QUANTUM GROUP INC /FL
Form 10KSB
February 14, 2005

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D. C. 20549

FORM 10-KSB

(Mark One)
[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE TWELVE MONTH PERIOD ENDED OCTOBER 31, 2004

[ ] TRANSITION REPORT UNDER SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934

COMMISSION FILE NUMBER 000-31727

THE QUANTUM GROUP, INC.
(Name of registrant as specified in its charter)

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

3460 FAIRLANE FARMS ROAD, SUITE 4
WELLINGTON, FLORIDA 33414
(Address of principal executive offices) (Zip Code)

REGISTRANT'S TELEPHONE NUMBER: (561) 227-1597
SECURITIES REGISTERED UNDER SECTION 12(B) OF THE EXCHANGE ACT: NONE
SECURITIES REGISTERED UNDER SECTION 12(G) OF THE EXCHANGE ACT:
TITLE OF EACH CLASS
COMMON STOCK, $.001 PAR VALUE
SERIES A PREFERRED, $.001 PAR VALUE

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

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

Revenues for the most recent fiscal year: $0

The aggregate market value of the Registrant's voting Common Stock held by non-affiliates of the registrant was approximately $3,251,950 (computed using the closing price of $.50 per share of Common Stock on January 27, 2005 as reported by OTCBB, based on the assumption that directors and officers and more than 5% stockholders are affiliates).

There were 18,659,238 shares of the registrant's Common Stock, par value $.001 per share, outstanding on January 27, 2004.

AVAILABLE INFORMATION

The public may read and copy any materials filed by The Quantum Group (referred to throughout this Report as "our company") with the United States Securities and Exchange Commission (the "Commission") at the Commission's Public Reference Room at 450 Fifth Street, Northwest, Washington, D.C. 20549. The public may obtain information on the operation of the Public Reference Room by calling the Commission at 1-800-SEC-0330. The Commission maintains an Internet site that contains reports, proxy and information statements, and other information regarding our Company and other issuers that file reports electronically with the Commission at http://www.sec.gov

FORWARD LOOKING STATEMENTS

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

CONTEXT

The information in this report is qualified in its entirety by reference to the entire report; consequently, this report must be read in its entirety. This is especially important in light of material subsequent events disclosed. Information may not be considered or quoted out of context or without referencing other information contained in this report necessary to make the information considered, not misleading.

The Quantum Group, Inc.

FORM 10-KSB FOR THE YEAR ENDED OCTOBER 31, 2004

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PART I

ITEM 1. DESCRIPTION OF BUSINESS

INTRODUCTION

The Quantum Group, Inc. (the terms "Company", "us" "QTUM" and/or "we" and other similar terms as used herein refer collectively to the Company together with its principal operating subsidiaries) is a Nevada corporation created for the sole purpose to reorganize and change domicile of the predecessor company, Transform Pack International, Inc. (TPII). Transform Pack was originally formed as a Minnesota corporation in February 1975 under the name Automated Multiple Systems, Inc., subsequently changed its name to Stylus, Inc., and then changed its name to Cybernetics, Inc. in December 1997. Throughout the early years of the corporation, its business and management were located in Minnesota. However, since 2000 the business and management of Transform Pack have been located in Moncton, New Brunswick, and as of May 29, 2003 in Wellington, Florida.

On May 28, 2003, Transform Pack completed the acquisition of Quantum HIPAA Consulting Group, Inc., a Florida Corporation based in Wellington, Florida. Quantum HIPAA Consulting Group was in the business of advising the healthcare industry on the implementation of regulations created to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Transform Pack made the acquisition by issuing 27,000,000 shares of Common Stock ($0.004 par value) to Noel J. Guillama, the sole stockholder of Quantum HIPAA Consulting Group, in exchange for all the issued and outstanding shares of Quantum HIPAA Consulting Group. As a result, Mr. Guillama became the direct and beneficial owner of approximately 80.18% of the issued and outstanding shares of

the Company. For accounting purposes, this transaction was treated as a reorganization. Prior to the acquisition of Quantum HIPAA Consulting Group, there was no affiliation or other relationship between Transform Pack and Quantum HIPAA Consulting Group or Mr. Guillama.

Since Transform Pack no longer has any business or management connection with the state of Minnesota, the Board of Directors determined late in 2003, that the corporation could benefit from changing its domicile to a state such as Nevada. With the ratification by the Shareholders on January 30, 2004, completed in February 2004, the Company's new stock symbol on the Over-the-Counter Bulletin Board market was changed to QTUM.

The Company is a development stage company with no current revenues. As of February 6, 2004 management's efforts have been primarily in market research, business development, negotiations of various Letters of Intent and due diligence on potential acquisitions, joint ventures and licensing agreements. Its business model today is to become a leading provider of services to the healthcare industry in three complementary areas: outsourcing administrative responsibilities for physicians, Managed Care Organizations, healthcare facilities, physician associations; developing new technologies to create a more effective and responsive healthcare system; and providing leading edge healthcare services to consumers.

In developing this model, the Company originally purchased 20% interest from our major shareholder in two companies which he was developing. These companies are Quantum Medical Technologies, Inc. (QMT) (a Florida corporation) and Renaissance Health Systems, Inc. (RHS) (a Florida corporation). Both QMT and RHS are also development stage companies. In both cases each company has a Letter of Intent (LOI) to develop products and services with institutions in the healthcare field; however, the capital has not been secured to exploit these opportunities. Management believes that with a more complex and complementary model the Company is more likely to obtain financing that in the end will produce results for shareholders.

At a Special Meeting of the shareholders held on January 30, 2004 the majority of the shareholders agreed to issue 13,300,000 post reverse shares and 200,000 Series A Preferred Stock (subsequently added to the purchase price by the Board of Directors on July 19, 2004) to the majority shareholder of the Company, Mr. Guillama, of both QMT and RHS for the 80% of each of those companies. Mr. Guillama had previously granted 7,175,000 options exercisable at $.001 per share on the shares he owned in the two Companies. 1,000,000 options are held by an affiliate of Mr. Guillama, 2,180,000 are held by Directors of the Quantum Group and 3,995,000 are held by non affiliates. As of October 31, 2004,

965,000 options were exercised leaving Mr. Guillama with a direct and beneficial ownership of approximately 79% of the issued and outstanding shares of the Company. Control in the Company will not material change, since all the shareholders in numbers and relative beneficial ownership of both QMT and RHS are also material and beneficial owners of the common share of the Company today. The final merger was completed in August 2004.

The Company is organized in three key operating divisions:

>> THE QUANTUM GROUP, as the parent company, will provide outsourcing to physicians and healthcare organizations. Our services will include: privacy consulting, human resources management, managed care contracting, government compliance, financial management, facilities management, venture management, and healthcare venture/merchant banking. The Company has identified potential acquisitions to give it a core group of services, such as medical billing and collections,

consulting and financial services.

>> QUANTUM MEDICAL TECHNOLOGIES (QMT). The QMT team has spent 4 years in the development of technology systems to increase the efficiency of the healthcare system. The Company has in development process three PATENT PENDING business processes. In addition, the Company also provides webservices to medical societies and is currently developing a web-based health information platform to use both internally and market to non-affiliated physicians.

>> RENAISSANCE HEALTH SYSTEMS (RHS). RHS is organized as a new breed, next generation Community Health System (CHS), contracting with Florida Managed Care Organizations (MCOs) to manage the care of patients in a proactive and cost effective environment. RHS has secured an agreement with one Florida MCO, and is currently in final negotiations with two other Florida-based MCOs.

Success in developing the Company will be highly dependant on the Company's ability to attract capital, people and contracts and on management's ability to manage a complex organization.

MISSION STATEMENT:

To identify and pursue leading edge opportunities within the healthcare industry and bring significant return on investment ("ROI") to all shareholders, employees and the community at large.

VISION STATEMENT:

As the US healthcare system nears its most critical period, The Quantum Group seeks to develop efficient, quality, proactive, cost effective and innovative healthcare solutions through the integration of intelligence, products, services, technology, and outsourcing. This will permit the healthcare industry to effectively deliver highly personal, quality-focused healthcare services in a cost effective and profitable manner.

VALUES STATEMENT:

To increase the value of our shareholders, provide leadership in our industry, our community and our employees, and provide our patients with the absolute best possible products and services.

BUSINESS STRATEGY OVERVIEW

The Quantum Group, Inc. - Outsourcing

The Quantum Group, Inc. is a development stage company which intends to provide a broad range of consulting services and products to the healthcare community, consisting primarily of individual physician practices, ancillary providers and other small to mid-size healthcare facilities. The Company is focusing on medical practices and business with annual revenues in the $500,000 to $20,000,000 range. The Company believes that this is a highly underserved market, and when these businesses receive consulting services they are in a fragmented, sporadic and inefficient manner.

