achieve this, our strategy includes:

Remaining intensely focused on our clients success. Our business model aligns our goals with our clients goals and provides an incentive for us to continually improve the performance of our clients. We believe that this approach enables us to maintain client loyalty, to enhance our reputation and to improve the quality of our solutions.

Maintaining and growing our payer rules database. Our rules engine development work increases the percentage of transactions that are successfully executed on the first attempt and reduces the time to resolution after claims or other transactions are submitted. An important component of increasing value to our clients is that we continue to develop our centralized payer reimbursement process rules database, athenaRules, using our experience gained each day across our network of clients. This continued development allows all our clients to benefit from our more than 50 full-time equivalent staff focused on finding, researching, documenting and implementing new payer rules.

Attracting new clients. We expect to continue with current and expanded sales and marketing efforts to address our market opportunity by aggressively seeking new clients. We believe that our internet-based business services provide significant value for physician offices of any size. We estimate that our athenaCollector client base represents less than two percent of the U.S. addressable market for revenue cycle management.

Increasing revenue per client by adding new service offerings. We have only recently begun to offer our athenaClinicals service, which we combine with athenaCollector for sale to prospective clients. In the future, we plan to offer athenaClinicals as a stand-alone option. We are also developing additional services to address other administrative tasks within the physician office, such as patient communications for scheduling appointments, accessing lab results and refilling prescriptions.

Expanding operating margins by reducing the costs of providing our services. We believe we can increase our operating margins as we increase the scalability of our service operations. Our integrated operations enable us to deploy efficient and effective resources at each step of the revenue and clinical cycle workflow.

Risks Associated with Our Business

Our business is subject to a number of risks which you should be aware of before making an investment decision. Those risks are discussed more fully in Risk Factors beginning on page 8. For example:

we have incurred significant losses since inception, including net losses of $9.2 million and $6.1 million for the year ended December 31, 2006 and the six months ended June 30, 2007, respectively, resulting in an accumulated deficit of $71.3 million at June 30, 2007;

we operate in a highly competitive industry, and if we are not able to compete effectively, our business and operating results will be harmed;

our proprietary internet-based software may not operate properly, which could damage our reputation, give rise to claims against us or divert application of our resources from other purposes, any of which could cause harm to our business and operating results; and

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government regulation of healthcare creates risks and challenges with respect to our compliance efforts and our business strategies.

Our Corporate Information

We were incorporated in Delaware on August 21, 1997 as Athena Healthcare Incorporated. We changed our name to athenahealth.com, Inc. on March 31, 2000 and to athenahealth, Inc. on November 17, 2000. Our corporate headquarters are located at 311 Arsenal Street, Watertown, Massachusetts 02472, and our telephone number is (617) 402-1000. Our website address is www.athenahealth.com. The information on, or that can be accessed through, our website is not part of this prospectus. In this prospectus, the terms athena, athenahealth, we, us and our refer athenahealth, Inc. and its subsidiary, Athena Net India Pvt. Ltd., and any subsidiary that may be acquired or formed in the future.

athenahealth, athenaNet and the athenahealth logo are registered trademarks of athenahealth and athenaCollector, athenaClinicals, athenaEnterprise and athenaRules are trademarks of athenahealth. This prospectus also includes the registered and unregistered trademarks of other persons.

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THE OFFERING

Common stock offered by us	5,000,000 shares
Common stock offered by the selling stockholders	1,286,819 shares
Common stock to be outstanding after this offering	31,600,399 shares
Option to purchase additional shares offered by the selling stockholders	To the extent that the underwriters sell more than 6,286,819 shares of common stock, the underwriters have the option to purchase up to an additional 943,023 shares from the selling stockholders, including up to an additional 80,000 shares from our chief executive officer, at the initial public offering price less the underwriting discount. We will not receive any additional proceeds if the underwriters exercise the option to purchase additional shares because only selling stockholders will sell additional shares if the option to purchase additional shares is exercised.
Use of proceeds	We expect our net proceeds from the offering to be approximately $81.7 million, based on the initial public offering price of $18.00 per share, after deducting the estimated underwriting discounts and commissions and estimated fees and expenses payable by us. We will not receive any of the proceeds from the sale of shares by the selling stockholders. We intend to use the net proceeds to us from this offering to repay outstanding indebtedness and the remainder for working capital and other general corporate purposes. We may also use a portion of the net proceeds to acquire complementary technologies or businesses. See Use of Proceeds.
NASDAQ Global Market symbol	ATHN

The number of shares of common stock to be outstanding after this offering is based on 26,600,399 shares of common stock outstanding as of June 30, 2007. The number of shares of common stock to be outstanding after this offering does not include:

- 3,010,054 shares of common stock issuable upon the exercise of stock options outstanding as of June 30, 2007 with a weighted average exercise price of $3.43 per share;
- 634,787 shares of common stock issuable upon the exercise of warrants outstanding as of June 30, 2007 with a weighted average exercise price of $3.28 per share; and
- 1,500,000 shares of common stock currently reserved for future issuance under our equity incentive plans.

Unless otherwise indicated, all information in this prospectus assumes that the underwriters do not exercise their option to purchase 943,023 shares of our common stock in this offering from selling stockholders and also reflects:

our amended and restated certificate of incorporation and the adoption of our amended and restated by-laws, which will be in place prior to the completion of this offering; and

the conversion of all our outstanding preferred stock into 21,531,457 shares of common stock upon the closing of this offering.

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SUMMARY CONSOLIDATED FINANCIAL DATA

The following tables present our summary consolidated financial data for our fiscal years 2004 through 2006 and for the six months ended June 30, 2006 and 2007 and our summary consolidated balance sheet data as of June 30, 2007. The consolidated financial data for the fiscal years ended December 31, 2004, 2005 and 2006 and for the six months ended June 30, 2006 and 2007 and as of June 30, 2007 has been derived from our consolidated financial statements, which appear elsewhere in this prospectus. The financial data as of and for the six months ended June 30, 2006 and 2007 are derived from our consolidated financial statements, which in the opinion of management contain all adjustments necessary for a fair presentation of such consolidated financial data. Operating results for these interim periods are not necessarily indicative of the operating results for a full year. Historical results are not necessarily indicative of the results to be expected in future periods. You should read this information in conjunction with our consolidated financial statements, the related notes to these financial statements and Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this prospectus.

	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
				(unaudited)	
	(in thousands except share and per share data)				
Consolidated Statements of Operations Data:					
Revenue:					
Business services	$ 35,033	$ 48,958	$ 70,652	$ 32,822	$ 43,268
Implementation and other	3,905	4,582	5,161	2,517	3,172
Total revenue	38,938	53,540	75,813	35,339	46,440
Operating expenses(1):					
Direct operating	20,512	27,545	36,530	17,458	22,168
Selling and marketing	7,650	11,680	15,645	7,435	8,314
Research and development	1,485	2,925	6,903	2,509	3,599
General and administrative	8,520	15,545	16,347	7,771	9,571
Depreciation and amortization	3,159	5,483	6,238	2,952	3,048
Total operating expenses	41,326	63,178	81,663	38,125	46,700
Operating loss	(2,388)	(9,638)	(5,850)	(2,786)	(260)
Other income (expense):					
Interest income	140	106	372	152	214
Interest expense	(1,362)	(1,861)	(2,671)	(1,206)	(1,622)
Other expense			(702)	(342)	(4,416)
Total other expense	(1,222)	(1,755)	(3,001)	(1,396)	(5,824)
Loss before cumulative effect of change in accounting principle	(3,610)	(11,393)	(8,851)	(4,182)	(6,084)

Cumulative effect of change in accounting principle			(373)	(373)	
Net loss	$ (3,610)	$ (11,393)	$ (9,224)	$ (4,555)	$ (6,084)
Net loss per share basic and diluted	$ (0.87)	$ (2.51)	$ (1.96)	$ (0.98)	$ (1.23)
Weighted average shares outstanding basic and diluted	4,151,156	4,531,691	4,707,902	4,656,924	4,933,666
Pro forma net loss per share basic and diluted (unaudited)			$ (0.35)		$ (0.23)
Pro forma weighted average shares outstanding basic and diluted (unaudited)			26,239,359		26,465,123

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	Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
				(unaudited)	
	(in thousands except share and per share data)				
(1) Amounts include stock-based compensation expense as follows:					
Direct operating	$	$	$ 64	$ 27	$ 93
Selling and marketing			43	19	81
Research and development			53	24	99
General and administrative			196	26	331
Total	$	$	$ 356	$ 96	$ 604

The summary consolidated balance sheet data as of June 30, 2007 is presented:

on an actual basis;

on a pro forma basis to reflect the conversion of all of our outstanding preferred stock into 21,531,457 shares of our common stock upon the closing of this offering; and

on a pro forma as adjusted basis to further reflect:

the receipt by us of net proceeds of $81.7 million from the sale of the 5,000,000 shares of common stock offered by us in this offering at the public offering price of $18.00 per share, less underwriting discounts and commissions and estimated offering expenses payable by us; and

the payment by us of approximately $32.7 million to repay our outstanding indebtedness with, and other amounts payable to, our financial lenders as described under Use of Proceeds.

	As of June 30, 2007		
	Actual	Pro Forma (unaudited)	Pro Forma As Adjusted
		(in thousands)	
Consolidated Balance Sheet Data:			
Cash, cash equivalents and short-term investments	$ 12,660	$ 12,660	$ 61,636
Working capital	(2,380)	(2,380)	62,650
Total assets	44,345	44,345	92,113
Total indebtedness, including current portion	32,038	32,038	309
Convertible preferred stock	50,094		
Total stockholders equity (deficit)	(68,528)	(12,256)	68,214

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RISK FACTORS

Investing in our common stock involves a high degree of risk. You should consider carefully the risks and uncertainties described below, together with all of the other information in this prospectus, including the consolidated financial statements and the related notes appearing at the end of this prospectus, before deciding to invest in shares of our common stock. If any of the following risks actually occurs, our business, financial condition, results of operations and future prospects could be materially and adversely affected. In that event, the market price of our common stock could decline and you could lose part or all of your investment.

RISKS RELATED TO OUR BUSINESS

We have incurred significant operating losses in the past and may not be profitable in the future.

We have incurred significant operating losses since our inception. For the year ended December 31, 2006, we had a net loss of $9.2 million and a loss from operations of $5.9 million and for the six months ended June 30, 2007 we had a net loss of $6.1 million and a loss from operations of $0.3 million. We have an accumulated deficit of $71.3 million as of June 30, 2007. It is not certain that we will become profitable, or that, if we become profitable, our profitability will increase. In addition, we expect our costs and operating expenses to increase in the future as we expand our operations. If our revenue does not grow to offset these expected increased costs and operating expenses, we may not be profitable. You should not consider recent quarterly revenue growth as indicative of our future performance. In fact, in future quarters we may not have any revenue growth and our revenue could decline. Furthermore, if our costs and operating expenses exceed our expectations, our financial performance will be adversely affected.

Our operating results have in the past and may continue to fluctuate significantly and if we fail to meet the expectations of analysts or investors, our stock price and the value of your investment could decline substantially.

Our operating results are likely to fluctuate, and if we fail to meet or exceed the expectations of securities analysts or investors, the trading price of our common stock could decline. Moreover, our stock price may be based on expectations of our future performance that may be unrealistic or that may not be met. Some of the important factors that could cause our revenues and operating results to fluctuate from quarter to quarter include:

- the extent to which our services achieve or maintain market acceptance;
- our ability to introduce new services and enhancements to our existing services on a timely basis;
- new competitors and introduction of enhanced products and services from new or existing competitors;
- the length of our contracting and implementation cycles;
- the financial condition of our current and potential clients;
- changes in client budgets and procurement policies;
- amount and timing of our investment in research and development activities;
- technical difficulties or interruptions in our services;

our ability to hire and retain qualified personnel, including the rate of expansion of our sales force;

changes in the regulatory environment related to healthcare;

regulatory compliance costs;

the timing, size and integration success of potential future acquisitions; and

unforeseen legal expenses, including litigation and settlement costs.

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Many of these factors are not within our control, and the occurrence of one or more of them might cause our operating results to vary widely. As such, we believe that quarter-to-quarter comparisons of our revenues and operating results may not be meaningful and should not be relied upon as an indication of future performance.

A significant portion of our operating expense is relatively fixed in nature and planned expenditures are based in part on expectations regarding future revenue. Accordingly, unexpected revenue shortfalls may decrease our gross margins and could cause significant changes in our operating results from quarter to quarter. In addition, our future quarterly operating results may fluctuate and may not meet the expectations of securities analysts or investors. If this occurs, the trading price of our common stock could fall substantially either suddenly or over time.

We operate in a highly competitive industry, and if we are not able to compete effectively, our business and operating results will be harmed.

The provision by third parties of revenue cycle services to physician practices has historically been dominated by small service providers who offer highly individualized services and a high degree of specialized knowledge applicable in many cases to a limited medical specialty, a limited set of payers or a limited geographical area. We anticipate that the software, statistical and database tools that are available to such service providers will continue to become more sophisticated and effective and that demand for our services could be adversely affected.

Revenue cycle software for physician practices has historically been dominated by large, well-financed and technologically-sophisticated entities that have focused on software solutions. The size and financial strength of these entities is increasing as a result of continued consolidation in both the information technology and healthcare industries. We expect large integrated technology companies to become more active in our markets, both through acquisition and internal investment. As costs fall and technology improves, increased market saturation may change the competitive landscape in favor of competitors with greater scale than we currently possess.

Some of our current large competitors, such as GE Healthcare, Sage Software Healthcare, Inc., Misys Healthcare Systems, Allscripts Healthcare Solutions, Inc., Quality Systems, Inc., Siemens Medical Solutions USA, Inc. and McKesson Corp. have greater name recognition, longer operating histories and significantly greater resources than we do. As a result, our competitors may be able to respond more quickly and effectively than we can to new or changing opportunities, technologies, standards or client requirements. In addition, current and potential competitors have established, and may in the future establish, cooperative relationships with vendors of complementary products, technologies or services to increase the availability of their products to the marketplace. Accordingly, new competitors or alliances may emerge that have greater market share, larger client bases, more widely adopted proprietary technologies, greater marketing expertise, greater financial resources and larger sales forces than we have, which could put us at a competitive disadvantage. Further, in light of these advantages, even if our services are more effective than the product or service offerings of our competitors, current or potential clients might accept competitive products and services in lieu of purchasing our services. Increased competition is likely to result in pricing pressures, which could negatively impact our sales, profitability or market share. In addition to new niche vendors, who offer stand-alone products and services, we face competition from existing enterprise vendors, including those currently focused on software solutions, which have information systems in place at clients in our target market. These existing enterprise vendors may now, or in the future, offer or promise products or services with less functionality than our services, but which offer ease of integration with existing systems and which leverage existing vendor relationships.

The market for our services is immature and volatile, and if it does not develop or if it develops more slowly than we expect, the growth of our business will be harmed.

The market for internet-based business services is relatively new and unproven, and it is uncertain whether these services will achieve and sustain high levels of demand and market acceptance. Our success

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will depend to a substantial extent on the willingness of enterprises, large and small, to increase their use of on-demand business services in general, and for their revenue and clinical cycles in particular. Many enterprises have invested substantial personnel and financial resources to integrate established enterprise software into their businesses, and therefore may be reluctant or unwilling to switch to an on-demand application service. Furthermore, some enterprises may be reluctant or unwilling to use on-demand application services, because they have concerns regarding the risks associated with security capabilities, among other things, of the technology delivery model associated with these services. If enterprises do not perceive the benefits of our services, then the market for these services may not develop at all, or it may develop more slowly than we expect, either of which would significantly adversely affect our operating results. In addition, as a new company in this unproven market, we have limited insight into trends that may develop and affect our business. We may make errors in predicting and reacting to relevant business trends, which could harm our business. If any of these risks occur, it could materially adversely affect our business, financial condition or results of operations.

If we do not continue to innovate and provide services that are useful to users, we may not remain competitive, and our revenues and operating results could suffer.

Our success depends on providing services that the medical community uses to improve business performance and quality of service to patients. Our competitors are constantly developing products and services that may become more efficient or appealing to our clients. As a result, we must continue to invest significant resources in research and development in order to enhance our existing services and introduce new high-quality services that clients will want. If we are unable to predict user preferences or industry changes, or if we are unable to modify our services on a timely basis, we may lose clients. Our operating results would also suffer if our innovations are not responsive to the needs of our clients, are not appropriately timed with market opportunity or are not effectively brought to market. As technology continues to develop, our competitors may be able to offer results that are, or that are perceived to be, substantially similar to or better than those generated by our services. This may force us to compete on additional service attributes and to expend significant resources in order to remain competitive.

As a result of our variable sales and implementation cycles, we may be unable to recognize revenue to offset expenditures, which could result in fluctuations in our quarterly results of operations or otherwise harm our future operating results.

The sales cycle for our services can be variable, typically ranging from three to five months from initial contact to contract execution. During the sales cycle, we expend time and resources, and we do not recognize any revenue to offset such expenditures. Our implementation cycle is also variable, typically ranging from three to five months from contract execution to completion of implementation. Some of our new-client set-up projects are complex and require a lengthy delay and significant implementation work. Each client s situation is different, and unanticipated difficulties and delays may arise as a result of failure by us or by the client to meet our respective implementation responsibilities. During the implementation cycle, we expend substantial time, effort and financial resources implementing our service, but accounting principles do not allow us to recognize the resulting revenue until the service has been implemented, at which time we begin recognition of implementation revenue over the life of the contract. This could harm our future operating results.

After a client contract is signed, we provide an implementation process for the client during which appropriate connections and registrations are established and checked, data is loaded into our athenaNet system, data tables are set up and practice personnel are given initial training. The length and details of this implementation process vary widely from client to client. Typically implementation of larger clients takes longer than implementation for smaller clients. Implementation for a given client may be cancelled. Our contracts typically provide that they can be terminated for any reason or for no reason in 90 days. Despite the fact that we typically require a deposit in advance of implementation, some clients have cancelled before our service has been started. In addition, implementation may be

delayed or the target dates for completion may be extended into the future for a variety of reasons, including to meet the needs and requirements of the client, because of delays with payer processing and because of the volume and complexity of the implementations

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awaiting our work. If implementation periods are extended, our provision of the revenue cycle or clinical cycle services upon which we realize most of our revenues will be delayed and our financial condition may be adversely affected. In addition, cancellation of any implementation after it has begun may involve loss to us of time, effort and expenses invested in the cancelled implementation process and lost opportunity for implementing paying clients in that same period of time.

These factors may contribute to substantial fluctuations in our quarterly operating results, particularly in the near term and during any period in which our sales volume is relatively low. As a result, in future quarters our operating results could fall below the expectations of securities analysts or investors, in which event our stock price would likely decrease.

If the revenue of our clients decreases, our revenue will decrease.

Under most of our client contracts, we base our charges on a percentage of the revenue that the client realizes while using our services. Many factors may lead to decrease in client revenue, including:

- interruption of client access to our system for any reason;
- our failure to provide services in a timely or high-quality manner;
- failure of our clients to adopt or maintain effective business practices;
- actions by third-party payers of medical claims to reduce reimbursement;
- government regulations reducing reimbursement; and
- reduction of client revenue resulting from increased competition or other changes in the marketplace for physician services.

If the clients revenue decreases for any reason, our revenue will likely decrease.

If participants in our channel marketing and sales lead programs do not maintain appropriate relationships with potential clients, our sales accomplished with their help or data may be unwound and our payments to them may be deemed improper.

We maintain a series of relationships with third parties that we term channel relationships. These relationships take different forms under different contractual language. Some relationships help us identify sales leads. Other relationships permit third parties to act as value-added resellers or as independent sales representatives for our services. In some cases, for example in the case of some membership organizations, these relationships involve endorsement of our services as well as other marketing activities. In each of these cases, we require contractually that the third party disclose information to and/or limit their relationships with potential purchasers of our services for regulatory compliance reasons. If these third parties do not comply with these regulatory requirements, sales accomplished with the data or help that they have provided may not be enforceable and may be unwound. Third parties that, despite our requirements, exercise undue influence over decisions by prospective clients, occupy positions with obligations of fidelity or fiduciary obligations to prospective clients, or who offer bribes or kickbacks to prospective clients or their employees, may be committing wrongful or illegal acts that could render any resulting contract between us and the client unenforceable. Any misconduct by these third parties with respect to prospective clients may result in allegations that we have encouraged or participated in wrongful or illegal behavior and that payments to such third parties under our channel contracts are improper. This misconduct could subject us to civil or

criminal claims and liabilities, could require us to change or terminate some portions of our business, could require us to refund portions of our services fees and could adversely effect our revenue and operating margin. Even an unsuccessful challenge of our activities could result in adverse publicity, require costly response from us, impair our ability to attract and maintain clients and lead analysts or potential investors to reduce their expectations of our performance, resulting in reduction to our market price.

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Failure to manage our rapid growth effectively could increase our expenses, decrease our revenue and prevent us from implementing our business strategy.

We have been experiencing a period of rapid growth. To manage our anticipated future growth effectively, we must continue to maintain and may need to enhance our information technology infrastructure, financial and accounting systems and controls and manage expanded operations in geographically-distributed locations. We also must attract, train and retain a significant number of qualified sales and marketing personnel, professional services personnel, software engineers, technical personnel and management personnel. Failure to manage our rapid growth effectively could lead us to over-invest or under-invest in technology and operations, could result in weaknesses in our infrastructure, systems or controls, could give rise to operational mistakes, losses, loss of productivity or business opportunities, and could result in loss of employees and reduced productivity of remaining employees. Our growth could require significant capital expenditures and may divert financial resources from other projects, such as the development of new services. If our management is unable to effectively manage our growth, our expenses may increase more than expected, our revenue could decline or may grow more slowly than expected, and we may be unable to implement our business strategy.

We depend upon a third-party service provider for important processing functions. If this third-party provider does not fulfill its contractual obligations or chooses to discontinue its services, our business and operations could be disrupted and our operating results would be harmed.

We have entered into a service agreement with Vision Healthsource, a subsidiary of Perot Systems Corporation, through which more than 700 people provide data entry and other services from facilities located in India and the Philippines to support our client service operations. Among other things, this provider processes critical claims data and patient statements. If these services fail or are of poor quality, our business, reputation and operating results could be harmed. Failure of the service provider to perform satisfactorily could result in client dissatisfaction, disrupt our operations and adversely affect operating results. With respect to this service provider, we have significantly less control over the systems and processes than if we maintained and operated them ourselves, which increases our risk. In some cases, functions necessary to our business are performed on proprietary systems and software to which we have no access. If we need to find an alternative source for performing these functions, we may have to expend significant money, resources and time to develop the alternative, and if this development is not accomplished in a timely manner and without significant disruption to our business, we may be unable to fulfill our responsibilities to clients or the expectations of clients, with the attendant potential for liability claims and a loss of business reputation, loss of ability to attract or maintain clients and reduction of our revenue or operating margin.

Various risks could interrupt international operations, exposing us to significant costs.

We have contracted with companies operating in Canada, India and the Philippines for various services, including data entry, outgoing calls to payers, data classification and software development. In addition, in October 2005, we established a subsidiary in Chennai, India to conduct research and development activities. International operations expose the company to potential operational disruptions as a result of currency valuations, political turmoil and labor issues. Any such disruptions may have a negative effect on our profits, on client satisfaction and on our ability to attract or maintain clients.

Because competition for our target employees is intense, we may not be able to attract and retain the highly-skilled employees we need to support our planned growth.

To continue to execute on our growth plan, we must attract and retain highly-qualified personnel. Competition for these personnel is intense, especially for engineers with high levels of experience in designing and developing software and internet-related services and senior sales executives. We may not be successful in attracting and retaining

qualified personnel. We have from time to time in the past experienced, and we expect to continue to experience in the future, difficulty in hiring and retaining highly-skilled employees with appropriate qualifications. Many of the companies with which we compete for experienced personnel have greater resources than we have. In addition, in making employment decisions, particularly in the Internet and

high-technology industries, job candidates often consider the value of the stock options they are to receive in connection with their employment. Volatility in the price of our stock may, therefore, adversely affect our ability to attract or retain key employees. Furthermore, the new requirement to expense stock options may discourage us from granting the size or type of stock option awards that job candidates require to join our company. If we fail to attract new personnel or fail to retain and motivate our current personnel, our business and future growth prospects could be severely harmed.

