QUANTUM GROUP INC /FL
Form SB-2/A
September 26, 2007

As filed with the Securities and Exchange Commission on September 25, 2007

Registration No. 333-142990

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

AMENDMENT NO. 4 TO

FORM SB-2

REGISTRATION STATEMENT UNDER THE SECURITIES ACT OF 1933

THE QUANTUM GROUP, INC.

(Name of Small Business Issuer in Its Charter)

Nevada	**8742**	**20-0774748**
(State or Other Jurisdiction of Incorporation or Organization)	*(Primary Standard Industrial Classification Code Number)*	*(I.R.S. Employer Identification No.)*

3420 Fairlane Farms Road, Suite C

Wellington, Florida 33414

(Address and Telephone Number of Principal Executive Offices)
(Address of Principal Place of Business)

Noel J. Guillama
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Wellington, Florida 33414
(561) 798-9800

(Name, Address and Telephone Number of Agent for Service)

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As soon as practicable after the effective date of this registration statement.

(Approximate Date of Proposed Sale to the Public)

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. þ

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this form is a post effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this form is a post effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If delivery of the prospectus is expected to be made pursuant to Rule 434, check the following box. o

The registrant hereby amends this registration statement on such date or dates as may be necessary to delay its effective date until the registrant shall file a further amendment which specifically states that this registration statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the registration statement shall become effective on such date as the Commission, acting pursuant to said Section 8(a), may determine.

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	**Amount to be Registered**	**Proposed Maximum Offering Price Per Security(1)**	**Proposed Maximum Aggregate Offering Price**	**Amount of Registration Fee**
Units, each unit consisting of: (2)	1,725,000	$12.00	$20,700,000	$ 635.49
(i)				
two shares of common stock;	3,450,000			
(ii)				
two non-callable Class A warrants, each to purchase one share of common stock; and (3)	3,450,000			
(iii)				
two non-callable Class B warrant, each to purchase one share of common stock (3)	3,450,000			
Representative s warrants (3)(4)	150,000			
Units issuable upon exercise of the representative s warrants, each consisting of:	150,000	$14.40	$ 2,160,000	$ 66.32
(i)				
two shares of common stock;	300,000			
(ii)				
two non-callable Class A warrants, each to purchase one share of common stock; and	300,000			
(iii)				
one non-callable Class B warrants, each to purchase one share of common stock	300,000			
Common stock issuable upon exercise of Class A warrants, including Class A warrants underlying the representative s warrants (2)(3)(5)	7,500,000	$ 7.00	$26,250,000	$ 805.88
Common stock issuable upon exercise of Class B warrants, including Class B warrants underlying the representative s warrants (2)(3)(6)	7,500,000	$11.00	41,250,000	1,266.38

Total	$90,360,000	$2,774.07	(7)

(1)

The number of units to be registered and the per-Unit price will depend on the market price of our Common Stock.

(2)

Includes 225,000 units, 450,000 shares of Common Stock and 450,000 non-callable Class A Warrants and 450,000 non-callable Class B Warrants underlying such units, which may be issued on exercise of a 45-day option granted to the underwriters to cover over-allotments, if any.

(3)

Estimated at $12.00 per Unit, for the purpose of calculating the registration fee in accordance with Rule 457(g) under the Securities Act.

(4)

Pursuant to Rule 416 of the Securities Act, there are also being registered thereby such additional indeterminate number of securities as may become issuable pursuant to the anti-dilution provisions of the warrant and the Representative s Warrants.

(5)

Estimated at $7.00 per share, for the purpose of calculating the registration fee in accordance with Rule 457(g) under the Securities Act.

(6)

Estimated at $11.00 per Unit, for purposes of calculating the registration fee in accordance with Rule 457(g)(2) under the Securities Act.

(7)

$1,105 of total SEC registration filing fee was previously paid.

The information in this prospectus is not complete and may be changed. These securities may not be sold, except pursuant to a transaction exempt from the registration requirements of the Securities Act of 1933, as amended until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities and it is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED SEPTEMBER 25, 2007

PROSPECTUS

1,500,000 UNITS

Each unit consisting of two shares of common stock, two non-callable Class A warrants and two non-callable Class B warrants

healthcare solutions for a new generation SM

We are offering 1,500,000 units, each unit consisting of two shares of common stock, two non-callable Class A warrants and two non-callable Class B warrants. Each Class A warrant entitles its holder to purchase one share of common stock at an exercise price of $7.00. Each Class B warrant entitles its holder to purchase one share of common stock at an exercise price of $11.00. The warrants are exercisable at any time after they become separately tradable until their expiration date, which is seven years after the date of this prospectus.

Our common stock is currently traded on the Over-The-Counter Bulletin Board (OTCBB) under the symbol QNTM.OB. On September 12, 2007, the last reported sale price of our common stock was $6.00 per share. Prior to this offering, there has been no public market for the units or the warrants and a limited trading market for the common stock. The warrants will trade only as part of a unit for 30 calendar days following the date of this prospectus.

We have applied to list our units, common stock, Class A warrants and Class B warrants on the American Stock Exchange under the symbols QGP.U, QGP, QSP.WS.A and QGP.WS.B, respectively, which listing we expect to occur concurrently with the effectiveness of this offering.

Investing in these units involves significant risks. See Risk Factors beginning on page 7.

	Per Unit	Total
Public offering price	$_______	$_______
Underwriting discount	$_______	$_______
Proceeds to us, before expenses	$_______	$_______

THE SECURITIES AND EXCHANGE COMMISSION AND STATE SECURITIES REGULATORS HAVE NOT APPROVED OR DISAPPROVED OF THESE SECURITIES OR DETERMINED IF THIS

PROSPECTUS IS TRUTHFUL OR COMPLETE. IT IS ILLEGAL FOR ANY PERSON TO TELL YOU OTHERWISE.

We estimate the cash expenses of this offering will be approximately $2,140,000 and will include a non-accountable expense allowance payable to the representative equal to 3% of the gross offering proceeds from the sale of the units offered hereby. We have also agreed to issue a warrant to the representative, entitling it to purchase up to 150,000 units identical to the units offered to the public, exercisable at $ (120% of the public offering price of the units.) Other terms of the Representative s Warrants are described under the heading Underwriting.

The underwriters may purchase up to an additional 225,000 units from us at the public offering price, less the underwriting discount, within 45 days from the date of this prospectus, to cover over-allotments.

Paulson Investment Company, Inc.

Newbridge Securities Corporation **Neidiger Tucker Bruner, Inc.**

The date of this Prospectus is , 2007.

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References in this prospectus to we, us, our, the Company and Quantum refer to The Quantum Group, In and it consolidated subsidiaries.

You should rely only on the information contained in this prospectus and in any prospectus supplement we may file after the date of this prospectus. We have not authorized anyone to provide you with different information. If anyone provides you with different or inconsistent information, you should not rely on it. These securities will not be offered in any jurisdiction where an offer or sale is not permitted. You should assume that the information appearing in this prospectus or any supplement is accurate only as of the date on the front cover of this prospectus, any free writing prospectus or any supplement. Our business, financial condition, results of operations and prospects may have changed since that date.

PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus and does not contain all of the information you should consider in making your investment decision. You should read this summary together with the more detailed information, including our consolidated financial statements and the related notes, elsewhere in this prospectus. You should carefully consider, among other things, the matters discussed in Risk Factors beginning on page 7. In addition, some of the statements made in this prospectus discuss future events and developments, including our future strategy and our ability to generate revenue, income and cash flow. These forward-looking statements involve risks and uncertainties which could cause actual results to differ materially from those contemplated in these forward-looking statements. See Cautionary Note Regarding the Forward Looking Statements.

The Company

We offer business solutions for health maintenance organizations (HMOs) that market Medicare Advantage managed healthcare plans as well as to healthcare providers in the state of Florida. Medicare Advantage is Medicare s managed care alternative to Medicare s original fee-for-service model. The foundation of our business model is a network of medical service providers, including primary care physicians, specialists and ancillary service providers such as laboratories and pharmacies, among others, all of whom must satisfy the requirements of the Centers for Medicare & Medicaid Services (CMS), the U.S. federal agency that administers Medicare, Medicaid and the Medicare Advantage program. We also offer to healthcare providers various management support services that enable them to decrease their costs and increase their operating efficiency and productivity. These management support services are available to all healthcare providers, whether or not they are part of our network. In the future, we expect to leverage our relationships with our healthcare providers to cross-market our management support services and the benefits of participation in our network.

As required by CMS, we have separate networks of healthcare providers covering all mandated medical fields and ancillary services in every county where we currently operate, each of which serves as a community-based comprehensive delivery system of care, and which we call Community Health Systems (CHS). Once CMS-compliant, we then make our county-wide CHS network of healthcare providers available to HMOs with whom we contract on a non-exclusive basis. All of our network participants in a particular county-specific CHS, whether physicians or other healthcare providers, are eligible to treat member/patients of all of our contracted HMOs and can do so without going through separate admission processes with the various HMOs.

Our network places us in the position of being the primary interface between the HMOs and the contracted healthcare providers and affords us the opportunity of becoming the preferred management service provider of administrative, practice management and ancillary services to healthcare providers that participate in our network as well as to other healthcare providers, physician groups, testing facilities, nursing homes and hospitals. It is our philosophy to provide high quality service as the link between our HMOs and our network participants. By virtue of this relationship, we can relieve the healthcare providers and the HMOs of substantial administrative and repetitive burdens generally associated with the operations of a managed care enterprise and with the verification of medical credentials (credentialing) of healthcare providers that desire to participate in the HMO managed care plans, as required by CMS regulations. It also enables HMOs to establish the network of contracted healthcare providers necessary to enter any new geographic market without having to interact with numerous healthcare providers or multiple service organizations.

As of August 31, 2007, we have three contracts with HMOs under which we are earning revenues, and we expect that two additional executed HMO contracts will begin generating revenues in fiscal 2008 and 2009, respectively. Our

revenues under these contracts are heavily dependent on the number of patients who select our network physicians as their primary care physicians.