The Company's initial product/service offered is assistance to healthcare providers and organizations generally covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that deal with administrative simplifications, privacy and security of both electronic and

physical (paper) medical records.

The Company has developed a comprehensive system for training non-medical consultants in the implementation of HIPAA regulations. The Company has in the past trained approximately 100 consultants in a trial project and intends to fully deploy its ability to create documentation and systems beyond HIPAA into other areas of healthcare consulting, ranging from medical billing and coding to information technology, once sufficient capital has been secured.

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

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

To address the increased industry-wide focus on patient safety, clinical excellence, compliance with security regulations and financial performance, we intend to design solutions that give the healthcare industry the tools and strategies they need to serve their customers effectively, improve the quality and safety of clinical care, secure and authenticate online healthcare transactions, reduce cost and ensure compliance with evolving government and industry requirements, including the Health Insurance Portability and Accountability Act ("HIPAA").

From education, visioning and planning, to implementation and outsourcing, the Company intends to provide the following services and solutions that are designed to help client organizations perform better:

- >> Government Compliance
  - o HIPAA
  - o Medicare
  - o Medicaid
  - o HMO/PPO
- >> Managed Care
  - o Contract Negotiations
  - o Auditing
  - o Business Development
  - o MSO Development
  - o IPA Development
- >> Financial Management
  - o Billing Services
  - o Collection Services
  - o Payroll Services
  - o Accounts Receivable Financing
  - o Equipment Financing
  - o Executive Lines of Credit
- >> Information Technology
  - o Website Development
  - o Information Management
  - o ASP Services
  - o Secure Communications
  - o Business Process Management
- >> Information Technology
  - o Full Medical Office Management
  - o Facilities Management
  - o Employee Management

- Placement Services
- Personnel Training

>> Business Venture Management

>> Healthcare Merchant Banking Services

Because of our management team's extensive knowledge of the healthcare industry, our future clients' needs, and our management's range of healthcare experience in healthcare operations and workflow, IT and clinical systems, we should be able to work with clients to enable them to leverage their existing systems and processes to accelerate their return on investments. Once fully operational, we believe that our in-depth knowledge of the healthcare industry and the range of services we intend to offer endow us with significant advantages over small competitors in marketing additional services and winning new engagements. We believe that with this plan we will be well positioned to help healthcare providers bridge traditional services in a new environment to create new efficiencies and a better, more responsive healthcare system. Our goal is to be the preferred, if not sole, provider of a broad range of outsourcing and consulting solutions for each of our clients.

Quantum Medical Technologies, Inc. - Technology

Quantum Medical Technologies, Inc. (QMT) was incorporated in January 2000 by our current Chairman to create a new model for managing information in the medical industry. In a pending business process environment branded as Cybernaptic (SM), connecting all the `touch points' of healthcare in one ASP based system, the Clients of QMT will be able to choose any combination of support, including full outsourcing with data center consolidation, 24/7/365 network monitoring and help desk through our network control center, as well as facility management, application unification, application outsourcing and interim management of their entire IT operations.

The healthcare IT environment is increasingly complex and costly as a result of the challenges inherent in deploying new technologies, maintaining or integrating older computer systems and deploying an IT function capable of meeting new objectives designed to improve clinical quality and patient safety, achieve regulatory compliance and ensure secure digital transactions while at the same time improving business operations and the revenue cycle as well as reducing supply costs. With all of these pressures, healthcare organizations must become more efficient and effective. As a result, we believe that the healthcare industry will increase the percentage of its budget devoted to IT solutions.

Computer-based patient record systems and other technologies into the healthcare delivery process can enable organizations to improve their bottom line. These technologies help healthcare organizations reduce costs through clinical and supply chain efficiencies, enhance communications with physicians, patients, payers and other constituencies, improve care delivery and patient safety and streamline activities such as claims processing, eligibility verification and billing.

We believe that healthcare participants will continue to turn to outside consultants, external management of formerly internal information systems, application support and full outsourcing arrangements as a means of coping with the financial and technical demands of information systems management and integration of web-based solutions. QMT anticipates responding to these demands by developing and providing information technology and management consulting services and solutions along with flexible business process and information technology outsourcing solutions, business process and IT operations. Through outsourcing, clients can achieve their business process and information technology goals while remaining focused on expanding their primary

businesses and reducing related capital outlay.

The Company has also begun to develop a new method to track improvement in patient life style with a patent pending process called QuantumQuotient (sm) or Qx2 (sm) . The Company is exploring validation by a major research university in the U.S.

Renaissance Health Systems, Inc. - Services

Renaissance Health Systems, Inc. ("Renaissance" or "RHS") was incorporated in the State of Florida on December 13, 2002. The RHS strategy is to create a new type of healthcare delivery system built on the extensive experience of our senior management team. We intend to specialize in managed

care Percentage of Premium (POP) contracting. RHS expects to create a new model for healthcare called the Community Health System (CHS) to contract with Florida Managed Care Organizations (MCOs) to manage the care of patients in a proactive and cost effective environment. RHS has secured an agreement with one Florida MCO and is currently in final negotiations with two other Florida-based MCOs.

INDUSTRY BACKGROUND

Recent developments in healthcare:

In 2004 total health spending in the U.S. will account for nearly 15 percent of the nation's gross domestic product, or GDP. The Department of Health and Human Services (HHS) announced that healthcare spending shot up 9.3 percent in 2002, the largest increase in 11 years, to a total of $1.55 trillion. HHS estimates that healthcare expenditures will reach $2 trillion by 2008; that represents an increase for each person from $5,440 to $7,100 in the United States alone. Projections put health spending at 17.7 percent of GDP, by 2008.

On December 8, 2003, the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act--the most significant improvement in healthcare coverage for senior citizens and those with disabilities in nearly forty years. This historic legislation makes available a prescription drug benefit to all 41 million Medicare beneficiaries, helping them afford the cost of their medicines, and offering other significant improvements as well.

According to President Bush's proposed 2005 Federal Budget, Medicare Advantage (formerly Medicare + Choice) growth is projected to increase nearly 100% over the next 4 years. In addition, actual "per member per month" (PMPM) payments to Managed Care Organizations (MCO) are expected to be increased by a record 10.6% nationwide. In Palm Beach County Florida where the Company is based, federal funding to Medicare HMOs is increasing about 16 percent. MCOs will receive $734.51 per member per month from the federal government, up from $633.86 per member per month.

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

With Medicare payments to MCO's rising 2 percent annually in recent years, many insurance executives decided that they could no longer do business with the program because their Medicare-related costs were rising about 10

percent a year. From 1999 to 2003, health plans dropped more than 2.4 million Medicare beneficiaries. Some pulled out of Medicare entirely, while others curtailed their participation by withdrawing from specific counties. Leslie V. Norwalk, acting deputy administrator of the Federal Centers for Medicare and Medicaid Services, predicted publicly that as a result of the increased payments, which took effect March 1, 2004, many private plans would return to the Medicare program.

About 4.6 million beneficiaries, or 11 percent of the 41 million people enrolled in Medicare, are now in MCO's, which have customarily provided drug benefits and preventive care not available in the original fee-for-service program. The number of people in private plans reached a peak of 6.3 million, or 16 percent of beneficiaries, in late 1999.

The Bush administration predicts that the Medicare law enacted in December 2003, to encourage people to enroll in MCO's and similar private plans called Preferred Provider Organizations (PPO's), so that by 2007, 35 percent of beneficiaries will be members of such plans. Tommy G. Thompson, the Secretary of Health and Human Services, described the increased payments as "an investment in our seniors." As a result of the increase, Mr. Thompson said, Medicare beneficiaries will have more options and better services. Private plans will be able to use the additional money to enhance benefits, to reduce premiums or co-payments paid by beneficiaries, or, as a way of stabilizing the network of healthcare providers who serve the beneficiaries, to increase payments to doctors and hospitals.

The new Medicare law not only created a prescription drug benefit but also gave private health plans a larger role in the program. Indeed, how much to pay the private plans was one of the biggest issues in Congressional debate over the bill.

As enacted, the legislation established a complex new formula for determining such payments, a provision that the President is now applying in arriving at an increase of 10.6 percent. The Congressional Budget Office estimates that the extra payments to private plans under that formula will slightly exceed $500 million this year and will total $14 billion from 2004 to 2013.

The Centers for Medicare & Medicaid Services announced January 16, 2004 that this significantly increases in federal payment rates for Medicare Advantage health plans, aimed at supporting improvements in services and lower costs for Medicare beneficiaries enrolled in private health plans, as well as more options for Medicare coverage.

The increased payments to Medicare Advantage were included in the bipartisan Medicare Prescription Drug, Improvement and Modernization Act recently signed into law by President Bush. The increases will average 10.6 percent across plans.

The provision requires managed care organizations to use the funds to:

- Reduce beneficiary premiums or co-pays
- Enhance benefits
- Stabilize or expand the network of doctors and other healthcare providers available to seniors o Reserve funds to offset either premium increases or reduced benefits in the future.