If we acquire companies or technologies in the future, they could prove difficult to integrate, disrupt our business, dilute stockholder value and adversely affect our operating results and the value of our common stock.

As part of our business strategy, we may acquire, enter into joint ventures with, or make investments in complementary companies, services and technologies in the future. Acquisitions and investments involve numerous risks, including:

- difficulties in identifying and acquiring products, technologies or businesses that will help our business;
- difficulties in integrating operations, technologies, services and personnel;
- diversion of financial and managerial resources from existing operations;
- risk of entering new markets in which we have little to no experience; and
- delays in client purchases due to uncertainty and the inability to maintain relationships with clients of the acquired businesses.

As a result, if we fail to properly evaluate acquisitions or investments, we may not achieve the anticipated benefits of any such acquisitions, we may incur costs in excess of what we anticipate, and management resources and attention may be diverted from other necessary or valuable activities.

If we are required to collect sales and use taxes on the services we sell in additional jurisdictions, we may be subject to liability for past sales and our future sales may decrease.

We may lose sales or incur significant expenses should states be successful in imposing broader guidelines to state sales and use taxes. A successful assertion by one or more states that we should collect sales or other taxes on the sale of our services could result in substantial tax liabilities for past sales, decrease our ability to compete with traditional retailers and otherwise harm our business. Each state has different rules and regulations governing sales and use taxes and these rules and regulations are subject to varying interpretations that may change over time. We review these rules and regulations periodically and, when we believe our services are subject to sales and use taxes in a particular state, voluntarily engage state tax authorities in order to determine how to comply with their rules and regulations. For example, in April 2006 we entered into a settlement agreement with the Ohio Department of Taxation after it determined that we owed sales and use taxes for sales made in the State of Ohio between July 2005 and January 2006. In connection with this settlement we paid the State of Ohio $0.2 million in taxes, interest and penalties. Additionally, in November 2004, we began paying sales and use taxes in the State of Texas. We cannot assure you that we will not be subject to sales and use taxes or related penalties for past sales in states where we believe no compliance is necessary.

Vendors of services, like us, are typically held responsible by taxing authorities for the collection and payment of any applicable sales and similar taxes. If one or more taxing authorities determines that taxes should have, but have not, been paid with respect to our services, we may be liable for past taxes in addition to taxes going forward. Liability for

past taxes may also include very substantial interest and penalty charges. Our client contracts provide that our clients must pay all applicable sales and similar taxes. Nevertheless, clients may be reluctant to pay back taxes and may refuse responsibility for interest or penalties associated with those taxes. If we are required to collect and pay back taxes and the associated interest and penalties and if our clients fail or refuse to reimburse us for all or a portion of these amounts, we will have incurred unplanned expenses that may be substantial. Moreover, imposition of such taxes on our services going forward will effectively increase the cost of such services to our clients and may adversely affect our ability to retain existing clients or to gain new clients in the areas in which such taxes are imposed.

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We may be unable to adequately protect, and we may incur significant costs in enforcing, our intellectual property and other proprietary rights.

Our success depends in part on our ability to enforce our intellectual property and other proprietary rights. We rely upon a combination of trademark, trade secret, copyright, patent and unfair competition laws, as well as license and access agreements and other contractual provisions, to protect our intellectual property and other proprietary rights. In addition, we attempt to protect our intellectual property and proprietary information by requiring certain of our employees and consultants to enter into confidentiality, noncompetition and assignment of inventions agreements. Our attempts to protect our intellectual property may be challenged by others or invalidated through administrative process or litigation. While we have six U.S. patent applications pending, we currently have no issued patents and may be unable to obtain meaningful patent protection for our technology. We have received a final office action rejecting application on our oldest and broadest application and have filed a request for continued examination, along with a response and revised claims with respect to that patent. In addition, if any patents are issued in the future, they may not provide us with any competitive advantages, or may be successfully challenged by third parties. Agreement terms that address non-competition are difficult to enforce in many jurisdictions and may not be enforceable in any particular case. To the extent that our intellectual property and other proprietary rights are not adequately protected, third parties might gain access to our proprietary information, develop and market products or services similar to ours, or use trademarks similar to ours, each of which could materially harm our business. Existing U.S. federal and state intellectual property laws offer only limited protection. Moreover, the laws of other countries in which we now or may in the future conduct operations or contract for services may afford little or no effective protection of our intellectual property. Further, our platform incorporates open source software components that are licensed to us under various public domain licenses. While we believe we have complied with our obligations under the various applicable licenses for open source software that we use, there is little or no legal precedent governing the interpretation of many of the terms of certain of these licenses and therefore the potential impact of such terms on our business is somewhat unknown. The failure to adequately protect our intellectual property and other proprietary rights could materially harm our business.

In addition, if we resort to legal proceedings to enforce our intellectual property rights or to determine the validity and scope of the intellectual property or other proprietary rights of others, the proceedings could be burdensome and expensive, even if we were to prevail. Any litigation that may be necessary in the future could result in substantial costs and diversion of resources and could have a material adverse effect on our business, operating results or financial condition.

We may be sued by third parties for alleged infringement of their proprietary rights.

The software and Internet industries are characterized by the existence of a large number of patents, trademarks and copyrights and by frequent litigation based on allegations of infringement or other violations of intellectual property rights. Moreover, our business involves the systematic gathering and analysis of data about the requirements and behaviors of payers and other third parties, some or all of which may be claimed to be confidential or proprietary. We have received in the past, and may receive in the future, communications from third parties claiming that we have infringed on the intellectual property rights of others. For example, in 2005, Billingnetwork Patent, Inc. sued us in Florida federal court alleging infringement of its patent issued in 2002 entitled Integrated Internet Facilitated Billing, Data Processing and Communications System. We have moved to dismiss that case and oral argument on that motion was heard by the court in March 2006. We are awaiting further action from the court at this time. Our technologies may not be able to withstand any third-party claims or rights against their use. Any intellectual property claims, with or without merit, could be time-consuming and expensive to resolve, could divert management attention from executing our business plan and could require us to pay monetary damages or enter into royalty or licensing agreements. In addition, many of our contracts contain warranties with respect to intellectual property rights, and some require us to indemnify our clients for third-party intellectual property infringement claims, which would

increase the cost to us of an adverse ruling on such a claim.

Moreover, any settlement or adverse judgment resulting from such a claim could require us to pay substantial amounts of money or obtain a license to continue to use the technology or information that is the subject of the claim, or otherwise restrict or prohibit our use of the technology or information. There can be

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no assurance that we would be able to obtain a license on commercially reasonable terms, if at all, from third parties asserting an infringement claim; that we would be able to develop alternative technology on a timely basis, if at all; or that we would be able to obtain a license to use a suitable alternative technology to permit us to continue offering, and our clients to continue using, our affected services. Accordingly, an adverse determination could prevent us from offering our services to others. In addition, we may be required to indemnify our clients for third-party intellectual property infringement claims, which would increase the cost to us of an adverse ruling for such a claim.

We are bound by exclusivity provisions that restrict our ability to enter into certain sales and marketing relationships in order to market and sell our services.

Our marketing and sales agreement with Worldmed Shared Services, Inc. (d/b/a PSS World Medical Shared Services, Inc.), or PSS, restricts us during the term of the agreement from certain sales and marketing relationships, including relationships with certain competitors of PSS and certain distributors and manufacturers of medical, surgical or pharmaceutical supplies. This restriction may make it more difficult for us to realize sales, distribution and income opportunities with certain potential clients, in particular small physician practices, which could adversely affect our operating results.

We may require additional capital to support business growth, and this capital might not be available.

We intend to continue to make investments to support our business growth and may require additional funds to respond to business challenges or opportunities, including the need to develop new services or enhance our existing service, enhance our operating infrastructure or acquire complementary businesses and technologies. Accordingly, we may need to engage in equity or debt financings to secure additional funds. If we raise additional funds through further issuances of equity or convertible debt securities, our existing stockholders could suffer significant dilution, and any new equity securities we issue could have rights, preferences and privileges superior to those of holders of our common stock. Any debt financing secured by us in the future could involve restrictive covenants relating to our capital raising activities and other financial and operational matters, which may make it more difficult for us to obtain additional capital and to pursue business opportunities, including potential acquisitions. In addition, we may not be able to obtain additional financing on terms favorable to us, if at all. If we are unable to obtain adequate financing or financing on terms satisfactory to us when we require it, our ability to continue to support our business growth and to respond to business challenges could be significantly limited.

Our loan agreements contain operating and financial covenants that may restrict our business and financing activities.

We have loan agreements that provide for up to $38.5 million of total borrowings, of which $32.0 million was outstanding at June 30, 2007. Borrowings are secured by substantially all of our assets including our intellectual property. Our loan agreements restrict our ability to:

incur additional indebtedness;

create liens;

make investments;

sell assets;

pay dividends or make distributions on and, in certain cases, repurchase our stock; or

consolidate or merge with other entities.

In addition, our credit facilities require us to meet specified minimum financial measurements. The operating and financial restrictions and covenants in these credit facilities, as well as any future financing agreements that we may enter into, may restrict our ability to finance our operations, engage in business activities or expand or fully pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, and we may not be able to meet those covenants. A breach of any of

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these covenants could result in a default under the loan agreement, which could cause all of the outstanding indebtedness under both credit facilities to become immediately due and payable and terminate all commitments to extend further credit.

We will incur significant increased costs as a result of operating as a public company, and our management will be required to devote substantial time to new compliance initiatives.

We have never operated as a public company. As a public company, we will incur significant legal, accounting and other expenses that we did not incur as a private company. In addition, the Sarbanes-Oxley Act of 2002, as well as rules subsequently implemented by the Securities and Exchange Commission and the NASDAQ Global Market, have imposed various new requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will need to devote a substantial amount of time to these new compliance initiatives. Moreover, these rules and regulations will increase our legal and financial compliance costs and will make some activities more time-consuming and costly. For example, we expect these new rules and regulations to make it more difficult and more expensive for us to obtain director and officer liability insurance, and we may be required to incur substantial costs to maintain the same or similar coverage.

In addition, the Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting and disclosure controls and procedures. In particular, commencing in 2008, we must perform system and process evaluation and testing of our internal control over financial reporting to allow management and our independent registered public accounting firm to report on the effectiveness of our internal control over financial reporting, as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal control over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will require that we incur substantial accounting expense and expend significant management time on compliance-related issues. Moreover, if we are not able to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline, and we could be subject to sanctions or investigations by the NASDAQ Global Market, the Securities and Exchange Commission or other regulatory authorities, which would require additional financial and management resources.

Current and future litigation against us could be costly and time consuming to defend.

We are from time to time subject to legal proceedings and claims that arise in the ordinary course of business, such as claims brought by our clients in connection with commercial disputes and employment claims made by our current or former employees. Litigation may result in substantial costs and may divert management s attention and resources, which may seriously harm our business, overall financial condition and operating results. In addition, legal claims that have not yet been asserted against us may be asserted in the future. Insurance may not cover such claims, may not be sufficient for one or more such claims and may not continue to be available on terms acceptable to us. A claim brought against us that is uninsured or underinsured could result in unanticipated costs thereby reducing our operating results and leading analysts or potential investors to reduce their expectations of our performance resulting in a reduction in the trading price of our stock.

RISKS RELATED TO OUR SERVICE OFFERINGS

Our proprietary athenaNet software may not operate properly, which could damage our reputation, give rise to claims against us or divert application of our resources from other purposes, any of which could harm our business and operating results.

Proprietary software development is time-consuming, expensive and complex. Unforeseen difficulties can arise. We may encounter technical obstacles, and it is possible that we discover additional problems that prevent our proprietary athenaNet application from operating properly. If athenaNet does not function reliably

or fails to achieve client expectations in terms of performance, clients could assert liability claims against us and/or attempt to cancel their contracts with us. This could damage our reputation and impair our ability to attract or maintain clients.

Moreover, information services as complex as those we offer have in the past contained, and may in the future develop or contain, undetected defects or errors. We cannot assure you that material performance problems or defects in our services will not arise in the future. Errors may result from interface of our services with legacy systems and data which we did not develop and the function of which is outside of our control. Despite testing, defects or errors may arise in our existing or new software or service processes. Because changes in payer requirements and practices are frequent and sometimes difficult to determine except through trial and error, we are continuously discovering defects and errors in our software and service processes compared against these requirements and practices. These defects and errors and any failure by us to identify and address them could result in loss of revenue or market share, liability to clients or others, failure to achieve market acceptance or expansion, diversion of development resources, injury to our reputation and increased service and maintenance costs. Defects or errors in our software and service processes might discourage existing or potential clients from purchasing services from us. Correction of defects or errors could prove to be impossible or impracticable. The costs incurred in correcting any defects or errors or in responding to resulting claims or liability may be substantial and could adversely affect our operating results.

In addition, clients relying on our services to collect, manage and report clinical, business and administrative data may have a greater sensitivity to service errors and security vulnerabilities than clients of software products in general. We market and sell services that, among other things, provide information to assist care providers in tracking and treating ill patients. Any operational delay in or failure of our technology or service processes may result in the disruption of patient care and could cause harm to our business and operating results.

Our clients or their patients may assert claims against us in the future alleging that they suffered damages due to a defect, error or other failure of our software or service processes. A product liability claim or errors or omissions claim could subject us to significant legal defense costs and adverse publicity regardless of the merits or eventual outcome of such a claim.

If our security measures are breached or fail and unauthorized access is obtained to a client s data, our service may be perceived as not being secure, clients may curtail or stop using our service and we may incur significant liabilities.

Our service involves the storage and transmission of clients proprietary information and protected health information of patients. Because of the sensitivity of this information, security features of our software are very important. If our security measures are breached or fail as a result of third-party action, employee error, malfeasance or otherwise, someone may be able to obtain unauthorized access to client or patient data. As a result, our reputation could be damaged, our business may suffer and we could face damages for contract breach, penalties for violation of applicable laws or regulations and significant costs for remediation and remediation efforts to prevent future occurrences.

In addition, we rely upon our clients as users of our system for key activities to promote security of the system and the data within it, such as administration of client-side access credentialing and control of client-side display of data. On occasion, our clients have failed to perform these activities. For example, our physician practice clients have, on occasion, failed to terminate the athenaNet login/password of former employees, or permitted current employees to share login/passwords, each of which is a violation of our contractual arrangement with these clients. When we become aware of such breaches, we work with the client to terminate the inappropriate access and provide additional instruction to our clients in order to avoid the reoccurrence of such problems. Although to date these breaches have not resulted in claims against us or in material harm to our business, the failure of our clients in future periods to perform these activities may result in claims against us, which could expose us to significant expense and harm to our

reputation.

Because techniques used to obtain unauthorized access or to sabotage systems change frequently and generally are not recognized until launched against a target, we may be unable to anticipate these techniques

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or to implement adequate preventive measures. If an actual or perceived breach of our security occurs, the market perception of the effectiveness of our security measures could be harmed and we could lose sales and clients. In addition, our clients may authorize or enable third parties to access their client data or the data of their patients on our systems. Because we do not control such access, we cannot ensure the complete integrity or security of such data in our systems.

Failure by our clients to obtain proper permissions and waivers may result in claims against us or may limit or prevent our use of data which could harm our business.

We require our clients to provide necessary notices and to obtain necessary permissions and waivers for use and disclosure of the information that we receive, and we require contractual assurances from them that they have done so and will do so. If they do not obtain necessary permissions and waivers, then our use and disclosure of information that we receive from them or on their behalf may be limited or prohibited by state or federal privacy laws or other laws. This could impair our functions, processes and databases that reflect, contain or are based upon such data and may prevent use of such data. In addition, this could interfere with or prevent creation or use of rules, analyses or other data-driven activities that benefit us. Moreover, we may be subject to claims or liability for use or disclosure of information by reason of lack of valid notice, permission or waiver. These claims or liabilities could subject us to unexpected costs and adversely affect our operating results.

Various events could interrupt clients access to athenaNet, exposing us to significant costs.

The ability to access athenaNet is critical to our clients cash flow and business viability. Our operations and facilities are vulnerable to interruption and/or damage from a number of sources, many of which are beyond our control, including, without limitation: (i) power loss and telecommunications failures; (ii) fire, flood, hurricane and other natural disasters; (iii) software and hardware errors, failures or crashes in our own systems or in other systems; and (iv) computer viruses, hacking and similar disruptive problems in our own systems and in other systems. We attempt to mitigate these risks through various means including redundant infrastructure, disaster recovery plans, separate test systems and change control and system security measures, but our precautions will not protect against all potential problems. If clients access is interrupted because of problems in the operation of our facilities, we could be exposed to significant claims by clients or their patients, particularly if the access interruption is associated with problems in the timely delivery of funds due to clients or medical information relevant to patient care. Our plans for disaster recovery and business continuity rely upon third-party providers of related services, and if those vendors fail us at a time that our systems are not operating correctly, we could incur a loss of revenue and liability for failure to fulfill our obligations. Any significant instances of system downtime could negatively affect our reputation and ability to retain clients and sell our services which would adversely impact our revenues.

In addition, retention and availability of patient care and physician reimbursement data are subject to federal and state laws governing record retention, accuracy and access. Some laws impose obligations on our clients and on us to produce information to third parties and to amend or expunge data at their direction. Our failure to meet these obligations may result in liability which could increase our costs and reduce our operating results.

Interruptions or delays in service from our third-party data-hosting facilities could impair the delivery of our service and harm our business.

As of the date of this prospectus, we serve our clients from a third-party data-hosting facility located in Waltham, Massachusetts. As part of our current disaster recovery arrangements, a subset of our production environment and client data is currently replicated in a separate standby facility located in Chicago, Illinois. We do not control the operation of any of these facilities, and they are vulnerable to damage or interruption from earthquakes, floods, fires, power loss, telecommunications failures and similar events. They are also subject to break-ins, sabotage, intentional

acts of vandalism and similar misconduct. Despite precautions taken at these facilities, the occurrence of a natural disaster or an act of terrorism, a decision to close the facilities

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without adequate notice or other unanticipated problems at both facilities could result in lengthy interruptions in our service. Even with the disaster recovery arrangements, our service could be interrupted.

We are planning to transition our primary hosting relationship from Waltham, Massachusetts to another third-party hosting facility located in Bedford, Massachusetts. In connection with this transition, we will be moving, transferring or installing equipment, data and software to and in that other facility. Despite precautions taken during this process, any unsuccessful transfers may impair the delivery of our service. Further, any damage to, or failure of, our systems generally could result in interruptions in our service. Interruptions in our service may reduce our revenue, cause us to issue credits or pay penalties, may cause clients to terminate services and may adversely affect our renewal rates and our ability to attract new clients. Our business may also be harmed if our clients and potential clients believe our service is unreliable.

We rely on Internet infrastructure, bandwidth providers, data center providers, other third parties and our own systems for providing services to our users, and any failure or interruption in the services provided by these third parties or our own systems could expose us to litigation and negatively impact our relationships with users, adversely affecting our brand and our business.

Our ability to deliver our internet-based services is dependent on the development and maintenance of the infrastructure of the Internet by third parties. This includes maintenance of a reliable network backbone with the necessary speed, data capacity and security for providing reliable Internet access and services. Our services are designed to operate without interruption in accordance with our service level commitments. However, we have experienced and expect that we will in the future experience interruptions and delays in services and availability from time to time. We rely on internal systems as well as third-party vendors, including data center providers and bandwidth providers, to provide our services. We do not maintain redundant systems or facilities for some of these services. In the event of a catastrophic event with respect to one or more of these systems or facilities, we may experience an extended period of system unavailability, which could negatively impact our relationship with users. To operate without interruption, both we and our service providers must guard against:

- damage from fire, power loss and other natural disasters;
- communications failures;
- software and hardware errors, failures and crashes;
- security breaches, computer viruses and similar disruptive problems; and
- other potential interruptions.

Any disruption in the network access or co-location services provided by these third-party providers or any failure of or by these third-party providers or our own systems to handle current or higher volume of use could significantly harm our business. We exercise limited control over these third-party vendors, which increases our vulnerability to problems with services they provide.

Any errors, failures, interruptions or delays experienced in connection with these third-party technologies and information services or our own systems could negatively impact our relationships with users and adversely affect our business and could expose us to third-party liabilities. Although we maintain insurance for our business, the coverage under our policies may not be adequate to compensate us for all losses that may occur. In addition, we cannot provide assurance that we will continue to be able to obtain adequate insurance coverage at an acceptable cost.

The reliability and performance of the Internet may be harmed by increased usage or by denial-of-service attacks. The Internet has experienced a variety of outages and other delays as a result of damages to portions of its infrastructure, and it could face outages and delays in the future. These outages and delays could reduce the level of Internet usage as well as the availability of the Internet to us for delivery of our internet-based services.

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We rely on third-party computer hardware and software that may be difficult to replace or which could cause errors or failures of our service which could damage our reputation, harm our ability to attract and maintain clients and decrease our revenue.

We rely on computer hardware purchased or leased and software licensed from third parties in order to offer our service, including database software from Oracle Corporation. These licenses are generally commercially available on varying terms, however it is possible that this hardware and software may not continue to be available on commercially reasonable terms, or at all. Any loss of the right to use any of this hardware or software could result in delays in the provisioning of our service until equivalent technology is either developed by us, or, if available, is identified, obtained and integrated, which could harm our business. Any errors or defects in third-party hardware or software could result in errors or a failure of our service which could damage our reputation, harm our ability to attract and maintain clients and decrease our revenue.

We are subject to the effect of payer and provider conduct which we cannot control and which could damage our reputation with clients and result in liability claims that increase our expenses.

We offer certain electronic claims submission services as part of our service, and we rely on content from clients, payers and others. While we have implemented certain features and safeguards designed to maximize the accuracy and completeness of claims content, these features and safeguards may not be sufficient to prevent inaccurate claims data from being submitted to payers. Should inaccurate claims data be submitted to payers, we may experience poor operational results and may be subject to liability claims which could damage our reputation with clients and result in liability claims that increase our expenses.

If our services fail to provide accurate and timely information, or if our content or any other element of our service is associated with faulty clinical decisions or treatment, we could have liability to clients, clinicians or patients which could adversely affect our results of operations.

Our software, content and services are used to assist clinical decision-making and provide information about patient medical histories and treatment plans. If our software, content or services fail to provide accurate and timely information or are associated with faulty clinical decisions or treatment, then clients, clinicians or their patients could assert claims against us that could result in substantial costs to us, harm our reputation in the industry and cause demand for our services to decline.

Our proprietary athenaClinicals service is utilized in clinical decision-making, provides access to patient medical histories and assists in creating patient treatment plans including the issuance of prescription drugs. If our athenaClinicals service fails to provide accurate and timely information, or if our content or any other element of our service is associated with faulty clinical decisions or treatment, we could have liability to clients, clinicians or patients.

The assertion of such claims and ensuing litigation, regardless of its outcome could result in substantial cost to us, divert management s attention from operations, damage our reputation and decrease market acceptance of our services. We attempt to limit by contract our liability for damages and to require that our clients assume responsibility for medical care and approve key system rules, protocols and data. Despite these precautions, the allocations of responsibility and limitations of liability set forth in our contracts may not be enforceable, may not be binding upon patients or may not otherwise protect us from liability for damages.

We maintain general liability and insurance coverage, but this coverage may not continue to be available on acceptable terms or may not be available in sufficient amounts to cover one or more large claims against us. In addition, the insurer might disclaim coverage as to any future claim. One or more large claims could exceed our

available insurance coverage.