As of August 31, 2007, our network includes over 1,600 healthcare providers and operates in 26 counties in central and southern Florida. Our goal is to increase the number of healthcare providers participating in our network to 2,500 by the end of calendar year 2007 and to continue a measured rollout of additional CHS to eventually encompass all 67 Florida counties. We believe that each new CHS represents an opportunity for HMOs that are not marketing their managed care plans in that county to expand their market by providing them ready-made or turnkey access to that county without substantial delay or start-up cost.

In fiscal 2006, we began offering billing and collection services and insurance products tailored specifically to a physician s needs, such as health, disability, life and malpractice insurance. We intend to build upon this support services foundation to develop a full suite of services for the healthcare community, including an integrated practice management platform that will provide a management information system based upon an Application Services Provider (ASP) web-based model to connect healthcare providers and physician groups with their patients, hospitals and payers. We intend to build that suite of services through a combination of acquisitions of existing providers of technology and partnerships with technology companies and other entities. When fully developed, the system will eliminate the need for substantial paper record creation and storage, reduce the administrative burdens and back office costs of the users and comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We anticipate that this platform will be available for deployment by the summer of 2008.

Market Opportunity

We operate in the state of Florida, where spending in the healthcare industry amounts to more than $95 billion annually according to the February 2007 CMS report. Florida s population, the fourth largest in the country, continues to increase. It contains the largest senior population, by percentage, of any state in the United States: Florida s senior population accounts for 16.8% of the total statewide population as compared to the national average of 12.4%.

According to The Henry J. Kaiser Family Foundation report (April 2005), in 2005, nationwide healthcare spending of almost $2 trillion accounted for approximately 16% of our gross domestic product (GDP), or an average of over $6,697 per person. Given current demographic trends, by 2015, the February 2007 CMS report projected that nationwide healthcare spending would reach $4 trillion, representing approximately 20% of GDP.

The healthcare services industry is highly fragmented, with a variety of services and solutions being offered by numerous entities, some of which are associated with companies that have a specific interest in selling a particular product or service or in enhancing the revenues of an associated entity, such as a hospital. We believe that there are few integrated or comprehensive service arrangements available to the healthcare community.

Corporate Offices

Our principal executive offices are located at 3420 Fairlane Farms Road, Suite C, Wellington, Florida 33414 and our telephone number is (561) 798-9800. Our website address is www.QuantumMD.com. The website does not form a part of this prospectus.

The Offering

Securities offered

1,500,000 units, with each Unit consisting of two shares of common stock, two Class A non-callable warrants and two non-callable Class B warrants, each warrant to purchase one share of common stock. The Units will trade as a single security until separation, which will occur on the 30th calendar day following the date of this prospectus or the next trading day thereafter if the 30th day falls on a weekend or stock market holiday, at which time the units will cease to trade.

Warrants:

Class A warrants outstanding

after this offering

3,000,000

Class B warrants outstanding

after this offering

3,000,000

Exercise terms

Each Class A warrant entitles its holder to purchase one share of common stock at an exercise price of $7.00 per share. Each Class B warrant entitles its holder to purchase one share of common stock at an exercise price of $11.00 per share. Neither the Class A warrants nor Class B warrants are subject to redemption.

Term of the warrants

The Class A warrants and Class B warrants will become exercisable upon separation of the units on _____________, 2007 (30 days from the date of this prospectus) and will expire on ____________, 2014.

Common stock outstanding after

this Offering

5,145,796 shares

Use of proceeds

We intend to use the net proceeds from this offering for repayment of convertible bridge notes and other debts, further development of our medical service provider networks and management support services, payment of accrued compensation to our executive management and working capital purposes. See Use of Proceeds.

Anticipated AMEX symbols

QGP.U (Unit)

QGP (Common Stock)

QGP.WS.A (Class A Warrant)

QGP.WS.B (Class B Warrant)

The number of shares of common stock outstanding after this offering is based on 2,145,796 shares outstanding as of September 24, 2007. Unless the context indicates otherwise, all share, per share common stock and warrant information in this prospectus:

•

reflects a 1-for-25 reverse stock split of our common stock effected on March 29, 2007;

•

assumes no exercise of the Class A warrants and Class B warrants included in the units offered hereby;

•

assumes no exercise of the underwriters over-allotment option to purchase up to an additional 225,000 units;

•

assumes no exercise of warrants to purchase up to 150,000 units issued to the representative in connection with this offering;

•

assumes no exercise of vested options, which as of September 24, 2007, aggregate 887,633, with a weighted average exercise price of $5.09;

•

assumes no exercise of outstanding warrants, which as of September 24, 2007, aggregate 108,319, with a weighted average exercise price of $8.47;

- excludes the potential issuance of up to 3,712,693 shares of common stock issuable upon exchange of the Bridge Shares into (a) 1,550,200 shares of common stock issuable upon the exchange of 937,907 Bridge Shares, based on an assumed offering price of $10 per unit; (b) 1,550,200 shares of common stock issuable upon the exercise of 1,550,200 Class A warrants at $7.00 per share; and (c) 1,550,200 shares of common stock issuable upon the exercise of 1,550,200 Class B warrants at $11.00 per share. Such right of exchange is in the discretion of the bridge investors and it is currently unknown how many Bridge Shares will be exchanged, if any; and

- excludes the potential issuance of up to 5,494,218 shares of common stock issuable upon conversion of the $6,050,000 in convertible Bridge Notes, plus accrued interest of $359,294, into (a) 1,831,406 shares of common stock, based on an assumed offering price of $10 per unit; (b) 1,831,406 shares of common stock issuable upon the exercise of 1,831,406 Class A warrants at $7.00 per share; and (c) 1,831,406 shares of common stock issuable upon the exercise of 1,831,406 Class B warrants at $11.00 per share. Such right of conversion is in the discretion of the bridge investors and it is currently unknown how many Bridge Notes will be exchanged, if any.

Significant Risks

Our business is subject to substantial risks and challenges relating to, without limitation or any specific order:

- need for substantial additional financing after this offering;

- history of operating losses and limited operating history;

- going concern opinion of our independent auditors;

- cumulative net loss from operations from inception to date is approximately $10.1 million;

- dependence on revenues from a small number of HMOs accounts;

- difficulties relating to estimating incurred but not reported (IBNR) claims;

- cyclical nature of the Medicare Advantage enrollment;
- uncertainty in the reimbursement rates for and service fee collectibility;
- adverse effect on the price of common stock and dilution that may result from additional share issuances upon conversion of Bridge Notes, Bridge Shares and late registration shares and that the Company s intent to file a registration statement for such shares immediately after this registration statement is effective;
- disruption in healthcare provider networks;
- ability to successfully integrate any future acquisitions or technologies; and
- ability to satisfy HIPAA and other applicable healthcare laws and regulations.

For a detailed description of these and additional risk factors, please refer to Risk Factors beginning at page 7 of this prospectus.

SUMMARY FINANCIAL DATA

In the table below, we provide you with historical summary consolidated financial information for the two years ended October 31, 2005 and 2006, derived from our audited consolidated financial statements included elsewhere in this prospectus. We also provide below consolidated financial information for the nine months ended July 31, 2007, derived from our unaudited consolidated financial statements included elsewhere in this prospectus. Historical results are not necessarily indicative of the results that may be expected for any future period. When you read this historical summary consolidated financial information, you should also consider the historical financial statements and related notes, and the section entitled Management s Discussion and Analysis of Financial Condition and Results of Operations.

Statements of Operations Data:

					Nine Months Ended July 31,	
	Fiscal Year Ended October 31,					
	2005		**2006** (restated)		**2007** (unaudited)	
Revenues	$	1,119	$	95,253	$	2,516,137
Direct costs	$	1,119	$	82,210	$	2,110,526
Gross profit	$		$	13,043	$	405,611
Total operating expenses	$	1,820,226	$	2,931,350	$	4,233,969
Income/(Loss) from operations	$	(1,820,226)	$	(2,918,307)	$	(3,828,358)
Total non-operating expenses	$	33,394	$	1,754,453	$	4,884,023
Net Income/(Loss)	$	(1,853,620)	$	(4,672,760)	$	(8,712,381)
Net Income/(Loss) per share basic and fully diluted	$	(2.29)	$	(4.72)	$	(5.36)
Weighted average shares outstanding		810,454		989,140		1,626,362

Balance Sheet Data:

	As of	As of

	October 31,		July 31,
	2005	2006	2007
		(restated)	(unaudited)
Total assets	$ 733,444	$ 1,091,861	$ 1,961,375
Total liabilities	$ 1,334,214	$ 3,454,721	$ 9,256,593
Working capital (deficiency)	$ (1,126,671)	$ (2,769,266)	$ (7,560,070)
Shareholders' (deficit)	$ (600,770)	$ (2,362,860)	$ (7,295,218)

Pro Forma Balance Sheet Data:

	As of July 31, 2007			
	Actual	**Pro Forma (1)**	**This Offering (2)**	**Pro Forma as Adjusted (1) (2)**
Total assets	$ 1,961,375	$ 1,583,954	$ 12,860,000	$ 14,443,954
Total liabilities	$ 9,256,593	$ 8,596,201	$	$ 8,596,201
Working capital (deficiency)	$ (7,560,070)	$ (6,836,924)	$ 12,860,000	$ 6,023,076
Shareholders equity (deficit)	$ (7,295,218)	$ (7,012,247)	$ 12,860,000	$ 5,847,753

(1)

Gives effect to the accrued compensation conversion agreements whereby Noel J. Guillama and Donald B. Cohen have agreed to convert 50% of their accrued but unpaid compensation and other amounts owed to them into unregistered units of shares and warrants otherwise identical to the units offered hereby. As a result of such conversions, those executives will receive a combined total of 64,578 units.

(2)

Gives effect to the sale of an aggregate of 1,500,000 units in this offering at a proposed offering price of $10.00 per Unit, resulting in net proceeds of $12,860,000. Does not assume over allotment option of 225,000 units.

