PATIENT INFOSYSTEMS INC
Form 424B3
July 21, 2006
Filed Pursuant to Rule 424(b)(3), Registration Statement No. 333-134148

Dated July 20, 2006

PROSPECTUS

PATIENT INFOSYSTEMS, INC.

3,895,598 Shares of Common Stock

This prospectus relates to the sale of up to an aggregate of 3,895,598 shares of the common stock of Patient Infosystems which may be offered by the selling stockholders identified in this prospectus for their own account. Of such shares, 3,588,562 shares were outstanding as of July 18, 2006 and 307,036 shares are issuable upon exercise of warrants that we have issued to the selling stockholders.

The selling stockholders may offer and sell their shares on a continuous or delayed basis in the future. These sales may be conducted in the open market or in privately negotiated transactions and at market prices, fixed prices or negotiated prices. We will not receive any of the proceeds from the sale of shares by the selling stockholders, but we will receive funds from the exercise of their warrants. The selling stockholders and the participating brokers or dealers may be deemed to be underwriters within the meaning of the Securities Act, in which event any profit on the sale of shares by the selling stockholders, and any commissions or discounts received by the brokers or dealers, may be deemed to be underwriting compensation under the Securities Act.

Our common stock is currently listed on the OTC Bulletin Board under the symbol PATY. On July 17, 2006, the last reported sale price of our common stock on the OTC Bulletin Board was $1.09 per share.

Investing in our common stock involves risks. Please read and carefully consider the Risk Factors beginning on page 9 of this prospectus before making a decision to purchase shares of our common stock.

NEITHER THE SECURITIES AND EXCHANGE COMMISSION NOR ANY STATE SECURITIES COMMISSION HAS APPROVED OR DISAPPROVED OF THESE SECURITIES OR PASSED UPON THE ADEQUACY OR ACCURACY OF THIS PROSPECTUS. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

The date of this prospectus is July 20, 2006

No dealer, salesperson or other person has been authorized to give any information or to make any representations other than those contained in this prospectus, and if given or made, such information or representations must not be relied upon as having been authorized by us, the selling stockholders or any underwriter. You should rely only on the information contained in this prospectus. This prospectus does not constitute an offer to sell or the solicitation of an offer to buy any security other than the common stock offered by this prospectus, or an offer to sell or a solicitation of an offer to buy any security by any person in any jurisdiction in which such offer or solicitation would be unlawful. Neither the delivery of this prospectus nor any sale made hereunder shall, under any circumstances, imply that the information in this prospectus is correct as of any time subsequent to the date of this prospectus.

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SUMMARY

You should read this summary together with the more detailed information, including our financial statements and related notes and the pro forma statement of operations and related notes, appearing elsewhere in this prospectus. Unless otherwise stated or required by the context, in this prospectus when we use the terms we, us, our company, CareGuide or Patient Infosystems we are referring to Patient Infosystems, Inc. a its subsidiaries.

Patient Infosystems, Inc.

Patient Infosystems, Inc. was incorporated in the State of Delaware on February 22, 1995 under the name DSMI Corp., changed its name to Disease State Management, Inc. on October 13, 1995, and then changed its name to Patient Infosystems, Inc. on June 28, 1996. Our principal executive offices are located at 12301 N.W. 39th Street, Coral Springs, Florida 33065, and our telephone number is (954) 796-3714. Our Internet addresses are www.careguide.com and www.ptisys.com. The information contained on our websites does not constitute part of, nor is it incorporated by reference into, this prospectus. We became a public company on December 26, 1996 upon the consummation of our initial public offering. Our common stock is traded on the Over-The-Counter Bulletin Board under the stock ticker symbol PATY.

