PATIENT INFOSYSTEMS INC
Form 8-K/A
March 08, 2006

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 8-K/A

(Amendment No. 1)

CURRENT REPORT

Pursuant to Section 13 or 15(d) of the

Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): **January 25, 2006**

PATIENT INFOSYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware

(State or other jurisdiction of incorporation)

0-22319	**16-1476509**
(Commission File No.)	(IRS Employer Identification No.)

46 Prince Street

Rochester, New York 14607

(Address of principal executive offices and zip code)

Registrant s telephone number, including area code**(585) 242-7200**

(Former name or former address, if changed since last report.)

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions (see General Instruction A.2. below):

o Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

o Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

o Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

o Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

Explanatory Note

Pursuant to an Agreement and Plan of Merger dated September 19, 2005, as amended on November 22, 2005 and December 23, 2005, by and among Patient Infosystems, Inc. (the ***Registrant***), PATY Acquisition Corp., a wholly-owned subsidiary of the Registrant (***Merger Sub***) and CCS Consolidated, Inc. (***CCS Consolidated***), Merger Sub merged with and into CCS Consolidated (the ***Merger***) and CCS Consolidated became a wholly-owned subsidiary of the Registrant. The Merger closed and became effective on January 25, 2006.

The Registrant reported the closing of the Merger and certain related matters under Item 2.01 of its Current Report on Form 8-K dated January 31, 2006 and undertook therein to file with the Securities and Exchange Commission (the ***Commission***) the financial statements required by Item 9.01(a) of Form 8-K (the ***Historical Financial Statements***) and the pro forma financial information required by Item 9.01(b) of Form 8-K (the ***Pro Forma Financial Information***), in each case, in connection with the closing of the Merger, by amendment to the Form 8-K within 71 calendar days of January 31, 2006.

Because the former CCS Consolidated securityholders held approximately 63% of the Registrant s fully diluted shares of common stock immediately following the merger, CCS Consolidated s designees to the Registrant s board of directors represent a majority of the Registrant s directors and CCS Consolidated s executive management represent a majority of the executive management of the combined company, CCS Consolidated is deemed to be the acquiring company for accounting purposes.

The Historical Financial Statements and the Pro Forma Financial Information are being filed herewith under Item 9.01 of this Current Report on Form 8-K/A (Amendment No. 1). Additional information with respect to CCS Consolidated s business is being filed herewith under Item 8.01 of this Current Report on Form 8-K/A (Amendment No. 1).

Item 5.02 Departure of Directors or Principal Officers; Election of Directors; Appointment of Principal Officers.

As described in Item 5.02 of the Form 8-K filed on January 31, 2006, in connection with the closing of the Merger, three individuals who were designees of the stockholders of CCS Consolidated were appointed by the Registrant s board of directors to fill the vacancies on the Registrant s board of directors, such appointments to become effective as of the date that is 10 days following the filing with the Commission and delivery to the Registrant s stockholders of the information required pursuant to Rule 14f-1 of the Securities Exchange Act of 1934, as amended. These appointments became effective as of February 17, 2006, such that the full board of the Registrant consists of John Pappajohn, Derace Schaffer, Mark Pacala, Daniel Lubin and Albert Waxman, with Dr. Waxman serving as chairman and Mr. Pappajohn serving as vice chairman. Messrs. Pappajohn and Schaffer have been elected to the Registrant s audit committee. Messrs. Pappajohn, Schaffer and Waxman have been elected to the Registrant s compensation committee.

Item 7.01 Regulation FD Disclosure.

On March 7, 2006, CCS Consolidated issued a press release providing financial guidance. The press release is included as Exhibit 99.4 and is hereby incorporated by reference.

Item 8.01 Other Events.

The information below is intended to provide an overview of CCS Consolidated and, except where otherwise noted, the information does not give effect to the Merger. Unless the context otherwise

requires, the words we, us, the Company, CareGuide and similar words refer to CCS Consolidated and its consolidated subsidiaries.