RISK FACTORS

Investing in our securities involves a high degree of risk. Prospective investors should carefully consider the risks described below, together with all of the other information included or referred to in this prospectus, before purchasing units. There are numerous and varied risks, known and unknown, that may prevent us from achieving our goals. If any of these risks actually occurs, our business, financial condition or results of operations may be materially and/or adversely affected. In that case, the trading price of our securities could decline and investors in our securities could lose all or part of their investment.

We will need substantial additional financing after this offering.

We will need additional capital in the future. To date, we have relied almost exclusively on financing transactions to fund our operations. Our inability to obtain sufficient additional financing would have a material adverse effect on our ability to implement our business plan and, as a result, could require us to diminish or suspend activities. We believe our cash resources, including the net proceeds from this offering, will be sufficient to fund our planned operations for at least twelve months. However, our projections could be wrong. We could face unforeseen costs, or our revenues could fall short of our projections. We do not have any currently identified sources of additional capital on which we could rely if we find our revenues and the offering proceeds are insufficient to fund our operations. New sources of capital may not be available to us when we need it or may be available only on terms we would not find acceptable. If such capital is not available on satisfactory terms or is not available at all, we may be unable to continue to fully develop our business; our operations and financial condition may be materially and adversely affected. Currently, we are incurring losses from operations, have a significant capital deficit and do not have access to a line of credit or other debt facility. If we raise additional capital through the issuance of debt securities, the interests of our shareholders would be subordinated to the interests of our debt holders, and any interest payments would reduce the amount of cash available to operate and grow our business. If we raise additional capital through the sale of equity securities, the ownership of our shareholders would be diluted. Additionally, we do not know whether any financing, if obtained, will be adequate to meet our capital needs and to support our growth.

We have a history of losses and cannot assure you that we will be profitable in the foreseeable future, if ever.

Since inception in 2001, we have incurred net losses in every year, as well as the most recent interim period ended July 31, 2007, including net losses of $1,853,620 for the fiscal year ended October 31, 2005, $4,672,760 for the fiscal year ended October 31, 2006 and $8,712,381 for the nine months ended July 31, 2007. We had a working capital deficit of $7,560,070 at July 31, 2007 and have had significant negative cash flows from operations in every period. As a result of ongoing operating losses, we also had an accumulated deficit of $16,819,277 and a shareholders deficit of $7,295,218 at July 31, 2007. Historically, we have funded our operations through the sale of common stock and a series of debt financings. There is no assurance that we will be able to rely on obtaining similar loans and to sell additional equity in the future and, therefore, our ability to remain in business will depend upon being able achieve positive cash flow from operations and net income. We expect to incur losses until at least fiscal 2009 and may never become profitable. We expect our expenses will increase substantially for the foreseeable future as we seek to expand our operations, implement internal systems and infrastructure and hire additional personnel. These ongoing financial losses may adversely affect our stock price.

Our limited operating history makes evaluation of our business difficult.

We have a limited operating history and have encountered and expect to continue to encounter many of the difficulties and uncertainties often faced by early stage companies. We were a development stage company through July 31, 2006

and only began to report minimal revenues in the fourth quarter of fiscal 2006. Our limited operating history makes it difficult to evaluate our future prospects, including our ability to develop a wide base of healthcare providers for our services, expand our operations to include additional services and control healthcare costs, all of which are critical to our success. An investor must consider our business and our prospects in light of the risks, uncertainties and difficulties frequently encountered by early stage companies, including limited capital, delays in service rollouts, marketing and sales obstacles and significant competition. We may encounter unanticipated problems, expenses and delays in developing and marketing our services and securing additional healthcare providers. We may not be able to successfully address these risks, and while these risks are common in early stage companies, they create uncertainties for investors evaluating our business. If we are unable to address these risks, our business may not grow, our stock price may suffer, and we may be unable to stay in business.

Our independent auditors have issued a going concern opinion that has raised substantial doubt about our ability to continue as a going concern.

Our independent auditor s report on our consolidated financial statements for the fiscal year ended October 31, 2006 includes an explanatory paragraph stating that because we have had recurring losses from operations since inception and a working capital deficiency, there is a substantial doubt about our ability to continue as a going concern. Our consolidated financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our net loss from operations from inception in 2001 to July 31, 2007 is approximately $10.1 million. Our continued existence will depend in large part on our ability to successfully secure additional financing to fund future operations. This offering is expected to raise net proceeds that we believe will be sufficient to fund our operations for the next twelve months. However, even after this offering, if we are not able to achieve positive cash flows from operations or to secure additional financing as needed, we may again experience the risk that we will not be able to continue as a going concern.

We derive our revenues from a small number of HMOs accounts.

In the past year, we negotiated five full risk contracts with HMOs, three of which agreements earn revenues and accept patients and the remaining two of which have been executed, but contain no patient coverage yet. Under a full risk contract, we are responsible for covering the direct costs of medical care for each covered patient, subject to a stop-loss ceiling we negotiate with each HMO. This limits our exposure to catastrophic claims from a single patient for the year of care once we incur a certain amount of cost. Once the limit is reached, we are no longer responsible for the expenses of medical care provided to that patient. The stop-loss ceilings vary by HMO. In general, we are charged a negotiated monthly rate that is deducted from the capitation we receive from the HMO. The stop loss thresholds are between $35,000 and $50,000 for a single patient for any one calendar year. Although we are attempting to expand our healthcare provider customer base, we expect that a limited number of HMO customers will continue to represent a substantial portion of our revenues for the foreseeable future. Moreover, under our current business model, we do not plan to have a large number of HMO contracts. The three HMOs for which we service patients account for approximately 50% of our revenues for the nine months ended July 31, 2007, and approximately 64% of the total number of patients covered under our existing HMO contracts is concentrated under a single HMO contract. If our contract with that HMO is terminated, our financial results would be adversely affected. We anticipate that the percentage of our revenues derived from the HMO contracts will represent the majority of our revenues for the foreseeable future. This lack of diversification makes us highly susceptible to conditions affecting HMO operations. Although we work closely with our HMOs to attempt to limit the risk of an adverse event, the loss of any one or more of such HMOs could have a material adverse effect on our revenues, results of operations and financial condition.

Failure to estimate incurred but not reported (IBNR) claims and risk-sharing arrangements accurately may affect our reported financial results.

Our medical care costs include estimates of our IBNR claims. These claims are for medical costs that are incurred in one month, but not submitted for payment until a subsequent month. We estimate our medical expense liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, cyclicality, use of healthcare services and other relevant factors and in consultation with our HMO partners. Actual conditions, however, could differ from those we assume in our estimation process. Accurate estimates are important both from an accounting and an operations perspective. We continually review and update our estimation methods and the resulting accruals, if necessary, to make adjustments, if necessary, to medical expenses when the criteria used to determine the IBNR estimate changes 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. Out inability to accurately estimate IBNR could also make it difficult for the investors to estimate future results, which could lead to negative impact on our stock price.

The HMO agreements often contain shared-risk provisions under which additional revenues may be earned or economic penalties may be incurred based upon the use of hospital healthcare providers and ancillary services by HMO members. These estimates are based upon resource consumption, use and associated costs incurred by HMO

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members compared to budgeted costs. Differences between actual contract settlements and amounts estimated as receivable or payable relating to HMO risk-sharing arrangements are generally reconciled annually, which may cause fluctuations from amounts previously accrued.

Failure to attract and retain highly qualified personnel could have a material negative impact on our business.

Implementation of our business strategy is predominantly dependent on the efforts of two senior officers, Noel J. Guillama, our President and Chief Executive Officer, and Donald B. Cohen, Chief Financial Officer. If we were to lose the services of either individual, our business and operations would be severely affected. Competition for highly qualified personnel is intense, and we have very limited resources. The loss of any executive officer or key employee or the failure to attract and retain other skilled employees could have a material adverse impact upon our business, operations or financial condition.

Cyclical nature of the Medicare Advantage enrollment could have a material adverse effect on our operations.

Under current Medicare Advantage enrollment rules, Medicare beneficiaries have defined enrollment periods in which they can select a Medicare Advantage plan, a stand-alone Prescription Drug Program (PDP), or traditional fee-for-service Medicare coverage. Starting in November 2006 and on a going-forward basis, the annual enrollment period for a stand alone PDP is November 15 through December 31 of each year, and enrollment in Medicare Advantage plans occurs November 15 through March 31 of the subsequent year. Enrollment prior to December 31 is generally effective as of January 1 of the following year, and enrollment on or after January 1 and within the enrollment period is effective the first day of the month following enrollment. After the defined enrollment period ends, generally only seniors turning 65 years of age during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries, others who qualify for special needs plans and employer group retirees are permitted to enroll in or change health plans until the next open enrollment period opens again on November 15. In certain circumstances, such as the bankruptcy of a health plan, CMS may offer a special election period during which the customers affected are allowed to change plans. There is no assurance that we will be able to successfully market our services during these enrollment periods.

If we do not meet ongoing technology challenges, our business will be negatively impacted.

We face challenges in technology development, deployment and use. Our future operations will depend on the use of electronic healthcare information to facilitate communication with our healthcare service providers and others in our networks and, more importantly, to monitor and control our patient medical costs by reducing unnecessary care, fraud, over-use in the treatment of our patients, paying such providers and reporting to the payers. If we are not able to make the appropriate and material investments in such technology, we may not be able to create and maintain gross margins between medical costs and medical payments, which may require that we redesign our model and/or experience substantial and unsustainable medical costs, jeopardizing our contracts and our business relationships.

We have secured convertible bridge notes, which are currently in default.

We have $6,050,000 in 8% Subordinated Secured Convertible Bridge Notes, which are secured by all our assets. None of those Bridge Notes have been paid at the original or extended maturity dates and, therefore, may be deemed in default under their terms and provisions. The note holders and High Capital Funding, LLC, the lead investor in each private placement, have not declared the Bridge Notes in default, and we are in discussions with the lead investor to extend the maturity date of the Bridge Notes.

