Company Information and Disclosure Statement

PPJ Healthcare Enterprises, Inc.
A Florida Corporation
(Formerly PPJ Enterprise until November 2014,
formerly Winfield Financial Group, Inc. until December 2005,
formerly Healthcare Business Services Group, Inc. until April 2008)
401 E. Jackson Street, Suite 2340, Tampa, FL 33602
Phone (813) 693-5192, Fax (866) 622-3215
website: www.ppjenterprise.com

Federal EIN:
SIC Code: 7389 - Business services, misc.

PERIOD ENDING September 30, 2016

Common Stock
$0.00001 Par Value per Share
10,000,000,000 Authorized
3,802,203,338
Issued and Outstanding
OTC Markets Symbol: PPJE
CUSIP No. 35369D407

Class A Non-Dilutive Common Stock
$0.0001 Par Value per Share
10,000,000,000 Authorized
None Issued
(This Class of shares authorized to cover shareholders' loss)

Class A Preferred Stock
$10.00 Par Value per Share
5,000,000 Authorized
None issued and outstanding

Class B Preferred Stock
$2.50 Par value per Share
50,000,000 Authorized
2,118,000 Issued and outstanding

Class E Preferred Stock
$.01 Par value per Share
100,000,000 Authorized
10,005,000 issued and outstanding

PPJ Healthcare Enterprises, Inc. is responsible for the content of this Report. The securities described in this document are not registered with, and the information contained in this report has not been filed with, or approved by, the U.S. Securities and Exchange Commission.

The Company recently made a one for 100 reverse split of the Common Stock, payable July 25, 2016. The numbers in these financial statements do not reflect this reverse split.

TABLE OF CONTENTS

Part A		**General Company Information**	**Page #**
	Item 1	The exact name of the Issuer and its predecessor (if any)	6
	Item 2	The address of the Issuer's principal executive offices	6
	Item 3	The jurisdiction(s) and date of the Issuer's incorporation or organization	6
Part B		**Share Structure**	
	Item 4	The exact title and class of securities outstanding	6
	Item 5	Par or stated value and description of the security	7
	Item 6	The number of shares or total amount of the securities	20

		outstanding for each class of securities authorized	
	Item 7	The name and address of the transfer agent	21
Part C		**Business Information**	
	Item 8	The nature of the issuer's business	21
	Item 9	The nature of products or services offered	27
	Item 10	The nature and extent of the issuer's facilities	53
Part D		**Management Structure and Financial Information**	
	Item 11	The name of the chief executive officer, members of the board of directors, as well as control persons	98
	Item 12	Financial information for the issuer's most recent fiscal period	102
	Item 13	Similar financial information for such part of the two preceding fiscal years as the issuer or its predecessor has been in existence	102
	Item 14	Beneficial Owners	102
	Item 15	The name, address, telephone number, and email address of certain outside providers that advise the issuer on matters relating to the operations, business development and disclosure.	103
	Item 16	Management's Discussion and Analysis or Plan of Operation	104
Part E		**Issuance History**	
	Item 17	List of securities offerings and shares issued for services in the past two years	106
Part F		**Exhibits**	
	Item 18	Material Contracts	109
	Item 19	Articles of Incorporation and By-Laws	109
	Item 20	Purchases of Equity Securities by the Issuer and Affiliated Purchasers	109
	Item 21	Issuer's Certifications	110

PPJ Healthcare Enterprises, Inc.
A Florida Corporation
(Formerly PPJ Enterprise until November 2014,
formerly Winfield Financial Group, Inc. until December 2005,
formerly Healthcare Business Services Group, Inc. until April 2008)
401 E. Jackson Street, Suite 2340, Tampa, FL 33602
Phone (813) 693-5192, Fax (866) 622-3215
website: www.ppjenterprise.com

Federal EIN: 880-47-8644
SIC Code: 7389 - Business services, misc

September 30, 2016 REPORT

Cautionary Note Regarding Forward-Looking Statements

Information set forth in this updated September 30, 2016 Report (the "Report") contains forward-looking statements, which involve several risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Forward-looking statements can be identified using the words "expect," "project," "may," "might," potential," and similar terms. PPJ Healthcare Enterprises, Inc. ("PPJ Healthcare Enterprises," "we," the "Issuer" or the "Company") cautions readers that any forward-looking information is not a guarantee of future performance and that actual results could differ materially from those contained in the forward-looking information. Forward-looking statements involve several risks, uncertainties or other factors beyond our control. These factors include, but are not limited to, our ability to implement our strategic initiatives, economic, political and market conditions and price fluctuations, government and industry regulation, U.S. and global competition, and other factors. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, readers are cautioned not to place undue reliance on such forward-looking statements. We undertake no obligation to update any forward-looking statement, whether because of new information, future events or otherwise.

Section One: Issuers' Initial Disclosure Obligations

Part A General Company Information

Item 1 The exact name of the issuer:

PPJ Healthcare Enterprises, Inc. (hereinafter referred to as "PPJE," or "PPJ Healthcare Enterprises," or the "Company," the "Issuer," or "We" or "Us"), formerly PPJ Enterprise until November 2014, formerly Winfield Financial Group, Inc. until December 2005, formerly Healthcare Business Services Group, Inc. until April 2008.

Item 2 The Address of the Issuer's Principal Executive Offices

PPJ Healthcare Enterprises, Inc.
401 E. Jackson Street, Suite 2340
Tampa, FL 33602
Phone (813) 693-5192, Fax (866) 622-3215
website: www.ppjenterprise.com

Federal EIN: 880-47-8644
SIC Code: 7389 - Business services, misc.

Item 3 The Jurisdiction(s) and Date of the Issuer's Incorporation or Organization:

The Company, sometimes referred to herein as "we," "us," "our," and the "Company" and/or "PPJ Healthcare Enterprises" was incorporated on November 7, 2014, under the laws of the State of Florida, to engage in any lawful corporate undertaking.

Part B. Share Structure

Item 4 The Exact Title and Class of Securities Outstanding:

The Company recently made a one for 100 reverse split of the Common Stock, payable July 25, 2016. The numbers in these financial statements do not reflect this reverse split.

Common Stock
$0.0001 Par Value per Share
Twenty Billion (20,000,000,000) Authorized
4,002,203,338 Shares Issued and Outstanding as of November 7, 2016
Restricted shares 3,725,554,267
Public Float 276,649,071
OTC Markets Symbol: PPJE
CUSIP No. 35369D407.

As of October 31, 2016, 119 shareholders on record and approximately 2200 shareholders in NOBO list.

Item 5. Par or Stated Value and Description of the Security

The Par Value for Common Stock is $0.0001 per share.

The Company has authorized 1,000,000,000 (One Billion) Shares par value of $0.0001 of Class A Non-Dilutive Common Stocks to cover stockholders loss during the past several years;

PART B - PREFERRED STOCK

The Board of Directors is expressly vested with the authority to divide any or all of the Preferred Stock into series and to fix and determine the relative rights and preferences of the shares of each series so established, provided, however, that the rights and preferences of the various series may vary only with respect to:

(a) the rate of dividend;

(b) whether the shares may be called and, if so, the call price and the terms and conditions of call;

(c) the amount payable upon the shares in the event of voluntary and involuntary liquidation;

(d) sinking fund provisions, if any for the call or redemption of the shares;

(e) the terms and conditions, if any, on which the shares may be converted;

(f) voting rights; and

(g) whether the shares will be cumulative, noncumulative or partially cumulative as to dividends and the dates from which any cumulative dividends are to accumulate.

The Board of Directors shall exercise the foregoing authority by adopting a resolution setting forth the designation of each series and the number of shares therein, and fixing and determining the relative rights and preferences thereof. The Board of Directors may make any change in the designations, terms, limitations or relative rights or preferences of any series in the same manner, so long as no shares of such series are outstanding at such time.

Within the limits and restrictions, if any, stated in any resolution of the Board of Directors originally fixing the number of shares constituting any series, the Board of Directors is authorized to increase or decrease (but not below the number of shares of such series then outstanding) the number of shares of any series after the issue of shares of such series. In case the number of shares of any series shall be so decreased, the share constituting such decrease shall resume the status which they had prior to the adoption of the resolution originally fixing the number of shares of such series.

CLASSES OF PREFERRED STOCK

Summary of Preferred Stock Classes **This is only a summary, be sure to refer to the full terms for details.**			
Class	**A**	**B**	**E**
Authorized	5,000,000	50,000,000	100,000,000
Par	$10.00	$2.50	$0.001
Ranking	Senior	Junior to A, Senior to E	Junior to A and B

Dividends	Based on shares and not votes	Based on votes per share	Based on shares and not votes
Liquidation	Converted into common	$1.00 per share	Converted into common
Conversion	At 50% of market	At 70% of market	At 70% of market
Voting	5,000 votes per share	One million votes vote per share	None
Lockup	No	Yes	No
Anti-dilutive in reverse splits	Yes	Yes	Yes

CLASS A PREFERRED STOCK

There shall be authorized Five Million (5,000,000) shares of Class A Preferred Stock with a par value of Ten Dollars ($10.00) per share which shall have the voting powers, designations, preferences and relative participating, optional or other rights, if any, or the qualifications, limitations, or restrictions, as set forth below:

DESIGNATION. The Preferred Stock subject hereof shall be designated Class A Preferred Stock ("Class A Preferred"). No other shares of Preferred Stock shall be designated as Class A Preferred stock.

RANKING. The Class A Preferred Stock shall rank senior to the Corporation's Common Stock, any other shares of Preferred Stock the Corporation may issue in the future with respect to the right to receive dividends, distributions or proceeds in a liquidation, dissolution or winding up of the Corporation. In the event of a liquidation, dissolution or winding up of the Corporation, and the assets of the Corporation are insufficient to satisfy the Corporation's obligations to the holders of the Class A Preferred Stock, all payments shall be made to the holders of the Class A Preferred Stock on a pro rata basis.

DIVIDENDS. The Class A Preferred Stock shall participate in dividends based on shares and not on votes per share in pari passu with the Common Stock.

CONVERSION. Each share of Class A Preferred shall, at the option of the holder thereof, at any time and from time to time, be convertible into shares of fully paid and non-assessable Common Stock of the Corporation. The number of shares of Common Stock shall be determined by dividing the par value of the Class A Preferred by the a umber representing 50% of the bid price of the Common Stock on the day of the election to convert. The conversion right of the holders of Class A Preferred Stock shall be exercised by the surrender of the certificates representing shares to be converted to the Corporation or its transfer agent for the Class A Preferred, accompanied by written notice electing conversion. No additional consideration or any other action need to be taken in order to effectively convert the Class A Preferred to the Common Stock of the Corporation. Immediately prior to the close of business on the date the Corporation receives written notice of conversion, each converting holder of Class A Preferred shall be deemed to be the holder of record of Common Stock issuable upon conversion of such holder's Class A Preferred notwithstanding that the share register of the Corporation shall then be closed or that certificates representing such Common Stock shall not then be actually delivered to such person.

Promptly after the Conversion Date, the Corporation shall issue and deliver to such holder a certificate or certificates for the number of full shares of Common Stock issuable to the holder pursuant to the holder's conversion of Class B Preferred Stock in accordance with the provisions of this Section. The stock certificate(s) evidencing the Common Stock shall be issued with a restrictive legend indicating that it was issued in a transaction exempt from registration under the Securities Act of 1933, as amended (the "Securities Act"), and that it cannot be transferred unless it is so registered, or an exemption from registration is available, in the opinion of counsel to the Corporation. The Common Stock shall be issued in the same name as the person who is the holder of the Class B Preferred Stock unless, in the opinion of counsel to the Corporation, such transfer can be made in compliance with applicable securities laws. The person in whose name the certificate(s) of Common Stock are so registered shall be treated as a holder of shares of Common Stock of the Corporation on the date the Common Stock certificate(s) are so issued.

All shares of Common Stock delivered upon conversion of the Class B Preferred Stock as provided herein shall be duly and validly issues and fully paid and non-assessable. Effective as of the Conversion Date, such converted Class B Preferred Stock shall no longer be deemed to be outstanding and all rights of the holder with respect to such

shares shall immediately terminate except the right to receive the shares of Common Stock issuable upon conversion.

The Corporation covenants that, within 30 days of receipt of the Conversion Notice from any holder of shares of Class B Preferred Stock wherein which such conversion would create more shares of Common Stock than are authorized, the Corporation will increase the number of authorized the authorized number of shares of Common Stock sufficient to satisfy such holder of shares of Class B Preferred Stock submitting such Conversion Notice.

Shares of Class A Preferred Stock are anti-dilutive to reverse splits, and therefore in the case of a reverse split, are convertible into the number of shares of Common Stock after the reverse split as would have been equal to the ratio established prior to the reverse split. The Conversion Rate of shares of the Class B Preferred Stock, however, would increase proportionately in the case of forward splits, and may not be diluted by reverse split following the forward split.

ADJUSTMENTS FOR RECLASSIFICATION AND REORGANIZATION, MERGERS, CONSOLIDATIONS or SALES OF ASSETS. If the Common Stock issuable upon conversion of the Class A Preferred shall be changed into the same or different number of shares of any other class or classes of stock, whether by capital reorganization, reclassification or otherwise, the conversion rate shall, concurrently with the effectiveness of such reorganization or reclassification, be proportionately adjusted so that the Class A Preferred shall be convertible into, in lieu of the number of shares of Common Stock which the holders would otherwise have been entitled to receive, a number of shares of such other class or classes of stock equivalent to the number of shares of Common Stock that would have been subject to receipt by the holders upon conversion of the Class A Preferred immediately before that change.

REORGANIZATIONS. If at any time or from time to time after the date of this Certificate, there is a capital reorganization of the Common Stock (reverse split, forward split, etc.), as a part of such capital reorganization, provision shall be made so that the holders of the Class A Preferred shall thereafter be entitled to receive upon conversion of the Class A Preferred the same number of shares of Common Stock to which that holder would have been entitled prior to such capital reorganization. In essence, the number of Class A Preferred Stock authorized, issued and outstanding, and the number of shares of Common Stock into which such Class A Preferred is convertible, shall not be affected by any such capital reorganization.

NO IMPAIRMENT. The Corporation will not, by amendment of its Certificate of Incorporation or through any reorganization, transfer of assets, consolidation, merger, dissolution, issue or sale of securities or any other voluntary action, avoid or seek to avoid the observance or performance of any of the terms to be observed or performed hereunder by the Corporation, but will at all times in good faith assist in the carrying out all the provisions of this Certificate and in the taking of all such action as may be necessary or appropriate in order to protect the conversion rights of the holders of the Class A Preferred against impairment.

RESERVATION OF STOCK ISSUABLE UPON CONVERSION. The Corporation shall at all times reserve and keep available out of its authorized but unissued shares of Common Stock, solely for the purpose of effecting the conversion of the shares of the Class A Preferred, such number of its shares of Common Stock as shall from time to time be sufficient to effect the conversion of all outstanding shares of the Class A Preferred; and if at any time the number of authorized but unissued shares of Common Stock shall not be sufficient to effect the conversion of all then outstanding shares of the Class A Preferred, the Corporation will take such corporate action as may, in the opinion of its counsel, be necessary to increase its authorized but unissued shares of Common Stock to such number of shares as shall be sufficient for such purpose, including, without limitation, engaging in best efforts to obtain the requisite stockholder approval of any necessary amendment to this Certificate.