Business of CCS Consolidated

General

CCS Consolidated, Inc., doing business as CareGuide, is a national care management company providing high-risk and elderly care management services to health plans, work/life benefits companies, and self-funded employers. By providing comprehensive medical and psychosocial care management services for the highest-risk, medically complex members, the Company enables clients to realize lower health care costs, while optimizing the quality of care and lifestyle of members. We bring to our partnerships with private and government payors a highly specialized infrastructure and multi-disciplinary clinical care management staff to improve the appropriateness and reduce the overall costs of care. The Company differentiates itself from utilization management companies by focusing on comprehensively managing care, rather than concentrating solely on authorizing individual health care services. We believe that we are also unique in our integration of risk assessment and stratification processes, clinical care management pathways, disease management protocols, intensive multi-disciplinary staffing, and credentialed post-acute specialty provider networks, including a national network of field-based geriatric case managers.

We coordinate care for elderly and chronically ill populations across the full spectrum of post-acute needs, including home health, acute rehabilitation and skilled nursing care. We work with customers to identify members who are medically complex, and we provide telephonic and face-to-face care management to people who need assistance in achieving recovery. By focusing on patients with complex medical profiles who generate the majority of health care costs, our strategy combines the use of lower cost care delivered outside the hospital with intensive patient-focused interventions to reduce the high cost of hospitalization and maximize an individual s health status and independence. We believe that we have organized a proprietary delivery system that reduces overall health care costs and improves outcomes for patients.

We were incorporated under the laws of the State of Delaware in March 1998 as a spin off company of Integrated Health Services, Inc., a multi-billion dollar provider of post-acute care. During 2005 we began doing business using the CareGuide name. We operate through our wholly-owned direct and indirect subsidiaries. On January 25, 2006, the Company merged with PATY Acquisition Corp., a wholly-owned subsidiary of Patient Infosystems, Inc., and became a wholly-owned subsidiary of Patient Infosystems, Inc. The Company s headquarters are located at 12301 N.W. 39th Street, Coral Springs, FL 33065, and our telephone number is (888) 721-9797. Our website address is http://www.careguide.com.

Business Strategy

Our business strategy is to contract with health plans, government agencies, and employer groups to help them reduce health care costs while improving the quality of care. We believe that the steadily rising cost of healthcare for employers, increasing demands on Medicare and Medicaid funding that are outpacing resources, and an emerging interest in care management and disease management services by the federal government and large insurers creates a fertile environment for our business model.

While we have historically derived the majority of our income from risk-based contracts, we are currently diversifying our revenue sources by adding more administrative fee contracts. We will continue to offer risk-based and non-risk-based post acute care management products, but where possible we will link them to a Continuous Care Management (CCM) service which will allow us to follow the complex

patients over the long term after their return to their home environment. We implemented our first CCM program on January 1, 2005. In July 2005, we implemented our second CCM customer.

We have been able to deliver substantial cost savings for our clients by preventing hospital admissions and readmissions among the most complex and chronically ill members. These members account for a disproportionate share of medical spending, with a much higher number of hospitalizations and episodes of emergency care than the rest of the population. Our focus is typically on only 0.5% to 6% of a plan s membership. These members are usually suffering from many illnesses simultaneously and often have non-medical concerns as well that contribute to poor health outcomes and high cost.

We achieve these medical cost savings by developing an individualized, information-driven, physician-guided care management plan for each patient. Because we are working with the most complex and chronically ill patients, the care management interventions are typically more intensive, involving face-to-face visits, regular telephonic contact, and, where indicated, remote tele-health interventions. Every effort is made to prevent medical destabilization, promote recovery, and help the patient remain in his or her home environment.

Our approach to care management is holistic in nature, recognizing that factors other than physical maladies contribute to an individual s decline. Our nurses, physicians, and licensed social workers consider environmental, psychological and social issues as they develop each care management plan.

Products and Services Description

We presently offer three major service-based products:

CCS Care Solutions . CCS Care Solutions provides a single point of access to the post-acute continuum of services including post-hospital discharge planning, utilization/case management, quality management, and financial responsibility for acute inpatient rehabilitation, skilled nursing facility care, home health care, durable medical equipment and home infusion services. We have developed significant expertise in managing the post-acute care management cycle and are able to significantly reduce errors and readmissions to the hospital.

Continuous Care Management. Continuous Care Management (CCM) is our disease management product for chronically and complexly ill members. Member populations typically include 0.5% to 6% of a health plan s membership. CCM proactively identifies the highest risk health plan members, such as frail, elderly individuals and other persons with multiple chronic diseases or complex medical illness, provides comprehensive multi-disciplinary physician-guided care planning and structured care management interventions in order to mitigate risk and improve patients health status and quality of life. CCM features evidence-based physician-guided treatment guidelines, remote monitoring technology, a network of skilled nursing facilities and home health providers, and a national network specialized care managers, who provide face-to-face and in-home member assessments. Designed for patients with multiple co-morbidities, CCM involves the management of the full range of medical and psychosocial conditions affecting a patient, using preventative care management before, during and after a post-acute episode.