Our proprietary software may contain errors or failures that are not detected until after the software is introduced or updates and new versions are released. It is challenging for us to test our software for all potential problems because it is difficult to simulate the wide variety of computing environments or treatment methodologies that our clients may deploy or rely upon. From time to time we have discovered defects or errors in our software, and such defects or errors can be expected to appear in the future. Defects and errors

that are not timely detected and remedied could expose us to risk of liability to clients, clinicians and patients and cause delays in introduction of new services, result in increased costs and diversion of development resources, require design modifications or decrease market acceptance or client satisfaction with our services.

If any of these risks occur, they could materially adversely affect our business, financial condition or results of operations.

We may be liable for use of incorrect or incomplete data we provide which could harm our business, financial condition and results of operations.

We store and display data for use by healthcare providers in treating patients. Our clients or third parties provide us with most of these data. If these data are incorrect or incomplete or if we make mistakes in the capture or input of these data, adverse consequences, including death, may occur and give rise to product liability and other claims against us. In addition, a court or government agency may take the position that our storage and display of health information exposes us to personal injury liability or other liability for wrongful delivery or handling of healthcare services or erroneous health information. While we maintain insurance coverage, we cannot assure that this coverage will prove to be adequate or will continue to be available on acceptable terms, if at all. Even unsuccessful claims could result in substantial costs and diversion of management resources. A claim brought against us that is uninsured or under-insured could harm our business, financial condition and results of operations.

RISKS RELATED TO REGULATION

Government regulation of healthcare creates risks and challenges with respect to our compliance efforts and our business strategies.

The healthcare industry is highly regulated and is subject to changing political, legislative, regulatory and other influences. Existing and new laws and regulations affecting the healthcare industry could create unexpected liabilities for us, could cause us to incur additional costs and could restrict our operations. Many healthcare laws are complex, and their application to specific services and relationships may not be clear. In particular, many existing healthcare laws and regulations, when enacted, did not anticipate the healthcare information services that we provide, and these laws and regulations may be applied to our services in ways that we do not anticipate. Our failure to accurately anticipate the application of these laws and regulations, or our other failure to comply, could create liability for us, result in adverse publicity and negatively affect our business. Some of the risks we face from healthcare regulation are as follows:

False or Fraudulent Claim Laws. There are numerous federal and state laws that forbid submission of false information or the failure to disclose information in connection with submission and payment of physician claims for reimbursement. In some cases, these laws also forbid abuse of existing systems for such submission and payment. Any failure of our services to comply with these laws and regulations could result in substantial liability, including but not limited to criminal liability, could adversely affect demand for our services and could force us to expend significant capital, research and development and other resources to address the failure. Errors by us or our systems with respect to entry, formatting, preparation or transmission of claim information may be determined or alleged to be in violation of these laws and regulations. Determination by a court or regulatory agency that our services violate these laws could subject us to civil or criminal penalties, could invalidate all or portions of some of our client contracts, could require us to change or terminate some portions of our business, could require us to refund portions of our services fees, could cause us to be disqualified from serving clients doing business with government payers and could have an adverse effect on our business.

In most cases where we are permitted to do so, we calculate charges for our services based on a percentage of the collections that our clients receive as a result of our services. To the extent that violations or liability for violations of these laws and regulations require intent, it may be alleged that this percentage calculation provides us or our employees with incentive to commit or overlook fraud or abuse in connection with submission and payment of reimbursement claims. The U.S. Centers for

Medicare and Medicaid Services has stated that it is concerned that percentage-based billing services may encourage billing companies to commit or to overlook fraudulent or abusive practices.

HIPAA and other Health Privacy Regulations. There are numerous federal and state laws related to patient privacy. In particular, the Health Insurance Portability and Accountability Act of 1996, or HIPAA, includes privacy standards that protect individual privacy by limiting the uses and disclosures of individually identifiable health information and data security standards that require covered entities to implement administrative, physical and technological safeguards to ensure the confidentiality, integrity, availability and security of individually identifiable health information in electronic form. HIPAA also specifies formats that must be used in certain electronic transactions, such as claims, payment advice and eligibility inquiries. Because we translate electronic transactions to and from HIPAA-prescribed electronic formats and other forms, we are a clearinghouse and as such are a covered entity. In addition, our clients are also covered entities and are mandated by HIPAA to enter into written agreements with us, known as business associate agreements, that require us to safeguard individually identifiable health information. Business associate agreements typically include:

- a description of our permitted uses of individually identifiable health information;
- a covenant not to disclose the information other than as permitted under the agreement and to make our subcontractors, if any, subject to the same restrictions;
- assurances that appropriate administrative, physical and technical safeguards are in place to prevent misuse of the information;
- an obligation to report to our client any use or disclosure of the information not provided for in the agreement;
- a prohibition against our use or disclosure of the information if a similar use or disclosure by our client would violate the HIPAA standards;
- the ability for our clients to terminate the underlying support agreement if we breach a material term of the business associate agreement and are unable to cure the breach;
- the requirement to return or destroy all individually identifiable health information at the end of our support agreement; and
- access by the Department of Health and Human Services to our internal practices, books and records to validate that we are safeguarding individually identifiable health information.

We may not be able to adequately address the business risks created by HIPAA implementation. Furthermore, we are unable to predict what changes to HIPAA or other law or regulation might be made in the future or how those changes could affect our business or the costs of compliance. In addition, the federal Office of the National Coordinator for Health Information Technology, or ONCHIT, is coordinating the development of national standards for creating an interoperable health information technology infrastructure based on the widespread adoption of electronic health records in the healthcare sector. We are unable to predict what, if any, impact the creation of such standards will have on our compliance costs or our services.

In addition some payers and clearinghouses with which we conduct business interpret HIPAA transaction requirements differently than we do. Where clearinghouses or payers require conformity with their interpretations a

condition of successful transaction we seek to comply with their interpretations.

The HIPAA transaction standards include proper use of procedure and diagnosis codes. Since these codes are selected or approved by our clients, and since we do not verify their propriety, some of our capability to comply with the transaction standards is dependant on the proper conduct of our clients.

In addition to the HIPAA Privacy and Security Rules, most states have enacted patient confidentiality laws that protect against the disclosure of confidential medical information, and many states have adopted or are considering further legislation in this area, including privacy safeguards, security standards, and data security breach notification requirements. Such state laws, if more stringent than HIPAA requirements, are not preempted by the federal requirements we are required to comply with them.

Failure by us to comply with any of the federal and state standards regarding patient privacy may subject us to penalties, including civil monetary penalties and in some circumstances, criminal penalties. In addition, such failure may injure our reputation and adversely affect our ability to retain clients and attract new clients.

Anti-Kickback and Anti-Bribery Laws. There are federal and state laws that govern patient referrals, physician financial relationships and inducements to healthcare providers and patients. For example, the federal healthcare programs anti-kickback law prohibits any person or entity from offering, paying, soliciting or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. Many states also have similar anti-kickback laws that are not necessarily limited to items or services for which payment is made by a federal healthcare program. Moreover, both federal and state laws forbid bribery and similar behavior. Any determination by a state or federal regulatory agency that any of our activities or those of our clients or vendors violate any of these laws could subject us to civil or criminal penalties, could require us to change or terminate some portions of our business, could require us to refund a portion of our service fees, could disqualify us from providing services to clients doing business with government programs and could have an adverse effect on our business. Even an unsuccessful challenge by regulatory authorities of our activities could result in adverse publicity and could require costly response from us.

Anti-Referral Laws. There are federal and state laws that forbid payment for patient referrals, patient brokering, remuneration of patients or billing based on referrals between individuals and/or entities that have various financial, ownership or other business relationships. In many cases, billing for care arising from such actions is illegal. These vary widely from state to state, and one of the federal law, termed the Stark Law, is very complex in its application. Any determination by a state or federal regulatory agency that any of our clients violate or have violated any of these laws may result in allegations that claims that we have processed or forwarded are improper. This could subject us to civil or criminal penalties, could require us to change or terminate some portions of our business, could require us to refund portions of our services fees and could have an adverse effect on our business. Even an unsuccessful challenge by regulatory authorities of our activities could result in adverse publicity and could require costly response from us.

Corporate Practice of Medicine Laws and Fee-Splitting Laws. In many states, there are state laws that forbid physicians from practicing medicine in partnership with non-physicians, such as business corporations. In some states, including New York, these take the form of laws or regulations forbidding splitting of physician fees with non-physicians or others. In some cases, these laws have been interpreted to prevent business service providers from charging their physician clients on the basis of a percentage of collections or charges. We have varied our charge structure in some states to comply with these laws, which may make our services less desirable to potential clients. Any determination by a state court or regulatory agency that our service contracts with our clients violate these laws could subject us to civil or criminal penalties, could invalidate all or portions of some of our client contracts, could require us to change or terminate some portions of our business, could require us to refund portions of our services fees and could have an adverse effect on our business. Even an unsuccessful challenge by regulatory authorities of our activities could result in adverse publicity and could require costly response from us.

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Anti-Assignment Laws. There are federal and state laws that forbid or limit assignment of claims for reimbursement from government-funded programs. In some cases, these laws have been interpreted in regulations or policy statements to limit the manner in which business service companies may handle checks or other payments for such claims and to limit or prevent such companies from charging their physician clients on the basis of a percentage of collections or charges. Any determination by a state court or regulatory agency that our service contracts with our clients violate these laws could subject us to civil or criminal penalties, could invalidate all or portions of some of our client contracts, could require us to change or terminate some portions of our business, could require us to refund portions of our services fees and could have an adverse effect on our business. Even an unsuccessful challenge by regulatory authorities of our activities could result in adverse publicity and could require costly response from us.

Prescribing Laws. The use of our software by physicians to perform a variety of functions, including electronic prescribing, electronic routing of prescriptions to pharmacies and dispensing of medication, is governed by state and federal law, including fraud and abuse laws, drug control regulations and state department of health regulations. States have differing prescription format requirements. Many existing laws and regulations, when enacted, did not anticipate methods of e-commerce now being developed. For example, while federal law and the laws of many states permit the electronic transmission of prescription orders, the laws of several states neither specifically permit nor specifically prohibit the practice. Given the rapid growth of electronic transactions in healthcare, and particularly the growth of the Internet, we expect the remaining states to directly address these areas with regulation in the near future. Regulatory authorities such as the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services may impose functionality standards with regard to electronic prescribing and EMR technologies. Determination that we or our clients have violated prescribing laws may expose us to liability, loss of reputation and loss of business. These laws and requirements may also increase the cost and time necessary to market new services and could affect us in other respects not presently foreseeable.

Electronic Medical Records Laws. A number of federal and state laws govern the use and content of electronic health record systems, including fraud and abuse laws that may affect the donation of such technology. As a company that provides EMR functionality, our systems and services must be designed in a manner that facilitates our clients compliance with these laws. Because this is a topic of increasing state and federal regulation, we expect additional and continuing modification of the current legal and regulatory environment. We cannot predict the content or effect of possible future regulation on our business activities. The software component of our athenaClinicals service complies with the Certification Commission for Healthcare Information Technology, or CCHIT, for ambulatory electronic health record criteria for 2006.

Claims Transmission Laws. Our services include the manual and electronic transmission of our client s claims for reimbursement from payers. Federal and various state laws provide for civil and criminal penalties for any person who submits, or causes to be submitted, a claim to any payer, including, without limitation, Medicare, Medicaid and any private health plans and managed care plans, that is false or that that overbills or bills for items that have not been provided to the patient.

Prompt Pay Laws. Laws in many states govern prompt payment obligations for healthcare services. These laws generally define claims payment processes and set specific time frames for submission, payment and appeal steps. They frequently also define and require clean claims. Failure to meet these requirements and timeframes may result in rejection or delay of claims. Failure of our services to comply may adversely affect our business results and give rise to liability claims by clients.

Medical Device Laws. The U.S. Food and Drug Administration (FDA) has promulgated a draft policy for the regulation of computer software products as medical devices under the 1976 Medical Device Amendments to the Federal Food, Drug and Cosmetic Act. To the extent that computer software is a

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medical device under the policy, we, as a provider of application functionality, could be required, depending on the functionality, to:

register and list our products with the FDA;

notify the FDA and demonstrate substantial equivalence to other products on the market before marketing our functionality; or

obtain FDA approval by demonstrating safety and effectiveness before marketing our functionality.

The FDA can impose extensive requirements governing pre- and post-market conditions like service investigation, approval, labeling and manufacturing. In addition, the FDA can impose extensive requirements governing development controls and quality assurance processes.

Potential regulatory requirements placed on our software, services and content could impose increased costs on us, could delay or prevent our introduction of new services types and could impair the function or value of our existing service types.

Our services are and are likely to continue to be subject to increasing regulatory requirements in a multitude of ways. As these requirements proliferate, we must change or adapt our services and our software to comply. Changing regulatory requirements may render our services obsolete or may block us from accomplishing our work or from developing new services. This may in turn impose additional costs upon us to comply or to further develop services or software. It may also make introduction of new service types more costly or more time consuming than we currently anticipate. It may even prevent such introduction by us of new services or continuation of our existing services unprofitably or impossible.

Potential additional regulation of the disclosure of health information outside the United States may adversely affect our operations and may increase our costs.

Federal or state governmental authorities may impose additional data security standards or additional privacy or other restrictions on the collection, use, transmission and other disclosures of health information. Legislation has been proposed at various times at both the federal and the state level that would limit, forbid or regulate the use or transmission of medical information outside of the United States. Such legislation, if adopted, may render our use of our off-shore partners, such as our data-entry and customer service provider, Vision Healthsource, for work related to such data impracticable or substantially more expensive. Alternative processing of such information within the United States may involve substantial delay in implementation and increased cost.

Errors or illegal activity on the part of our clients may result in claims against us.

We rely on our clients, and we contractually obligate them, to provide us with accurate and appropriate data and directives for our actions. We rely upon our clients as users of our system for key activities to produce proper claims for reimbursement. Failure of clients to provide these data and directives or to perform these activities may result in claims against us that our reliance was misplaced.

Our services present the potential for embezzlement, identity theft or other similar illegal behavior by our employees or subcontractors with respect to third parties.

Among other things, our services involve handling mail from payers and from patients for many of our clients, and this mail frequently includes original checks and/or credit card information, and occasionally, it includes currency.

Even in those cases in which we do not handle original documents or mail, our services also involve the use and disclosure of personal and business information that could be used to impersonate third parties or otherwise gain access to their data or funds. If any of our employees or subcontractors takes, converts or misuses such funds, documents or data, we could be liable for damages, and our business reputation could be damaged or destroyed.

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Potential subsidy of services similar to ours may reduce client demand.

Recently, entities such as the Massachusetts Healthcare Consortium have offered to subsidize adoption by physicians of electronic health record technology. In addition, federal regulations have been changed to permit such subsidy from additional sources subject to certain limitations. To the extent that we do not qualify or participate in such subsidy programs, demand for our services may be reduced which may decrease our revenues.

RISKS RELATED TO THIS OFFERING AND OWNERSHIP OF OUR COMMON STOCK

An active, liquid and orderly market for our common stock may not develop.

Prior to this offering there has been no market for shares of our common stock. An active trading market for our common stock may never develop or be sustained, which could depress the market price of our common stock and could affect your ability to sell your shares. The initial public offering price will be determined through negotiations between us and the representatives of the underwriters and may bear no relationship to the price at which our common stock will trade following the completion of this offering. The trading price of our common stock following this offering is likely to be highly volatile and could be subject to wide fluctuations in response to various factors, some of which are beyond our control. In addition to the factors discussed in this Risk Factors section and elsewhere in this prospectus, these factors include:

- our operating performance and the operating performance of similar companies;
- the overall performance of the equity markets;
- announcements by us or our competitors of acquisitions, business plans or commercial relationships;
- threatened or actual litigation;
- changes in laws or regulations relating to the sale of health insurance;
- any major change in our board of directors or management;
- publication of research reports or news stories about us, our competitors or our industry or positive or negative recommendations or withdrawal of research coverage by securities analysts;
- large volumes of sales of our shares of common stock by existing stockholders; and
- general political and economic conditions.

In addition, the stock market in general, and the market for internet-related companies in particular, has experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of those companies. These fluctuations may be even more pronounced in the trading market for our stock shortly following this offering. Securities class action litigation has often been instituted against companies following periods of volatility in the overall market and in the market price of a company s securities. This litigation, if instituted against us, could result in very substantial costs, divert our management s attention and resources and harm our business, operating results and financial condition.

Future sales of shares of our common stock by existing stockholders could depress the market price of our common stock.

Upon completion of this offering, there will be 31,600,399 shares of our common stock outstanding. The 6,286,819 shares being sold in this offering (or 7,229,842 shares, if the underwriters exercise their option to purchase additional shares in full) will be freely tradable immediately after this offering (except for shares purchased by affiliates) and of the 25,595,157 shares outstanding as of June 30, 2007 (assuming no exercise of the underwriters option to purchase additional shares and no exercise of outstanding options or warrants after June 30, 2007), 270,594 shares are freely tradeable shares saleable under Rule 144(k) that are not subject to a lock-up, 8,767 shares are shares saleable under Rules 144 and 701 that are not subject to a lock-up, 1,470,589 shares are restricted securities held for one year or less and 23,845,207 shares may be sold upon expiration of lock-up agreements 180 days after the date of this offering (subject in some cases to volume

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limitations). In addition, as of June 30, 2007, we had outstanding options to purchase 3,010,054 shares of common stock that, if exercised, will result in these additional shares becoming available for sale upon expiration of the lock-up agreements. A large portion of these shares and options are held by a small number of persons and investment funds. Sales by these stockholders or optionholders of a substantial number of shares after this offering could significantly reduce the market price of our common stock. Moreover, after this offering, the holders of shares of common stock will have rights, subject to some conditions, to require us to file registration statements covering the shares they currently hold, or to include these shares in registration statements that we may file for ourselves or other stockholders.

We also intend to register all common stock that we may issue under our 1997 Stock Plan, 2000 Stock Plan, 2007 Stock Option and Incentive Plan and 2007 Employee Stock Purchase Plan. Effective upon the completion of this offering, an aggregate of 1,500,000 shares of our common stock will be reserved for future issuance under these plans. Once we register these shares, which we plan to do shortly after the completion of this offering, they can be freely sold in the public market upon issuance, subject to the lock-up agreements referred to above. If a large number of these shares are sold in the public market, the sales could reduce the trading price of our common stock. See Shares Eligible for Future Sale for a more detailed description of sales that may occur in the future.

You will experience immediate and substantial dilution.

The initial public offering price will be substantially higher than the net tangible book value of each outstanding share of common stock immediately after this offering. If you purchase common stock in this offering, you will suffer immediate and substantial dilution. At the initial public offering price of $18.00 with net proceeds of $81.7 million, after deducting estimated underwriting discounts and commissions and estimated offering expenses, investors who purchase shares in this offering will have contributed approximately 60% of the total amount of funding we have received to date, but will only hold approximately 16% of the total voting rights. The dilution will be $15.80 per share in the net tangible book value of the common stock from the assumed initial public offering price. In addition, if outstanding options to purchase shares of our common stock are exercised, there could be further dilution. For more information refer to Dilution.

We have broad discretion in the use of the net proceeds from this offering and may not use them effectively.

We cannot specify with certainty the particular uses of the net proceeds we will receive from this offering. Our management will have broad discretion in the application of the net proceeds, including for any of the purposes described in Use of Proceeds . Accordingly, you will have to rely upon the judgment of our management with respect to the use of the proceeds, with only limited information concerning management s specific intentions. Our management may spend a portion or all of the net proceeds from this offering in ways that our stockholders may not desire or that may not yield a favorable return. The failure by our management to apply these funds effectively could harm our business. Pending their use, we may invest the net proceeds from this offering in a manner that does not produce income or that loses value.

A limited number of stockholders will have the ability to influence the outcome of director elections and other matters requiring stockholder approval.

After this offering, our directors, executive officers and their affiliated entities will beneficially own more than 46.0% of our outstanding common stock. These stockholders, if they act together, could exert substantial influence over matters requiring approval by our stockholders, including the election of directors, the amendment of our certificate of incorporation and by-laws and the approval of mergers or other business combination transactions. This concentration of ownership may discourage, delay or prevent a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their stock as part of a sale of our company and might reduce

our stock price. These actions may be taken even if they are opposed by other stockholders, including those who purchase shares in this offering.

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Provisions in our certificate of incorporation and by-laws or Delaware law might discourage, delay or prevent a change of control of our company or changes in our management and, therefore, depress the trading price of our common stock.

Provisions of our certificate of incorporation and by-laws and Delaware law may discourage, delay or prevent a merger, acquisition or other change in control that stockholders may consider favorable, including transactions in which you might otherwise receive a premium for your shares of our common stock. These provisions may also prevent or frustrate attempts by our stockholders to replace or remove our management. These provisions include:

limitations on the removal of directors;

advance notice requirements for stockholder proposals and nominations;

the inability of stockholders to act by written consent or to call special meetings; and

the ability of our board of directors to make, alter or repeal our by-laws.

The affirmative vote of the holders of at least 75% of our shares of capital stock entitled to vote is necessary to amend or repeal the above provisions of our certificate of incorporation. In addition, our board of directors has the ability to designate the terms of and issue new series of preferred stock without stockholder approval. Also, absent approval of our board of directors, our by-laws may only be amended or repealed by the affirmative vote of the holders of at least 75% of our shares of capital stock entitled to vote.

In addition, Section 203 of the Delaware General Corporation Law prohibits a publicly-held Delaware corporation from engaging in a business combination with an interested stockholder, generally a person which together with its affiliates owns, or within the last three years has owned, 15% of our voting stock, for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner.

The existence of the foregoing provisions and anti-takeover measures could limit the price that investors might be willing to pay in the future for shares of our common stock. They could also deter potential acquirers of our company, thereby reducing the likelihood that you could receive a premium for your common stock in an acquisition.

We do not currently intend to pay dividends on our common stock and, consequently, your ability to achieve a return on your investment will depend on appreciation in the price of our common stock.

We have never declared or paid any cash dividends on our common stock and do not currently intend to do so for the foreseeable future. We currently intend to invest our future earnings, if any, to fund our growth. Therefore, you are not likely to receive any dividends on your common stock for the foreseeable future and the success of an investment in shares of our common stock will depend upon any future appreciation in its value. There is no guarantee that shares of our common stock will appreciate in value or even maintain the price at which our stockholders have purchased their shares.

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SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements. All statements other than statements of historical fact contained in this prospectus are forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as may, will, should, expects, plans, anticipates, believes, estimates, predicts, pot or the negative of these terms or other comparable terminology. These statements are only current predictions and are subject to known and unknown risks, uncertainties and other factors that may cause our or our industry s actual results, levels of activity, performance, or achievements to be materially different from those anticipated by the forward-looking statements. These factors include, among other things, those listed under Risk Factors and elsewhere in this prospectus.

Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements. Except as required by law, we are under no duty to update or revise any of the forward-looking statements, whether as a result of new information, future events or otherwise, after the date of this prospectus.

This prospectus contains statistical data that we obtained from industry publications and reports generated by third parties. Although we believe that the publications and reports are reliable, we have not independently verified this statistical data.

INDUSTRY DATA

Unless otherwise indicated, information contained in this prospectus concerning our industry and the markets in which we operate, including our general expectations and market position, market opportunity and market share, is based on information from independent industry analysts and third party sources (including industry publications, surveys and forecasts and our internal research), and management estimates. Management estimates are derived from publicly available information released by independent industry analysts and third-party sources, as well as data from our internal research, and are based on assumptions made by us based on such data and our knowledge of such industry and markets, which we believe to be reasonable. None of the sources cited in this prospectus has consented to the inclusion of any data from its reports, nor have we sought their consent. Our internal research has not been verified by any independent source, and we have not independently verified any third-party information. While we believe the market position, market opportunity and market share information included in this prospectus is generally reliable, such information is inherently imprecise. In addition, projections, assumptions and estimates of our future performance and the future performance of the industries in which we operate are necessarily subject to a high degree of uncertainty and risk due to a variety of factors, including those described in Risk Factors and elsewhere in this prospectus. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

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USE OF PROCEEDS

We estimate that the net proceeds to us from the sale of the shares of common stock in this offering will be approximately $81.7 million, based on the initial public offering price of $18.00 per share, and after deducting estimated underwriting discounts and commissions and estimated offering expenses. We will not receive any of the proceeds from the sale of shares by the selling stockholder. We will not receive any additional proceeds if the underwriters exercise the option to purchase additional shares because only selling stockholders will sell additional shares if the option to purchase additional shares is exercised.

