ATHENAHEALTH INC
Form 10-K
March 15, 2010

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2009

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission File Number 001-33689
athenahealth, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**04-3387530**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
311 Arsenal Street, Watertown, Massachusetts	**02472**
(Address of principal executive offices)	*(Zip Code)*

617-402-1000
Registrant s telephone number, including area code

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

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $0.01 par value	The NASDAQ Stock Market LLC

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

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

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

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes o No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

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

Large accelerated filer þ Accelerated filer o Non-accelerated filer o Smaller reporting company o
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No þ

The aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the registrant s most recently completed second fiscal quarter was $1,169,309,706.

Indicate the number of shares outstanding of each of the registrant s classes of common stock, as of the latest practicable date. At March 12, 2010, the registrant had 34,034,323 shares of Common Stock, par value $0.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III of this Form 10-K incorporate information by reference from the registrant s definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the close of the fiscal year covered by this annual report.

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EXPLANATORY NOTE REGARDING RESTATEMENT

In this Annual Report on Form 10-K, the terms athena, athenahealth, we, us, and our refer to athenahealth, Inc. its subsidiaries, Anodyne Health Partners, Inc., athenahealth MA, Inc., and athenahealth Technology Private Limited, and any subsidiary that may be acquired or formed in the future.

athenahealth, athenaNet, and the athenahealth logo are registered service marks of athenahealth; Anodyne Analytics, Anodyne Intelligence Platform, athenaClinicals, athenaCollector, athenaCommunicator, athenaEnterprise, athenaRules, PayerView, and ReminderCall are service marks of athenahealth. This Annual Report on Form 10-K also includes the registered and unregistered trademarks and service marks of other persons.

This Annual Report on Form 10-K for the fiscal year ended December 31, 2009, includes restatement of the following previously filed consolidated financial statements and data (and related disclosures): (1) our consolidated balance sheet as of December 31, 2008, and the related consolidated statements of operations, stockholders equity, and cash flows for each of the fiscal years ended December 31, 2007 and 2008; (2) our selected financial data as of and for our fiscal years ended December 31, 2005, 2006, 2007, and 2008, located in Part II, Item 6 of this Annual Report on Form 10-K; (3) our management s discussion and analysis of financial condition and results of operations as of and for our fiscal years ended December 31, 2007 and 2008, contained in Part II, Item 7 of this Annual Report on Form 10-K; and (4) our unaudited quarterly financial information for each quarter in our fiscal year ended December 31, 2008, and for the first three quarters in our fiscal year ended December 31, 2009, in Note 20, Summarized Quarterly Unaudited Financial Data of the Notes to Consolidated Financial Statements in Part II, Item 8 of this Annual Report on Form 10-K.

We have completed our previously announced internal accounting review related to the amortization period for deferred implementation revenue. Implementation revenue consists primarily of professional services fees related to assisting customers with the implementation of our services. These non-refundable fees are generally billed up front and recorded as deferred revenue until the implementation is complete and then recognized ratably over the expected performance period. Previously, the expected performance period was estimated based upon the initial customer contract terms, the vast majority of which were one year in duration. Implementation and other revenue has ranged from four to seven percent of total revenue on an annual basis since 2007.

As a result of this review, we have concluded that in prior and future periods, we will amortize deferred implementation revenue over a longer expected performance period of twelve years in order to reflect the estimated expected customer life. Accordingly, we will restate the implementation and other revenue within our previously filed consolidated financial statements to reflect the longer amortization period for deferred implementation revenue. We will continue to record implementation expenses in the period as incurred. The length of the amortization period for deferred implementation revenue recognition does not impact cumulative total implementation revenue under contract nor does it impact cash flow. The restatement will result in the deferral to future periods of $22.3 million of implementation revenue previously recognized through September 30, 2009.

In addition, in connection with the restatement, certain prior year amounts have been reclassified to conform to revised accounting policies. These reclassifications had no effect on net income or shareholders equity for any period and pertain to: (1) reimbursements of out-of-pocket expenses that were previously netted against corresponding expense and have now been grossed up and included in implementation and other revenue; (2) certain deferred tax liabilities that have been reclassified from non-current to current; (3) draw downs of capital leased lines that were previously presented as sources of cash within the financing activities section of the cash flow statements and have now been reclassified as investing activities; and (4) the excess tax benefit from stock-based awards that were previously presented as sources of cash within the operating activities section of the consolidated statements of cash flows in the accrued expense line have been reclassified as operating activities in the excess tax benefit from

stock-based awards line item.

Financial information included in the Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K filed by us prior to March 15, 2010, and all earnings, press releases, and similar communications issued by us prior to March 15, 2010, should not be relied upon and are superseded in their entirety by this Annual Report on Form 10-K.

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For more information regarding the restatement, please refer to Part II, Item 6, Selected Financial Data ; Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations ; Note 2, Restatement and Reclassification of Previously Issued Consolidated Financial Statements, and Note 20, Summarized Quarterly Unaudited Financial Data, of the Notes to Consolidated Financial Statements in Part II, Item 8; and Part II, Item 9A, Controls and Procedures.

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PART I

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS AND INDUSTRY DATA

This Annual Report on Form 10-K contains forward-looking statements. All statements other than statements of historical fact contained in this Annual Report on Form 10-K are forward-looking statements, including those regarding our patient cycle management service; the combination or integration of newly acquired services with athenaCollector and athenaNet; expanded sales and marketing efforts; changes in expenses related to operations, selling, marketing, research and development, general and administrative matters, and depreciation and amortization; liquidity issues; additional fundraising; and the expected performance period and estimated term of our client relationships, as well as more general statements regarding our expectations for future financial or operational performance, product and service offerings, regulatory environment, and market trends. In some cases, you can identify forward-looking statements by terminology such as may, will, should, expects, plans, anticipates, b estimates, predicts, potential, or continue ; the negative of these terms; or other comparable terminology.

Forward-looking 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 such statements. These factors include, among other things, those listed under Risk Factors and elsewhere in this Annual Report on Form 10-K.

Although we believe that the expectations reflected in the forward-looking statements contained in this Annual Report on Form 10-K 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 such forward-looking statements, whether as a result of new information, future events, or otherwise, after the date of this Annual Report on Form 10-K.

Unless otherwise indicated, information contained in this Annual Report on Form 10-K 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), 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 Annual Report on Form 10-K 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 Annual Report on Form 10-K 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 in Item 1A of Part 1 of this Annual Report on Form 10-K and elsewhere in this Annual Report on Form 10-K. These and other factors could cause results to differ materially from those expressed in the estimates made by the independent parties and by us.

Item 1. ***Business.***

Overview

athenahealth is a leading provider of Internet-based business services for physician practices. Our service offerings are based on four integrated components: our proprietary Internet-based software, our continually updated database of payer reimbursement process rules, our back-office service operations that perform administrative aspects of billing and clinical data management for physician practices, and our automated and live patient communication services. Our principal offering, athenaCollector, automates and manages billing-

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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 health record, or EHR, platform. ReminderCall, which we added to our service suite in September 2008, is our automated appointment reminder system that allows patients to either confirm the appointment or request rescheduling. We have now combined ReminderCall with other automated patient messaging services, live operator services, and a patient web portal in the first edition of our athenaCommunicator services suite that we beta launched in 2009 and expect to offer commercially in the first half of 2010. We refer to athenaCollector as our revenue cycle management service, athenaClinicals as our clinical cycle management service, and athenaCommunicator as our patient cycle management service. As a complement to these services, our newest offering, Anodyne Analytics, is a web-based, Software-as-a-Service business intelligence platform that organizes and displays detailed and insightful practice performance data for decision makers at our client practices. 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, improve patient satisfaction and compliance, and more efficiently manage clinical and billing information.

In the last six years, we have primarily focused on developing our proprietary Internet-based software application and integrated service operations to expand our client base. In 2005, 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. In September 2008, we completed our first acquisition, purchasing the assets of Crest Line Technologies, LLC (d.b.a. MedicalMessaging.net), a privately held company that developed ReminderCall and associated services. We continued this expansion of our offerings in October 2009 with our acquisition of our new operating subsidiary, Anodyne Health Partners, Inc. (Anodyne), a privately held company that developed the Anodyne Analytics service. In 2009, we generated revenue of $188.5 million from the sale of our services, compared to $136.3 million in 2008. As of December 31, 2009, there were more than 23,350 medical providers, including more than 15,700 physicians, using our services across 43 states and the District of Columbia and 60 medical specialties.