CareGuide@Home . CareGuide@Home is a national care management program that uses our national specialized care manager network to provide in-home assessments, comprehensive care plans and hands-on assistance to access community-based supportive

services for homebound seniors and their families and caregivers. Clients for this program include national health plans, employee assistance programs and work/life companies.

Customers

As of December 31, 2005, the Company had post-acute care management contracts with health plans covering approximately 65,000 Medicare, approximately 544,000 commercial and approximately 133,000 Medicaid lives in the northeastern United States. Additionally, approximately 1.6 million members in Florida have access to our services through their health plans and approximately 843,000 employees have access to CareGuide@Home through employee assistance work/life programs sold by our distributors.

For the years ended March 31, 2005 and 2004, approximately 68% and 95%, respectively, of the Company s revenues were earned under contracts with affiliates of a single company, Health Net, Inc. In addition, during the year ended March 31, 2005, approximately 28% of the Company s revenues were earned under contracts with Aetna Health Plans. Effective May 1, 2005, the Company s contract with Health Net in the state of Connecticut was amended from a risk-bearing contract under which the Company was responsible for the payment of claim costs to an administrative fee only arrangement. Subsequently, in February 2006 we signed a transition agreement with Health Net that was effective as of January 1, 2006. This transition agreement results in the reduction of services to Health Net through April 30, 2006, after which time no services will be provided to Health Net under the existing contract. As part of the transition, the risk contracts with Health Net for the states of New York and New Jersey were also converted to administrative fee only contracts effective as of January 1, 2006.

Competition

The healthcare industry is highly competitive and subject to continual change in the manner in which services are provided. Other entities, whose financial, research, staff, and marketing resources may exceed our resources, are marketing care management services to health plans or have announced an intention to offer such services. These entities include disease management companies, major pharmaceutical companies, healthcare organizations, independent care management organizations, provider groups, pharmacy benefit management companies, and other entities that provide services to health plans and self-insured employers. In addition, many payor organizations, including health plans, have internal network development and medical case management staff that provide services similar to those we provide. Many of our competitors have significantly greater financial resources than we have, and these companies also compete with us in recruiting and retaining qualified personnel. Our failure to compete effectively could have a material adverse affect on our business.

We believe we have advantages over many of our competitors because of the comprehensive clinical nature of our product offerings, our established reputation for providing care to enrollees with chronic diseases, our hands-on approach, our ability to manage many diseases simultaneously and the financial and medical outcomes of our programs; however, we cannot assure you that we can compete effectively with these companies.

Consolidation has been, and may continue to be, an important factor in all aspects of the healthcare industry, including the health and care support sector. While we believe the size of our membership base provides us with the economies of scale to compete even in a consolidating market, we cannot assure you that we can effectively compete with companies formed as a result of industry consolidation or that we can retain existing customers if they are acquired by other health plans which already have or are not interested in health and care support programs.

Government Regulation

Governmental regulation impacts us in a number of ways in addition to those regulatory risks presented under the Risk Factors below.

While many of the governmental and regulatory requirements affecting healthcare delivery do not directly affect us, our client health plans must comply with a variety of regulations including the licensing and reimbursement requirements of federal, state and local agencies. Additionally, services provided to health benefit plans in certain cases are subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as amended.

Our subsidiaries are licensed to take risk in certain states. These subsidiaries must meet certain minimum capital and surplus tests as well as file quarterly and annual filings with state regulatory authorities. We believe that all of our subsidiaries are in compliance with such requirements.

Certain of our professional healthcare employees, such as nurses, must comply with individual licensing requirements. All of our healthcare professionals who are subject to licensing requirements are licensed in the state in which they are physically present. Multiple state licensing requirements for healthcare professionals who provide services telephonically across state lines may require us to license some of our healthcare professionals in more than one state. We continually monitor legislative, regulatory and judicial developments in telemedicine; however, new judicial decisions, agency interpretations, or federal or state legislation or regulations could increase the requirement for multi-state licensing of certain of our health professionals, which would increase our administrative costs.