The principal reasons for this offering are to obtain additional capital, to create a public market for our common stock and to facilitate our future access to public equity markets. As a result, we believe we will be better able to address our various strategic initiatives and respond to changes in our industry than we otherwise would as a private company.

We currently estimate that of the net proceeds we receive from this offering we will spend approximately $32.7 million to repay the following indebtedness outstanding as of June 30, 2007, plus accrued but unpaid interest and prepayment penalties thereon:

- approximately $8.9 million in aggregate principal and interest under our working capital line of credit with Silicon Valley Bank, or SVB;
- approximately $1.3 million in aggregate principal, interest and prepayment penalties under our equipment line of credit with Bank of America, N.A., or Bank of America;
- approximately $4.7 million in aggregate principal, interest and prepayment penalties under our equipment line of credit with Oxford Finance Corporation, or Oxford;
- approximately $0.3 million in aggregate principal, interest and prepayment penalties under our equipment line of credit with General Electric Capital Corporation; and
- approximately $17.5 million in aggregate principal, interest and prepayment penalties under our term loans with ORIX Venture Finance LLC, or ORIX.

Our working capital line of credit currently bears interest at a per annum rate equal to SVB s prime rate, which was 8.25% as of June 30, 2007, matures on August 31, 2008. Our equipment line of credit with Bank of America currently bears interest at per annum rate equal to the greater of 9% or the Bank of America s prime rate, which was 8.25% as of June 30, 2007, plus 3.75%, matures on December 1, 2008 and may be prepaid with a 1% penalty. Our equipment line of credit with Oxford currently bears interest at 10.73% per annum, matures on December 1, 2009 and may be prepaid with a 2%-3% penalty if prepayment occurs prior within 90 days of the effectiveness of this registration statement. Our equipment line of credit with General Electric Capital Corporation currently bears interest at 8.49% per annum, matures on March 1, 2008 and may be prepaid with a 3% penalty if prepayment occurs prior to December 1, 2007. Each of our term loans with ORIX currently bears interest at prime, which was 8.25% as of June 30, 2007, plus 1.75% per annum, matures on June 30, 2010, and may be prepaid in whole or in part with a prepayment penalty equal to 3% of the amount prepaid if prepayment occurs prior to December 28, 2007. We used the proceeds from indebtedness incurred during the past year to acquire equipment and for other general working capital purposes.

We anticipate that we will use the remaining net proceeds we receive from this offering for working capital and other general corporate purposes, including the funding of our marketing activities and further investment in the development of our service offerings. Other than the repayment of indebtedness, we have not allocated any specific

portion of the net proceeds to any particular purpose, and our management will have the discretion to allocate the proceeds as it determines. We may use a portion of the net proceeds for the acquisition of businesses, products and technologies that we believe are complementary to our own, although we have no agreements or understandings with respect to any acquisition at this time.

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Pending our use of the net proceeds from this offering, we intend to invest the net proceeds of this offering in short-term, interest-bearing, investment-grade securities.

This expected use of the net proceeds of this offering represents our current intentions based upon our present plans and business condition. The amounts and timing of our actual expenditures will depend upon numerous factors, including cash flows from operations and the anticipated growth of our business. We will retain broad discretion in the allocation and use of our net proceeds. See Risk Factors Risks Related to This Offering and Ownership of Our Common Stock.

DIVIDEND POLICY

We have never declared or paid any dividends on our capital stock and our loan agreements restrict our ability to pay dividends. We currently intend to retain any future earnings and do not intend to declare or pay cash dividends on our common stock in the foreseeable future. Any future determination to pay dividends will be, subject to applicable law, at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, contractual restrictions and capital requirements.

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CAPITALIZATION

The following table sets forth our capitalization as of June 30, 2007:

- on an actual basis;
- on a pro forma basis to reflect the conversion of all of our outstanding preferred stock into 21,531,457 shares of our common stock upon the closing of this offering; and
- on a pro forma as adjusted basis to further reflect:
  - the receipt by us of net proceeds of $81.7 million from the sale of the 5,000,000 shares of common stock offered by us in this offering at the public offering price of $18.00 per share, less underwriting discounts and commissions and estimated offering expenses payable by us; and
  - the payment by us of approximately $32.7 million to repay our outstanding indebtedness with, and other amounts payable to, our financial lenders as described under Use of Proceeds.

You should read this information together with Management s Discussion and Analysis of Financial Condition and Results of Operations, our consolidated financial statements and the notes to those statements appearing elsewhere in this prospectus.

	As of June 30, 2007		
	Actual	Pro Forma	Pro Forma As Adjusted
	(in thousands, except share and per share data)		
Long-term debt	$ 32,038	$ 32,038	$ 309
Deferred rent	11,670	11,670	11,670
Warrant liability	6,178		
Convertible preferred stock; $0.01 par value per share; 26,389,684 shares authorized, 22,331,991 shares issued and 21,531,457 shares outstanding, actual; no shares authorized, issued and outstanding, pro forma and pro forma as adjusted	50,094		
Preferred stock, $0.01 par value; no shares authorized, issued and outstanding, actual and pro forma; 5,000,000 shares authorized and no shares issued and outstanding, pro forma as adjusted			
Common stock; $0.01 par value per share; 50,000,000 shares authorized, 5,546,267 shares issued and 5,068,942 shares outstanding, actual; 50,000,000 shares authorized, 27,878,258 shares issued and 26,600,399 shares outstanding, pro forma; 125,000,000 shares authorized and 32,878,258 shares issued and 31,600,399 shares outstanding, pro forma as adjusted	55	270	320
Additional paid-in capital	3,819	59,876	141,526
Accumulated other comprehensive income	62	62	62
Accumulated deficit	(71,264)	(71,264)	(72,493)
Treasury stock, 1,277,859 shares	(1,200)	(1,200)	(1,200)

Total stockholders deficit	(68,528)	(12,256)	68,215
Total capitalization	$ 31,452	$ 31,452	$ 80,194

The number of shares shown as issued and outstanding in the table above does not include:

3,010,054 shares of common stock issuable upon the exercise of stock options outstanding as of June 30, 2007 with a weighted average exercise price of $3.43 per share; and

634,787 shares of common stock issuable upon the exercise of warrants outstanding as of June 30, 2007 with a weighted average exercise price of $3.28 per share.

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DILUTION

If you invest in our common stock in this offering, your interest will be diluted to the extent of the difference between the public offering price per share of our common stock and the pro forma net tangible book value per share of our common stock.

The net tangible book value of our common stock as of June 30, 2007 was a deficit of $68.5 million, or $13.52 per share. Net tangible book value per share represents the amount of stockholders deficit divided by shares of common stock outstanding at that date. The pro forma net tangible book value of our common stock as of June 30, 2007 was a deficit of $12.3 million, or a deficit of approximately $0.46 per share, excluding proceeds from this offering. Pro forma net tangible book value gives effect to the conversion of all shares of outstanding preferred stock into shares of common stock upon the closing of this offering.

Net tangible book value dilution per share to new investors represents the difference between the amount per share paid by purchasers of common stock in this offering and the pro forma net tangible book value per share of common stock immediately after completion of this offering. After giving effect to our sale of 5,000,000 shares of common stock in this offering at the initial public offering price of $18.00 per share, and after deducting estimated underwriting discounts and commissions and estimated offering expenses, our pro forma net tangible book value as of June 30, 2007 would have been $2.20 per share. This represents an immediate increase in net tangible book value of $2.66 per share to existing stockholders and an immediate dilution in net tangible book value of $15.80 per share to purchasers of common stock in this offering, as illustrated in the following table:

Assumed initial public offering price per share		$ 18.00
Pro forma net tangible book value per share as of June 30, 2007	$ (0.46)	
Increase per share attributable to new investors	2.66	
Pro forma net tangible book value per share at June 30, 2007 after giving effect to the offering		$ 2.20
Dilution per share to new investors		$ 15.80

Any exercise by the underwriters of the underwriters option to purchase additional shares of our common stock from selling stockholders will not affect the pro forma net tangible book value per share or dilution per share to new investors because no additional shares will be sold by us if this option is exercised.

The following table summarizes, on a pro forma basis, as of June 30, 2007, the difference between the number of shares of common stock purchased from us, the total consideration paid to us and the average price per share paid by existing stockholders and by new investors at the initial public offering price of $18.00 per share, before deducting estimated underwriting discounts and commissions and estimated offering expenses.

	Shares Purchased		Total Consideration		Avg Price
	Number	%	Amount	%	/ Share
Existing stockholders	26,600,399	84%	$ 53,968,788	37%	$ 2.03

New investors	5,000,000	16	90,000,000	63	$ 18.00
Total	31,600,399	100%	$ 143,968,788	100%	

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The discussion and the tables above assume no exercise of stock options outstanding on June 30, 2007 and no issuance of shares reserved for future issuance under our equity compensation plans. In addition, the numbers set forth in the table above assume the conversion as of June 30, 2007 of all outstanding shares of our preferred stock into shares of our common stock. As of June 30, 2007, there were:

- 3,010,054 shares of common stock issuable upon the exercise of stock options outstanding with a weighted average exercise price of $3.43 per share;

- 634,787 shares of common stock issuable upon the exercise of warrants outstanding with a weighted average exercise price of $3.28 per share; and

- 1,500,000 shares of common stock currently reserved for future issuance under our equity incentive plans.

If the underwriters option to purchase additional shares is exercised in full, the following will occur:

- the percentage of shares of common stock held by existing stockholders will decrease to approximately 77% of the total number of shares of our common stock outstanding after this offering; and

- the number of shares held by new investors will be increased to 7,229,842, or approximately 23%, of the total number of shares of our common stock outstanding after this offering.

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SELECTED CONSOLIDATED FINANCIAL DATA

The following tables summarize our consolidated financial data for the periods presented. You should read the following financial information together with the information under Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and the related notes to these consolidated financial statements appearing elsewhere in this prospectus. The selected consolidated statements of operations data for the fiscal years ended December 31, 2004, 2005 and 2006, and the selected consolidated balance sheet data as of December 31, 2005 and 2006 are derived from our consolidated financial statements, which are included elsewhere in this prospectus, and have been audited by Deloitte & Touche LLP, an independent registered public accounting firm, as indicated in their report. The selected consolidated statements of operations data for the years ended December 31, 2002 and 2003, and the consolidated balance sheet data at December 31, 2002, 2003 and 2004 are derived from our audited consolidated financial statements not included in this prospectus. The selected consolidated balance sheet data as of June 30, 2007 and the selected consolidated statements of operations data for six months ended June 30, 2006 and 2007 are derived from our unaudited consolidated financial statements appearing elsewhere in this prospectus. The unaudited consolidated financial statements have been prepared on the same basis as our audited financial statements and include, in the opinion of management, all adjustments that management considers necessary for a fair presentation of the financial information set forth in those statements. Operating results for these periods are not necessarily indicative of the operating results for a full year. Historical results are not necessarily indicative of the results to be expected in future periods.

	Year Ended December 31,					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
						(unaudited)	
	(in thousands except share and per share data)						
Revenue:							
Business services	$ 10,475	$ 21,953	$ 35,033	$ 48,958	$ 70,652	$ 32,822	$ 43,268
Implementation and other	1,509	2,713	3,905	4,582	5,161	2,517	3,172
Total revenue	11,984	24,666	38,938	53,540	75,813	35,339	46,440
Operating expenses(1):							
Direct operating	10,107	15,396	20,512	27,545	36,530	17,458	22,168
Selling and marketing	3,952	4,994	7,650	11,680	15,645	7,435	8,314
Research and development	488	1,051	1,485	2,925	6,903	2,509	3,599
General and administrative	4,448	5,222	8,520	15,545	16,347	7,771	9,571
Depreciation and amortization	2,493	2,894	3,159	5,483	6,238	2,952	3,048
Total operating expenses	21,488	29,557	41,326	63,178	81,663	38,125	46,700
Operating loss	(9,504)	(4,891)	(2,388)	(9,638)	(5,850)	(2,786)	(260)

Other income (expense):							
Interest income	326	65	140	106	372	152	214
Interest expense	(380)	(540)	(1,362)	(1,861)	(2,671)	(1,206)	(1,622)
Other expense					(702)	(342)	(4,416)
Total other expense	(54)	(475)	(1,222)	(1,755)	(3,001)	(1,396)	(5,824)
Loss before cumulative effect of change in accounting principle	(9,558)	(5,366)	(3,610)	(11,393)	(8,851)	(4,182)	(6,084)
Cumulative effect of change in accounting principle					(373)	(373)	
Net loss	$ (9,558)	$ (5,366)	$ (3,610)	$ (11,393)	$ (9,224)	$ (4,555)	$ (6,084)
Net loss per share basic and diluted					$ (1.96)		$ (1.23)

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	Year Ended December 31,					Six Months Ended June 30,	
	2002	2003	2004	2005	2006	2006	2007
						(unaudited)	
	(in thousands except share and per share data)						
Weighted average shares outstanding basic and diluted					4,707,902		4,933,666
Pro forma net loss per share basic and diluted (unaudited)					$ (0.35)		$ (0.23)
Pro forma weighted average shares outstanding basic and diluted (unaudited)					26,239,359		26,465,123
(1) Amounts include stock-based compensation expense as follows:							
Direct operating	$	$	$	$	$ 64	$ 27	$ 93
Selling and marketing					43	19	81
Research and development					53	24	99
General and administrative					196	26	331
Total	$	$	$	$	$ 356	$ 96	$ 604

	As of December 31,					As of June 30,
	2002	2003	2004	2005	2006	2007
						(unaudited)
Balance Sheet Data:			(in thousands)			
Cash, cash equivalents and short-term investments	$ 7,634	$ 8,432	$ 8,763	$ 9,309	$ 9,736	$ 12,660
Current assets	10,017	12,791	14,981	17,722	21,355	26,569
Total assets	16,520	18,830	26,022	38,345	39,973	44,345
Current liabilities	7,317	8,474	14,196	16,947	23,646	28,949
Total non-current liabilities	1,514	7,442	5,335	25,640	30,504	33,830
Total liabilities	8,831	15,916	19,531	42,587	54,150	62,779
Convertible preferred stock	43,678	43,678	50,094	50,094	50,094	50,094
	4,775	9,852	11,467	20,137	27,293	32,038

Total indebtedness including current portion						
Total stockholders deficit	(35,989)	(40,764)	(43,603)	(54,336)	(64,271)	(68,528)

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

The following discussion and analysis should be read in conjunction with our consolidated financial statements, the accompanying notes to these financial statements and the other financial information that appear elsewhere in this prospectus. This discussion contains predictions, estimates and other forward-looking statements that involve a number of risks and uncertainties. Actual results may differ materially from those discussed in these forward-looking statements due to a number of factors, including those set forth in the section entitled Risk Factors and elsewhere in this prospectus.

Overview

athenahealth is a provider of internet-based business services for physician practices. Our service offerings are based on three integrated components: our proprietary internet-based software, our continually updated database of payer reimbursement process rules and our back-office service operations that perform administrative aspects of billing and clinical data management for physician practices. Our principal offering, athenaCollector, automates and manages billing-related functions for physician practices and includes a medical practice management platform. We have also developed a service offering, athenaClinicals, that automates and manages medical record-related functions for physician practices and includes an electronic medical record, or EMR, platform. We refer to athenaCollector as our revenue cycle management service and athenaClinicals as our clinical cycle management service. Our services are designed to help our clients achieve faster reimbursement from payers, reduce error rates, increase collections, lower operating costs, improve operational workflow controls and more efficiently manage clinical and billing information.

Our services require relatively modest initial investment, are highly adaptable to changing healthcare and technology trends and are designed to generate significant financial benefit for our physician clients. Our results are directly tied to the financial performance of our clients because the majority of our revenue is based on a percentage of their collections. Our services have enabled our clients on average, to resolve 93% of their claims to payers on their first submission attempt, compared to an industry average we estimate to be 70%. Our internal studies show that we have reduced the days in accounts receivable of our client base by more than 30%. We have experienced a contract renewal rate of at least 97% in each of the last five years, and this persistent client base drives a predictable revenue stream.

In 2006, we generated revenue of $75.8 million from the sale of our services compared to $53.5 million in 2005. For the six months ended June 30, 2007 we generated revenue of $46.4 million versus $35.3 million for the six months ended June 30, 2006. Given the scope of our market opportunity, we have increased our spending each year on growth, innovation and infrastructure. Despite increased spending in these areas, higher revenue and lower direct operating expense as a percentage of revenue have led to smaller net losses.

Our revenues are predominately derived from business services that we provide on an ongoing basis. This revenue is generally determined as a percentage of payments collected by our clients, so the key drivers of our revenue include growth in the number of physicians working within our client accounts and the collections of these physicians. To provide these services we incur expense in several categories, including direct operating, selling and marketing, research and development, general and administrative and depreciation and amortization expense. In general, our direct operating expense increases as our volume of work increases, whereas our selling and marketing expense increases in proportion to our rate of adding new accounts to our network of physician clients. Our other expense categories are less directly related to growth of revenues and relate more to our planning for the future, our overall business management activities and our infrastructure. As our revenues have grown, the difference between our revenue and our direct operating expense also has grown, which has afforded us the ability to spend more in other

categories of expense and to experience an increase in operating margin. Due to growth in the value of our equity, we have incurred substantial expenses related to warrants that will cease to accrue further upon the completion of this offering. We manage our cash and our use of credit facilities to ensure adequate liquidity, in adherence to related financial covenants. As a result of this offering, we expect to retire most of our current debt and seek to establish sufficient liquidity to achieve our business objectives.

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Sources of Revenue

We derive our revenue from two sources: from business services associated with our revenue cycle and clinical cycle offerings and from implementation and other services. Implementation and other services consist primarily of professional services fees related to assisting clients with the initial implementation of our services and for ongoing training and related support services. Business services accounted for approximately 93% of our total revenues for the six months ended June 30, 2007 and 90%, 91% and 93% for the twelve months ended December 31, 2004, 2005 and 2006, respectively. Business services fees are typically 2% to 8% of a practice s total collections depending upon the size, complexity and other characteristics of the practice, plus a per statement charge for billing statements that are generated for patients. Accordingly, business services fees are largely driven by: the number of physician practices we serve; the number of physicians working in those physician practices; and the volume of activity and related collections of those physicians, which is largely a function of the number of patients seen or procedures performed by the practice, the medical specialty in which the practice operates and the geographic location of the practice. For example, high volume, specialty practices in metropolitan areas tend to collect more payments than slower, primary care practices in rural areas. There is moderate seasonality in the activity level of physician offices. Typically, discretionary use of physician services declines in the late summer and during the holiday season, which leads to a decline in collections by our physician clients of about 30-50 days later. None of our clients accounted for more than 5% of our total revenues for the six months ended June 30, 2007 or the twelve months ended December 31, 2006. For the twelve months ended December 31, 2004 and 2005, our largest client accounted for approximately 7% of revenues in both years and no other client exceeded 5% of our total revenues in those years.

Operating Expense

Direct Operating Expense. Direct operating expense consists primarily of salaries, benefits, claim processing costs, other direct costs and stock-based compensation related to personnel who provide services to clients, including staff who implement new clients. Although we expect that direct operating expense will increase in absolute terms for the foreseeable future, the direct operating expense is expected to decline as a percentage of revenues as we further increase the percentage of transactions that are resolved on the first attempt. In addition, over the longer term, we expect to increase our overall level of automation and to reduce our direct operating expense as a percentage of revenues as we become a larger operation, with higher volumes of work in particular functions, geographies and medical specialties. In 2007, we include in direct operating expense the service costs associated with our athenaClinicals offering, which includes transaction handling related to lab requisitions, lab results entry, fax classification and other services. We also expect these costs to increase in absolute terms for the foreseeable future but to decline as a percentage of revenue. This decrease will be driven by increased levels of automation and by economies of scale. Direct operating expense does not include allocated amounts for rent, depreciation and amortization.

Selling and Marketing Expense. Selling and marketing expense consists primarily of marketing programs (including trade shows, brand messaging and on-line initiatives) and personnel related expense for sales and marketing employees (including salaries, benefits, commissions, stock-based compensation, non-billable travel, lodging and other out-of-pocket employee-related expense). Although we recognize substantially all of our revenue when services have been delivered, we recognize a large portion of our sales commission expense at the time of contract signature and at the time our services commence. Accordingly, we incur a portion of our sales and marketing expense prior to the recognition of the corresponding revenue. We plan to continue to invest in sales and marketing by hiring additional direct sales personnel to add new clients and increase sales to our existing clients. We also plan to expand our marketing activities such as attending trade shows, expanding user groups and creating new printed materials. As a result, we expect that in the future, sales and marketing expense will increase in absolute terms but decline over time as a percentage of revenue.

Research and Development Expense. Research and development expense consists primarily of personnel-related expenses for research and development employees (including salaries, benefits, stock-based compensation, non-billable travel, lodging and other out-of-pocket employee-related expense) and consulting fees for third-party developers. We expect that in the future, research and development expense will increase in absolute terms but not as a percentage of revenue as new services and more mature products require incrementally less new research and

development investment. For our revenue cycle related application development, we expense nearly all of the development costs because we believe the development is substantially complete. For our clinical cycle related application development, we capitalized nearly all of our research and development costs during the year ended December 31, 2006 and the six months ended June 30, 2007, which capitalized costs represented approximately 16% of our total research and development expenditures in 2006 and approximately 14% in the six months ended June 30, 2007. We expect these capitalized expenditures will begin to amortize during the first quarter of 2008 when we begin to implement our services to clients who are not part of our beta-testing program. Our beta-testing program is the implementation and utilization of a test version of our athenaClinicals product with a client. It allows for testing, in a live environment, of the features and functionality of the product. The intent is to find errors in the application and subsequently correct them.

General and Administrative Expense. General and administrative expense consists primarily of personnel-related expense for administrative employees (including salaries, benefits, stock-based compensation, non-billable travel, lodging and other out-of-pocket employee-related expense), occupancy and other indirect costs (including building maintenance and utilities) and insurance, as well as software license fees and outside professional fees for accountants, lawyers and consultants and temporary employees. We expect that general and administrative expense will increase in absolute terms for the foreseeable future as we invest in infrastructure to support our growth and incur additional expense related to being a publicly traded company. Though expenses are expected to continue to rise in absolute terms, we expect general and administrative expense to decline as a percentage of overall revenues.

Depreciation and Amortization Expense. Depreciation and amortization expense consists primarily of depreciation of fixed assets and amortization of capitalized software development costs, which we amortize over a two-year period from the time of release of related software code. Because our core revenue cycle application is relatively mature, we elect to expense those costs as incurred, and as a result in 2006 approximately 86% of our software development expenditures were expensed rather than capitalized. In the six months ended June 30, 2007, approximately 86% were expensed rather than capitalized. As we grow we will continue to make capital investments in the infrastructure of the business and we will continue to develop software that we capitalize. At the same time, because we are spreading fixed costs over a larger client base, we expect related depreciation and amortization expense to decline as a percentage of revenues over time.

Other Income (Expense). Interest expense consists primarily of interest costs related to our working capital line of credit, our equipment-related term loans and our subordinated term loan, offset by interest income on investments. Interest income represents earnings from our cash, cash equivalents and short-term investments. The unrealized loss on warrant liability represents the change in the fair value of our warrants to purchase shares of our preferred stock at the end of each reporting period. This ongoing loss will cease upon the completion of this offering at which time the associated liability will convert to additional paid-in-capital.

Critical Accounting Policies

We prepare our financial statements in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements requires us to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue, expense and related disclosures. We base our estimates and assumptions on historical experience and on various other factors that we believe to be reasonable under the circumstances. We evaluate our estimates and assumptions on an ongoing basis. Our actual results may differ from these estimates under different assumptions or conditions.