Market Opportunity

We believe that the market opportunity for our services is, in large part, currently driven by physician practice collections in the United States. According to the U.S. Centers for Medicare and Medicaid Services, physician and clinical services spending increased since 2000 by an average of 7.0% per year to $496 billion in 2008.

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, many 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 practice-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 for 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 frequently specific to each individual health plan, physician practices need

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to be continually aware of this dynamic element of the reimbursement cycle as it could impact overall reimbursement and specific workflows.

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 of 1996, 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. Among the changes introduced by HIPAA, physicians have been required to adopt National Provider Identifiers, and this has affected physician practice billing and collection workflow requirements.

In addition to administering typical business functions, physician practices must invest significant time and resources in activities that are required to secure reimbursement from patients or third-party payers and process inbound and outbound communications related to physician orders to laboratories and pharmacies. In order to process these communications, physician practices often manipulate locally or remotely 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 three ways: purchasing, installing, and operating locally installed practice management software; paying for use of remotely installed on-demand practice management software; or hiring a third-party billing service to collect billing-related information and input the information into a software system maintained by the service. In terms of medical-record-management, the majority of physician practices rely on paper-based systems or use locally or remotely installed EHR software to generate electronic medical record information. However, these software systems do not eliminate paper-based transactions and information exchanges with intermediaries such as labs, pharmacies, and hospitals. Physician practices are still responsible for inputting all medical record information into the software, as these systems are not automatically linked to those of the intermediaries. In many instances, the solutions that are installed at a physician practice or a remote location are operated by that practice s administrative staff. As the complexity and number of health benefit plan payer rules has increased, the ability of locally or remotely installed software solutions to keep up with new and revised payer rules has lagged behind this trend, leading to higher levels of unpaid claims, prolonged billing cycles, increased clinical inefficiencies, and missed opportunities for reimbursements for participation in P4P programs. While locally or remotely installed software has been shown to provide improvement in physician practice efficiency and collections relative to paper-based systems, we believe that such standalone software is not suited for today s dynamic and increasingly complex healthcare system.

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

Software is static and isolated. Payer rules change continuously, and the systems used to seek reimbursement require constant updating to remain accurate. If it is not 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

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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 that their inability to keep current on these rule 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 practice personnel. Physician practices have difficulty managing the increased complexity of billing, collections, and medical record management because they lack the necessary infrastructure and suffer from significant staff turnover rates. Despite attempts to automate workflow, many software solutions still require that a number of healthcare supply chain interactions be executed manually via paper, fax, 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, and monitoring and classification of all inbound faxes. These tasks are prone to human error, are inefficient, and generally require the accumulation of rules and claims processing knowledge by the individuals involved. High employee turnover in physician practices leads to critical reimbursement and transaction processing knowledge being lost.

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

We believe that the use of traditional outsourced back-office service providers does not adequately compensate for the deficiencies of the locally or remotely installed software model. Such 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 sometimes utilize separate processes for each client they serve, which affords limited advantages of scale, thereby conferring limited cost advantages to physician practices. Without either control over the software application or an integrated rules database, outsourced service providers cannot offer physicians the benefits of our Internet-based business service model.

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. In addition, clinical data management and reporting is also beginning to impact reimbursement for physician practices. While locally or remotely 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 well suited 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 manage the reimbursement and clinical landscape effectively. We believe that we are the first company to integrate web-based software, a continually updated database of payer rules, back-office service operations, and automated and live patient

communication services into a single Internet-based business service for physician practices.

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We seek to 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 EHR application, is a workflow management tool used to properly handle billing, collections, patient communications, 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 reimbursement process rules, enforces physician practice 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 packages. athenaRules is also designed to 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 comply with P4P programs.

Work. The athenahealth service operations, consisting of approximately 582 people, 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. The positive results of our approach are seen in the significant growth in the number of clients serviced, collections under management, and overall revenue in each of the preceding nine years.

Key advantages of our solution include:

Low total cost of the athenahealth solutions. The cost of our services includes a modest upfront expenditure for implementation and training, with ongoing monthly service fees typically based on a percentage of client collections. This approach differs from the established model that requires upfront investments in software, hardware, implementation service and support, and additional information technology staff. We continually update our web-based software and add or revise over 100 rules on average each month in our shared payer knowledge base, which enables our clients to use these new features with minimal disruption and no incremental cost. Once implemented, our clients access our services by using an Internet connection and a web browser. We believe that our services-based model provides advantages 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 that 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 of 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 in many cases to catch billing-related errors immediately at the beginning of the reimbursement cycle, fix these errors quickly, and generate medical claims that achieve high first-pass success rates. Payer rules change frequently and are not commonly published by payers; therefore most rules must be learned from experience. We have full-time

staff focused on finding, researching, documenting, and implementing new rules, enabling our solution to consistently deliver quantifiably improved financial results for our clients. Additionally, we discover and implement even more new rules as new clients connect to our rules engine and expose our staff to new reimbursement scenarios. Our other clients

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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 result in improved financial and operational outcomes. Our solution enables real-time communications between the physician practice s staff and our service operations staff throughout the patient encounter and billing processes. We believe that this online interaction is vital for delivering the financial and operational performance our clients enjoy. The monitoring and managing of physician practice workflows allows us to stay close to client needs and constantly upgrade our offerings in order to improve the effectiveness of our overall service. These elements allow us to identify and influence critical practice workflow steps to maximize billing performance and deliver improved financial and operational outcomes for our clients.

Critical mass and access to superior scale and capabilities. We have taken physician back-office tasks that would otherwise be performed on a local or regional basis and have brought them together on a single national platform. Our platform was designed and constructed to enable us to assume 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. As a result of our centralized infrastructure, we can apply a broad array of resources (from athenahealth, our clients, and our off-shore partners) to address the myriad of discrete tasks within the revenue and clinical workflow cycles in a cost-effective manner. This approach allows us to deliver services and performance superior to what any particular physician practice could achieve on its own.

Our Strategy

Our mission is to be the most trusted business service to medical groups. 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 improve the performance of our clients continually. We believe that this approach enables us to maintain client loyalty, enhance our reputation, and improve the quality of our solutions.

Maintaining and growing our payer rules database. Our rules engine development work is designed to increase the percentage of transactions that are successfully executed on the first attempt and to reduce the time to resolution after claims or other transactions are submitted. We continue to develop our centralized payer reimbursement process rules database, athenaRules, by learning from experience gained across our national network of clients.

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 practices of any size. With more than 600,000 practicing physicians in the United States, we estimate that our client base currently represents less than three percent of the U.S. addressable market for revenue cycle management and clinical cycle management services.

Increasing revenue per client by adding new service offerings. We expanded our offerings in September 2008 by acquiring the assets of Crest Line Technologies, LLC, which provided our ReminderCall service, and in October 2009 by acquiring Anodyne, which developed our Anodyne Analytics service. In 2009, we beta launched our athenaCommunicator services suite that combined ReminderCall with other automated patient messaging services, live operator services, and a patient web portal, and we expect to offer athenaCommunicator commercially in the first half of 2010. We continue to explore additional services to

address other administrative tasks within physician practices.

Expanding operating margins by reducing the costs of providing our services. We believe that 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 in providing our services.

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Our Services

athenahealth is a leading 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, integrated back-office service operations, and our automated and live patient communication services. 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 manage reimbursement 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 2009 year-end Best in KLAS survey, KLAS Enterprises, LLC, a healthcare information technology industry research firm, reported athenaNet No. 1 in the Other Revenue Cycle Solutions category for practices with a single physician, No. 1 in the Practice Management category for practice groups with two to five physicians, No. 2 in the Practice Management category for practice groups with six to 25 physicians, and No. 2 in the Practice Management category for practice groups with 25 to 100 physicians. Apart from the single-physician practice category, which was first instituted in 2008, athenaNet has been ranked in the top 5 in each of these categories in each annual Best in KLAS ranking since 2004.