Because the Bridge Notes were not paid in accordance with their terms and provisions by the original maturity date, they are deemed in default. This caused the interest on the Bridge Notes to increase from 8% to 18% per annum. However, a default may only be called by holders of at least 50% of the aggregate principal amount of the Bridge Notes then outstanding, including High Capital Funding, LLC, which they have not done as of the date of this filing. If we are unable to repay these obligations, or obtain waivers of events of default or forbearance to seek remedies under the terms of the Bridge Notes, or the lenders do not convert the Bridge Notes into our common stock, we could be forced to forfeit all of our assets.

We are dependent on HMO contracts at capitated rates that are subject to yearly renewal, and there is no assurance that these contracts can be renewed on favorable terms.

Currently, a substantial part of our revenues is derived from agreements with HMOs 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 delivered to a patient. The fees are determined on a per capita basis paid monthly by the HMOs. HMO members may come from the integration or acquisition of healthcare providing entities, additional affiliated healthcare providers and increased enrollment in each contract/region we service. We intend to continue to enter into HMO agreements generally for one-year terms and therefore will be subject to annual negotiation of rates, covered benefits and other terms and conditions. Such agreements are often negotiated and executed in arrears. There can be no assurance that we will be able to continue to enter into such agreements, or, if we do, that we will be able to renew them. Failure to renew these HMO contracts, unless replaced with relationships with other reputable HMOs, would cause us to cease or substantially restructure our operations. If we enter into and/or renew them, the agreements and renewals may not be on favorable terms to us and our contracted providers. There can be no assurance that we will be successful in identifying, acquiring and integrating HMOs into our company or increasing the number of HMO members. Once acquired, a decline in the number of members in our HMOs could also have a material adverse effect on our profitability.

We are subject to changes in the reimbursement rates for our provider services.

We are dependent on reimbursements from third parties, directly from HMOs and indirectly from state and federal agencies, for the services that we provide. Reduction in reimbursement rates or fees could force us to stop, change or reduce operations. Healthcare providers that render services on a fee-for-service basis (as opposed to a capitated plan) typically submit bills to various third-party payers, such as governmental programs (e.g., Medicare and Medicaid), private insurance plans and managed care plans, for the healthcare services provided to their patients. A substantial portion of our future revenues is likely to be derived from payments made by these third-party payers. These third-party payers increasingly negotiate the prices charged for healthcare services to lower reimbursement and use rates. Our success depends, in part, on the effective management of healthcare costs and our ability to negotiate reimbursements that are commensurate with the actual costs of the services, in effect, creating a spread (gross margin) between what we receive in payment and what we pay others, and in part by managing the system to reduce cost. There can be no assurance that payments under governmental programs, or from other third-party payers, will remain at present levels. Moreover, 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 determined to be experimental or if for other reasons reimbursement is denied, our gross margins suffer.

Violation of the laws and regulations could expose us to liability, reduce our revenues and profitability or otherwise adversely affect our operations and operating results.

The federal and state agencies administering the laws and regulations applicable to our business and operations have broad discretion to enforce them. We expect to be and are subject on an ongoing basis to various governmental reviews, audits and investigations to verify our compliance with our contracts, licenses and applicable laws and regulations. The portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that deals with patient privacy became effective April 14, 2003. These federal health privacy laws and regulations set a national floor of privacy protections that reassure patients that their medical records are kept confidential. The rules, intended to ensure appropriate privacy safeguards, are in place as we use information technologies to improve the quality of patient care.

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. Patients are required to receive a notice explaining how their health plans, doctors, pharmacies and other healthcare providers use, disclose and protect their personal information. Patients now have the ability to see and copy their health records and to request corrections of any errors included in their records. Patients may file complaints about privacy issues with their health plans or providers or with the Office for Civil Rights.

Federal anti-kickback laws and regulations prohibit certain offers, payments or receipts of remuneration in return for referring Medicare, 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

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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 that 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.

If we and/or our contracted providers are found in violation of HIPAA regulations, we could face substantial fines and restrictions including the loss of our HMO contracts. An adverse review, audit, or investigation could result in any of the following:

- cancellation of any or all of our HMO 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.

Some of these sanctions would adversely impact our operations and financial results. However, others of these sanctions, if not waived or modified, would cause us to cease operations.

We depend on third parties to provide us with crucial information and data.

Our HMOs provide us a significant amount of information and services to our subsidiary, Renaissance Health Systems, Inc. (RHS), including claims processing, data collection and other information, including reports and

calculations of costs of services provided and payments to be received by RHS. RHS does not own or control such systems and, accordingly, has limited ability to ensure that these systems are properly maintained, serviced and updated. In addition, information systems such as these may be vulnerable to failure, acts of sabotage and obsolescence. The business and results of operations of RHS could be materially and adversely affected by its inability, for any reason, to receive timely and accurate information from our HMOs. Because these services are outsourced as opposed to performed internally, we have less control over the manner in which these matters are handled and the accuracy and timeliness of the data provided to us than if we handled these functions internally. Additionally, any loss of information by our HMOs could have a material adverse effect on our business and the results of its operations.

Claims relating to medical malpractice and other litigation could cause us to incur significant expenses.

From time to time, we may be party to various litigation matters, some of which could expose us to monetary damages. HMOs and their affiliates may be sued directly for alleged negligence, including the process of credentialing of network providers or alleged improper denials or delay of care. In addition, Congress and several states have considered, or are considering, legislation that would expressly permit HMOs to be held liable for negligent treatment decisions or benefits coverage determinations. In addition, healthcare providers participating in our networks may be exposed to the risk of medical malpractice claims. As a result of increased costs or inability to secure malpractice insurance, the percentage of healthcare providers who do not have malpractice insurance may increase.

Our profitability is based on our ability to control healthcare costs.

Under our HMO agreements, through our contracted providers, we are generally responsible for the provision of all covered medical benefits. To the extent that members require more care than is anticipated, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of members. If

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revenues are insufficient to cover costs, our operating results could be adversely affected. As a result, our success will depend in large part on the effective management of healthcare costs through various methods, including, without limitation, utilization management, competitive pricing for purchased services and favorable agreements with payers. Recently, many providers have experienced pricing pressures with respect to negotiations with HMOs. There can be no assurance that these pricing pressures will not have a material, adverse impact on our operating results. In connection with hospital covered benefits, we will seek to 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. However, there is no assurance that we will be able to secure such an arrangement. In some cases, we would be required to pay a percentage of usual and customary hospital charges if a capitated patient is seen in or admitted to a hospital not under contract with us. We intend to seek additional hospital providers to provide covered services to HMO members assigned to our affiliated healthcare providers, but we may not be able to reach agreements with additional hospital providers. Changes in healthcare practices, inflation, new technologies, major epidemics (such as avian flu), natural disasters (such as hurricanes) and numerous other factors affecting the delivery and cost of healthcare are beyond our control and may adversely affect our operating results.

We have entered into management agreements where we are at full risk of the operations and therefore could expose us to material deficits if revenues generated are less than expenses.

We have entered into two management agreements with medical billing and collection organizations through our subsidiary, QMed Solutions, Inc., and have accepted a supervisory management role in their operations. To the extent that revenues do not cover the overhead of these companies, we are required to make up any shortfall and this may expose us to material deficits if revenues generated are less than expenses. Both of these agreements are set to expire on September 30, 2007. Although we believe we can renew or extend one or both of these agreements, there is no assurance that we will or that any such renewal will be on favorable terms.

We may incur additional penalties for late registration of securities sold in certain private placements in 2006 and 2007.

Under the terms of registration rights agreements entered into between investors and us in August 2006, December 2006 and March 2007 private placements of our securities, we are obligated to register the underlying equity securities. The registration rights carry penalties in the event we do not meet the registration obligations. If we fail to have the securities registered by the dates set forth in the operative agreements, then for each 30-day period or part thereof that we are out of compliance, we are obligated to issue to the investors additional shares of our common stock equal in value to 2% of the original principal amount of the Bridge Notes until the date that the registration statement is declared effective by the SEC. The additional penalty shares must also be registered. In addition, we are obligated to keep the registration statement effective with a current prospectus available until the registered securities have been resold, or in the case of any warrants, until all warrants have expired, have been exercised or have been sold in the public market, allowing for a lapse of no more than 25 consecutive calendar days or 40 total calendar days in any 12 month period. If we fail to do so, we are obligated to extend the terms of the warrants issuable to these investors one day for each day on which the registration statement is not currently effective. We can offer no assurance that the volume of trading of our shares in the public markets will be sufficient to allow all sellers to sell at the times or prices sellers desire. Future sales of substantial amounts of our shares in the public market could adversely affect market prices prevailing from time to time and could impair our ability to raise capital through the sale of our equity securities.

We recently completed a placement of debt that included a beneficial conversion feature. That feature will have the effect of reducing our reported net income during the term of the debt.

We have 8% issued Bridge Notes in the amount of $6,050,000 that can be converted by the note holders, until such time as the Bridge Notes are paid in full, into unregistered units otherwise similar to the units offered hereby at 70% of the public offering price of the units. At the assumed public offering price of $10.00 per unit, we would issue (i) an additional 1,831,406 shares, 1,831,406 Class A warrants and 1,831,406 Class B warrants if all the Bridge Notes are converted and (ii) an additional 612,293 shares, 1,550,200 Class A warrants and 1,550,200 Class B warrants upon exchange of Bridge Shares. Certain of those conversion features that allow for the reduction in conversion price upon the occurrence of stated events constitute a beneficial conversion feature for accounting purposes. The accounting treatment related to the beneficial conversion feature will have an adverse impact on our results of operations for the term of the Bridge Notes. This accounting will result in an increase in interest expense in all reporting periods during the term of the debt.

Our inability to retain the Medicare Advantage Members or our HMO partners or to increase 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 participation by attracting more HMOs, 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:

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negative accreditation results or loss of licenses or contracts by our affiliated HMOs or our network healthcare providers;

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negative publicity and news coverage relating to us, our affiliated HMOs or the managed healthcare industry in general; and

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litigation or threats of litigation against us or our contracted healthcare providers or our affiliated HMOs.

