QUANTUM GROUP INC /FL
Form 10KSB/A
March 22, 2007

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D. C. 20549

Form 10-KSB/A

(Mark One)

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

For the Twelve Month Period Ended October 31, 2006

¨ TRANSITION REPORT UNDER SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

Commission File Number 000-31727

THE QUANTUM GROUP, INC.

(Name of registrant as specified in its charter)

Nevada	**20-0774748**
(State or other jurisdiction of Incorporation or organization)	*(I.R.S. Employer Identification No)*

3420 Fairlane Farms Road, Suite C

Wellington, Florida 33414

(Address of principal executive offices) (Zip Code)

Registrant s telephone number: (561) 798-9800

Securities registered under Section 12(b) of the Exchange Act: none

Securities registered under Section 12(g) of the Exchange Act:

Title of Each Class

Common Stock, $.001 par value

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

Check whether there is no disclosure of delinquent filers in response to Item 405 of Regulation S-K contained in this form, and no disclosure will be contained, to the best of registrant s knowledge, in the definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨

Check whether the issuer is not required to file reports pursuant to Section 13 or 15(d) of the Exchange Act. ¨

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

Revenues for the most recent fiscal year: $95,253

The aggregate market value of the Registrant s voting Common Stock held by non-affiliates of the registrant was approximately $3,412,260 (computed using the closing price of $.18 per share of Common Stock on March 13, 2007, as reported by OTCBB, based on the assumption that directors, officers and more than 5% stockholders are affiliates).

There were 41,218,583 shares of the registrant s Common Stock, par value $.001 per share, outstanding on March 13, 2007.

Explanatory Note

The following sets forth an explanatory note of the changes to the Company s Form 10-KSB.

We are filing this Form 10-KSB/A to reflect corrections made to our financial statements and related Management s Discussion and Analysis. The financial statements included have been restated to reflect the appropriate allocation of the components of the sale of units which included secured convertible debentures with a beneficial conversion feature and common stock and the resulting amortization of the corresponding costs. In addition, the unearned shares of common stock granted to employees were incorrectly included in the outstanding common shares. Also, the Company has reclassified accrued interest.

General

Unless other wise indicated or the context otherwise requires, all references in the Form 10-KSB/A to we , us , our , Quantum or the Company refer to The Quantum Group, Inc. and its consolidated subsidiaries. All references to a Fiscal year refer to our fiscal year which ends October 31. As used herein, Fiscal 2007 refers to the fiscal year ended October 31, 2007, Fiscal 2006 refers to fiscal year ended October 31, 2006 and Fiscal 2005 refers to the fiscal year ended October 31, 2005

FORWARD LOOKING STATEMENTS

The Private Securities Litigation Reform Act of 1995 provides a safe harbor for forward-looking statements. Certain statements contained herein, which are not historical facts, are forward-looking statements with respect to events, the occurrence of which involve risks and uncertainties. These forward-looking statements may be impacted, either positively or negatively, by various factors. Information concerning potential factors that could affect us is frequently detailed in our Company s reports filed with the Commission. This Report contains forward-looking statements relating to our current expectations and beliefs. These include statements concerning operations, performance, financial condition, anticipated acquisitions and anticipated growth. For this purpose, any statements contained in this Form 10-KSB/A, Form 10QSB, Form 8K, Form 14-C and other reports filed with the Commission referred to herein that are not statements of historical fact are forward-looking statements. Without limiting the generality of the foregoing, words such as may, will, would, expect, believe, anticipate, intend, could, estimate, or c negative or other variation thereof or comparable terminology are intended to identify forward-looking statements. These statements by their nature involve substantial risks and uncertainties, which are beyond our Company s control. Should one or more of these risks or uncertainties materialize or should our underlying assumptions prove incorrect, actual outcomes and results could materially differ from those indicated in the forward-looking statements.

The Quantum Group, Inc.

FORM 10-KSB/A FOR THE YEAR ENDED OCTOBER 31, 2006

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PART I

Item 1.

Description of Business

Introduction

The Quantum Group, Inc. (the terms Company , us , Quantum and/or we and other similar terms as used herein refer collectively to the Company together with its principal operating subsidiaries) is a Nevada corporation based in Wellington, Florida.

We currently have nominal revenues as we are building our Provider Systems and Provider Support Services. From inception, management s efforts have been primarily focused on negotiations of managed care contacts, contracting a base of physicians, building support staff, market research, business development, developing a utilization team, developing system procedures and training personnel, and due diligence on potential acquisitions, joint ventures and licensing agreements In other types of industries, all of these may have been referred to as research and development, in healthcare it is generally referred to as infrastructure development. During 2005 and 2006, we negotiated contracts with five Managed Care Organizations (MCOs), three of which are currently operational; the remaining two are currently in development. We have assembled a provider relations department that has contracted with over 1,200 physicians, ancillary providers and hospitals. We believe we are Florida s largest independent provider network, and we expect to be doing business only in Florida for the next few years.

Our business model is to become Florida s leading provider of support services to the healthcare industry in three complementary areas: providing leading edge healthcare *provider systems* to consumers; *provider support services* for physicians, MCOs, healthcare facilities and physician associations; and developing *provider technology solutions* to create a more effective and responsive healthcare system.

The Company is organized in three key operating divisions:

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Renaissance Health Systems (RHS) (*Provider Systems*). Renaissance Health Systems which contracts with MCOs in Florida to coordinate the delivery of healthcare services via its proprietary model, the *Community Health System* (CHS), generally in return for a percentage of Medicare reimbursement rates. We deliver our services through a network of over 1,200 affiliated physicians in south and central Florida, an area that represents 22 counties, with access to over 50 hospitals. As we expand further into Florida, we anticipate securing an additional 1,300 individual providers over the next twelve months. Similar companies engage in exclusive contracts with one managed care organization (in rare cases two), while we have executed five managed care contracts; three of which are active, and are generating minimal revenues, two are expected to be operational January 1, 2008. We are also in discussions with two additional plans. The Renaissance model allows for contracts with a multitude of MCOs thereby increasing its reach, diversification and potential for continued growth.

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Quantum Provider Support Services (PSS) (Provider Support Services). Quantum Provider Support Services provides healthcare support services, systems, technology solutions and management to physicians (with expected expansion to hospitals in 2007). The Company currently has, and is in development of, a range of strategic services including: managed care contracting, privacy consulting, human resources management, government compliance and financial management. Through its network of subsidiary companies which includes Renaissance Health Systems,

Quantum Medical Technologies, QMed BILLING and The Quantum Agency, the Company intends to strategically address many of the administrative needs of physicians, physician associations and hospitals that bring increased and highly valued efficiencies to this rapidly growing industry. We have recently negotiated to manage two medical billing and collections operations in South and Central Florida. The managed operations currently provide services to over 200 Florida Physicians.

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Quantum Medical Technologies (QMT) (Provider Technology Solutions). In addition to acquiring and developing medical technologies to provide solutions in managed care, Quantum Medical Technologies was created to support the continued growth and development of RHS and PSS, in addition to acquiring licensing and developing medical technologies to provide solutions in managed care organizations, hospitals and physician support services - including medical billing, web services, and electronic health record management. As a result, we are growing an integrated practice management platform that will provide a full Health Insurance Portability and Accountability Act of

1996 (HIPAA) compliant health information system to connect physicians with their patients, hospitals, and payers. The opportunity is to leverage and cross-market this platform into the existing client base of RHS, as well as those physicians and future hospitals utilizing the support services offered by The Quantum Group. We executed an agreement with Biocard Corporation of Miami to acquire its Biocard $_{sm}$ and Biorecord $_{sm}$ products (electronic patient medical record management). QMT has also recently developed a new aggregation of medical billing and electronic health records under the brand name of *Q-Care* $_{sm}$ systems.