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athenaNet includes a workflow dashboard used by our clients and our services team to track claims requiring edits in real-time 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 run through our centralized rules engine so that mistakes can be corrected quickly across all of our clients. In the future, we plan to further leverage the efficiencies currently provided by athenaNet with the additional detail and analysis offered by our Anodyne Analytics service.

Knowledge (athenaRules)

Physician practices route all of their day-to-day electronic and paper-based payer communications to us, which we then process using athenaRules and our service operations to avoid reimbursement delays and improve practice performance. Our proprietary database of payer knowledge has been constructed based on over nine years of experience in dealing with physician workflow in hundreds of physician practices with medical claims from tens of thousands of health benefit packages. 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. On average, over 100 rules are added or revised in our rules engine each month. athenaRules has been designed to interact seamlessly with athenaNet in the medical office workflow and in our service operations.

Work (athenahealth Service Operations)

athenahealth Service Operations enables the service teams that collaborate with client staff to achieve successful transactions. Our Service Operations consists of both knowledgeable staff and technological infrastructure used to execute the key steps associated with proper handling of physician claims and clinical data management. The service team is comprised of approximately 582 people on our service teams who interact with physicians, providers, and clinicians 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 electronically or via printed claim forms;
- obtaining confirmation of claim receipt from payers, 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 to permit assembling all key data 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

athenaClinicals is our clinical cycle management service that automates and manages medical-record-management-related functions for physician practices and includes an EHR 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, and its software component has received certification from the Certification Commission for Healthcare Information Technology, or CCHIT, under that body s 2008 standards.

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. According to the 2009 year-end Best in KLAS survey, athenaClinicals achieved 100% client confidence in its ability to enable clients to meet the 2011 Meaningful Use standards under the Health Information Technology for Economic and Clinical Health Act (the HITECH Act). 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 is designed to 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 P4P programs including Medicare incentive payments under the HITECH Act, which can add incremental revenue to the physician practice.

Work (athenahealth Service Operations)

athenaClinicals provides the additional functionality that we believe medical groups expect from an EHR 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 and assisting with the enrollment and data submission for those programs;
- entering data about patient encounters as they happen;
- delivering outbound physician orders such as prescriptions and lab requisitions; and
- capturing, classifying, and presenting inbound documentation, such as lab results, electronically or via fax.

athenaCommunicator

As a result of our acquisition of the assets of Crest Line Technologies, LLC (d.b.a. MedicalMessaging.net) in September 2008, we offer automated messaging services that remind patients of appointment details and allow them

to use that automated system to confirm or reschedule the appointment or to speak with a live operator. These services help to reduce no-shows and thereby increase the number of revenue-generating appointments. We have renamed these services ReminderCall and expanded their marketing to our existing clients and prospective clients while also offering our other services to existing MedicalMessaging clients. We have developed an expanded set of services, called athenaCommunicator, which includes ReminderCall and other automated patient messaging services, live operator services, and a patient web portal. A beta version of athenaCommunicator was first offered to clients in July 2009, and, although the specific packaging, pricing,

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and marketing plans for this new service line have not been completed, we expect to offer an initial commercial version of these services in the first half of 2010, with expanded versions likely to follow in subsequent years.

Anodyne Analytics

With the acquisition of our newest operating subsidiary, Anodyne, in October 2009, we expanded the business intelligence function of our existing services through the addition of Anodyne Analytics. This web-based Software-as-a-Service platform organizes and analyzes billing and claims-based data, allowing physician practices to quickly and easily visualize that data through a wide array of business performance metrics. These metrics can be provided either as broad, practice-wide summaries or as discrete, highly specific analyses based on complex user-defined requests. In the future, we plan to further leverage the efficiencies currently provided by athenaNet with the additional detail and analysis offered by Anodyne Analytics and the Anodyne Intelligence Platform.

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 December 31, 2009, we employed a direct sales and sales support force of 124 employees. Of these employees, 94 were sales professionals. Due to of our ongoing service relationship with clients, we conduct a consultative sales process. This process includes understanding the needs of prospective clients, developing service proposals, and negotiating contracts to enable the commencement of services. Our sales team can be divided into three groups: the enterprise team who are dedicated to physician practices with 150 or more physicians; the group team who are dedicated to physician practices with four to 149 physicians; and the small group team who are dedicated to physician practices with one to three physicians. This sales force includes 45 quota-carrying sales representatives, five members of the enterprise team, 18 members of the group team, and 22 members of the small group team. Our sales force is supported by 30 personnel in our marketing organization who provide specialized support for promotional and selling efforts.

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 or geographic regions, which we refer to as channels. We refer to these individuals and organizations as our channel partners. In most cases, these relationships are generally agreements that compensate channel partners for providing us sales lead information that results 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. Other channel relationships permit third parties to act as value-added resellers or as independent sales representatives. In some instances, the channel relationship involves endorsement or promotion of our services by these third parties. In 2009, 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. The agreement shall automatically renew after the initial term for

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successive one year periods unless athenahealth or PSS gives notice of termination no later than sixty days prior to expiration of the then-current term. 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 each client, in order 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 funded $0.3 million toward the establishment of an incentive plan for the PSS sales representatives during the first twelve months of the agreement and are responsible for co-sponsoring training sessions and conducting on-line education for PSS sales representatives.

Under the terms of the agreement, athenahealth s revenue cycle services and clinical cycle services are now the exclusive revenue and clinical cycle solutions sold by PSS, except that PSS may sell clinical cycle services not based on an application service provider model. 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 that 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 are the largest provider of medical and surgical supplies to the physician market in the United States, with a sales force consisting of more than 750 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 execute on this strategy, we have designed and implemented specific activities and programs aimed at converting leads to new clients.

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

- traditional print advertising;
- sponsoring pay-per-click search advertising and other Internet-focused awareness building efforts (such as social media, online videos, webinars, and destination websites covering compliance and other issues of interest to physician practices);
- engaging in public relations activities aimed at generating media coverage;
- participating in industry-focused trade shows;
- disseminating targeted mail, e-mail, and phone calls to physician practices;
- conducting informational meetings (such as strategic retreats with targeted potential clients); and
- dinner seminar series.

In June 2006, we introduced our annual PayerView rankings in order to provide an industry-unique framework to systematically address what we believe is 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 our experience in dealing with individual payers across the nation. The rankings include national payers that meet a minimum yearly threshold of 120,000 charge lines of data and regional payers that meet a minimum yearly threshold of 20,000 charge lines.

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Technology, Development, and Operations

Our primary data center is in Bedford, Massachusetts with Digital 55 Middlesex, LLC (as successor to Sentinel Properties Bedford, LLC) and our production data is housed in systems at our Watertown, Massachusetts and Belfast, Maine offices. As backup to the primary data center, we have a backup data center at our Belfast, Maine offices. In addition, in December 2009 we signed a contract with a major provider of disaster recovery services, SunGard Availability Services, LP, to store our disaster recovery plans, deepen the resiliency of our technology recovery infrastructure, and provide disaster recovery testing services. In the case of a significant event at our primary data center, we could become operational in a reasonable timeframe at our backup data center. The services provided by our data centers and disaster recovery service providers are generally commercially available at comparable rates from other service providers.

Our mission-critical business application is hosted by us and accessed by clients using 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 services. Software licenses for the commercially sourced software are generally available on commercially reasonable terms. The design of our application and database servers is modular and scalable in that, as new clients are added, we are able to add 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 existing clients.

We devote significant resources to innovation. We execute monthly releases of new software functionality to our clients each year. Our software development life cycle methodology ensures that each software release is properly designed, built, tested, and rolled out. Our clients all operate on the same version of our software, although some rules are designed to take effect only locally for particular clients. Our software development activities involve approximately 78 technologists employed by us in the United States as of December 31, 2009. We complement this team s work with software development services from third-party technology development providers in Huntsville, Alabama and Pune, India, and with our own direct employees at our development centers operated through our subsidiaries located in Alpharetta, Georgia, and Chennai, India. In addition to our core software development activities, we dedicate full-time staff to our ongoing development and maintenance of the athenaRules database. On average, over 100 rules are added or revised in our rules engine each month. We also employ process program management 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 business results. We employed approximately 582 people in our service operations dedicated to providing these services to our clients as of December 31, 2009. These employees assist our clients at each critical step in the revenue cycle and clinical cycle workflow process and provide services that include insurance benefits packaging, insurance eligibility confirmation, claims submission, claims tracking, remittance posting, denials management, payment processing, formatting of lab requisitions, submission of lab requisitions, and 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 International Business Machines Corporation and Vision Business Process Solutions Inc., a subsidiary of Dell, Inc. (formerly Perot Systems Corporation), to 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 2009, athenahealth:

- posted approximately $4.9 billion in physician collections;

processed over 40 million medical claims;

handled approximately 96.5 million charge postings; and

sorted over 30 million pages of paper, which amounted to approximately 300,000 pounds of mail.

