QUANTUM GROUP INC /FL
Form 424B4
December 14, 2007

As filed pursuant to Rule 424(b)(4)

under the Securities Act of 1933

Registration No. 333-142990

PROSPECTUS

1,200,000 UNITS

Each unit consisting of three 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 1,200,000 units, each unit consisting of three 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 December 11, 2007, the last reported sale price of our common stock was $4.50 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.

Our units, common stock, Class A warrants and Class B warrants, have been approved for listing on the American Stock Exchange under the symbols QGP.U, QGP, QGP.WS.A and QGP.WS.B, respectively.

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

	Per Unit	**Total**
Public offering price	$11.0000	$13,200,000

Underwriting discount	$ 0.6325	$ 759,000
Proceeds to us, before expenses	$10.3675	$12,441,000

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 $1,504,000 and will include a non-accountable expense allowance payable to the representative equal to 2.5% 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 120,000 units identical to the units offered to the public, exercisable at $13.20 (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 180,000 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 December 12, 2007.

TABLE OF CONTENTS

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 October 1, 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 December 12, 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 2,000 by early 2008 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 and 2007, 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

1,200,000 units, with each unit consisting of three 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

2,400,000

Class B warrants outstanding

after this offering

2,400,000

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 January 12, 2007 (30 days from the date of this prospectus) and will expire on January 12, 2014.

Common stock outstanding after

this Offering

8,753,448 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.

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 the pro forma shares outstanding of 5,153,448 as of December 12, 2007. Pro forma shares outstanding include 2,037,596 shares of common stock outstanding on that date and, at the $11.00 unit price in this offering: (i) 176,121 shares of common stock issuable in conjunction with the executive compensation conversion agreements, (ii) 1,176,172 net shares of common stock which may be issued upon the exchange of all outstanding Bridge Shares, and (iii) 1,763,559 shares of common stock which will be issued upon conversion of $5,151,932 in convertible Bridge Notes, including accrued interest as of December 12, 2007 of $501,932, into 587,853 units. We gave the bridge investors two conversion options. Under the first option (Option 1), the Bridge Notes converted into the Conversion Securities at 100% of the public offering price, which Conversion Securities and underlying securities are subject to a one year lockup. Under the second option (Option 2), the Bridge Notes converted into the Conversion Securities at a 30% discount to the public offering price, which Conversion Securities and underlying securities are subject to a two year lockup. Of the total of $6,050,000 Bridge Notes, a total of $1,727,500, plus interest, or 28.55%, elected to convert under Option 1 into 172,983 units; and $2,922,500, plus interest, or 48.31%, elected to convert under Option 2 into

414,870 units. Under either option, we have agreed to pay a fee of 3% the aggregate amount of principal and accrued interest, payable quarterly for one year, unless the lockups are earlier released. 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 2,400,000 Class A warrants and 2,400,000 Class B warrants included in the units offered hereby;

.

assumes no exercise of the underwriters over-allotment option to purchase up to an additional 180,000 units;

.

assumes no exercise of warrants to purchase up to 120,000 units issuable to the representative in connection with this offering;

.

assumes no exercise of vested options, which as of December 12, 2007, aggregate 887,633 options to purchase shares of common stock at a weighted average exercise price of $5.09;

.

assumes no exercise of outstanding warrants, which as of December 12, 2007, aggregate 108,319 warrants to purchase shares of common stock at a weighted average exercise price of $8.47;

.

assumes no exercise of Class A warrants or Class B warrants included in the units resulting from the Bridge Shares exchange. In connection with our August 2006 Interim Bridge Financing and our series of private placements between August 2006 and May 2007, we issued a total of 937,907 bridge shares. Bridge Share holders have the right to exchange their bridge shares for unregistered units identical to the units offered in this offering equivalent to their initial investment in the bridge units. Based on the public offering price of $11.00, the Bridge Shares may be exchanged for 704,693 units (See Description of Securities Convertible Bridge Notes, Bridge Shares and Registration Rights.)

Significant Risks

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

.

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:

	Fiscal Year Ended October 31,		Nine Months Ended July 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)	$ (2,651,549)	$ (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) (2) (3) (4)**	**This Offering (5)**	**Pro Forma as Adjusted (1) (2) (3) (4) (5)**
Total assets	$ 1,961,375	$ 2,067,954	$ 9,522,567	$ 11,590,521
Total liabilities	$ 9,256,593	$ 4,337,985	$ (2,050,292)	$ 2,287,693
Working capital (deficiency)	$ (7,560,070)	$ (2,094,707)	$ 11,572,859	$ 9,478,152
Shareholders equity (deficit)	$ (7,295,218)	$ (2,270,031)	$ 11,572,859	$ 9,302,828

(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 58,707 units at the $11.00 per unit offering price.

(2)

Gives effect to two working capital financing arrangements entered into in October 2007, which, in the aggregate, resulted in $484,000 in net proceeds to us. Namely, we issued a two-year 10% promissory note, dated December 4, 2007, in the principal amount of $250,000 to Paulson Investment Company, Inc., representative of the underwriters in this public offering. We agreed to prepay the principal amount of the note, plus accrued interest, at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In addition, we executed a financing agreement with High Capital Funding LLC, a principal shareholder (HCF), and a third party lender that has no prior affiliation with us (TPL). The financing arrangement involved the issuance of two-year promissory notes to each of HCF and TPL in the aggregate principal amounts of $166,667 and $83,333, respectively. In satisfaction of the notes in full, we agreed to pay to HCF and TPL $238,094 and $119,047, respectively, with $71,427 and $35,714 representing the respective original issue discounts on the HCF and TPL notes. We also agreed to prepay the principal amount of the notes at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In the event of default on these notes, including the failure to make the prepayment required thereunder, the interest on the notes will become immediately due and payable at the rate of 3% per month on the principal amount outstanding. We paid a 5% cash commission in the amount $12,500 to Newbridge Securities Corporation, one of the underwriters in this offering, in connection with the HCF and TPL financings. Net proceeds to us from the HCF and TPL financing arrangements was in the amount of $234,000. All three promissory notes contain events of default and other terms and provisions customary for instruments of this nature.

(3)

Gives effect to the issuance of shares of common stock issuable upon exchange of the Bridge Shares into 2,114,079 shares of common stock issuable upon the exchange of 937,907 Bridge Shares, at the offering price of $11.00 per unit.

(4)

Gives effect to conversion of $5,151,932 in convertible Bridge Notes, including accrued interest as of December 12, 2007 of $501,932, into 587,853 units. See Description of Securities Convertible Bridge Notes, Bridge Shares and Registration Rights.

(5)

Gives effect to the sale of an aggregate of 1,200,000 units in this offering at the offering price of $11.00 per unit, resulting in net proceeds of $11,696,000 and the repayment from the proceeds of $1,566,292 Bridge Notes, including $166,292 in interest; and $607,141, plus accrued interest, in connection with the two working capital financing arrangements entered into in October 2007.

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 to 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

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 patients 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 $1,400,000 in 8% Subordinated Secured Convertible Bridge Notes, which are secured by all our assets. None of those Bridge Notes have been paid as of 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 prospectus. These Bridge Notes, plus accrued interest as of December 12, 2007 of $166,292, will be paid from proceeds of this offering.

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 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 our 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 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 December 31, 2007. Although we believe we can renew or extend one or both of these agreements past the expiration date, 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. We failed to have the securities registered by the dates set forth in the operative agreements (March 31, 2007, June 30, 2007 and July 31, 2007, respectively), therefore, 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. We have issued 92,323 late registration shares through August 31, 2007, and, upon our underwriters request, we have requested from our investors a waiver on future late registration penalties after that date. 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 issued 8% Bridge Notes in the amount of $6,050,000, plus accrued interest of $688,224 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. Bridge Notes totaling $5,151,932, including interest of $501,932, will be converted into 587,853 units. The balance of $1,566,292, including interest on such notes of $166,292, will be repaid out of the net proceeds of this offering.

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:

.

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

.

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

.

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

Immediately following effectiveness of this registration statement we intend to file another registration statement to register the shares of our common stock issuable pursuant to Bridge Share exchanges; future sales of such securities may cause the price of our common stock and other listed securities to decline.

We have Bridge Notes in the aggregate principal amount of $6,050,000 and accrued interest on such notes of $668,224 through December 12, 2007, which amount is convertible into Convertible Securities. Although under the original terms of the Bridge Notes, the bridge investors are entitled to be repaid out of the net proceeds of this offering, in November 2007, we requested that the bridge investors amend their prior agreements with us and agree to convert their Bridge Notes at the closing of this offering into Conversion Securities under either of two options we have made available. See Description of Securities Convertible Bridge Notes, Bridge Shares and Registration Rights. Bridge Notes totaling $5,151,932, including interest of $501,932, will be converted into 587,853 units. The balance of $1,566,292, including interest on such notes of $166,292, will be repaid out of the net proceeds of this offering. In

addition to the Convertible Securities, at the offering price of $11.00 per unit, we will issue: (i) 704,693 units upon the exchange of 937,907 Bridge Shares held by Interim Bridge and private placement investors, (ii) 176,121 shares of common stock issuable in conjunction with the executive compensation conversion agreements, and (iii) 92,323 Late Registration shares to Bridge Share holders calculated at 2% of the original principal amount of the Bridge Notes for each month or part thereof that we have been unable to register the shares through August 31, 2007. Immediately following the effectiveness of this registration statement, we intend to file another registration statement to register shares of our common stock issuable pursuant to Bridge Share exchanges and the late registration penalty shares. Sales in the public market of a substantial number of any of these and other of our securities 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 13% of the net proceeds will be used to repay outstanding debt and, consequently, will not be available to grow our business. 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 effect 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 up to 30,000,000 shares of our 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 shareholders. 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, to attract and retain personnel, including highly qualified executives, management and operational personnel, to negotiate favorable current debt and future capital raises, 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 $11,696,000 (approximately $13,562,150 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 the offering price of $11.00 per unit.