Success in our development will be highly dependant on our ability to attract substantial capital, qualified people and on management s ability to manage an integrated but diverse business structure. Our Management Team believes we have assembled the foundation to become one of Florida s largest Provider Systems.

Mission Statement:

To identify and pursue leading edge opportunities within the healthcare industry, to develop efficient and cost effective healthcare solutions, to manage our patient s treatment outcomes through a wellness concept.

Vision Statement:

The Company seeks to develop productive and cost effective and innovative healthcare solutions through the integration of products, services, technology, and partnering with healthcare professionals thus permitting the healthcare professional to effectively deliver highly personal, quality-focused healthcare services in a cost effective and profitable manner.

Values Statement:

Provide leadership to our industry, our community and our employees; provide our patients with the products and services needed to ensure their wellness; and to ensure adherence to a high standard of corporate governance and ethics.

Industry Background

Current healthcare spending in the United States accounts for 16.7% of the nation s gross domestic product (GDP). The Department of Health and Human Services (HHS) announced that healthcare spending increased 6.9% in 2005 and 7.3% in 2006, to a total surpassing $2 trillion. That represents an average of over $6,600 for each person in the United States. Healthcare as a portion of our national gross domestic product (GDP) has risen from 5.7% in 1966 to 16.7% in 2005. The GDP has grown 1640% during the same period. Healthcare is the only net growth sector over the last 10 years, as Healthcare spending has risen from 13.3% of GNP to 16.7%, while housing, food, technology, auto and defense have remained flat as a percent of GDP. Medicare Advantage growth is projected to increase nearly 100% over the next four years. In addition, Medicare spending increased 8.9% to a record high of $400 billion in 2006.

The healthcare industry in the state of Florida is a $100+ billion industry[1], with over 56,000 licensed physicians[2]. Florida today is the fourth largest state in population in the union and will likely be the third largest within the next decade. With a population just under 18 million, current demographers estimate that over 10 million people will move into Florida over the next 20 years[3]. As of today, over 1,000 people move here every single day[4]. In our primary service areas of Dade, Broward and Palm Beach Counties, which correspond to the major cities of Miami, Ft. Lauderdale and West Palm Beach, there are over 20,000 physicians and a population near 5.5 million[5]. In excess of 15% of this population is over the age of 65. This senior population is our primary target today and in the future.

Medicare is the health insurance program for retired United States citizens or qualified legal permanent residents aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by the Centers for Medicare and Medicaid Services (CMS). The Medicare eligible population is large and growing. During 2005, approximately 41.5 million people, or approximately 14% of the United States population, were enrolled in Medicare according to CMS. The Henry J.

[1]

Florida Hospital Association, Facts About Florida's Health Care System, http://www.fha.org/facts.html.

[2]

Florida Department of Health, Health Professional Licensure, http://www.doh.state.fl.us/.

[3]

US Census Bureau, Press Release April 21, 2005. Florida, California and Texas to Dominate Future Populations Growth, Census Bureau Reports .

[4]

Florida Trend Magazine, April 2006, The Mega-Trends: Good Migration .

[5]

Florida Department of Health, Health Professional Licensure, http://www.doh.state.fl.us/.

Kaiser Family Foundation estimates that the number of Medicare enrollees will increase to 43.1 million in 2006, 46 million by 2010, 61 million by 2020, and 78 million by 2030. The Congressional Budget Office expects Medicare expenditures, without taking into account the new prescription drug benefit, will rise at a compounded annual growth rate of 8.9%, from approximately $342 billion in 2005 to approximately $800 billion in 2015.

We expect that most of our revenue will be derived, directly or indirectly, from medical services to Medicare Advantage members. Medicare is offered to eligible beneficiaries on a fee-for-service basis or through a managed care plan that has contracted with CMS pursuant to the Medicare Advantage program. In 2005, nationwide Medicare Advantage penetration, expressed as a percentage of total Medicare eligible beneficiaries who belong to a Medicare Advantage plan, is approximately 13%. Medicare Advantage penetration is anticipated to grow to almost 30% by 2013, according to the Henry J. Kaiser Family Foundation. We believe that the projected favorable Medicare Advantage enrollment trends and the reforms proposed by the MMA will have a positive impact on our Medicare Advantage plans.

MEDICARE SPENDING

	Spending in Billions		Medicare as
Year	GDP	Medicare	a % of GDP
1966	787.8	1.8	0.2%
1976	1,825.3	19.7	1.1%
1986	4,462.8	76.4	1.7%
1996	7,816.9	198.7	2.5%
2006	12,906.8	400.0	3.1%
2015	20,000.0	800.0	4.0%

According to the 2005 Federal Budget, Medicare Advantage (formerly Medicare + Choice) growth was projected to increase nearly 100% over the following 4 years. In addition, actual per member per month (PMPM) payments to MCOs were increased by a record 10.6% nationwide. Medicare spending increased 8.9% to a record high of $309 billion in 2005. In Palm Beach County Florida, where the Company is based, federal funding to Medicare MCOs was increased about 16 percent in 2005. MCOs receive a base of $734.51 per member per month from the federal government, up from $633.86 per member per month.

Federal officials and members of Congress are on the record stating that they hoped the increase, five times as large as the typical annual increase in recent years, would reverse the exodus of private plans from the Medicare program. The administration, trying to enhance competition and efficiency in the Medicare marketplace, wants to triple enrollment in private plans within three years.

With Medicare payments to MCOs rising two percent annually in recent years, many insurance executives decided that they could no longer do business with the program because their Medicare-related costs were rising about 10 percent a year. From 1999 to 2003, health plans dropped more than 2.4 million Medicare beneficiaries. Some withdrew from Medicare entirely, while others curtailed their participation by withdrawing from specific counties. The Federal Centers for Medicare and Medicaid Services predicted publicly that as a result of the increased payments, which took effect March 1, 2004, many private plans would return to the Medicare program.

Currently, of nearly 40 million Americans in Medicare, about 4.6 million (12 percent of all beneficiaries) have chosen to be in a Medicare & Choice Plan.[6]

The federal government predicts that due to the Medicare law enacted in December 2003 to encourage people to enroll in MCOs by 2007 and similar private plans called Preferred Provider Organizations (PPOs), 35 percent of beneficiaries will be members of such plans. Tommy G. Thompson, Secretary of Health and Human Services described the increased payments as an investment in our seniors. As a result of the increase, Medicare beneficiaries will have more options and better services. Private plans will be able to use the additional money to

[6]

Centers for Medicare & Medicaid Services, Press Release September 1, 2003, More Choices, Better Benefits: The Medicare + Choice Program

enhance benefits, to reduce premiums or co-payments paid by beneficiaries, or, as a way of stabilizing the network of healthcare providers who serve the beneficiaries, to increase payments to doctors and hospitals.[7]

We expect that these new rates will help beneficiaries by enabling their plans to deliver better benefits, such as enhanced prescription drug coverage, reduced out-of-pocket costs, and more reliable access to the providers in their communities, said Dennis Smith, CMS acting Administrator. They will provide equitable payments to private plans to support better service for Medicare beneficiaries. Over the long term, sharing this investment with the private plans can yield important benefits to beneficiaries and taxpayers.