We believe the following critical accounting policies, among others, affect our more significant judgments and estimates used in the preparation of our financial statements.

Revenue Recognition

We recognize revenue when all of the following conditions are satisfied:

there is evidence of an arrangement;

the service has been provided to the client;

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the collection of the fees is reasonably assured; and

the amount of fees to be paid by the client is fixed or determinable.

Our arrangements do not contain general rights of return. All revenue, other than implementation revenue, is recognized when the service is performed. As the implementation service is not separable from the ongoing business services, we record implementation fees as deferred revenue until the implementation service is complete, at which time we recognize revenue ratably on a monthly basis over the expected performance period.

Our clients typically purchase one-year contracts that renew automatically upon completion. In most cases, our clients may terminate their agreements with 90 days notice without cause. We typically retain the right to terminate client agreements in a similar timeframe. Our clients are billed monthly, in arrears, based either upon a percentage of collections posted to athenaNet, minimum fees, flat fees or per claim fees where applicable. Invoices are generated within the first two weeks of the month and delivered to clients primarily by email. For most of our clients, fees are then deducted from a pre-determined bank account one week after invoice receipt via an auto-debit transaction. Amounts that have been invoiced are recorded as revenue or deferred revenue, as appropriate, and are included in our accounts receivable balances. Deposits received for future services (such as implementation fees) are recorded as deferred revenue and amortized over the term of the service agreement when ongoing services commence.

Software Development Costs

We account for software development costs under the provisions of American Institute of Certified Public Accountants Statement of Position (SOP) 98-1, *Accounting for the Costs of Computer Software Developed or Obtained for Internal Use*. Under SOP 98-1, costs related to the preliminary project stage of subsequent versions of athenaNet and/or other technology are expensed as incurred. Costs incurred in the application development stage are capitalized. Such costs are amortized over the software s estimated economic life of two years. In 2006 approximately 86% of our software development expenditures were expensed rather than capitalized based upon the stage of development of the software. In the six months ended June 30, 2007, approximately 86% of our software development expenditures were expensed rather than capitalized.

Stock-Based Compensation

Prior to January 1, 2006, we accounted for stock-based awards to employees using the intrinsic value method as prescribed by Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees,* and related interpretations. Under the intrinsic value method, compensation expense is measured on the date of grant as the difference between the deemed fair value of our common stock and the option exercise price multiplied by the number of options granted. Generally, we grant stock options with exercise prices equal to or above the estimated fair value of our common stock. The option exercise prices and fair value of our common stock is determined by our management and board of directors. Accordingly, no compensation expense was recorded for options issued to employees prior to January 1, 2006 in fixed amounts and with fixed exercise prices at least equal to the fair value of our common stock at the date of grant.

On January 1, 2006, we adopted SFAS No. 123(R), *Share-Based Payment*, which requires companies to expense the fair value of employee stock options and other forms of share-based awards. SFAS 123(R) addresses accounting for share-based awards, including shares issued under employee stock purchase plans, stock options and share-based awards, with compensation expense measured using the fair value, for financial reporting purposes, and recorded over the requisite service period of the award. In accordance with SFAS 123(R), we recognize compensation expense for awards granted and awards modified, repurchased or cancelled after the adoption date. Under SFAS 123(R), we

estimate the fair value of stock options and share-based awards using the Black-Scholes option-pricing model.

We have recorded stock-based compensation under SFAS 123(R) using the prospective transition method and accordingly, will continue to account for awards granted prior to the adoption date of SFAS 123(R) following the provisions of APB Opinion No. 25. Prior periods have not been restated. For awards granted after January 1, 2006, we have elected to recognize compensation expense for awards with service conditions

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on a straight line basis over the requisite service period. Prior to the adoption of SFAS 123(R), we used the straight-line method of recognition for all awards. For the six months ended June 30, 2007 and for the twelve months ended December 31, 2006, we recorded $0.6 million and $0.4 million in stock-based compensation expense, respectively. As of December 31, 2006 the future expense of non-vested options of approximately $2.5 million is to be recognized through 2010. There was no impact on the presentation in the consolidated statements of cash flows as no excess tax benefits have been realized in 2006.

The fair value of our options issued during the six months ended June 30, 2007 and the twelve months ended December 31, 2006 was determined using the Black-Scholes model with the following range of assumptions:

	Year Ended December 31, 2006	Six Months Ended June 30, 2007 (unaudited)
Risk-free interest rate	4.9%	4.5%
Expected dividend yield	0.0%	0.0%
Expected option term (years)	6.25	6.25
Expected stock volatility	71.0%	71.0%

As there was no public market for our common stock prior to this offering, we have determined the volatility for options granted in 2006 and 2007 based on an analysis of reported data for a peer group of companies that issued options with substantially similar terms. These companies include: HLTH Corporation (formerly known as Emdeon Corp.), Quality Systems, Inc., Per Se Technologies, Inc. (acquired by McKesson Corp.) and Allscripts HealthCare Solutions, Inc. The expected volatility of options granted has been determined using an average of the historical volatility measures of this peer group of companies. The expected volatility for options granted during 2006 and 2007 was 71%. The expected life of options granted during the year ended December 31, 2006 and the six months ended June 30, 2007 was determined to be 6.25 years using the simplified method as prescribed by SAB No. 107, *Share-Based Payment*. For 2006 and the six months ended June 30, 2007, the weighted-average risk free interest rate used was 4.9% and 4.5%, respectively. The risk-free interest rate is based on a treasury instrument whose term is consistent with the expected life of the stock options. We have not paid and do not anticipate paying cash dividends on our shares of common stock; therefore, the expected dividend yield is assumed to be zero. In addition, SFAS No. 123(R) requires companies to utilize an estimated forfeiture rate when calculating the expense for the period. Our estimated forfeiture rate of 17% in 2006 and 2007 used in determining the expense recorded in our consolidated statement of operations is based on our actual forfeiture rate since 1997.

We believe there is a high degree of subjectivity involved when using option-pricing models to estimate share-based compensation under SFAS 123(R). There is currently no market-based mechanism or other practical application to verify the reliability and accuracy of the estimates stemming from these valuation models, nor is there a means to compare and adjust the estimates to actual values. Although the fair value of employee share-based awards is determined in accordance with SFAS 123(R) using an option-pricing model, that value may not be indicative of the fair value observed in a market transaction between a willing buyer and willing seller. If factors change and we employ different assumptions in the application of SFAS 123(R) in future periods than those currently applied under SFAS 123(R), the compensation expense that we record in future under SFAS 123(R) may differ significantly from what we have historically reported.

For example, if the volatility percentage used in calculating our SFAS 123(R) stock compensation expense had fluctuated by 10%, the total stock compensation expense to be recognized over the stock options four year vesting

period would have increased or decreased by approximately $0.3 million. If the volatility percentage had fluctuated by the 10%, the effect on our stock compensation expense for the year ended December 31, 2006 and for the six months ended June 30, 2006 and 2007 would be an increase or decrease of approximately $6,000, $18,000 and $38,000, respectively. If the forfeiture rate used in calculating our SFAS 123(R) stock compensation expense had fluctuated by 10%, the total stock compensation expense to be recognized over the stock options four year vesting period would have decreased or increased by approximately $0.5 million. If the forfeiture rate had fluctuated by the 10%, the effect on our stock compensation expense for the year ended December 31, 2006 and for the six months ended June 30, 2006 and 2007 would be a decrease or increase of approximately $9,000, $25,000 and $50,000, respectively. There would be no

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fluctuation in the expected life used in calculating our SFAS 123(R) stock compensation expense as the expected life was determined to be 6.25 years for all period using the simplified method as prescribed by SAB No. 107, *Share-Based Payment*. There would be no fluctuation in the risk free interest rate used in calculating our SFAS 123(R) stock compensation expense as the risk free interest rate used in the calculation is dependant upon the expected life used in the calculation which remains stagnant as discussed above. There would also be no fluctuation in the dividend rate used in calculating our SFAS 123(R) stock compensation expense as we have never paid a dividend and currently have no plans to pay a dividend in the future.

Prior to offering, the fair value for our common stock, for the purpose of determining the exercise prices of our common stock options, was estimated by our board of directors, with input from management. Our board of directors exercised judgment in determining the estimated fair value of our common stock on the date of grant based on several factors, including:

- the nature and history of our business;
- our significant accomplishments and future prospects;
- our revenue growth and expected future revenue rates;
- our book value and financial condition;
- the existence of goodwill or other intangible value within our company;
- our ability (or inability) to pay dividends;
- external market conditions affecting the healthcare information technology industry sector;
- the illiquid nature of an investment in our common stock;
- the prices at which we sold shares of our convertible preferred stock;
- the superior rights and preferences of securities senior to our common stock at the time of each grant;
- the likelihood of achieving a liquidity event such as an initial public offering or sale; and
- the market prices of publicly traded companies engaged in the same or similar lines of business.

We believe this to have been a reasonable approach to estimating the fair value of our common stock for those periods along with our analyses of comparable companies in our industry and arm s-length transactions involving our common stock. Determining the fair value of our stock requires making complex and subjective judgments, however, and there is inherent uncertainty in our estimate of fair value.

The following table presents the grant dates and related exercise prices of stock options granted to employees in the year ended December 31, 2006 and the six months ended June 30, 2007:

Grants Made During Quarter Ended	Number of	Weighted Average Exercise Price

	Options Granted		
March 31, 2006	174,978	$	5.26
June 30, 2006	107,702		5.72
September 30, 2006	66,652		6.16
December 31, 2006	353,200		6.58
March 31, 2007 (unaudited)	468,350		7.36
June 30, 2007 (unaudited)	52,900		9.30
Total grants	1,223,782	$	6.71

The exercise price of all stock options described above was equal to the estimated fair value of our common stock on the date of grant, and therefore the intrinsic value of each option grant was zero.

The exercise price of the stock options granted after January 1, 2006 was set by the board of directors based upon, in addition to what is described above, an internal valuation model. The internal valuation model used the weighted average of the guideline public company method and the discounted future cash flow

method. The enterprise value from that analysis was then utilized in the option pricing method as outlined in the American Institute of Certified Public Accountants (AICPA) Technical Practice Aid, *Valuation of Privately-Held-Company Equity Securities Issued as Compensation* (Practice Aid). The exercise price for stock options granted subsequent to January 1, 2006, was based upon our contemporaneous valuation completed on a quarterly basis.

We estimated our enterprise value under the guideline public company method by comparing our company to publicly-traded companies in our industry group. The companies used for comparison under the guideline public company method were selected based on a number of factors, including but not limited to, the similarity of their industry, business model and similar financial risk to those of ours. We used those companies that we believed were closely comparable to ours, based on the above factors. In determining our enterprise value under this method, we utilized a risk-adjusted enterprise value multiple to sales ratio, which ranged from 3.0 to 5.6 during the period from January 1, 2006 through June 30, 2007, based on the median of the guideline companies and applied the ratio to the sales of our company.

We also estimated our enterprise value under the discounted future cash flow method, which involves applying appropriate discount rates to estimated cash flows that are based on forecasts of revenue and costs. Our revenue forecasts were based on expected market growth rates ranging from 12% to 38% during the next five years, as well as related assumptions about our future costs during this period. There is inherent uncertainty in making these estimates. These assumptions underlying the estimates are consistent with the plans and estimates that we use to manage the business. The risks associated with achieving our forecasts were assessed in selecting the appropriate discount rates, which was approximately 15% to 17% for all periods during the period from January 1, 2006 through June 30, 2007. If different discount rates had been used, the valuations would have been different.

The enterprise value was then allocated to preferred and common shares using the option-pricing method. The option-pricing method involves making estimates of the anticipated timing of a potential liquidity event such as a sale of our company or an initial public offering, and estimates of the volatility of our equity securities. The anticipated timing is based on the plans of our board and management. Estimating the volatility of the share price of a privately held company is complex because there is no readily available market for the shares. We estimated the volatility of our stock based on available information on volatility of stocks of publicly traded companies in the industry. Had we used different estimates of volatility, the allocations between preferred and common shares would have been different.

The determination of the deemed fair value of our common stock has involved significant judgments, assumptions, estimates and complexities that impact the amount of deferred stock-based compensation recorded and the resulting amortization in future periods. If we had made different assumptions, the amount of our deferred stock-based compensation, stock-based compensation expense, operating loss, net loss attributable to common stockholders and net loss per share attributable to common stockholders amounts could have been significantly different. We believe that we have used reasonable methodologies, approaches and assumptions to determine the fair value of our common stock and that stock-based deferred compensation and related amortization have been recorded properly for accounting purposes.

As discussed more fully in Note 10 to our consolidated financial statements which appear elsewhere in this prospectus, we granted stock options with a weighted average exercise price of $6.08 per share during the twelve months ended December 31, 2006 and with a weighted average exercise price of $7.56 per share during the six months ended June 30, 2007. The increase in weighted average exercise price resulted from continued growth in our revenue and a reduction in the net loss. Both of these factors resulted in an increase in common stock value when factored into our internal valuation model.

For each of the stock options described above, the exercise price was equal to the estimated fair value of our common stock on the date of grant, as determined by our board of directors. In making these determinations our board of directors relied upon the internal valuation model and other factors described above. Specifically, our board of directors took into account our operating results, market position and

operating achievements at the time of grant, among other factors. The primary reasons for the difference between the fair value of our common stock on each of these dates are as follows:

On February 28, 2006, we granted options to purchase an aggregate of 174,978 shares of our common stock with an exercise price of $5.26 per share. Total revenues increased approximately 41.6% from the year ended December 31, 2005 to the year ended December 31, 2006. Total revenue increased approximately 12.7% for the quarter ended September 30, 2005 to the quarter ended December 31, 2005 and the number of clients and the number of physicians live on athenaNet also increased by 9 clients and 505 physicians, respectively, during that same period.

On May 4, 2006, we granted options to purchase an aggregate of 107,702 shares of our common stock with an exercise price of $5.72 per share. Total revenue increased approximately 9.4% from the quarter ended December 31, 2005 to the quarter ended March 31, 2006 and the number of clients and the number of physicians live on athenaNet also increased by 58 clients and 166 physicians, respectively, during that same period. Additionally, in April 2006, the first beta client went live on our athenaClinicals service offering. A beta-client is a client willing to implement a test version of our athenaClinicals product. They agree to do so with the understanding that the product is being used for testing purposes in an attempt to identify and correct product errors.

On July 27, 2006, we granted options to purchase an aggregate of 66,652 shares of our common stock with an exercise price of $6.16 per share. Total revenue increased approximately 10.6% from the quarter ended March 31, 2006 to the quarter ended June 30, 2006 and the number of clients and the number of physicians live on athenaNet also increased by 48 clients and 284 physicians, respectively, during that same period. Additionally, during this period we announced several strategic partner alliances, including our announcement on June 30, 2006 of a channel marketing agreement with a leading provider of advanced clinical, financial and management software and service solutions.

On October 31, 2006 and November 3, 2006, we granted options to purchase an aggregate of 1,000 and 352,200 shares, respectively, of our common stock with an exercise price of $6.58 per share. Total revenue increased approximately 5.8% from the quarter ended June 30, 2006 to the quarter ended September 30, 2006 and the number of clients and the number of physicians live on athenaNet also increased by 59 clients and 587 physicians, respectively, during that same period. Additionally, in September 2006, we hired a chief operations officer.

On February 7, 2007 and March 15, 2007, we granted options to purchase an aggregate of 77,100 and 391,250 shares of our common stock with exercise prices of $7.20 and $7.39 per share, respectively. Total revenue increased approximately 6.2% from the quarter ended September 30, 2006 to the quarter ended December 31, 2006 and the number of clients and the number of physicians live on athenaNet also increased by 72 clients and 313 physicians, respectively, during that same period. Additionally, during this period we announced several strategic partner alliances and we first began to offer our athenaClinicals service offering.

On May 3, 2007, we granted options to purchase an aggregate of 52,900 shares of our common stock with an exercise price of $9.30 per share. Total revenue increased approximately 5.3% from the quarter ended December 31, 2006 to the quarter ended March 31, 2007 and the number of clients and the number of physicians live on athenaNet also increased by 31 clients and 265 physicians, respectively, during that same period. In addition, new client implementations during this period occurred at a rate above those experienced during any previous period. Also, in April 2007 the Certification Commission for Healthcare Information Technology, or CCHIT, an independent, industry recognized accreditation organization created to certify EMR applications, certified our athenaClinicals service offering as meeting the CCHIT ambulatory electronic health

record (EHR) criteria for 2006.

On July 27, 2007, we granted options to purchase an aggregate of 89,500 shares of our common stock with an exercise price of $15.27 per share. In determining this significant increase in fair value from May 3, 2007, our board of directors took into account significant progress in our business since the

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earlier date in terms of continuing revenue growth and increasing client acceptance of our athenaClinicals service offering. Specifically:

- total revenue increased approximately 11.6% from the quarter ended March 31, 2007 to the quarter ended June 30, 2007 and the number of clients and the number of physicians live on athenaNet also increased by 68 clients and 504 physicians, respectively, during that same period;

- in the month of June 2007, our income from operations surpassed breakeven for the first time in our company s history with revenues for the month surpassing $8.5 million for the first time in our company s history;

- on May 24, 2007 we signed a marketing and sales agreement with PSS World Medical Shared Services, Inc., or PSS, for the marketing and sales of athenaClinicals and athenaCollector, and during this period we announced that one of the nation s leading academic health care organizations, comprised of nearly 200 physicians, selected athenaCollector for its physician organization, representing one of the largest client additions in our company s history;

- the number of physicians using our athenaClinicals service offering exceeded 100, an important milestone for this new service offering;

- on June 29, 2007, certain of our existing stockholders sold to PSS an aggregate of 1,470,589 shares of our previously issued and outstanding convertible preferred stock for an aggregate purchase price of $22.5 million, equating to a per share price of $15.30 per share; and

- finally, in late June 2007, we filed a registration statement with the Securities and Exchange Commission for our initial public offering.

Based on the initial public offering price of $18.00, the intrinsic value of the options outstanding at June 30, 2007, was $43.9 million, of which $29.5 million related to vested options and $14.4 million related to unvested options.

Income Taxes

We are subject to federal and various state income taxes in the United States, and we use estimates in determining our provision and related deferred tax assets. At December 31, 2006, our deferred tax assets consisted primarily of federal and state net operating loss carry forwards, research and development credit carry forwards, and temporary differences between the book and tax bases of certain assets and liabilities.

We assess the likelihood that deferred tax assets will be realized, and we recognize a valuation allowance if it is more likely than not that some portion of the deferred tax assets will not be realized. This assessment requires judgment as to the likelihood and amounts of future taxable income by tax jurisdiction. At December 31, 2006, we had a full valuation allowance against our deferred tax assets. Although we believe that our tax estimates are reasonable, the ultimate tax determination involves significant judgment that is subject to audit by tax authorities in the ordinary course of business.

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Consolidated Results of Operations

The following table sets forth our consolidated results of operations as a percentage of total revenue for the periods shown:

	Fiscal Year Ended December 31,			Six Months Ended June 30,	
	2004	2005	2006	2006	2007
			(in thousands)	(unaudited)	
Revenue:					
Business services	90.0%	91.4%	93.2%	92.9%	93.2%
Implementation and other	10.0	8.6	6.8	7.1	6.8
Total revenue	100.0	100.0	100.0	100.0	100.0
Operating expense:					
Direct operating	52.7	51.4	48.2	49.4	47.7
Selling and marketing	19.6	21.8	20.6	21.0	17.9
Research and development	3.8	5.5	9.1	7.1	7.8
General and administrative	21.9	29.0	21.6	22.0	20.6
Depreciation and amortization	8.1	10.3	8.2	8.4	6.6
Total operating expense	106.1	118.0	107.7	107.9	100.6
Operating loss	(6.1)	(18.0)	(7.7)	(7.9)	(0.6)
Other income (expense):					
Interest income	0.3	0.2	0.5	0.4	0.5
Interest expense	(3.5)	(3.5)	(3.6)	(3.4)	(3.5)
Other expense			(0.9)	(0.9)	(9.5)
Total other expense	(3.2)	(3.3)	(4.0)	(3.9)	(12.5)
Loss before cumulative effect of change in accounting principle	(9.3)	(21.3)	(11.7)	(11.8)	(13.1)
Cumulative effect of change in accounting principle			(0.5)	(1.1)	
Net loss	(9.3)%	(21.3)%	(12.2)%	(12.9)%	(13.1)%

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Comparison of the Six Months ended June 30, 2007 and 2006

	Six Months Ended June 30,					
	2006		2007 (unaudited) (in thousands)		Change	
	Amount	% of Revenues	Amount	% of Revenues	Amount	%
Business services	$ 32,822	92.9%	$ 43,268	93.2%	$ 10,446	31.8%
Implementation and other	2,517	7.1	3,172	6.8	655	26.0
Total	$ 35,339	100.0%	$ 46,440	100.0%	$ 11,101	31.4%

Revenue. Total revenue from business services for the six months ended June 30, 2007 was $46.4 million, an increase of $11.1 million, or 31.4%, over revenue of $35.3 million for the six months ended June 30, 2006. This increase was due almost entirely to an increase in business services revenue.

Business Services Revenue. Revenue from business services for the six months ended June 30, 2007 was $43.3 million, an increase of $10.5 million, or 32%, over revenue of $32.8 million for the six months ended June 30, 2006. This increase was primarily due to the growth in the number of physicians using our services. The average number of physicians using our services during the six months ended June 30, 2007 was 7,768, an increase of 1,764 or 28%. Also contributing to this increase was the growth in related collections on behalf of these physicians. Total collections generated by these providers which was posted for the six months ended June 30, 2007 was $1.3 billion an increase of $345 million, or 37%, over posted collections of $927 million for the six months ended June 30, 2006.

Implementation and Other Revenue. Revenue from implementations and other sources was $3.2 million for the six months ended June 30, 2007, an increase of $0.7 million, or 26%, over revenue of $2.5 million for the six months ended June 30, 2006. This increase was driven by new client implementations and increased professional services for our larger client base.

	Six Months Ended June 30,					
	2006		2007		Change	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
			(unaudited) (in thousands)			
Direct operating expense	$ 17,458	49.4%	$ 22,168	47.7%	$ 4,710	27.0%

Direct operating expense. Direct operating expense for the six months ended June 30, 2007 was $22.2 million, an increase of $4.7 million, or 27%, over costs of $17.5 million for the six months ended June 30, 2006. This increase was primarily due to an increase in the number of claims that we processed on behalf of our clients and the related expense of providing services, including transactions expense and salary and benefits expense. Additionally, beginning in the six months ended June 30, 2007 we are now allocating costs to direct operating expense related to our launch of athenaClinicals which was previously included with research and development. The amount of collections

processed for the six months ended June 30, 2007 was $1.3 billion, which was 37% higher than for the six months ended June 30, 2006.

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	Six Months Ended June 30,					
	2006		2007 (unaudited) (in thousands)		Change	
	Amount	% of Revenues	Amount	% of Revenues	Amount	%
Selling and marketing	$ 7,435	21.0%	$ 8,314	17.9%	$ 879	11.8%
Research and development	2,509	7.1	3,599	7.8	1,090	43.4
General and administrative	7,771	22.0	9,571	20.6	1,800	23.2
Depreciation and amortization	2,952	8.4	3,048	6.6	96	3.3
Total	$ 20,667	58.5%	$ 24,532	52.9%	$ 3,865	18.7%

Selling and Marketing Expense. Selling and marketing expense for the six months ended June 30, 2007 was $8.3 million, an increase of $0.9 million, or 12%, over costs of $7.4 million for the six months ended June 30, 2006. This increase was primarily due to increases in sales commissions and salaries and benefits.

Research and Development Expense. Research and development expense for the six months ended June 30, 2007 was $3.6 million, an increase of $1.1 million, or 43%, over research and development expense of $2.5 million for the six months ended June 30, 2006. This increase was primarily due to $0.7 million increase in salaries and benefits and $0.4 million increase in consulting fees.