Changes in laws governing reimbursement under governmental programs such as Medicare and Medicaid may affect us. Legislative and regulatory bodies may continue to reduce the funding of the Medicare and Medicaid programs in an effort to reduce overall federal health-care spending. In recent years, federal legislation has reduced or significantly altered Medicare and Medicaid reimbursements. These changes, future legislative initiatives or government regulation could adversely affect our operations or reduce the demand for our services.

Federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, or HIPAA, extensively restrict the use and disclosure of individually-identifiable health information by certain entities. We are contractually required to comply with certain aspects of the regulations. Further, we are required to comply with any applicable state laws or regulations related to privacy that are more restrictive than the federal privacy laws. Beginning April 20, 2005, health plans, most healthcare providers and certain other entities were required to comply with federal security regulations issued pursuant to HIPAA, which require the use of administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic individually-identifiable health information. We are contractually required to comply with certain aspects of the confidentiality and security regulations.

Various federal and state laws regulate the relationships among providers of health-care services, other health-care businesses and physicians. The fraud and abuse provisions of the Social Security Act provide civil and criminal penalties and potential exclusion from the Medicare and Medicaid programs for persons or businesses who offer, pay, solicit or receive remuneration in order to induce referrals of patients covered by federal health-care programs (which include Medicare, Medicaid, TriCare and other federally funded health programs). While we believe that our business arrangements with our health plans and medical directors comply with these statutes, these fraud and abuse provisions are broadly written, and we do not yet know the full extent of their application. Therefore, we are unable to predict the effect, if any, of broad enforcement interpretation of these fraud and abuse provisions.

Further, the healthcare industry is highly regulated at the federal and state levels. For example, federal law contains various prohibitions related to false statements and false claims, some of which apply to private payors as well as federal programs. Our participation in programs being administered by federal agencies may subject us directly to various laws and regulations applicable to entities contracting to provide services to federal programs, including but not limited to provisions related to billing and reimbursement and the False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to $11,000 per false claim. Actions may be brought under the False Claims Act by the government as well as by private individuals, known as whistleblowers, who are permitted to share in any settlement or judgment.

When a private party brings an action under the False Claims Act under the whistleblower provisions, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. There are many potential bases for liability under the False Claims Act. Although liability under the False Claims Act arises when an entity knowingly submits a false claim for reimbursement to the federal government, the False Claims Act defines the term knowingly broadly. Thus, although simple negligence generally will not give rise to liability under the False Claims Act, submitting a claim with reckless disregard for its truth or falsity can constitute knowingly submitting a claim. In some cases, whistleblowers or the federal government have taken the position that entities who allegedly have violated other statutes, such as the fraud and abuse provisions of the Social Security Act, have thereby submitted false claims under the False Claims Act. From time to time, participants in the health care industry, including our company, may be subject to actions under the False Claims Act, and it is not possible to predict the impact of such actions.

Insurance

We maintain directors and officers, errors and omissions, medical professional liability (related to care management and utilization management, but not covering the practice of medicine) and general liability insurance for all of our locations and operations. While we believe our insurance coverage is adequate for our current operations, it might not be sufficient to cover all future claims. In recent years, the cost of liability and other forms of insurance has increased significantly. Such insurance might not continue to be available in adequate amounts or at a reasonable cost. We also maintain property and workers compensation insurance with commercial carriers for each of our locations; these policies contain relatively standard commercial terms and conditions.

Properties

Our executive and corporate offices are located in Coral Springs, Florida in approximately 76,000 square feet of leased office space under an operating lease that expires in February 2007. We also lease approximately 3,300 square feet of office space in Southfield, Michigan under an operating lease that expires in September 2008. These facilities are in good condition, and we believe that they are adequate for our requirements.

Employees

As of December 31, 2005, we employed 155 full time and 8 part time employees. None of our employees is represented by a union. We consider our relationship with our employees to be good.