Recent Future Developments for Healthcare Technology

Attendees at the World Health Care Congress were asked about the most significant opportunities that their organization can pursue during the next two years; 79% responded that greater emphasis on data-driven clinical care or the development of portable shared electronic health records were needed.[8]

During a speech February 2004 at the World Healthcare Congress in Washington, D.C., Health and Human Services Secretary Tommy Thompson said that Four years into the 21st century, the healthcare industry still depends on pencils, papers, manila folders, and memo sheets as primary tools for getting its work done. He further said the nation s healthcare delivery system needs to more widely incorporate business practices used in other industries, especially information technology. In the same speech, Thompson told attendees that supermarket clerks rely on technology to ensure they give customers the right change without mistakes. Yet, the Institute of Medicine estimates that 98,000 patients die, and even more are disabled each year, due to errors that can be largely prevented by technologies such as computerized prescription ordering, drug bar-code systems, and electronic patient medical records. The adoption of those and other technologies in healthcare could save the U.S. $100 billion a year through reduced deaths and disabilities. Because the government s Medicare program makes the federal government the country s largest insurance company, the feds are taking a lead role in trying to make it easier for more healthcare providers to adopt these technologies. The ability to share patient information electronically can help doctors and other providers to make better-informed decisions and spot potential mistakes before they happen. However, without data and other technical standards, the sharing of patient information electronically among health providers is often difficult or impossible[9].

Today, there is a greater emphasis than ever placed on issues of patient safety and the prevention of medical errors, competition in clinical care quality and IT innovation, as well as heightened awareness of the urgency to implement digital security measures and compliance strategies. We believe that these factors, combined with changes in federal, state and commercial/private payer reimbursement, slowed growth of Medicare payments, the aging of the U.S. population and the growing acceptance of the Internet and web-based technologies, and spurred by the increasingly vocal demands of consumers for quality care, will result in continued dramatic change in the healthcare industry.

Presently, we also see that there are, with minor exceptions, only two places physicians or medical providers can turn for help in meeting all the demands placed on them by the business and healthcare environment. These are highly paid consultants that could be represented by large accounting and large consulting firms, or the local cottage industry of healthcare consultants that range from HR functions to accounting and tax work, generally specializing in one or two areas and stretching to meet the ever increasing needs of their clients.

The changing business environment has produced an evolving range of strategic and operating options for healthcare entities. In response, healthcare participants are formulating and implementing new strategies and tactics, redesigning business processes and workflows, acquiring better technology to improve operations and patient care, integrating legacy systems with web-based technologies, developing e-commerce abilities and adopting or remodeling customer service, patient care and marketing programs. We believe that healthcare participants will continue to turn to outside consultants to assist in this vast array of initiatives for the following reasons: the pace of change is eclipsing the capacity of their own internal resources to identify, evaluate and implement the full range of options and consultants

enable healthcare participants to develop better solutions in less time and can be more cost effective. By employing outside expertise, healthcare providers can often improve their ability to compete by more rapidly deploying new processes.

[7]

Centers for Medicare & Medicaid Services, Office of the Actuary, NHE Projections 2005-2015

[8]

Harris Interactive January 26, 2005

[9]

Information Week, January 27, 2004, “Thompson: Health Care Needs More IT”

The healthcare consulting industry is highly fragmented and consists primarily of:

- Larger systems integration firms, including the consulting divisions of the national accounting firms and their spin-offs, which may or may not have a particular healthcare focus or offer healthcare consulting as one of several specialty areas;

- Healthcare information system vendors that focus on services relating to the software solutions they offer;

- Healthcare consulting firms, many of which focus on selected specialty areas, such as strategic planning or vendor-specific implementation;

- Large general management consulting firms that may or may not specialize in healthcare consulting and/or do not offer systems implementation; and

- Boutique firms that offer one or two specialized services, or who service a particular geographic market.

In response to escalating expenditures in healthcare costs, MCOs have increasingly pressured physicians, hospitals and other providers to contain costs. This pressure has led to the growth of lower cost outpatient care and reduction of hospital admissions and lengths of stay. To further increase efficiency and reduce the incentive to provide unnecessary healthcare services to patients, payers have developed a reimbursement structure called percentage of premium (POP). POP contracts require the payment to healthcare providers of a fixed amount per patient for a given patient population. The providers assume responsibility for servicing all of the healthcare services needs of those patients, regardless of their condition. We believe that low cost providers will succeed in the POP environment because such companies have the ability to manage the cost of patient care.

The highly fragmented nature of the delivery of outpatient services has created an inefficient healthcare services environment for patients, payers and providers. MCOs and other payers must negotiate with multiple healthcare services providers, including physicians, hospitals and ancillary services providers, to provide geographic coverage to their patients. Physicians who practice alone or in small groups have experienced difficulty negotiating favorable contracts with managed care companies and have trouble providing the burdensome documentation required by such entities. Healthcare service providers may lose control of patients when they refer them out of their network for additional services that such providers do not offer. We will continue affiliating with physicians who are sole practitioners or who operate in small groups to staff and expand our CHS enabling us to be a provider of choice to MCOs.

Business Strategy

I. Renaissance Health Systems, Inc. Provider Systems

A. Overview

RHS was incorporated in the State of Florida on December 13, 2002. The RHS strategy is to create a new type of healthcare delivery system built on the extensive experience of our senior management team. We intend to specialize in managed care Percentage of Premium (POP) contracting. RHS is creating a model for healthcare called the Community Health System (CHS) to contract with Florida MCOs to manage the care of patients in a proactive and cost effective environment.

We currently have been contracted for 22 of 67 counties in Florida. These 22 counties contain 76.26% of the Medicare population of the state.

We negotiated contracts with five MCOs, three of which are operational; the remaining two are currently in development. One operational contract started to accept patients in September 2005 in Volusia County, Florida with Dade and Broward Counties added in January 2006. Revenue and expense from this contract is minimal and will continue as such until we take over full risk of the member s healthcare costs upon the MCO enrolling a minimum of 300 members. The two other MCO contracts became operational December 1, 2006 and are full risk from the first patient forward. Further, the Company has been engaged in negotiations with an additional two MCOs. We have assembled a Provider Relations department that has contracted with over 1,200 physicians, ancillary providers and hospitals.

Since our inception, our management team has been part of the experimental process when acquiring doctors was expected to be the solve-all solution, to the later evolution of Physician Practice Management (PPM), Management Services Organization (MSO) and Provider Sponsored Network (PSN).

RHS has developed a new model for managing patients, providers, and insurers: the Community Health System (CHS). In a CHS, the patient is recognized as the true consumer of healthcare services. The doctor and patient, jointly make the critical decisions, not the MCO. Patients are actively involved in the improvement of their own well-being. We not only help and facilitate treating the sick, but proactively keep the patient healthy, thus reducing the overall costs for the patient and the industry. RHS will pay physicians to keep their patients healthy, and also intends to provide incentives to the patient at the end of each year for actively participating in his or her own health improvement.

B. MCO Arrangements

Executed Agreements

We have executed five contracts with Florida MCOs, three of which are currently active, with the remaining two currently in development. The terms of the active contracts detail that RHS will be responsible for arranging a Community Health System in named Florida counties. The contracts differ in terms regarding the type of delivery system and the way the capitations are set up, in addition to the way in which membership is established. The agreements call for RHS to receive a percentage of premiums received by the MCO. Relating to these agreements, we are required to place designated amounts in segregated bank accounts for each contract to start and increase this amount by a percentage of the revenues generated by the agreement up to a specific dollar amount.

Future Agreements

We intend to derive a substantial amount of our revenues from agreements with MCOs that provide for the receipt of capitated fees. Capitated fees are determined on a per capita basis and are paid monthly by MCOs. MCO enrollees may come from the integration or acquisition of healthcare providing entities, additional affiliated physicians, and acquire and increase enrollment in MCOs currently contracting with the Company through our Physician Practices and Ancillary Services, or from agreements with new MCOs. We intend to enter into additional MCO agreements, which generally will be for a one-year term, and subject to annual negotiation of rates, covered benefits and other terms and conditions. MCO agreements are often negotiated and executed in arrears.