LIQUIDATION RIGHTS. In the event of any voluntary or involuntary liquidation, dissolution or winding up of the Corporation, the holders of the Class A Preferred shall not be entitled to receive liquidation in preference to the holders of common shares or any other class or series of preferred stock. Rather, the Class A Preferred shall automatically be converted into Common Stock at the conversion rate hereinabove stated.

INVOLUNTARY LIQUIDATION. In the event of involuntary liquidation, the shares of this series shall be entitled to the same amounts as in the event of voluntary liquidation. The Class A Preferred shall automatically be converted into Common Stock at the conversion rate hereinabove stated.

OTHER RESTRICTIONS. There shall be no conditions or restrictions upon the creation of indebtedness of the Corporation, or any subsidiary or upon the creation of any other series of preferred stock with any other preferences.

VOTING. Except as otherwise expressly provided herein or as required by law, the Holders of shares of Class A Preferred Stock shall be entitled to vote on any and all

matters considered and voted upon by the Corporation's Common Stock. The Holders of the Class A Preferred Stock shall be entitled to Five Thousand (5,000) votes per share of Class A Preferred Stock.

STATED VALUE. The shares of Class A Preferred shall have a stated value of $10.00 per share.

OTHER PREFERENCES. The shares of the Class A Preferred shall no other preferences, rights, restrictions, or qualifications, except as otherwise provided by law or the certificate of incorporation of the Corporation.

CLASS B PREFERRED

There shall be authorized Fifty Million (50,000,000) shares of Class B Preferred Stock with a par value of Two Dollars and Fifty Cents ($2.50) per share, which shall have the voting powers, designations, preferences and relative participating, optional or other rights, if any, or the qualifications, limitations, or restrictions, as set forth below:

DESIGNATION. The Preferred Stock subject hereof shall be designated Class B Preferred Stock ("Class B Preferred"). No other shares of Preferred Stock shall be designated as Class B Preferred stock.

RANKING. The Class B Preferred Stock shall rank senior to the Corporation's Common Stock, junior to the Class A Preferred stock, and senior to any other shares of Preferred Stock the Corporation may issue in the future with respect to the right to receive dividends, distributions or proceeds in a liquidation, dissolution or winding up of the Corporation. In the event of a liquidation, dissolution or winding up of the Corporation, and the assets of the Corporation are insufficient to satisfy the Corporation's obligations to the holders of the Class B Preferred Stock, all payments shall be made to the holders of the Class B Preferred Stock on a pro rata basis.

DIVIDENDS. The holders of Class B Preferred Stock shall be entitled to receive dividends when, as and if declared by the Board of Directors in its sole discretion. The Class B Preferred Stock shall participate in dividends based on votes per share in pari passu with the Common Stock, and not based on shares.

CONVERSION. Each share of Class B Preferred shall, at the option of the holder thereof, at any time and from time to time, be convertible into shares of fully paid and non-assessable Common Stock of the Corporation. The number of shares of Common

Stock shall be determined by dividing the par value of the Class B Preferred by the number representing 70% of the bid price of the Common Stock on the day of the election to convert. The conversion right of the holders of Class E Preferred Stock shall be exercised by the surrender of the certificates representing shares to be converted to the Corporation or its transfer agent for the Class E Preferred, accompanied by written notice electing conversion. No additional consideration or any other action need to be taken to effectively convert the Class B Preferred to the Common Stock of the Corporation. Immediately prior to the close of business on the date the Corporation receives written notice of conversion, each converting holder of Class B Preferred shall be deemed to be the holder of record of Common Stock issuable upon conversion of such holder's Class B Preferred notwithstanding that the share register of the Corporation shall then be closed or that certificates representing such Common Stock shall not then be delivered to such person.

Promptly after the Conversion Date, the Corporation shall issue and deliver to such holder a certificate or certificates for the number of full shares of Common Stock issuable to the holder pursuant to the holder's conversion of Class B Preferred Stock in accordance with the provisions of this Section. The stock certificate(s) evidencing the Common Stock shall be issued with a restrictive legend indicating that it was issued in a transaction exempt from registration under the Securities Act of 1933, as amended (the "Securities Act"), and that it cannot be transferred unless it is so registered, or an exemption from registration is available, in the opinion of counsel to the Corporation. The Common Stock shall be issued in the same name as the person who is the holder of the Class B Preferred Stock unless, in the opinion of counsel to the Corporation, such transfer can be made in compliance with applicable securities laws. The person in whose name the certificate(s) of Common Stock are so registered shall be treated as a holder of shares of Common Stock of the Corporation on the date the Common Stock certificate(s) are so issued.

All shares of Common Stock delivered upon conversion of the Class B Preferred Stock as provided herein shall be duly and validly issues and fully paid and non-assessable. Effective as of the Conversion Date, such converted Class B Preferred Stock shall no longer be deemed to be outstanding and all rights of the holder with respect to such shares shall immediately terminate except the right to receive the shares of Common Stock issuable upon conversion.

The Corporation covenants that, within 30 days of receipt of the Conversion Notice from any holder of shares of Class B Preferred Stock wherein which such conversion would create more shares of Common Stock than are authorized, the Corporation will increase the number of authorized the authorized number of shares of Common Stock sufficient

to satisfy such holder of shares of Class B Preferred Stock submitting such Conversion Notice.

Shares of Class B Preferred Stock are anti-dilutive to reverse splits, and therefore in the case of a reverse split, are convertible into the number of shares of Common Stock after the reverse split as would have been equal to the ratio established prior to the reverse split. The Conversion Rate of shares of the Class B Preferred Stock, however, would increase proportionately in the case of forward splits, and may not be diluted by reverse split following the forward split.

VOTING RIGHTS. Except as otherwise expressly provided herein or as required by law, the Holders of shares of Class B Preferred Stock shall be entitled to vote on any and all matters considered and voted upon by the Corporation's Common Stock. The Holders of the Class B Preferred Stock shall be entitled to One (1) vote per share of Class B Preferred Stock.

LOCKUP RESTRICTIONS ON CONVERSION. The shares of Class B Preferred Stock may not be converted into shares of Common Stock for a period of (a) six (6) months after purchase if the company voluntary files public reports pursuant to Section 12 or Section 15 of the Securities Exchange Act of 1934; or (b) twelve months after purchase if the Corporation does not file such public reports.

ADJUSTMENTS FOR RECLASSIFICATION AND REORGANIZATION, MERGERS, CONSOLIDATIONS or SALES OF ASSETS. If the Common Stock issuable upon conversion of the Class B Preferred shall be changed into the same or different number of shares of any other class or classes of stock, whether by capital reorganization, reclassification or otherwise, the conversion rate shall, concurrently with the effectiveness of such reorganization or reclassification, be proportionately adjusted so that the Class B Preferred shall be convertible into, in lieu of the number of shares of Common Stock which the holders would otherwise have been entitled to receive, a number of shares of such other class or classes of stock equivalent to the number of shares of Common Stock that would have been subject to receipt by the holders upon conversion of the Class B Preferred immediately before that change.

REORGANIZATIONS. If at any time or from time to time after the date of this Certificate, there is a capital reorganization of the Common Stock (reverse split, forward split, etc.), as a part of such capital reorganization, provision shall be made so that the holders of the Class B Preferred shall thereafter be entitled to receive upon conversion of the Class B Preferred the same number of shares of Common Stock to which that holder would have been entitled prior to such capital reorganization. In essence, the number of

Class B Preferred Stock authorized, issued and outstanding, and the number of shares of Common Stock into which such Class B Preferred is convertible, shall not be affected by any such capital reorganization.

NO IMPAIRMENT. The Corporation will not, by amendment of its Certificate of Incorporation or through any reorganization, transfer of assets, consolidation, merger, dissolution, issue or sale of securities or any other voluntary action, avoid or seek to avoid the observance or performance of any of the terms to be observed or performed hereunder by the Corporation, but will at all times in good faith assist in the carrying out all the provisions of this Certificate and in the taking of all such action as may be necessary or appropriate in order to protect the conversion rights of the holders of the Class B Preferred against impairment.

RESERVATION OF STOCK ISSUABLE UPON CONVERSION. The Corporation shall at all times reserve and keep available out of its authorized but unissued shares of Common Stock, solely for the purpose of effecting the conversion of the shares of the Class B Preferred, such number of its shares of Common Stock as shall from time to time be sufficient to effect the conversion of all outstanding shares of the Class B Preferred; and if at any time the number of authorized but unissued shares of Common Stock shall not be sufficient to effect the conversion of all then outstanding shares of the Class B Preferred, the Corporation will take such corporate action as may, in the opinion of its counsel, be necessary to increase its authorized but unissued shares of Common Stock to such number of shares as shall be sufficient for such purpose, including, without limitation, engaging in best efforts to obtain the requisite stockholder approval of any necessary amendment to this Certificate.

LIQUIDATION RIGHTS. Upon any liquidation dissolution or winding up of the Corporation, whether voluntary or involuntary, before any distribution or payment shall be made to the holders of any stock ranking junior to the Class B Preferred Stock, the holders of the Class B Preferred Stock shall be entitled to be paid out of the assets of the Corporation an amount equal to One Dollar ($1.00) per share, or in the event of an aggregate subscription by a single subscriber for Class B Preferred Stock in excess of $100,000 and $0.997 per share (as adjusted for any stock dividends, combinations, splits, recapitalizations and the like with respect to such shares) (the "Preference Value"), plus all declared but unpaid dividends for each share of Class B Preferred Stock held by them. After the payment of the full applicable Preference Value of each share of the Class B Preferred Stock as set forth herein, the remaining assets of the Corporation legally available for distribution, if any, shall be distributed ratably to the holders of the Corporation's Common Stock.

INVOLUNTARY LIQUIDATION. In the event of involuntary liquidation, the shares of this series shall be entitled to the same amounts as in the event of voluntary liquidation. The Class B Preferred shall automatically be converted into Common Stock at the conversion rate hereinabove stated.

OTHER RESTRICTIONS. There shall be no conditions or restrictions upon the creation of indebtedness of the Corporation, or any subsidiary or upon the creation of any other series of preferred stock with any other preferences.

CLASS E PREFERRED STOCK

There shall be authorized Ten Million (10,000,000) (being amended to increase to 100,000,000) shares of Class E Preferred Stock with a par value of One Cent ($0.01) per share which shall have the voting powers, designations, preferences and relative participating, optional or other rights, if any, or the qualifications, limitations, or restrictions, as set forth below:

DESIGNATION. The Preferred Stock subject hereof shall be designated Class E Preferred Stock ("Class E Preferred"). No other shares of Preferred Stock shall be designated as Class E Preferred stock.

RANKING. The Class E Preferred Stock shall rank senior to the Corporation's Common Stock, junior to the Class A Preferred stock and Class B Preferred Stock, and senior to any other shares of Preferred Stock the Corporation may issue in the future with respect to the right to receive dividends, distributions or proceeds in a liquidation, dissolution or winding up of the Corporation. In the event of a liquidation, dissolution or winding up of the Corporation, and the assets of the Corporation are insufficient to satisfy the Corporation's obligations to the holders of the Class B Preferred Stock, all payments shall be made to the holders of the Class B Preferred Stock on a pro rata basis.

DIVIDENDS. The Class E Preferred Stock shall participate in dividends based on shares and not on votes per share in pari passu with the Common Stock.

CONVERSION. Each share of Class E Preferred shall, at the option of the holder thereof, at any time and from time to time, be convertible into shares of fully paid and non-assessable Common Stock of the Corporation. The number of shares of Common Stock shall be determined by dividing the par value of the Class E Preferred by a number representing 70% of the bid price of the Common Stock on the day of the election to convert. The conversion right of the holders of Class E Preferred Stock shall

be exercised by the surrender of the certificates representing shares to be converted to the Corporation or its transfer agent for the Class E Preferred, accompanied by written notice electing conversion. No additional consideration or any other action need to be taken to effectively convert the Class E Preferred to the Common Stock of the Corporation. Immediately prior to the close of business on the date the Corporation receives written notice of conversion, each converting holder of Class E Preferred shall be deemed to be the holder of record of Common Stock issuable upon conversion of such holder's Class E Preferred notwithstanding that the share register of the Corporation shall then be closed or that certificates representing such Common Stock shall not then be delivered to such person.

Promptly after the Conversion Date, the Corporation shall issue and deliver to such holder a certificate or certificates for the number of full shares of Common Stock issuable to the holder pursuant to the holder's conversion of Class B Preferred Stock in accordance with the provisions of this Section. The stock certificate(s) evidencing the Common Stock shall be issued with a restrictive legend indicating that it was issued in a transaction exempt from registration under the Securities Act of 1933, as amended (the "Securities Act"), and that it cannot be transferred unless it is so registered, or an exemption from registration is available, in the opinion of counsel to the Corporation. The Common Stock shall be issued in the same name as the person who is the holder of the Class B Preferred Stock unless, in the opinion of counsel to the Corporation, such transfer can be made in compliance with applicable securities laws. The person in whose name the certificate(s) of Common Stock are so registered shall be treated as a holder of shares of Common Stock of the Corporation on the date the Common Stock certificate(s) are so issued.

All shares of Common Stock delivered upon conversion of the Class B Preferred Stock as provided herein shall be duly and validly issues and fully paid and non-assessable. Effective as of the Conversion Date, such converted Class B Preferred Stock shall no longer be deemed to be outstanding and all rights of the holder with respect to such shares shall immediately terminate except the right to receive the shares of Common Stock issuable upon conversion.

The Corporation covenants that, within 30 days of receipt of the Conversion Notice from any holder of shares of Class B Preferred Stock wherein which such conversion would create more shares of Common Stock than are authorized, the Corporation will increase the number of authorized the authorized number of shares of Common Stock sufficient to satisfy such holder of shares of Class B Preferred Stock submitting such Conversion Notice.

Shares of Class B Preferred Stock are anti-dilutive to reverse splits, and therefore in the case of a reverse split, are convertible into the number of shares of Common Stock after the reverse split as would have been equal to the ratio established prior to the reverse split. The Conversion Rate of shares of the Class B Preferred Stock, however, would increase proportionately in the case of forward splits, and may not be diluted by reverse split following the forward split.

ADJUSTMENTS FOR RECLASSIFICATION AND REORGANIZATION, MERGERS, CONSOLIDATIONS or SALES OF ASSETS. If the Common Stock issuable upon conversion of the Class E Preferred shall be changed into the same or different number of shares of any other class or classes of stock, whether by capital reorganization, reclassification or otherwise, the conversion rate shall, concurrently with the effectiveness of such reorganization or reclassification, be proportionately adjusted so that the Class E Preferred shall be convertible into, in lieu of the number of shares of Common Stock which the holders would otherwise have been entitled to receive, a number of shares of such other class or classes of stock equivalent to the number of shares of Common Stock that would have been subject to receipt by the holders upon conversion of the Class E Preferred immediately before that change.

REORGANIZATIONS. If at any time or from time to time after the date of this Certificate, there is a capital reorganization of the Common Stock (reverse split, forward split, etc.), as a part of such capital reorganization, provision shall be made so that the holders of the Class E Preferred shall thereafter be entitled to receive upon conversion of the Class E Preferred the same number of shares of Common Stock to which that holder would have been entitled prior to such capital reorganization. The number of Class E Preferred Stock authorized, issued and outstanding, and the number of shares of Common Stock into which such Class E Preferred is convertible, shall not be affected by any such capital reorganization.