"These increases are an investment in our seniors. They are aimed at supporting better services for Medicare beneficiaries in healthcare plans. And

at the same time they will help support more choice of Medicare options for all beneficiaries," HHS Secretary Tommy G. Thompson said. "We want private health plans to develop attractive benefits and strong networks of providers. And we want beneficiaries to have a range of reliable alternatives so they can choose the coverage options that serve them best. This is an important improvement to the Medicare system that addresses a long-standing concern by seniors who prefer managed care plans."

The new provision gives those managed care organizations that announced they were leaving Medicare Advantage or reducing their services the opportunity to remain in the program, providing continued service for seniors who choose a managed care plan.

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

The new rate is one of many steps being taken rapidly in response to the Medicare Improvement Act. CMS has also launched its plans to make a drug discount card available to Medicare beneficiaries this spring, and published updated payment rates for physicians and outpatient hospitals.

"We are encouraged by the number of plans that continue to expand their reach and bring more choices to millions of beneficiaries, and we expect this trend to accelerate with this announcement," Smith said. "These health plans are very important for lower-income seniors, minority seniors and disabled individuals who rely on them for their healthcare, to keep costs affordable, and for the valuable benefits that are not available in fee-for-service Medicare."

The amount of the increase varies by county. The average increase in 2004 was about 10.6 percent for those counties where Medicare Advantage plans are available. That increase includes an average 3.2 percent increase that plans were expected to receive in 2004 before the enactment of the new Medicare law.

In a survey completed by Harris Interactive(R) of attendees at the World Health Care Congress, top executives in the healthcare industry believe information technology is key to containing rising healthcare costs in the U.S. Seventy-nine percent of those polled - leaders of health insurance companies, hospitals, pharmaceutical corporations and large employers - cited information technology's ability to improve the quality of care in conjunction with practice guidelines and other proposals made by the Institute of Medicine (IOM) as effective and desirable ways to contain costs. When respondents were asked to identify their top two priorities for containing costs, use of information technology in conjunction with practice guidelines and other proposals made by IOM emerged as the number one choice with 49 %.

During a speech on February 2004 at the World Healthcare Congress in Washington, U.S. Health and Human Services Secretary Tommy Thompson said that "Four years into the 21st century, the healthcare industry still depends on pencils, papers, manila folders, and memo sheets as primary tools for getting its work done" he further said "the nation's healthcare delivery system needs to more widely incorporate business practices used in other industries, especially information technology."

In the same speech, Thompson told attendees that supermarket clerks rely on technology to ensure they give customers the right change, without mistakes. Yet, the Institute of Medicine estimates that 98,000 patients die--and even more are disabled each year--due to errors that can be largely prevented by technologies such as computerized prescription ordering, drug bar-code systems, and electronic patient medical records.

The adoption of those and other technologies in healthcare "could save [the U.S.] $100 billion" a year, through reduced deaths and disabilities. Because the government's Medicare program makes the federal government "the country's largest insurance company, the feds are taking a lead role in trying to make it easier to for more health-care providers to adopt these technologies. The ability to share patient information electronically can help doctors and other providers to make better-informed decisions and spot potential mistakes before they happen. However, without data and other technical standards, the sharing of patient information electronically among health providers is often difficult or impossible. Over the last year or so, Health and Human Services has adopted five key standards related to formats and transmission of patient data, so that electronic medical records can be more easily shared among caregivers. That includes adopting SnoMed as the federal government's standard lexicon for medical diagnosis and treatments. The government is also offering the healthcare industry use of SnoMed free of licensing fees."

(Information compiled from reliable media/new sources and websites of US Health and Human Service and Center for Medicare Services)

GENERAL

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

We also see that today there are, with minor exceptions, only two places physicians or medical providers can turn for help in meeting all the demands placed on him or her by the business and healthcare environment. Those are high-end highly paid consultants that could be represented by large accounting and large consulting firms, or the local cottage industry of healthcare consultants that range from HR functions to accounting and tax work, generally specializing in one or two areas and stretching to meet the ever increasing needs of his or her client.

Consulting & Outsourcing

The changing business environment has produced an evolving range of strategic and operating options for healthcare entities. In response, healthcare participants are formulating and implementing new strategies and tactics, redesigning business processes and workflows, acquiring better technology to

improve operations and patient care, integrating legacy systems with web-based technologies, developing e-commerce abilities and adopting or remodeling

customer service, patient care and marketing programs. We believe that healthcare participants will continue to turn to outside consultants to assist in this vast array of initiatives for several reasons: the pace of change is eclipsing the capacity of their own internal resources to identify, evaluate and implement the full range of options; consultants enable healthcare participants to develop better solutions in less time and can be more cost effective. By employing outside expertise, healthcare providers can often improve their ability to compete by more rapidly deploying new processes.

In 2004, the healthcare consulting industry was highly fragmented and consisted primarily of:

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

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

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

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

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

The Company believes that, increasingly, the competitive advantage in healthcare consulting will be gained by those consulting firms which:

>> Are able to coordinate the necessary expertise and resources to offer comprehensive skill sets and packaged solutions to clients;

>> Have the vision, strength and consistency to advise clients along the entire service continuum, from strategy to selection to implementation to operation;

>> Offer the flexibility to meet the challenges of the rapidly changing healthcare, e-commerce and IT environment; and

>> Have assets to bring total solutions including offerings that address the clients' need for market expansion and capital replacement.

Healthcare Services

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

the cost of patient care.

The highly fragmented nature of the delivery of outpatient services has created an inefficient healthcare services environment for patients, payers and providers. MCOs and other payers must negotiate with multiple healthcare services providers, including physicians, hospitals and ancillary services providers, to provide geographic coverage to their patients. Physicians who

practice alone or in small groups have experienced difficulty negotiating favorable contracts with managed care companies and have trouble providing the burdensome documentation required by such entities. Healthcare service providers may lose control of patients when they refer them out of their network for additional services that such providers do not offer. We intend to continue affiliating with physicians who are sole practitioners or who operate in small groups to staff and expand our Health System which should make us a provider of choice to managed care organizations.

We intend to pay the physicians a capitated fee for providing the services and assume a portion of the financial risk for the physician's performance related to our members. In addition to providing certain administrative services to the physicians, we also provide utilization assistance.

Renaissance Health Services and the Community Health System (CHS)

Management views the U.S. healthcare systems as broken. Though a 1.7 trillion dollar business, the fragmented industry is materially ineffective in providing cost effective and quality healthcare. Over the last 15 years there have been many experiments on how to make the treatment of patients more effective, faster and with a sensitivity to cost and outcomes.

The management of this Company has been part of that experimental process from the days when acquiring doctors was expected to be the "solve-all" solution, to the later evolution of Physician Practice Management (PPM), Management Services Organization (MSO) and Provider Sponsored Network (PSN).

Management believes that in all these models the patient is effectively placed last by the healthcare system. Renaissance has developed a new model for treating patients, providers, and insurers: the Community Health System or CHS. In a CHS the patient is recognized as the true consumer of healthcare services. The doctor and patient jointly call the shots, not the Managed Care Organization (MCO) by itself. Patients are actively involved in the improvement of their own healthcare lifestyle. The benefits of the MCO, Renaissance (RHS), the physician, and most importantly the patients are aligned, not just to treat the sick, but to proactively keep the patient healthy and well, thus, reducing the overall costs for the patient and the industry. RHS will pay the physicians to keep their patients healthy, and also directly incentivize the patient at the end of each year for actively participating in his or her own healthcare improvement.

The listed table below identifies Florida counties where the Company intends to focus its business.. The table identifies each county by name, total population, HMO enrollment and contains other relevant data, intended to demonstrate financial opportunity. There is no statement made as to the probability of entering more than one county or having a material penetration of the Medicare lives in those counties. The information was gathered exclusively from Federal and State of Florida websites, and should only be used as representative of opportunity for the Company and its subsidiary.

COUNTY	TOTAL POPULATION (2003)	TOTAL MEDICARE POPULATION	TOTAL HMO ENROLLMENT	% OF MEDICARE PENETRATION	PER CAPITA INCOME (2002)	G
DADE	2,341,176	317,289	150,780	47.50%	$26,780	2
BROWARD	1,731,347	253,695	103,486	40.80%	$31,785	3
PALM BEACH	1,216,282	269,119	64,615	24.01%	$44,120	4
MARTIN	135,122	36,585	2,625	7.20%	$44,370	3
ST. LUCIE	213,447	46,575	4,115	8.80%	$23,458	4
OKEECHOBEE	37,481	6,049	642	10.60%	$18,818	2
INDIAN RIVER	120,463	33,520	2,524	7.50%	$39,830	3
VOLUSIA	468,663	99,753	32,517	32.60%	$24,747	2
FLAGLER	62,206	16,680	4,472	26.80%	$24,041	11
BREVARD	505,711	101,176	16,577	16.40%	$27,762	2
ST. JOHN	142,869	21,601	22	0.10%	$37,191	7

Strategy Overview - RHS Services

Management expertise will allow the Company to provide a service and manage the risk that health insurance companies cannot provide on an efficient and economic level. Health insurance companies are typically structured as marketing entities to sell their products on a broad scale. Due to mounting pressures from the industry, MCO's have altered their strategy, returning to the traditional model of selling insurance and transferring the risk to the CHS's. Under such arrangements MCO's receive premiums from the Center for Medicare Services (CMS), a division of the Department of Health and Human Services, and commercial groups and pass a significant percentage of the premium on to a third party such as RHS, to provide covered benefits to patients including pharmacy and other enhanced services.