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

		Use of proceeds based on the repayment of debt	
Repayment of Bridge Notes (1)	$	1,566,292	13%
Expansion of medical service provider networks (2)		1,000,000	9%
Letters of credit (3)		500,000	4%
Development of infrastructure and technology (4)		500,000	4%
Repayment of Bridge Loan (5)		607,141	5%
Payment of financing fee (8)		558,000	5%
Payment of taxes on conversion of accrued executive compensation (6)		377,422	3%
Working capital (7)		6,587,145	57%
Net proceeds	$	11,696,000	100%

(1)

We have $6,050,000 in Bridge Notes, plus accrued interest of $668,224 as of December 12, 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 this offering at a 30% discount to the public offering price at the option of the note holder. Bridge Notes totaling $5,151,932, including interest of $501,932, will be converted into 587,853 units. The balance of $1,566,292, including interest on such notes of $166,292, will be repaid out of the net proceeds of this offering.

(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 between $500,000 and $1,000,000, depending on the Bridge Note conversion decisions, 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 entered into two financing arrangements in October 2007 to obtain working capital which, in the aggregate, resulted in $484,000 in net proceeds to us. Namely, we issued a two-year 10% promissory note, dated December 4, 2007, in the aggregate principal amount of $250,000 to Paulson Investment Company, Inc., representative of the underwriters in this public offering. We agreed to prepay the principal amount of the note, plus accrued interest, at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In addition, we executed a financing agreement with High Capital Funding, LLC, a principal shareholder (HCF), and a third party lender that has no prior affiliation with us (TPL). The financing arrangement involved the issuance of two-year promissory notes to each of HCF and TPL in the aggregate principal amounts of $166,667 and $83,333, respectively. In satisfaction of the notes in full, we agreed to pay to HCF and TPL $238,094 and $119,047, respectively, with $71,427 and $35,714 representing the respective original issue discounts on the HCF and TPL notes. We also agreed to prepay the full principal amount of the notes at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In the event of default on these notes, including the failure to make the prepayment required thereunder, the interest on the notes will become immediately due and payable at the rate of 3% per month on the principal amount outstanding. We paid a 5% cash commission in the amount $12,500 to Newbridge Securities Corporation, one of the underwriters in this offering, in connection with the HCF and TPL financings. Net proceeds to us from the HCF and TPL financing arrangements was in the amount of

$234,000. All three promissory notes contain events of default and other terms and provisions customary for instruments of this nature.

(6)

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 $377,422. 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%.

(7)

The amounts allocated for 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. In addition, a certain amount, which we are currently unable to estimate precisely, may be used to repay any Bridge Notes that are not converted. In addition, we agreed to repurchase 70,911 warrants from Newbridge from the proceeds of this offering at a total cost of $70,911.

(8)

In November 2007, we requested that the bridge investors amend their prior agreements with us and convert their Bridge Notes into unregistered securities otherwise identical to the units offered in this Public Offering (the Conversion Securities). We gave the bridge investors two conversion options. Under the first option, the Bridge Notes will convert into the Conversion Securities at 100% of the unit public offering price, which Conversion Securities will be subject to a one year lockup in exchange for a lockup fee of 3% of the aggregate amount of principal and accrued interest, payable quarterly. Under the second option, the Bridge Notes will convert into the Conversion Securities at a 30% discount to the unit price in this Public Offering, which Conversion Securities will be subject to a two year lockup in exchange for a lockup fee of 3% of the aggregate amount of principal and accrued interest, payable quarterly for one year. Of the total of $6,050,000 Bridge Notes, a total of $1,727,500, plus interest, or 28.55%, elected to convert under Option 1 into 172,983 units; and $2,922,500, plus interest, or 48.31%, elected to convert under Option 2 into 414,870 units. Under both options, the cash payment for the first three months will be paid in advance at the closing of this Public Offering and the payments for the remaining nine months will be paid in arrears after each quarter. Similarly, under both options, the cash payment is only payable for each full quarter during which the Conversion Securities are subject to the lockups. Finally, under both options, the lockups may be released at any time after six months in the representative s discretion.

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.

20

DILUTION

If you invest in our units in this offering, you will experience dilution in your shares of common stock to the extent of the difference between the offering price attributable to each share of common stock and the pro forma, as adjusted, net tangible book value per share of common stock after this offering. For purposes of the dilution computation and the following tables, we have allocated the full purchase price of a unit to the shares of common stock included in the unit and none to the warrant.

As of July 31, 2007, we had a negative net tangible book value of $7,318,518 or $3.67 per share. The negative net tangible book value per share of common stock is determined by subtracting total liabilities from the total book value of the tangible assets and dividing the difference by the number of shares of common stock deemed to be outstanding on the date the book value is determined.

Our pro forma negative net tangible book value at July 31, 2007 was $2,293,331 or $0.45 per share, which reflects the effect of (i) 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, (ii) the exchange of Bridge Shares into 704,693 units resulting in the issuance of an additional 1,176,172 shares of common stock, (iii) the conversion of a portion of the $6,050,000 Bridge Notes (a total of $1,727,500, plus interest, or 28.55%, elected to convert under Option 1 into 172,983 units; and $2,922,500, plus interest, or 48.31%, elected to convert under Option 2 into 414,870 units); and (iv) two working capital financing arrangements entered into October, 2007 providing $500,000 in working capital. The pro forma negative net tangible book value per share of common stock is determined by subtracting total pro forma liabilities from the total pro forma tangible assets and dividing the difference by the pro forma number of shares of common stock deemed to be outstanding on the date the tangible book value is determined.

After giving effect to the accrued compensation conversion agreements, the exchange of Bridge Shares, the conversion of a portion of the Bridge Notes, explained above, and the application of the estimated net proceeds from this offering excluding repurchase of warrants of $70,911, our as adjusted pro forma net tangible value as of July 31, 2007, would have been $9,279,528 or $1.06 per share. This represents an immediate increase in pro forma net tangible value to existing shareholders of $1.51 per share and an immediate dilution to new investors of $2.61 per share. The following table illustrates this per share dilution to new investors purchasing units in this offering.

Assumed offering price per share		$ 3.67
Pro Forma net tangible book value deficit per share as of July 31, 2007	$ (0.45)	
Increase per share attributable to new investors	$ 1.51	
Pro Forma, as adjusted, net tangible book value per share after the offering		$ 1.06
Dilution per share to new investors		$ 2.61

If the underwriters exercise in full their option to purchase additional units in this offering, the as adjusted, net tangible book value per share after the offering, the conversion 77% of the bridge notes, and the repayment of the remaining balance, would be $1.20 per share, the increase in net tangible book value per share to existing shareholders would be $1.65 per share, and the dilution to new investors purchasing units in this offering would be $2.47 per share.

21

The following table sets forth the unaudited pro forma as adjusted basis, as of July 31, 2007, the differences between the total consideration paid and the average price per share paid by existing shareholders and by the new investors purchasing units in this offering before deducting underwriting discounts and estimated offering expenses paid by us:

	Shares Purchased		Total Consideration		
	Number	Percent	Amount	Percent	Average Price per Share
Existing Shareholders (pro forma)	2,037,596	23,3%	$ 13,067,162	40.8%	$ 6.41
Conversion of Bridge Notes	2,939,731	33.6%	5,151,932	16.0%	$ 1.75
Conversion of Executive Compensation	176,121	2.0%	645,768	2.0%	$ 3.67
New Investors	3,600,000	41.1%	13,200,000	41.2%	$ 3.67
	8,753,448	100.0%	$ 32,064,862	100.0%	$ 3.87

The foregoing discussion and tables assume no exercise of any options or warrants, no issuance of shares reserved for future issuances under our equity plans, or exchange of Bridge Shares. As of December 12, 2007, there were vested stock options outstanding to purchase 258,571 shares of our common stock at a weighted average exercise price of $5.09 per share and warrants outstanding to purchase 108,319 shares of our common stock at a weighted average exercise price of $8.49 per share. To the extent that any of these options or warrants are exercised, your investment will be further diluted. In addition, we may grant options or warrants in the future, which will cause further dilution to your investment.

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 2007	$ 7.25	$ 4.50
Fiscal Year Ended October 31, 2008		
1st Quarter 2008 (through December 11, 2007)	$ 6.00	$ 4.50

The OTCBB trading in our common stock 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 December 11, 2007, was $4.50 per share. As of December 11, 2007, we had approximately 700 holders of record of our common stock.

Our units, common stock, Class A warrants and Class B warrants have been approved for listing 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: (i) the conversion of accrued but unpaid executive compensation into unregistered units, shares of common stock, Class A warrants and Class B warrants otherwise identical to the units offered hereby at a conversion price of $11.00 per unit; the conversion will take place at the closing of this public offering; (ii) the exchange of Bridge Shares, at the public offering price of $11.00 per unit; (iii) the bridge loan dated October 23, 2007 with the net proceeds of $484,000, (iv) the conversion of $4,650,000 in Bridge Loans, plus accrued interest, under the terms of either Option 1 or Option 2 and the public offering price of $11.00 per unit; and (v) other issuances of common stock subsequent to July 31, 2007 as described in footnote (1).

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, at the public offering price of $11.00 per unit, repayment of unconverted bridge loan and the repayment of the bridge loan dated October 23, 2007.