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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 for athenaCollector, 88.7% 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 our client services center that is designed to address client questions and concerns rapidly, whether those questions and concerns are registered via a phone call or via an online support case through our customized use of customer relationship management technology;

account performance and issue resolution activities performed by the account management organization that are designed to address open issues and focus clients on the financial results of the co-sourcing relationship; these activities are intended to aid in client retention, determine appropriate adjustments to service pricing at renewal dates, and provide incremental services when appropriate; and

relationship management by regional leaders of the client services organization to ensure that decision-makers at client practices are satisfied and that regional performance is managed proactively with regard to client satisfaction, client margins, client retention, renewal pricing, and added services.

The increased burden on patients to pay for a larger percentage of their healthcare services, together with the need for providers to have the ability to determine this patient payment responsibility at the time of service, has led some payers to develop the capability to accept and process claims in real time. Under such a real-time adjudication, or RTA, system, payers notify physicians immediately upon receipt of billing information if third-party claims are accepted or rejected, the amount that will be paid by the payer, and the amount that the patient may owe under the particular health plan involved. This capability is frequently referred to within the industry as real time adjudication because it avoids the processing time that adjudication of claims by payers has historically involved. Taking advantage of this payer capability, we have designed a platform for transacting with payer RTA systems that is payer-neutral and designed to integrate the various payer RTA processes so that our clients experience the same workflow regardless of payer. Using this platform, we have collaborated with two major payers, Humana and United Healthcare, to process RTA transactions with their systems.

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. Other nationwide competitors have begun introducing services that they refer to as on-demand or software-as-a-service models, under which software is centrally hosted and services are provided from central locations. Software and service companies that sell practice management and EHR software and medical billing and collection services include GE Healthcare, Sage Software Healthcare, Inc., Allscripts-Misys Healthcare Solutions, Inc., Siemens Medical Solutions USA, Inc., eClinical Works, LLC, and Quality Systems, Inc. As a service company that provides revenue cycle services, we also compete against large billing companies such as McKesson Corp.; Ingenix, a division of United Healthcare, 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;

ease of use and rates of user adoption;

product functionality and scope of services;

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scope of network connections to support electronic data interactions;

performance, security, scalability, and reliability of service;

sale and marketing capabilities of the 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, as well as 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 than we can in research and development, strategic acquisitions, sales and marketing, and patent prosecution and litigation and to finance capital equipment acquisitions for their customers.

Government Regulation

Although we generally do not contract with U.S. state or local 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

HIPAA Privacy and Security Rules. 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 considered 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 client in question with certain of its duties under the Privacy Rule.

HIPAA 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

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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.

HITECH Act. The HITECH Act, which became law in February 2009, and the regulations issued and to be issued under it have provided and are expected to provide, among other things, clarification of certain aspects of both the Privacy and Security Rules, expansion of the disclosure requirements for a breach of the Security Rule, and strengthening of the civil and criminal penalties for failure to comply with HIPAA. As these additional requirements are adopted, we will be required to comply with them.

State Laws. In addition to the HIPAA Privacy and Security Rules and the requirements imposed by the HITECH Act, 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 and HITECH Act requirements, are not preempted by the federal requirements, and we must comply with them. For example, the Massachusetts Office of Consumer Affairs and Business Regulations issued final data security regulations, which became effective in March 2010 and establish minimum standards for protecting and storing personal information about Massachusetts residents contained in paper or electronic format.

Red Flag Rules. Starting June 1, 2010, medical practices that act as creditors to their patients will need to comply with new Federal Trade Commission rules promulgated under the Fair and Accurate Credit Transactions Act of 2003 that are aimed at reducing the risk of identity theft. These rules require creditors to adopt policies and procedures that identify patterns, practices, or activities that indicate possible identity theft (called red flags); detect those red flags; and respond appropriately to those red flags to prevent or mitigate any theft. The rules also require creditors to update their policies and procedures on a regular basis. Because most practices treat their patients without receiving full payment at the time of service, our clients are generally considered creditors for purposes of these rules and are required to comply with them. Although we are not directly subject to these rules since we do not extend credit to customers we do handle patient data that, if improperly disclosed, could be used in identity theft. Because the red flag rules were originally slated to take effect in November 2008, we have been assisting in our clients efforts to the extent necessary to implement appropriate procedures for some time and plan on continuing to do so.

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 or by increasing our cost of serving clients.

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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; the transactions that we undertake on behalf of our clients; and the financial arrangements through which we market, sell, and distribute our services. 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 government 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 for 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 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.

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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, prevent corporations from being licensed as practitioners, and 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.

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 dependent 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. However, due in part to recent industry initiatives, federal law and the laws of all 50 states now permit the electronic transmission of prescription orders. In addition, on November 7, 2005, the Department of Health and Human Services published its final E-Prescribing and the Prescription Drug Program regulations, referred to below as the 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.

Anti-Tampering Laws

For certain prescriptions that cannot or may not be transmitted electronically from physician to pharmacy, both federal and state laws require that the written forms used exhibit anti-tampering features. For example, the U.S. Troop Readiness, Veterans Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 has since April 2008 required that most prescriptions covered by Medicaid must demonstrate security features that prevent copying, erasing, or counterfeiting of the written form. Because our clients will, on

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occasion, need to use printed forms, we must take these laws into consideration for purposes of the prescription functions of our athenaClinicals service.

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 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, that certifies electronic health record systems as meeting minimum functional and interoperability requirements. Our clinical application functionality is certified by CCHIT under its 2008 criteria. Due to the possible incorporation of CCHIT s criteria into the meaningful use standards under the HITECH Act, such certification may become a *de facto* requirement for selling clinical systems in the future; however, CCHIT s certification requirement may change substantially. While we believe our system is well designed in terms of function and interoperability, we cannot be certain that it will meet future requirements.

United States Food and Drug Administration

The FDA has promulgated a draft policy for the regulation of computer software products as medical devices and a proposed rule for reclassification of medical device data systems under the Federal Food, Drug and Cosmetic Act, as amended, or FDCA. If our computer software functionality is a medical device under the policy or a medical device data system under the rule, we could be subject to the FDA requirements discussed below. Although it is not possible to anticipate the final form of the FDA s policy or final rule with regard to computer software, we expect that the FDA is likely to become increasingly active in regulating computer software intended for use in healthcare settings regardless of whether the draft policy or proposed rule is finalized or changed.

Medical devices are subject to extensive regulation by the FDA under the FDCA. Under the FDCA, medical devices include any instrument, apparatus, machine, contrivance, or other similar or related article that is intended for use in the diagnosis of disease or other conditions or in the cure, mitigation, treatment, or prevention of disease. FDA regulations govern, among other things, product development, testing, manufacture, packaging, labeling, storage, clearance or approval, advertising and promotion, sales and distribution, and import and export. FDA requirements with respect to devices that are determined to pose lesser risk to the public include:

- establishment registration and device listing with the FDA;
- the Quality System Regulation, or QSR, which requires manufacturers, including third-party or contract manufacturers, to follow stringent design, testing, control, documentation, and other quality assurance procedures during all aspects of manufacturing;
- labeling regulations and FDA prohibitions against the advertising and promotion of products for uncleared, unapproved off-label uses and other requirements related to advertising and promotional activities;
- medical device reporting regulations, which require that manufacturers report to the FDA if their device may have caused or contributed to a death or serious injury or malfunctioned in a way that would likely cause or contribute to a death or serious injury if the malfunction were to recur;
- corrections and removal reporting regulations, which require that manufacturers report to the FDA any field corrections and product recalls or removals if undertaken to reduce a risk to health posed by the device or to remedy a violation of the FDCA that may present a risk to health; and

post-market surveillance regulations, which apply when necessary to protect the public health or to provide additional safety and effectiveness data for the device.