NO IMPAIRMENT. The Corporation will not, by amendment of its Certificate of Incorporation or through any reorganization, transfer of assets, consolidation, merger, dissolution, issue or sale of securities or any other voluntary action, avoid or seek to avoid the observance or performance of any of the terms to be observed or performed hereunder by the Corporation, but will at all times in good faith assist in the carrying out all the provisions of this Certificate and in the taking of all such action as may be necessary or appropriate in order to protect the conversion rights of the holders of the Class E Preferred against impairment.

RESERVATION OF STOCK ISSUABLE UPON CONVERSION. The Corporation

shall at all times reserve and keep available out of its authorized but unissued shares of Common Stock, solely for the purpose of effecting the conversion of the shares of the Class E Preferred, such number of its shares of Common Stock as shall from time to time be sufficient to effect the conversion of all outstanding shares of the Class E Preferred; and if at any time the number of authorized but unissued shares of Common Stock shall not be sufficient to effect the conversion of all then outstanding shares of the Class E Preferred, the Corporation will take such corporate action as may, in the opinion of its counsel, be necessary to increase its authorized but unissued shares of Common Stock to such number of shares as shall be sufficient for such purpose, including, without limitation, engaging in best efforts to obtain the requisite stockholder approval of any necessary amendment to this Certificate.

LIQUIDATION RIGHTS. In the event of any voluntary or involuntary liquidation, dissolution or winding up of the Corporation, the holders of the Class C Preferred shall not be entitled to receive liquidation in preference to the holders of common shares or any other class or series of preferred stock. Rather, the Class C Preferred shall automatically be converted into Common Stock at the conversion rate hereinabove stated.

INVOLUNTARY LIQUIDATION. In the event of involuntary liquidation, the shares of this series shall be entitled to the same amounts as in the event of voluntary liquidation. The Class E Preferred shall automatically be converted into Common Stock at the conversion rate hereinabove stated.

OTHER RESTRICTIONS. There shall be no conditions or restrictions upon the creation of indebtedness of the Corporation, or any subsidiary or upon the creation of any other series of preferred stock with any other preferences.

VOTING. The Holders of shares of Class E Preferred Stock shall not be entitled to vote on all matters considered and voted upon by the Corporation's Common Stock.

STATED VALUE. The shares of Class E Preferred shall have a stated value of $0.01 per share.

OTHER PREFERENCES. The shares of the Class E Preferred shall have no other preferences, rights, restrictions, or qualifications, except as otherwise provided by law or the certificate of incorporation of the Corporation.

Item 6. The Number of Shares or Total Amount of the Securities Outstanding for Each Class of Securities Authorized.

Common Stock

Number of Common Outstanding as of September 30, 2016
Shares Outstanding**:** 3,802,203,338
Shares Authorized –Ten Billion (10,000,000,000)
Public Float 77,149,071
Total number of Shareholders of Record: 119

The Company recently made a one for 100 reverse split of the Common Stock, payable July 25, 2016. The numbers in these financial statements do not reflect this reverse split.

Class A Non -Dilutive Common Stock
Number of Common Outstanding as of September 30, 2016
Shares Outstanding: None
Shares Authorized – One Billion (1,000,000,000)
Total number of Shareholders of Record: None

Class A Preferred Stock
Number of Common Outstanding as of September 30, 2016
Shares Outstanding: None
Shares Authorized – Five Million (5,000,000)
Total number of Shareholders of Record: None

Class B Preferred Stock
Number of Common Outstanding as of September 30, 2016
Shares Outstanding: 2,118,000
Shares Authorized – Fifty Million (50,000,000)
Total number of Shareholders of Record: 6

Class E Preferred Stock
Number of Common Outstanding as of September 30, 2016
Shares Outstanding: 10,0005,000
Shares Authorized – Ten Million (10,000,000)

Total number of Shareholders of Record:2

Item 7 Transfer Agent

Pacific Stock Transfer Company
6725 Via Austi Pkwy
Suite 300
Las Vegas, NV 89119
Phone Number (702) 361-3033

The transfer agent is registered under the Exchange Act and operates under the regulatory authority of the SEC and FINRA.

Part C. Business Information

Item 8 Nature of Business

A. Business Development:

1. The form of organization of the issuer is that PPJ Healthcare Enterprises, Inc. is a Florida corporation.

2. The year that the issuer (or any predecessor) was organized;

May 2, 2000

3. The issuer’s fiscal year end date;

The Issuer's fiscal year-end date is December 31.

4. Whether the issuer (or any predecessor) has been in bankruptcy, receivership or any similar proceeding.

The Issuer has not been in bankruptcy, receivership or any similar proceeding.

5. Any material reclassification, merger, consolidation, or purchase or sale of a significant number of assets not in the ordinary course of business;

See “Business Development.”

6. The Issuer is in default of the terms of any note, loan, lease or other indebtedness or financing arrangement requiring the issuer to make payments.

The Issuer is not in such default.

7. Any change of control;

There has been no recent change of control.

8. Any recent increase of 10% or more of the same class of outstanding equity securities;

There has been an increase of 10% or more of the same class of outstanding equity securities in the year 2016, see Item 17 below.

Section 15(g) of the Securities Exchange Act of 1934

Our shares are covered by section 15(g) of the Securities Exchange Act of 1934, as amended that imposes additional sales practice requirements on broker/dealers who sell such securities to persons other than established customers and accredited investors (generally institutions with assets more than $5,000,000 or individuals with net worth more than $1,000,000 or annual income exceeding $200,000 or $300,000 jointly with their spouses). For transactions covered by the Rule, the broker/dealer must make a special suitability determination for the purchase and have received the purchaser's written agreement to the transaction prior to the sale. Consequently, the Rule may affect the ability of broker/dealers to sell our securities and may affect your ability to sell your shares in the secondary market.

Section 15(g) also imposes additional sales practice requirements on broker/dealers who sell penny securities. These rules require a one-page summary of certain essential items. The items include the risk of investing in penny stocks in both public offerings and

secondary marketing; terms important to in understanding of the function of the penny stock market, such as id and offer quotes, a dealers spread and broker/dealer compensation; the broker/dealer compensation, the broker/dealers' duties to its customers, including the disclosures required by any other penny stock disclosure rules; the customers' rights and remedies in cases of fraud in penny stock transactions; and, the FINRA's toll free telephone number and the central number of the North American Administrators Association, for information on the disciplinary history of broker/dealers and their associated persons.

Dividends

The Company has not declared or paid a cash dividend to stockholders since it was organized and does not intend to pay dividends in the foreseeable future. (except in press release in the past, but has not taken any steps to get that approved by FINRA) The board of directors presently intends to retain any earnings to finance our operations and does not expect to authorize cash dividends in the foreseeable future. Any payment of cash dividends in the future will depend upon the Company's earnings, capital requirements and other factors.

9. Any Past, Pending or Anticipated Stock Split, Stock Dividend, Recapitalization, Merger, Acquisition, Spin-Off, or Reorganization;

The Company did a one for 100 reverse split of the Common Stock. Shares were decreased by a one for 100 reverse split. The split was paid on 12/01/2014.

The Company recently made a one for 100 reverse split of the Common Stock, payable July 25, 2016. The numbers in these financial statements do not reflect this reverse split.

10. Any de-listing of the Issuer's Securities by any Securities Exchange or Deletion from the OTC Bulletin Board; and

The Issuer's securities have not recently been de-listed by any securities exchange. The Issuer filed a Form 15-12G with the Securities and Exchange Commission de-registering its Common Stock on August 27, 2009.

11. Any Current, Past, Pending or Threatened Legal Proceedings or Administrative Actions Either by or Against the Issuer that could have a material effect on the issuer's

business, financial condition, or operations and any current past or pending trading suspensions by a securities regulator.

There are no current, past, pending or threatened legal proceedings or administrative actions either by or against the PPJ Healthcare Enterprises that could have a material effect on the issuer's business, financial condition, or operations and any current past or pending trading suspensions by a securities regulator, except those detailed herein.

The Company sued Narinder S. Grewal, MD et al and the Company was awarded $374,000. The Company feels that this low award was since most of the Company's admitted evidence was stolen by the Defendants.

On November 17, 2015, the Company filed a lawsuit against the Company's counsel in the litigation involving Narindar S. Grewal et al. This lawsuit asks for $6 million in damages on the grounds of negligence. There is no assurance that anything will be recovered.

The Company has written off $8,127,041 of Contingent Assets booked about the Grewal litigation. See Financial Statements, Note B.

New Lines of Business

The Issuer is joint venturing with doctors in setting up new practices, marketing and management of pain management practices and blood culture labs with a higher percentage of revenue. The Company has two such new relationships with Southern California with physicians and is looking forward to growing this line of business in the very near future. This project has been running slow due lack of resources and time for trial preparation.

The Company has been pursuing the Medical Marijuana Potency Testing line of business since 2014, even though many clients committed to test their products but due to lack of enforceable laws, vendors do not spend the money for testing; We are hoping that the new approval of Recreational Marijuana use in California will boom our revenue in the months to come.

If funding is available, of which there is no assurance, the Company intends to take very aggressive attempts to affect all its business plans such as (1) aggressive marketing of medical billing software. The Company believes that this software will be accepted as a blessing by the healthcare providers and dental will follow; (2) start blood cultures labs for bacteria and Candida species nationwide; (3) start medicinal marijuana potency test

centers wherever legally permitted; (4) start pain management surgical suites in partnerships with pain specialists all over the country.

B. Business of Issuer

1. The Issuer's primary SIC code is SIC Code 7389 - Business services, misc.

2. PPJ Healthcare Enterprises, Inc. is currently conducting operations.

3. PPJ Healthcare Enterprises Corporation is not currently and has never been Shell Company.

4. PPJ Healthcare Enterprises owns and operates daily business operations.

The following companies are wholly-owned subsidiaries of the Issuer:

a. AutoMed Software Corp. a Nevada Company: (Merged with Winfield Financial Group, Inc. in 2004). Providing developed medical practice management, electronic health record, automated billing software, one of a kind, highly privileged software, not offered by any other company, can take the health care field by storm if marketed adequately. This software can save health care provider up to 70% of their cost and increase their collection as much as 30%. Please visit www.automated-biller.com for details. This product needs update to current compliance, Issuer is seeking capital to upgrade, package to market and sell.

b. Professional Billing Services, LLC. (PBS) On Jun 20, 2014, the Board approved a sale of Professional Billing Service to Health Care Practice Partners, LLC., with the following terms: HPP will takeover of Professional Billing Service including all law suits filed or to be filed against the clients who did not pay billing fees. Once the money is collected, HPP will pay 50% of the net gain to PPJ.

5. The effect of existing or probable governmental regulations on the business.

See "Risk Factors" below.

6. An estimate of the amount spent during each for the last two fiscal years on research

and development activities, and if applicable, the extent to which the cost of such activities is borne directly by customers.

The Issuer estimates that it has spent the following amounts on research and development:

a. 2010 - $24,000
b. 2011 - $10,300
c. 2012 - $18,000
c. 2013 - $6,500
d. 2014 - $6,500
e. 2015 – $6,102
f. 2016--$0.00

7. Costs and effects of compliance with environmental laws (federal, state and local); and

See “Risk Factors” below.

8. The number of total employees and number of full-time employees.

The number of total employees and number of full-time employees usually varies from 8 to 22, increased or reduced as per need for the time.

Item 9 Nature of Products or Services Offered

A. Principal Products or Services and Their Markets.

BUSINESS

PPJ Healthcare Enterprises – Our History

We incorporated in Nevada on May 2, 2000 as Winfield Financial Group, Inc. In December 2005, we changed our name to Healthcare Business Services Groups, Inc. In February 2008, we changed our name to PPJ Enterprise. In November 2014, we move our state of incorporation to Florida and changed our name to PPJ Healthcare Enterprises, Inc.

Our offices are located at 401 E. Jackson Street, Suite 2340, Tampa, FL 33602, and our telephone number is (813) 693-5192, Fax (866) 622-3215. Our websites are located at www.ppjenterprise.com, http://www.automated-biller.com, http://professionalbillingservice.net, https://www.flowertesting.com, and https://www.paincarecentersusa.com .

Overview

The Automated Biller is a medical billing system which is comprised of both hardware and software. The system uses Touch Screen technology to allow physicians to bill their medical insurance claims at the point of service without data entry, coding or billing personnel. In 2014, there were 763,000 physicians with working privileges in the United States (bls.gov). The initial financial analysis shows that the Automated Biller has a great competitive advantage in that there are no similar medical billing products commercially available that target the healthcare industry. With current Federal incentives that promote all healthcare entities to establish electronic health records, the Automated Biller is a cost-effective solution to meet today's healthcare information standards.

Background

The Automated Biller was created through the professional experiences of a well known medical billing service Healthcare Business Services Groups, Inc. (HBSGI) in 2003. At that time, HBSGI was using a DOS based medical billing program called Versaform. Versaform was used as the primary medical billing software program since the early 1990's and was not able to keep up with the changing regulations in the medical insurance agency. After searching for other medical billing software programs that could handle the demands of multiple medical practice billing while managing other aspects of billing more effectively such as reimbursement posting and accounting consoles. After spending a year searching with no avail, in 2005 Chandana Basu, CEO of HBSGI at the time, decided to invest into developing a software system in house that

could handle more than just medical billing.

So, in 2002, the Automated Biller concept was born; it took a year to develop most of the consoles of the system. The medical billing software, MedPro was easy to use, used the Windows Operating System, and could meet the proposed HIPAA regulations which would come into effect by April 2006. Once Ms. Basu realized that other medical billing software was falling behind in attaining HIPAA compliance, she immediately took steps to modify the data entry process by introducing the scanning feature. This patented procedure reduces billing time by at least two weeks and can increase revenue for the novice medical biller because all the codes are imbedded into the scanning form.

Today, the unique process of the Automated Biller is still one of its kind. Through research and development, the product is scheduled to be enhanced by allowing physicians to complete all their medical billing through a hand-held device such as a PDA or today's Ipad. The revenue potential of the Automated Biller is extreme; But the product needs upgrade then it only has to get to the market to almost sell itself.

Mission Statement

PPJ Enterprise's mission statement is**: *"To enable busy physicians to streamline their insurance billing process so that they can focus more of their energy into enhanced patient care. "*** The company envisions that The Automated Biller's will make the once mundane and tedious task of insurance billing for medical procedures quick and easy so that physicians are able to spend less time billing insurance companies and more time with their patients. By leveraging technology, the physician can save both time and money on their billing processes.

Marketing Plan

The mission of the marketing team is to employ strategies to reach the target market. The sales mix includes:

3. Developing the www.theautomatedbiller.com website to detail the system and its operations
4. Advertising in physician's trade specific journals
5. Introduce the Automated Biller during the American Society of Anesthesiologists Annual Meeting in October
6. Purchase the attendees list from the American Society of Anesthesiologists to send out mailers throughout the country

7. Demonstrating hands-on Automated Biller workshops in all major markets throughout the United States
8. Distribute among medical billing services worldwide.

Operations Plan

Automated Biller is a subsidiary project under the publicly traded company PPJ Enterprise; all operations are established in Reno, Nevada. Sales will be promoted throughout the continuous 50 states. Satellite offices may be established in metro areas of future high demand.

Each $49,500 retail sale of the Automated Biller less cost of products, customization, installation and training will allow 30% sales commission for all levels.

Finance Plan

To ensure the quality and customer satisfaction of the Automated Biller, the staffing budget will focus primarily on customer service representatives and IT support specialists. Other departments such as accounting, graphic design, and legal counsel are outsourced to focus capital on operations improvements.