	July 31, 2007		
	Actual	Pro Forma (1) (2) (3) (4)	Pro Forma as Adjusted (1) (2) (3) (4) (5)
Debt:			
Short-term debt:			
Notes payable - bridge loan, net of discount $123,141	$	$ 484,000	$
Notes payable shareholders	238,274	238,274	238,274
Convertible debentures - net of discount	6,027,271	1,400,000	
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	2,696,145	812,145
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	3,183,524	1,299,524

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: 5,153,448		5,153	
As Adjusted: 8,753,448			8,753
Additional paid in capital	12,254,964	17,366,008	29,058.408
Warrants	503,334	1,493,701	1,493,701
Deferred compensation	(3,236,232)	(3,236,232)	(3,236,232)
Accumulated deficit	(16,819,277)	(17,898,660)	(18,021,802)
Total shareholders equity (deficit)	(7,295,218)	(2,270,031)	9,302,828
Total capitalization	$ (848,773)	$ 913,493	$ 10,602,352

(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, consisting of three shares of common stock, two Class A warrants and two Class B warrants. 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 58,707 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 (i) the issuance of 21,278 shares of common stock for late registration penalties; (ii) 23,050 shares of common stock issued in lieu of cash through October 1, 2007 and (iii) the exchange of 937,907 Bridge Shares into 704,693 units.

(2)

Gives effect to two working capital financing arrangements entered into in October 2007, which, in the aggregate, resulted in $484,000 in net proceeds to us. Namely, we issued a two-year 10% promissory note, dated December 4, 2007, in the aggregate principal amount of $250,000 to Paulson Investment Company, Inc., representative of the underwriters in this public offering. We agreed to prepay the principal amount of the note, plus accrued interest, at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In addition, we executed a financing agreement with High Capital Funding, LLC, a principal shareholder (HCF), and a third party lender that has no prior affiliation with us (TPL). The financing arrangement involved the issuance of two-year promissory notes to each of HCF and TPL in the aggregate principal amounts of $166,667 and $83,333, respectively. In satisfaction of the notes in full, we agreed to pay to HCF and TPL $238,094 and $119,047, respectively, with $71,427 and $35,714 representing the respective original issue discounts on the HCF and TPL notes. We also agreed to prepay the full principal amount of the notes at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In the event of default on these notes, including the failure to make the prepayment required thereunder, the interest on the notes will become immediately due and payable at the rate of 3% per month on the principal amount outstanding. We paid a 5% cash commission in the amount $12,500 to Newbridge Securities Corporation, one of the underwriters in this offering, in connection with the HCF and TPL financings. Net proceeds to us from the HCF and TPL financing arrangements was in the amount of $234,000. All three promissory notes contain events of default and other terms and provisions customary for instruments of this nature.

(3)

Gives effect to the issuance of 2,114,079 shares of common stock issuable upon the exchange of 937,907 Bridge Shares into 704,693 units, based on the offering price of $11.00 per unit.

(4)

Gives effect to conversion of $4,650,000 in convertible Bridge Notes, including accrued interest as of December 12, 2007 of $501,932 into 587,853 units. We offered the bridge investors two conversion options. Under the first option, the Bridge Notes will convert into the Conversion Securities at 100% of the public offering price, which Conversion Securities and underlying securities will be subject to a one year lockup. Under the second option, the Bridge Notes will convert at the closing of this offering into the Conversion Securities at a 30% discount to the public offering price, which Conversion Securities and underlying securities will be subject to a two year lockup. Of the total of $6,050,000 Bridge Notes, a total of $1,727,500, plus interest, or 28.55%, elected to convert under Option 1 into

172,983 units; and $2,922,500, plus interest, or 48.31%, elected to convert under Option 2 into 414,870 units. Under either option, we have agreed to pay a fee of 3% the aggregate amount of principal and accrued interest, payable quarterly for one year, unless the lockups are earlier released.

(5)

Gives effect to the sale of an aggregate of 1,200,000 units in this offering at the offering price of $11.00 per unit, resulting in net proceeds of $11,656,000 and the repayment from the proceeds of $1,566,292 Bridge Notes, including $166,292 in interest; and $607,141, plus accrued interest, in connection with the two working capital financing arrangements entered into in October 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 December 12, 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 2,000 by early 2008 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

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 CMS-compliant 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 generally consist of a percentage of premiums paid by CMS to the contracted HMOs on a Per Member Per Month (PMPM) basis, known as a capitated fee. 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 December 31, 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 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 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 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 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 presented on 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 being reported. We have analyzed the claims paid history to determine the Date-of-Service to Date-Claim-Paid-By-Month percentage. 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 Pronouncements

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 have assessed the effect of this pronouncement on our consolidated financial statements, and at this time, no material effect is expected.

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 consolidated 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 *(i.e.,* fiscal year 2009). We have assessed the effect of this pronouncement on our consolidated 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 December 31, 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. In the 2006 Period, we entered into an agreement with one HMO to assist it in increasing its membership. Under that agreement, during the 2006 Period, we received commissions on the sale of Medicare HMO coverage to those who were eligible for the Medicare Advantage program. This was done on a limited basis. The net commission received was $4,975 for the 2006 Period and is reflected in the management support services revenues. 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. As of October 1, 2007, the third HMO contract reached the patient threshold of 300. Therefore, this contract has converted to full-risk status and will result in our receipt of capitated fees in future periods.

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. Because direct costs include the cost of patient care and related services, as the number of patients increases, so do direct costs. Accordingly, provider systems direct costs increased in the 2007 Period 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 under 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 2006. Their expenses include staffing costs, employee benefits, software, electronic transmission fees, claims forms and other items required to file insurance claims for physicians.

Throughout the 2006 Period and in the 2007 Period through September 2007, we had only one HMO contract that was not-at-risk. Provider systems revenues and direct costs for these periods are the same due to the nature of a not-at-risk arrangement with this HMO contract. The contract stipulates that we were not-at-risk for services rendered to members as long as the membership had not crossed a threshold of 300 members. During these periods, we were not paid premiums but instead were reimbursed for expenses paid. As a result there was no gross profit margin. As of October 1, 2007, the threshold of 300 patients has been reached and we have begun to operate at full risk. The transactions in future periods will be similar to the two full-risk contracts we had in operation in the 2007 Period.

Gross Profit

For the 2007 Period, the gross profit from management support services was $349,609, or 28.0% of management support services revenues, and the gross profit from the provider systems was $56,002, or 4.4% of provider systems revenues. The gross profit margins on the provider systems are directly related to the terms and rates of our HMO agreements and are not likely to change over the life of the individual agreement unless we are able to renegotiate the terms and rates of such agreements to obtain a more favorable rate. We expect that the gross profit will increase as the number of member/patients under our care increases and our technology solutions are implemented.

Operating and Non-operating Expenses

The following table presents the operating and non-operating expenses incurred for the nine months ended July 31, 2006 and 2007. These items are discussed in detail following the table.

	For the Nine Months Ended July 31,	
	2006	**2007**
Operating expenses		
Salaries and employee costs	$ 1,314,879	$ 2,336,282
Consulting	180,971	321,492
Occupancy	65,875	267,042
Depreciation & amortization	34,171	74,543
Other general & administrative expenses	435,318	1,234,610
Total operating expenses	$ 2,031,214	$ 4,233,969

Non-operating expenses		
Amortization of debt discount	$	$ 3,789,747
Amortization of financing costs	1,012,508	749,755
Interest	118,752	344,521
Total non-operating expenses	$ 1,131,260	$ 4,884,023

Operating expense for the 2007 Period increased $2,202,755 or 108.5%. Salaries and employee costs increased $1,021,403 due to compensation for additional employees, annual salary increases and stock-based compensation. During this period, we hired additional employees to service the expansion of provider systems and added corporate staff to support our expanded operations. Additional increases of $341,688 were incurred for consulting fees and occupancy expenses because in the 2007 Period, we paid higher occupancy costs than in the 2006 Period on the new larger office space for our corporate offices, two virtual offices in Tampa and Orlando and an office established for provider representatives in Miami-Dade County. In addition, in the 2007 Period, we

executed management agreements with three billing and collections companies under which we agreed to assume full profit and loss risk and, as a result, incurred occupancy expenses for their offices in Orlando and Miami. General and administrative costs increased by $799,292, of which $391,965 was attributable to additional financing costs, primarily in late registration fees on Bridge Shares; $81,179 in provider systems costs related to travel, credentialing and marketing expenses; and $293,257 in other costs such as communications, insurance, office supplies and other general expenses. Non-operating expenses increased $3,752,763 due to the amortization of debt discount and financing costs related to the debt financing.

Net Loss

Net loss for the nine months ended July 31, 2006 and 2007 was $3,151,444 and $8,712,381, respectively, which represented a 176% increase. Net loss per share was $3.32 and $5.36 for the nine months ended July 31, 2006 and 2007, respectively. This majority of the increase was attributed to costs related to the debt financing.

Results of Operations

Fiscal years ended October 31, 2005 as compared to October 31, 2006 (as restated)

Revenues and Direct Costs

The following table presents the revenues and direct costs for the fiscal years ended October 31, 2005 and 2006, respectively. These items are discussed in detail following the table.

	For the Fiscal Years Ended October 31,	
	2005	**2006**
Revenues		
Provider systems	$ 1,119	$ 41,203
Management support services		54,050
	1,119	95,253
Direct Costs		
Provider systems	1,119	41,203
Management support services		41,007
	1,119	82,210
Gross Profit	$	$ 13,043

Revenues

Total revenues for the fiscal year ended October 31, 2006 (the 2006 Period) increased by $94,134 from the fiscal year ended October 31, 2005 (the 2005 Period). In the 2005 Period, we were in the development stage and only earned minimal revenues of $1,119 for the period. The increase in the 2006 Period was due to the implementation of one management contract for billing and collections and an increase in the number of members associated with the one operational not-at risk HMO contract. Provider systems revenues of $41,203 accounted for 43.2% our total revenues in the 2006 Period and reflected reimbursement of primary care physician cost. In the 2006 Period, we entered into an

agreement with one HMO to assist it in increasing its membership. Under that agreement, during the 2006 Period, we received commissions on the sale of Medicare HMO coverage to those who were eligible for the Medicare Advantage program. This was done on a limited basis. The net commission received was $5,225 for the 2006 Period and is reflected in management support services revenues.