Pursuant to an Agreement and Plan of Merger dated September 19, 2005, as amended on November 22, 2005 and December 23, 2005 (as so amended, the Merger Agreement) by and among Patient Infosystems, Inc., PATY Acquisition Corp., a wholly-owned subsidiary of Patient Infosystems, Inc. (Merger Sub) and CCS Consolidated, Inc. (CCS Consolidated), Merger Sub merged with and into CCS Consolidated (the Merger), and CCS Consolidated became a wholly-owned subsidiary of Patient Infosystems, Inc. CCS Consolidated is a national care management company providing higher-risk and elderly care management services to health plans, work/life benefits companies and self-funded employers. The Merger closed and became effective on January 25, 2006. Patient Infosystems, Inc. and its subsidiaries collectively do business under the name CareGuide. Our board of directors has approved an amendment to our certificate of incorporation to change our name to CareGuide, Inc., which amendment has not yet been approved by our stockholders.

At the closing of the Merger, we issued 43,224,352 shares of its common stock to the former stockholders of CCS Consolidated. This represented approximately 64% of our issued and outstanding voting shares upon the closing of the merger, and as a result there was a change of control of our company.

In addition, under a stockholders agreement entered into at the closing of the Merger, stockholders holding approximately 65% of the outstanding voting shares of our common stock after the consummation of the Merger have agreed to vote their shares in favor of the election of John Pappajohn, a director of our company prior to the Merger, Derace Schaffer, M.D., a director of our company prior to the Merger, and three individuals designated by holders of at least a majority of our common stock held by the former stockholders of CCS Consolidated who are parties to the stockholders agreement. The three new directors appointed after the Merger were Mark L. Pacala, Daniel C. Lubin and Albert S. Waxman, Ph.D. As provided by the stockholders agreement, two additional directors may be added to our board of directors, which individuals must be unanimously approved by the other five members of our board of directors. These additional directors have not yet been appointed as of the date of this prospectus.

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Because the former CCS Consolidated securityholders held approximately 63% of our fully diluted shares of common stock immediately following the Merger, CCS Consolidated s designees to our board of directors represent a majority of our directors and CCS Consolidated s executive management represent a majority of the executive management of the combined company, CCS Consolidated was deemed to be the acquiring company for accounting purposes and the transaction has been accounted for as a reverse acquisition under the purchase method of accounting for business combinations in accordance with generally accepted accounting principles in the United States. We have adopted March 31 as our fiscal year end, which was CCS Consolidated s fiscal year end.

Because the Merger between CCS Consolidated and Patient Infosystems was treated as a reverse acquisition for accounting purposes, the financial statements of the accounting acquirer, CCS Consolidated, became our historical financial statements. The financial statements included in this prospectus as of and for the year ended March 31, 2005 are those of CCS Consolidated only. The balance sheet included in this prospectus as of March 31, 2006 is a consolidated balance sheet of Patient Infosystems, Inc. and its subsidiaries after the Merger. The statement of operations and the statement of cash flows for the year ended March 31, 2006 included in this prospectus include the operations of CCS Consolidated only for the period from April 1, 2005 to January 24, 2006 and include the combined operations of Patient Infosystems, Inc. and its consolidated subsidiaries, including CCS Consolidated, for the period beginning with the merger completion date of January 25, 2006 through March 31, 2006.

On September 22, 2004, we acquired 100% of CBCA Care Management, Inc., or CMI, a New York corporation. CMI provides case and utilization management services primarily to self insured employers and health and welfare funds. We have sold case and utilization management services since 2000 and until 2004 outsourced the operations to CMI. We intend to continue to market case and utilization management services.

On December 31, 2003, we acquired the assets of American Caresource Corporation and formed American Caresource Holdings, Inc., or ACS, to operate those assets. ACS provides ancillary benefits management services, including a network of ancillary specialty providers and value-added services that assist its clients in controlling the cost of a range of ancillary medical services. On December 16, 2005, we distributed approximately 12 million shares of common stock of ACS as a dividend to our stockholders and retained approximately 300,000 shares of ACS, of which we closed on the sale of 88,525 shares on December 30, 2005. Following the spin-off of ACS shares, ACS became an independent public company with its own management and board of directors. Two of our directors, John Pappajohn and Derace Schaffer, also serve as directors of ACS.