Marketing

Opportunity

Health insurance carries more risk than any other type of insurance; this is because all people are subject to illness at some point in their lives. Thus, medical insurance billing is very complicated; it must meet the standards of loss verification to claim insurance benefits while maintaining the federally mandated and required Health Insurance Portability and Accountability Act. (HIPAA) Thus in the medical billing industry, accuracy is a highly regarded trait and is essential for provider reimbursement.

As the demand for medical services rise, so will the need for effective medical billing services. Most traditional forms of insurance use their internal processes to file and process claims; medical insurance requires effort on the provider's part for them to be reimbursed for services rendered. The task of providing medical service and maintaining the accuracy and understanding of medical billing code sets can be very overwhelming to any medical professional; thus, medical providers can turn to The Automated Biller.

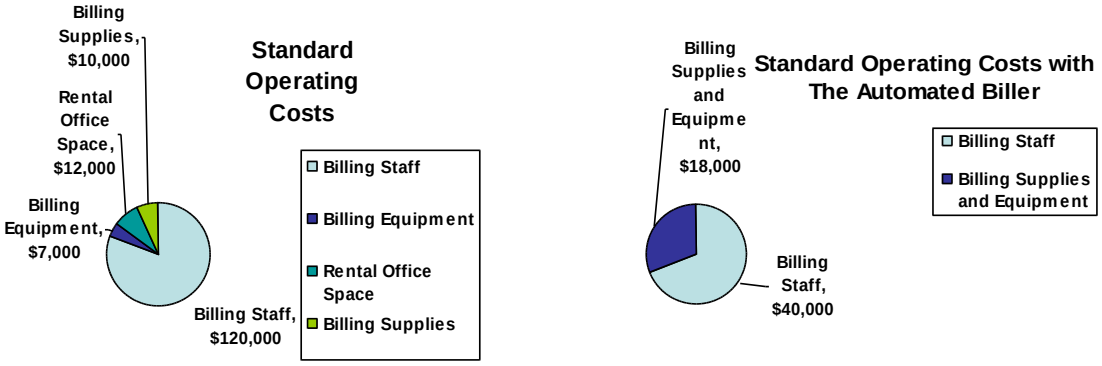
Product Concept

The Automated Biller is comprised of multiple software programs and the database medical billing software. The system is designed for providers to touch screen devices such as ipads and or touch screen computers, using electronic superbills custom designed for each specialist for their medical procedures via and accompanying medical records at the point of medical service. The Automated Biller creates a paperless workflow; this process can assist all medical professionals to meets all compliance standards.

The Electronic Superbills are custom designed to meet the needs of each individual provider's subspecialties. At the point of service, the provider will touch services provided which will then generate insurance claims and patients' statements once all patient demographic information is entered either by patients prior to their visit by online registration and or other means. The key feature of the Automated Biller is that the provider can view the insurance claim on the screen before processing the claim through the software; this way the user can catch errors before the information enters the patient ledger database. The provider then has the option to bill the insurance via EDI, electronic data interchange, or to print a paper claim that is then sent to the appropriate insurance company.

This process takes approximately 3 to 5 minutes per transaction. The revolutionary The Automated Biller program can thus reduce the typical 7 to 14-day turnaround time between completing the procedure and the medical biller sending the medical claim forms to the insurance company, so The Automated Biller offers savings of $90,000 in billing services and materials. The Automated Biller software gives the opportunity for health care providers to perform more services daily because of the short time for billing and coding. It also eliminates the cost of a complete billing service since The Automated Biller software is easy and no data entry is involved.

Chart II: Cost Comparison with or without the Automated Biller



While the Automated Biller offers paperless medical billing solutions, it also handles the functions of traditional software. Here is a glimpse of its many features that allow individual practices manage their medical practices more effectively:

- Automatically calculate all complex anesthesia procedures and time accurately, including appropriate modifiers,
- Automatically calculate all drugs and supplies used
- Automatically generates follow up letters to insurance companies if no payment received every 30 days,
- Each system is customized to meet the medical insurance regulations of the provider's state,
- Automatically posts all electronic payments and generate Secondary Insurance claims or patients' statements,
- Automatically transfer the checks to Quick Books Pro accounting systems to track daily deposits into bank accounts,

Automatically generates following reports

1. Daily charge, payment, adjustment by each provider
2. Weekly charge, payment, adjustment by each provider
3. Monthly charge, payment, adjustment, and customizable financial reports
4. Tracking inventory for all medical supplies used
5. Monthly patient count to reconcile with appointment schedule
6. Practice analysis by % of payor base like Medicare, Medicaid, and private insurance
7. Aging Accounts Receivable Account, by number of days (30, 60, 90 and 120) and by insurance
8. Yearly charge, payment, adjustment, and financial
9. Patient Statement
10. Collection Letters

Target Market Analysis

The target market includes any medical practices, chiropractic, physical therapy surgery

centers and hospitals all which operated in the United States, including dental practices that needs to improve their current billing practices. The Automated Biller can improve any medical practice cash flow, but is not limited to, the following ways:

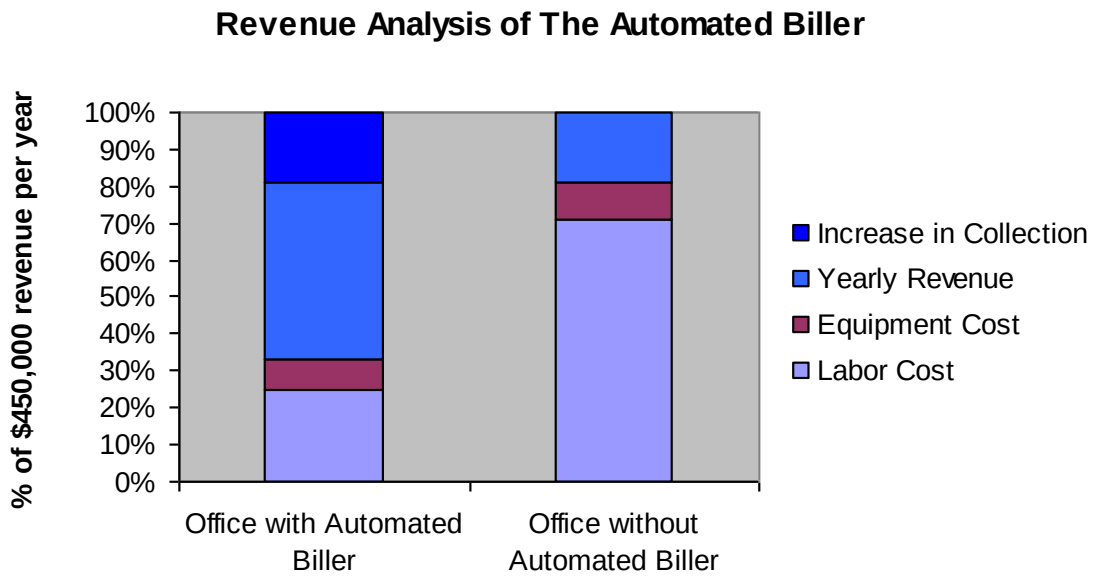
The Automated Biller enhances healthcare entities' ability to reach and maintain HIPAA compliance through its unique medical record storage capabilities
Reduces medical billing costs by eliminating the medical biller/coder
Increases healthcare entity control of reimbursements, billing and scheduling, and financial practice management
Reduces turnover time to receive medical service reimbursement because electronic billing occurs at the point of service
Healthcare entities can spend more time developing their practices and spending more time with their patients instead of maintaining their current billing practices

It is important to note that The Automated Biller will only be available through the US market; Canada would not have a use for this software because of their socialized medicine structure. While other countries utilize a similar medical insurance billing process as the US, the system is not equipped to meet foreign needs at this moment. Depending on the success of The Automated Biller in the US medical billing industry, executives may venture to conquer foreign markets as well.

Evidence of Market Need

Medical billing is an ongoing challenge for all healthcare entities; they usually will only see patients right before procedures or during times of patient unconsciousness. Traditionally these professionals do not have their own office or staff to complete their billing; many times, the failure to provide medical records to a medical billing professional has elongated, or even halted, their payment process. Per Salary.com, the average medical biller should make about $30K per year plus benefits. Medical billing services, the alternative, are expensive; with the new HIPAA compliance regulations, providers need to be especially careful where they send their patient's medical records. HIPAA compliance violations can come with expensive penalties and can bar providers from being a Medicare participant. Violations are mishandling of patient medical record documentation, lack of proper medical file discarding techniques, and poor training for employees that handle private patient information. If a medical billing firm is charged with HIPAA violation, the provider is also fined for their actions. These problems have caused the medical professional industry to seek alternatives to expensive medical billing firms and restrictive insurance reimbursements. Chart I portray the cost savings that The Automated Biller provides compared to a traditional billing service.

Chart I: Revenue Analysis of Automated Biller



The Federal Government is aware of the cost savings opportunities that electronic health records will bring. Therefore, in February 2009, Barack Obama allocated $76 billion in healthcare information management technology reform. The primary goal of these expenditures is to "accelerate the adoption of health information technology and utilization of electronic health records" (Department of Health and Human Service, 2009). By offering medical record scanning services, The Automated Biller scanning feature will capitalize early in an industry that is about to explode due to the outlined federal mandate.

Traditional medical billing services are expensive; depending on the service that is offered, physicians can spend up to 15% of their collectable reimbursements on medical billing services. Considering if an average physician earns $200,000 in reimbursed revenues per year, they can spend about $30,000 a year for a traditional medical billing service alone. There are so many regulation changes in the medical insurance industry, codes are constantly changing; providers need to ensure that their medical billing agency is maintaining these changes and doctors are getting paid efficiently. The tasks of regulating a medical billing firm's practices combined with the excessive costs are better spent on The Automated Biller package.

There are so many regulation changes in the medical insurance industry, codes are constantly changing; providers need to ensure that their medical billing agency is maintaining these changes and he is getting paid efficiently. The tasks of regulating a medical billing firm's practices combined with the excessive costs are better spent on The Automated Biller system package.

This market need has given rise to the Automated Biller, makes medical billing fast, easy, and HIPAA compliant. The long term financial benefit of a healthcare entity that invests in the Automated Biller is very promising. The long-term benefits of the Automated Biller are lower labor costs, no more information technology upgrade costs, and no medical billing agency costs. These reasons plus the added benefit of taking hold of medical practice management in-house will be enticing to most medical practices.

Competitive Landscape

There are many medical billing services available to physicians in the United States; performing a web search results in hundreds of entries. Most of the companies listed provide medical billing and collections services focusing on physician's groups and small medical centers. A competitive advantage of The Automated Biller is that it targets individual medical providers or specialist, like Anesthesiologists, that are normally not an employee of one specific medical facility. Through research and analysis, this is a dramatically under-served market and provides great opportunity for The Automated Biller.

There are two main competitors targeting the same customer base and offering similar medical billing firm software packages as the ones proposed by The Automated Biller; ProMed Billing Services- a wholly owned subsidiary of Omni Medical Holdings, and Professional Associates. Both ProMed and Professional Associates provide comprehensive billing and collection services to a variety of medical professionals such as radiology technicians and physicians in private practice.

General Company Information for Main Competitors

Professional Associates is based in Delaware, and serves customers located in Pennsylvania, Maryland and Delaware. Professional Associates was formed in 1971 to provide billing services for doctor's providing emergency services primarily in the Wilmington, Delaware area. The main customer based remained Emergency Room Physicians until 1995 when Professional Associates acquired Doctor's Bookkeeping

Service. Professional Associates then expanded their customer base to include Radiologists, Anesthesiologists and Physicians in Private Practice. They have ninety full time employees and approximately sixty-percent of the customers using their billing services are in private practice.

ProMed is headquartered in Shelton Nebraska and serves customers located primarily Nebraska, Iowa, Missouri, Kansas, Arkansas and Mississippi. ProMed is a subsidiary and wholly owned by the parent company Omni Medical Holdings and is a division of Data fusion, Inc. ProMed considers their operation a turnkey operation for any customer, and does not publish information about employees, staff size or customers.

Professional Associates generally targets medical care facilities with ten providers or less, focusing on small practices and individual independent contractors. ProMed targets small practices of ten health care providers or less. Each advertises the use of HIPAA compliant software and architecture, but neither offers specific software of hardware information on their websites.

Expansion capabilities and resource availability for ProMed is limited because it is a privately held corporation. Professional Associates is part of a larger medical services organization and does have the potential to leverage services, infrastructure and staff to medical billing subsidiary.

ProMed and Professional Associates both have a niche business in a limited market with services based on existing customer's needs. Neither company has an advertised business model or strategy to create services aimed specifically at the type of medical professionals The Automated Biller wants to serve. Both companies have built infrastructure and business models to serve small groups of doctors, and adapted services and processes to individuals. The Automated Biller sees the individual Anesthesiologist or Emergency Room Physician as a lucrative customer with huge profit potential. To fully evaluate the competition and determine where the risks and opportunities exist for The Automated Biller refer to Table 1, SWOT Analysis.

Table II: Comparing the Automated Biller with its Competitors

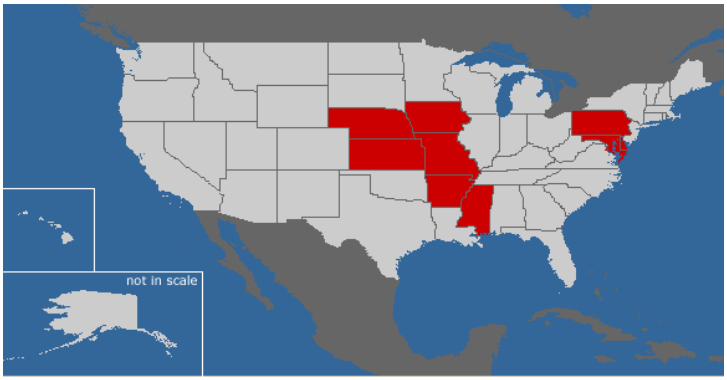
SWOT ANALYSIS		
Strengths		
The Automated Biller	**Professional Associates**	**Pro-Med**

▪ Ease of installation ▪ Compatibility with most scheduling software ▪ No additional hardware requirements for most users ▪ Most advanced technology available	▪ Strong market presence in a few states ▪ Existing, successful processes ▪ Personalized approach to customers	▪ Strong market presence in a few states ▪ Existing Successful processes ▪ Large parent company resources ▪ Image in marketplace of being a technology provider
Weaknesses		
▪ Start-up costs ▪ No name recognition in the marketplace	▪ Lack of current technology ▪ Large reliance on human intervention and manual processes ▪ Limited market presence ▪ Reliance on acquisition for growth	▪ No clear business strategy or target market ▪ Business decisions driven by parent company needs ▪ No current plans for growth or expansion into underserved markets
Opportunities		
2. Ease of entry into market 3. National access to underserved customers 4. No national competitor	5. Leverage of current relationships and providers with related customers 6. Niche service to certain customers	7. Large resources from parent company 8. Economies of scale with other subsidiaries 9. National presence of parent company and other subsidiaries
Threats		

10. Government Regulations 11. Technology Advancements 12. Nationalized healthcare 13. Reliance on investors	14. Government Regulations 15. Regional and National competition 16. Staffing resources 17. Hostile takeover	18. Government Regulations 19. Regional and National competition

Figure I depict competitors' location and target geographic. Professional Associates and ProMed both lack a presence, customer base or sales force in the Southern and Western United States. Neither company is currently servicing any of the following states with some of the largest populations of Emergency Room Physicians and Anesthesiologists; California, Texas, Florida, Arizona, Massachusetts or New York. Professional Associates and ProMed combined operate in only 17 percent of the United States. Through this analysis it is apparent that there is a large opportunity for The Automated Biller.