Direct Costs

Direct costs were $1,119 and $82,210 for the fiscal year ended October 31, 2005 and 2006, respectively. The increase of $81,091 in the 2006 Period primarily related to $41,203 of provider systems costs and $41,007 of management support services costs. Provider systems direct costs increased because we were responsible for additional patient months under our HMO contracts as of the end of the 2006 Period as compared to the same period in 2005. The entirety of the management support services direct costs was from billing and collection services.

Provider systems revenues and direct costs for the 2006 Period were the same due to the nature of a not-at-risk arrangement under the HMO contract. The contract stipulates that we are not-at-risk for services rendered to members as long as the membership has not crossed a threshold of 300 members. During the 2006 Period, we were not paid premiums but instead were reimbursed for expenses paid. As a result there was no profit margin.

Gross Profit

For the 2006 Period, the gross profit from management support services was $13,043, or 24.1% of management support services revenue. The gross profit margins on the provider systems are directly related to the terms and rates of our HMO agreement.

Operating and Non-operating Expenses

The following table presents the operating and non-operating expenses incurred for the fiscal years ended October 31, 2005 and 2006. These items are discussed in detail following the table.

	For the Fiscal Years Ended October 31,	
	2005	**2006**
Operating expenses		
Salaries and employee costs	$ 1,238,416	$ 1,782,497
Consulting	169,641	308,282
Occupancy	59,525	114,492
Depreciation & amortization	23,186	62,126
Other general & administrative expenses	329,458	663,953
Total operating expenses	$ 1,820,226	$ 2,931,350
Non-operating expenses		
Amortization of debt discount	$	$ 1,152,071
Amortization of financing costs		431,449
Interest	33,394	170,933
Total non-operating expenses	$ 33,394	$ 1,754,453

Operating expense for the 2006 Period increased $1,111,124, or 61%. Salaries and employee costs increased $544,081 due to compensation for additional employees, annual salary increases and stock-based compensation. During this period, we hired additional employees to service the expansion of provider systems and added corporate staff to support our expanded operations. Additional increases of $528,103 were incurred for consulting fees, occupancy and general and administrative expenses because in the 2006 Period, we paid higher occupancy costs than in the 2005 Period on the new larger office space for our corporate offices. General and administrative costs increased by $334,495, of which $91,803 was attributable to professional fees. Non-operating expenses increased $1,721,059 due to the amortization of debt discount and financing costs related to the debt financing.

Net Loss

Net loss for the fiscal year ended October 31, 2005 and 2006 was $1,853,620 and $4,672,760, respectively, which represented a 152% increase. Net loss per share was $2.29 and $4.72 for the fiscal year ended October 31, 2005 and 2006, respectively. The majority of the increase was attributed to costs related to the debt financing.

Liquidity and Capital Resources

We have incurred recurring losses and negative cash flows from our development and organizational activities and have negative working capital and shareholders deficit. These conditions raise substantial doubt about our ability to continue as a going concern. There can be no assurance that we will be able to successfully implement our plans to raise additional capital or, if such plans are successfully implemented, that we will achieve our goals. Furthermore, if we are unable to raise additional funds, we may be required to modify our growth and development plans, and may be forced to severely limit development operations.

As of July 31, 2007, our principal sources of liquidity were cash and cash equivalents of $1,046,129, which were available to us as a result of a series of bridge loan transactions between August 2006 and May 2007 in the principal amount of $6,050,000 and other notes payable. During the nine months ended July 31, 2007, we also drew down on a $300,000 credit line from High Capital Funding, LLC with two credit limit increases totaling an additional $151,000 which have since been paid off and terminated.

We were a development stage company through July 31, 2006 and began to report revenues from our operations in the third quarter of fiscal 2006. Since our inception, we have funded our business primarily through sales of our equity and debt securities. Since inception in 2001 through July 31, 2007, we have incurred a net loss from operations of more than $10.1 million and an accumulated deficit of more than $16.8 million. Our operations will not become profitable in the fiscal year ending October 31, 2007.

We had a working capital deficit as July 31, 2007 of approximately $7,560,000 as compared to a working capital deficit of $2,560,000 at July 31, 2006, which represents an increase of $5,000,000. The increase in the working capital deficiency was primarily due to the issuance of 8% Subordinated Secured Convertible Bridge Notes (Bridge Notes) relating to the sale of Bridge units during fiscal 2006 and fiscal 2007. Our working capital needs over the past year have been met from the issuance of the debt securities. We have a total of $6,050,000 in principal amount of debt outstanding, none of which was paid by the respective original maturity dates. These Bridge Notes are secured by all of our assets. The Bridge Note holders and the lead investor have not declared the Bridge Notes to be in default, and we are in discussions with the lead investor to extend the respective maturity dates. At the option of the note holders, the Bridge Notes may be converted into unregistered securities otherwise identical to the securities sold in the pending secondary offering at 70% of the offering price, or be paid from net proceeds of the offering. In November 2007, we requested, among other things, that the bridge investors reinstate their previously waived conversion rights and convert their Bridge Notes into unregistered securities of our company which are otherwise identical to the units offered in this Public Offering (the Conversion Securities). Specifically, we requested that the bridge investors consider two options. Under the first option, the bridge investors were asked to (i) convert their Bridge Notes into the Conversion Securities at 100% of the unit public offering. price and (ii) to lockup such Conversion Securities for the 12 month period in exchange for cash payments in the amount of 3% of the bridge investors principal and interest accrued on the Bridge Notes payable quarterly beginning three months after the closing of this Public Offering for the duration of the lockup period. Under the second option, the bridge investors were asked to (i) convert their Bridge Notes into the Conversion Securities at a 30% discount to the unit price in this Public Offering and (ii) to lockup such Conversion Securities for the 24 month period in exchange for the same cash payments as provided in the first option except that, under the second option, such payments will cease after the first 12 months of the lockup period. Under both options, the cash payment for the first three months will be paid in advance at the closing of this Public Offering and the payments for the remaining nine months will be paid in arrears after each quarter. Similarly, under both options, the cash payment is only payable for each full quarter during which the Conversion Securities are subject to the lockups. Finally, under both options, the lockups may be released at any time after six months in the underwriters discretion. As of the date hereof, we are unable to estimate how many of such bridge investors will agree to execute one of the above options. Of the total of $6,050,000 Bridge Notes, a total of $1,727,500, plus interest, or 28.55%, elected to convert under Option 1 into 172,983 units; and $2,922,500, plus interest, or 48.31%, elected to convert under Option 2 into 414,870 units.

The Bridge Notes not paid by their original maturity date are deemed in default, thereby causing the interest on the notes to increase from 8% to 18% per annum. Under the terms of the Bridge Notes, a default may be called by holders of at least 50% of the aggregate principal amount of the Bridge Notes then outstanding, including High Capital Funding, LLC, the lead investor. We have not received a notice of default and are in discussions with all note holders, including the lead investor, to extend the maturity dates of all Bridge Notes.

We have been dependent upon private capital to meet our short and long-term cash needs. We expect to continue to experience negative cash flow from operating activities through at least the next twelve months as we continue to build our CHS networks (provider systems) and develop a suite of management support services. If we continue to incur negative cash flow from operating activities for longer than expected, our ability to continue as a going concern could be in substantial doubt. We have sufficient cash and cash equivalents to maintain our operations at the current level through the end of November 2007. After which period, we will require additional funds through debt facilities, public or private equity and/or debt financings to continue operations.

We will need to raise additional funds to finance our future capital needs. We have executed a non-binding letter of intent with an investment banker contemplating a secondary public offering of our equity securities in the

fourth quarter of calendar year 2007. This offering will provide for the repayment of most of our debt and provide the working capital to sustain our operations for at least twelve months. Our development plan includes the identification of, negotiation with, and acquisition or joint venturing of businesses and services that will allow us to provide comprehensive management support services. We expect to secure financing for any such acquisition by selling common and/or preferred shares or issuing debt or notes. We are not currently in any negotiation with any acquisition candidate. After this offering, we may need to raise additional financing if our business strategy is not successful or we do not achieve positive cash flow from operating activities.

Financing Activities

The net cash provided from financing activities for the nine-month period ended July 31, 2007 was $3,428,276. During this period, we sold $4,941,000 of the $6,050,000 of Bridge Notes we currently have outstanding, paid $707,117 in placement agent commissions and expenses, raised an additional $346,371 from issuances of other notes and the use of a credit line and repaid loans and capital lease obligations totaling $1,151,978.