After all medical expenses are paid any surplus or deficit remains with the CHS. When managed properly accepting this risk can create a significant surplus. Under the RHS model the physicians maintain their independence but are aligned with a professional staff to assist in providing cost effective healthcare. This in turn helps maximize profits for the physicians and RHS. To limit exposure RHS intends to secure reinsurance (stop-loss coverage).

Our RHS business model is unique and based on educating, motivating and assembling physicians in groups that are prepared to assume managed care risk. We envision expanding our Health System of Physicians to provide our members healthcare services on an efficient and cost effective basis through strategic

alliances with insurance companies and other healthcare providers on a statewide basis. Beyond that, our model is based on a direct, proactive, involved participation with our real client, the patient members of our CHS program.

Under our proposed MCO agreement(s), RHS, through affiliated providers, is responsible for the provision of all covered benefits. While responsible for all medical expenses for each covered life, we intend to limit our exposure by obtaining reinsurance/stop-loss coverage. We have capitated high volume specialties, fixing our cost on a per-member-per-month (PMPM) basis. Low volume providers remain at a discounted fee-for-service basis. A change in healthcare legislation, inflation, major epidemics, natural disasters and other factors affecting the delivery and cost of healthcare are beyond our control and may adversely affect our operating results.

Under our model, the physicians maintain their complete independence but are aligned with our professional staff to assist in providing cost effective quality medicine. Each primary care physician provides direct patient services as a primary care doctor including referrals to specialists, hospital admissions and referrals to diagnostic services and rehabilitation. In the future, we may seek to acquire, develop or partner with a number our providers in Company owned medical centers of excellence that will serve as our model facilities.

We enhance administrative operations of our physician practices by providing management functions, such as payer contract negotiations, credentialing assistance, financial reporting, risk management services and the operation of integrated billing and collection systems. We offer the physicians increased negotiating power associated with managing their practice and fewer administrative burdens. This allows the physician to focus on providing care to patients.

We intend to use the Internet extensively to help process referral claims between our Health System's primary care physicians and specialists and to communicate with patients. This process helps reduce paperwork in the physician's office as well as provide a more efficient method for the patients in our Health System. Our utilization management team will communicate with the physicians on a daily basis to provide overall management of the patient.

MCO Arrangements

Executed Agreements The Company has executed a Letter of Intent (LOI) with a Florida Managed Care Organization (MCO), and, subject to completion of each party's respective due diligence investigation anticipates a formal contract in the near future. The terms of the LOI detail that RHS will be responsible for arranging a Provider Health System in the Central Florida market place. The agreement calls

for RHS to receive a percentage of premiums received by the MCO. Relating to this agreement, the Company is required to place $50,000 in a segregated bank account to start and increase this amount by 3% of the revenues generated by the agreement up to a total $1,000,000. The Company anticipates that if properly funded, this agreement will be generating $10,000,000 in revenues by December 1, 2005. The Company anticipates a formal agreement as soon as the Company is able to meet the capital requirements.

Future Agreements

The Company further intends to have a substantial amount of its

revenues derived from agreements with MCOs that provide for the receipt of capitated fees. Capitated fees are negotiated fees that stipulate a specific dollar amount or a percentage of premiums (POP) collected by an insurer or payer source to cover the partial or complete healthcare services deliveries to a person. The fees are determined on a per capita basis paid monthly by managed care organizations. MCO enrollees may come from the integration or acquisition of healthcare providing entities, additional affiliated physicians, and acquire and increase enrollment in MCOs currently contracting with the Company through its Physician Practices and Ancillary Services, or from agreements with new MCOs. The Company intends to enter into MCO agreements, which generally will be for one-year terms, and subject to annual negotiation of rates, covered benefits and other terms and conditions. MCO agreements are often negotiated and executed in arrears.

The Company in the future may negotiate discounts for service arrangements with managed care companies. These arrangements would place no additional financial risk to the Company. In all cases, they are either negotiated flat, mutually agreed upon rates for covered services, usually calling for a discount of 30% from usual and customary charges, or a call for payment at a percentage of Medicare allowable rates (ranging from 70% to 150%).

OPPORTUNITY

We believe that the current environment in the healthcare industry is consistent with the Company's business plan. As physicians try to reverse what has been declining net revenues adjusted for inflation over the last 15 years, they will seek to outsource non-core competencies such as the services the Company intends to provide. We believe we can offer those services at a lower cost and with better results than the physician can achieve on the physician's own. This trend, if it continues, will benefit the Company's Consulting-Outsourcing operations. We also believe that with the projected growth in Medicare Advantage, as described above, MCOs will be even more likely to contract with third-party organization such as our RHS to bring them and then manage Medicare Advantage members. If this trend materializes as expected this would materially benefit RHS. Lastly, as both the trends discussed above, we believe that with the proper and smart use of technology and new systems the industry and both of the Company's operations in Outsourcing-Consulting and Services will benefit from the use of the technology QMT is anticipated to bring to the Company. In addition, QMT services as those of RHS and QTUM can and will stand on their own.

COMPETITION

The healthcare industry is highly competitive and is subject to continuing changes in the provision of services and the selection and compensation of providers. The Company will compete with numerous national, regional and local companies in providing services, products and technology. Excluding individual physicians and small medical groups, all of the Company's competitors are larger and better capitalized and may have longer established relationships with buyers of such services.

EMPLOYEES

As of February 1, 2005, the Company had 9 full-time employees employed at the Company's executive offices. No employees of the Company are covered by a collective bargaining agreement or are represented by a labor union. The Company considers its employee relations to be excellent.

RECENT CORPORATE EVENTS

During the summer of 2004, the Company leased a new facility to house its corporate office. The 2,750 square foot facility was remodeled and equipped at a cost of $55,000. The new facility is capable of providing work space for 15 employees. It is anticipated that the Company will need to seek larger facilities before the end of 2005.

GOVERNMENT REGULATION

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

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

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

Certain provisions of the Social Security Act, commonly referred to as the "Anti-Kickback Statute," prohibit the offer, payment, solicitation or receipt of any form of remuneration in return for the referral of Medicare or state health program patients or patient care opportunities, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered by Medicare or state health programs. The Anti-Kickback Statute is broad in scope and has been broadly interpreted by courts in many jurisdictions. Read literally, the statute places at risk many business arrangements, potentially subjecting such arrangements to lengthy, expensive investigations and prosecutions initiated by federal and state governmental officials. Violation of the Anti-Kickback Statute is a felony, punishable by significant fines and/or imprisonment. In addition, the Department of Health and

Human Services may impose civil penalties excluding violators from participation in Medicare or state health programs.

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

Congress, in the Omnibus Budget Reconciliation Act of 1993, enacted significant prohibitions against physician referrals. These prohibitions, commonly known as "Stark II," amended prior physician self-referral legislation known as "Stark I" by dramatically enlarging the field of physician-owned or physician-interested entities to which the referral prohibitions apply.

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

RISK FACTORS

FORWARD LOOKING STATEMENTS

The discussion in this report regarding our business and operations includes "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1996. Such statements consist of any statement other than a recitation of historical fact and can be identified by the use of forward-looking terminology such as "may," "expect," "anticipate," "intend," "estimate" or "continue" or the negative thereof or other variations thereof or comparable terminology. The reader is cautioned that all forward-looking statements are speculative, and there are certain risks and

uncertainties that could cause actual events or results to differ from those referred to in such forward-looking statements. This disclosure highlights some of the important risks regarding our business. The number one risk of the Company is its ability to attract fresh and continued capital to execute its comprehensive business plan. In addition, the risks included should not be assumed to be the only things that could affect future performance. Additional risks and uncertainties include the potential loss of contractual relationships, changes in the reimbursement rates for those services as well as uncertainty about the ability to collect the appropriate fees for services provided by us. Also, the Company faces challenges in technology development, deployment and use, medical malpractice exposure and the fluctuation of medical costs vs. medical payments. The Company may also be subject to disruptions, delays in collections, or facilities closures caused by potential or actual acts of terrorism or government security concerns.