Because our contract with HMOs and healthcare providers we are largely dependent on third parties to provide the patients on which our provider systems revenues are based.

A disruption in healthcare provider networks could have an adverse effect on our operations and profitability.

Our operations and future profitability are dependent, in large 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 HMO members or create difficulties in meeting our regulatory or accreditation requirements. In some service areas, certain healthcare providers may have a significant market presence. If healthcare providers refuse to contract with us, use their market position to negotiate unfavorable contracts or place us at a competitive disadvantage, our ability to market services 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 HMO members/patients and/or higher healthcare costs.

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 possible loss of data critical to our operations.

Our business will depend significantly on effective and secure information systems. Once completed, the information gathered and processed by our management information systems will assist us in, among other things, billing, claims processing, medical management, medical care cost and utilization trending, financial and management accounting, reporting, planning and analysis, marketing and sales tracking and potential e-commerce. In the future, these systems could support online 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 will

require continual investment 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, impairment of the implementation of our growth strategies, delays in settling 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 security breaches occur.

If we are unable to implement effective internal controls over financial reporting or maintain compliance with periodic or other reporting requirements under the federal securities laws, investors could lose confidence in the reliability of our financial statements, which could result in a decrease in the price of our common stock.

Our ability to manage our operations and growth requires us to maintain effective operations, compliance and management controls, as well as our internal controls over financial reporting. We may not be able to implement necessary improvements to our internal control over financial reporting in an efficient and timely manner and may discover deficiencies and weaknesses in existing systems and controls, especially when such systems and controls are tested by our anticipated increased rate of growth or the impact of potential acquisitions. In addition, anticipated upgrades or enhancements to our computer systems could cause internal control weaknesses.

It may be difficult to design and implement effective internal controls over financial reporting for combined operations as we integrate acquired businesses in the future. In addition, differences in existing controls of acquired businesses may result in weaknesses that require remediation when internal controls over financial reporting are combined.

If we fail to maintain an effective system of internal controls or if management or our independent registered public accounting firm were to discover material weaknesses in our internal control systems, we may be unable to produce reliable financial reports or prevent fraud. If we are unable to assert that our internal controls over financial reporting is effective at any time in the future, or if our independent registered public accounting firm is unable to attest to the effectiveness of our internal controls or is unable to deliver its report on our financial statements or can deliver only a qualified report, we could be subject to regulatory actions and may lose investor confidence in our ability to operate in compliance with existing internal control rules and regulations, any of which could result in a decline in our stock price.

Our business will suffer if we fail to successfully integrate any potential acquisition or technologies in the future.

Part of our business plan is to acquire, license or joint venture other organizations   products, services and/or technology. If we are unable to acquire and/or successfully integrate the acquired businesses or technologies, this could have a material impact on our business model and/or development. We may not be successful in integrating acquired businesses or technologies and therefore might not be able to achieve anticipated revenues and/or cost benefits. We also cannot guarantee that these acquisitions will result in sufficient revenues or earnings to justify our investment in, or expenses related to, these acquisitions, or that any synergies will develop. The healthcare technology industry is consolidating, and we expect that we will face intensified competition for acquisitions. If we fail to execute our acquisition strategy successfully for any reason, our business could suffer significantly.

Competition in our industry may limit our ability to maintain or attract new members.

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 HMOs that compete with HMOs we have under contract. Our principal competitors for contracts, members and providers vary by local service area and are comprised of national, regional, and local HMOs that serve Medicare recipients, including, among others, UnitedHealth Group, Humana, Metcare Healthplan, Leon Medical Center Health Plan, Partner Care, Preferred Care Partners, Vista Health Plans, Wellcare Healthplans and others. Our failure to maintain or attract members to our HMO partners could adversely affect our results of operations. We also compete with numerous other entities that provide services to both HMOs and healthcare providers independently. In particular, Metropolitan Health Networks and ContinuCare, both based in south Florida, provide similar services to HMOs. We believe changes resulting from the Medicare

Modernization Act (MMA) may bring additional competitors into our Medicare Advantage service areas. Recently, Healthspring and Coventry Health, both based outside of Florida, have announced acquisitions of health plans in Florida. 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.

Negative publicity regarding the managed healthcare industry could adversely affect our results of operations or business.

Negative publicity regarding the managed healthcare industry in general, and any of our HMO 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;
- restricting our ability to market our products or services; or
- restricting our ability to attract and retain members.

Government healthcare reform could negatively impact our revenues.

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, which include, but are not limited to, national healthcare insurance. There can be no assurance as to the ultimate content, timing or effect that any healthcare reform legislation will have on the Medicare Advantage structure and government payment of medical costs. It is impossible at this time to estimate the impact of potential legislation that may be material to our operations and profitability. However, if such or similar legislation is enacted, our business operations may be adversely affected.

Offering Risks

Future sales of our common stock may cause the price of our common stock to decline.

Future sales of a substantial number of shares of our common stock or other securities in the public markets, or the perception that these sales may occur, could cause the market price of our common stock and our Class A and Class B warrants to decline, and could materially impair our ability to raise capital through the sale of additional securities.

In addition, under the terms of the Bridge Notes we have issued in several bridge financings in 2006 and 2007, we are required to register the shares by specific dates, which have not been met. We have issued 92,323 late registration shares to our bridge investors to date. Sales in the public market of a substantial number of any of these and other securities of the Company could depress the market price of our securities and impair our ability to raise capital through the sale of additional equity securities in the future at a time and price that we deem necessary or appropriate.

There has been a limited public market for our securities and our stock price could be volatile and could decline following this offering, resulting in a substantial loss in your investment.

Prior to this offering, our common stock has been trading on the OTCBB on very light volume. There has been no public market in the units, Class A warrants or Class B warrants. Concurrent with this offering, we expect our securities will trade on the American Stock Exchange. An active trading market for our securities may not develop or if it develops it may not be sustained, which could affect investors ability to sell their securities and could depress the market price of their securities. The stock market can be highly volatile. As a result, the market price of our common stock can be similarly volatile, and investors in our common stock may experience a decrease in the value of their stock, including decreases unrelated to our operating performance or prospects. The market price of our common stock after the offering will likely vary and is likely to continue to be highly volatile and subject to wide fluctuations in response to various factors, many of which are beyond our control. These factors include:

- variations in our operating results;
- changes in the general economy and in the local economies in which we operate;
- the departure of any of our key executive officers and directors;
- the level and quality of securities analysts coverage for our common stock;

- announcements by us or our competitors of significant acquisitions, strategic partnerships, joint ventures or capital commitments;
- changes in the federal, state, and local regulations to which we are subject; and
- future sales of our common stock.

The occurrence of any one or more of these factors may have negative effects on our stock price.

We have not paid dividends in the past and do not expect to pay dividends in the future.

We have never paid cash dividends on our common stock and do not anticipate doing so in the foreseeable future. The payment of dividends on our common stock will depend on our earnings, financial condition and other business and economic factors as our Board may consider relevant. If we do not pay dividends, our common stock may be less valuable because a return on your investment will only occur if our stock price appreciates.

We have substantial discretion as to how to use the net proceeds of this offering.

While we intend to use the net proceeds of our offering as set forth in Use of Proceeds, approximately 49% of the net proceeds could be used to repay outstanding debt and, consequently, will not be available to grow our business. However, the Bridge Note holders may elect to convert their debt, making those funds available for other purposes. In addition, unforeseen circumstances may cause us to use the net offering proceeds for different purposes or in different amounts as compared to our current plan. The effect of this offering of shares will be to increase the capital resources available to our management, and our management will allocate these capital resources as it determines is necessary, in its discretion to enhance shareholder value. Investors will be relying on the judgment of our management and Board with regard to the use of these net proceeds, and the results of their decisions may not be favorable. We cannot guarantee that the net proceeds, if any, will improve our operations.

If we do not maintain an effective registration statement or comply with applicable state securities laws, investors may not be able to exercise the warrants issued in this offering.

Holders of our Class A warrants and Class B warrants issued in this offering will be able to exercise their warrants only if a current registration statement covering the issuance of the shares of common stock upon exercise is in effective and the issuance of the securities qualifies for or is exempt under the securities laws of the state or other jurisdiction in which the holders live. Under the terms of the underwriting agreement with the underwriters in this offering, we have undertaken and intend to maintain a current registration statement covering the shares of common stock issuable upon exercise of the warrants. However, we may not be able to do so. Consequently, there is a possibility that the holders of the warrants will never be able to exercise those warrants and that they will never receive shares upon exercise, which could have an adverse effect on demand for the warrants and their market price.

While warrants are outstanding, it may be more difficult to raise additional equity capital.

During the term that the Class A warrants, Class B warrants and our other warrants are outstanding, the holders of those warrants are given the opportunity to profit from a rise in the market price of our common stock. We may find it more difficult to raise additional equity capital while these warrants are outstanding. At any time during which these warrants are likely to be exercised, we may be able to obtain additional equity capital on more favorable terms from other sources.

If we issue shares of preferred stock, the investment of the holders of our common stock could be diluted or subordinated to the rights of the holders of preferred stock.

Our Board of Directors is authorized by our Articles of Incorporation to establish classes or series of preferred stock and fix the designation, powers, preferences and rights of the shares of each such class or series without any further vote or action by our stockholders. Any shares of preferred stock so issued could have priority over our common stock with respect to dividend or liquidation rights. Although we have no plans to issue any shares of preferred stock or to adopt any new series, preferences or other classification of preferred stock, any such action by our Board of Directors or issuance of preferred stock by us could dilute the investment of purchasers in this offering or subordinate their interests to the interests of the holders of the preferred stock.

FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements (as defined in Section 27A of the Securities Act of 1933, which we refer to as the Securities Act and Section 21E of the Exchange Act). To the extent that any statements made in this prospectus contain information that is not historical, these statements are essentially forward-looking.
Forward-looking statements can be identified by the use of words such as expects, plans, will, may, anticipates, believes, should, intends, estimates and other words of similar meaning. These statements are subject to risks and uncertainties that cannot be predicted or quantified and, consequently, actual results may differ materially from those expressed or implied by these forward-looking statements. Such risk factors include, without limitation, our ability to properly execute our business model, to raise substantial and immediate additional capital to implement our business model, our ability to attract and retain personnel, including highly qualified executives, management and operational personnel, our ability to negotiate favorable current debt and future capital raises, our ability to negotiate favorable agreements with a diversified and expanding provider base and our ability to continue to supply the services needed by our HMO clients as well physician clients.

Information regarding market and industry statistics contained in this prospectus is included based on information available to us that we believe is accurate. It is generally based on industry and other publications that are not produced for purposes of securities offerings or economic analysis. We have not reviewed or included data from all sources and cannot assure investors of the accuracy or completeness of the data included in this prospectus. Forecasts and other forward-looking information obtained from these sources are subject to the same qualifications and the additional uncertainties accompanying any estimates of future market size, revenues and market acceptance of products and services.

We do not undertake any obligation to publicly update any forward-looking statements. As a result, investors should not place undue reliance on these forward-looking statements.

USE OF PROCEEDS

We will receive net proceeds from this offering of approximately $12,860,000 (approximately $14,918,750 if the underwriters exercise their over-allotment option in full), after deducting estimated underwriting discounts and commissions and estimated offering expenses payable by us. These amounts are based on an assumed offering price of $10.00 per unit.

We intend to use the proceeds of our offering of units as follows:

		Amount	Percent
Repayment of debt (1)	$	6,409,500	49.8%
Expansion of medical service provider networks (2)		1,000,000	7.8%
Letters of credit (3)		500,000	3.9%
Development of infrastructure and technology (1)(4)		500,000	3.9%
Payment of taxes on conversion of accrued executive compensation (5)		377,500	2.9%
Working capital (1)(6)		4,073,000	31.7%
Net proceeds	$	12,860,000	100.0%

(1)

We have $6,050,000 in 8% Subordinated Secured Convertible Bridge Notes (Bridge Notes), plus accrued interest of $359,500 as of August 31, 2007, none of which was paid on the maturity date. These Bridge Notes can be converted into units otherwise identical to the units offered in the offering at a price equal to 70% of the public offering price at the option of the note holder. Should all of such Bridge Notes be converted, which we do not anticipate, we will issue an additional 1,831,406 shares of common stock plus an equal number of Class A and Class B warrants. We will reallocate the net proceeds to increase the funds for acquisitions by $500,000-$1,000,000, $500,000 for infrastructure and technology and the balance used for working capital.

(2)

We intend to expand our existing and add new, CMS-compliant, county-wide networks of medical service providers in Florida by increasing the number of total contracted healthcare providers or establishing new networks by contracting with healthcare providers in the required medical fields in each of our targeted Florida counties.

(3)

We have contracts with HMOs that require letters of credit to guarantee expenditures for medical costs in excess of contracted revenues.

(4)

We intend to spend approximately $500,000 to develop, acquire and/or license enhanced software systems for healthcare support and physician services. Also, although we believe our corporate offices are adequate for our current

needs, in March 2008 we plan to expand our current office space and add additional satellite offices.

(5)

We have agreed to pay the income taxes associated with the conversion of up to 50% of the accrued but unpaid compensation amounts owed to Mr. Guillama and Mr. Cohen, which are estimated to be $377,500. The remaining balance of the accrued but unpaid compensation owed to Mr. Guillama and Mr. Cohen will be converted into a two year promissory note bearing interest at 8%.

(6)

The amounts allocated for the working capital purposes also include amounts allocated to future acquisitions of businesses and technology. We currently do not have any agreements or specific plans to acquire other companies.

The amounts and timing of our expenditures will depend on numerous factors, including the results of our operations, marketing activities, competition and the amount of cash generated or used by our operations. We may change these anticipated uses as we deem appropriate. We may find it necessary or advisable to use the net proceeds for other purposes, and we will have broad discretion in the application of the balance of the net proceeds. Pending the uses described above, we intend to invest the net proceeds in certificates of deposit, short-term obligations of the United States government or other money-market instruments that are rated investment grade or its equivalent. We currently estimate that the proceeds of this offering will be sufficient to enable us to meet our working capital requirements for a minimum of 12 months.

PRICE RANGES OF COMMON STOCK

Our common stock is quoted on the OTCBB under the symbol QNTM.OB. Prior to this offering, there was no current market for the units, the Class A warrants or the Class B warrants. The following table sets forth the high and low prices for our common stock for the periods indicated, as reported by the OTCBB. All share and per share amounts have been restated to reflect the 1:25 reverse stock split effectuated on March 29, 2007.

Quarter	High	Low
Fiscal Year Ended October 31, 2005		
1st Quarter 2005	$25.25	$11.75
2nd Quarter 2005	$15.00	$ 7.50
3rd Quarter 2005	$17.50	$12.50
4th Quarter 2005	$25.25	$17.50
Fiscal Year Ended October 31, 2006		
1st Quarter 2006	$21.25	$ 7.50
2nd Quarter 2006	$22.50	$20.00
3rd Quarter 2006	$27.50	$13.50
4th Quarter 2006	$20.00	$ 6.25
Fiscal Year Ended October 31, 2007		
1st Quarter 2007	$15.00	$ 4.25
2nd Quarter 2007	$ 5.00	$ 2.00
3rd Quarter 2007	$ 7.25	$ 4.00
4th Quarter (through September 17, 2007)	$ 7.25	$ 5.00

The OTCBB trading in our common stock t has been limited and sporadic, and the quotations set forth above are not necessarily indicative of actual market conditions. The quotations reflect inter-dealer prices, without retail mark-up, markdown, or commissions and may not represent actual transactions.

The last reported sales price of our common stock on the OTCBB on September 12, 2007, was $6.00 per share. As of September 24, 2007, we had approximately 700 holders of record of our common stock.

We have applied for listing of our units, common stock, Class A warrants and Class B warrants on the American Stock Exchange under the symbols QGP.U, QGP, QGP.WS.A, and QGP.WS.B, respectively.

DIVIDEND POLICY

We have not declared or paid any cash dividends on our common stock and do not anticipate declaring or paying any cash dividends in the foreseeable future. We currently expect to retain future earnings, if any, for the development of our business. Dividends may be paid on our common stock only if and when declared by our Board and will depend on a number of factors, including but not limited to, future operating results, capital requirements, financial condition

and the terms of any credit facility or other financing arrangements we may obtain or enter into, future prospects and any other factors our Board may deem relevant at the time such payment is considered. There is no assurance that we will be able, or will desire, to pay dividends in the near future or, if dividends are paid, in what amount.

CAPITALIZATION

The following table sets forth our capitalization as of July 31, 2007. You should read this table in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations and the consolidated financial statements and accompanying notes included elsewhere in this prospectus. Such information is set forth on the following basis:

Actual is based on our condensed consolidated unaudited financial statements as of July 31, 2007.

Pro Forma reflects conversion of accrued but unpaid executive compensation occurring subsequent to August 31, 2007.

Pro Forma as Adjusted gives effect to the pro forma events and the sale of our units sold in this offering and the application of the net proceeds there from as described under Use of Proceeds, assuming a public offering price of $10 per unit.

		July 31, 2007	
	Actual	**Pro Forma (1)**	**Pro Forma as Adjusted (1)**
Debt:			
Short-term debt:			
Notes payable - shareholders	$ 238,274	$ 238,274	$ 238,274
Convertible debentures - net of discount	6,027,271	6,027,271	6,027,271
Loans payable - current portion	122,898	563,073	563,073
Capital lease obligations - current portion	10,798	10,798	10,798
Total short-term debt	6,399,241	6,839,416	6,839,416
Long-term debt:			
Loans payable - less current portion	31,646	471,821	471,821
Capital lease obligations - less current portion	15,558	15,558	15,558
Total long-term debt	47,204	487,379	487,379
Total indebtedness	6,446,445	7,326,795	7,326,795
Shareholders equity (deficit)			
Preferred stock, par value $.001 per share Authorized 30,000,000, none issued or outstanding			
Common Stock, par value $.001 per share 170,000,000 shares authorized Shares issued and outstanding:			

Actual: 1,993,268		1,993				
Pro Forma: 2,145,796				2,145		
As Adjusted: 5,145,796						5,145
Additional paid in capital		12,254,964		12,854,760		25,711,760
Warrants		503,334		718,601		718,601
Deferred compensation		(3,236,232)		(3,236,232)		(3,236,232)
Accumulated deficit		(16,819,277)		(17,351,521)		(17,351,521)
Total shareholders equity (deficit)		(7,295,218)		(7,012,247)		5,847,753
Total capitalization	$	(848,773)	$	314,548	$	13,174,548

(1)

Gives effect to the accrued compensation conversion agreements whereby Noel J. Guillama and Donald B. Cohen have agreed to convert 50% of their accrued but unpaid compensation and other amounts owed to them into unregistered units, shares of common stock, Class A warrants and Class B warrants otherwise identical to the units offered hereby. As a result of such conversions, which will take place on the closing date of this offering, these executives will receive a combined total of 64,578 units. This also gives effect to the conversion of the balance of the accrued compensation to Mr. Guillama and Mr. Cohen and all of Mrs. Guillama s to an 8% two year promissory note. Also reflects the issuance of 21,278 shares of common stock for late registration penalties and 2,094 shares of common stock issued in lieu of cash through August 31, 2007.

MANAGEMENT S DISCUSSION AND ANALYSIS OR PLAN OF OPERATION

You should read the following discussion and analysis of our financial condition and results of operations in conjunction with our condensed consolidated financial statements and related notes appearing elsewhere in this prospectus. The discussion in this section 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, estimate, or continue, or the negative thereof or other variations thereof or comparable terminology. You are 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. Our actual results may differ materially from those anticipated in these forward-looking statements as a result of various factors, including those set forth in the Risk Factors section and elsewhere in this prospectus.