Figure I: Defining the Current Geographic Market



(States in Red are the only states currently serviced by Professional Associates or PayMed billing services)

Pricing Strategy

The Automated Biller is a medical billing service in a box: the system comes with all the equipment and the accompanying resources to bill as a professional billing service. All medical billing industry regulations are built into the software code so medical

professionals can feel confident that medical insurance claims that are generated using the Automated Biller will be reimbursed.

Ten to fifteen percent of the commission from provider reimbursements generated by a traditional medical billing service covers a variety of services; most of these services can be handled by the Automated Biller. This system addresses initial coding and billing, addresses all insurance denials, collects payments from patients, and processes all insurance payments to match with the respecting patient accounts and hard and soft collections, while maintaining all insurance regulation changes to ensure timely payments.

Since the Automated Biller has capabilities above and beyond any medical billing service on the market, its price is based on what a typical medical provider would pay for a medical billing service on a yearly basis. Its cost includes the scanner technology, powerful database medical billing software, and a secure Internet connection to meet the needs of any medical practice.

For $49,000 the Automated Biller user receives the following:

- → Programmed scanner with scanning software which has OCR capabilities that processes custom-designed forms which includes the following software
    1. Electronic Form (E-Forms)- $9,600 Retail Price (cost)
    2. Microsoft Small Business Enterprise Edition - $1,699 Retail Price (cost)
    3. AMA coding software CPT and ICD-9 - $1,185 Retail Price(cost)
    4. MedPro Medical Practice Management Software - $9,500 Retail Price (cost)

- → E- Forms which are custom-designed to meet the needs of the individual practice; these forms include imbedded code sets that can be upgraded as regulations change, instead of discarding forms

- → Windows-based medical billing software that provides many tools to manage individual practices such as custom-designed reports, automated insurance and patient collection letters, and varying payment posting options

- → Full setup and ongoing training provided at additional cost

- → Technical Support available for most business hours from coast to coast at a small monthly fee

There are many medical billing software options available on the market, but none of them offer all the features that can replace a medical billing staff. So, there is a wide array of pricing levels depending on the options the user would prefer. The Automated Biller is priced significantly higher than other software because it has the most billing options available to the user and the system does not require that the user have medical billing experience or any knowledge of medical billing code sets. The Automated Biller is a sensible solution for an individual provider taking control of their own medical billing obligations and still bill with accuracy and confidence. Table III compares The Automated Biller to some of the other common medical billing software options available on the market such as MedisoftV12 and AltaPoint5.

Table III: Feature Descriptions of the Automated Biller and other Software Solutions

The Automated Biller Cost and Features	**MedisoftV12 Cost and Features**	**AltaPoint 5 Cost and Features**
$49,000	$7,000	$4,995
Upgrades for insurance regulation changes included for the life of the software	Standard program only; specialists must purchase their modules for the system to work for them	Standard program only; focuses more on managing medical records
System generates letters for patient collection and insurance payment every 30, 60, 90, 120 days	All collection letters are generated through individual patient accounts	All collection letters are generated through individual patient accounts
Includes hardware such as the desktop and the scanner for a complete billing system	Cost supports only one user on one desktop; no hardware included	Cost supports 5 users on 5 desktops; no hardware included

Instant snapshot reports that perform financial analysis of the medical practice	Users can add more modules for the system to handle more; separate disks available for Code Sets	Maintains all patient medical records digitally including x-rays, patient history, and prescriptions

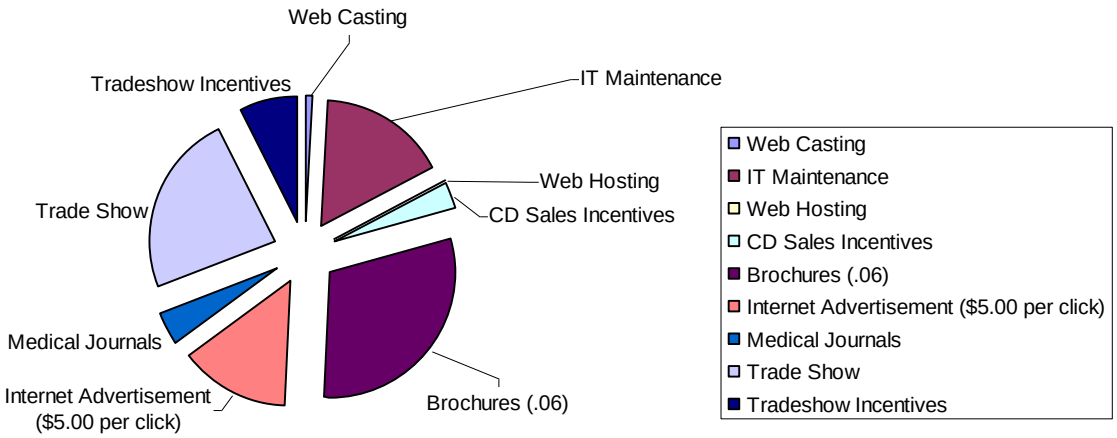
Marketing Communication Plan

The Automated Biller will offer some demos in a few different medical professional conferences throughout the year, such as the Academy of Pain Medicine Professionals. The purpose of attending these trade shows is to build clientele and demonstrate firsthand the effectiveness and efficiency of the Automated Biller system. Staff will also contact specific entities to demonstrate the benefits of the software, identify the target needs of individual customers, and implement the cost savings software package offered by The Automated Biller. The company will spend $273K during the first three months to advertise the efficiency of the software through media advertising, sampling demo, and trade shows to illustrate the benefits.

Chart II identifies the marketing efforts by category during the first six months. The Automated Biller will allocate a total of $522K for integrated marketing communications for the first year.

Chart II: Marketing Budget – First Six Months

Marketing Budget: First Six Months



The Automated Biller will continue an aggressive marketing mix of customer demonstrations and exhibitions through web casting and private audiences directing relating the need and the savings that The Automated Biller software offers Anesthesiologist. Direct mailings of CDs and brochures will continue throughout the first and second year during the high peaks of health awareness. The Automated Biller will build awareness through goodwill of existing clients while seeking national attention because of the costing savings and HIPAA requirements that is offered by The Automated Biller. The Automated Biller's web presence will promote product awareness for a paperless medical billing system in compliance with HIPAA regulation.

To increase the presence of The Automated Biller's software the following marketing mix will continue:

- Increase trade show appearances throughout the west coast as identified in Figure 3
- Place advertisement in professional-specific journals
- Increase Internet advertisements on physicians and local hospital web sites

- Develop clientele in other specialty areas requiring billing services
- Institute additional trade shows during the year to increase client pipeline

Sales Force

The Automated Biller's staff is currently made up of two individuals who will utilize web casting to promote and entice clients into purchasing the software. In today's business health service market, health care providers don't have time to seek out and interview prospective billing services; many times, billing services are promoted through word of mouth. The Automated Biller sales force offers web casting to eliminate the time constraints of the busy health care professional. This preview will be a recorded session of a live demonstration of the software through web casting. Web casting gives the sales force the opportunity to record and play back the introduction while minimizing the travel time and costs related to traditional business demonstrations. Each person will be assigned a region to advertise, promote, and demonstrate the effectiveness of The Automated Biller.

Impact of the Affordable Care Act ("Obamacare")

By automating the process of coding and billing, our Automated-Biller is helps to drive down the operating costs of healthcare providers and enabling them to capture more revenue than in the past. With Automated-Biller, all claims are automatically coded, charged and billed directly to the payer with maximum efficiency, right at the point of care. We are convinced that Automated-Biller can reduce operating costs for billing, follow up and collection by as much as 70% and can increase revenue by as much as 100% or more just by submitting accurate billing to insurance companies and governmental payers.

Obamacare is expected to result in more patients as more people are required to purchase healthcare. Reimbursement is expected to be worse due to Obamacare supporting expansion of Medicare, which does not reimburse well. With skyrocketing operating costs and bottom line bleeding, Automated Biller can play a key role in helping healthcare providers maintaining their income under Obamacare.

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 health care providers who engage in HIPAA-defined standard electronic transactions, health plans, and health care 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. 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 in a 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;
- 1. that we will enter in a similar agreement 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 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 under it, have provided, 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 become effective, 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.

Government Regulation of Reimbursement

Our clients are subject to regulation by several 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 health care 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 health care providers and adjustments that have affected the complexity of our work. 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.

Fraud and Abuse

Several federal and state laws, loosely referred to as "fraud and abuse laws," are used to prosecute health care 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 health care 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 health care providers and patients. The federal health care 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 health care 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 health care 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 health care 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 health care 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, about the submission and payment of physician claims for reimbursement. In some cases, these laws also forbid abuse about 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. Thus, 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 because 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 about submission and payment of reimbursement claims. CMS has stated that it is concerned that percentage-based billing services may encourage billing companies to commit or to overlook fraudulent or abusive practices.

PPACA. In addition to the provisions relating to health care access and delivery, the Patient Protection and Affordable Care Act made changes to health care fraud and abuse laws. The PPACA expands false claim laws, amends key provisions of other anti-fraud and abuse statutes, provides the government with new enforcement tools and funding for enforcement, and enhances both criminal and administrative penalties for noncompliance. The PPACA may result in increased anti-fraud enforcement activities.

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 health care entities. Physicians are prohibited from referring patients for certain designated health services reimbursed under federally funded programs to entities with which they or their immediate family members have a financial relationship or an ownership interest, unless such referrals fall within a specific exception. Violations of the statute can result in civil monetary penalties and/or exclusion from the Medicare and Medicaid programs. Furthermore, reimbursement claims for care rendered under forbidden referrals may be deemed false or fraudulent, resulting in liability under other fraud and abuse laws.

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

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

In many states, there are laws that prohibit non-licensed practitioners from practicing medicine, prevent corporations from being licensed as practitioners, and prohibit 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 based on 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 way business service companies may handle payments for such claims and prevent such companies from charging their physician clients based on a percentage of collections or charges. 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 about 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.

Electronic Health Records Certification Requirements

The HITECH Act directs the Office of the National Coordinator for Health Information Technology, or ONCHIT, to support and promote meaningful use of certified EHR technology nationwide through the adoption of standards, implementation specifications, and certification criteria as well as the establishment of certification programs for EHR technology. In January 2011, HHS issued a final rule to establish a permanent certification program for EHR technology, including how organizations can become ONC-Authorized Testing and Certification Bodies (ONC-ATCBs). ONC-ATCBs are required to test and certify that EHR technology is compliant with the standards, implementation specifications, and certification criteria adopted by the Secretary and meet the definition of "certified EHR technology." In July 2010, the Secretary published the final rule that adopted standards, implementation specifications, and certification criteria for EHR technology. 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 U.S. Food and Drug Administration ("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. The FDA has stated that health information technology software is a medical device under the FDCA, and we expect that the FDA is likely to become increasingly active in regulating computer software intended for use in health care settings regardless of whether the draft policy or proposed rule is finalized or

changed. We anticipate additional guidance on this subject by early 2014, in the form of a report to be issued by the FDA, ONCHIT, and the Federal Communications Commission. This report would propose a regulatory framework for health information technology that promotes innovation, protects patient safety, and avoids regulatory duplication.

If our computer software functionality is considered a medical device under the FDCA, we could be subject to additional regulatory requirements. 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 un cleared, 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, failure of the FDA to grant marketing approvals, withdrawal of marketing approvals, a recommendation by the FDA to disallow us from entering government contracts, and criminal prosecutions. The FDA also has the authority to request repair, replacement, or refund of the cost of any device.

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 reliance, 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 health care domain expertise and payer rules knowledge of our service operations and research and development teams;

- the real-time connectivity of our service offerings;

- the continued expansion of our proprietary Rules Engine; and

- a continued focus on the improved financial results of our clients.

We have registered our trademark “AutoMed” and copyrights were approved in 2006. We continuously need to update copyright due to updated source codes.

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.

Seasonality

There is moderate seasonality in the activity level of medical practices. Typically, discretionary use of physician services declines in the late summer and during the holiday season, which leads to a decline in collections by our physician clients about 30 to 50 days later. In addition, as further explained in “Risk Factors,” our revenues and operating results may fluctuate from quarter to quarter depending on a host of factors including, but not limited to, the severity, length, and timing of seasonal and pandemic illness.

Litigation

The Company was the plaintiff in a lawsuit seeking to recover $15 million, including penalties and interest. The Company alleged that the defendant, Dr. Narinder Grewal of Chatsworth, California, a customer, cashed checks we sent for payment of his insurance reimbursement after receiving bank wires from us for this same reimbursement, and engaged in other frauds.

The Company sued Narinder S. Grewal et al and the Company was awarded $374,000. The Company feels that this low award was since most of the Company's admitted evidence was stolen by the Defendants.

On November 17, 2015, the Company filed a lawsuit against the Company's counsel in the litigation involving Narinder S. Grewal et al. This lawsuit asks for $6 million in damages on the grounds of negligence. There is no assurance that anything will be

recovered.

The Company has written off $3,205,695 of Contingent Assets booked about the contingency assets. See Financial Statements, Note B.

The Company has no other current, pending or threatened legal proceedings or administrative actions either by or against the Company issuer that could have a material effect on the issuer's business, financial condition, or operations and any current, past or pending trading suspensions

Research and Development

We estimate that we have spent the following amounts on research and development activities: 2010 - $24,000, 2011 - $10,300, 2012 - $18,000, 2013 - $6,500, 2014 – $6,500, 2015 – $6,102.

We have update d (2013), The Automated Biller by updating the “Capture Cost” module. Capture Cost is designed to keep tabs of expenses such as every day health care practice supplies, mediation vials, disposables and consumables that are used to provide medical services. These materials are costly but most of these charges are not billed and are not recovered due to lack of billing knowledge and or error billing. Automated-Biller has been designed extensively to keep track of all expenses. The Automated Biller bills these charges automatically, further increasing cash flow for the health care practitioner.

Item 10 The Nature and Extent of Issuer’s Facilities

Property

Our corporate office is located at 401 E. Jackson Street, Suite 2340, Tampa, FL 33602. Our mailing address is P.O. Box 2013, Upland, CA 91785-2013 for all correspondence for all services. Our current lease payments are $2,600.00 per month for all locations.

Employees

As of September 30, 2016, we had eight employees, including officers and directors. We believe that we have been successful in attracting experienced and capable personnel. All our employees have entered agreements with us requiring them not to compete or

disclose our proprietary information. Our employees are not represented by any labor union. We believe that relations with our employees are excellent. Usually the number of total employees and number of full-time employees varies between 10 – 22, increased or reduced as per need for the time.

RISK FACTORS

The following is only a brief summary of the risks involved in investing in our Company. Investment in our Securities involves risks. You should carefully consider the following risk factors in addition to other information contained in this Disclosure Document. The occurrence of any of the following risks might cause you to lose +all or part of your investment. Some statements in this Document, including statements in the following risk factors, constitute "Forward-Looking Statements."