C. Credentialing

Part of our responsibility in our current MCO contracts is to certify physician credentials. The RHS credentialing department became operational in September 2005. Credentialing is part of the underwriting process that the healthcare provider undergoes to participate with RHS. RHS has agreed contractually to perform Delegated Credentialing functions. The MCO delegates the credentialing process to RHS in order to proceed with contract negotiations. RHS must comply with all regulatory requirements and strict guidelines that the MCO is subjected to by the Agency for Health Care Administration and (AHCA) CMS. The MCO will perform periodic audits to ensure compliance.

When Providers contract with various MCOs, each MCO has its own, unique credentialing process that they must comply with. By participating with RHS, the provider only has to complete one credentialing application and undergo one credentialing process regardless of how many MCOs he/she participates with through RHS.

By performing the delegated credentialing functions, RHS has the ability to expedite and control the processing time when the MCO requests to submit a specific county for approval to CMS. This is consistent with our model where RHS establishes a direct relationship with the Provider. It is also an advantage that RHS does not have to rely on the

Healthcare Plan s processes to initiate a Provider.

RHS utilizes National Committee for Quality Assurance (NCQA) compliant software to manage this process. Currently, the service is extended for RHS Physicians. The Company is exploring the possibility of providing the credentialing services to hospitals.

We have established a Credentialing Committee for the purpose of making recommendations to approve or deny Provider participation in RHS. The Credentialing Committee is made up of practicing physicians with participation by the President and Vice President of RHS.

II. Quantum Provider Support Services - Provider Support Services

We intend to provide a broad range of management systems and products to the healthcare community; consisting primarily of individual and small physician practices, ancillary providers and other small to mid-size healthcare facilities including hospitals. We believe that this is a highly underserved market, and when these businesses do receive management system services it is usually in a fragmented, sporadic and inefficient manner.

We anticipate providing consulting services and solutions to healthcare organizations including health plans and technology providers with special emphasis on physician practices, ancillary providers, hospitals and an integrated delivery of health systems.

We intend to design solutions to enable clients to reap the benefits of their investments in new systems and information technology by improving financial performance, increasing productivity, and improving clinical and operational performance.

To address the increased industry-wide focus on patient safety, clinical excellence, compliance with security regulations and financial performance, our Company s ongoing mission is to design solutions that give the healthcare industry the tools and strategies they need to serve their customers effectively, improve the quality and safety of clinical care, secure and authenticate online healthcare transactions, reduce cost and ensure compliance with evolving government and industry requirements, including HIPAA.

Through our management team s knowledge and experience in healthcare operations and workflow, IT and clinical systems, we intend to work with clients to leverage their existing systems and processes to accelerate their return on investments. Our goal is to be the preferred, if not sole, provider of a broad range of support services and consulting solutions for each of our clients.

We deliver a number of solutions designed to enhance the physician s communications, workflow, patient wellness, and practice profitability. The purpose of these solutions is to act as a component of the Community Health System enterprise system. The Company utilizes our subsidiaries QMed BILLING (QMB) and The Quantum Agency (TQA) to deliver the solutions.

The solutions currently delivered are:

Medical billing and collections services

Insurances Malpractice, Health & Life, Property, Disability and, Workers Comp

Electronic Health Records (EHR) and Electronic Prescription Writing

Additional solutions to be added in fiscal year 2007 include:

Hospitalist Services

Personal Health Record (PHR)

Personnel Employment Organization (PEO)

Group Purchasing Organization (GPO)

Physician Receivable Financing

Third Party Adminstrator (TPA)

These solutions are designed to integrate with the RHS systems including Utilization Management, Case Management, Disease Management, Credentialing, Risk Management and Patient Wellness Management. By integrating all of these solutions, the Company is establishing an enterprise system which electronically and clinically connects all aspects of RHS interests in managing the full purview of the MCO and the physician practice. Management believes establishing an enterprise system to manage RHS will be the most effective means to achieve the best returns as it relates to patient wellness. The utilization of the enterprise system and its support solutions will also provide the physician practice with added efficiency and profitability.

We will market these solutions as the products are launched under *Q-Care* $_{sm}$ system. Some of the solutions will be revenue generating and others cost saving and communication enhancing. Unique to the healthcare industry, our comprehensive offerings will deliver a compact and complete healthcare system to individual communities.

The utilization of the solutions listed above allows the physician to:

-

Better document the patient care, including storage of lab tests, x-rays, etc

-

Utilize best practices knowledge to diagnosis and treat patients

-

Improve practice efficiency

-

Focus more time resources on clinical issues vs. administrative issues

-

Improve communications with hospitals and specialists

-

Use Hospitalist services to monitor patients while they are in hospitals

-

Improve the practice’s cash flow and profitability

-

Improve marketing ability of the practice to attract patients

-

Issue electronic prescriptions to the patient s pharmacy

QMed BILLING, Inc. Medical Billing and Collection Services

QMed BILLING (QMB) was incorporated in the State of Florida on May 8, 2006. QMB s plan is to satisfy medical billing and collection needs of physicians and hospitals throughout the state with the use of healthcare technology and strategically sizeable branches. In the past year, QMB has entered into two Management Agreements with Florida based billing and collection companies serving the Southern and Central Florida regions. The Company has begun conducting the appropriate due diligence and pre-closing process necessary to facilitate full acquisitions. QMB expects to close these acquisitions within the next few months. The Company plans to continue to seek potential acquisitions of medical billing companies to complete this portion of its strategic plan.

Our goal is to provide quality services that enable physicians to improve their practices. QMB provides services through traditional systems and through a new fully electronic, integrated system consisting of an advanced electronic health record (EHR) and a billing claims system. To help improve physician practices, QMB utilizes the electronic processing systems to more efficiently and timely processes claims and collect payments. Superbills, sent electronically in real time or batch mode, allow for improvement in the collection time for most physicians by 2-7 days. QMB is able to service any account in Florida from our two operation centers. In January 2007, QMB began marketing the combined solutions of EHR and billing under the Company's "Q-Care"sm system.

QMB services include:

- Processing physician prepared superbills into valid medical claims
- Electronically forwarding the claim to the appropriate payor (insurance, government, private)
- Recording collections from all sources and preparing account receivable reports for the physician
- Invoicing for patient portion of charges
- Other collection activities
- Follow up on denials and re-filing the claim
- Interfacing with payors regarding claim issues

The Quantum Agency, Inc. Insurance Agency

The Quantum Agency (TQA) was incorporated in the State of Florida on October 20, 2003 to serve as an insurance broker exclusively to physicians in Florida. TQA specializes in insurance programs most beneficial to

medical practices and individual physicians. We offer an array of products including property/casualty liability, health savings accounts, workers compensation, individual health plans, malpractice, group health, life, disability and more.

The Quantum Agency has contracted with five different agents to service our clients. Each agent specializes in a specific insurance product. Each agent has agreed to develop a program that is specialized for our RHS providers. In addition, TQA has agreements with certain MCOs to assist in the recruitment of members.

III. Quantum Medical Technologies, Inc. Provider Technology Solutions

Quantum Medical Technologies (QMT) was incorporated in January 18, 2000 to create a new model for managing information in the medical industry. A business process branded as Cybernaptic $_{sm}$ which connects all of the touch points of healthcare in an enterprise technology environment , utilizing Application Service Provider (ASP), web based platforms, will allow QMT clients to choose any combination of technical and software support. This will include: (i) full support servicing with data center consolidation, (ii) 24/7/365 network monitoring and help desk through our network control center, as well as (iii) facility management, application unification, application support servicing and interim management of the entire IT operations.