Executive Overview

We offer *business solutions* for health maintenance organizations (HMOs) that market Medicare Advantage managed healthcare plans as well as to healthcare providers in the state of Florida, through our Community Health Systems, also referred to as *provider systems* .. Medicare Advantage is Medicare s managed care alternative to Medicare s traditional fee-for-service model. The foundation of our business model is a network of medical service providers, including primary care physicians, specialists and ancillary service providers such as laboratories and pharmacies, among others, all of whom must satisfy the requirements of the Centers for Medicare & Medicaid Services (CMS), which is the U.S. federal agency that administers Medicare, Medicaid and the Medicare Advantage program. We also offer healthcare providers various *management support services* that enable them to decrease their operating costs and increase efficiency and productivity. These management support services are available to all healthcare providers, whether or not they are part of our network. In the future, we expect to leverage our relationships with our healthcare providers to cross-market our management support services and the benefits of participation in our network.

As mandated by CMS, we have separate networks of healthcare providers covering all required medical fields and ancillary services in every county where we currently operate, each of which serves as a community-based comprehensive delivery system of care, and which we call Community Health Systems (CHS). Once CMS-compliant, we then make our county-wide CHS network of healthcare providers available to HMOs with whom we contract on a non-exclusive basis. Our network participants, whether physicians, physician groups or other healthcare providers, are eligible to treat member/patients of all of our contracted HMOs and can do so without going through separate admission processes with the various HMOs.

Our network places us in the position of being the primary interface between the HMOs and the contracted healthcare providers and affords us the opportunity of becoming the preferred management service provider of administrative, practice management and ancillary services to healthcare providers that participate in our network as well as to other healthcare providers, physician groups, testing facilities, nursing homes and hospitals. It is our philosophy to provide high quality service as the link between our HMOs and our network contracted providers. By virtue of this relationship, we can relieve the healthcare providers and the HMOs of substantial administrative and repetitive burdens generally associated with the operations of a managed care enterprise and with the verification of medical credentials (credentialing) of healthcare providers that desire to participate in the HMO managed care plans, as required by CMS regulations. It also enables HMOs to establish a network of contracted healthcare providers necessary to enter any new geographic market without having to interact with numerous healthcare providers or multiple service organizations.

As of August 31, 2007, our network included over 1,600 healthcare providers and operated in 26 counties in central and southern Florida. Our goal is to increase the number of healthcare providers participating in our network to 2,500 by the end of calendar year 2007 and to continue a measured rollout of additional CHS to eventually encompass all 67 Florida counties. We believe that each new CHS represents an opportunity for HMOs that are not marketing their managed care plans in that county to expand their market by providing them ready-made or turnkey access to that county without substantial delay or start-up cost.

We were a development stage company until July 2006. From inception, we have spent approximately $10.1 million building networks of healthcare providers, negotiating and signing contracts with HMOs, providing services for members of three HMO contracts and developing our business administration and support team. We

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have executed full risk contracts with five HMOs, under three of which our provider systems are actively providing healthcare for the HMOs members. Under a full risk contract, we receive a monthly dollar amount (a capitated rate) for each patient that chooses one of our contracted healthcare providers as his or her primary care physician. We expect that the remaining two contracts will become active in 2008 and 2009. A contract generally will not generate revenues until we have a complete county network of healthcare providers or a CHS (which is in compliance with CMS requirements) that is ready to provide comprehensive care to the Medicare Advantage patients in the specified counties, and patients enrolled under the contract with contracted healthcare providers in our CHS. Annually, beginning on November 15, HMOs can sign up new members who may elect to join our provider systems during the open enrollment period under a managed care plan operated under the Medicare Advantage program. Open enrollment ends March 31 of each year. This is our window of opportunity for new contracts to begin generating revenues on January 1 of each calendar year. Although not as predictable, other opportunities also occur at the time that a person becomes eligible to participate in a managed care plan, *e.g.* , when he or she becomes 65 years of age or becomes disabled, when enrolled patients are transferred from another plan, when another managed care plan is terminated by CMS or when a person moves from one service area to another. Revenues under these agreements are generally recorded in the period in which we are responsible for providing services at the rates then in effect as determined by the respective contract. As part of the Medicare Advantage program, CMS periodically re-computes the premiums to be paid to the HMOs based on the updated health status of the member and updated demographic factors. Any change in premium from CMS to the HMO will adjust the premiums we receive from the HMO. We record any adjustments to these revenues at the time that the information necessary to make the determination of the adjustment is received from the HMO. We commenced generating revenues under one contract in September 2005 in Volusia County, Florida, with Dade and Broward Counties added in January 2006, under the second HMO contract in December 2006, and under the third contract in January 2007.

Our provider systems revenues consist of a percentage of premiums paid by CMS to the contracted HMOs on a Per Member Per Month (PMPM) basis. The actual percentage is negotiated with the HMO. The amount of PMPM varies depending upon the CMS premium, which is influenced by a patient s age, residing county, health profile and other factors. Management support services revenues are generated by contracting with healthcare providers to provide billing and collections services and, to a limited degree, insurance products specifically tailored to physician s needs, such as health, life, disability and malpractice insurance. We earn revenues from our billing and collections services by retaining a negotiated percentage of the amounts we collect. Our insurance revenues are commissions paid to us on insurance products sold. We currently operate management support services under management agreements, one of which we terminated after only one quarter in fiscal 2007. The other two will terminate September 30, 2007, unless renewals or extensions are negotiated. We intend to negotiate extensions to these contracts, but there is no assurance that we will be able to accomplish this.

The provider systems direct medical costs are a combination of actual medical costs paid by the HMO plus a reserve for future medical costs incurred but not reported (IBNR). Our provider systems direct costs include capitation payments to participating physicians and specialists, fee-for-service payments to non-participating physicians and specialists, payments to hospitals for in-patient and out-patient services, payments to pharmacies for prescription drugs and the allowance for those expenses incurred but not reported (IBNR). The management support services direct costs are related to the billing companies and include salaries, benefits and claims processing costs.

We maintain a corporate office in Wellington, Florida that houses operational personnel, as well as accounting, marketing and other support staff. Occasionally, we have engaged consultants to assist on a specific project, or for a short time period. Office space rent, supplies, other general costs and depreciation expense related to office furniture and equipment costs are also included in general and administrative costs.

Critical Accounting Policies and Estimates

The preparation of financial statements in accordance with generally accepted accounting principles requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses in the reporting period. We regularly make estimates and assumptions that affect the reported amounts of assets and liabilities.

We base our estimates and assumptions on current facts, historical experience and various other factors that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities and the accrual of costs and expenses that are not readily apparent from other sources. The actual results experienced by us may differ materially and adversely from our estimates. To the

extent there are material differences between our estimates and the actual results, our future results of operations will be affected.

Our critical accounting policies and estimates involve the use of complicated processes, assumptions, estimates and/or judgments in the preparation of our condensed consolidated financial statements. An accounting estimate is an approximation made by management of a financial statement element, item or account in the financial statements. Accounting estimates in our historical condensed consolidated financial statements measure the effects of past business transactions or events, or the present status of an asset or liability. The accounting estimates described below require us to make assumptions about matters that are uncertain at the time the estimate is made. Additionally, different estimates that we could have used or changes in an accounting estimate that are reasonably likely to occur could have a material impact on the presentation of our condensed consolidated financial condition or results of operations. We base our estimates on historical experience and on various other assumptions that we believe are reasonable under the circumstances, the results of which form the basis for making judgments. These estimates may change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. Our significant accounting policies are discussed in Note 2 to our Condensed Consolidated Financial Statements. We have discussed the development and selection of our critical accounting policies and related disclosures with our Audit Committee and have identified the following critical accounting policies for the current fiscal year.

Principles of Consolidation

We consolidate entities when we have the ability to control the operating and financial decisions and policies of that entity. The determination of our ability to control or exert significant influence over an entity involves the use of judgment. Therefore, we have included in our condensed consolidated financial statements the transactions of the billing companies that have been operating under management agreements under which we have taken on the profit and loss risk.

Goodwill and Other Intangibles

Statement of Financial Accounting Standards No. 142 *Goodwill and Other Intangible Assets,* (SFAS No. 142) requires that goodwill and intangible assets with indefinite useful lives be tested for impairment annually or more frequently if an event occurs or circumstances change that may reduce the fair value of our goodwill below its carrying value. We completed an impairment test as required under SFAS No. 142 in the fourth quarter of fiscal year 2006 and determined that the goodwill was not impaired. Changes in estimates or application of alternative assumptions and definitions could produce significantly different results.

Allowance for Doubtful Accounts

We establish provisions for losses on accounts receivable if we determine that we will not collect all or part of the outstanding balance. We regularly review collectability and establish or adjust our allowance as necessary using the specific identification method.

Medicare Considerations

Substantially all of our provider systems revenues from continuing operations are based upon Medicare funded programs. The federal government from time to time explores ways to reduce medical care costs through Medicare reform and through healthcare reform generally. Any changes that would limit, reduce or delay receipt of Medicare

funding or any developments that would disqualify us from receiving Medicare funding could have a material adverse effect on our business, results of operations, prospects, financial results, financial condition or cash flows. Due to the diverse range of proposals put forth and the uncertainty of any proposal s adoption, we cannot predict what impact any Medicare reform proposal ultimately adopted may have on our business, financial position or results of operations.

Revenue Recognition

Under our full-risk contracts with HMOs, we receive a percentage of premium or other capitated fee for each patient who chooses one of our network physicians as his or her primary care physician. Revenues under these agreements are generally recorded in the period we are responsible to provide services at the rates then in effect as determined by the respective contract. As part of the Medicare Advantage program, CMS periodically re-computes the premiums to be paid to the HMOs based on updated health status of participants and demographic factors. We

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record any adjustments to these revenues at the time that the information necessary to make the determination of the adjustment is received from the HMO.