Legal Proceedings

One of our subsidiaries entered into a Health Services Agreement with Oxford Health Plans (NY) Inc., or Oxford, pursuant to which each party made payments to the other based on services provided. As

permitted by the agreement, we terminated the agreement by written notice to Oxford, which termination was effective as of August 31, 2005. Oxford contends that we owe it approximately $1.5 million for the periods through August 31, 2005, while we believe that Oxford owes us approximately $180,000 for the period ending December 31, 2004. We have not yet determined whether Oxford owes us any amounts for 2005, other than an unpaid $75,000 administrative fee for the month of August 2005. Negotiations to settle the matter have been unsuccessful to date. On July 22, 2005, over our objections, Oxford drew down on a $500,000 letter of credit that we had provided under the contract. We received a letter dated September 8, 2005 from Oxford requesting that we replenish our existing letter of credit in the amount of approximately $1.5 million, but we have denied this request. We received a letter from Oxford dated September 26, 2005 indicating that Oxford has submitted the matter to the American Health Lawyers Association for binding arbitration, seeking to compel us to replenish the letter of credit in the amount of approximately $1.5 million and to pay Oxford approximately $1.0 million. We intend to vigorously defend this claim.

We are also subject to various legal claims and actions incidental to our business, including professional liability claims. We maintain insurance, including insurance covering professional liability claims, with customary deductible amounts. There can be no assurance that (i) claims will not be filed against us in the future, (ii) our prior experience with respect to the disposition of litigation is representative of the results that will occur in future cases or (iii) adequate insurance coverage will be available at acceptable prices for incidents arising or claims made in the future. There are no pending legal or governmental claims to which we are a party that we believe would, if adversely resolved, have a material adverse effect on us.

Management s Discussion and Analysis of Financial Condition and Results of Operations

Overview

Management s discussion and analysis provides a review of our operating results for the fiscal years ended March 31, 2005 and 2004 and for the six months ended September 30, 2005 and 2004. We have three types of revenue. First, we accept risk on the providing of post-acute services and receive a Per Member Per Month (PMPM) capitation revenue. Alternatively, we provide services to health plans without accepting risk, and for these type of contracts, we may receive either an administration service fee or we may provide these services on a fee-for-service basis. For risk contracts, the cost of services includes the cost of providing clinical care and the incurred claims.

Our business strategy is to contract with health plans, government agencies, and employer groups to help them reduce health care costs while improving the quality of care. We believe that the steadily rising cost of healthcare for employers, increasing demands on Medicare and Medicaid funding that are outpacing resources, and an emerging interest in care management and disease management services by the federal government and large insurers creates a fertile environment for our business model.

While we have historically derived most of our income from risk-based contracts, we are currently diversifying our revenue sources by adding more administrative fee contracts. We will continue to offer risk-based and non-risk-based post acute care management products, but where possible we will link them to a Continuous Care Management service which will allow us to follow the complex patients over the long term after their return to their home environment.

Critical Accounting Policies and Estimates

Our consolidated financial statements are prepared in accordance with generally accepted accounting principles in the United States, which require management to make estimates, judgments and

assumptions that affect the reported amounts of assets, liabilities, revenue and expenses. Management bases its estimates on historical experience and on various other assumptions that it believes to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of certain assets and liabilities. Management believes that the accounting estimates employed and the resulting balances are reasonable; however, actual results may differ from these estimates under different assumptions or conditions.

An accounting policy is deemed to be critical if it requires an accounting estimate to be made based on assumptions about matters that are highly uncertain at the time the estimate is made, if different estimates reasonably could have been used, or if changes in the estimate that are reasonably likely to occur could materially impact the financial statements. Management believes the following critical accounting policies reflect the significant estimates and assumptions used in the preparation of the consolidated financial statements of CCS Consolidated.

Revenue Recognition

We recognize capitated revenue for contracts whereby the Company accepts risk. Capitated revenue is recorded by multiplying a contractually negotiated revenue rate per health plan member per month (PMPM) by the number of health plan members covered by our services during the month. These PMPM rates are initially determined during contract negotiations with customers based on estimates of the costs of our services, including the cost of claims. Such rates are generally renegotiated at contract renewal. In certain contracts, the PMPM rates differ depending on the health plan s lines of business, such as Medicare, Commercial or Medicaid. The PMPM rates will also differ in certain cases depending on the type of service provider, such as a skilled nursing facility or a home health provider. Contracts with health plans generally range from one to two years with provisions for subsequent renewal.

We recognize Administrative Services Only (ASO) revenue for contracts whereby the Company receives a fee for providing its services without the Company accepting risk for claims. Such contracts include those that pay a set fee each month. Other contracts include a PMPM ASO fee and other contracts include a per day per member case rate based on the number of health plan members who receive services during the month. Such fees are negotiated with the health plan or employer group based on estimated costs and anticipated level of services.