- Dilution and Exposure Relating to Recent Shareholder Vote

The Company issued 13,300,000 shares of common stock and 200,000 shares of Series A preferred stock to acquire the remaining 80% of Renaissance Health Systems and Quantum Medical Technologies from the majority shareholder of those companies. The majority shareholder had granted 7,175,000 options at $.001 to purchase shares held by Mr. Guilllama. The shareholders of RHS and QMT are beneficial shareholders of the Company, including all executive officers and directors. Therefore, this is clearly not an arms-length transaction; however, management feels it is in the best interest of the Company's current and future shareholders by widely expanding the business strategy, acquiring letters of intents in place and by eliminating distractions from management. As a result of this action and the approval by the board of directors, the Company could face scrutiny by regulators, SEC and IRS; and further could face complaints and/or lawsuit from dissident minority shareholders. In potential offset, the Chairman has proposed to the Board that he will allow restrictions on the shares he would receive in this consolidation to serve as collateral for any successful claims made on anyone as it specifically relates to this transaction. The Company does

not have any reason to believe that anyone would object, however if someone objects and successfully wins in a claim against the Company, the Company may not have the resources to defend or prevail is such actions.

- Need for Substantial Additional Financing

There can be no assurance that the Company will be able to obtain additional financing if, and when, it is needed on terms the Company deems acceptable. The inability of the Company to obtain additional financing would have a material adverse effect on the Company's ability to implement its business, and as a result, could require the Company to diminish or suspend activities.

- Dependence on MCO Agreements; Capitated Nature of Revenues; Control of Healthcare Costs

The Company intends to have a substantial part of its revenues derived from agreements with Managed Care Organizations ("MCOs") that provide for the receipt of capitated fees. Capitated fees are a negotiated percentage of total premiums collected by an insurer or payer source to cover the partial or complete healthcare services deliveries to a person. The fees are determined on a per capita basis paid monthly by managed care organizations. MCO enrollees may come from the integration or acquisition of healthcare providing entities, additional affiliated physicians and acquire and increase enrollment in each contract/region serviced by the Company. The Company intends to enter into MCO

agreements, which generally will be for one-year terms, and subject to annual negotiation of rates, covered benefits and other terms and conditions. MCO agreements are often negotiated and executed in arrears. There can be no assurance that such agreements will be entered into, or renewed, or if entered into and/or renewed that they will contain these favorable reimbursement terms to the Company and its affiliated providers. There can be no assurance that the Company will be successful in identifying, acquiring and integrating MCO entities or in increasing the number of MCO enrollees. Once acquired, a decline in enrollees in MCOs could also have a material adverse effect on the Company's profitability.

Under the MCO agreements the Company, through its affiliated providers, will generally be responsible for the provision of all covered hospital benefits as well as outpatient benefits regardless of whether the affiliated providers directly provide the healthcare services associated with the covered benefits. To the extent that enrollees require more care than is anticipated or require supplemental healthcare, which is not otherwise reimbursed by the MCO, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of enrollees. If revenue is insufficient to cover costs, the Company's operating results could be adversely affected. As a result the success of the Company will depend in large part on the effective management of healthcare costs through various methods, including utilization management, competitive pricing for purchased services and favorable agreements with payers. Recently many providers have experienced pricing pressures with respect to negotiations with MCOs. There can be no assurance that these pricing pressures will not have a material adverse impact on the operating results of the Company. Changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters and numerous other factors affecting the delivery and cost of healthcare are beyond the control of the Company and may adversely affect its operating results.

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

The MCO agreements often contain shared-risk provisions under which additional revenue can be earned or economic penalties can be incurred based

upon the utilization of hospital physicians and ancillary services by MCO enrollees. These estimates are based upon resource consumption, utilization and associated costs incurred by MCO enrollees compared to budgeted costs. Differences between actual contract settlements and amounts estimated as receivable or payable relating to MCO risk-sharing arrangements are generally

reconciled annually, which may cause fluctuations from amounts previously accrued. See "Business".

- Reductions in Third-Party Reimbursement

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

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

- Risks Associated with Development of Management Information Systems; Dependence on Major Customers for Management Information Systems

The Company's management information systems will be an important component of the business. The Company is participating in the development of an integrated management information system. This would be designed to provide centralized billing, permit the review of a patient's electronic medical records and information on practice guidelines, monitor utilization, and measure patient satisfaction and outcomes of care. The development and implementation of such systems involve the risk of unanticipated delay and expense, and there can be no assurance that the Company will be successful in implementing the integrated management information system. The Company has no active information system installed currently, and may seek to outsource all management system functions to a third party.

- Exposure to Professional Liability; Liability Insurance

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

- Competition

The healthcare industry is highly competitive and subject to continual changes in the method in which services are provided and the manner in which healthcare providers are selected and compensated. Companies in other healthcare industry segments, some of which have financial and other resources greater than we do, may become competitors in providing similar services. Our principal

competitors include Metropolitan Health Networks, Inc. (a company that our CEO and CFO jointly co-founded) Continucare, Primary Care Specialists and First Consulting Group, WebMD, Z Consulting. Our strength, in comparison with our competitors, is our knowledge, understanding, and experience in managed care risks, information technology and systems development.

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

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

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

- HIPAA

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

The new protections give patients greater access to their own medical records and more control over how their personal information is used by their health plans and healthcare providers. Consumers are required to receive a notice explaining how their health plans, doctors, pharmacies and other

healthcare providers use, disclose and protect their personal information. Consumers now have the ability to see and copy their health records and to request corrections of any errors included in their records. Consumers may file complaints about privacy issues with their health plans or providers or with the Office for Civil Rights.

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

- Healthcare Reform

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

- Control by Management and Present Shareholders of the Company

As of October 31, 2004, Mr. Guillama and his family control approximately 79.0%, of the Company's issued and outstanding Common Stock. The Officers and Directors of the Company collectively control 81.4% of the common shares of the Corporation. This effectively gives Mr. Guillama material control of the Company and with the ability to change the entire Board of Directors.

- Dependence on Key Personnel

Implementation of the Company's business strategy is largely dependent on the efforts of two senior officers, Noel J. Guillama, Chief Executive Officer, and Donald B. Cohen, Chief Financial Officer. The Company's operations are dependent to a great degree on the continued efforts of the President, Chief Executive and Operation Officer of the Company, Noel J. Guillama. Furthermore, the Company will likely be dependent on other senior management and the entire Board of Directors as the Company grows. Competition for highly qualified personnel is intense and the Company has very limited resources. The loss of any executive officer or other key employee, or the failure to attract and retain other skilled employees could have a material adverse impact upon the Company's business, operations or financial condition.

- Capital Needs May Have Dilutive Effect

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

- Shares Eligible for Future Sale

At October 31, 2004, the Company had 18,307,276 outstanding shares of common stock of which 17,997,388 are "restricted securities" and in the future

may be sold upon compliance with Rule 144 adopted under the Securities Act. Rule 144 provides that a person holding "restricted securities" for a period of two years may sell only an amount every three months equal to the greater of (a) one percent of the Company's issued and outstanding shares, or (b) the average weekly volume of sales during the four calendar weeks preceding the sale. A proposed rule that may be adopted by the Commission will reduce these two and three year periods to one and two years, respectively.

- Anti-Takeover Provisions

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

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

- Absence of Dividends

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

- The loss of a future agreement and the capitated nature of our future revenues could materially affect our operations.

Once operational, the majority of our revenues will come from agreements with managed care organizations that provide for the receipt of capitated fees. Capitated fees are negotiated fees that stipulate a specific dollar amount or a percentage of total premiums collected by an insurer or payer source to cover the partial or complete healthcare services deliveries to a person. We expect to enter into one-year and three-year term agreements that are renewable annually thereafter. These agreements may be terminated on short notice or not renewed on terms favorable to our affiliated providers and us. We may not be successful in obtaining additional MCO agreements or in increasing the number of MCO enrollees once we secure such agreements.

Under the MCO agreements the Company through its affiliated providers, generally will be responsible for the provision of all covered hospital benefits, as well as outpatient benefits, regardless of whether the affiliated providers directly provide the healthcare services associated with the covered benefits. To the extent that enrollees require more care than is anticipated, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of enrollees. If revenue is insufficient to cover costs, our operating results could be adversely affected. As a result, our success will depend in large part on the effective management of healthcare costs. Pricing pressures may have a material adverse effect on our operating results. Changes in healthcare practices, inflation, new technologies, and numerous other factors affecting the delivery and cost of healthcare are beyond our control and may adversely affect our operating results.

- The price of the Company's Common Stock could fall dramatically.

Due to the substantial number of shares that will be eligible for sale in the future, the market price of our common stock could fall if a publicly traded market develops, as a result of sales of a large number of shares of common stock in the market, or the price could remain lower because of the perception that such sales may occur.

These factors could also make it more difficult for us to raise funds through future offerings of our common stock. As of January 27, 2005, there were 18,659,238 shares of our common stock outstanding.