The healthcare technology environment is increasingly complex and costly as a result of the challenges inherent in developing and/or deploying new technologies to meet the growing needs of the industry and new objectives designed to improve clinical quality and patient safety. Maintaining or integrating legacy computer systems and deploying an IT function capable of achieving regulatory compliance, ensuring secure digital transactions, improving business operations and the revenue cycle as well as reducing supply costs prove costly and inefficient. As a result, we believe that the healthcare industry will continue to increase the percentage of its budget devoted to new technology solutions.

Computer-based patient record systems (electronic health records) and other technologies in the healthcare delivery process can enable organizations to improve their bottom line. These technologies help healthcare organizations reduce costs through clinical and supply chain efficiencies, enhance communications with physicians, patients, payers and other constituencies, improve care delivery and patient safety and streamline activities such as claims processing, eligibility verification and billing. QMT is developing its Q-Care$_{sm}$ system, an enterprise solutions system, to help healthcare organizations reduce costs through clinical and supply chain efficiencies, improve care delivery and patient safety, and streamline administrative activities such as claims processing, eligibility verification and billing.

We believe that healthcare providers and facilities will continue to turn to outside consultants, external management of formerly internal information systems, application support and full support servicing arrangements as a means of coping with the financial and technical demands of information systems management and integration of web-based solutions. QMT is ahead of the industry in recognizing and developing the first of its kind ASP based Community Health System enterprise system. Through business services offered by the Company through our *Q-Care*$_{sm}$ system, we provide flexible business processes, technology outsourcing solutions and operations management. Through *Q-Care*$_{sm}$ clients can achieve their business process and information technology goals while remaining focused on expanding their primary businesses and reducing related capital outlay.

QMT has begun to develop a new method to track improvement in patient life style with a patent pending process called Quantum Quotient$_{sm}$ or Qx2 $_{sm}$. The Company has filed a provisional application in connection with this process with the U.S. Patent Office. The assessing and purpose of the Quantum Quotient is to create a scientific method of qualifying healthcare condition, lifestyle risk and improvement in patients who participate in the federal Medicare Advantage program. The Quotient accomplishes this by using existing actuarial figures on mortality, morbidity, age, sex, diagnosis, prescription, environment and geography as well as job classification to qualify, quantify and predict future medical use and lifestyle risk of patients. MCO, MSO and CHS will use this index to further motivate patients to improve their health and lifestyle extending their lives, reducing illnesses and reducing future healthcare costs.

QMT acquired an electronic health record (EHR) and an integrated billing system for use by physicians and QMed BILLING. It is an ASP, web based platform utilizing knowledge based workflow methodology familiar to physicians. The solution was developed to meet the CCHIT and CCR standards. It also contains the ability to receive and send information in the HL7 and X12 formats, thus allowing physicians to transfer data and tests to and

from hospitals and labs. QMT developed a utilization management program which allows the Renaissance management team to manage its patient base. Combined with the EHR it creates the core of the *Q-Care*sm system.

QMT provides in-house web services in developing and maintaining web sites for RHS and Quantum needs, and several county medical associations. In December 2006, QMT installed a credentialing program, allowing Renaissance to credential its physicians for all MCO plans contracted. This service will be extended to hospitals in which RHS physicians hold or seek active privileges .

The Company seeks to assemble the solutions which become part of the Community Health Enterprise System. A number of additional solutions have been identified that the Company will acquire or internally develop, to support the RHS and Quantum Medical Management s operations.

Our Employees

We currently have 26 full-time employees at the Company s executive offices in Wellington, Florida. No employees of the Company are covered by a collective bargaining agreement or are represented by a labor union. The Company considers its employee relations to be good.

Government Regulation

As a player in the healthcare industry, the Company s operations and relationships are subject to extensive and increasing regulation by a number of governmental entities at the federal, state and local levels. The Company has structured its operations to be in material compliance with applicable laws. There can be no assurance that a review of the Company s or the affiliated physician s business by courts or regulatory authorities will not result in a determination that could adversely affect the operations of the Company or the affiliated physicians or that the healthcare regulatory environment will not change so as to restrict the Company s or the affiliated physicians existing operations or their expansion.

The laws of many states prohibit business corporations such as the Company from practicing medicine and employing physicians to practice medicine. In Florida, non-licensed persons or entities, such as the Company, are prohibited from engaging in the practice of medicine directly. However, Florida does not prohibit such non-licensed persons or entities from employing or otherwise retaining licensed physicians to practice medicine so long as the Company does not interfere with the physician s exercise of independent medical judgment in the treatment of patients. The laws in most states, including Florida, regarding the corporate practice of medicine have been subjected to limited judicial and regulatory interpretation and, therefore, no assurances can be given that the Company s activities will be found to be in compliance, if challenged.

There are also state and federal civil and criminal statutes imposing substantial penalties, including civil and criminal fines and imprisonment, administrative sanctions and possible exclusion from Medicare and other governmental programs on healthcare providers that fraudulently or wrongfully bill governmental or other third-party payers for healthcare services. The federal law prohibiting false billings allows a private person to bring a civil action in the name of the United States government for violations of its provisions. Moreover, technical Medicare and other reimbursement rules affect the structure of physician and ancillary billing arrangements. The Company believes it will always be in material compliance with such laws, but there is no assurance that the Company s activities will not be challenged or scrutinized in the future by courts or governmental authorities. Noncompliance with such laws may adversely affect the operation of the Company and subject it to penalties and additional costs.

Certain provisions of the Social Security Act, commonly referred to as the Anti-Kickback Statute, prohibit the offer, payment, solicitation, or receipt of any form of remuneration in return for the referral of Medicare or state health program patients or patient care opportunities, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered by Medicare or state health programs. The Anti-Kickback Statute is broad

in scope and has been broadly interpreted by courts in many jurisdictions. Read literally, the statute places at risk many business arrangements, potentially subjecting such arrangements to lengthy, expensive investigations and prosecutions initiated by federal and state governmental officials. Violation of the Anti-Kickback Statute is a felony, punishable by significant fines and/or imprisonment. In addition, the Department of Health and Human Services may impose civil penalties excluding violators from participation in Medicare or state health programs.

The federal Health Insurance Portability and Accountability Act (HIPAA) expands the government s resources to combat healthcare fraud, creates several new criminal healthcare offenses, and establishes a new advisory opinion mechanism under which the Office of Inspector General is required to respond to requests for interpretation of the Anti-Kickback Statute, in an effort to bring clarity and relief to the uncertainty of the Anti-Kickback Statute. Due to the newness of the legislation, it is impossible to predict the impact of the new law on the Company s operations.

Congress, in the Omnibus Budget Reconciliation Act of 1993, enacted significant prohibitions against physician referrals. These prohibitions, commonly known as Stark II, amended prior physician self-referral legislation known as Stark I by dramatically enlarging the field of physician-owned or physician-interested entities to which the referral prohibitions apply. Effective January 1, 1995, Stark II prohibits, subject to certain exceptions, including a group practice exception, a physician from referring Medicare or Medicaid patients to an entity providing designated health services in which the physician or immediate family member has an ownership or investment interest or with which the physician has entered into a compensation arrangement. The designated health services include clinical laboratory services, radiology and other diagnostic services, radiation therapy services, physical and occupational therapy services, durable medical equipment, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, outpatient prescription drugs, home health services, and inpatient and outpatient hospital services. The penalties for violating Stark II include a prohibition on payment by these government programs and civil penalties of as much as $15,000 for each violative referral and $100,000 for participation in a circumvention scheme. The Stark legislation is broad and ambiguous. Interpretive regulations clarifying the provisions of Stark II have not been issued. Florida has also enacted similar self-referral laws. The Florida Patient Self-Referral Act of 1992 severely restricts patient referrals for certain services by physicians with ownership or investment interests, requires disclosure of physician ownership in businesses to which patients are referred and places other regulations on healthcare providers. While the Company believes it is in compliance with the Florida and Stark legislation and their exceptions, future laws, regulations, or interpretations of current law could require the Company to modify the form of its relationships with physicians and ancillary service providers. Moreover, the violation of Stark I or II or the Florida Patient Self-Referral Law of 1992 by the Company s Physician group could result in significant fines and loss of reimbursement which would adversely affect the Company.