General and Administrative Expense. General and administrative expense for the six months ended June 30, 2007 was $9.6 million, an increase of $1.8 million, or 23%, over general and administrative expenses of $7.8 million for the six months ended June 30, 2006. This increase was primarily due to $1.2 million increase in salaries and benefits and a $0.3 million increase in facility fees and a $0.3 million increase in professional fees.

Depreciation and Amortization. Depreciation and amortization expense for the six months ended June 30, 2007 was $3.0 million, an increase of $0.1 million, or 3%, from depreciation and amortization of $2.9 million for the six months ended June 30, 2006. This increase was primarily due to the larger base of depreciable assets.

Other income (expense). Interest expense, net for the six months ended June 30, 2007 was $1.4 million, an increase of $0.3 million, or 27%, over other income (expense), of $1.1 million for the six months ended June 30, 2006. The increase is related to an increase in bank debt, a working capital line of credit and an equipment line of credit during 2007. The unrealized loss on warrant liability for the six months ended June 30, 2007 was $3.7 million an increase of $3.4 million from $0.3 million for the six months ended June 30, 2006, as a result of the change in the fair value of the warrants. This change in the fair value of the warrant is attributable to the appreciation in the fair value of our common stock during this period, which increased from $5.26 to $9.30 per share. These warrants will convert to warrants to purchase shares of common stock upon the consummation of this offering, at which time the existing liability will be reclassified to additional paid-in-capital. Also included in other expense for the six months ended June 30, 2007, was $0.1 million in loss on disposal of assets and $0.6 million of financial advisor fees paid by shareholders.

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Comparison of the Years ended December 31, 2006 and 2005

	Year Ended December 31,					
	2005		2006		Change	
	Amount	% of Revenue	Amount	% of Revenue	Amount	%
	(in thousands)					
Business services	$ 48,958	91.4%	$ 70,652	93.2%	$ 21,694	44.3%
Implementation and other	4,582	8.6	5,161	6.8	579	12.6
Total	$ 53,540	100.0%	$ 75,813	100.0%	$ 22,273	41.6%

Revenue. Total revenue for 2006 was $75.8 million, an increase of $22.3 million, or 42%, over revenue of $53.5 million for 2005. This increase was almost entirely due to an increase in business services revenue.

Business Services Revenue. Revenue from business services for 2006 was $70.7 million, an increase of $21.7 million, or 44%, over revenue of $49.0 million for 2005. This increase was primarily due to the growth in the number of physicians using our services. The average number of active physicians using our services in 2006 was 6,588, an increase of 1,633, or 33%, over the 4,955 physicians in 2005. Also contributing to this increase was growth in collections on behalf of these physicians. These providers generated collections posted in 2006 of $2.0 billion, which was a 45% increase over $1.4 billion posted collections in 2005.

Implementation and Other Revenue. Revenue from implementations and other sources was $5.2 million, an increase of $0.6 million, or 13%, over revenue of $4.6 million for 2005. This increase was primarily due to the expansion of our client base, which required additional implementation services.

	Year Ended December 31,					
	2005		2006		Change	
	Amount	% of Revenue	Amount	% of Revenue	Amount	%
	(in thousands)					
Direct operating expense	$ 27,545	51.4%	$ 36,530	48.2%	$ 8,985	32.6%

Direct operating expense. Direct operating expense for 2006 was $36.5 million, an increase of $9.0 million, or 33%, over direct operating expense of $27.5 million for 2005. This increase was primarily due to an increase in the number of claims that we processed on behalf of our clients and the related expense of providing services, including transactions expense and salary and benefits expense. The amount of collections processed for our clients in 2006 was $2.0 billion, which was 45% higher than in 2005.

	Year Ended December 31,					
	2005		2006		Change	
	Amount	% of Revenue	Amount	% of Revenue	Amount	%

	(in thousands)					
Selling and marketing	$ 11,680	21.8%	$ 15,645	20.6%	$ 3,965	33.9%
Research and development	2,925	5.5	6,903	9.1	3,978	136.0
General and administrative	15,545	29.0	16,347	21.6	802	5.2
Depreciation and amortization	5,483	10.3	6,238	8.2	755	13.8
Total	$ 35,633	66.6%	$ 45,133	59.5%	$ 9,500	26.7%

Selling and Marketing Expense. Selling and marketing expense for 2006 was $15.6 million, an increase of $4.0 million, or 34%, over sales and marketing expense of $11.7 million for 2005. This increase was primarily due to a $1.7 million increase in salaries and benefits, a $1.7 million increase in marketing programs and a $0.5 million increase in travel and other expenses.

Research and Development Expense. Research and development expense for 2006 was $6.9 million, an increase of $4.0 million, or 136%, over research and development expense of $2.9 million for 2005. This increase was primarily due to a $2.8 million increase in salaries and benefits related to the development of our

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athenaClinicals product and other product and business development initiatives, a $0.6 million increase in consulting fees, a $0.4 million increase in expenses related to the expansion of Athena Net India and a $0.2 million increase in travel and other expenses of our research team.

General and Administrative Expense. General and administrative expense for 2006 was $16.3 million, an increase of $0.8 million, or 5%, over general and administrative expense of $15.5 million for 2005. This increase was primarily due to an increase in salaries and benefits.

Depreciation and Amortization Expense. Depreciation and amortization expense for 2006 was $6.2 million, an increase of $0.8 million, or 14%, from depreciation and amortization expense of $5.5 million for 2005. This increase was primarily due to the larger base of depreciable assets in 2006.

Other Income (Expense). Interest expense, net, for 2006 was $2.3 million, an increase of $0.5 million, or 31%, over interest expense, net, of $1.8 million for 2005. This increase was related to an increase in bank debt, a working capital line of credit and an equipment line of credit during 2006, offset by an increase in interest income associated with an increase in cash, cash equivalents and short-term investments. The unrealized loss on warrant liability for 2006 was $0.7 million and represents the remeasurement of the fair value of warrants.

Comparison of the Years ended December 31, 2005 and 2004

	Year Ended December 31,					
	2004		2005		Change	
	Amount	% of Revenue	Amount	% of Revenue	Amount	%
	(in thousands)					
Business services	$ 35,033	90.0%	$ 48,958	91.4%	$ 13,925	39.7%
Implementation and other	3,905	10.0	4,582	8.6	677	17.3
Total	$ 38,938	100.0%	$ 53,540	100.0%	$ 14,602	37.5%

Revenue. Total revenue for 2005 was $53.5 million, an increase of $14.6 million, or 38%, over revenue of $38.9 million for 2004. This increase was due almost entirely to an increase in business services revenue.

Business Services Revenue. Revenue from business services for 2005 was $49.0 million, an increase of $13.9 million, or 40%, over revenue of $35.0 million for 2004. This increase was primarily due to the growth in the number of physicians using our services. The average number of active physicians using our services in 2005 was 4,955, an increase of 1,402, or 39%, over 3,553 physicians in 2004. Also contributing to this increase was growth in collections on behalf of these physicians. These providers generated posted collections of $1.4 billion in 2005, which was a 39% increase over $972 million posted collections in 2004.

Implementation and Other Revenue. Revenue from implementations and other sources was $4.6 million, an increase of $0.7 million, or 17%, over revenue of $3.9 million for 2004. This increase was primarily due to the expansion of our client base and increased professional services provided to that base.

Year Ended December 31,

	2004		2005		Change	
	Amount	% of Revenue	Amount	% of Revenue	Amount	%
	(in thousands)					
Direct operating expense	$ 20,512	52.7%	$ 27,545	51.4%	$ 7,033	34.3%

Direct Operating Expense. The direct operating expense for 2005 was $27.5 million, an increase of $7.0 million, or 34%, over direct operating expense of $20.5 million for 2005. This increase was primarily due to an increase in the number of claims that we processed on behalf of our clients and the related expense of providing services, including transactions expense and salary and benefits expense. The amount of collections processed in 2005 was $1.4 billion or 39% higher than 2004.

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	Year Ended December 31,					
	2004		2005		Change	
	Amount	% of Revenue	Amount	% of Revenue	Amount	%
	(in thousands)					
Selling and marketing	$ 7,650	19.6%	$ 11,680	21.8%	$ 4,030	52.7%
Research and development	1,485	3.8	2,925	5.5	1,440	97.0
General and administrative	8,520	21.9	15,545	29.0	7,025	82.5
Depreciation and amortization	3,159	8.1	5,483	10.3	2,324	73.6
Total	$ 20,814	53.4%	$ 35,633	66.6%	$ 14,819	71.2%

Selling and Marketing Expense. Selling and marketing expense for 2005 was $11.7 million, an increase of $4.0 million, or 53%, over selling and marketing expense of $7.7 million for 2004. This increase was primarily due to a $2.0 million increase in marketing programs, a $1.6 million increase in salaries and benefits and a $0.4 million increase in travel expense.

Research and Development Expense. Research and development expense for 2005 was $2.9 million, an increase of $1.4 million, or 97%, over research and development expense of $1.5 million for 2004. This increase was primarily due to a $0.9 million increase in salaries and benefits and a $0.5 million increase in expense related to the expansion of Athena Net India.

General and Administrative Expense. General and administrative expense for 2005 was $15.5 million, an increase of $7.0 million, or 83%, over general and administrative expense of $8.5 million for 2004. This increase was primarily due to a $3.2 million increase in rent and related expense associated with our move into the Watertown, Massachusetts facility, a $1.2 million increase in salaries and benefits, a $0.6 million increase in consulting fees and a $0.3 million increase in utility expenses.

Depreciation and Amortization Expense. Depreciation and amortization expense for 2005 was $5.5 million, an increase of $2.3 million, or 74%, from depreciation and amortization expense of $3.2 million for 2004. The increase was primarily due to the larger base of depreciable assets in 2005, due to capital expenditures related to company infrastructure and client servicing capacity.

Other Income (Expense). Interest expense, net, for 2005 was $1.8 million, an increase of $0.5 million, or 44%, over interest expense, net, of $1.2 million for 2004. The increase is related to an increase in bank debt, a working capital line of credit and an equipment line of credit during 2005.

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Quarterly Results of Operations

The following table presents our unaudited consolidated quarterly results of operations for the eight fiscal quarters ended June 30, 2007. This information is derived from our unaudited consolidated financial statements, and includes all adjustments, consisting only of normal recurring adjustments, that we consider necessary for fair statement of our financial position and operating results for the quarters presented. Operating results for these periods are not necessarily indicative of the operating results for a full year. Historical results are not necessarily indicative of the results to be expected in future periods. You should read this data together with our consolidated financial statements and the related notes to these financial statements included elsewhere in this prospectus.

	Fiscal Quarter Ended,							
	September 30, 2005	December 31, 2005	March 31, 2006	June 30, 2006	September 30, 2006	December 31, 2006	March 31, 2007	June 30, 2007
	(unaudited) (in thousands)							
Revenue:								
Business services	$ 12,465	$ 13,822	$ 15,490	$ 17,332	$ 18,345	$ 19,485	$ 20,490	$ 22,778
Implementation and other	1,136	1,509	1,289	1,228	1,283	1,361	1,457	1,715
Total revenue:	13,601	15,331	16,779	18,560	19,628	20,846	21,947	24,493
Operating expense(1):								
Direct operating	7,019	7,814	8,256	9,202	9,166	9,906	10,807	11,361
Selling and marketing	3,322	3,324	3,743	3,692	3,813	4,397	4,330	3,984
Research and development	773	906	1,110	1,399	2,137	2,257	1,819	1,780
General and administrative	3,627	3,746	4,099	3,672	4,150	4,426	4,583	4,988
Depreciation and amortization	1,332	1,377	1,440	1,512	1,636	1,650	1,564	1,484
Total operating expense	16,073	17,167	18,648	19,477	20,902	22,636	23,103	23,597
Operating (loss) income	(2,472)	(1,836)	(1,869)	(917)	(1,274)	(1,790)	(1,156)	896
Other income (expense):								
Interest income	23	18	72	80	99	121	117	97
Interest expense	(346)	(784)	(568)	(638)	(677)	(788)	(771)	(851)
Other expense			(212)	(130)	(103)	(257)	(860)	(3,556)
Total other expense	(323)	(766)	(708)	(688)	(681)	(924)	(1,514)	(4,310)
	(2,795)	(2,602)	(2,577)	(1,605)	(1,955)	(2,714)	(2,670)	(3,414)

Loss before cumulative effect of change in accounting principle								
Cumulative effect of change in accounting principle			(373)					
Net loss	$ (2,795)	$ (2,602)	$ (2,950)	$ (1,605)	$ (1,955)	$ (2,714)	$ (2,670)	$ (3,414)
(1) Amounts include stock-based compensation expense as follows:								
Direct operating costs	$	$	$ 8	$ 19	$ 16	$ 21	$ 43	$ 50
Selling and marketing			3	16	12	12	35	46
Research and development			11	13	13	16	36	63
General and administrative			10	16	34	136	164	167
Total	$	$	$ 32	$ 64	$ 75	$ 185	$ 278	$ 326

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During these periods, total revenue increased each quarter, primarily due to the expansion of our client base and growth in revenue collections made on behalf of our existing clients. Our direct operating expense and selling and marketing expense also increased each quarter, primarily due to an increase in salary and benefit expense as we expanded our operations to serve and sell to our increasing client base. Research and development expense increased in each quarter during this period, primarily due to our development of athenaClinicals and other product and business development initiatives as well as the expansion of Athena Net India. General and administrative expense fluctuated during this period, with an overall upward trend, primarily as a result of our hiring additional personnel in connection with our anticipated growth and incurred expenses in preparation for becoming a public company.

We have experienced consistent revenue growth over the past several years, which is primarily the result of a steady increase in the number of physicians and other medical providers served by us. This sequential revenue increase is driven by the implementation of new accounts and the retention of existing accounts. Because we earn ongoing fees, a large percentage of each quarter s revenue comes from accounts that also contributed to the revenues of the preceding quarter. The vast majority of our clients pay for services as a percentage of collections posted, so the company s revenue is highly correlated to the underlying collections of our clients. The provision of medical services by our clients takes place throughout the year, but there are seasonal factors that affect the total volume of patients seen by our clients, which in turn impacts the collections per physician and our related revenues per physician. In particular, for patient visits that are discretionary or elective, we typically see a reduction of office visits during the late summer and during the end of year holiday season, which leads to a decline in collections by our physician clients of about 30 to 50 days later. Therefore, the negative impact on client collections and related company revenues per physician is generally experienced in the first and third calendar quarters of the year. In our experience, client collections and related company revenues per physician are seasonally stronger in the second and fourth calendar quarters of each year.

Liquidity and Capital Resources

At June 30, 2007 our principal sources of liquidity were cash and cash equivalents and short-term investments totaling $12.7 million. We have funded our growth primarily through the private sale of equity securities, totaling approximately $50.6 million as well as through long-term debt and working capital and equipment-financing loans. Our total indebtedness was $32.0 million at June 30, 2007 and was comprised mainly of term debt which is subordinated to our senior debt.

Cash used in operating activities during the six months ended June 30, 2007 was $.1 million and consisted of a net loss of $6.1 million and $3.3 million utilized by working capital and other activities, offset by positive non-cash adjustments of $3.0 million related to depreciation and amortization expense, $3.8 million of warrant expense, $1.3 million of non-cash rent expense, $0.6 million of non-cash stock compensation, and $0.6 million of financial adviser fees paid by shareholders. Cash used by working capital and other activities was primarily attributable to a $0.2 million increase in accrued expense, a $1.7 million decrease in deferred rent, a $2.6 million increase in accounts receivable, a $0.4 million decrease in prepaid and other assets, and a $0.4 million decrease in accounts payable, offset in part by a $0.8 million increase in deferred revenue. These changes were attributable to growth in the size of our business and in related direct operating expense.

Cash used in operating activities during the year ended December 31, 2006 was $2.1 million and consisted of a net loss of $9.2 million and $3.5 million utilized by working capital and other activities, offset by positive non-cash adjustments of $6.2 million related to depreciation and amortization expense and $2.6 million of non-cash rent expense. Cash used by working capital and other activities was primarily attributable to a $3.3 million decrease in deferred rent and a $3.1 million increase in accounts receivable, offset in part by a $1.8 million increase in accrued expense and a $0.7 million increase in deferred revenue. These changes were attributable to growth in the size of our business and in related direct operating expense.

Cash provided by operating activities during the year ended December 31, 2005 was $6.0 million and consisted of a net loss of $11.4 million offset by $7.9 million provided by working capital and other activities, non-cash adjustments of $5.5 million related to depreciation and amortization expense and $3.2 million related

to non-cash rent expense. Cash provided by working capital and other activities was primarily attributable to a $9.4 million increase in deferred rent and a $2.0 million increase in accrued expense, offset by $1.8 million increase in accounts receivable and a $1.3 million decrease in accounts payable. The change in deferred rent was caused by the build out of our new company headquarters and related inducements to enter into a lease for that facility by the property owner. In addition, these changes were attributable to growth in the size of our business and in related direct operating expense. Cash provided by operating activities during the year ended December 31, 2004 was $0.2 million and consisted of a net loss of $3.6 million offset by a non-cash adjustment of $3.2 million related to depreciation and amortization expense and $0.1 million provided by working capital and other activities. Cash provided by working capital and other activities was primarily attributable to a $1.3 million increase in accrued expense and a $0.6 million increase in accounts payable, offset by a $1.7 million increase in accounts receivable and a $0.2 million increase in prepaid expenses and other current assets. These changes were attributable to growth in the size of our business and in related direct operating expense.

Net cash generated by investing activities was $4.0 million for the six months ended June 30, 2007, which consisted of purchases of investments of $2.0 million, purchases of property, plant and equipment, or PP&E, of $1.5 million and expenditures for internal development of the athenaClinicals application of $0.5 million. This outgoing investment cash flow was offset by positive investment cash flow of $7.4 million, from proceeds of the sales and maturities of investments and the return of $0.6 million in restricted cash. Net cash used in investing activities was $10.4 million during 2006, $10.3 million during 2005 and $10.1 million during 2004 primarily consisting of purchases of property and equipment, purchases of investments, and capitalized software development costs, offset in part by proceeds from the sales of securities.

Net cash provided by financing activities was $4.3 million for the six months ended June 30, 2007. This consisted of $1.8 million of net proceeds under a line of credit, $4.6 million of proceeds from long term debt, and $.5 million in proceeds from exercises of stock options offset by $1.6 million of payments for long term debt and $1.0 million in deferred offering costs. Net cash provided by financing activities was $7.3 million during 2006, consisting primarily of $4.3 million of net borrowings under a bank term loan and $2.8 million of net borrowings under a line of credit. Net cash provided by financing activities was $8.9 million during 2005 and $8.5 million during 2004, consisting primarily of net borrowing under a bank term loan and a line of credit as well as the net proceeds from the issuance of convertible preferred stock.

At December 31, 2006, we had available, subject to review and possible adjustment, federal and state net operating loss carry forwards of approximately $55.6 million and $23.4 million, respectively, to be used to offset future federal and state taxable income. These net operating loss carry forwards will expire through 2026. We also have federal and state research and development tax credit carry forwards of approximately $0.7 million and $0.3 million, respectively, available to offset future federal and state taxes. Such credits expire at various times through 2021. The utilization of net operating loss and research and development tax credit carry forwards may be subject to annual limitations under Sections 382 and 383 of the Internal Revenue Code.

Given our current cash and cash equivalents, short-term investments, restricted cash, accounts receivable and funds available under our existing line of credit, we believe that we will have sufficient liquidity to fund our business and meet our contractual obligations for at least the next twelve months. We may increase our capital expenditures consistent with our anticipated growth in infrastructure and personnel, and as we expand our national presence. In addition, we may pursue acquisitions or investments in complementary businesses or technologies or experience unexpected operating losses, in which case we may need to raise additional funds sooner than expected. Accordingly, we may need to engage in private or public equity or debt financings to secure additional funds. If we raise additional funds through further issuances of equity or convertible debt securities, our existing stockholders could suffer significant dilution, and any new equity securities we issue could have rights, preferences and privileges superior to those of holders of our common stock, including shares of common stock sold in this offering. Any debt financing

obtained by us in the future could involve restrictive covenants relating to our capital raising activities and other financial and operational matters, which may make it more difficult for us to obtain additional capital and to pursue business opportunities, including potential acquisitions. In addition, we may not be able to obtain additional financing on terms favorable to us,

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if at all. If we are unable to obtain required financing on terms satisfactory to us, our ability to continue to support our business growth and to respond to business challenges could be significantly limited. Beyond the twelve month period, we will seek to maintain sufficient liquidity through continued improvements in the size and profitability of our business and through management of our cash resources and our credit arrangements.

The company makes investments in PP&E and in software development on an ongoing basis. Our PP&E investments consist primarily of technology infrastructure to provide capacity for expansion of our client base, including computers and related equipment in our data centers and infrastructure in our service operations. Our software development investments consist primarily of company-managed design, development, testing and deployment of new application functionality. Because the practice management component of athenaNet is considered mature, we expense nearly all software development for this component of our platform as incurred. For the EMR component of athenaNet, which is the platform for our athenaClinicals offering, we capitalize nearly all software development. In 2006, we capitalized $4.1 million in PP&E and $1.1 million in software development. During the six months ended June 30, 2007, we capitalized $1.5 million of PP&E and $0.5 million of software development. We expect capital expenditures for 2007 to range from $5.9 million to $6.3 million.

Credit Facilities

Line of Credit

We have a revolving loan and security agreement with a bank, which has a maximum available borrowing amount of $10.0 million at December 31, 2006 and matures in August 2008. Borrowings under the agreement are limited by our outstanding accounts receivable balance, and may be further limited by accounts receivable concentrations. Under this agreement, we may not borrow more than 80% of our accounts receivable that are less than 90 days old and no receivables in excess of 25% of our total accounts receivable may be included in that borrowing limit. Use of this facility is also permitted only when our adjusted quick ratio is at or greater than 0.9. This ratio is defined as cash, cash equivalents, investments and accounts receivable over current liabilities excluding deferred revenue. As of June 30, 2007, we are in compliance with each of these provisions. The agreement is collateralized by a first security interest in receivables, deposit accounts and investments of athenahealth that have not been pledged as collateral under previous outstanding loan agreements and a second priority interest in intellectual property. Principal amounts outstanding under the agreement accrue interest at a per annum rate equal to the bank s prime rate. Beginning in January 2007, principal amounts outstanding under the agreement will accrue interest at a per annum rate equal to the bank s prime rate. We had $9.0 million and $7.2 million outstanding under this agreement at June 30, 2007 and December 31, 2006, respectively. The available borrowing under the agreement at June 30, 2007 was approximately $35,000. We expect to repay all amounts outstanding under this facility from the proceeds of this offering and maintain this line of credit for the duration of its term. See Use of Proceeds.

Equipment Lines of Credit

As of December 31, 2006, there was a total of $6.5 million in aggregate principal amount outstanding under a series of promissory notes and security agreements with various finance companies. These amounts are secured by specific equipment, they accrue interest at a weighted-average rate of 10.6% per annum and they are payable on a monthly basis through December 2009.

In March 2007 and May 2007, we entered into additional promissory notes that aggregated $1.2 million in principal amount. These amounts are also secured by specific equipment, they accrue interest at a weighted-average rate of 11.6% per annum and they are payable on a monthly basis through May 2010.

In June 2007, we entered into an additional promissory note that aggregated $0.3 million in principal amount. This amount is secured by specific equipment and accrues interest at a rate of 4.6% per annum and is payable on a monthly basis through June 2010.

We expect to repay all but this most recent equipment line of credit from the proceeds of this offering. See Use of Proceeds.