- 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 organization's products, services and/or technology. If we are unable to acquire and/or successfully integrate the acquisitions, this could have a material impact on our business model and/or development.

Consequently, we may not be successful in integrating acquired businesses or technologies and may not achieve anticipated revenue and 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 will suffer significantly.

- Developing our intellectual property may be subjected to infringement claims or may be infringed upon.

Our intellectual property will be important to our business. We could be subject to intellectual property infringement claims as the number of our competitors grows and the functionality of our applications overlaps with competitive offerings. These claims, even if not meritorious, could be expensive and divert management's attention from our operations. If we become liable to third parties for infringing their intellectual property rights, we could be required to pay a substantial damage award and to develop non-infringing technology, obtain a license or cease selling the applications that contain the infringing intellectual property.

- Limited release of information

Due to the highly competitive nature of the healthcare industry in Florida, the Company has taken a position that disclosing certain information like name of HMOs (under LOIs or contract), counties of service, detailed terms of contracts with these HMOs and/or strategic partnerships may be used by our competitors to our determent, therefore the Company intends to be as cautious as possible in press releases and public filings as not to divulge confidential and strategic corporate information, as such it will be hard to fully access the risk of the company's future development.

ITEM 2. DESCRIPTION OF PROPERTY

Our offices are located at 3460 Fairlane Farms Road, Suite 4, Wellington, Florida where the Company occupies approximately 2,750 square feet at a current monthly rent of $3,470 pursuant to a lease expiring July 14, 2007.

The Company's property is not leased from an affiliate.

ITEM 3. LEGAL PROCEEDINGS

None

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

The Company held a Special Meeting of the stockholders of The Company International, Inc. called by the Board of Directors on January 30, 2004, at 12230 Forest Hill Blvd., Conference Room One, Wellington, Florida. The Special Meeting was called to obtain stockholder approval of:

(1) The change of the state of incorporation of Transform Pack from Minnesota to Nevada through a merger with and into The Quantum Group, Inc., a Nevada company formed for that purpose, so that The Quantum Group becomes the surviving corporation;

(2) A 1-for-10 reverse split in the outstanding common stock of Transform Pack, which will be effected in the merger with The Quantum Group by exchanging one share of The Quantum Group for every ten shares of Transform Pack;

(3) An amendment to the Articles of Incorporation of Transform Pack to change the name of the corporation to The Quantum Group, Inc., which will be effected in the merger as a result of the Articles of Incorporation of The Quantum Group becoming the Articles of Incorporation of the surviving corporation;

(4) An amendment to the Articles of Incorporation of Transform Pack to increase the number of authorized shares of common stock from 40,000,000 to 170,000,000 and increase the number of authorized shares of preferred stock from 5,000,000 to 30,000,000, which will be effected in the merger as a result of the Articles of Incorporation of The Quantum Group becoming the Articles of Incorporation of the surviving corporation;

(5) An amendment to the Articles of Incorporation of Transform Pack to opt out of the application of business combination and control share

acquisition restrictions imposed under state law, which will be effected in the merger as a result of the Articles of Incorporation of The Quantum Group becoming the Articles of Incorporation of the surviving corporation;

(6) An amendment to the Articles of Incorporation of Transform Pack to allow the Board of Directors to remove a Director for cause, which will be effected in the merger as a result of the Articles of Incorporation of The Quantum Group becoming the Articles of Incorporation of the surviving corporation; and

(7) The 2003 Incentive Equity & Option Plan adopted by the Board of Directors of Transform Pack on October 2, 2003.

All items before the shareholders all passed consecutively with 27,000,000 votes for and none against.

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PART II

ITEM 5. MARKET FOR COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

CAPITALIZATION OF COMPANY

Post re-organization, the Company has 200,000,000 shares authorized; of which, 170,000,000 are common shares with a par value of $0.001; and 30,000,000 are undesignated preferred shares with a par value of $0.001. As of January 27, 2005 there are 18,659,238 common shares and 200,000 preferred shares issued.

COMMON STOCK

The holders of Common Stock are entitled to one vote for each share held of record on all matters to be voted on by stockholders. There is no cumulative voting with respect to the election of directors with the result that the holders of more than 50% of the shares voted for the election of directors and can elect all of the directors. The holders of Common Stock are entitled to receive dividends, when, and if, declared by the Board of Directors out of funds legally available. In the event of liquidation, dissolution or winding up, the holders of Common Stock are entitled to share ratably in all assets remaining available for distribution to them after payment of liabilities and after provision has been made for each class of stock, if any, having preference over the Common Stock. Holders of shares of Common Stock, as such, have no conversion, preemptive or other subscription rights, and there are no redemption provisions applicable to Common Stock. All of the outstanding shares of Common Stock, and the shares of Common Stock offered hereby, will be, duly authorized,

validly issued, fully paid and non-assessable.

The Company currently believes it has approximately 710 beneficial shareholders of record.

PREFERRED STOCK

We are authorized to issue 30,000,000 shares of Preferred Stock with such designation, rights and preferences as may be determined from time to time by the Board of Directors. Accordingly, the Board of Directors is empowered, without stockholder approval, to issue Preferred Stock with dividend, liquidation, conversion, voting or other rights that could adversely affect the voting power or other rights of the holders of the Common Stock. In the event of issuance, the Preferred Stock could be utilized, under certain circumstances, as a method of discouraging, delaying or preventing a change in control. In August 2004, the Company issued 200,000 special Series A-1 preferred to the majority shareholder of the Company as part of the transaction to acquire Quantum Medical Technologies, Inc., and Renaissance Health Systems, Inc. The shares are convertible into 30 shares of common stock after four years at the option of holder.

(a) Market Information

As of the fiscal year ended October 31, 2004, our common stock was quoted on the Over-The- Counter Bulletin Board Trading System ("OTCBB") under the symbol "QTUM". Until February 6, 2004, our common stock trade under the symbol TPII.

The price range per share reflected in the table below is the high and low bid quotation for our common stock and reflects all stock splits affected by the Company.

Quarter	High	Low
Fiscal Year Ended October 31, 2003		
1st Quarter 2003	$ 1.30	$ 0.20
2nd Quarter 2003	$ 1.50	$ 0.70
3rd Quarter 2003	$ 1.60	$ 0.20
4th Quarter 2003	$ 1.60	$ 0.70
Fiscal Year Ended October 31, 2004		
1st Quarter 2004	$ 1.30	$ 0.60
2nd Quarter 2004	$ 1.00	$ 0.04
3rd Quarter 2004	$ 1.50	$ 0.55
4th Quarter 2004	$ 1.05	$ 0.75

Trading in our common stock on the OTCBB market 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, mark-down or commissions and may not represent actual transactions.

We have never declared or paid any cash dividends on our common stock. We currently intend to retain future earnings, if any, to finance the expansion and growth of our business and do not expect to pay any cash dividends in the

foreseeable future. Payment of future cash dividends, if any, will be at the discretion of our board of directors after taking into account various factors, including our financial condition, operating results, current and anticipated cash needs, plans for expansion and other factors considered relevant by our Board of Directors.

(b) Holders

The Company believes that there were approximately 710 beneficial shareholders of record of our common stock as of October 31, 2004.

(c) Dividends

The Company has not paid any dividends on its common stock nor does the Company anticipate paying any dividends in the foreseeable future. All earnings, if any, will be reinvested in the Company.

(d) Recent sale of Unregistered Securities:

The following information is furnished with regard to all securities sold by us since inception that were not registered under the Securities Act. The issuances described hereunder were made in reliance upon the exemptions from registration set forth in Section 4(2) of the Securities Act or Regulation D, Rule 506 of the Securities Act. None of the foregoing transactions involved a distribution or public offering.

During the period July through December 2004, the Company sold 1,378,905 shares of common stock to foreign investors for an average sale price of $0.275 per share under an agreement the Company signed with an investment group. Each investor represented to us that the investor was not a "U.S. Person", as defined under Regulation S of the 1933 Act. The shares were issued as restricted shares under the 1933 Act and were endorsed with a restrictive legend. The Company realized net proceeds, after commissions, approximately $330,000. The Company issued another 68,904 shares of common stock as additional commission and 199,170 warrants to purchase common stock at a price of $.275 per share expiring January 4, 2010. Shares were issued to 150 investors.

On June 4, 2004, the Company received a loan for $30,000 from an accredited investor. On August 26, 2004, the Company issued 300,000 restricted common shares exempt from registration, under Rule 144, to satisfy this obligation.

Transfer Agent

The Transfer Agent for our shares of Common Stock is Fidelity Transfer Company, Salt Lake City, Utah.