Non-compliance with applicable FDA requirements can result in, among other things, public warning letters, fines, injunctions, civil penalties, recall or seizure of products, total or partial suspension of production,

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failure of the FDA to grant marketing approvals, withdrawal of marketing approvals, a recommendation by the FDA to disallow us from entering into government contracts, and criminal prosecutions. The FDA also has the authority to request repair, replacement, or refund of the cost of any device.

Foreign Regulations

Our subsidiary in Chennai, India, is subject to additional regulations by the Government of India, as well as its regional subdivisions. These regulations include Indian federal and local corporation requirements, restrictions on exchange of funds, employment-related laws, and qualification for tax status and tax incentives.

Intellectual Property

We rely on a combination of patent, trademark, copyright, and trade secret laws in the United States as well as confidentiality procedures and contractual provisions to protect our proprietary technology, databases, and our brand. Despite these reliances, we believe the following factors are more essential to establishing and maintaining a competitive advantage:

- the statistical and technological skills of our service operations and research and development teams;
- the healthcare domain expertise and payer rules knowledge of our service operations and research and development teams;
- the real-time connectivity of our solutions;
- the continued expansion of our proprietary rules engine; and
- a continued focus on the improved financial results of our clients.

Our first patent application described and documented our unique patient workflow process, including the athenaNet Rules Engine, which applies proprietary rules to practice and payer inputs on a live, ongoing basis to produce cleaner healthcare claims, which can be adjudicated more quickly and efficiently. This patent application was granted in November 2009 and expires in December 2023. We have filed seven subsequent patent applications and two provisional patent applications that describe and document other unique aspects of our functionality and workflow processes during calendar years 2006 through 2009 and are currently pending before the United States Patent and Trademark Office. We also acquired one patent application each in connection with the acquisitions of MedicalMessaging.net in September 2008 and Anodyne in October 2009.

We also rely on a combination of registered and unregistered service marks to protect our brands. athenahealth, athenaNet, and the athenahealth logo are registered service marks of athenahealth. In 2009, we applied for the registration of athenaClinicals, athenaCollector, athenaCommunicator, and PayerView as service marks of athenahealth, and we are currently corresponding with the examiner to resolve some technical issues. Additionally, athenaEnterprise, athenaRules, and ReminderCall are service marks of athenahealth, and in connection with the acquisition of Anodyne we acquired Anodyne Analytics and Anodyne Intelligence Platform as service marks.

We have a policy of requiring key employees and consultants to execute confidentiality agreements upon the commencement of an employment or consulting relationship with us. Our employee agreements also require relevant employees to assign to us all rights to any inventions made or conceived during their employment with us. In addition, we have a policy of requiring individuals and entities with which we discuss potential business relationships to sign non-disclosure agreements. Our agreements with clients include confidentiality and non-disclosure provisions.

Employees

As of December 31, 2009, we had 1,035 employees. Of these employees, 966 were employed in the U.S., including 582 in service operations, 124 in sales and marketing, 139 in research and development, and 121 in general and administrative functions. In addition, as of that date, we had 68 employees located in Chennai, India, who were employed by our foreign subsidiary, athenahealth Technology Private Limited, including

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thirteen in service operations, 42 in research and development, and thirteen in general and administrative functions. As of the same date, our domestic operating subsidiary, Anodyne had 37 U.S. employees, of whom seventeen were in service operations, ten were in sales and marketing, three were in research and development, and seven provided general and administrative services. We believe that we have good relationships with our employees. None of our employees are subject to collective bargaining agreements or are represented by a union.

Organization and Trademarks

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. In this Annual Report on Form 10-K, the terms athena, athenahealth, we, us, and our refer to athenahealth, Inc. and its subsidiaries, Anodyne Health Partners, Inc., athenahealth MA, Inc., and athenahealth Technology Private Limited, and any subsidiary that may be acquired or formed in the future.

Our marks include athenahealth, athenaNet, and the athenahealth logo as registered service marks; Anodyne Analytics, Anodyne Intelligence, athenaClinicals, athenaCollector, athenaCommunicator, athenaEnterprise, athenaRules, PayerView, and ReminderCall, as unregistered service marks. This Annual Report on Form 10-K also includes the registered and unregistered trademarks and service marks of other persons.

Financial Information

The financial information required under this Item 1 is incorporated herein by reference to Part II, Item 8 of this Annual Report on Form 10-K.

Where You Can Find More Information

Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are available through the investor relations portion of our website (*www.athenahealth.com*) free of charge as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission, or SEC. As discussed in Explanatory Note Regarding Restatement, financial information included in the reports on Form 10-K, Form 10-Q, and Form 8-K filed by us prior to March 15. 2010, and all earnings press releases and similar communications issued by us prior to March 15, 2010, should not be relied upon and are superseded in their entirety by this Annual Report on Form 10-K. Information on our investor relations page and on our website is not part of this Annual Report on Form 10-K or any of our other securities filings unless specifically incorporated herein by reference. In addition, our filings with the Securities and Exchange Commission may be accessed through the Securities and Exchange Commission s Interactive Data Electronic Applications (IDEA) system at www.sec.gov. All statements made in any of our securities filings, including all forward-looking statements or information, are made as of the date of the document in which the statement is included, and we do not assume or undertake any obligation to update any of those statements or documents unless we are required to do so by law.

Item 1A. ***Risk Factors.***

Our operating results and financial condition have varied in the past and may in the future vary significantly depending on a number of factors. Except for the historical information in this report, the matters contained in this report include forward-looking statements that involve risks and uncertainties. The following factors, among others, could cause actual results to differ materially from those contained in forward-looking statements made in this report and presented elsewhere by management from time to time. Such factors, among others, may have a material adverse

effect upon our business, results of operations, and financial condition.

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RISKS RELATED TO OUR BUSINESS

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 the 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;
- the 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 and maintain an adequate 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.

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.

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Revenue cycle software for physician practices has historically been dominated by large, well-financed and technologically sophisticated entities that have focused on software solutions. Some of these entities are now offering on-demand services or a software-as-a-service model under which software is centrally administered, and administrative services may be provided on a vendor basis. The size, financial strength, and breadth of offerings 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 possess.

Some of our current large competitors, such as GE Healthcare, Sage Software Healthcare, Inc., Allscripts-Misys 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. Current or future competitors may consolidate to improve the breadth of their products, directly competing with our integrated offerings. Accordingly, new competitors or alliances may emerge that have greater market share, larger client bases, more widely adopted proprietary technologies, broader offerings, 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 with 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 that offer ease of integration with existing systems and that leverage existing vendor relationships.

The market for our services is relatively immature and volatile, and if it does not develop further 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 still relatively new and narrowly based, and it is uncertain whether these services will achieve and sustain high levels of demand and market acceptance. Our success 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 expand as much or develop as quickly as we expect, either of which would significantly adversely affect our operating results. In addition, as a relatively new company in the healthcare business services 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

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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. In some cases, especially those involving larger clients, the sales cycle and the implementation cycle may exceed the typical ranges by substantial margins. During the implementation cycle, we expend substantial time, effort, and financial resources implementing our services, 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 an expected attribution period of the longer of the estimated expected customer life, currently twelve years, or the contract term. 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 services have 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 the needs and requirements of the client, delays with payer processing, and the volume and complexity of the implementations 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, or if our clients cancel or elect not to renew their contracts, 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;

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failure of our clients to adopt or maintain effective business practices;

actions by third-party payers of medical claims to reduce reimbursement;

government regulations and government or other payer actions reducing or delaying reimbursement; and

reduction of client revenue resulting from increased competition or other changes in the marketplace for physician services.