To obtain working capital, in October 2007, we entered into two financing arrangements which, in the aggregate, resulted in $484,000 in net proceeds to us. Namely, we issued a two-year 10% promissory note, dated December 4, 2007, in the aggregate principal amount of $250,000 to Paulson Investment Company, Inc., representative of the underwriters in this public offering. We agreed to prepay the principal amount of the note, plus accrued interest, at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In addition, we executed a financing agreement with High Capital Funding, LLC, a principal shareholder (HCF), and a third party lender that has no prior affiliation with us (TPL). The financing arrangement involved the issuance of two-year promissory notes to each of HCF and TPL in the aggregate principal amounts of $166,667 and $83,333, respectively. In satisfaction of the notes in full, we agreed to pay to HCF and TPL $238,094 and $119,047, respectively, with $71,427 and $35,714 representing the respective original issue discounts on the HCF and TPL notes. We also agreed to prepay the full principal amount of the notes at the closing of any public or private financing for which we receive gross proceeds of at least $10,000,000. In the event of default on these notes, including the failure to make the prepayment required thereunder, the interest on the notes will become immediately due and payable at the rate of 3% per month on the principal amount outstanding. We paid a 5% cash commission in the amount $12,500 to Newbridge Securities Corporation, one of the underwriters in this offering, in connection with the HCF and TPL financings. Net proceeds to us from the HCF and TPL financing arrangements was in the amount of $234,000. All three promissory notes contain events of default and other terms and provisions customary for instruments of this nature.

There is no assurance that we will be able to execute on our plans. To continue our operations and complete the implementation of our current business plan, we will require significant additional long-term financing. There are no assurances that such financing will be available, or if available, it will be on terms acceptable to us. Any financing may result in significant dilution.

Inflation

We believe that the relatively moderate rates of inflation in recent years have not had a significant impact on our operations.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements that have or are reasonably likely to have a current or future effect on our financial condition, changes in financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources that are material to investors.

BUSINESS

Overview

The Quantum Group, Inc. is headquartered in Wellington, Florida. We believe we are positioned to develop, deploy and capitalize on new business, services and technology models specifically focusing in the healthcare industry. Our business model integrates services encompassing a broad range of functionality and information indispensable to providers, patients and payers.

Our business model is to become Florida s leading provider of outsourcing solutions and services to the healthcare industry in three complementary areas: providing leading edge healthcare to consumers; supplying support services for physicians, health maintenance organizations (HMOs), healthcare facilities and physician associations; and developing provider technology solutions to create a more effective and responsive healthcare system.

To serve the various business requirements, The Quantum Group is organized into three distinct yet integrated operating divisions:

.

Renaissance Health Systems (RHS)

.

Quantum Medical Support Services (QMSS)

.

Quantum Medical Technology (QMT)

The foundation of our business model is the healthcare providers who have joined our Community Health Systems in each of the 26 Florida counties in which we currently operate. The next component of our model includes the full risk contracts we have negotiated with five HMOs; three of which are currently providing services for the members of these HMOs, and the other two of which are expected to begin generating revenues early 2008 and 2009. Further, we have developed a shared services structure. This provides providers, payers and patients a common set of resources at optimized cost and high quality. As a shared services resource, we can make available to providers billing, records and scheduling services, to name a few, at costs unattainable by any individual organization. The same information can be repurposed and provided to patients to enable them to become more active participants in their improved health and wellness. Subsets of this information can be provided to payers in standard electronic format for effective reconciliation and management.

As a shared services company, we derive leverage from a critical mass of resources (employees, infrastructure, the large number of providers engaged in our Community Health Systems), expertise attributable to our experienced team (skills, processes), aggregation of technology and an information base that can derive intelligence value. Our company will perform many of the functions that physicians groups cannot afford to do themselves. This provides the skill

execution and cost base that allows physicians to concentrate on patient care (the core competence of physicians).

Current highlights of the Company include but are not limited to:

.

We have secured contracts with and credentialed over 1,600 healthcare providers in 26 Florida counties;

.

We have negotiated full risk contracts with five health maintenance organizations; three of which are currently providing services for members of those HMOs, the remaining two are expected to generate revenues beginning in early 2008 and 2009;

.

We have begun to offer management support services, including billing and collections and a variety of insurance and financial products specialized for physicians;

.

We expect to begin marketing additional services in early 2008, including medical staffing, payroll support services, group purchasing and physician receivable financing to our billing customers;

.

RHS will continue to expand its provider network, by increasing the number of total healthcare providers participating to a goal of 2,000 by early 2008, developing a new Community Health System (CHS) in each of the targeted northern counties of Florida. Further, in the developing CHS counties, RHS will continue to add physicians to create a fully marketable network; and

.

RHS expects to add two or three more HMO contracts and expand its credentialing services to hospitals.

QMT is developing technology solutions to support the efforts of RHS and each of the shared services companies to provide expanded communications, lower cost of technology services, greater information storage and ease of use.

U.S. Healthcare Industry

Current healthcare spending in the United States accounts for 16% of the nation s gross domestic product (GDP[1]). Healthcare has been the only net growth sector over the last 10 years as healthcare spending has risen from 13.7% (1995) of GDP to 16% (2005) while housing, food, technology, auto and defense have remained flat as a percentage of GDP.[2] This represents an average of over $6,697 for each person in the United States.[3] By 2015, total healthcare spending is projected to reach $4 trillion or 20% of GDP.[4]

In its February 2007 report, CMS estimated that healthcare spending in the United States was $2 trillion or approximately 17% of the GDP in 2006 and would grow to $4 trillion, or 20% of the GDP, by 2016. In the United States, healthcare outlays have grown faster than the consumer price index. According to CMS, healthcare outlays are projected to grow at a rate of 6.4% annually between 2007 and 2016. The projected principal drivers for this growth include continued cost-increasing medical innovation, inflation, continued strong demand for prescription drugs and the aging baby-boomer demographic.

Medicare & Medicare Advantage

Medicare benefits totaled $374 billion in 2006 and, as a portion of the nation s GDP, are expected to rise from 2.7% in 2005 to 4.7% in 2020.[5] Medicare offers beneficiaries the option to receive care through private insurance or managed care plans. These private insurance options are part of Medicare Part C, which is now referred to as Medicare Advantage. These plans are gaining popularity due to their lower out-of-pocket costs and access to a greater number of covered services. Some plans cover prescription drugs.

The Medicare program has four primary components:

.

Medicare Part A covers inpatient hospital, skilled nursing facility and hospice care. All citizens of the United States are automatically enrolled in Medicare Part A upon reaching the age of 65;

.

Medicare Part B is optional and is financed largely by monthly premiums paid by individuals enrolled in the program. Medicare Part B covers almost all reasonable and necessary medical services, including doctors' services, laboratory and x-ray services, durable medical equipment (*i.e.*, wheelchairs and hospital beds), ambulance services, outpatient hospital care, home healthcare, blood and medical supplies. Participants often have the Medicare Part B monthly premium automatically deducted from their Social Security check.;

.

Medicare Part C is an alternative to the traditional fee-for-service Medicare program. In geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a managed care plan. The current Medicare managed care program was established in 1997 when Congress created Medicare Part C, formerly known as Medicare Choice and now known as Medicare Advantage; and

.

Medicare Part D. First available in 2006, Medicare Part D permits every Medicare recipient to select a prescription drug plan. Medicare Part D replaces the transitional prescription drug discount program and replaces Medicaid prescription drug coverage for dual-eligible beneficiaries.

1

Centers for Medicare & Medicaid Services, Office of the Actuary: Data from the National Health Statistics Group. National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Annual Percent Change by Source of Funds: Calendar Years 2005-1960.

2

Bureau of Economic Analysis. Table 1.5.5. *Gross Domestic Product, Expanded Detail.* (December 21, 2006).

3

CMS Releases U.S. Health Spending Estimates Through 2005. (January 9, 2007).

4

National Health Care Expenditures Projections: 2005-2015. (February 2006).

5

The Henry J. Kaiser Family Foundation. (February 2007). *Medicare: Medicare at a Glance.*

Individuals who elect to participate in the Medicare Advantage program receive greater benefits than traditional fee-for-service Medicare beneficiaries, which benefits may include eye exams, hearing aids and routine physical exams. Out-of-pocket costs for the Medicare beneficiary may also be lower. However, in exchange for these enhanced benefits, customers are generally required to use only the services and provider networks offered by the Medicare Advantage plan. This participation of private health plans in the Medicare Advantage Program under full risk contracts began in the 1980s and grew to approximately 6.9 million customers in 1999. According to information provided by the Henry J. Kaiser Family Foundation, after a drop to approximately 5.3 million customers in 2003, the number of enrollees in Medicare Advantage plans in the United States has increased to approximately 8.3 million as of February 2007. Also, since 2003, the number of Medicare Advantage plans in the United States has increased from 285 to 604 as of February 2007. Medicare Advantage plans contract with CMS to provide benefits that exceed those offered under the traditional fee-for-service Medicare program by at least 30% in exchange for a fixed premium payment per member per month from CMS. The monthly premium varies based on the county in which the customer resides, as adjusted to reflect the customer's demographics and the individual customer's health status.

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans' customers. CMS has phased in its risk adjustment payment system, originally implemented as part of the Balanced Budget Act of 1997 and modified pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. During 2003, risk adjusted payments accounted for only 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional demographic rate book. The portion of risk adjusted payments was increased to 30% in 2004, 50%, in 2005 and 75% in 2006, and increased to 100% in 2007. The risk adjusted payment model bases the CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS internal database. Under this system, the risk adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan's customers average gender, age and disability demographics.

The Medicare Modernization Act

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, known as the Medicare Modernization Act (MMA), provided sweeping changes to the Medicare program. The MMA increased the amount paid to Medicare Advantage plans and expanded Medicare beneficiary healthcare options. We believe that the changes enacted by the MMA have enabled Medicare Advantage plans to offer more attractive and comprehensive benefits and increase preventive care to its customers, while also reducing out-of-pocket expenses for beneficiaries. We further believe that these changes will encourage increased enrollment in Medicare managed care plans in the upcoming years.

In addition to generally increasing the rates payable to Medicare Advantage plans from CMS, the MMA, among other things, (i) added the Medicare Part D prescription drug benefit beginning in January 2006, (ii) implemented a competitive bidding process for the Medicare Advantage Program and (iii) provided a limited annual enrollment period.