ITEM 6 MANAGEMENT'S PLAN OF OPERATIONS

RISK FACTORS

FORWARD-LOOKING STATEMENTS AND ASSOCIATED RISKS

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. The reader is cautioned that all forward-looking statements are speculative, and there are certain risks and uncertainties that could cause actual events or results to differ from those referred to in such forward-looking statements. This disclosure highlights some of the important risks regarding our business. The number one risk of the Company is its ability to attract fresh and continued capital to execute its comprehensive business plan. In addition, the risks included should not be assumed to be the only things that could affect future performance. Additional risks and uncertainties include the potential loss of contractual relationships, changes in the reimbursement rates for those services as well as uncertainty about the ability to collect the appropriate fees for services provided by us. Also, the Company faces challenges in technology development, attracting competent personnel, deployment and use, medical malpractice exposure and the fluctuation of medical costs vs. medical payments. The Company may also be subject to disruptions, delays in collections, or facilities closures caused by potential or actual acts of terrorism or government security concerns.

GOING CONCERN

The Company is a development stage company that over the last three years has expensed material sums in creating procedures, manuals and systems to assist the medical community in the implementation of medical regulations. Though the Company has materially finished developing its training programs, additional updates and deployment will be required. The Company has completed creating a Community Health System (medical delivery network) in Northern Florida and has been negotiating an MCO contract as well as creating two websites for medical societies.

As shown in the accompanying condensed financial statements, the Company has incurred recurring losses and negative cash flows from its development and organization activities and has negative working capital and shareholders' deficit. Under normal conditions, these conditions raise substantial doubt about the Company's ability to continue as a going concern.

There can be no assurance that the Company will be able to successfully implement its plans to generate additional investor interest and raise additional capital, or if such plans are successfully implemented, that the Company will achieve its goals.

Furthermore, if the Company is unable to raise additional funds, it may be required to modify its growth and developmental plans, and even be forced to severely limit development operations completely.

The accompanying consolidated financial statements have been prepared assuming that the Company will continue as a going concern and do not include any adjustments to reflect the possible future effects of the recoverability and classification of assets or the amounts and classification of liabilities that might result from the outcome of this uncertainty. See "Liquidity and Capital Resources," below.

MANAGEMENT'S PERSPECTIVE AND DEVELOPMENT PLAN FOR THE FISCAL YEAR ENDING OCTOBER 31, 2005

The Company is a development stage company and has no current revenues. The Company has raised a total of approximately $856,000 to date, approximately $180,000 from loans and stock purchases from our Chairman and approximately $676,000 from convertible loans and the sale of stock to others. As of February 1, 2005 management's efforts have been primarily in market research, creating a business model, investigating best practices, business development, negotiations of various Letters of Intent and due diligence on potential acquisitions/joint ventures and licensing agreements. It has developed HIPAA compliance manuals and a training material. The Company has created an interactive educational compact disk in conjunction with a public university in Florida. The Company has recently completed developing its first CHS. It has secured two medical associations to provide web services and is in negotiations with several others. The Company has acquired a Health Information Platform currently undergoing upgrades.

In the Company's business model we seek to become a leading provider of services to the healthcare industry in three complementary areas. Those include: outsourcing administrative responsibilities for physicians, Managed Care Organizations, healthcare facilities, physician associations; developing new technologies to create a more effective and responsive healthcare system; and providing leading edge healthcare services to consumers.

In developing this mode further, the Company purchased 20% interest from our Chairman and major shareholder in two companies which he was developing. These companies are Quantum Medical Technologies, Inc ("QMT") (a Florida corporation) and Renaissance Health Systems, Inc. ("RHS") (a Florida corporation). These agreements were not negotiated at arm's length and no independent valuation was made. Both QMT and RHS are also development stage companies. In both cases each company has a Letter of Intent (LOI) to develop products and services with institutions in the healthcare field; however the capital has not been secured at this time to exploit these opportunities. Management believes that with a more complex and complementary model the Company is more likely to obtain financing that in the end will produce results for shareholders. At a Special Meeting of the shareholders held on January 30, 2004 the majority of the shareholders agreed to issue 13,300,000 post reverse shares and 200,000 Series A Preferred Stock (subsequently added to the purchase price by the Board of Directors on July 19, 2004) to the majority shareholder of the Company, Mr. Guillama, of both QMT and RHS for the 80% of each of those companies. Mr. Guillama had previously granted 7,175,000 options exercisable at $.001 per share on the shares he owned in the two Companies. 1,000,000 options are held by an affiliate of Mr. Guillama, 2,180,000 are held by Directors of the Quantum Group and 3,995,000 are held by non affiliates. As of October 31, 2004, 965,000 options were exercised leaving Mr. Guillama with a direct and beneficial ownership of approximately 79% of the issued and outstanding shares of the Company. Control in the Company will not material change, since all the shareholders in numbers and relative beneficial ownership of both QMT and RHS are also material and beneficial owners of the common share of the Company today. The final merger was completed in August 2004.

Upon completion of the acquisition, the Company is now organized in three key operating divisions consisting of:

>> THE QUANTUM GROUP, as the parent company, will provide outsourcing to physicians and healthcare organizations. Our services will include: privacy consulting, human resources management, managed care contracting, government compliance, financial management, facilities management, venture management, and healthcare venture/merchant banking. The Company has identified potential acquisitions to give it a

core group of services, such as medical billing and collections, consulting and financial services.

>> QUANTUM MEDICAL TECHNOLOGIES (QMT). The QMT team has spent 4 years in the development of technology systems to increase the efficiency of the healthcare system. The Company has in development process three PATENT PENDING business processes. In addition, the Company also provides webservices to medical societies and is currently developing a web-based health information platform to use both internally and market to non-affiliated physicians.

>> RENAISSANCE HEALTH SYSTEMS (RHS). RHS is organized as a new breed, next generation Community Health System (CHS), contracting with Florida Managed Care Organizations (MCOs) to manage the care of patients in a proactive and cost effective environment. RHS has secured an agreement with one Florida MCO, and is currently in final negotiations with two other Florida-based MCOs.

We are focusing all our efforts on reaching and selling our services to medical practices and businesses with annual revenues in the $500,000 to $20,000,000 range. We believe that this is a highly underserved market, and when these businesses receive consulting services they are in a fragmented, sporadic and inefficient manner.

We expect to use a portion of any capital available that the Company raises to invest in designing solutions to enable clients to reap the benefits of their investments in new systems and information technology by improving financial performance, increasing productivity, and improving clinical and operational performance.

From education, visioning and planning, to implementation and outsourcing, the Company intends to provide the following specific services and solutions that are designed to help client organizations perform better:

>> Government Compliance
- o HIPAA
- o Medicare
- o Medicaid
- o HMO/PPO

>> Managed Care
- o Contract negotiations
- o Auditing
- o Business development
- o MSO development
- o IPA development

>> Financial Management
- o Billing Services
- o Collection services
- o Payroll services
- o Accounts receivable financing
- o Equipment Financing
- o Executive lines of credit

>> Information Technology
- o Website development
- o Information management
- o ASP services
- o Secure Communications

- Business Process Management

>> Human Resource Services
- Full medical office management
- Facilities management
- Employee management
- Placement services
- Personnel training

>> Business Venture Management

>> Healthcare Merchant Banking Services

QUANTUM MEDICAL TECHNOLOGIES, INC. - TECHNOLOGY

QMT expects in the coming year to continue to work on developing and enhancing its current patent pending business processes. The first is branded as Cybernaptic (sm), connecting all the `touch points' of healthcare in one ASP based system. The clients of QMT will be able to choose any combination of support, including full outsourcing with data center consolidation, 24/7/365 network monitoring and help desk through a to-be-developed network control center, as well as facility management, application unification, application outsourcing and interim management of their entire IT operations for healthcare facilities. The Company has also begun to develop a new method to track patient's improvement in their healthcare/lifestyle in a patent pending process called QuantumQuotient (sm) or Qx2 (sm) . The Company is exploring validation by a major research university in the U.S. If the current expectations are met, this product could have a material effect on behavior and controlling medical cost. In addition the Company is also exploring developing a web-based marketplace for diagnostic services that is in a patent pending business process.

The Company has executed two agreements with medical associations that show great promise, in the development and operation of a complete website and secure information between member and other member and their patients. These first two medical societies collectively have 2000 active physician members. We seek to develop this relationship and produce revenues by the end of the year.

The Company is currently in discussion with four separate companies that have foreign healthcare technology with application in the US and with US companies that have technology that is used in other industries with healthcare applications. The Company expects that a portion of any money secured by the Company will go towards development of these technologies or relationships. These products include the secure transfer of medical records over the Internet, secure verifiable clearing of medical transactions, HIPAA compliant email and instant messaging, all to be included in a QuantumSuites (SM) packaging. We expect with the development of this QuantumSuite (SM) of products we will begin to receive revenues by the end of the year.