The current economic situation may give rise to several of these factors. For example, patients who have lost health insurance coverage due to unemployment or who face increased deductibles imposed by financially struggling employers or insurers could reduce the number of visits those patients make to our physician clients. Patients without health insurance or with reduced coverage may also default on their payment obligations at a higher rate than patients with coverage. Added financial stress on our clients could lead to their acquisition or bankruptcy, which could cause the termination of some of our service relationships. Further, despite the cost benefits that we believe our services provide, prospective clients may wish to delay contract decisions due to implementation costs or be reluctant to make any material changes in their established business methods in the current economic climate. With a reduction in tax revenue, state and federal government health care programs, including reimbursement programs such as Medicaid, may be reduced or eliminated, which could negatively impact the payments that our clients receive. Also, although we currently estimate our expected customer life to be twelve years, this is only an estimate and there can be no assurance that our clients will elect to renew their contracts for this period of time. Our clients typically purchase one-year contracts that, in most cases, may be terminated on 90 days notice without cause. If our clients revenue decreases for any of the above or other reasons, or if our clients cancel or elect not to renew their contracts, our revenue will decrease.

We may not see the benefits of, or have our services approved under, government programs initiated to counter the effects of the current economic situation or foster the adoption of certain health information technologies, which could reduce client demand, trigger certain guarantee obligations, and affect our access to the market.

Although government programs have been initiated to counter the effects of the current economic situation and foster the adoption of certain health information technologies, we cannot assure you that we will receive any funds from, or have our services approved under, those programs. For example, the HITECH Act has authorized approximately $17 billion in expenditures to further adoption of electronic health records, and entities such as the Massachusetts Healthcare Consortium have offered to subsidize such adoption, as permitted by recent changes in federal regulations.

While we believe that our service offerings will meet the requirements of the HITECH Act and other programs in order for our clients to qualify for additional reimbursement for implementing and using our services, there can be no certainty that any of the planned additional reimbursements, if made, will be made in regard to our services. To the extent that we do not qualify for or participate in such subsidy programs, demand for our services may be reduced, which may result in decreased revenues, perhaps material decreases. Furthermore, we have offered certain existing and prospective clients a guarantee that they will receive Medicare incentive reimbursement under the 2011 HITECH Act program year for meaningful use of our athenaClinicals EHR service. If such reimbursements are delayed or not made because of a failure on our part, we could be obligated to credit up to six months of our EHR services fees for each client participating in our guarantee program.

In addition, if our services are not approved or included as a preferred solution under certain programs, our access to the market could be reduced. For example, the Health Information Technology Extension Program under the HITECH Act provides for 70 or more regional centers that will assist local healthcare providers in selecting and using EHR

products and services. If any of our services are not approved, or not included in a list of preferred products and services, under one or more programs, demand for our services and our access to the market could be reduced, which could have a material adverse effect on our business, including a material decrease in revenues and possibly market share.

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If participants in our channel marketing and sales lead programs do not maintain appropriate relationships with current and 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 or if our requirements are deemed insufficient, sales accomplished with the data or help that they have provided as well as the channel relationship themselves may not be enforceable, may be unwound, and may be deemed to violate relevant laws or regulations. Third parties that, despite our requirements, exercise undue influence over decisions by current and prospective clients, occupy positions with obligations of fidelity or fiduciary obligations to current and prospective clients, or who offer bribes or kickbacks to current and prospective clients or their employees may be committing wrongful or illegal acts that could render any resulting contract between us and the client unenforceable or in violation of relevant laws or regulations. Any misconduct by these third parties with respect to current or prospective clients, any failure to follow contractual requirements, or any insufficiency of those contractual requirements 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, require us to change or terminate some portions of our business, require us to refund portions of our services fees, and adversely affect 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 investors to reduce their expectations of our performance, resulting in reduction in the market price of our stock.

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 and financial and accounting systems and controls, as well as 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; result in weaknesses in our infrastructure, systems, or controls; give rise to operational mistakes, losses, or loss of productivity or business opportunities; and 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 two third-party service providers for important processing functions. If either of these third-party providers 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 service agreements with International Business Machines Corporation and Vision Business Process Solutions Inc., a subsidiary of Dell, Inc. (formerly Perot Systems Corporation), to provide data entry and other

services from facilities located in India and the Philippines to support our client service operations. Among other things, these providers process critical claims data and clinical documents. If these services fail or are of poor quality, our business, reputation, and operating results could be harmed. Failure of

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either service provider to perform satisfactorily could result in client dissatisfaction, disrupt our operations, and adversely affect operating results. With respect to these service providers, we have significantly less control over the systems and processes involved 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 affect our worldwide operations, exposing us to significant costs.

We conduct operations throughout the world, including the United States, India, and the Philippines, either directly or through our service providers. Such worldwide operations expose us to potential operational disruptions and costs as a result of a wide variety of events, including local inflation or economic downturn, currency exchange fluctuations, political turmoil, terrorism, labor issues, natural disasters, and pandemics. Any such disruptions or costs could have a negative effect on our ability to provide our services or meet our contractual obligations, the cost of our services, client satisfaction, our ability to attract or maintain clients, and, ultimately, our profits.

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 senior sales executives and engineers with high levels of experience in designing and developing software and Internet-related services. 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 equity awards 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 requirements to expense equity awards may discourage us from granting the size or type of equity 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;
- the risk of entering new markets in which we have little to no experience;

risks related to the assumption of known and unknown liabilities;

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the risk of write-offs and the amortization of expenses related intangible assets 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.

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 or as a result of the current condition of the equity and debt markets limited financing may be available, 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.

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 incur additional related costs and expenses, and our future sales may decrease.

We may lose sales or incur significant expenses should states be successful in imposing state sales and use taxes on our services. 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

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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.

We may also become subject to tax audits or similar procedures in states where we already pay sales and use taxes. For example, in October 2007, we received an audit notification from the Commonwealth of Massachusetts Department of Revenue requesting materials relating to the amount of use tax we paid on account of our purchases for the audit periods between January 1, 2004, and December 31, 2006. The audit was resolved in 2008. We paid a liability of approximately $0.1 million in connection with this audit. The incurrence of additional accounting and legal costs and related expenses in connection with, and the assessment of taxes, interest, and penalties as a result of, audits, litigation, or otherwise could be materially adverse to our current and future results of operations and financial condition.

From time to time we may become subject to income tax audits or similar proceedings, and as a result we may incur additional costs and expenses or owe additional taxes, interest, and penalties in amounts that may be material.

We are subject to income taxes in the United States at both the federal and state levels. In determining our provision for income taxes, we are required to exercise judgment and make estimates where the ultimate tax determination is uncertain. While we believe that our estimates are reasonable, we cannot assure you that the final determination of any tax audit or tax-related litigation will not be materially different from that reflected in our income tax provisions and accruals. The incurrence of additional accounting and legal costs and related expenses in connection with, and the assessment of taxes, interest, and penalties as a result of, audits, litigation, or otherwise could be materially adverse to our current and future results of operations and financial condition.

In December 2009, the IRS completed the audit of our 2006, 2007, and 2008 tax returns commenced earlier in the year and found that no amounts were due from us in connection with either return.

Unanticipated changes in our tax rates or our exposure to additional income tax liabilities could affect our operating results and financial condition.

Our future effective tax rates could be favorably or unfavorably affected by unanticipated changes in the valuation of our deferred tax assets and liabilities, the geographic mix of our revenue, or changes in tax laws or their interpretation. Significant judgment is required in determining our provision for income taxes. In addition, we are subject to the continuous examination of our income tax returns by tax authorities. We regularly assess the likelihood of adverse outcomes resulting from these examinations to determine the adequacy of our provision for income taxes. There can be no assurance, however, that the outcomes from these continuous examinations will not have an adverse effect on our operating results and financial condition. Additionally, due to the evolving nature of tax rules combined with the number of jurisdictions in which we operate, it is possible that our estimates of our tax liability and our ability to realize our deferred tax assets could change in the future, which may result in additional tax liabilities and adversely affect our results of operations, financial condition, and cash flows.

The results of our review of our revenue recognition practices and resulting restatement may continue to have adverse effects on our financial results.

Our review of our revenue recognition practices and our restatement of our historical financial statements have resulted in the deferral of previously recognized revenue and have required and may continue to require us to expend significant management time and incur significant accounting, legal, and other expenses, all of which may have an adverse effect on our financial results.

As a result of our revenue recognition review and related restatement, approximately $22.3 million of implementation services revenue previously recognized through September 30, 2009, will be deferred to periods after that date. See the Explanatory Note Regarding Restatement immediately preceding Item 1 of Part I; Part II, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations ; and Note 2, Restatement and Reclassification of Previously Issued Consolidated Financial Statements, and Note 20, Summarized Quarterly Unaudited Financial Data, in Notes to Consolidated

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Financial Statements in Part II, Item 8 for further discussion. The accounting, legal, and other expenses associated with this restatement may also have a material adverse effect on our results of operations.