Enrollment Period

Since 2006, Medicare beneficiaries have been restricted to a 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. As of November 2006, 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 will be permitted to enroll in or change health plans during the year. In addition, 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. Further,

certain individuals who receive both Medicare and Medicaid benefits (known as dual eligibles) have no defined enrollment period and may change plans at any point.

The Florida Medicare Advantage Market

Florida has the second largest Medicare population in the U.S. with an estimated 3.1 million Medicare eligible beneficiaries. At December 31, 2006, Florida s Medicare Advantage penetration was 22% of Medicare-eligible beneficiaries. According to the Florida Office of Economic and Demographic Research, Florida's Medicare eligible population is expected to grow from approximately 2.8 million per the 2000 census to almost 5.0 million by 2020.

According to CMS, the number of enrollees in PDPs as of January 16, 2007 was approximately 10.98 million, compared to approximately 10.37 million in June 2006, an increase of 5.9%. Medicare Advantage-Prescription Drug enrollment increased to approximately 6.65 million from 6.04 million, a 10% increase over the same period, while Medicare-Medicaid dual eligible enrollment increased to approximately 6.27 million nationwide from 6.07 million during this same period.

Our Business Model and Strategy

Our subsidiary, **Renaissance Health Systems, Inc. (RHS)**, operates our network of healthcare providers and physician groups. Our network consists of a series of county-wide networks (sometimes collectively referred to as our network), which we call Community Health Systems (CHS). As of December 12, 2007, our network included 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 2,000 by early 2008. We will continue to expand our network by increasing the number of contracted healthcare providers in our existing CHS and developing a new CHS in each of our targeted Florida counties. Our business plan includes a gradual rollout of additional Florida counties based on county demographics and other relevant factors. Our current goal is to have a CMS-compliant CHS in all 67 Florida counties operational by January 2011, although we cannot guarantee that we will be able to accomplish this goal in that time frame. 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.

For each CHS, we are required to have a minimum number of physicians and other providers in specific CMS-mandated areas of medical care and specific ancillary services facilities. We contract with individual physicians and physician groups, as well as ancillary facilities, such as laboratories, pharmacies and diagnostic centers, among others. Under our contracts with our healthcare providers, our physicians and other providers are contractors rather than employees. We pay our primary care physicians capitated fees and when specialists or ancillary facilities are used by the covered patients, we pay a pre-negotiated fee, depending on the specialty or the kind of facility. In addition to acting as a revenue source for our network providers, we act as a liaison between our network providers and our HMOs, thereby relieving the healthcare providers of many of the administrative burdens that are associated with managed care operations. Under our contracts, any participant in our network is eligible to provide medical services to the member/patients of any of our HMOs operating in the county in which the provider is located.

As of October 1, 2007, we have five executed contracts with HMOs and are generating revenues under three of these contracts. All but one contract was full risk at the outset, while our first contract was designed to be a not at risk agreement until the point at which there were 300 HMO member/patients using our network providers as their primary care physicians. Beginning October 1, 2007, all three of our contracts generating revenues are at full risk. 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.

Our model allows for contracts with many HMOs in order to leverage the continued growth of our network. However, we do not expect to have more than approximately eight HMOs under contract at any time. The terms of our active contracts require that we establish and maintain a CHS in specified Florida counties. The contracts vary by the type of delivery system, the capitation setups and membership criteria. We intend to enter into additional

HMO agreements, which generally will be for a one-year term and subject to annual negotiation of rates, covered benefits and other terms and conditions. HMO agreements are often negotiated and executed in arrears.

The direct medical costs for which we are responsible are a combination of actual medical costs incurred by the HMO plus a reserve for future medical costs incurred but not reported, which is referred to as expenses incurred but not recorded (IBNR). Pursuant to our HMO contracts, we receive a monthly dollar amount for each patient who chooses one of our contracted healthcare providers as his or her primary care physician. This is known as a capitated fee. The capitated fee that we receive is a fixed fee, based on a percentage of the premium that the HMO receives.
The percentage negotiated is different with each HMO, and the fee we collect further varies, depending on the age, health profile and other factors relevant to each specific patient. If a patient sees a specialist or receives services at an ancillary service facility, in general we pay a pre-negotiated fee, based on a percentage of Medicare s allowable rate.

There is a built-in time delay between execution of a contract and our ability to earn revenues under that contract. A contract generally will not generate revenues until we have a county-specific, CMS-compliant, complete network of healthcare providers that is ready to provide comprehensive medical care to the Medicare Advantage patients, the HMO has received CMS certification to operate in specific counties with our network of providers, and patients have enrolled in the HMO and selected healthcare providers in our network. This start to revenue cycle can take up to twenty-four months. Our window of opportunity for contracts to begin to generate revenues generally coincides with the open enrollment period under a managed care plan operated under the Medicare Advantage program, which is between January 1 and March 31 of each calendar year.

Part of our responsibility under our current HMO contracts is to certify physician credentials. Our credentialing department commenced operations in September 2005. Credentialing is part of the underwriting process that the healthcare provider undergoes to participate in our network and is required by the Medicare Advantage program. We must comply with all regulatory requirements and strict guidelines to which the HMO is subject under the rules and regulations of the Florida Agency for Health Care Administration (AHCA) and the CMS. RHS uses National Committee for Quality Assurance (NCQA) compliant systems, procedures and software to manage this process. We have also established a Medical Credentialing Committee for the purpose of making recommendations to approve or deny physician participation in our network. The Medical Credentialing Committee is made up of practicing healthcare providers with participation by licensed Florida physicians. HMOs perform periodic routine audits in accordance with their internal schedule to ensure our compliance.

By contrast, when a physician contracts directly with several HMOs, each HMO has its own, unique credentialing process with which the provider must comply. By participating in our network, the physician only has to complete one credentialing application and undergo one credentialing process regardless of how many HMOs he or she participates in through our network. By performing the credentialing through RHS, we have the ability to expedite and control the processing time when the HMO submits a specific county to CMS for approval. In addition, it enables us to add providers without the HMO involvement.

We began generating revenues under one HMO contract in September 2005 in Volusia County, Florida, followed by Dade and Broward Counties in January 2006. The second and third HMO contracts began generating revenues in December 2006 and January 2007, respectively. We expect that the two remaining contracts will begin generating revenues in each of fiscal 2008 and 2009. In fiscal 2007, provider systems revenues, which are the revenues we earn from our network providers treating the HMO patients, are expected to account for approximately 50% of our total revenues. However, by fiscal 2008, we expect that most of our revenues will be derived, directly or indirectly, from the medical services provided by our network healthcare providers to patients enrolled in Medicare Advantage managed care plans.

41

Management Support Services

We provide management support services to healthcare providers that participate in our network as well as to other healthcare providers, physician groups and other providers of medical services in the state of Florida. We began offering management support services in November 2006 and are methodically building a core group of management support services we believe will be attractive to medical service providers. The management support services we currently make available include the following:

.

Medical billing and collections services which may include electronic medical records, as well as electronic prescription writing, practice management tools and transcription, all combined into the QMed Solutions system; and

.

Insurance such as malpractice, health and life and disability.

Our subsidiary, **QMed Solutions, Inc.** (QMS) *Comprehensive Patient Management*sm, d/b/a QMed BILLING, Inc. (QMB), offers our medical billing and collection services to healthcare providers and hospitals throughout Florida through two management agreements with a Florida-based billing and collection company serving the southern and central Florida regions. Under these agreements, we run the operations of the billing company and accept all of the risks of ownership. We charge for our billing and support services based on a percentage of the amounts we collect. The termination date on these agreements has been extended to December 31, 2007. Although we believe we should be able to reach an agreement with the billing and collections companies to extend the term of the management agreements beyond December 31, 2007, we do not have a unilateral right to do so, and any newly negotiated terms could be less favorable to us than the existing contractual terms. We plan to continue to seek potential acquisitions of medical billing companies to complete certain portions of our strategic plan.

QMS uses an electronic processing system to process claims and collect payments. QMS is able to service any account in Florida from one of our two operation centers. In January 2007, QMS began marketing the combined solutions of electronic medical records (EMR) and billing. QMS services include:

.

processing physician-prepared medical claims;

.

electronically forwarding the claim to the appropriate payer (insurance, government, private);

.

recording collections from all sources and preparing account receivable reports for the physician;

.

preparing encounter reports, *i.e.*, the record of each service received or performed for a patient to CMS;

.

invoicing for patient portion of charges;

.

collecting fees;

.

following up on denials and re-filing of claims;

.

interfacing with payers regarding claim issues;

.

advising healthcare providers as to coding requirements and regulation/rate changes;

.

providing an audit trail if the physician uses the EMR/Billing solution; and

.

providing accumulation and preparation of data for the Physician Quality Reporting Index (PQRI).

In August 2007, we began offering insurance products to healthcare providers on a commission basis. Although this portion of our business does not represent a significant source of revenues yet, we are in the early stages of building a suite of support services and products that we intend to make available to healthcare providers on an ala carte basis in the future, and our insurance products will be included in the mix of such services and products.

QMT also provides in-house web services for use in developing and maintaining web sites for RHS and Quantum needs and several county medical associations.