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Contractual Obligations

We have contractual obligations under our bank debt, a working capital line of credit and an equipment line of credit. We also maintain operating leases for property and certain office equipment. The following table summarizes our long-term contractual obligations and commitments as of December 31, 2006:

	Payments Due by Period (in thousands)				
	Total	Less Than 1 Year	1-3 Years	4-5 Years	After 5 Years
Long-term debt	$ 20,469	$ 3,116	$ 17,353	$	$
Working capital line	7,204	7,204			
Operating lease obligations	35,928	3,655	11,801	9,102	11,370
Total	$ 63,602	$ 13,975	$ 29,154	$ 9,102	$ 11,370

These amounts include interest payments of $2,684,110 and $1,766,366 that would be due in less than one year and one to three years as we anticipate repaying our outstanding indebtedness with proceeds from this offering.

The working capital line and the portion of equipment lines of credit included in long-term debt are described above under Credit Facilities. Also included in long-term debt is a term loan with a finance company with an outstanding balance of $14.0 million at December 31, 2006 which increased to $17.0 million at June 30, 2007, which we intend to repay from the proceeds of this offering. See Use of Proceeds. Under the terms of the agreement, the term loan would have to be repaid in thirty monthly installments starting February 1, 2008.

The commitments under our operating leases shown above consist primarily of lease payments for our Watertown, Massachusetts corporate headquarters and our Chennai, India subsidiary location.

Off-Balance Sheet Arrangements

As of June 30, 2007 and 2006 and December 31, 2006, 2005 and 2004, we did not have any relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. Other than our operating leases for office space and computer equipment, we do not engage in off-balance sheet financing arrangements.

Recent Accounting Pronouncements

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements* (SFAS 157), which establishes a framework for measuring fair value and expands disclosures about the use of fair value measurements and liabilities in interim and annual reporting periods subsequent to initial recognition. Prior to the issuance of SFAS 157, which emphasizes that fair value is a market-based measurement and not an entity-specific measurement, there were different definitions of fair value and limited definitions for applying those definitions under generally accepted accounting principles. SFAS 157 is effective for us on a prospective basis for the reporting period beginning January 1, 2008. We are evaluating the impact of SFAS 157 on our financial position, results of operations and cash

flows.

In February 2007, the FASB issued SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* (SFAS 159). SFAS 159 expands opportunities to use fair value measurements in financial reporting and permits entities to choose to measure many financial instruments and certain other items at fair value. SFAS 159 is effective for fiscal years beginning after November 15, 2007. We have not decided if we will early adopt SFAS 159 or if we will choose to measure any eligible financial assets and liabilities at fair value.

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Quantitative and Qualitative Disclosures about Market Risk

Foreign Currency Exchange Risk. Our results of operations and cash flows are subject to fluctuations due to changes in the Indian rupee. None of our consolidated revenues are generated outside the United States. None of our vendor relationships, including our contract with our offshore service provider Vision Healthsource for work performed in India, is denominated in any currency other than the U.S. dollar. In 2006 and for the six months ended June 30, 2007, 0.7% and 0.8%, respectively, of our expenses occurred in our direct subsidiary in Chennai, India and were incurred in Indian rupees. We therefore believe that the risk of a significant impact on our operating income from foreign currency fluctuations is not substantial.

Interest Rate Sensitivity. We had unrestricted cash, cash equivalents and short-term investments totaling $12.7 million at June 30, 2007. These amounts are held for working capital purposes and were invested primarily in deposits, money market funds and short-term, interest-bearing, investment-grade securities. In addition, some of the net proceeds of this offering may be invested in short-term, interest-bearing, investment-grade securities pending their application. Due to the short-term nature of these investments, we believe that we do not have any material exposure to changes in the fair value of our investment portfolio as a result of changes in interest rates. The value of these securities, however, will be subject to interest rate risk and could fall in value if interest rates rise.

We have bank debt and a line of credit which bears interest based upon the prime rate. At June 30, 2007, there was an aggregate of $32.0 million outstanding under these borrowing arrangements. If the prime rate fluctuated by 10% as of June 30, 2007, interest expense would have fluctuated by approximately $0.3 million.

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BUSINESS

Overview

athenahealth is a provider of internet-based business services for physician practices. Our service offerings are based on three integrated components: our proprietary internet-based software, our continually updated database of payer reimbursement process rules and our back-office service operations that perform administrative aspects of billing and clinical data management for physician practices. Our principal offering, athenaCollector, automates and manages billing-related functions for physician practices and includes a medical practice management platform. We have also developed a service offering, athenaClinicals, that automates and manages medical record-related functions for physician practices and includes an electronic medical record, or EMR, platform. We refer to athenaCollector as our revenue cycle management service and athenaClinicals as our clinical cycle management service. Our services are designed to help our clients achieve faster reimbursement from payers, reduce error rates, increase collections, lower operating costs, improve operational workflow controls and more efficiently manage clinical and billing information.

Our services require relatively modest initial investment, are highly adaptable to changing healthcare and technology trends and are designed to generate significant financial benefit for our physician clients. Our results are directly tied to the financial performance of our clients, because the majority of our revenue is based on a percentage of their collections. Our services have enabled our clients, on average, to resolve 93% of their claims to payers on their first submission attempt, compared to an industry average we estimate to be 70%. Our internal studies show that we have reduced the days in accounts receivable of our client base by more than 30%. We have experienced a contract renewal rate of at least 97% in each of the last five years, and this persistent client base drives a predictable revenue stream. In 2006, we generated revenue of $75.8 million from the sale of our services, compared to $53.5 million in 2005. As of June 30, 2007, there were more than 10,500 medical providers, including more than 8,000 physicians, using our services across 32 states and 54 medical specialties.

We believe our innovative internet-based business services model represents a significant departure from the traditional model of physicians relying upon on-site or outsourced administrative staff, using stand-alone software that is not internet-based, to run the back-office aspects of their practices. By continuously improving all three components of our services, we drive improvement in the business results of our network of clients: we typically update our centralized internet-based software every six to eight weeks; we add more than 100 rules on average each month to our database of payer rules; and we regularly improve our integrated back-office service operations with more efficient technology and processes. Additionally, as our database of aggregated health information grows, we are able to use this information to further the strategic position of our company. For example, in June 2006 we introduced our annual PayerView rankings of health plans performance with respect to the speed and accuracy of reimbursement processes at different insurance companies, an initiative that we believe increases our profile in the provider and payer communities.

In the last five years, we have focused on developing our proprietary internet-based software application and integrated service operations to expand our client base. During this period we undertook no acquisitions. In 2006, we formed a subsidiary in India to complement our U.S.-based software development activities and to work closely with our business partners in India.

Industry Overview

We believe that the market we address is defined by the total annual physician office expenditures in the United States for revenue and clinical cycle management solutions and by the total annual physician office collections for services

rendered. We estimate that total annual physician office expenditures in the United States for revenue and clinical cycle management solutions exceed $18 billion and $9 billion, respectively. These expenditures are primarily comprised of salary, wages and benefits for in-house administrative staff and third-party practice management and EMR software. In 2005, physicians collected approximately $420 billion for services rendered, representing 21% of total health care industry expenditures of $2.0 trillion according to

the U.S. Centers for Medicare and Medicaid Services. From 2000 to 2005, payments to physicians increased by an average of 7.7% per year.

In addition, growth in managed care has increased the complexity of physician practice reimbursement. Managed care plans typically create reimbursement structures with greater complexity than previous methods, placing greater responsibility on the physician practice to capture and provide appropriate data to obtain payments. Also, despite substantial consolidation in the number of managed care organizations over the last decade, most of the legacy information technology platforms used to manage the plans operated by these companies have remained in place. As a result of this increasing complexity, physician practices must keep track of multiple plan designs and processing requirements to ensure appropriate payment for services rendered.

Physician office-based billing activities that are required to ensure appropriate payment for services rendered have increased in number and complexity for the following reasons:

Diversity of health benefit plan design. Health insurers have introduced a wide range of benefit structures, many of which are customized to unique goals of particular employer groups. This has resulted in an increase in rules regarding who is eligible for healthcare services, what healthcare services are eligible for reimbursement and who is responsible for payment of healthcare services delivered.

Dynamic nature of health benefit plan design. Health insurers continuously update their reimbursement rules based on ongoing monitoring of consumption patterns, in response to new medical products and procedures, and to address changing employer demands. As these changes are made frequently throughout the year and are typically specific to each individual health plan, physician practices need to be continually aware of this dynamic element of the reimbursement cycle as it could impact overall reimbursement and specific workflow.

Proliferation of new payment models. New health benefit plans and reimbursement structures have considerably modified the ways in which physician practices are paid. For example, there is an increasing trend toward consumer driven health plans, or CDHPs, that require a far greater portion of fees to be paid by the consumer, typically until a pre-specified threshold is achieved. Care-based initiatives, including pay-for-performance, or P4P programs, which provide reimbursement incentives centered around capture and submission of specified clinical information have dramatically increased the administrative and clinical documentation burden of the physician practice.

Changes in the regulatory environment. The Health Insurance Portability and Accountability Act, or HIPAA, required changes in the way private health information is handled, mandated new data formats for the health insurance industry and created new security standards. As part of HIPAA, adoption of National Provider Identifiers affects physician office billing and collection workflow requirements.

In addition to administering typical small business functions, smaller physician practices must invest significant time and resources in activities that are required to secure reimbursement from third party payers or patients and process inbound and outbound communications related to physician orders to laboratories and pharmacies. In order to process these communications, physician offices often manipulate locally installed software, execute paper-based and fax-based communications to and from payers and conduct telephone-based discussions with payers and intermediaries to resolve unpaid claims or to inquire about the status of transactions.

The Established Model

Currently, the majority of physician practices bill for their services in one of two ways, either purchasing, installing and operating locally installed practice management software or hiring a third-party billing service to collect

billing-related information and input the information into a locally installed software system. In almost all instances, the solutions are installed and operated at the clinic by the administrative personnel on staff. As the complexity and number of health benefit plan payer rules has increased, the ability of locally installed software solutions to keep up with new and revised payer rules has lagged this trend, leading to higher levels

of unpaid claims, prolonged billing cycles and increased clinical inefficiencies. While locally installed software has been shown to provide improvement in physician practice efficiency and collections relative to paper-based systems, we believe such software alone is not suited for today s dynamic and increasingly complex healthcare system.

At present, we estimate that 70% of all medical claims submitted to payers are resolved on the first submission attempt, which we refer to as a practice s first pass resolution rate. Medical practices typically will attempt to fix a denied claim and then resubmit it for payment, frequently leading to multiple cycles of submission and rejection. In addition to the time and cost of these activities, medical offices typically stop seeking reimbursement (and write off associated receivables) for approximately ten percent of their medical claims. Beyond the high rate of claim rejection that typically occurs, it also is common for physicians to be paid at levels below contracted amounts due to administrative error, contract complexity or other factors.

Despite advances in practice management software to address the administrative needs of the physician office, the billing, collections and medical record management functions remain expensive, inefficient and challenging for many physician practice groups. We believe that established locally installed physician practice management software has generally suffered from the following challenges:

Software is static. Payer rules change continuously and the systems used to seek reimbursement require constant updating to remain accurate. By not being linked to a centrally-hosted, continuously updated knowledge base of payer rules, software typically cannot reflect real-time changes based upon health benefit plan specific requirements. Additionally, since most software vendors are not in the business of processing claims, they are often unaware of the creation of new payer rules and changes to existing payer rules. As a result, physician practices typically have the responsibility to navigate this complex and dynamic reimbursement system in order to submit accurate and complete claims. We believe their inability to keep current on these rules changes is the single largest factor leading to claims denials and diverting time and resources away from revenue and clinical cycle workflow.

Software requires reliance on physician office personnel. Physician offices have difficulty managing the increased complexity of billing, collections and medical record management because they lack the necessary infrastructure and suffer from a high staff turnover rate. Despite attempts to automate workflow, many software solutions still require that a number of payer interactions be executed manually via paper or phone. These manual interactions include insurance product monitoring, insurance eligibility, claims submission, claims tracking, remittance posting, denials management, payment processing, formatting of lab requisitions, submitting of lab requisitions, monitoring and classification of all inbound faxes. These tasks are prone to human error, are inefficient and require the accumulation of rules and claims processing knowledge. Given that employee clinic turnover in physician offices averages 10-25% annually, critical reimbursement knowledge can be lost.

Software vendors are not paid on results. Most established software companies operate under a business model that does not directly incentivize them to improve their client s financial results. The established software business model involves a substantial upfront license payment in addition to ongoing maintenance fees. While the goal of practice management software is to improve reimbursement and clinical efficiency, realizing these efficiencies still largely rests on the physician office s administrative staff.

Traditional outsourced back office service providers do not compensate significantly for these deficiencies of the locally installed software model. These service providers generally rely on third-party software that suffers from the same deficiencies that physicians experience when they perform their own back office processing operations. The software often is not connected to payer rules that can be enforced in real-time by office staff throughout the patient workflow. In addition, these service providers typically operate discrete databases and separate processes for each

client they serve, which affords limited advantages of scale, thereby conferring limited cost advantages to physician practices. Without control over the software application and without an integrated rules database, outsourced service providers cannot offer physicians the benefits of our internet-based business service model.

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The payer universe is dynamic and continuously growing in complexity as rules are changed and new rules are added, making it extremely difficult for physician practices, and even payers, to effectively manage the reimbursement rules landscape. While locally installed software has struggled to meet these challenges, the Internet has developed in the broader economy into a reliable and efficient medium that opens the door to entirely new ways of performing business functions. The Internet is ideally suited to centralization of the large-scale research needed to stay current with payer rules and to the instantaneous dissemination of this information. The Internet also allows real-time consolidation and centralized execution of administrative work across many medical practice locations. As a result, the health care industry is an ideal industry to benefit from the efficiency and effectiveness of the Internet as a delivery platform.

Our Solution

The dynamic and increasingly complex healthcare market requires an integrated solution to effectively manage the reimbursement and clinical landscape. We believe we are the first company to integrate web-based software, a continually updated database of payer rules and back-office service operations into a single internet-based business service for physician practices. We deliver these services at each critical step in the revenue and clinical cycle workflow through a combination of software, knowledge and work:

Software. athenaNet, our proprietary web-based practice management and EMR application, is a workflow management tool used in every work step that is required to properly handle billing, collections and medical record management-related functions. All users across our client-base simultaneously use the same version of our software application, which connects them to our continually updated database of payer rules and to our services team.

Knowledge. athenaRules, our proprietary database of payer rules, enforces physician office workflow requirements, and is continually updated with payer-specific coding and documentation information. This knowledge continues to grow as a result of our years of experience managing back office service operations for hundreds of physician practices, including processing medical claims with tens of thousands of health benefit plans.

Work. The athenahealth service operations, consisting of nearly 400 people in the United States, and more than 700 people at our off-shore service provider, interact with clients at all key steps of the revenue and clinical cycle workflow. These operations include setting up medical providers for billing, checking the eligibility of scheduled patients electronically, submitting electronic and paper-based claims to payers directly or through intermediaries, processing clinical orders, receiving and processing checks and remittance information from payers, documenting the result of payers responses and evaluating and resubmitting claims denials.

We are economically aligned with our physician practice clients because payment for our services in most cases is dependent on the results our services achieve for our clients. As a result of this approach, the effectiveness of our revenue cycle management services are borne out by measurable improvements in the financial performance for physician practices within a short period of time after they start using our services. These results include:

a successful resolution rate of over 93% on average on the first submission attempt of claims to payers compared to the national average which we estimate to be 70%;

an average reduction in days-in-accounts receivable of more than 30% within 90 days of implementation;

an average increase in the collection rate of approximately 4%; and

an average increase in total collections of 10%.

The positive results of our approach are seen in the significant growth in clients serviced, collections under management and overall revenue in each of the preceding seven years.

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Key advantages of our solution include:

Lower total cost of the athenahealth solutions. The cost of our services includes a modest up-front expenditure, with subsequent costs based on the amounts collected. This approach eliminates the large and risky upfront investments in software, hardware, implementation service and support and additional IT staff often associated with the established software model. We update our web-based software every six to eight weeks and we add over 100 new rules on average each month to our shared payer knowledge base, which enables our clients to use these new features with minimal disruption and no incremental cost. Once implemented, only an Internet connection and a web browser are required to run our internet-based practice management system and EMR. By removing cost barriers to initial adoption, we believe our services-based model provides a lower total cost to our clients based on the elimination of future upgrade, training and extra follow-up costs associated with the established model.

Comprehensive payer rules engine that is continuously expanded and updated. We believe we have the largest and most comprehensive continually updated database of payer reimbursement process rules in the United States. We collect health benefit plan specific processing information so that the medical office workflow and the work at our service operations can be tailored to the requirements of each health benefit plan. Real-time error alerts automatically triggered by our rules engine enable our clients to catch billing-related errors immediately at the beginning of the reimbursement cycle, fix these errors quickly and easily and generate medical claims that achieve substantially higher first-pass success rates than the industry norm. Payer rules are frequently unavailable from the payers and therefore must be learned from experience. We have more than 50 full-time equivalent staff focused on finding, researching, documenting and implementing new rules, enabling our solution to consistently deliver quantifiably superior financial results for our clients. Additionally, we discover and implement even more new rules as new clients connect to our rules engine. Our other clients benefit from the addition of these new rules, and this continuous updating increases our value proposition benefiting both current and future clients.

Real-time workflow and process optimization resulting in improved financial outcomes. Our solution incorporates a large number of efficient, real-time communications between the physician practice s staff and our rules engine and service operations staff throughout the patient encounter and billing processes. These process steps begin prior to the claims submission process, making our efficient online interaction vital for delivering the financial performance our clients enjoy. This enables us to stay close to client needs and constantly upgrade our offerings in order to continuously improve the effectiveness of our overall service. These elements ensure we can identify and influence critical practice workflow steps to maximize billing performance and deliver improved financial outcomes for our physician clients.

Critical mass and access to superior scale and capabilities. We believe that our service site in Watertown, Massachusetts is the largest single-site operation in the United States for physician back-office operations. Our platform was designed and constructed to enable us to assume full responsibility for the completion of automated and manual tasks in the revenue and clinical workflow cycles, while providing critical tools and knowledge to effectively assist clients in completing those tasks that must be done on-site in the physician practice. By taking on the administrative effort associated with revenue and clinical workflow, we free our clients from the burden of performing these laborious tasks in a time-consuming and expensive manner with insufficient scale to operate effectively. As a result of our substantial infrastructure, we can apply a broad array of resources (from athenahealth, our clients and our off-shore partners) to cost-effectively address the myriad of discrete tasks within the revenue and clinical workflow cycles. This approach allows us to deliver resources, expertise and performance superior to what any individual physician practice could achieve on its own.

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Our Strategy

Our mission is to be the most trusted and effective provider of business services for physician practices. Key elements of our strategy include:

Remaining intensely focused on our clients success. Our business model aligns our goals with our clients goals and provides an incentive for us to continually improve the performance of our clients. We believe that this approach enables us to maintain client loyalty, to enhance our reputation and to improve the quality of our solutions. For instance, we collaborate closely with our clients to identify the resources required to efficiently manage each critical step in the revenue and clinical cycle workflow so that they fully realize the intended benefits of our solutions. We also provide benchmarking against physician practices as measured by size, geography and specialty which enables clients to measure their results against and learn from their peers.

Maintaining and growing our payer rules database. An important component of increasing value to our clients is that we continue to develop our centralized payer rules database, athenaRules, based on experience gained each day across our network of clients. This allows all of our clients to benefit from our more than 50 full-time equivalent staff focused on finding, researching, documenting and implementing new payer rules. Our rules engine development work increases the percentage of transactions that are successfully executed on the first attempt and reduces the time to resolution after claims or other transactions are submitted. Over 100 new rules on average are added to our rules engine each month and approximately 50% of the rules triggered each month were added within the previous six months. We intend to maintain a work environment that fosters creativity and innovation so that we can continue to attract and retain the type of employees needed to find, research, document and implement new payer rules. Additionally, we will discover and implement even more rules as new clients connect to our rules engine.

Attracting new clients. We estimate that our current athenaCollector client base represents less than 2% of the U.S. addressable market for revenue cycle management. We expect to continue with current and expanded sales and marketing efforts to address our market opportunity by aggressively seeking new clients. We believe that our internet-based business services provide significant value for physician offices of any size, from small practices (one to three physicians) to larger practices (greater than 26 physicians). We have steadily increased and plan to continue to increase the number of direct sales professionals we employ, and we intend to develop additional distribution channels for our services. For example, we have developed a remote sales and implementation model (web and phone only), which creates a distinct advantage in the small practice segment, which we define as offices with fewer than four physicians.

Increasing revenue per client by adding new service offerings. We have only recently begun to offer our athenaClinicals service, which we combined with athenaCollector for sale to prospective clients. Given the recent advances in the overall EMR market and recent regulatory changes, we expect that many of our current and future clients will be making purchasing decisions based in part on EMR functionality. Our recent certification by the Certification Commission for Healthcare Information Technology, or CCHIT, an independent, industry-recognized accreditation organization created to certify EMR applications, for the software component of athenaClinicals provides further opportunity for it to be combined with athenaCollector for sale to prospective new clients. In the future, we plan to offer athenaClinicals as a stand-alone option. We are developing additional services to address other administrative tasks within the physician office that create opportunities to leverage our healthcare domain knowledge and create increased revenue opportunity from our existing clients. These additional services will focus on managing patient communications with the physician office such as scheduling appointments, accessing lab results and refilling prescriptions. Consistent with our other offerings, we intend to deliver these services on an ongoing basis for a percentage of collections. Like our

other services, this new service would be delivered through use of the athenaNet platform, through use of the athenaRules database of payer rules and through our integrated service operations.

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Expanding operating margins by reducing the costs of providing our services. We believe we can increase our operating margins as we increase the scalability of our service operations. Our integrated operations enable us to deploy the most efficient resources to lower the cost of providing specific discrete tasks at each step of the revenue and clinical cycles workflow. To do this, we will make targeted investments that are likely to include additional and geographically diverse datacenter capacity, an additional service center location in the United States, enhanced use of off-shore capacity for processing work and increased capability in our off-shore software development center. As we add new service offerings, these offerings will also utilize our current capabilities, ultimately further reducing the cost of providing our services to our clients.

Our Services

athenahealth is a provider of internet-based business services for physician practices. Our service offerings are based on our proprietary web-based software, a continually updated database of payer rules and integrated back-office service operations. Our services are designed to help our clients achieve faster reimbursement from payers, reduce error rates, increase collections, lower operating costs, improve operational workflow controls and more efficiently manage clinical and billing information.

athenaCollector

Our principal offering, athenaCollector, is our revenue cycle management service that automates and manages billing-related functions for physician practices, and includes a practice management platform. athenaCollector assists our physician clients with the proper handling of claims and billing processes to help submit claims quickly and efficiently.

Software (athenaNet)

Through athenaNet, athenaCollector utilizes the Internet to connect physician practices to our rules engine and service operations team. In its 2006 year-end Best in KLAS survey, KLAS Enterprises, LLC, a healthcare information technology industry research firm, rated athenaNet No. 3 in the Ambulatory and Billing Scheduling category for practice groups with one to five physicians, No. 1 in the Ambulatory and Billing Scheduling category for practice groups with six to 25 physicians and No. 2 in the Ambulatory and Billing

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Scheduling category for practice groups with 25 to 100 physicians. athenaNet has been ranked No. 1, No. 2 or No. 3 in each of these categories in each annual Best in KLAS ranking since 2004. It includes a workflow dashboard used by our clients and our services team to track in real-time claims requiring edits before they are sent to the payer, claims requiring work that have come back from the payer unpaid and claims that are being held up due to administrative steps required by the individual client. This internet-native functionality provides our clients with the benefits of our database of payer rules as it is updated and enables them to interact with our services team to efficiently monitor workflows. The internet-based architecture of athenaNet allows each transaction to be available to our centralized rules engine so that mistakes can be corrected quickly across all of our clients.