In addition, future private or government actions may be brought against us or our current or former officers relating to a failure to apply generally accepted accounting principles in the reporting of quarterly and annual financial statements and securities prospectuses from the time of our initial public offering to our most recent filing with the SEC. Such actions could have a material adverse effect on our business, financial condition, results of operations, and cash flows and the trading price for our securities. Litigation would be time-consuming, expensive, and disruptive to normal business operations, and the outcome of litigation is difficult to predict. The defense of any litigation would result in significant expenditures and the continued diversion of our management s time and attention from the operation of our business, which could impede our business. In addition, while we maintain standard directors and officers insurance, all or a portion of any amount we may be required to pay to satisfy a judgment or settlement of any or all of these claims may not be covered by insurance.

We cannot be certain that the measures we have taken that address this restatement will ensure that restatements will not occur in the future. Execution of restatements like the one described above could create a significant strain on our internal resources, cause delays in our filing of quarterly or annual financial results, increase our costs, and cause management distraction.

We have identified a material weakness in our internal control over financial reporting, which has required us to incur substantial costs and diverted management resources in connection with our efforts to remediate this material weakness

In connection with our internal accounting policy review of our revenue recognition policies for the fiscal year ended December 31, 2009, and as discussed in Item 9A, Controls and Procedures, of this Annual Report on Form 10-K, we have identified a control deficiency relating to the application of generally accepted accounting principles to revenue recognition. Management has concluded that this control deficiency constituted a material weakness in internal control over financial reporting as of December 31, 2009. A material weakness in internal control over financial reporting is one or more deficiencies in process that create a reasonable possibility that a material misstatement of a company s annual or interim financial statements will not be prevented or detected on a timely basis. The deficiency in the application of our controls relating to the review of our revenue recognition policy resulted in a reasonable possibility that a material misstatement of our financial statements would not have been prevented or detected by us in the normal course of our financial statement close process.

We have discussed the identified control deficiency in our financial reporting and the remediation of such deficiency with the audit committee of our board of directors and will continue to do so as necessary. We believe that recent key additions to our financial staff, the use of external experts, and revisions to our internal training programs have remediated this control deficiency. However, we cannot be certain that the remedial measures that we have taken will ensure that we maintain adequate controls over our financial reporting in the future and, accordingly, additional material weaknesses could occur or be identified. Any future deficiencies could materially and adversely affect our ability to provide timely and accurate financial information, and the current and future deficiencies may impact investors confidence in our internal controls and our company, which could cause our stock price to decline.

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 one issued U.S. patent and have nine

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more U.S. patent applications and two provisional patent applications pending, we may be unable to obtain further meaningful patent protection for our technology. In addition, any patents issued in the future 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 that 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. Although we settled this case in 2008, the prospect of similar litigation remains. Our technologies may not be able to withstand third-party claims of rights against their use. Any intellectual property claims, with or without merit, could be time-consuming and expensive to resolve, divert management attention from executing our business plan, and 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 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

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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.

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

We have loan and capital lease agreements with $12.4 million outstanding at December 31, 2009. 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 loan agreements also contain certain financial and nonfinancial covenants, including limitations on our consolidated leverage ratio and capital expenditures, as well as defaults relating to non-payment, breach of covenants, inaccuracy of representations and warranties, default under other indebtedness (including a cross-default with our interest rate swap), bankruptcy and insolvency, inability to pay debts, attachment of assets, adverse judgments, ERISA violations, invalidity of loan and collateral documents, and change of control. 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 these covenants could result in a default under either or both of the loan agreements, 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 have entered into a derivative contract with a financial counterparty, the effectiveness of which is dependent on the continued viability of this financial counterparty, and its nonperformance could harm our financial condition.

We have entered into an interest rate swap contract as part of our strategy to mitigate risks related to fluctuations in cash flow from movement in interest rates. The effectiveness of our hedging programs using this instrument is dependent, in part, upon the counterparty to this contract honoring its financial obligations. The recent upheaval in the capital markets has caused the viability of certain counterparties to be questioned. While we have not experienced any losses due to counterparty nonperformance, if our counterparty is unable to perform its obligations in the future, we could be exposed to increased earnings and cash flow volatility.

We may incur additional costs as a result of continuing to operate as a public company, and our management may be required to devote substantial time to new compliance initiatives.

As a public company, we incur significant legal, accounting, and other expenses that we did not incur as a private company, and greater expenditures may be necessary in the future with the advent of new laws and regulations pertaining to public companies. In addition, the Sarbanes-Oxley Act of 2002, as well as rules subsequently implemented by the Securities and Exchange Commission and the NASDAQ Global Select Market, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel continue to devote a substantial amount of time to these compliance initiatives, and additional laws and regulations may divert further management resources. Moreover, if we are not able to comply with the requirements of new compliance initiatives in a timely

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manner, the market price of our stock could decline, and we could be subject to sanctions or investigations by the NASDAQ Global Select Market, the Securities and Exchange Commission, or other regulatory authorities, which would require additional financial and management resources.

Changes in accounting standards issued by the Financial Accounting Standards Board (FASB) or other standard-setting bodies may adversely affect our financial statements.

Our financial statements are subject to the application of U.S. GAAP, which are periodically revised or expanded. Accordingly, from time to time we are required to adopt new or revised accounting standards issued by recognized authoritative bodies, including the FASB and the SEC. It is possible that future accounting standards we are required to adopt could change the current accounting treatment that we apply to our consolidated financial statements and that such changes could have a material adverse impact on our results of operations and financial condition.

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, be sufficient for one or more such claims, or 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 software or our services 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 receipt, entry, or interpretation of patient information or from interface of our services with legacy systems and data that 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.

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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 patients and thereby harm our business and operating results.

Our clients or their patients may assert claims against us 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 services may be perceived as not being secure, clients may curtail or stop using our services, and we may incur significant liabilities.

Our services involve 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, insufficiency, defective design, 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. 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. Failure of clients to perform these activities may result in claims against us that this reliance was misplaced, 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 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 propriety of that access or 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, and analyses or limit 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 administering care, 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,

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including redundant infrastructure, disaster recovery plans, business continuity 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 that 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 services and harm our business.

We currently serve our clients from a third-party data-hosting facility located in Bedford, Massachusetts, operated by Digital 55 Middlesex, LLC (as successor to Sentinel Properties-Bedford, LLC). In addition, in December 2009 we signed a contract with a major provider of disaster recovery services, SunGard Availability Services, LP, to store our disaster recovery plans, deepen the resiliency of our technology recovery infrastructure, and provide disaster recovery testing services. In the case of a significant event at our primary data center, we could become operational in a reasonable timeframe at our backup data center.

However, 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 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 services could be interrupted.

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- and telecommunications-based services is dependent on the development and maintenance of the infrastructure of the Internet and other telecommunications services 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 and reliable telephone, facsimile, and pager systems. 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, bandwidth, and telecommunications equipment 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;

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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, telecommunications, 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.

We rely on third-party computer hardware and software that may be difficult to replace or that could cause errors or failures of our services, 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 services, including database software from Oracle Corporation and storage devices from International Business Machines Corporation and EMC 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 services 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 services, 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 that we cannot control and that could damage our reputation with clients and result in liability claims that increase our expenses.

We offer certain electronic claims submission services for which 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 any of our services 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.

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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 that 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, be binding upon patients, or 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 that 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, cause us to incur additional costs, and 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

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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 described below:

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), adversely affect demand for our services, and 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. Any determination by a court or regulatory agency that our services violate these laws could subject us to civil or criminal penalties, invalidate all or portions of some of our client contracts, require us to change or terminate some portions of our business, require us to refund portions of our services fees, cause us to be disqualified from serving clients doing business with government payers, and 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.

In addition, we may contract with third parties that offer software relating to the selection or verification of codes used to identify and classify the services for which reimbursement is sought. Submission of codes that do not accurately reflect the services provided or the location or method of their provision may constitute a violation of false or fraudulent claims laws. Our ability to comply with these laws depends on the coding decisions made by our clients and the accuracy of our vendors software and services in suggesting possible codes to our clients and verifying that proper codes have been selected.