RISK FACTORS

Forward Looking Statements

The discussion in this annual report regarding our business and operations includes forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1996. Such statements consist of any statement other than a recitation of historical fact and can be identified by the use of forward-looking terminology such as may, expect, anticipate, intend, estimate or continue or the negative thereof or other variations thereof or comparable terminology. The reader is cautioned that all forward-looking statements are speculative, and there are certain risks and uncertainties that could cause actual events or results to differ from those referred to in such forward-looking statements. This disclosure highlights some of the important risks regarding our business. The number one risk of the Company is its ability to attract fresh and continued capital to execute its comprehensive business plan. In addition, the risks included should not be assumed to be the only things that could affect future performance. Additional risks and uncertainties include the potential loss of contractual relationships, changes in the reimbursement rates for those services as well as uncertainty about the ability to collect the appropriate fees for services provided by us. Also, the Company faces challenges in technology development, deployment and use, medical malpractice exposure and the fluctuation of medical costs vs. medical payments. We may also be subject to disruptions, delays in collections, or facilities closures caused by potential or actual acts of terrorism or government security concerns.

Substantial Additional Financing

Need for Substantial Additional Financing and Going Concern. Since the Company s inception, we have relied upon the sale of common stock and convertible debt in order to maintain our operations. There can be no assurance that the Company will be able to obtain additional financing if, and when, it is needed on terms the Company deems acceptable. Our inability to obtain sufficient additional financing would have a material adverse effect on the Company s ability to implement its business plan. As a result, the Company could be required to diminish or suspend activities. The Company s financial statements have been qualified as to our ability to continue as a going concern. This qualification may adversely affect our capital raising efforts.

MCO Agreements

Dependence on MCO Agreements; Capitated Nature of Revenues; Control of Healthcare Costs. The Company intends to have a substantial part of its revenues derived from agreements with Managed Care Organizations (MCOs) that provide for the receipt of capitated fees. Capitated fees are a negotiated percentage of total premiums collected by an insurer or payer source to cover the partial or complete healthcare services deliveries to a person. The fees are determined on a per capita basis paid monthly by managed care organizations. MCO enrollees may come from the integration or acquisition of healthcare providing entities, additional affiliated physicians and increase enrollment in each contract/region serviced by the Company. We intend to enter into MCO agreements, which generally will be for one-year terms, and subject to annual negotiation of rates, covered benefits and other terms and conditions. MCO agreements are often negotiated and executed in arrears. There can be no assurance that such agreements will be entered into, or renewed, or if entered into and/or renewed that they will contain these favorable reimbursement terms to the Company and its affiliated providers. There can be no assurance that we will be successful in identifying, acquiring and integrating MCO entities or in increasing the number of MCO enrollees. Once an MCO is acquired, a decline of enrollees in MCOs could also have a material adverse effect on our profitability.

Under the MCO agreements, the Company, through its affiliated providers, will generally be responsible for the provision of all covered hospital benefits as well as outpatient benefits regardless of whether the affiliated providers directly provide the healthcare services associated with the covered benefits. To the extent that enrollees require more care than is anticipated or require supplemental healthcare, which is not otherwise reimbursed by the MCO, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of enrollees. If revenue is insufficient to cover costs, our operating results could be adversely affected. As a result, our success will depend

largely on the effective management of healthcare costs through various methods, including utilization management, competitive pricing for purchased services and favorable agreements with payers. Recently many providers have experienced pricing pressures with respect to negotiations with MCOs. There can be no assurance that these pricing pressures will not have a material adverse impact on the operating results of the Company. Changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters and numerous other

factors affecting the delivery and cost of healthcare are beyond the control of the Company and may adversely affect its operating results.

Under the MCO agreements, the Company will be responsible for the provision of all covered hospital benefits regardless of whether it is responsible for provision of the hospital services associated with the covered benefits. In connection with hospital covered benefits, the Company will enter into a per diem arrangement with a hospital or hospitals whereby we will pay the hospital service provider a flat per diem fee, for which the hospital will provide all hospital directed services for a single per diem fee. In some cases, we would be required to pay a percentage of usual and customary hospital charges if a capitated patient is seen or admitted in a hospital not under contract to the Company. We intend to contract with a number of hospitals to provide covered services to MCO enrollees who have been assigned to the physician practices affiliated with the Company. We also expect to seek additional hospital providers to provide covered services to MCO enrollees assigned to its affiliated physicians. To the extent that enrollees require more care than is anticipated or require supplemental care that is not otherwise reimbursed by the MCOs, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of enrollees. If such revenue is insufficient, the Company s operating results could be adversely affected.

The MCO agreements often contain shared-risk provisions under which additional revenue can be earned or economic penalties can be incurred based upon the utilization of hospital physicians and ancillary services by MCO enrollees. These estimates are based upon resource consumption, utilization and associated costs incurred by MCO enrollees compared to budgeted costs. Differences between actual contract settlements and amounts estimated as receivable or payable relating to MCO risk-sharing arrangements are generally reconciled annually, which may cause fluctuations from amounts previously accrued.

Failure to Estimate IBNR Claims

Our Failure to Estimate IBNR Claims Accurately Will Affect Our Reported Financial Results. Our medical care costs include estimates of our incurred but not reported (IBNR) claims. We estimate our medical expense liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services, and in consultation with our MCO Partners, other relevant factors. Actual conditions, however, could differ from those we assume in our estimation process. We continually review and update our estimation methods and the resulting accruals and make adjustments, if necessary, to medical expense when the criteria used to determine IBNR change and when actual claim costs are ultimately determined.

As a result of the uncertainties associated with the factors used in these assumptions, the actual amount of medical expense that we incur may be materially more or less than the amount of IBNR originally estimated. If our estimates of IBNR are inadequate in the future, our reported results of operations will be negatively impacted. Further, our inability to estimate IBNR accurately may also affect our ability to take timely corrective actions or otherwise establish appropriate premium pricing, further exacerbating the extent of any adverse effect on our results.

Competition

Competition in Our Industry May Limit Our Ability to Maintain or Attract Members, Which Could Adversely Affect Our Results of Operations. We operate in a highly competitive environment subject to significant changes as a result of business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations that compete with us for members. Our principal competitors for contracts, members, and providers vary by local service area and are comprised of national, regional, and local managed care organizations that serve Medicare recipients, including, among others, UnitedHealth Group, Humana, Metcare Healthplan, America s Health Choice, Vista Health Plans, Wellcare Healthplans and others. Our failure to maintain or attract members to our MCO Partners could adversely affect our results of operations. We believe changes resulting from the MMA may bring additional competitors into our Medical Advantage service areas. In addition, we face competition from other managed care companies that often have greater financial and other resources, larger enrollments, broader ranges of

products and benefits, broader geographical coverage, more established reputations in the national market and our markets, greater market share, larger contracting scale, and lower costs. Such competition may negatively impact our enrollment, financial forecasts, and profitability.

Inability to Maintain Members

Our Inability to Maintain The Medicare Advantage Members, or our MCO Partners, or Increase Our Membership Could Adversely Affect Our Results of Operations. A reduction in the number of members in our Affiliated Medicare Advantage plans, or the failure to increase our membership, could adversely affect our results of operations. In addition to competition, factors that could contribute to the loss of, or failure to attract and retain, members include:

- negative accreditation results or loss of licenses or contracts to offer Medicare Advantage plans;
- negative publicity and news coverage relating to us or the managed healthcare industry generally;
- litigation or threats of litigation against us;
- disenrollment as a result of members choosing a stand-alone PDP; and
- our inability to market to and re-enroll members who enlist with our competitors because of the new annual enrollment and lock-in provisions under the MMA.