Future Services

Renaissance Services

In late 2007, we plan to begin providing hospital care services through our subsidiary, **Renaissance Hospital Associates, Inc.** (RHA). This part of our business will coordinate all aspects of a patient s hospitalization, from admission to release, through the use of physicians dedicated to handling in-patient care. We believe that RHA will be a key component of our comprehensive enterprise system as an added measure towards controlling costs and redundancy. This service is designed to alleviate the time demands on primary care physicians imposed by rounds and the continual monitoring that is required to provide effective and efficient patient care during a hospitalization. Further, RHA will manage the communications and coordination of data transfer and treatment costs to the PCP to ensure the integrity of each patient s health records. Additionally, part of RHA s function will be to redirect patients to urgent care centers for non-emergency care needs. To the extent that we have a HMO to which we are providing hospital admissions, RHA will allow us to reduce hospital days, provide better continuation of care and more effective communications with our contracted primary care providers. In addition to our current contracted HMOs, for members that are not a part of RHS, we are able to contract with HMOs to provide hospitalist services whether we have a full risk contract with them or not. Generally, hospitalists are paid a flat rate per admission regardless of length of stay.

Quantum Services

We are also developing a suite of additional services for the healthcare community, including an integrated practice management platform that will provide a management information system based upon an Application Services Provider model that will connect healthcare providers and physician groups with their patients, hospitals and payers. We intend to build that suite of services through a combination of the acquisition of existing providers and technology and partnering with technology companies and other entities. If developed as currently anticipated, we believe that the system will eliminate the need for substantial paper record creation and storage, will reduce the administrative burdens and back office costs of the users and will comply with the HIPAA requirements. We expect that this platform will be available for deployment in the summer of 2008, although we cannot guarantee that unforeseen factors will not cause a delay in the development and later rollout of this platform.

Additional support services that we expect to make available include:

.

Personal Health Record (PHR) will provide patients of our network physicians with a personal, portable health record of essential information;

.

Patient Portal will provide patients with access to online scheduling with their physician and the ability to download their current PHR data;

.

Staffing will provide healthcare providers, clinics and hospitals with temporary and permanent staffing options, payroll services, tax filings and benefits administration;

.

Group Purchasing Organization will provide central purchasing with discounted pricing for clinical, office and other items;

.

Physician Medical Receivable Financing will integrate medical billing and collections and electronic medical records to facilitate third party financing of physician medical receivables;

.

Physician Accounting System will provide a system whereby physicians will be able to ascertain their true financial and cash position on a daily basis; and

.

Clinical Testing Programs will coordinate drug and medical device clinical testing between RHS healthcare providers and research and development groups as a Certified Research Organization.

We intend to integrate these services in an enterprise system that will electronically and clinically connect all aspects of RHS involvement in managing the full range of patient care for the HMO and the physician practice. We believe that the use of our enterprise system will improve the efficiency and profitability of the physician s practice.

The Importance of Technology in Our Future Development

Our subsidiary **Quantum Medical Technologies, Inc.** (QMT) provides access to an electronic medical record (EMR) and an integrated billing system for use by healthcare providers and our company. It is a web-based platform using knowledge-based workflow methodology familiar to healthcare providers. It also includes the ability to receive and send information in the HL7 and X12 formats, thus allowing healthcare providers to transfer data and tests to and from hospitals and labs. In addition, QMT is developing a utilization management (UM) program that will allow the RHS patient care coordination team to manage its patient base. Additional elements of the system will include:

.

disease management;

.

patient health record;

.

case management;

.

HMO plan administration;

.

physician accounting system;

.

A/R financing reporting and reconciliation;

.

management and clinical reporting; and

.

data transfer from hospitals and labs to physician.

QMT is developing an enterprise practice management platform that is designed to help healthcare providers and healthcare organizations reduce costs through clinical and supply chain efficiencies, improve care delivery and patient safety and streamline administrative activities such as claims processing, eligibility verification and billing. QMT will provide a full HIPAA-compliant health information system to connect healthcare providers with their patients, hospitals and payers. Our target market is the existing network of healthcare providers, as well as those healthcare providers and future hospitals using the support services offered by us. Clients will be able to choose from a number

of technical and software support options.

Competition

The healthcare services industry is highly fragmented. It consists primarily of:

.

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

.

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

.

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

.

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

.

boutique firms that offer a limited number of specialized services or which service a particular geographic market.

As a result, we face competitors that vary in type, size and sophistication. On the one hand, we encounter competition from large publicly traded HMO service organizations, *e.g.*, Metropolitan Health Networks, Inc. and ContinuCare, Inc., which collectively provide approximately $450 million in medical services to HMO clients in south and central Florida every year. There are also a number of small and private organizations providing similar type of HMO support services. We also face substantial competition from numerous support organizations that market medical billing and collections and insurance products, as well as an array of other services we intend to provide to physicians in the foreseeable future. Most of our competitors 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. In addition, new competitors may enter our markets, and this increased competition may have an adverse effect on our results of operations. There is no assurance that we will be able to successfully compete in our chosen markets.

Even in this competitive environment we believe that our business model of building CHSs to facilitate a cost effective expansion opportunity to our contracted HMOs in 26 counties gives us an advantage over larger, more geographically-limited competitors. Helping the physicians in their administrative and support services gives us an opportunity to attract physicians to our CHS and to establish a stronger relationship with these physicians going forward. We also believe that our focus on using an integrated technology solution to reduce costs and improve patient care will be a strategic advantage that will make us more competitive in our industry.

Sales and Marketing Strategy

We employ different marketing strategies to accommodate the different types of entities to which we market. Our largest source of future revenues is our relationships with HMOs. The marketing to new HMOs is primarily done directly by our senior management team, in particular Noel J. Guillama, our Chief Executive Officer. We have opportunities with HMOs currently operating in Florida as well as HMOs that operate outside of Florida that may plan expansion into the state in the near future. As of October 1, 2007, we are in discussions with three additional Florida-based HMOs.

Our marketing strategy focuses on two areas. Initially, we market to healthcare providers to encourage them to join our provider network and to treat the members of our HMO clients. This marketing is performed by our team of provider specialists, in person or through direct mail, advertising, trade show participation and through referrals from existing providers. We also market our support services to providers with specialized employees as well as commission-based individuals. With respect to our management support services, we currently market primarily to existing providers within our networks, both in person and through general advertising and direct mail.

Government Regulation

Our operations and relationships are subject to extensive and increasing regulation by a number of governmental entities at the federal, state and local levels. We have structured our operations to be in material compliance with applicable laws. There can be no assurance that a review of our, or the affiliated physicians , business, by courts or regulatory authorities will not result in a determination that could adversely affect our operations, or the affiliated healthcare providers, or that the healthcare regulatory environment will not change so as to restrict our, or the affiliated healthcare providers , existing operations or expansion.

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

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

Certain provisions of the Social Security Act, commonly referred to as the Anti-Kickback Statute, prohibit the offer, payment, solicitation, or receipt of any form of remuneration in return for the referral of Medicare

or state health program patients or patient care opportunities, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered by Medicare or state health programs. The Anti-Kickback Statute is broad in scope and has been broadly interpreted by courts in many jurisdictions. Read literally, the statute places at risk many business arrangements, potentially subjecting such arrangements to lengthy, expensive investigations and prosecutions initiated by federal and state governmental officials. Violation of the Anti-Kickback Statute is a felony, punishable by significant fines and/or imprisonment. In addition, the Department of Health and Human Services may impose civil penalties excluding violators from participation in Medicare or state health programs.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) expands the government s resources to combat healthcare fraud, creates several new criminal healthcare offenses, and establishes a new advisory opinion mechanism under which the Office of Inspector General is required to respond to requests for interpretation of the Anti-Kickback Statute. HIPAA is a relatively young statute, and the case law construing HIPAA is continuing to develop. Therefore, it is impossible to predict the impact of the law on our operations.

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

Employees

As of December 12, 2007, we have 38 full-time employees. None of our employees are covered by a collective bargaining agreement or represented by a labor union. We consider our employee relations to be good.

Legal Proceedings

We are not aware of any pending legal proceedings against us.

Properties

The following table lists our facilities:

Property Location	Purpose	Monthly Rent and Term	Size
Wellington, Florida	Executive Offices	$9,580 June 2009	6,600 sq. feet
Miami, Florida	Corporate offices to support Renaissance operations	$3,150 March 2012	1,450 sq. feet

We believe the space is adequate for our immediate needs. We have plans to expand our current executive offices in March 2008, when the adjacent space in our Wellington facility becomes available. We do not foresee any significant difficulties in obtaining any required additional space.

Corporate Information

Our corporate headquarters are located at 3420 Fairlane Farms Road, Suite C, Wellington, FL 33414. Our telephone number is (561) 798-9800, and our fax number is (561) 296-3456. We were formed as a Minnesota corporation in 2001 and reincorporated in Nevada in 2003.

MANAGEMENT

The following table sets forth information regarding the members of our Board of Directors (Board) and our executive officers and other significant employees as of December 12, 2007.

Name	Age	Positions
Noel J. Guillama (4)	48	Chairman of the Board, Chief Executive Officer and President
Donald B. Cohen (4)	54	Executive Vice President, Chief Financial Officer, Director
Susan Darby Guillama	47	Executive Vice President, Secretary, Chief Administrative Officer, Director
James D. Baker (4)(2)	64	Director
Jose de la Torre (2)(3)	64	Director
Alberto Del Valle, CPA (1)(4)	64	Director
Lawrence B. Fisher, Esquire (1)(3)	69	Director
Mark Haggerty (1)	59	Director
Michael Rosenbaum	70	Director
Gregg M. Steinberg (2)(3)	45	Director

(1)

Member of the Audit Committee.

(2)

Member of the Compensation and Options Committee.

(3)

Member of the Nominating and Governance Committee.

(4)

Member of the Executive Committee.

Board of Directors

Effective June 12, 2007, we expanded the Board to 11 members. On August 19, 2007, one of our directors passed

away, reducing our current Board membership to 10, plus one vacancy. Our Board oversees our business affairs and monitors the performance of our management. Each director and executive officer holds office until his or her successor is duly elected and qualified, his or her resignation or he or she is removed in the manner provided by our Bylaws. All officers serve at the discretion of the Board and are elected annually at the annual meeting of our Board held after each annual meeting of shareholders. Our Board has determined that all directors, except for Noel J. Guillama, Donald Cohen and Susan Darby Guillama, are independent within the meaning of the SEC Rule 10A-3.