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 implementing 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, 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 except 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 other than as provided for in the agreement;

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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 of 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 laws or regulations might be made in the future or how those changes could affect our business or the costs of compliance. For example, the provisions of the HITECH Act and the regulations issued under it have provided and are expected to provide clarification of certain aspects of both the Privacy and Security Rules, expansion of the disclosure requirements for a breach of the Security Rule, and strengthening of the civil and criminal penalties for failure to comply with HIPAA. In addition, the federal Office of the National Coordinator for Health Information Technology, or ONCHIT, is coordinating the ongoing 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 changes in 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 as a condition of effecting transactions, 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 dependent on the proper conduct of our clients.

Among our services, we provide telephone reminder services to patients, Internet- and telephone-based access to medical test results, pager and email notification to practices of patient calls, and patient call answering services. We believe that reasonable efforts to prevent disclosure of individually identifiable health information have been and are being taken in connection with these services, including the use of multiple-password security. However, any failure of our clients to provide accurate contact information for their patients or physicians or any breach of our telecommunications systems could result in a disclosure of individually identifiable health information.

In addition to the HIPAA Privacy and Security Rules and the HITECH Act requirements, 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 and HITECH Act requirements, are not preempted by the federal requirements, and 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.

We are subject to a variety of other regulatory schemes, including:

Red Flag Rules. Although the federal and state laws regarding patient privacy help to maintain the confidentiality of personal information that could be used in identity theft, they were not drafted with that risk in mind. To fill this gap, the Federal Trade Commission has issued new rules under the Fair and Accurate Credit Transactions Act of 2003 that go into effect on June 1, 2010. These rules require medical practices that act as creditors to their patients to adopt policies and procedures that identify

patterns, practices, or activities that indicate possible identity theft (called red flags); detect those red flags; and respond appropriately to those red flags to prevent or mitigate any theft. The rules also require creditors to update their policies and procedures on a regular basis. Because most practices treat their patients without receiving full payment at the time of service, our clients are generally considered creditors for purposes of these rules and are required to comply with them. Although we are not directly subject to these rules since we do not extend credit to customers we do handle patient data that, if improperly disclosed, could be used in identity theft. If we are not successful in assisting our clients in implementing necessary procedures, 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, vendors, or channel partners violate any of these laws could subject us to civil or criminal penalties, require us to change or terminate some portions of our business, require us to refund a portion of our service fees, disqualify us from providing services to clients doing business with government programs, and 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 a 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 with health care providers. In many cases, billing for care arising from such actions is illegal. These vary widely from state to state, and one of the federal laws called 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, require us to change or terminate some portions of our business, require us to refund portions of our services fees, and 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 a costly response from us.

Corporate Practice of Medicine Laws and Fee-Splitting Laws. Many states have laws forbidding 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, invalidate all or portions of some of our client contracts, require us to change or terminate some portions of our business, require us to refund portions of our services fees, and 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 a costly response from us.

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

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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, invalidate all or portions of some of our client contracts, require us to change or terminate some portions of our business, require us to refund portions of our services fees, and 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 a costly response from us.

Prescribing Laws. The use of our software by physicians to perform a variety of functions relating to prescriptions, 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, and, due in part to recent industry initiatives, federal law and the laws of all 50 states now provide a regulatory framework for the electronic transmission of prescription orders. 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 EHR technologies. Any 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 how such technology is provided. As a company that provides EHR 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 CCHIT criteria for ambulatory electronic health records for 2008. Due to the possible incorporation of CCHIT s criteria into the meaningful use standards under the HITECH Act such certification may become a *de facto* requirement for selling EHR systems in the future; however, CCHIT s certification requirements may change substantially. ONCHIT may approve another certification body for EHRs and we plan on meeting ONCHIT certification criteria. While we believe that our system is well designed in terms of function and interoperability, we cannot be certain that it will meet future requirements.

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 overbills or bills for items that have not been provided to the patient. Although we do not determine what is billed to a payer, to the extent that such laws apply to a service that merely transmits claims on behalf of others, we could be subject to the same civil and criminal penalties as our clients.

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 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;

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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 such as service investigation and others relating to approval, labeling, and manufacturing. In addition, the FDA can impose extensive requirements governing development controls and quality assurance processes.

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

Our services may be significantly impacted by healthcare reform initiatives and are subject to increasing regulatory requirements, either of which could affect our business in a multitude of ways. If substantive healthcare reform or applicable regulatory requirements are adopted, we may have to change or adapt our services and software to comply. Reform or 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 adapt to the new operating environment 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. Such changes may even prevent introduction by us of new services or make the continuation of our existing services unprofitable 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 providers, International Business Machines Corporation and Vision Business Process Solutions Inc., 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.

Changes in the healthcare industry could affect the demand for our services, cause our existing contracts to terminate, and negatively impact the process of negotiating future contracts.

As the healthcare industry evolves, changes in our client and vendor bases may reduce the demand for our services, result in the termination of existing contracts, and make it more difficult to negotiate new contracts on terms that are acceptable to us. For example, the current trend toward consolidation of healthcare providers within hospital systems may cause our existing client contracts to terminate as independent practices are merged into hospital systems. Such larger healthcare organizations may also have their own practice management services and health IT systems, reducing demand for our services. Similarly, client and vendor consolidation results in fewer, larger entities with increased bargaining power and the ability to demand terms that are unfavorable to us. If these trends continue, we cannot assure you that we will be able to continue to maintain or expand our client base, negotiate contracts with acceptable terms, or maintain our current pricing structure, and our revenues may decrease.

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

We require our clients to provide us with accurate and appropriate data and directives for our actions. We also rely upon our clients as users of our system to perform key activities in order to produce proper claims for reimbursement. Failure of our clients to provide these data and directives or to perform these activities may result in claims against us alleging that our reliance was misplaced or unreasonable or that we have facilitated or otherwise participated in submission of false claims.

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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 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. In addition, we could be perceived to have facilitated or participated in illegal misappropriation of funds, documents, or data and therefore be subject to civil or criminal liability.

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, and the current administration has passed the HITECH Act, which will provide federal support for EHR initiatives. 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 OWNERSHIP OF OUR COMMON STOCK

An orderly market for our common stock may not be sustained.

The trading price of our common stock has been and is likely to remain 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 Annual Report on Form 10-K, 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. 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.

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If a substantial number of shares become available for sale and are sold in a short period of time, the market price of our common stock could decline.

If our existing stockholders sell a large number of shares of our common stock or the public market perceives that these sales may occur, the market price of our common stock could decline. As of December 31, 2009, we had approximately 33.9 million shares of common stock outstanding. Moreover, the holders of shares of common stock 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 have also registered 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. As of December 31, 2009, we had outstanding options to purchase approximately 3.4 million shares of common stock (approximately 1.6 million of which were exercisable at December 31, 2009) that, if exercised, will result in those shares becoming available for sale in the public market. If a large number of these shares are sold in the public market, the sales could reduce the trading price of our common stock.

Actual or potential sales of our stock by our employees, including members of our senior management team, pursuant to pre-arranged stock trading plans could cause our stock price to fall or prevent it from increasing for numerous reasons, and actual or potential sales by such persons could be viewed negatively by other investors.

In accordance with the guidelines specified under Rule 10b5-1 of the Securities and Exchange Act of 1934 and our policies regarding stock transactions, a number of our employees, including members of our senior management team, have adopted and will continue to adopt pre-arranged stock trading plans to sell a portion of our common stock. Generally, stock sales under such plans by members of our senior management team and directors require public filings. Actual or potential sales of our stock by such persons could cause our stock price to fall or prevent it from increasing for numerous reasons. For example, a substantial amount of our common stock becoming available (or being perceived to become available) for sale in the public market could cause the market price of our common stock to fall or prevent it from increasing. Also, actual or potential sales by such persons could be viewed negatively by other investors.

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. As our board of directors has the ability to designate

the terms of and issue new series of preferred stock without stockholder approval, the effective number of votes required to make such changes could increase. 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.

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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 an entity that, together with its affiliates, owns, or within the last three years has owned, 15% or more of our voting stock) for a period of three years after the date of the transaction in which the entity 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.

Item 1B.