The Offering

Shares of common stock offered	Up to 3,895,598 shares, assuming full exercise of warrants.
Terms of the offering	The selling stockholders will determine how and when they will sell the common stock offered by this prospectus. See Plan of Distribution.
Use of Proceeds	We will not receive any proceeds from the sale of the common stock offered by the selling stockholders. However, if all of the warrants are fully exercised for cash, we may receive up to approximately $460,554 from the warrant holders. We will use such funds, if any, for working capital and general corporate purposes.
OTC Bulletin Board Symbol	PATY

Selected Summary Historical and Pro Forma Financial Data

The following tables present summary historical condensed consolidated financial data for each of Patient Infosystems, Inc. after the Merger (f/k/a CCS Consolidated, Inc.) and Patient Infosystems, Inc. prior to the Merger, as well as summary condensed combined pro forma financial data. As described elsewhere in this prospectus, because the Merger was treated as a reverse acquisition for accounting purposes, the financial statements of the accounting acquirer, CCS Consolidated, became our historical financial statements.

Selected Summary Historical Financial Data of Patient Infosystems, Inc. f/k/a CCS Consolidated, Inc.

The following table sets forth summary historical condensed financial data of Patient Infosystems, Inc. and its subsidiaries (f/k/a CCS Consolidated, Inc.). The condensed consolidated statements of operations data for the fiscal years ended March 31, 2006 and March 31, 2005 have been derived from our audited financial statements, which are included in our Annual Report on Form 10-KSB for the year ended March 31, 2006.

You should read this information in conjunction with our financial statements, including the related notes, and Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this prospectus.

Patient Infosystems, Inc. and Subsidiaries (f/k/a CCS Consolidated, Inc.)
Condensed Consolidated Statement of Operations Data

(In thousands, except per share data)	**Years Ended March 31,**	
	2006	**2005**
Revenues:		
Capitation revenue	$ 39,508	$ 56,764
Administrative and fee revenue	15,186	9,473
Total revenues	54,694	66,237
Cost of services direct service costs	47,331	62,540
Gross profit	7,363	3,697
Operating costs and expenses:		
Selling, general and administrative expense	6,873	8,332
Depreciation and amortization	1,484	1,356
Total operating costs and expenses	8,357	9,688
Operating loss	(994)	(5,991)
Other expense, net	(1,173)	(65)
Loss from continuing operations before income taxes	(2,167)	(6,056)
Income tax benefit (expense)	(54)	91
Loss from continuing operations	(2,221)	(5,965)
Income (loss) from discontinued operations	290	(524)
Net loss	(1,931)	(6,489)
Accretion of preferred stock	(125)	(152)
Net loss attributable to common stockholders	$ (2,056)	$ (6,641)

	Years Ended March 31,	
	2006	**2005**
Net (loss) income attributable to common stockholders per share basic and diluted:		
Loss from continuing operations	$ (0.13)	$ (0.74)
Discontinued operations	0.02	(0.06)
Net loss	$ (0.11)	$ (0.80)
Weighted average common shares outstanding	18,814	8,256

Consolidated Balance Sheet Data	**March 31, 2006**
(In thousands)	
Cash and cash equivalents	$ 8,399
Current assets	19,209
Property and equipment, net	1,511
Intangible and other assets, net	4,219
Goodwill	28,666
Restricted cash, non-current	618
Total assets	54,223
Current liabilities	17,188
Long-term liabilities	8,328
Total stockholders equity	28,707

Selected Summary Historical Financial Data of Patient Infosystems, Inc. prior to the Merger

The following table sets forth summary historical financial data for Patient Infosystems, Inc. prior to the Merger. The consolidated statements of operations data for the fiscal years ended December 31, 2005 and December 31, 2004 have been derived from our audited financial statements, which are included in our Annual Report on Form 10-KSB for the year ended December 31, 2005. This financial data includes financial data related to ACS, a subsidiary that we spun off in a transaction which took the form of a dividend to our stockholders and which was effective on December 16, 2005.