Risks Related Our Industry

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

Revenue cycle and clinical cycle software for medical 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 these vendors may also provide administrative services. The size,

financial strength, and breadth of offerings of the larger entities is increasing because of continued consolidation in both the information technology and health care industries. We expect large integrated technology companies to continue 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. In addition, a few smaller companies have started providing software using a model like ours; the offerings of these smaller companies may reduce the perceived competitive advantage of our services and impact our market share. Further, while the market for patient communication and referral management services is growing and is not yet dominated by a small group of vendors with significant resources, our patient and referral cycle services face competition from a wide variety of market participants. For example, certain health systems have developed their own patient portals or referral management systems. If we fail to distinguish our patient and referral cycle offerings from the other options available to health care providers, the demand for and market share of those offerings may decrease.

Some of our current large competitors, such as Allscripts-Misys Healthcare Solutions, Inc.; Athena health, Inc.; GE Healthcare; and McKesson Corp., have greater name recognition, longer operating histories, and significantly greater resources than we do. Thus, our competitors may be able to respond more quickly and effectively than we can too 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, considering 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 may not develop substantially further or develop more slowly than we expect, harming the growth of our business.

While medical business services are becoming more accepted, the market for these services remains narrowly based, and it is uncertain whether these services will achieve and sustain the high levels of demand and market acceptance we anticipate. 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, clinical, and patient cycles. 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 the security and reliability, 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 business, financial condition, or operating results.

Changes in the health care 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 health care 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 health care providers within hospital systems may cause our existing client contracts to terminate as independent practices are merged into hospital systems. Such larger health care 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.

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

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

After funding, we expect to experience 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 and management attention 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.

Our business involves a high degree of risk.

An investment in our common stock is extremely speculative and of exceptionally high risk.

We may be unsuccessful in raising the necessary capital to fund operations and capital expenditures.

Our ability to generate cash flow is dependent upon the success of our ability to market our Automated Billing System. However, we cannot guarantee that the sales of our products and other available cash sources will generate sufficient cash flow to meet our overall cash requirements. If cash flow is not sufficient to meet our business requirements, we will be required to raise additional capital through other financing activities. While we have been successful in raising the necessary funds in the past, there can be no assurance we can continue to do so in the future.

We depend on key employees and face competition in hiring and retaining qualified employees.

Our employees are vital to our success, and our key management and other employees are difficult to replace. We currently do not have employment contracts with our key employees. We may not be able to retain highly qualified employees in the future which could adversely affect our business.

We may experience significant losses from operations.

Even if we do generate operating income in one or more quarters in the future, subsequent developments in our industry, customer base, business or cost structure or an event such as significant litigation or a significant transaction may cause us to again experience operating losses. We may not become profitable for the long-term, or even for any quarter.

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 about their employment. Volatility in the price of our stock or failure to obtain stockholder approval for increases in the number of shares available for grant under our equity plans 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 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;

- the risk of write-offs and the amortization of expenses related to purchased intangible assets; and

- delays in client purchases due to uncertainty and the inability to maintain relationships with clients of the acquired businesses.

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

We may choose to expand by strategic acquisitions. Completion of the any proposed acquisition is subject to various closing conditions, involves significant costs, and will require considerable attention from our management. Failure to complete the acquisition could adversely affect our stock price and our future business and operations.

The completion of the any proposed acquisition is subject to the satisfaction of various closing conditions, including the approval by target stockholders, and we cannot assure you that such conditions will be satisfied and that the acquisition will be successfully completed. If the acquisition is not consummated, we will have spent considerable time and resources, and incurred substantial costs, including costs related to the acquisition, many of which must be paid even if the merger is not completed. If the acquisition is not consummated, our reputation in our industry and in the investment community could be damaged and, thus, the market price of our common stock could decline.

We may fail to realize the anticipated benefits of the any acquisition.

The success of any acquisition will depend on, among other things, our ability to combine our businesses in a manner that does not materially disrupt existing relationships and that allows us to achieve operational synergies and capitalize on the increased brand recognition and customer base of the combined company. If we are not able to achieve these objectives, the anticipated benefits of the acquisition may not be realized fully or at all or may take longer to realize than expected. The acquisition may not be accretive or accelerate sales in near or long term.

The integration process could result in the loss of key employees; the disruption of our ongoing businesses; or inconsistencies in standards, controls, procedures, or policies that could adversely affect our ability to maintain relationships with third parties and employees or to achieve the anticipated benefits of the acquisition. Integration efforts between the two companies will also divert management's attention from our core business and other opportunities that could have been beneficial to our shareholders. An inability to realize the full extent of, or any of, the anticipated benefits of the acquisition, as well as any delays encountered in the integration process, could have an adverse effect on our business and results of operations, which may affect the value of the shares of our common stock after the completion of the acquisition.

Further, the actual integration may result in additional and unforeseen expenses. Operational improvements and actual cost synergies, if achieved at all, may be lower than we expect and may take longer to achieve than we anticipate. If we are not able to adequately address these challenges, we may be unable to realize the anticipated benefits of the integration of any acquisition.

Financial Risks

We will need additional financing.

Our development schedule could be delayed if we are unable to fund our activities. We believe we will need to raise additional funds to achieve full commercial operation. We do not know whether we will be able to secure additional funding, or funding on terms acceptable to us.

We face financial risk, including the risk of high leverage.

Our development and operation will entail uncertain cash flows. We may spend relatively large amounts on marketing and other expenses. These factors and more will result in substantial financial risk. See "Business."

We may be subject to the risks normally associated with debt financing, including the risk that payments of principal and interest on borrowings may leave us with insufficient cash to operate or to pay distributions.

We intend to make use of a very high degree of financial leverage. We could become more highly leveraged because our organizational documents contain no limitation on the amount of debt we may incur.

The use of a high degree of leverage will increase our sensitivity to increases in interest rates. Increases in interest rates may increase our interest expense and adversely affect our cash flow and our ability to service our indebtedness and make distributions to our stockholders.

Legal Risks

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 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.

Agreement terms that address non-competition are difficult to enforce in many jurisdictions and may not be enforceable in any 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 like

ours, or use trademarks like 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 know or 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 many 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 may receive in the future, communications from third parties claiming that we have infringed on the intellectual property rights of others. Our technologies may not be able to withstand such 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 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.

Current and future litigation against us could be costly and time-consuming to defend and could result in additional liabilities.

We may from time to time be subject to legal proceedings and claims that arise in the ordinary course of business, such as claims brought by our clients about commercial disputes and employment claims made by our current or former employees. Claims may also be asserted by or on behalf of a variety of other parties, including government agencies, patients of our physician clients, or stockholders. For example, we have entered a purchase and sale agreement for the property on which our corporate headquarters are located. This property is a former Superfund site, and our ownership of it, or any of our other properties, could expose us to liability under applicable environmental laws. Any litigation involving us 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. Insurance may not cover existing or future claims, be sufficient to fully compensate us for one or more of 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.

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 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.

Our clients may seek to defraud us.

We are currently engaged in litigation to recover substantial amounts owed to us by a client who defrauded us. If our clients seek to defraud us, we not be aware of this, we may not be able to obtain sufficient information on their activities, and we may have to engage in costly and time-consuming litigation to recover any amounts due.

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 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 relationships 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 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 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 responses 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.

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 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.

Risks Inherent in the Company

We are indemnifying our officers and directors.

Our By-Laws provide for the indemnification of officers and directors relating to their activities for the Company fully permitted under the Florida General Corporation Code. These provisions may have the effect of providing indemnity about suits brought by parties other than the Company against an officer or director who has been grossly negligent, though he acted in good faith and in the Company's interests. See "Indemnification."

We rely upon a few officers.

We are wholly dependent on the personal abilities of our officers in order to develop and conduct our operations. Our success will be largely dependent on the personal efforts of our key officers and directors. The loss of the services of any of these officers would have a material adverse effect on our business and prospects. Our success also may be dependent, in part, upon our ability to hire and retain additional qualified sales and marketing personnel. There can be no assurance that we will be able to hire or retain such necessary personnel. See "Management."

Our present shareholders will retain control.

Our present control shareholder owns __81% of the outstanding Common Stock. Because of this percentage of ownership, the existing shareholders will be able to control our management at least for the foreseeable future. Investors will not have the right to elect our directors and the Company's control will stay with the current shareholders. This shareholder will have full voting control of the Company and the Board of Directors. See "Management," "Principal Shareholders" and "Description of Securities."

The liability of our directors and officers is limited.

Our Articles of Incorporation include provisions to eliminate, to the full extent permitted by Florida corporate law as in effect from time to time, the personal liability of our directors for monetary damages arising from a breach of their fiduciary duties as directors. The Articles of Incorporation also includes provisions to the effect that (subject to certain exceptions) the Company shall, to the maximum extent permitted from time to time under Florida law, indemnify, and upon request shall advance expenses to, any director or officer to the extent that such indemnification and advancement of expenses is permitted under such law, as it may from time to time be in effect. In addition, our By-Laws require us to indemnify, to the full extent permitted by law, any of our directors, officers, employees or agents for acts which such person reasonably believes are not in violation of our corporate purposes as set forth in the Articles of Incorporation. As a result of such provisions in the Articles of Incorporation and the By-Laws, stockholders may be unable to recover damages against our directors and officers for actions taken by them which constitute negligence, gross negligence or a violation of their fiduciary duties, which may reduce the likelihood of stockholders instituting derivative litigation against directors and officers and may discourage or deter stockholders from suing our directors, officers, employees and agents for breaches of their duty of care, even though such action, if successful, might otherwise benefit us and our stockholders. See "Indemnification."

Our Board of Directors may unilaterally implement changes in our investment and financing policies that may affect the interests of our stockholders.

Our investment and financing policies, and our policies with respect to other activities, including growth, debt, capitalization, and operating policies, are determined by the Board of Directors. Although the Board of Directors has no present intention to do so, these policies may be amended or revised from time to time at the discretion of the Board of Directors without notice to stockholders or a vote of our stockholders.

Accordingly, stockholders have no direct control over changes in our policies and changes in our policies may affect them.

The loss of key executive officers could have an adverse effect on us.

We are dependent on the efforts of our President, Chandana Basu. The loss of her services could have an adverse effect on our operations. We do not currently maintain or contemplate obtaining any "key man" life insurance on, our executive officers. See "Management."

We are dependent on external sources of capital.

To achieve our business plan and to grow, we will need constant infusions of additional capital. We will need to fund our future capital needs, including capital for property development and acquisitions, from sources other than income from operations. We therefore must rely on third-party sources of debt and equity capital financing, which may or may not be available on favorable terms or at all. Our access to third party sources of capital depends on several things, including conditions in the capital markets generally and the market's perception of our growth potential and our current and potential future earnings. Additional equity offerings may result in substantial dilution of stockholders' interests, and additional debt financings may substantially increase our leverage. Further, there has been substantial turmoil in the financial markets and there is no assurance that we will be able to successfully access capital.

Risks in the Securities

You may experience dilution if we issue additional securities,

If we issue additional shares, you may find your holdings diluted, which if it occurs, means that you will own a smaller percentage of our company. Further, any issuance of additional securities to various persons or entities in lieu of cash payments will lead to further dilution.

We do not expect to pay dividends on our Common Stock.

We have never paid any dividends on our Common Stock. We have no plans to pay dividends on our Common Stock in the foreseeable future. Furthermore, the Company

may issue Preferred Stock or other securities senior to the Common Stock, under terms which provide that no dividends shall be payable to holders of Common Stock unless and until all accrued cash dividends through the most recent past annual dividend payment date have been paid in full to holders of such senior securities. See "Dividend Policy."

Our operating results have in the past fluctuated 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 an investment in our common stock 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;

- changes in Client Days in Accounts Receivable;

- seasonal declines in the use of physician services, generally in the late summer and during the holiday season, which lead to a decline in collections by our physician clients about 30 to 50 days later;

- the financial condition of our current and future clients;

- changes in client budgets and procurement policies;

- the amount and timing of our investment in research and development activities;

- the amount and timing of our investment in sales and marketing 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 health care;

- 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 and profitability. Accordingly, unexpected revenue shortfalls, lower-than-expected revenue increases because of planned expenditures, and longer-than-expected impact on profitability and margins because of planned revenue expenditures may decrease our gross margins and profitability 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.

If the revenue of our client's 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 decreases in client revenue, including:

- interruption of client access to our system for any reason;

- our failure to provide services in a timely or high-quality manner;

- failure of our clients to adopt or maintain effective business

practices;

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

- government regulations and government or other payer actions or inaction 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. 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.

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 software vendors subject to sales and use taxes, 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 that our services are subject to sales and use taxes in a state, we voluntarily approach state tax authorities to determine how to comply with their rules and regulations. We cannot assure you that we will not be subject to sales and use taxes or related penalties for past sales in states where we believe no compliance is necessary.

Vendors of services, like us, are typically held responsible by taxing authorities for the collection and payment of any applicable sales and similar taxes. If one or more taxing authorities determines that taxes should have, but have not, been paid with respect to our services, we may be liable for past taxes in addition to taxes going forward. Liability for past taxes may also include very substantial interest and penalty charges. Our client contracts provide that our clients must pay all applicable sales and similar taxes. Nevertheless, clients may be reluctant to pay back taxes and may refuse responsibility for interest or penalties associated with those taxes. If we are required to collect and pay back taxes and the associated interest and penalties, and if our clients fail or refuse to reimburse us for all or a portion of these amounts, we will have incurred unplanned expenses that may be substantial. Moreover, imposition of such taxes on our services going forward will effectively increase the cost of such services to our clients and may adversely affect our ability to retain existing clients or to gain new clients in the states 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. The occurrence of additional accounting and legal costs and related expenses about, and the assessment of, taxes, interest, and penalties because of audits, litigation, or otherwise could be materially averse to our current and future results of operations and financial condition.

Because 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, although this period can be substantially longer. 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, although some of our new-client set-up projects—especially those for larger clients—are complex and require a lengthy delay and significant implementation work. Each client's situation is different, and unanticipated difficulties and delays may arise because of failure by us or by the client to meet our respective implementation responsibilities. During the implementation cycle, we expend substantial time, effort, and financial resources implementing our 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.

Even if implementation has begun, there can be no assurance that we will recognize revenue on a timely basis or at all from our efforts. Implementation for a given client may be canceled, as our contracts typically provide that they can be terminated for any reason or no reason on 90 days' notice. Even though we typically require a deposit in advance of implementation, some clients have canceled 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, clinical cycle, or patient 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 canceled implementation process and lost opportunity for implementing paying clients in that same period.

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. Thus, 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.

Risks Related to Our Products and Services

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 methods. If we do not function reliably or fails to achieve client expectations in terms of performance, clients could assert liability claims against us 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.

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 claims 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 web-based 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. From time to time we may detect vulnerabilities in our systems, which, even if they do not result in a security breach, may reduce customer confidence and require substantial resources to address. If our security measures are breached or fail because 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. Thus, 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 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 because 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 our system, exposing us to significant costs.

The ability to access our services is critical to our clients' administration of care, cash flow, and business viability. Our operations and facilities are vulnerable to interruption or damage from several 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 systems or those of others; and (iv) computer viruses, hacking, and similar disruptive problems in our systems or those of others. We attempt to mitigate these risks through various means, 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 in part 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 have no disaster recovery services to store our disaster recovery plans and provide disaster recovery testing services. In the case of a significant event at any of our data centers, we could move operations from that data center to our other data centers within a reasonable time frame.