Disruption in Our Healthcare Provider Networks

A Disruption in Our Healthcare Provider Networks Could Have an Adverse Effect on Our Operations and Profitability. Our operations and future profitability are dependent, in part, upon our ability to contract with healthcare providers and provider networks on favorable terms. In any particular service area, healthcare providers or provider networks could refuse to contract with us, demand higher payments, or take other actions that could result in higher healthcare costs, disruption of benefits to our members, or difficulty in meeting our regulatory or accreditation requirements. In some service areas, healthcare providers may have significant market positions. If healthcare providers refuse to contract with us, use their market position to negotiate favorable contracts, or place us at a competitive disadvantage, then our ability to market products or to be profitable in those service areas could be adversely affected. Our provider networks could also be disrupted by the financial insolvency of a large provider group. Any disruption in our provider network could result in a loss of membership or higher healthcare costs.

Negative Publicity

Negative Publicity Regarding the Managed Healthcare Industry, in General or Us in Particular, Could Adversely Affect Our Results of Operations or Business. Negative publicity regarding the managed healthcare industry generally, any of our MCO Partners, or us in particular, may result in increased regulation and legislative review of industry practices that further increase our costs of doing business and adversely affect our results of operations by:

- requiring us to change our products and services;

-

increasing the regulatory burdens under which we operate;

-

adversely affecting our ability to market our products or services; or

-

adversely affecting our ability to attract and retain members.

Violation of the Laws and Regulations

Violation of the Laws and Regulations Applicable to Us Could Expose Us to Liability, Reduce Our Revenue and Profitability, or Otherwise Adversely Affect Our Operations and Operating Results. The federal and state agencies administering the laws and regulations applicable to us have broad discretion to enforce them. On an ongoing basis, we expect to be subject to various governmental reviews, audits, and investigations to verify our compliance with our contracts, licenses, and applicable laws and regulations. An adverse review, audit, or investigation could result in any of the following:

-

cancellation of any or all of our MCO contracts;

-

loss of our right to participate in the Medicare Advantage program;

- forfeiture or recoupment of amounts we have been paid pursuant to our contracts or performance bonds;
- imposition of significant civil or criminal penalties, fines, or other sanctions on us and our key employees;
- damage to our reputation in existing and potential markets;
- increased restrictions on marketing our products and services; and
- inability to obtain approval for future products and services, geographic expansions, or acquisitions.

Medical Malpractice Claims and Other Litigation

Claims Relating to Medical Malpractice and Other Litigation Could Cause Us to Incur Significant Expenses. Occasionally, we may be party to various litigation matters, some of which could seek monetary damages. Managed care organizations and their assets may be sued directly for alleged negligence, including in connection with the credentialing of network providers or for alleged improper denials or delay of care. In addition, Congress and several states have considered or are considering legislation that would expressly permit managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Of the states in which we anticipate future operations, only Texas has enacted legislation relating to health plan liability for negligent treatment decisions and benefits coverage determinations. In addition, our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. A material percentage of these providers do not have malpractice insurance. As a result of increased costs or inability to secure malpractice insurance, the percentage of physicians who do not have malpractice insurance may increase.

Effective and Secure Management Information Systems

The Inability or Failure to Properly Maintain Effective and Secure Management Information Systems, Successfully Update or Expand Processing Capability, or Develop New Capabilities to Meet Our Business Needs Could Result in Operational Disruptions and Other Adverse Consequences. Our business will depend significantly on effective and secure information systems. The information gathered and processed by our management information systems will, once completed, assist us in, among other things, marketing and sales tracking, billing, claims processing, medical management, medical care cost and utilization trending, financial and management accounting, reporting, planning and analysis, and e-commerce. These systems could, in the future, support on-line customer service functions, provider and member administrative functions, and support tracking and extensive analyses of medical expenses and outcome data. These information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs and handle our expansion and growth. Any inability or failure to properly maintain management information systems, successfully update or expand processing capability or develop new capabilities to meet our business needs in a timely manner, could result in operational disruptions, loss of existing customers, difficulty in attracting new customers, implementation of our growth strategies, disputes with customers and providers, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate reports, and other adverse consequences. To the extent a failure in maintaining effective information systems

occurs, we may need to contract for these services with third-party management companies, which may be on less favorable terms to us and significantly disrupt our operations and information flow. Furthermore, our business requires the secure transmission of confidential information over public networks. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability, and loss. Our security measures may be inadequate to prevent security breaches and our business operations and profitability would be adversely affected by cancellation of contracts, loss of members, and potential criminal and civil sanctions if they are not prevented.

Ineffective Internal Controls

If We Are Unable to Implement Effective Internal Controls Over Financial Reporting, Investors Could Lose Confidence in the Reliability of Our Financial Statements, Which Could Result in a Decrease in the Price of Our Common Stock. We are required to implement financial, internal, and management control systems to meet our obligations as a public company, including obligations imposed by the Sarbanes-Oxley Act of 2002. However, with limited resources, our ability to complete this task may be limited. These areas include corporate governance, corporate control, internal audit, and compliance requirements.

Reductions in Third-Party Reimbursement

Reductions in Third-Party Reimbursement. Healthcare providers that render services on a fee-for-service basis, as opposed to a capitated plan, typically submit bills for healthcare services provided to various third-party payers, such as governmental programs, for example Medicare and Medicaid, private insurance plans, and managed care plans, for the healthcare services provided to their patients. A portion of the future revenues of the Company are likely to be derived from payments made by these third-party payers. These third-party payers increasingly are negotiating the prices charged for healthcare services with the goal of lowering reimbursement and utilization rates. Our success depends in part on the effective management of healthcare costs. This includes controlling utilization of specialty care physicians and other ancillary providers and purchasing services from third-party providers at competitive prices. There can be no assurance that payments under governmental programs or from other third-party payers will remain at present levels. Third-party payers can deny reimbursement if they determine that treatment was not performed in accordance with the cost-effective treatment methods established by such payers, was experimental, or for other reasons.

Management Information Systems

The Development of Management Information Systems May Involve Significant Time and Expense. We expect to develop a management information system as an important component of the business. The development and implementation of such systems involve the risk of unanticipated delay and expense, which could have an adverse impact on our operations.

Development of Management Information Systems

Risks Associated with Development of Management Information Systems; Dependence on Major Customers for Management Information Systems. Our management information systems will be an important component of the business. The Company is participating in the development of an integrated management information system. This would be designed to provide centralized billing, permit the review of a patient s electronic health records and information on practice guidelines, monitor utilization, and measure patient satisfaction and outcome of care. The development and implementation of such systems involve the risk of unanticipated delay and expense, and there can be no assurance that we will be successful in implementing the integrated management information system. Currently, there is no active information system installed and we may seek to outsource all management system functions to a third party.

Liability

Exposure to Professional Liability; Liability Insurance. In recent years physicians, hospitals and other providers in the healthcare industry have become subject to an increasing number of lawsuits alleging medical malpractice and related legal theories. Many of these lawsuits involve large claims and substantial defense costs. Once funding is secured, we expect to secure professional liability insurance coverage, on a claim made basis, in amounts that exceed the requirements as mandated by the State of Florida, but which may not be adequate to protect the assets of the Company.