Knowledge (athenaRules)

Physician practices route all of their electronic and paper payer communications to us, which we then process using athenaRules and our significant understanding of payer rules to achieve faster reimbursement rates and improve practice revenue. Our proprietary database of payer knowledge has been constructed based on over seven years of experience in dealing with physician workflow in hundreds of physician practices with medical claims from tens of thousands of health benefit plans. The core focus of the database is on the payer rules which are the key drivers of claim payment and denials. Understanding denials allows us to construct rules to avoid future denials across our entire client base resulting in increased automation of our workflow processes. Over 100 new rules on average are added to our rules engine each month and approximately 50% of the rules triggered each month were added within the previous six months. athenaRules has been designed to interact seamlessly with athenaNet in the medical office workflow and in our service operations. As of the end of 2006, the company dedicated more than 50 full-time equivalents cross functionally to the process of analyzing denials and developing and adding new rules to the database.

Work (athenahealth Service Operations)

Our athenahealth service operations provides the service teams that collaborate with client staff to achieve successful outcomes or payment transactions. Our services operations consists of both the highly healthcare knowledgeable staff and technological infrastructure required to execute the key steps associated with proper handling of physician claims and clinical data management. It is comprised of nearly 400 people on our service teams in the United States and more than 700 people at our off-shore partners who interact with physicians at all of the key steps in the revenue cycle including:

- coordinating with payers to ensure that client providers are properly set-up for billing;
- checking the eligibility of scheduled patients electronically;
- submitting claims to payers directly or through intermediaries, whether electronic or via printed claim forms;
- obtaining confirmation of claim receipt from the payer either electronically or through phone calls;
- receiving and processing checks and remittance information from payers and documenting the result of payers responses;
- evaluating denied claims and determining the best approach to appealing and/or resubmitting claims to obtain payment;
- billing patients for balances that are due;

compiling and delivering management reporting about the performance of clients at both the account level and the provider level;

transmitting key clinical data to the revenue cycle workflow to eliminate the need for code re-entry and providing all key date elements required to achieve maximum appropriate reimbursement; and

providing proactive and responsive client support to manage issues, address questions, identify training needs and communicate trends.

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athenaClinicals

Our most recent offering, athenaClinicals, is our clinical cycle management service which automates and manages medical record management-related functions for physician practices, and includes an EMR platform. It assists medical groups with the proper handling of physician orders and related inbound and outbound communications to ensure that orders are carried out quickly and accurately and to provide an up-to-date and accurate online patient clinical record. athenaClinicals is designed to improve clinical administrative workflow, the software component of that recently received CCHIT certification.

Software (athenaNet)

Through athenaNet, athenaClinicals displays key clinical measures by office location related to the drivers of high quality and efficient care delivery on a workflow dashboard, including lab results requiring review, patient referral requests, prescription requests and family history of previous exams. Similar to its functionality within athenaCollector, athenaNet provides comprehensive reporting on a range of clinical results, including distribution of different procedure codes (leveling), incidence of different diagnoses, timeliness of turnaround by lab companies and other intermediaries and other key performance indicators.

Knowledge (athenaRules)

Clinical data must be captured according to the requirements and incentives of different payers and plans. Clinical intermediaries such as laboratories and pharmacy networks require specific formats and data elements as well. athenaRules can access medication formularies, identify potential medication errors such as drug-to-drug interactions or allergy reactions and identify the specific clinical activities that are required to adhere to pay-for-performance programs, which can add incremental revenue to the physician practice.

Work (athenahealth Service Operations)

athenaClinicals provides the additional functionality that medical groups expect from an EMR to help them complete the key processes that affect the clinical care record related to patient care including:

- identifying available P4P programs, incentives and enrollment requirements;
- entering data about patient encounters as they happen for general exams (well visits) as well as problem-focused visits (sick exams);
- delivering outbound physician orders such as prescriptions and lab requisitions; and
- capturing, classifying and presenting inbound documentation electronically or via fax such as lab results.

Sales and Marketing

We have developed a sales and marketing capability aimed at expanding our network of physician clients, and expect to expand these efforts in the future. We have a significant direct sales effort which we augment through our indirect channel relationships.

Direct Sales

As of June 30, 2007, we employed a direct sales and sales support force of 52 employees. Of these employees, 40 were sales professionals. Because of our ongoing service relationship with clients we conduct a consultative sales process. This process includes understanding the needs of perspective clients, developing service proposals and negotiating contracts to enable the commencement of services. Of this sales force, 32 members of our sales force are dedicated to physician practices with four or more physicians and eight members of our sales force are dedicated to physician practices with one to three physicians. Our sales force is supported by 12 personnel in our sales and marketing organizations that provide specialized support for promotional and selling efforts.

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Channel Partners

In addition to our employed sales force, we maintain business relationships with individuals and organizations that promote or support our sales or services within specific industries of geographic regions, which we refer to as channels. We refer to these individuals and organizations as our channel partners. These relationships are generally agreements that compensate channel partners for providing us sales lead information that result in sales. These channel partners generally do not make sales but instead provide us with leads that we use to develop new business through our direct sales force. In 2006, channel-based leads were associated with approximately half of our new business. Our channel relationships include state medical societies, Healthcare Information Technology product companies, healthcare product distribution companies and consulting firms. Examples of these types of channel relationships include:

the Ohio State Medical Society;

Eclipsys Corporation; and

WorldMed Shared Services, Inc. (d/b/a PSS World Medical Shares Services, Inc.), or PSS.

In May 2007, we entered into a marketing and sales agreement with PSS for the marketing and sale of athenaClinicals and athenaCollector. The agreement has an initial term of three years and may be terminated by either party for cause or convenience. Under the terms of the agreement, we will pay PSS sales commissions based upon the estimated contract value of orders placed with PSS, which will be adjusted 15 months after the date the service begins for a client to reflect actual revenue received by us from clients. Subsequent commissions will be based upon a specified percentage of actual revenue generated from orders placed with PSS. We will be responsible for funding $300,000 toward the establishment of an incentive plan for the PSS sales representatives during the first twelve months of the agreement, as well as co-sponsoring training sessions for PSS sales representatives and conducting on-line education for PSS sales representatives.

Under the terms of the agreement, no later than June 2009, revenue cycle services or software from athenahealth will be the exclusive revenue cycle solution distributed by PSS, and from and after the date that clinical cycle services and software from athenahealth has been CCHIT certified and is generally commercially released as a stand-alone service, such services and software will be the exclusive clinical cycle solution marketed and sold by PSS. Additionally, the terms of the agreement prohibit us from entering into a similar agreement with any business that has, as its primary source of revenue, revenue from the business of distributing medical and surgical supplies to the physician ambulatory care market in the United States. None of our existing channel relationships are affected by our exclusive arrangement with PSS, and while our agreement with PSS precludes us from entering into similar arrangements with other distributors of medical and surgical supplies to the physician ambulatory care market in the United States, we believe PSS is of sufficient size so as to offer us a compelling opportunity to market our services to prospective clients that would otherwise be difficult for us to reach. According to PSS, they have the largest medical and surgical supplies sales force in the United States, consisting of approximately 720 sales consultants who distribute medical supplies and equipment to more than 100,000 offices in all 50 states.

Marketing Initiatives

Since our service model is new to most physicians, our marketing and sales objectives are designed to increase awareness of our company, establish the benefits of our service model and build credibility with prospective clients, so that they will view our company as a trustworthy long-term service provider. To effect this strategy, we have designed and implemented specific activities and programs aimed at converting leads to new clients.

In June 2006, we introduced our annual PayerView rankings in order to provide an industry-unique framework to systematically address what we believe is unnecessary administrative complexity existing between payers and providers. PayerView is designed to look at payers performance based on a number of categories, which combine to provide an overall ranking aimed at quantifying the ease of doing business with the payer. All data used for the rankings come from actual claims performance data of our clients and depict

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our experience in dealing with individual payers across the nation. The rankings include national payers with at least 120,000 charge lines of data and regional payers with a minimum of 20,000 charge lines.

Our marketing initiatives are generally targeted towards specific segments of physician practices. These marketing programs primarily consist of:

- sponsoring pay-per-click search advertising and other internet-focused awareness building efforts (such as online videos and webinars);
- engaging in public relations activities aimed at generating media coverage;
- participating in industry-focused trade shows;
- disseminating targeted mail and phone calls to physician practices; and
- conducting informational meetings (such as town-hall style meetings or strategic retreats with targeted potential clients at an event called the athenahealth Institute).

Technology, Development and Operations

We currently operate data centers in Waltham, Massachusetts and in Bedford, Massachusetts. The company operates an application in a separate data center located in Chicago, Illinois, which we call athenaNet EmergencyEdition, which provides our clients access to their critical data and functionality in the event of a failure at our primary data centers. Our data centers are maintained and supported by third-parties at their dedicated locations. In addition, in 2007 we signed a disaster recovery contract with a major provider of these services, so that in the event of a total disaster at our primary data centers, we could become operational in an acceptable timeframe at a back-up location. The services provided by our data center and disaster recovery service providers are generally commercially available at comparable rates from other service providers. Our corporate technology support is augmented by a third-party service provider in New Brunswick, Canada.

Our mission-critical business application is hosted by the company and accessed by clients using high-speed Internet connections or private network connections. We have devoted significant resources to producing software and related application and data center services that meet the functionality and performance expectations of clients. We use commercially available hardware and a combination of proprietary and commercially available software to provide our service. These software licenses are generally available on commercially reasonable terms. The design of our application and database servers is modular and scaleable in that as new clients are added the company adds additional capacity as necessary. We refer to this as a horizontal scaling architecture, which means that hardware to support new clients is added alongside existing clients hardware and does not directly affect those clients.

The company devotes significant resources to innovation. We execute six to eight releases of new software functionality to our clients each year. We deploy a rigorous application development methodology so that each software release is properly designed, built, tested and rolled out. Our clients all operate on the same version of our software. Our software development activities involve more than 49 technologists employed by the company in the United States as of June 30, 2007. We complement this team s work with software development services from a third-party technology development provider in Pune, India and with our own direct employees at our development center operated through our wholly-owned subsidiary located in Chennai, India. As of June 30, 2007, we employed nine people in our direct subsidiary, and in the first half of 2007 this entity represented approximately 1.0% of our total operating expense. In addition to our core software development activities, we dedicate more than 50 full-time equivalent staff across the company to our ongoing development and maintenance of the athenaRules database. Over

100 new rules on average are added to our rules engine each month and approximately 50% of the rules triggered each month were added within the previous six months. We also employ process innovation specialists and product management personnel, who work continually on improvements to our service operations processes and our service design, respectively.

Once our clients are live on our service, we collaborate with them to generate strong business results. We employed nearly 400 people in our service operations dedicated to providing these services to our clients as of June 30, 2007. These employees assist our clients at each critical step in the revenue cycle and clinical cycle

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workflow process including, insurance benefits packaging, insurance eligibility, claims submission, claims tracking, remittance posting, denials management, payment processing, formatting of lab requisitions, submission of lab requisitions, monitoring and classification of all inbound faxes. Additionally we use third-parties for data entry, data matching, data characterization and outbound telephone services. Currently, we have contracted for these services with Vision Healthsource, a subsidiary of Perot Systems Corporation, through which more than 700 people provide data entry and other services from facilities located in India and the Philippines to support our client service operations. These services are generally commercially available at comparable rates from other service providers.

During 2006, athenahealth:

- posted over $2 billion in physician payments;
- processed over 17 million medical claims;
- handled over 38 million charge postings; and
- sorted approximately 14 million pages of paper which amounted to approximately 140,000 pounds of mail.

We depend on satisfied clients to succeed. Our client contracts require minimum commitments by us on a range of tasks, including claims submission, payment posting, claims tracking and claims denial management. We also commit to our clients that athenaNet is accessible 99.7% of the time, excluding scheduled maintenance windows. Each quarter, our management conducts a survey of clients to identify client concerns and track progress against client satisfaction objectives. In our most recent survey, 88% of the respondents reported that they would recommend our services to a trusted friend or colleague.

In addition to the services described above, we also provide client support services. There are several client service support activities that take place on a regular basis, including the following:

- client support by the client services center designed to address client questions and concerns rapidly, whether registered via a phone call or via an online support case through the company s customized use of customer relationship management technology;
- account performance and issue resolution activities by the account management organization, designed to address open issues and focus clients on the financial results of the co-sourcing relationship; these efforts also are intended to result in client retention, appropriate adjustments to service pricing at renewal dates and provision of incremental services when appropriate; and
- relationship management by regional leaders of the client services organization to ensure that decision-makers at clients are satisfied and that regional performance is managed proactively with regard to client satisfaction, client margins, client retention, renewal pricing and added services.

Competition

We have experienced, and expect to continue to experience intense competition from a number of companies. Our primary competition is the use of locally installed software to manage revenue and clinical cycle workflow within the physician s office. Software companies that sell practice management and EMR software and medical billing and collection organizations include GE Healthcare, Sage Software Healthcare, Inc., Misys Healthcare Systems, Allscripts Healthcare Solutions, Inc., Siemens Medical Solutions USA, Inc. and Quality Systems, Inc. As a service company that provides revenue cycle services, we also compete against large billing companies such as McKesson Corp., Medical

Management Professions, a division of CBIZ, Inc., and regional billing companies.

The principal competitive factors in our industry include:

- ability to quickly adapt to increasing complexity of the healthcare reimbursement system;
- size and scope of payer rules knowledge;

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ease of use and rates of user adoption;

product functionality;

performance, security, scalability and reliability of service;

sale and marketing capabilities of vendor; and

financial stability of the vendor.

We believe that we compete favorably with our competitors on the basis of these factors. However, many of our competitors and potential competitors have significantly greater financial, technological and other resources and name recognition than we do and more established distribution networks and relationships with healthcare providers. As a result, many of these companies may respond more quickly to new or emerging technologies and standards and changes in customer requirements. These companies may be able to invest more resources in research and development, strategic acquisitions, sales and marketing, patent prosecution and litigation and finance capital equipment acquisitions for their customers.

Government Regulation

Although we generally do not contract with U.S. government entities, the services that we provide are subject to a complex array of federal and state laws and regulations, including regulation by the Centers for Medicare and Medicaid Services, or CMS, of the U.S. Department of Health and Human Services, as well as additional regulation.

Government Regulation of Health Information

Privacy and Security Regulations. The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations that have been issued under it (collectively HIPAA) contain substantial restrictions and requirements with respect to the use and disclosure of individuals protected health information. These are embodied in the Privacy Rule and Security Rule portions of HIPAA. The HIPAA Privacy Rule prohibits a covered entity from using or disclosing an individual s protected health information unless the use or disclosure is authorized by the individual or is specifically required or permitted under the Privacy Rule. The Privacy Rule imposes a complex system of requirements on covered entities for complying with this basic standard. Under the HIPAA Security Rule, covered entities must establish administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic protected health information maintained or transmitted by them or by others on their behalf.

The HIPAA Privacy and Security Rules apply directly to covered entities, such as healthcare providers who engage in HIPAA-defined standard electronic transactions, health plans and healthcare clearinghouses. Because we translate electronic transactions to and from the HIPAA-prescribed electronic forms and other forms, we are a clearinghouse and as such are a covered entity. In addition, our clients are also covered entities. In order to provide clients with services that involve the use or disclosure of protected health information, the HIPAA Privacy and Security Rules require us to enter into business associate agreements with our clients. Such agreements must, among other things, provide adequate written assurances:

as to how we will use and disclose the protected health information;

that we will implement reasonable administrative, physical and technical safeguards to protect such information from misuse;

that we will enter into similar agreements with our agents and subcontractors that have access to the information;

that we will report security incidents and other inappropriate uses or disclosures of the information; and

that we will assist the covered entity with certain of its duties under the Privacy Rule.

State Laws. In addition to the HIPAA Privacy and Security Rules, most states have enacted patient confidentiality laws that protect against the disclosure of confidential medical information, and many states

have adopted or are considering further legislation in this area, including privacy safeguards, security standards and data security breach notification requirements. Such state laws, if more stringent than HIPAA requirements, are not preempted by the federal requirements, and we must comply with them.

Transaction Requirements. In addition to the Privacy and Security Rules, HIPAA also requires that certain electronic transactions related to health care billing be conducted using prescribed electronic formats. For example, claims for reimbursement that are transmitted electronically to payers must comply with specific formatting standards, and these standards apply whether the payer is a government or a private entity. As a covered entity subject to HIPAA, we must meet these requirements, and moreover, we must structure and provide our services in a way that supports our clients HIPAA compliance obligations.

Government Regulation of Reimbursement

Our clients are subject to regulation by a number of governmental agencies, including those that administer the Medicare and Medicaid programs. Accordingly, our clients are sensitive to legislative and regulatory changes in, and limitations on, the government healthcare programs and changes in reimbursement policies, processes and payment rates. During recent years, there have been numerous federal legislative and administrative actions that have affected government programs, including adjustments that have reduced or increased payments to physicians and other healthcare providers and adjustments that have affected the complexity of our work. For example, Medicare reimbursement was, for a period of time in 2006, reduced with respect to portions of the physician payment fee schedule. The federal government subsequently rescinded reduction and decided to pay physicians the amount of the reduction that had been applied to claims already processed under the reduced payment fee schedule. To collect these payments for our clients, we re-submitted claims that had previously been processed. This process required substantial unanticipated processing work by us, and the additional payments for re-submitted claims were sometimes very small. It is possible that the federal or state governments will implement future reductions, increases or changes in reimbursement under government programs that adversely affect our client base or our cost of providing our services. Any such changes could adversely affect our own financial condition by reducing the reimbursement rates of our clients.

Fraud and Abuse

A number of federal and state laws, loosely referred to as fraud and abuse laws, are used to prosecute healthcare providers, physicians and others that make, offer, seek or receive referrals or payments for products or services that may be paid for through any federal or state healthcare program and in some instances any private program. Given the breadth of these laws and regulations, they are potentially applicable to our business, to the transactions which we undertake on behalf of our clients and to the financial arrangements through which we market, sell and distribute our products. These laws and regulations include:

Anti-kickback Laws. There are numerous federal and state laws that govern patient referrals, physician financial relationships, and inducements to healthcare providers and patients. The federal healthcare programs anti-kickback law prohibits any person or entity from offering, paying, soliciting, or receiving anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. Courts have construed this anti-kickback law to mean that a financial arrangement may violate this law if any one of the purposes of one of the arrangements is to encourage patient referrals or other federal healthcare program business, regardless of whether there are other legitimate purposes for the arrangement. There are several limited exclusions known as safe harbors that may protect some arrangements from enforcement penalties. These safe harbors have very limited application. Penalties for federal anti-kickback violations are severe, and include imprisonment, criminal fines, civil money penalties with triple damages and exclusion from

participation in federal healthcare programs. Many states have similar anti-kickback laws, some of which are not limited to items or services for which payment is made by a federal healthcare program.

False or Fraudulent Claim Laws. There are numerous federal and state laws that forbid submission of false information or the failure to disclose information in connection with the submission and payment of

physician claims for reimbursement. In some cases, these laws also forbid abuse of existing systems for such submission and payment, for example, by systematic over treatment or duplicate billing of the same services to collect increased or duplicate payments. These laws and regulations may change rapidly, and it is frequently unclear how they apply to our business. For example, one federal false claim law forbids knowing submission to government programs of false claims for reimbursement for medical items or services. Under this law, knowledge may consist of willful ignorance or reckless disregard of falsity. How these concepts apply to a services such as ours that rely substantially on automated processes, has not been well defined in the regulations or relevant case law. As a result, our errors with respect to the formatting, preparation or transmission of such claims and any mishandling by us of claims information that is supplied by our clients or other third parties may be determined to or may be alleged to involve willful ignorance or reckless disregard of any falsity that is later determined to exist.

In most cases where we are permitted to do so, we charge our clients a percentage of the collections that they receive as a result of our services. To the extent that liability under fraud and abuse laws and regulations requires intent, it may be alleged that this percentage calculation provides us or our employees with incentive to commit or overlook fraud or abuse in connection with submission and payment of reimbursement claims. The Centers for Medicare and Medicaid Services has stated that it is concerned that percentage-based billing services may encourage billing companies to commit or to overlook fraudulent or abusive practices.

Stark Law and similar state laws. The Ethics in Patient Referrals Act, known as the Stark Law, prohibits certain types of referral arrangements between physicians and healthcare entities. Physicians are prohibited from referring patients for certain designated health services reimbursed under federally-funded programs to entities with which they or their immediate family members have a financial relationship or an ownership interest, unless such referrals fall within a specific exception. Violations of the statute can result in civil monetary penalties and/or exclusion from the Medicare and Medicaid programs. Furthermore, reimbursement claims for care rendered under forbidden referrals may be deemed false or fraudulent, resulting in liability under other fraud and abuse laws.

Laws in many states similarly forbid billing based on referrals between individuals and/or entities that have various financial, ownership or other business relationships. These laws vary widely from state to state.

Corporate Practice of Medicine Laws, Fee-Splitting Laws and Anti-Assignment Laws

In many states, there are laws that forbid non-licensed practitioners from practicing medicine, that prevent corporations from being licensed as practitioners and that forbid licensed medical practitioners from practicing medicine in partnership with non-physicians, such as business corporations. In some states, these prohibitions take the form of laws or regulations forbidding the splitting of physician fees with non-physicians or others. In some cases, these laws have been interpreted to prevent business service providers from charging their physician clients on the basis of a percentage of collections or charges.

There are also federal and state laws that forbid or limit assignment of claims for reimbursement from government funded programs. Some of these laws limit the manner in which business service companies may handle payments for such claims and prevent such companies from charging their physician clients on the basis of a percentage of collections or charges. In particular, the Medicare program specifically requires that billing agents who receive Medicare payments on behalf of medical care providers must meet the following requirements:

- the agent must receive the payment under an agreement between the provider and the agent;
- the agent s compensation may not be related in any way to the dollar amount billed or collected;
- the agent s compensation may not depend upon the actual collection of payment;

the agent must act under payment disposition instructions, which the provider may modify or revoke at any time; and

in receiving the payment, the agent must act only on behalf of the provider, except insofar as the agent uses part of that payment to compensate the agent for the agent s billing and collection services.

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Medicaid regulations similarly provide that payments may be received by billing agents in the name of their clients without violating anti-assignment requirements if payment to the agent is related to the cost of the billing service, not related on a percentage basis to the amount billed or collected and not dependant on collection of payment.

Electronic Prescribing Laws

States have differing prescription format and signature requirements. Many existing laws and regulations, when enacted, did not anticipate the methods of e-commerce now being developed. While federal law and the laws of many states permit the electronic transmission of prescription orders, the laws of several states neither specifically permit nor specifically prohibit the practice. Given the rapid growth of electronic transactions in healthcare and the growth of the Internet, we expect the remaining states to directly address the electronic transmission of prescription orders with regulation in the near future. In addition, on November 7, 2005, the Department of Health and Human Services published its final E-Prescribing and the Prescription Drug Program regulations (E-Prescribing Regulations). These regulations are required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) and became effective beginning on January 1, 2006. The E-Prescribing Regulations consist of detailed standards and requirements, in addition to the HIPAA standards discussed previously, for prescription and other information transmitted electronically in connection with a drug benefit covered by the MMA s Prescription Drug Benefit. These standards cover not only transactions between prescribers and dispensers for prescriptions but also electronic eligibility and benefits inquiries and drug formulary and benefit coverage information. The standards apply to prescription drug plans participating in the MMA s Prescription Drug Benefit. Aspects of our services are affected by such regulation, as our clients need to comply with these requirements.

Electronic Health Records Certification Requirements

The federal Office of the National Coordinator for Health Information Technology, or ONCHIT, is responsible for promoting the use of interoperable electronic health records, or EHRs, and systems. ONCHIT has introduced a strategic framework and has awarded contracts to advance a national health information network and interoperable EHRs. One project within this framework is a voluntary private sector based certification commission, CCHIT, to certify electronic health record systems as meeting minimum functional and interoperability requirements. The certification commission has begun and our clinical application functionality is certified by CCHIT under its 2006 criteria. It is possible that such certification may become a requirement for selling clinical systems in the future, and CCHIT s certification requirement may change substantially. While we believe our system is well designed in terms of function and interoperab