However, these facilities 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 two or more of the facilities could result in lengthy interruptions in our service. Even with our 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 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;

- 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 about 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 because 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 to offer our services, including database software. 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.

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 health care 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 health care 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.

'

Regulatory Risks

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

The health care industry is highly regulated and is subject to changing political, legislative, regulatory, and other influences. Existing and new laws and regulations affecting the health care industry could create unexpected liabilities for us, cause us to incur additional costs, and restrict our operations. Many health care laws are complex, and their application to specific services and relationships may not be clear. Many existing health care laws and regulations, when enacted, did not anticipate the health care information services that we provide, and these laws and regulations may be applied to our services in ways that we do not anticipate. Our failure to accurately anticipate the application of these laws and regulations, or our other failure to comply, could create liability for us, result in adverse publicity, and negatively affect our business. Some of the risks we face from health care 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, about submission and payment of physician claims for reimbursement. In some cases, these laws also forbid abuse about 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 because 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 about 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 engage in or 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 considered a clearinghouse and, as such, a covered entity subject to HIPAA. In addition, our clients are also covered entities and are mandated by HIPAA to enter 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 that 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 that information;

- an obligation to report to our client any use or disclosure of that information other than as provided for in the agreement;

- a prohibition against our use or disclosure of that 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 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, ONCHIT is coordinating the ongoing development of standards to enable interoperable health information technology infrastructure nationwide based on the widespread adoption of electronic health records in the health care 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, and their interpretations are no less stringent than ours, 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 about 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 and other personally identifiable 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.

In addition to false claims and HIPAA requirements, we are subject to a variety of other regulatory schemes, including:

- ***Anti-Kickback and Anti-Bribery Laws***. There are federal and state laws that govern patient referrals, physician financial relationships, and inducements to health care providers and patients. For example, the federal health care 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 health care 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

health care 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. As the recipients of those orders will in certain instances pay us for the submission of accurate, complete, and readable orders instead of the handwritten and often incomplete orders traditionally submitted, our service could potentially be providing referrals to the order recipients in exchange for payment. Although the Office of Inspector General issued an Advisory Opinion in November 2011 stating that our receipt of payments in such instances would not violate federal anti-kickback laws, we cannot predict whether changes in the law or our

- ***Anti-Kickback and Anti-Bribery Laws***. There are federal and state laws that govern patient referrals, physician financial relationships, and inducements to health care providers and patients. For example, the federal health care 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 health care 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 health care 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. As the recipients of those orders will in certain instances pay us for the submission of accurate, complete, and readable orders instead of the handwritten and often incomplete orders traditionally submitted, our service could potentially be providing referrals to the order recipients in exchange for payment. Although the Office of Inspector General issued an Advisory Opinion in November 2011 stating that our receipt of payments in such instances would not violate federal anti-kickback laws, we cannot predict whether changes in the law or our

services might lead to a challenge of the legality of those services by government regulators. 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 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 based on 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 prohibit 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 way business service companies may handle checks or other payments for such claims and to limit or prevent such companies from charging their physician clients based on 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 service 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 about 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 Health Records Laws***. Several 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. Department of Health and Human Services (HHS). The 2011/2012 criteria support the Stage 1 meaningful use measures required to qualify eligible providers and hospitals for funding under the HITECH Act. 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 health care 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 time frames 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. In addition, in February 2011 the FDA issued a final rule regarding regulation of Medical Device Data Systems (MDDSs), which

are systems that are intended to transfer, store, convert, or display medical device data. While EHRs are expressly exempted from the final rule, it is possible that future changes in our services could involve the transfer, storage, conversion, or display of medical device data. In addition, a report, due by early 2014 from the FDA, ONCHIT, and the Federal Communications Commission, is expected to propose a regulatory framework for health information technology for promoting innovation, protecting patient safety, and avoiding regulatory duplication. To the extent that our software is considered a medical device under the policy or an MDDS under the final rule, or is the subject of additional regulation promulgated because of the report, we, as a provider of application functionality, could be required, depending on the functionality, to:

- register and list our products with the FDA;

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

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

The FDA can impose extensive requirements governing pre- and post-market conditions, 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 health care 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 health care reform initiatives and will be subject to increasing regulatory requirements, either of which could affect our business in a multitude of ways. If substantive health care 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 also 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. Such reforms may also make introduction of new service types costlier 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, 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.

Due to the nature of certain services we provide or the way we provide them, we may be subject to government regulation unrelated to health care.

While our services are primarily subject to government regulations pertaining to health care, certain aspects of those services may require us to comply with regulatory schemes from other areas. Examples of such regulatory schema include:

Antitrust Laws. Our national cloud-based network allows us access to cost and pricing data for many providers in most regional markets, as well as to the contracted rates for third-party payers. To the extent that our services enable providers to compare their cost and pricing data with those of their competitors, those providers could collude to increase the pricing for their services, to reduce the compensation they pay their employees, or to collectively negotiate agreements with third parties. Similarly, if payers can compare their contracted rates of payment to providers, those payers may seek to reduce the amounts they might otherwise pay. Such actions may be deemed to be anti-competitive and a violation of federal antitrust laws. To the extent that we are deemed to have enabled such activities, we could be subject to fines and penalties imposed by the U.S. Department of Justice or the Federal Trade Commission and be required to curtail or terminate the services that permitted such collusion.

Debt Collection Laws. As a billing service that offers patient communication and registration services, our employees or those of our service providers may from time to time meet patients who owe our clients outstanding amounts. Communications with patients that relate to amounts owed may be deemed to subject us or our service providers to federal or state debt collection laws and regulations. Such laws and regulations, if deemed to apply to us, could require registration with government agencies and compliance with significant administrative obligations (*e.g.*, to maintain an in-state office with local employees), which could result in increased expenses and subject us to fines and penalties for violation. Following the disclosure in 2012 of the methods used by debt collector Accretive Health to obtain payment of amounts owed by patients to one of its hospital clients, heightened focus on debt collection practices may lead to additional regulation and greater scrutiny of existing debt collection practices.

Subsidy of services like ours may reduce client demand if we do not participate in such programs.

In the past few years, entities such as the Massachusetts Healthcare Consortium have offered to subsidize adoption by physicians of EHR technology. In addition, federal regulations have been changed to permit such subsidy from additional sources, subject to certain limitations, and the current administration passed the HITECH Act, which provides federal support for EHR initiatives. While we have qualified for and participated in many of such subsidy programs, we cannot guarantee that we will be able to do so in the future. To the extent that we do not participate in such programs, demand for our services may be reduced, which may decrease our revenues.

The price of our common stock may continue to be volatile.

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 or unrelated to our operating performance. In addition to the factors discussed in this "Risk Factors" section and elsewhere, these factors include: the operating performance of similar companies; the overall performance of the equity markets; the 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 provision of health care or 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 has experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of those company's securities. 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.

Florida 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.

Florida law may discourage, delay, or prevent a merger, acquisition, or other change in control that stockholders may consider favorable, including transactions in which they might otherwise receive a premium for their 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 director; notice requirements for stockholder proposals and nominations; inability of stockholders to act by written consent or call special meetings; and the ability of our board of directors to make, alter or repeal our by-laws.

Florida General Corporation Law prohibits a publicly held Florida 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 stockholders could receive a premium for their common stock in an acquisition.

Risks Associated with Investing in our Common Stock

If we obtain additional financing, existing investor interests may be diluted. We may need to raise additional funds soon to fund our operations, deliver, expand, or enhance our products and services, finance acquisitions and respond to competitive pressures or perceived opportunities. If we raise additional funds by issuing equity or convertible

debt securities, the percentage ownership of our investors will be diluted. Furthermore, we cannot assure you that additional financing will be available when and to the extent we require it or that, if available, it will be on acceptable terms.

Because we may be subject to the "penny stock" rules, you may have difficulty in selling our common stock. Because our stock price is less than $5.00 per share, our stock may be subject to the SEC's penny stock rules, which impose additional sales practice requirements and restrictions on broker-dealers that sell our stock to persons other than established customers and institutional accredited investors. The application of these rules may affect the ability of broker-dealers to sell our common stock and may affect your ability to sell any common stock you may own.

Per the SEC, the market for penny stocks has suffered in recent years from patterns of fraud and abuse. Additionally, we may be subject to short selling, manipulation by others, and the regulations of the Pink Sheets OTC markets, all of which may be outside our control.

As an issuer of "penny stock" the protection provided by the federal securities laws relating to forward looking statements does not apply to us. Although the federal securities law provides a safe harbour for forward-looking statements made by a public company that files reports under the federal securities laws, this safe harbour is not available to issuers of penny stocks. Thus, if we are a penny stock we will not have the benefit of this safe harbour protection in the event of any based upon an claim that the material provided by us contained a material misstatement of fact or was misleading in any material respect because of our failure to include any statements necessary to make the statements not misleading.

The volatility of and limited trading market in our common stock may make it difficult for you to sell our common stock for a positive return on your investment. The public market for our common stock has historically been very volatile. Any future market price for our shares is likely to continue to be very volatile. Further, our common stock is not actively traded, which may amplify the volatility of our stock. These factors may make it more difficult for you to sell shares of common stock.

The registration and potential sale, either pursuant to a prospectus or pursuant to Rule 144, by certain of our selling stockholders of a significant number of shares could encourage short sales by third parties. There may be significant downward pressure on our stock price caused by the sale or potential sale of a significant number of

shares by certain of our selling stockholders pursuant to this prospectus, which could allow short sellers of our stock an opportunity to take advantage of any decrease in the value of our stock. The presence of short sellers in our common stock may further depress the price of our common stock.

If the selling stockholders sell a significant number of shares of common stock, the market price of our common stock may decline. Furthermore, the sale or potential sale of the offered shares pursuant to a prospectus and the depressive effect of such sales or potential sales could make it difficult for us to raise funds from other sources.

Our listing in the "Pink Sheets" limits the marketability of our stock. We are traded in the Pink Sheets. Companies in this market generally are disadvantaged in attracting investor interest.

Complete conversion of our convertible securities would result in substantial dilution to the common shareholders. We have outstanding issues of convertible notes. The conversion of all or a part of these securities would result in substantial dilution to the common shares. The Issuer intends to convert such notes and issue many new shares which will dilute existing holders.

Because we do not intend to pay any dividends on our common shares, investors seeking dividend income or liquidity should not purchase our shares. We do not currently anticipate declaring and paying dividends to our shareholders soon. It is our current intention to apply net earnings, if any, in the foreseeable future to increasing our working capital. Prospective investors seeking or needing dividend income or liquidity should, therefore, not purchase our common stock. We currently have no revenues and a history of losses, so there can be no assurance that we will ever have sufficient earnings to declare and pay dividends to the holders of our shares, and in any event, a decision to declare and pay dividends is at the sole discretion of our board of directors, who currently do not intend to pay any dividends on our common shares for the foreseeable future.

You may experience dilution if we issue additional securities. If we issue additional shares, you may find your holdings diluted, which if it occurs, means that you will own a smaller percentage of our company. Further, any issuance of additional securities to various persons or entities in lieu of cash payments will lead to further dilution. The

Issuer intends to issue such new shares, see "MARKETING." The Issuer may acquire other companies which would also involve the issuance of new shares.

We may have material inadequacies in our financial reporting. Management believes that there may be material inadequacies in our financial reporting. To that degree our financial statements may be unreliable. Management is working to upgrade our financial reporting.

Our common stock may be subject to penny stock rules, which may make it more difficult for our stockholders to sell their common stock. Broker-dealer practices about transactions in "penny stocks" are regulated by certain penny stock rules adopted by the Securities and Exchange Commission ("SEC"). Penny stocks generally are equity securities with a price of less than $5.00 per share. The penny stock rules require a broker-dealer, prior to a purchase or sale of a penny stock not otherwise exempt from the rules, to deliver to the customer a standardized risk disclosure document that provides information about penny stocks and the risks in the penny stock market. The broker-dealer also must provide the customer with current bid and offer quotations for the penny stock, the compensation of the broker-dealer and its salesperson in the transaction, and monthly account statements showing the market value of each penny stock held in the customer's account. In addition, the penny stock rules generally require that prior to a transaction in a penny stock the broker-dealer make a special written determination that the penny stock is a suitable investment for the purchaser and receive the purchaser's written agreement to the transaction. These disclosure requirements may have the effect of reducing the level of trading activity in the secondary market for a stock that becomes subject to the penny stock rules.
We are not required to meet or maintain any listing standards for our common stock to be quoted on the OTC Bulletin Board or in the Pink Sheets, which could affect our stockholders' ability to access trading information about our common stock.

The OTC Bulletin Board and the Pink Sheets are each separate and distinct from the NASDAQ Stock Market and any national stock exchange, such as the New York Stock Exchange or the American Stock Exchange. Although the OTC Bulletin Board is a regulated quotation service operated by the NASD, that displays real-time quotes, last sale prices, and volume information in over-the-counter ("OTC") equity securities like our common stock, and although Pink Sheets' Electronic Quotation Service is an Internet-based, real-time quotation service for OTC equities for market makers and brokers that provides pricing and financial information for the OTC securities markets, we are not required to meet or maintain any qualitative or quantitative standards for our

common stock to be quoted on either the OTC Bulletin Board or in the Pink Sheets. Our common stock does not presently meet the minimum listing standards for listing on the NASDAQ Stock Market or any national securities exchange, which could affect our stockholders' ability to access trading information about our common stock. Additionally, we are required to satisfy the reporting requirements under the Securities Exchange.

As an issuer of "penny stock" the protection provided by the federal securities laws relating to forward looking statements does not apply to us. Although the federal securities law provides a safe harbor for forward-looking statements made by a public company that files reports under the federal securities laws, this safe harbor is not available to issuers of penny stocks. Thus, if we are a penny stock we will not have the benefit of this safe harbor protection in the event of any based upon a claim that the material provided by us contained a material misstatement of fact or was misleading in any material respect because of our failure to include any statements necessary to make the statements not misleading.

The volatility of and limited trading market in our common stock may make it difficult for you to sell our common stock for a positive return on your investment. The public market for our common stock has historically been very volatile. Any future market price for our shares is likely to continue to be very volatile. Further, our common stock is not actively traded, which may amplify the volatility of our stock. These factors may make it more difficult for you to sell shares of common stock.

The registration and potential sale, either pursuant to a prospectus or pursuant to Rule 144, by certain of our stockholders of a significant number of shares could encourage short sales by third parties. There may be significant downward pressure on our stock price caused by the sale or potential sale of a significant number of shares by certain of our stockholders, which could allow short sellers of our stock an opportunity to take advantage of any decrease in the value of our stock. The presence of short sellers in our common stock may further depress the price of our common stock.

If the selling stockholders sell a significant number of shares of common stock, the market price of our common stock may decline. Furthermore, the sale or potential sale of our shares and the depressive effect of such sales or potential sales could make it difficult for us to raise funds from other sources.

Statements Regarding Forward-looking Statements

This Disclosure Statement contains various "forward-looking statements." You can identify forward-looking statements using forward-looking terminology such as "believes," "expects," "may," "will," "would," "could," “should," "seeks," "approximately," "intends," "plans," "projects," "estimates" or "anticipates" or the negative of these words and phrases or similar words or phrases. You can also identify forward-looking statements by discussions of strategy, plans or intentions. These statements may be impacted by several risks and uncertainties.