QMEDSELECT SM

In December 2004, the Company purchased an Application Service Provider Platform (ASP) from a Florida based Limited Liability Corporation. This product has been previously certified in a Microsoft based platform. The Company has secured contracted programmers to debug the software program and anticipates beta-testing mid-2005. In conjunction with this acquisition, the Company has been accepted into the Microsoft ISV program and anticipates Microsoft partner recognition during 2005. The Company anticipates that it will need $500,000 over the balance of the year to complete redevelopment of the platform and begin beta testing. The Company anticipates revenues from this product late in 2005.

RENAISSANCE HEALTH SYSTEMS, INC. - SERVICES

RHS's model shows great promise in the short term for revenues and profitability of the Company. Therefore management will allocated a greater portion of all moneys raised in the Company's Plan to its development. The RHS strategy is to create a new type of healthcare delivery system built on the extensive experience of our management team. We intend to specialize in managed care Percentage of Premium (POP) contracting. RHS expects to create a new model for healthcare called a Community Health System (CHS).

Our RHS business model is unique and based on educating, motivating and assembling physicians in groups that are prepared to assume managed care risk with professionals by their side. We envision expanding our Health System of physicians to provide our members healthcare services on an efficient and cost effective basis through strategic alliances with insurance companies and other healthcare providers on a statewide basis. Our model is based on a direct, proactive, involved participation with our real client, the members of our CHS program.

Under our proposed MCO agreement(s), RHS, through affiliated providers, is responsible for the provision of all covered benefits. While responsible for all medical expenses for each covered life, we intend to limit our exposure by obtaining reinsurance/stop-loss coverage. We also intend to capitate high volume specialties, fixing our cost on a per-member-per-month (PMPM) basis. Low volume providers will remain at a discounted fee-for-service basis.

Under our model, the physicians maintain their complete independence but are aligned with our professional staff to assist in providing cost effective quality medicine. Each primary care physician provides direct patient services as a primary care doctor including referrals to specialists, hospital admissions and referrals to diagnostic services and rehabilitation. In the future, we may seek to acquire, develop or partner with a number our providers in creating Company owned medical centers of excellence that will serve as our model facilities.

We intend to use the Internet extensively, with available and to-be-developed applications, to help process referral claims between the Health System's primary care physicians and specialists and to communicate with patients. This process should help to reduce paperwork in the physician's office as well as provide a more efficient method for the patients in our Health System. Once developed, our utilization management team will communicate with the physicians on a daily basis to provide overall management of the patient.

We have executed a Letter of Intent (LOI) with a Florida MCO, which anticipates a formal contract in the near future. The terms of the LOI details that RHS will be responsible for arranging a Community Health System (CHS) in the Central Florida market place. The agreement calls for RHS to receive a percentage of premiums received by the MCO. Relating to this agreement, the Company is required to place $50,000 in a segregated bank account to start and increase this amount by 3% of the revenues generated by the agreement up to a total $1,000,000. The Company anticipates that if properly funded, this agreement will be generating $10,000,000 in revenues by December 1, 2005. The Company anticipates a formal agreement as soon as the Company is able to meet the capital requirements.

Use of Capital

The Company will need approximately $2.5-$3.5 million to implement its business plan over the next 12-18 months.

The first $1,000,000 in new capital will go towards the development and

completion of our second, third, fourth, and fifth CHS in the south Florida market, with approximately $500,000 going towards continued development of technology solutions. We expect to hire an additional 10 people to develop these networks on the ground and to create systems and protocols. As the Company's CHS business develops, the Company expects that it will have to increase the amount of reserves up to $500,000 over the following 12-18 months for a total of $1,000,000.

The Company expects to spend $500,000 to acquire a billing and collection company and further assumes certain obligations associated with that acquisition. With this acquisition, we expect to hire/acquire a minimum of 20 employees. In addition, we are likely to invest additional funds to update computers, technology and systems. We believe that identifying qualified candidates to staff these positions will not present a problem.

We expect to continue to expend resources in developing Cybernaptic (SM) and the Quantum Quotient (SM) solutions and utilize RHS for the trial, testing and deployment of these solutions. It is anticipated that this will cost from $100,000 to $300,000 in this initial phase, and will require the entire fiscal 2005 to complete. Revenues are not expected until fiscal year end 2005. We anticipate that the first trial of this new technology/system will be at RHS.

The balance of the funds needed will be used for working capital, legal, accounting, marketing and development of new markets within the state of Florida. If the additional capital is available, and the assumptions, contracts and relationship materialize as expected, the Company would expect to have 35 employees by October 31, 2005, generating run-rate revenues of $5-7 million per-year.

LIQUIDITY AND CAPITAL RESOURCES

The Company is a development stage company and has not generated any revenues during the prior year; therefore all our capital requirements will have to be raised through equity or debt financing. We will need approximately $2.5 to $3.5 million over the next 12 to 18 months to implement the Company's business plan.

As of October 31, 2004, we had cash of $35,968 and total assets of $125,175 as compared to $242 and $14,708 at October 31, 2003, respectively. We had current liabilities of $994,604 and $507,633 at October 31, 2004 and 2003, respectively.

At October 31, 2004 the Company had a working capital deficit of $958,636 as compared to a working capital deficit of $507,391 at October 31, 2003. The Company's expenses representing net loss for the year ended October 31, 2004 was $1,119,986 as compared to $246,555 for the year ended October 31, 2003. The increase of $873,431 was primarily due the increase in personnel costs due increase in staffing. Without a significant infusion of capital or revenues from proposed operations, it is unlikely that we will be able to sustain operations or implement our business plan.

Since its inception, the Company has been dependent upon the receipt of capital investment and loans to fund its continuing activities. In addition to the normal risks associated with a new business venture, there can be no assurance that the Company's business plan will be successfully executed. In addition, the responsibilities of a public company will require the Company to meet certain legal and accounting requirement that will stress any capital

available.

There can be no assurances that the Company, even with adequate equity financing, will be able to successfully implement its plans, or if such plans are successfully implemented, that the Company will achieve sustained profitability. Furthermore, if the Company is unable to raise adequate funds, it may be forced to terminate business activity partially or completely.

There can be no assurance that sufficient financing will be obtained to keep the company operating over the next twelve months. Nor can any assurance be made that the Company will generate substantial revenues or that the business operations will prove to be profitable. These conditions raise substantial doubt about the Company's ability to continue as a going concern. The accompanying financial statements reflect ongoing losses, negative cash flows from operating activities, negative working capital and shareholders' deficit. The financial statements do not include any adjustments that might result from the outcome of these uncertainties.

ITEM 7. FINANCIAL STATEMENTS

The financial statements required pursuant to this item are filed under Part III, Item 13(a) (1) of this report. The financial statement schedule required under Item 310 (a) of Regulation S-B is filed under Part III, Item 13 (a) (2) of this report.

ITEM 8. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None

ITEM 8A. CONTROLS AND PROCEDURES

The Company maintains disclosure controls and procedures, that are designed to ensure that information required to be disclosed in the Company's Securities Exchange Act reports is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to the Company's management, including its Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognized that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management necessarily was required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

Our Chief Executive Officer and Chief Financial Officer evaluated the effectiveness of the design and operation of the Company's disclosure controls and procedures for a Company of our size and simplicity. Based upon this evaluation, the Chief Executive Officer and Chief Financial Officer concluded that the disclosure controls and procedures are effective in ensuring that information required to be disclosed by the Company in the reports that it files or submits under the Securities and Exchange Act of 1934, as amended, is recorded, processed, summarized and reported within the time period specified by the Securities and Exchange Commission's rules and forms.

Additionally, there were no significant changes in the Company's internal controls that could significantly affect the Company's disclosure controls and procedures subsequent to the date of their evaluation, nor were

there any significant deficiencies or material weaknesses in the Company's internal controls. As a result, no corrective actions were required or undertaken.

Corporate Governance- Board of Directors

Election of Officers

Each director is elected at the Company's annual meeting of shareholders and holds office until the next annual meeting of stockholders or until the successors are qualified and elected. The Company's bylaws provide for not less than one (1) director. Currently there are six (6) directors in the Company; however, the Company will seek to elect at least one (1) additional outside director by the end of the fiscal year 2005. The bylaws permit the Board of Directors to fill any vacancy and such director may serve until the next annual meeting of shareholders or until his or her successor is elected and qualified. The bylaws also allow for removal of a director for cause as determined by the majority of the Board of Directors. The Board of Directors elects officers and their terms of office are, except to the extent governed by future employment contracts, at the discretion of the Board. Mr. Noel J. Guillama and Ms. Susan E. Darby are married. Other than as indicated above, there are no family relations among any officers or directors of the Company.

The Company has four committees: Audit, Executive, Compensation, and an Option Committee.

- The Audit Committee selects the independent auditors, reviews the results and scope of the audit and other services provided by independent auditors. It reviews and evaluates internal control functions. As an advisory function of the committee, members also participate in financings, review budgets prior to presentation to the Board of Directors and review budgets vs. act