We recognize fee-for-service revenue for certain services provided for our customers and expenses paid on behalf of our customers for which we are generally reimbursed on a cost-plus basis during the period in which the services are provided.

Some of our revenues are based on contractual arrangements which may be subject to retroactive adjustments as final settlements are determined. Such amounts are recorded on an estimated basis in the period the related services are rendered and are adjusted in future periods upon final settlement.

Intangibles and Other Assets

Intangible and other assets consist primarily of a website, trademarks, and goodwill associated with acquisitions. Our intangible assets are amortized over their respective estimated useful lives. Goodwill is not amortized to expense. Goodwill and identifiable intangible assets are reviewed annually for impairment and their recorded value is reduced whenever events or changes in circumstances indicate that the carrying value may not be recoverable. Based on the evaluation performed as of March 31, 2005, management concluded that no impairment of recorded goodwill or intangible asset existed as of that date. The evaluation approach utilized is dependent on a number of factors, including estimates of future

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revenues and costs, appropriate discount rates and other variables. Management bases its estimates on assumptions believed to be reasonable, but which are inherently uncertain. Therefore, future impairments could result if actual results differ from those estimates.

Direct Service Costs

Direct service costs are comprised of the incurred claims paid to third-party providers for services for which the Company is at risk and the related expenses of the Company associated with the providing of its services. Network provider and facility charges for authorized services that have yet to be billed to us are estimated and accrued in our Incurred But Not Reported (IBNR) claims payable liability. Such accruals are based on our historical experience, current enrollment statistics, patient census data, adjudication and authorization decisions and other information. The IBNR liability is adjusted as changes in these factors occur and such adjustments are reported in the period of determination. Although it is possible that actual results could vary materially from recorded claims in the near term, management believes that the recorded IBNR liability is adequate.

The above listing is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by generally accepted accounting principles, with no need for management s judgment in their application. There are also areas in which management s judgment in selecting any available alternative would not produce a materially different result. See the Notes to CCS Consolidated s Consolidated Financial Statements, included in Exhibits 99.1 and 99.2 to this Current Report on Form 8-K/A, which contain additional accounting policies and other disclosures required by generally accepted accounting principles.

Results of Operations

The following financial table presents data regarding our Results of Operations, Financial Position and Cash Flows as of and for the years ended March 31, 2005 and 2004 and as of and for the six months ended September 30, 2005 and 2004. Such data was derived from CCS Consolidated s financial statements. This information should be read in conjunction with (i) the Company s historical consolidated financial statements as of and for the years ended March 31, 2004 and 2005 and the related notes thereto, filed as Exhibit 99.1 to this Current Report on Form 8-K/A, and (ii) the Company s unaudited interim consolidated financial statements as of and for the six months ended September 30, 2004 and 2005, and the related notes thereto, filed as Exhibit 99.2 to this Current Report on Form 8-K/A. All dollar amounts are stated in thousands of dollars:

	Six Months Ended September 30,		Variance
	2005	**2004**	**Favorable (Unfavorable)**
Operating Results			
Capitated Revenue			
Health Net	$ 4,989	$ 20,066	$ (15,077)
Aetna	16,551	5,782	10,769
Total capitated revenue	**$ 21,540**	**$ 25,848**	**$ (4,308)**
Administrative Services Revenue			
Health Net	$ 2,250	$ -	$ 2,250
Aetna	18	724	(706)
Other	782	494	288
Total ASO revenue	**$ 3,050**	**$ 1,218**	**$ 1,832**
Fee-For-Service Revenue			
Health Net	$ 1,387	$ 3,325	$ (1,938)
Other	690	659	31
Total fee-for-service revenue	**$ 2,077**	**$ 3,984**	**$ (1,907)**
Total Revenue			
Health Net	$ 8,626	$ 23,391	$ (14,765)
Aetna	16,569	6,506	10,063
Other	1,472	1,153	319
Total revenue	**$ 26,667**	**$ 31,050**	**$ (4,383)**
Percentage of Revenue by Major Customer			
Health Net	32.3%	75.3%	(43.0)%
Aetna	62.1%	21.0%	41.1%
Other	5.6%	3.7%	1.9%
Total revenue	**100.0%**	**100.0%**	

	Six Months Ended September 30,		Variance Favorable