All our officers devote their full-time attention to our business. Except for Noel and Susan Guillama, who are married, no director or executive officer is related to any other of our directors or executive officers, and there are no arrangements or understandings between a director and any other person that such person will be elected as a director. There are no material proceedings to which any of our directors, executive officers or affiliates, any owner of record or beneficially of more than five percent of any class of our voting securities or those of our subsidiaries, or any associate of any such director, officer, and affiliate or security holder is a party adverse to us.

Below are descriptions of the backgrounds of our executive officers and directors:

Noel J. Guillama, Chairman of the Board, Chief Executive Officer and President. Noel J. Guillama is a co-founder of The Quantum Group, Inc., and has been our Chairman, Chief Executive Officer and President since its inception in 2001. Prior to The Quantum Group, from January 1996 to February 2000, he was the Chairman, President and Chief Executive Officer of Metropolitan Health Networks, Inc. Mr. Guillama also serves as Director and/or Chairman of several private family-controlled businesses, including Tektonica, Inc. Tektonica, established in 1991, is a commercial/industrial construction company based in Tequesta, Florida; MedTonics, Inc., established in 1984, has been involved in a broad range of real estate development activities (recently focusing on development of medical projects); and Guillama, Inc., a shareholder of our company, which holds passive investments in other companies. Mr. Guillama is also a director and treasurer of Florida International University Foundation, Inc., a direct support organization of Florida International University, a Florida public university. He also serves as a Director of the Palm Beach County Community College Foundation and is a trustee of Palms West Hospital.

Donald B. Cohen, Executive Vice President, Chief Financial Officer, Director. Mr. Cohen is a co-founder of Quantum. He has served as a director and our Vice President, Chief Financial Officer since inception in 2001. Prior to joining Quantum, from April 2001 through January 2002, he served as Chief Financial Officer of I-Titan Communications Network, Inc., a technology design and manufacturer. Mr. Cohen holds a Bachelor of Science degree from California State University, Northridge and is licensed as a CPA in the state of California.

Susan Darby Guillama, Executive Vice President, Secretary, Chief Administrative Officer, Director. Mrs. Guillama is also a co-founder of Quantum and has been a director, Vice President and Chief Administrative Officer since April 2003, before which she had been an outside consultant with Quantum from September 2001 to April 2003. Mrs. Guillama is on the Board of Directors of Junior Achievement of the Palm Beaches and has recently been elected Secretary of the Palm Beach County Homeless Advisory Board. Mrs. Guillama holds a Bachelor of Arts degree in Communication from the University of South Florida.

James D. Baker, Director. Mr. Baker joined our Board in October 2002. From December 2006 through July 2007, Mr. Baker was the Chief Executive Officer of AMD Telehealth, Inc., a home health provider. Since August 2004, Mr. Baker has served as the Chief Executive Officer of Homeland Security Networks, Inc. and, since October 2002, he has served as the sole director, President, and Chief Executive Officer of Q-Net Technologies, Inc., a consumer technology and value added Internet services company. From October 1999 to August 2003, Mr. Baker was President of TargitInteractive, Inc., an interactive marketing services provider. Mr. Baker holds a Bachelor of Science degree from the University of Cincinnati.

Jose de la Torre, Director. Dr. de la Torre joined our Board in June 2007. Dr. de la Torre has served as the Dean of the Alvah H. Chapman Graduate School of Business at Florida International University in Miami since July 2002, where he is also the J.K. Batten Eminent Scholar in Strategy. He received his Doctorate degree from the Harvard Business School and has undergraduate degrees in aerospace engineering and business administration from the Pennsylvania State University.

Alberto Del Valle, Director. Mr. Del Valle joined our Board in June 2007. Since 1991, Mr. Del Valle has been an independent contractor, specializing in small business advisory and financial services. In March 2007, he became an independent consultant for The Health Acquisition Group, a company specializing in mergers or acquisitions of healthcare providers. Since May 2003, he has also been an independent consultant for Arle Compressor Systems Corp, a distributor of Ingersoll Rand compressors and industrial equipment. Mr. Del Valle holds a Bachelor of Science degree in Accounting from Louisiana State University and was a licensed CPA in the state of Florida from November 1972 to September 1991.

Lawrence B. Fisher, Director. Mr. Fisher joined our Board in June 2007. Mr. Fisher is a securities law practitioner with over 35 years experience. From 1995 through the time of his retirement in 2005, Mr. Fisher was a partner at the law firm of Orrick, Herrington & Sutcliffe, LLP in New York. He has served on the Board of Directors of Financial Federal Corporation, a New York Stock Exchange-listed financial services company, for the past 14 years, where he is also a member of its Executive Committee and Chairman of its Corporate Governance Committee. Mr. Fisher also has served on the Board of Directors of the National Bank of New York City, a privately owned commercial bank, for over 20 years. He is also a member of its Audit Committee. Mr. Fisher holds a Bachelor of Arts degree in Political Science from Columbia College and a Bachelor of Law (LLB) degree from Columbia Law School.

Mark Haggerty, Director. Mr. Haggerty joined our Board in October 2003. Mr. Haggerty is a corporate, securities and medical laws practitioner with over 34 years experience. From 1993 to May 2003, he was President and Chairman of Voice and Wireless Corporation, a voice and wireless communications company. Since 2004, he has served as

general counsel to FFP Investment Advisors, Inc., an investment advisory firm in Minnesota. Mr. Haggerty holds a law degree from the University of Minnesota Law School.

Michael Rosenbaum, Director. Mr. Rosenbaum joined our Board in February 2006. Mr. Rosenbaum works in the areas of mergers and acquisitions, merchant banking and finance. Since 1984, he has served as a director for Protrak International, a developer of customer relationship management software and sales force automation to the investment management industry. Mr. Rosenbaum holds a Bachelor of Arts degree from Yale in Economics and Political Science, a Bachelor of Law (LLB) degree and a Masters degree in International Affairs, both from Columbia University.

Gregg M. Steinberg, Director. Mr. Steinberg joined our Board in June 2007. Mr. Steinberg is President of International Profit Associates and affiliated companies (IPA), a provider of various services to the small and midsize businesses. He has been with IPA since 1992, and President since 1997. Mr. Steinberg holds a Bachelor of Science degree in Business Administration from the University of Arizona and a Masters degree in Business Administration from the Thunderbird School of Global Management.

Below are descriptions of the backgrounds of other key employees:

P.L. Pete Martinez, Vice President, Chief Technology and Innovations Officer. Mr. Martinez joined Quantum in July 2007, having previously served for 32 years at IBM in several capacities, including that of the first executive of IBM s e-business Strategy Consulting and Consulting Profession Leader for the Americas from January 1999 to May 2001. Mr. Martinez serves on the Advisory Board of the University of Miami, Florida Atlantic University and Florida International University.

Ronald S. Smith, Vice President, Corporate Development. Mr. Smith joined Quantum in August 2007, having previously served as a consultant to Quantum from July 2006 to August 2007. Prior to joining Quantum, Mr. Smith spent eight years as Chief Executive Officer and twenty five years as Chief Financial Officer of various companies, including Johnson & Johnson, both domestically and internationally, as well as five years with Peat Marwick Mitchell (now KPMG) in audit and consulting.

Barbara A. Roqueta, Senior Vice President, Provider Operations, Renaissance Health Systems, Inc. Ms. Roqueta joined us in April 2005. Commencing in March 2003 through February 2005, Ms. Roqueta worked as the Network Development Manager for EMP Medical Services, Inc., a statewide, specialized management services organization. Prior to that, she worked for HIP Health Plan of Florida, Inc. (now Vista Healthplan, Inc.), Healthcare providers Healthcare Plan and CAC/CAC-Ramsey/United Healthcare of Florida, Inc.

D & O Insurance

We currently maintain a $3 million directors and officers liability insurance policy.

Board Committees

The Company has four standing committees: Audit, Executive, Compensation and Options, and Nominations and Governance. None of the Board committees held any meetings during the last fiscal year.

.

The Audit Committee selects the independent auditors and reviews the results and scope of the audit and other services provided by independent auditors. The Committee also reviews and evaluates internal control functions and discusses with management and the Board such matters as accounting policies, internal accounting controls and procedures for preparation of financial statements. In June 2007, the Board of Directors appointed Mr. Del Valle to chair the Audit Committee and as its financial expert as such term is defined under Item 407(d)(5) of Regulation S-B. The Committee consists of Mr. Haggerty, Mr. Fisher and Mr. Del Valle.

.

The Executive Committee may exercise all powers of the Board in the management of the business and affairs of our company at any time when the Board is not in session. The Executive Committee is, however, subject to the specific directions of the Board and consists of Mr. Del Valle, Mr. Baker, Mr. Guillama and Mr. Cohen. All actions of the Executive Committee require a unanimous vote.

.

The Compensation and Options Committee makes recommendations to the Board concerning compensation for our executive officers, employees and consultants, recommendations to the Board concerning our non-cash compensation plans and administers the plans. The Committee consists of Dr. de la Torre (Chairman), Mr. Baker and Mr. Steinberg.

.

The Nomination and Governance Committee makes recommendations to the Board concerning nominations to the Board and development and review on an ongoing basis of the adequacy of our corporate governance. The Committee consists of Mr. Steinberg (Chairman), Mr. Fisher and Dr. de la Torre.

Code of Conduct

We have adopted three Codes of Conduct that col