Competition

Competition. The healthcare industry is extremely competitive and subject to continual changes in the method in which services are provided and the manner in which healthcare providers are selected and compensated. Companies in other healthcare industry segments, some of which have financial and other resources greater than we do, may become competitors in providing similar services. Our principal competitors include Metropolitan Health Networks, Inc. (AMEX:MDF), a company that our CEO and CFO jointly co-founded, Continuecare Corporation (AMEX:CNU), Primary Care Specialists, First Consulting Group, Accuro Healthcare Solutions, Inc., WebMD, and Z Consulting. Our

strength, in comparison with our competitors, is our knowledge, understanding, and experience in managed care risks, information technology, and systems development.

The healthcare industry is highly regulated and failure to comply with laws or regulations, or a determination that in the past we have failed to comply with laws or regulations, could have an adverse effect on our financial condition and results of operations.

The healthcare services that we and our affiliated professionals intend to provide are subject to extensive federal, state, and local laws and regulations governing various matters such as the licensing and certification of our

facilities and personnel, the conduct of our operations, our billing and coding policies and practices, our policies and practices with regard to patient privacy and confidentiality, and prohibitions on payments for the referral of business and self-referrals. If we fail to comply with these laws, or a determination is made that in the past we have failed to comply with these laws, our financial condition and results of operations could be adversely affected. Changes to healthcare laws or regulations may restrict our existing operations, limit the expansion of our business, or impose additional compliance requirements. These changes could have the effect of reducing our opportunities or continued growth and imposing additional compliance costs on us that may not be recoverable through price increases.

Federal anti-kickback laws and regulations prohibit certain offers, payments, or receipts of remuneration in return for referring Medicaid or other government-sponsored healthcare program, patients, or patient care opportunities or purchasing, leasing, ordering, arranging for, or recommending any service or item for which payment may be made by a government-sponsored healthcare program. Federal physician self-referral legislation, known as the Stark Law, prohibits Medicare or Medicaid payments for certain services furnished by a physician who has a financial relationship with various physician-owned or physician-interested entities. These laws are broadly worded and, in the case of the anti-kickback law, have been broadly interpreted by federal courts, and potentially subject many business arrangements to government investigation and prosecution which can be costly and time consuming. Violations of these laws are punishable by monetary fines, civil and criminal penalties, exclusion from participation in government-sponsored healthcare programs, and forfeiture of amounts collected in violation of such laws, which could have an adverse effect on our business and results of operations. Florida also has anti-kickback and self-referral laws, imposing substantial penalties for violations.

HIPAA

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) portion that deals with patient privacy became effective April 14, 2003. These new federal health privacy regulations set a national floor of privacy protections that will reassure patients that their health and medical records are kept confidential. The rules intend to ensure appropriate privacy safeguards are in place as we harness information technologies to improve the quality of care provided to patients.

The new protections give patients greater access to their own medical records and more control over how their personal information is used by their health plans and healthcare providers. Consumers are required to receive a notice explaining how their health plans, doctors, pharmacies, and other healthcare providers use, disclose, and protect their personal information. Consumers now have the ability to see and copy their health records and to request corrections of any errors included in their records. Consumers may file complaints about privacy issues with their health plans, providers or with the Office for Civil Rights.

If the Company, and/or its affiliates, is found in violation of HIPAA regulations, we could face substantial fines and restrictions including the loss of its MCO contracts.

Healthcare Reform

Healthcare Reform. As a result of the continued escalation of healthcare costs and the inability of many individuals to obtain health insurance, numerous proposals have been or may be introduced in the U.S. Congress and state legislatures relating to healthcare reform. There can be no assurance as to the ultimate content, timing or effect of any healthcare reform legislation. It is impossible at this time to estimate the impact of potential legislation that may be material to the Company, its operations, and profitability.

Key Personnel

Dependence on Key Personnel. Implementation of our business strategy and operations are largely dependent on the efforts of two senior officers, Noel J. Guillama, Chief Executive Officer, and Donald B. Cohen, Chief Financial

Officer. Furthermore, the Company will likely be dependent on other senior management and the entire Board of Directors as we grow. Competition for highly qualified personnel is intense and the Company has very limited resources. The loss of either Mr. Guillama or Mr. Cohen or other key employees, or the failure to attract and retain other skilled employees could have a material adverse impact upon our business, operations, or financial condition.

Capital Needs

Capital Needs May Have Dilutive Effect. The Company will need to raise additional capital through the issuance of long-term or short-term indebtedness, a bank line of credit and/or accounts receivable factoring facility, and/or the issuance of additional equity securities including sale of common or preferred stock in private or public transactions at such times as management deems appropriate and the market allows. Any of such financings can result in dilution of existing equity positions, increased interest and amortization expense, or decreased income to fund future expansion. There can be no assurance that acceptable financing for future acquisitions, or for the integration and expansion of existing networks, can be obtained.

Shares Eligible for Future Sale

Shares Eligible for Future Sale. As of January 31, 2006, the Company had 34,716,523 outstanding shares of common stock of which 30,948,124 are restricted securities and in the future may be sold upon compliance with Rule 144 adopted under the Securities Act. Rule 144 generally provides that a person holding restricted securities for a period of one year may sell only an amount every three months equal to one percent of the Company s issued and outstanding shares. The sale of these securities could adversely affect the market for our common stock.

Anti-Takeover Provisions

Anti-Takeover Provisions. Certain provisions of the Articles of Incorporation and Bylaws of the Company may be deemed to have anti-takeover effects and may delay, defer, or prevent a takeover attempt of the Company, which include when and by whom special meetings of the Company may be called. In addition, the Company s Articles of Incorporation (Nevada) authorize the issuance of up to 30,000,000 shares of Preferred Stock with such rights and preferences as may be determined from time to time by the Board of Directors. Accordingly, the Board of Directors may, without shareholder approval, issue Preferred Stock with dividends, liquidation, conversion, voting, or other rights which could adversely affect the voting power or other rights of the holders of the Company s Common Stock.

Additionally, the Company s Articles of Incorporation, Bylaws, and Nevada corporate law, where the Company is incorporated, authorize the Company to indemnify its directors, officers, employees, and agents and limit the personal liability of corporate directors for monetary damages, except in certain instances.

Dividends

Absence of Dividends. The Management of the Company believes that the purpose of a corporation is to provide a return on the investments of its shareholders. Management s goal is to pay dividends to all shareholders, common and preferred within five years. Holders of the Company s Common Stock are entitled to cash dividends from funds legally available when, and if, declared by the Board of Directors. As a newly organized corporation, the Company has never paid dividends. We do not anticipate the declaration or payments of any dividends in the foreseeable future. We intend to retain any earnings in the first few years to finance the development and expansion of the business. Future dividend policy will be subject to the discretion of the Board of Directors and will be contingent upon future earnings, the Company s financial condition, capital requirements, general business conditions, and other factors. Future dividends may also be subject to covenants contained in loan or other financing documents. Therefore, there can be no assurance that cash dividends of any kind will ever be paid.

Capitated Fees

The Loss of Future Agreement and the Capitated Nature of Our Future Revenues Could Materially Affect Our Operations. The majority of our revenues will come from agreements with managed care organizations that provide for the receipt of capitated fees. Capitated fees are negotiated fees that stipulate a specific dollar amount or a percentage of total premiums collected by an insurer or payer source to cover the partial or complete healthcare

services deliveries to a person. We expect to enter into one-year and three-year term agreements that are renewable annually thereafter. These agreements may be terminated on short notice or not renewed on terms favorable to our affiliated providers and us. We may not be successful in obtaining additional MCO agreements or in increasing the number of MCO enrollees once we secure such agreements.

Under the MCO agreements, the Company, through its affiliated providers, generally will be responsible for the provision of all covered hospital benefits, as well as outpatient benefits, regardless of whether the affiliated providers directly provide the healthcare services associated with the covered benefits. To the extent that enrollees

require more care than is anticipated, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of enrollees. If revenue is insufficient to cover costs, our oper