PATIENT INFOSYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS DATA
YEARS ENDED DECEMBER 31, 2005 AND 2004

	2005	**2004**
REVENUES	$ 11,056,526	$ 9,699,325
COSTS AND EXPENSES:		
Cost of revenue	8,213,711	6,688,533
Sales and marketing	1,484,984	1,078,354
General and administrative	2,301,836	1,602,134
Research and development	145,396	130,443
Total costs and expenses	12,145,927	9,499,464
OPERATING (LOSS) INCOME	(1,089,401)	199,861
Gain on investment	63,249	
Debt financing costs	(1,689,244)	(812,630)
Interest expense	(270,421)	(126,828)
Other income	29,025	4,527
NET LOSS FROM CONTINUING OPERATIONS	(2,956,792)	(735,070)
LOSS FROM DISCONTINUED OPERATIONS OF ACS (includes $290,641 of expenses related to the distribution)	(2,419,522)	(2,831,238)
NET LOSS	(5,376,314)	(3,566,308)
CONVERTIBLE PREFERRED STOCK DIVIDENDS	(722,303)	(904,918)
NET LOSS ATTRIBUTABLE TO COMMON STOCKHOLDERS	$ (6,098,617)	$ (4,471,226)
NET LOSS PER SHARE - BASIC AND DILUTED FROM CONTINUING OPERATIONS	$ (0.33)	$ (0.21)
NET LOSS PER SHARE - BASIC AND DILUTED FROM DISCONTINUED OPERATIONS	$ (0.22)	$ (0.36)
NET LOSS PER SHARE - BASIC AND DILUTED	$ (0.55)	$ (0.57)
WEIGHTED AVERAGE COMMON SHARES OUTSTANDING	11,140,638	7,815,063

Consolidated Balance Sheet Data:	**December 31, 2005**
Cash and cash equivalents	$ 4,440,329
Current assets	7,430,438
Property and equipment, net	540,827
Intangible assets (including goodwill)	7,231,518

Total assets	15,202,783
Current liabilities	1,872,859
Total stockholders equity	13,329,924

Selected Unaudited Pro Forma Condensed Combined Statement of Operations Data

The following selected unaudited pro forma condensed combined statement of operations data was prepared using the purchase method of accounting. For accounting purposes, CCS Consolidated is considered to have acquired Patient Infosystems in the Merger. The CCS Consolidated and Patient Infosystems unaudited pro forma condensed combined statement of operations data for the year ended March 31, 2006 assume that the merger of CCS Consolidated and Patient Infosystems was consummated on April 1, 2005.

The selected unaudited pro forma condensed combined statement of operations data is presented for illustrative purposes only and is not necessarily indicative of the combined results of operations of future periods or the results that actually would have been realized had the entities been a single entity during this period. The selected unaudited pro forma condensed combined statement of operations data for the year ended March 31, 2006 is derived from the unaudited pro forma condensed combined statement of operations at page F-57 of this prospectus and should be read in conjunction with that statement and the related notes. See Unaudited Pro Forma Condensed Combined Statement of Operations.

Selected Unaudited Pro Forma Condensed Combined Statement of Operations Data

(Dollars in thousands, except per share data)	**Year Ended March 31, 2006**
Total revenues	$ 63,098
Cost of services direct service costs	53,231
Gross profit	9,867
Total operating costs and expenses	12,363
Other expenses	1,128
Net loss from continuing operations	$ (3,624)
Basic and fully-diluted net loss per common share	$ (0.05)
Weighted average number of shares outstanding	67,538,976

RISK FACTORS

You should carefully consider the following factors, in addition to the other information contained in this prospectus, in connection with an investment in our common stock. An investment in our common stock is speculative in nature and involves a high degree of risk. No investment in our common stock should be made by any person who is not in a position to lose the entire amount of such investment.

Risks related to Our Business

We have a history of operating losses, and such losses may continue in the future due to continued limited patient enrollment.