Under our full-risk agreements, we assume responsibility for the cost of substantially all medical services provided to the patient (including prescription drugs), even those services we do not provide directly, in exchange for a percentage of premium or other capitated fee. To the extent that patients require more frequent or expensive care, our revenues under a contract may be insufficient to cover the costs of care provided. We are covered by stop-loss insurance policies and programs that limit our maximum risk exposure for each of our patients. None of our contracted primary care providers were operating at a material medical loss as of July 31, 2007. If a primary care provider is operating at a material medical loss, our provider contracts permit us to terminate such contractual relationship and to ask the HMO to transfer those patients to another of our contracted primary care providers.

The majority of our revenues from management support services are generated from services provided from the billing and collections company. We receive a contractual fee based on the collections of medical claims.

Medical Claims Expense Recognition

The cost of healthcare services provided or contracted for is accrued in the period in which the services are provided. This cost includes our estimate of the related liability for medical claims incurred in the period but not yet reported, or IBNR. IBNR represents a material portion of our medical claims liability which is presented in the balance sheet. As of July 31, 2007, the balance of IBNR allowance is $203,478. Changes in this estimate can materially affect, either favorably or unfavorably, our results from operations and overall financial position.

Normally, IBNR claims are estimated using historical claims patterns, current enrollment trends, member utilization patterns, timeliness of claims submissions and other factors. However, we have a limited amount of history on which to base our estimated IBNR allowance. Therefore, we are currently using an approximation based on industry experience primarily based on historical claims incurred per member per month. We adjust our estimate if we have unusually high or low utilization or if benefit changes provided under the HMO plans are expected to significantly increase or reduce our claims exposure. We also adjust our estimate for differences between the estimated claims expense that are recorded in prior months and the actual claims expense as claims are paid by the HMO and reported to us.

To further corroborate our estimate of medical claims, we use statistical data provided by the HMO for the period of January through July. We have analyzed the claims paid history to determine the Date-of-Service to Date-Claim-Paid-By-Month percentage. Applying this analysis to the last three months, our calculation resulted in a variance of less than $100 from the recorded IBNR. Until we have accumulated adequate history to further refine our calculation of IBNR, we have determined that the current method allows for the calculation of a reasonable estimate of IBNR. There can, however, be no assurance that the ultimate liability will not exceed estimates. Adjustments to the estimated IBNR claims are recorded in results of our operations in the periods when such amounts are determined. Per guidance under SFAS No. 5, we accrue for IBNR claims when it is probable that expected future healthcare costs and maintenance costs under an existing contract have been incurred and the amount can be reasonably estimable. We record a charge related to these IBNR claims as medical claims expense.

Income Taxes

Income taxes are accounted for in accordance with the provisions of SFAS No. 109, *Accounting for Income Taxes.* SFAS No. 109 requires the use of an asset and liability approach for financial accounting and reporting for income

taxes. Under this approach, deferred tax assets and liabilities are recognized based on anticipated future tax consequences, using currently enacted tax laws, attributable to differences between financial statement carrying amounts of assets and liabilities and their respective tax basis. We record current income taxes based on our current taxable income, and we provide for deferred income taxes to reflect estimated future tax payments and receipts. Deferred tax assets are reduced by a valuation allowance when, based on our estimates, it is more likely than not that a portion of those assets will not be realized in a future period. The estimates utilized in recognition of deferred tax assets are subject to revision, either up or down, in future periods based on new facts or circumstances. During the three and nine-month periods ended July 31, 2007, we determined that it is more likely than not that the deferred tax assets will not be realized, resulting in a full valuation allowance at July 31, 2007.

Share-Based Payment

Effective November 1, 2006, we adopted the provisions of SFAS No. 123R, *Share-Based Payment,* which establishes accounting for stock-based awards exchanged for employee and non-employee services. Accordingly, equity classified stock-based compensation cost is measured at grant date, based on the fair value of the award and is recognized as expense over the requisite service period. Liability classified stock-based compensation cost is re-measured at each reporting date and is recognized over the requisite service period. Consistent with our practices prior to adopting SFAS 123(R), we have elected to calculate the fair value of our employee stock options using the Black-Scholes option pricing model. We elected to adopt the modified prospective application method as provided by SFAS No. 123R and, accordingly, financial statement amounts for the prior periods presented in these condensed consolidated financial statements have not been restated. Compensation expense for awards with graded vesting provisions is recognized on a straight-line basis over the requisite service period of each separately vesting portion of the award.

Pending Adoption of Accounting Pronouncement

Accounting for Uncertainty in Income Taxes

In July 2006, the FASB issued FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes-an Interpretation of FASB Statement 109,* (FIN 48), which clarifies the accounting for uncertainty in tax positions taken or expected to be taken in a tax return, including issues relating to financial statement recognition and measurement. FIN 48 provides that the tax effects from an uncertain tax position can be recognized in the financial statements only if the position is more-likely-than-not of being sustained if the position were to be challenged by a taxing authority. The assessment of the tax position is based solely on the technical merits of the position, without regard to the likelihood that the tax position may be challenged. If an uncertain tax position meets the more-likely-than-not threshold, the largest amount of tax benefit that is greater than 50% likely of being recognized upon ultimate settlement with the taxing authority, is recorded. The provisions of FIN 48 are effective for fiscal years beginning after December 15, 2006. We will adopt FIN 48 as of November 1, 2007 with the cumulative effect of the change in accounting principle recorded as an adjustment to opening retained earnings. We are currently evaluating the impact of adopting FIN 48 on our condensed consolidated financial statements.

Fair Value Measurements

In September 2006, the FASB issued SFAS No. 157 *Fair Value Measurements,* (SFAS No. 157). SFAS No. 157 defines fair value, establishes a framework for measuring fair value in generally accepted accounting principles, and expands disclosures about fair value measurements. SFAS No. 157 applies under other accounting pronouncements that require or permit fair value measurements, the FASB having previously concluded in those accounting pronouncements that fair value is the relevant measurement attribute. Accordingly, SFAS No. 157 does not require any new fair value measurements. However, for some entities, the application of SFAS No. 157 will change current practice. SFAS No. 157 is effective for fiscal years beginning after November 15, 2007 (*i.e.* , fiscal year 2009) and interim periods within those years. We have assessed the effect of this pronouncement on our financial statements, and at this time, no material effect is expected.

Fair Value Option for Financial Assets and Liabilities

In February 2007, the FASB issued SFAS No. 159 *The Fair Value Option for Financial Assets and Financial Liabilities, Including an Amendment of FASB Statement No. 115,* (SFAS No. 159). SFAS No. 159 permits entities to

choose to measure many financial instruments and certain other items at fair value. The objective is to improve financial reporting by providing entities with the opportunity to mitigate volatility in reported earnings caused by measuring related assets and liabilities differently without having to apply complex hedge accounting provisions. SFAS No. 159 is expected to expand the use of fair value measurement, which is consistent with the FASB s long-term measurement objectives for accounting for financial instruments. SFAS No. 159 is effective for fiscal years beginning after November 15, 2007 (fiscal year 2009). We have assessed the effect of this pronouncement on our financial statements, and at this time, no material effect is expected.

Results of Operations

Nine Months Ended July 31, 2006 as Compared to the Nine Months Ended July 31, 2007

Revenues and Direct Costs

The following table presents the revenues and direct costs for the nine months ended July 31, 2006 and 2007, respectively. These items are discussed in detail following the table.

	For the Nine Months Ended July 31,	
	2006	**2007**
Revenues		
Provider systems	$ 22,640	$ 1,268,253
Management support services	32,782	1,247,884
	55,422	2,516,137
Direct Costs		
Provider systems	22,640	1,212,251
Management support services	21,752	898,275
	44,392	2,110,526
Gross Profit	$ 11,030	$ 405,611

Revenues

Total revenues for the nine months ended July 31, 2007 (the 2007 Period) increased by $2,460,715 from the nine months ended July 31, 2006 (the 2006 Period). During most of the 2006 Period, we were in the development stage and only earned minimal revenues of $55,422 for the period. The increase in the 2007 Period was due to a combination of the addition of two new management contracts for billing and collections and increasing the number of members associated with three HMO contracts. We earned management support services revenues of $1,247,884 in the 2007 Period: $34,291 from one agreement that was in effect from November 2006 through February 2007 and $1,213,593 from two agreements that went into effect in December 2006, both of which are due to expire on September 30, 2007. Although we believe we will be able to renew or extend these management agreements, there is no assurance that we will be able to do so or that the new terms will be as favorable as the existing terms. Provider systems revenues of $1,268,253 account for approximately 50% our total revenues in the 2007 Period and reflect capitated fees from two HMOs and reimbursement of primary care physician costs on the third HMO.

Provider systems revenues growth is dependent on the number of new members/patients that enroll in the HMO network and are assigned to our healthcare providers. Although growth has been steady through the 2007 Period, growth has been limited by the fact that members cannot change HMO networks freely due to the statutory restrictions governing the Medicare Advantage plan enrollment and membership. We anticipate growth in the number of participating providers and members during the upcoming open enrollment period commencing November 15, 2007 through March 31, 2008. We expect that the growth in the management support services revenues will initially be derived from acquisitions, entering into additional management agreements for existing management support services businesses and joint ventures. As we develop our sales and marketing capabilities, we expect that growth in

management support services revenues will be derived from internal growth as we have the resources to market these services to the healthcare providers in our network.

Direct Costs

Direct costs were $44,392 and $2,110,526 for the nine months ended July 31, 2006 and 2007, respectively. The increase of $2,066,134 in the 2007 Period primarily relates to $1,189,611 of provider systems costs and $876,523 of management support services costs. Provider systems direct costs increased because we were responsible for approximately 2,000 additional patient months under our HMO contracts as of the end of the 2007 Period as compared to the same period in 2006, and these new patients were enrolled with the full-risk HMOs. This amount includes $1,055,680 of direct costs paid. An additional $156,571 was paid for reinsurance to cover excessive expenses (stop-loss insurance). The majority of the management support services direct costs are composed of the condensed consolidated transactions of the billing and collections companies that are under management contracts, which were incurred beginning November 2