The forward-looking statements are based on our beliefs, assumptions and expectations of our future performance considering all information currently available to us. These beliefs, assumptions and expectations are subject to risks and uncertainties and can change because of many possible events or factors, not all of which are known to us. If a change occurs, our business, financial condition, liquidity and results of operations may vary materially from those expressed in our forward-looking statements. You should carefully consider these risks before you make an investment decision with respect to our Securities. For a further discussion of these and other factors that could impact our future results, performance or transactions, see the section entitled "Risk Factors."

Part D Management Structure and Financial Information

Item 11 Officers and Directors

Chandana Basu, CEO, Director

Chandana Basu has taken her over 26 years of experience in the medical billing field to create a well-rounded software system. She knows that it not only takes an effective medical billing software program, but other consoles are needed to make the medical practice easier to manage such as accounting software links to QuickBooks Pro, automated posting capabilities, and simple patient schedule modules. Many of the Automated Biller’s innovation can be credited to Basu’s extensive computer programming experience.

Arjinderpal Singh Sekhon, MD, Director

Dr. Sekhon is a director of the Company. Dr. Sekhon specializes in pulmonary medicine and pain management. Dr. Sekhon was a candidate for U.S. Congress in 2008 and won the primary election. Dr. Sekhon is a humanitarian. He served in U.S. Army Reserve for over 20 years. Dr. Sekhon is currently off duties due to illness.

Daljit Kaur, DDS, Director

Dr. Kaur is a Director of the Company. See is a well-known dentist. Dr. Kaur has been a Board member since 11/2009. Her business name is Creative Dental.

None of our officers or directors in the last five years has been the subject of any conviction in a criminal proceeding or named as a defendant in a pending criminal proceeding (excluding traffic violations and other minor offenses), the entry of an order, judgment, or decree, not subsequently reversed, suspended or vacated, by a court of competent jurisdiction that permanently or temporarily enjoined, barred, suspended or otherwise limited such person's involvement in any type of business, securities, commodities, or banking activities; a finding or judgment by a court of competent jurisdiction (in a civil action), the Securities and Exchange Commission, the Commodity Futures Trading Commission, or a state securities regulator of a violation of federal or state securities or commodities law, which finding or judgment has not been reversed, suspended, or vacated; or the entry of an order by a self-regulatory organization that permanently or temporarily barred, suspended or otherwise limited such person's involvement in any type of business or securities activities.

Directors are nominated or chosen by the issuer to become directors or officers, or beneficial owners of more than five percent (5%) of the any class of the issuer's equity securities.

Related Party Transactions

During the last two full fiscal years and the current fiscal year or any currently proposed transaction, there are transaction involving the issuer, in which the amount involved exceeds the lesser of $120,000 or one percent of the average of the issuer's total assets at year-end for its last three fiscal years, except compensation awarded to Chandana Basu and the following:

On September 20, 2014, the Board approved a sale of Professional Billing Service to Health Care Practice Partners, LLC.in the following terms: HPP will takeover of

Professional Billing Service including all law suits filed or to be filed against the clients who did not pay billing fees. Once the money is collected, HPP will pay 50% of the net gain to PPJ. Healthcare Practice Partners, LLC, is an entity controlled by Chandana Basu who transferred ten million shares of Company stock to the Company as consideration for the assignment. The assignment was made because the Company did not have the resources to pursue the litigation, because of the risk of the litigation. The assignment was approved by all the Company's disinterested directors.

During 2014, Ms. Basu accepted Class B Preferred Stocks at 50% of stated value for six years of unpaid compensation and all other amounts or shares due.

During 2015, Ms. Basu accepted 2,100,000,000 shares of Common Stock for compensation and Dajit Kaur accepted 100,000 shares of Common Stock as compensation.

Disclosure of Conflicts of Interest

There are no conflicts of interest between the Company and any of its officers or directors.

Employment Agreements

Ms. Chandana Basu has entered an employment agreement with the Company for a term of five years. Pursuant to this employment agreement, she has agreed to devote a substantial portion of her business and professional time and efforts to our business as our President. The employment agreement provides that each employee shall receive a salary determined by the Board of Directors commensurate with the development of the Company. She may be entitled to receive, at the sole discretion of our Board of Directors or a committee thereof, bonuses based on the achievement (in whole or in part) by the Company of our business plan and achievement by the employee of fixed personal performance objectives.

The employment agreements also contain covenants (a) restricting the executive from engaging in any activities competitive with our business during the terms of such employment agreements and one year thereafter, and (b) prohibiting the executive from disclosure of confidential information regarding the Company at any time.

Compensation by the Issuer; Due to lack of adequate financial resources, Ms. Basu is currently working as employee, she is drawing about $7,000 per month as salary and$ 5,000 to $6,000 as draw whenever funds are available but unpaid amount is being accrued. During 2014, Ms. Basu accepted Class B Preferred Stocks at 50% of the Market value for six years of unpaid compensation and all other amounts or shares due.

The Company's directors are elected by shareholders at each annual meeting or, in the event of a vacancy, appointed by the Board of Directors then in office to serve until the next annual meeting or until their successors are duly elected and qualified. The Company's executive officers are appointed by the Board of Directors and serve at the discretion of the Board of Directors.

Legal/Disciplinary History

1. None of PPJ Healthcare Enterprises, Inc.'s Officers or Directors have been the subject of any criminal proceeding or named as a defendant in a pending criminal proceeding (excluding traffic violations and other minor offenses);

2. None of PPJ Healthcare Enterprises, Inc.'s Officers or Directors have been the subject of any entry of an order, judgment, or decree, not subsequently reversed, suspended or vacated, by a court of competent jurisdiction that permanently or temporarily enjoined, barred, suspended or otherwise limited such person's involvement in any type of business, securities, commodities, or banking activities;

3. None of PPJ Healthcare Enterprises, Inc.'s Officers or Directors have been the subject of any finding or judgment by a court of competent jurisdiction (in a civil action), the Securities and Exchange Commission, the Commodity Futures Trading Commission, or a state securities regulator of a violation of federal or state securities or commodities law, which finding or judgment has not been reversed, suspended, or vacated; or

4. None of PPJ Healthcare Enterprises, Inc.'s Officers or Directors has been the subject of any entry of an order by a self-regulatory organization that permanently or temporarily barred, suspended or otherwise limited such person's involvement in any type of business or securities activities.

Item 12 Financial Information for the Issuer's Most Recent Fiscal Period

Financial Information of the Issuer is posted through the OTC Disclosure and News Service and is hereby attached and include a Balance Sheet, Statement of Income, Statement of Cash Flows, Statement of Changes in Stockholder's Equity and Notes to Financial Statements. These financial statements for period ended September 30, 2016 are hereby incorporated by reference.

Item 13 Similar Financial Information for such Part of the Two Preceding Fiscal Years as the Issuer or its Predecessor has been in Existence.

Financial Information of the Issuer for the periods ended December 2015, and December 31, 2014 are posted through the OTC Disclosure and News Service and are hereby incorporated by reference. These financial statements include balance sheets, statements of income, statements of cash flows, a statement of changes in stockholders' equity, and financial statement notes.

Item 14 Beneficial Owners of more than 5% of any class

The following table gives information on ownership of our securities as of September 30, 2016. The following lists ownership of our Common Stock and Preferred Stock by each person known by us to be the beneficial owner of over 5% of the outstanding Common and Preferred Stock, and by our officers and directors:

Common Stock as of September 30, 2016

Name	Address	Shareholdings	Percentage of Class Outstanding
Chandana Basu	P.O.BOX 2013 UPLAND, CA 91785	Common Stock	81%
Chandana Basu	P.O.BOX 2013 UPLAND, CA 91785	Class B Preferred	80%+

Item 15 Outside Advisors
None

1. Investment Banker

None

2. Promoters

None

Legal Counsel Corporate Law

Thakur Law Firm, APC
Pamela Tahim, ESQ
Robert Hensley, ESQ
2331 W. Lincoln Ave. Suite 300
Anaheim, CA 92801
Office: (714) 772-7400
Fax: (714) 772-0650

Law Offices of Andrew Rosenfeld
30141 Antelope Road
Suite D-139
Menifee, CA 92584
800-658-4510

Securities Law
John E. Lux, Esq.
1629 K Street, Suite 300
Washington, DC 20006
Telephone: (202) 789-1000
Email: john.lux@securities-law.info
Website www.thesecuritiesattorneys.com

4. Accountant

The Issuer is not engaged an independent accountant now.

5. Public Relations Consultant – None

6. Investor Relations Consultant – None. Only occasional IR/PR is being done. The Company is working on to set up in house IR/PR.

Item 16 Management's Discussion and Analysis or Plan of Operations

A. Plan of Operation

1. The Issuer's plan of operation for the next twelve months.

See "Business."

There is no assurance that these efforts will be successful.

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

1. Full fiscal years. Discuss the issuer's financial condition, changes in financial condition and results of operations for each of the last two fiscal years. This discussion should address the past and future financial condition and results of operation of the issuer, with emphasis on the prospects for the future. The discussion should also address those key variable and other qualitative and quantitative factors that are necessary to an understanding and evaluation of the issuer. If material, the issuer should disclose the following:

i. Any known trends, events or uncertainties that have or are reasonably likely to have a material impact on the issuer's short-term or long-term liquidity;

The Issuer must raise capital to continue its development. There is no assurance that it will be able to do so. If funding is secured, the Company intends to take very aggressive attempts to affect all its business plans such as (1) Company believes that this software will be accepted as blessings by the healthcare providers and dental will follow; (2) start blood cultures labs for bacteria and Candida species nationwide; (3) start medicinal marijuana potency test centers wherever legally permitted; (4) start pain management surgical suites in partnerships with pain specialists all over the country. The amount of financing sought initially is $1,000,000.

The Issuer has no material internal sources of liquidity. The Issuer may issue debt and equity securities to obtain liquidity but there is no assurance that such securities can be sold. The issuer is currently dependent upon its majority shareholder for support.

iii. Any material commitments for capital expenditures and the expected sources of funds for such expenditures;

The Issuer has no material commitments for capital expenditures and no expected sources of funds for such expenditures, but is exploring financing alternatives.

iv. Any known trends, events or uncertainties that have had or that are reasonably expected to have a material impact on the net sales or revenues or income from continuing operations;

Other than mentioned in this report, there are no known trends that have had or that are reasonably expected to have a material impact on the net sales or revenues or income from continuing operations. There is uncertainty about the Issuer’s ability to realize income from its business.

v. Any significant elements of income or loss that do not arise from the issuer's continuing operations;

There no known elements of income or loss that do not arise from the Issuer's continuing operations other than as disclosed herein.

vi. The causes for any material changes from period to period in one or more line items of the issuer's financial statements; and

The causes for any material changes from period to period in one or more line items of the issuer's financial statements are as follows:

The Issuer has written off certain contracts receivable and contingent assets, see financial statements.

As mentioned above, changes in the medical billing industry may affect the financial condition value of the Issuer.

vii. Any seasonal aspects that had a material effect on the financial condition or results of operation.

There are no known seasonal aspects that have had a material effect on the financial condition or results of operation of the Issuer.

2. Interim Periods. Provide a comparable discussion that will enable the reader to assess material changes in financial condition and results of operations since the end of the last

fiscal year and for the comparable interim period in the preceding year.

Compared to 2015 gross revenue was $319,059 with a net loss was $161,767 before extraordinary write offs. See financial statements for December 31, 2015, 2016 3rd QTR Gross Revenue was $98,901* (accrued) with a loss of $4,6profit of $4,669.

**We have been engaged in processing claims adjudications for insurance company during the 3rd quarter of 2016. Our earned fees have been submitted on invoices thus using earned revenue as accrued revenue for the 3rd quarter.

The Issuer expects that the material changes in financial condition and the results of operation since the end of the last fiscal year and for the comparable interim period in the preceding year are that the Issuer is attempting to develop its business and bring its litigation to a successful conclusion. There is no assurance that the Issuer will be able to+ obtain financing, or if such financing is obtained, that it will be on favorable terms. See also “Risk Factors” for a more specific discussion of the issues faced by the Issuer.

C. Off-Balance Sheet Arrangements.

The Issuer has no off-balance sheet arrangements.

Part E Issuance History

Item 17 List of Securities Offerings and Shares issued for services in the past two years.

List of the securities offerings and shares issued for services in the past two years, financial information for the issuer's most recent. Fiscal period and for such part of the two preceding fiscal years as the issuer or its predecessor has been in existence.

The Issuer has issued the following shares or securities or options to acquire such securities for Services in the past two fiscal years and any interim periods. Unless otherwise specified, all issuances were pursuant to Section 4(2) of the Securities Act of 1933.

The number of shares listed are adjusted to reflect the recent one for 100 reverse split.

The Company issued “Restricted” Gift shares to long term loyal shareholders. Total number of shares issued is 1,026,803. The Company will issue more gift shares upon receipt of complete information from long term shareholders;

Securities	Persons or entities to whom such securities were issued	Consideration or services provided by such persons or entities.	Trading Status of Shares
Shares Issued in 2016 Prior to Reverse Split			
471,895,200	Several individuals and companies?	Issued on conversion of Notes	Free trading
Shares Issued in 2015			
1,4749,912,501	Several individuals and companies?	Issued on conversion of Notes	Free trading
2,100,000,000	Chandana Basu	Services as an officer and director	Restricted and Controlled
500,000	Dajit Kaur	Services as an officer and director	Restricted and Controlled
Shares Issued in 2014			
11,273,333		Conversion of notes purchased from third parties	Free trading
4,917,216		Note conversion	Free trading
600,000		Note conversion	Free Trading
800,000		Legal services	Restricted
340,000		Finder's fee	Restricted
900,000		Pursuant to a contract for services	Restricted
10,020,000	Chandana Basu	For unpaid salary and to repay loans to company	Restricted
50,000		Repay investment	Restricted
50,000		Fee on note	Restricted
2,300,000		Conversion third-party note	Restricted
116,340		Incentive shares	Restricted
46,500		Incentive shares	Restricted

102,375		Incentive shares	Restricted
104,685		Incentive shares	Restricted
105,105		Incentive shares	Restricted
411,390		Incentive shares	Restricted
82,258		Incentive shares	Restricted
50,000		Services	Restricted
200	Jay Amarillo	Services but forfeited	Restricted
200	Grant Galloway	Services but Forfeited	Restricted
1	Cede & Co.	To correct discrepancy	

Part F Exhibits

Item 18 Material Contracts

The following documents have been posted via the OTC Disclosure and News Service as material contracts: None.

Item 19 Articles of Incorporation and Bylaws. Attached

Item 20 Purchases of Equity Securities by the Issuer and Affiliated Purchasers. In Future for Reductions of No of Shares in markets.

No affiliate plan of purchase share.

Item 21 Issuer's Certifications

The Issuer shall include certifications by the chief executive officer and chief financial officer of the Issuer (or any other persons with different titles, but having the same responsibilities).

The certifications shall follow the format below:

I, Chandana Basu, CEO/ President of PPJ Healthcare Enterprises, Inc ., certify that:

1. I have reviewed this quarterly disclosure statement of PPJ Healthcare Enterprises, Inc.;

2. Based on my knowledge, this disclosure statement does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, considering the circumstances under which such statements were made, not misleading with respect to the period covered by this disclosure statement; and

3. Based on my knowledge, the financial statements, and other financial information included or incorporated by reference in this disclosure statement, present in all material respects the financial condition, results of operations and cash flows of the Issuer as of, and for, the periods presented in this disclosure statement.

Date: November 13, 2016

___/S/ Chandana Basu_____
[Signature]
CEO/President