We have incurred losses in the last several fiscal years. We reported net losses attributable to common stockholders of $2.1 million and $6.6 million for the years ended March 31, 2006 and 2005, respectively. Our ability to operate profitably is dependent upon our ability to develop and market our products in an economically successful manner. To date, we have been unable to do so. No assurances can be given that we will be able to ever operate profitably in the future.

Our prospects must be considered in light of the numerous risks, expenses, delays and difficulties frequently encountered in an industry characterized by intense competition, as well as the risks inherent in the development of new programs and the commercialization of new services particularly given our failure to date to operate profitably.

We will require significant working capital to continue to operate our business.

We currently believe that our resources will be sufficient to operate our business for at least the next twelve months. As with any forward-looking projection, and because the merger of Patient Infosystems with CCS Consolidated involves numerous issues relating to the logistics of merging two previously separate operating businesses, no assurances can be given that our working capital will be adequate to meet our needs or that we will be able to raise either the required working capital through the sale of our securities or by borrowing any additional amounts needed. Sales of securities or additional borrowings may place a significant strain upon the market price of our common stock. If we are unable to identify additional sources of capital, we would likely be forced to curtail our operations. Moreover, if we raise additional financing through the sale of our equity securities, any stock that we issue may be dilutive to our existing stockholders and result in material adverse changes to earnings per share. In addition, any debt financing we incur may impose significant financial and/or operating restrictions on us. As a result, the value of outstanding shares of our common stock could decline.

If we do not manage our growth successfully, our growth may slow, decline or stop, and we may never become profitable.

If we do not manage our growth successfully, our growth may slow or stop, and we may never become profitable. We have expanded our operations rapidly and plan to continue to expand, particularly in connection with the merger of Patient Infosystems with CCS Consolidated. This expansion has created significant demands on our administrative, operational and financial personnel and other resources. Additional expansion in existing or new markets could strain resources and increase the need for capital. Our personnel, systems, procedures, controls and existing space may not be adequate to support further expansion. In addition, because our business strategy emphasizes growth, the failure to

achieve our stated growth objectives or the growth expectations of investors could cause our stock price to decline.

Our products and services may not be accepted in the marketplace.

In connection with the commercialization of our health information system, we are marketing services designed to link patients, health care providers and payors in order to provide specialized disease management services for targeted chronic diseases. However, at this time, services of this type have not gained general acceptance from our customers. This is still perceived to be a new business concept in an industry characterized by an increasing number of market entrants who have introduced or are developing an array of new services. As is typical in the case of a new business concept, demand and market acceptance for newly introduced services are subject to a high level of uncertainty, and there can be no assurance as to the ultimate level of market acceptance for our system, especially in the health care industry, in which the containment of costs is emphasized. Because of the subjective nature of patient compliance, we may be unable, for an extensive period of time, to develop a significant amount of data to demonstrate to potential customers the effectiveness of our services. Even after such time, no assurances can be given that our data and results will be convincing or determinative as to the success of our system. There can be no assurance that increased marketing efforts and the effective implementation of our strategies will result in market acceptance for our services or that a market for our services will develop or not be limited.

Our agreements with our customers may be terminated by our customers on relatively short notice.

Our current services agreements with our customers generally automatically renew but may be terminated by those customers without cause upon notice of between 30 and 90 days. In general, customer contracts may include significant performance criteria and implementation schedules for us. Failure to satisfy such criteria or meet such schedules could also result in termination of the agreements.

The success of our programs is highly dependent on the accuracy of information provided by patients.

Our ability to monitor and modify patient behavior and to provide information to health care providers and payors, and consequently the success of our disease and care management systems, is dependent upon the accuracy of information received from patients. We have not taken and do not expect to take, specific measures to determine the accuracy of information provided to us by patients regarding their medical histories. No assurance can be given that the information our patients provide us will be accurate. To the extent that patients have chosen not to comply with prescribed treatments, such patients might provide inaccurate information to avoid detection. Because of the subjective nature of medical treatment, it will be difficult for us to validate or confirm any such information. In the event that patients enrolled in our programs provide inaccurate information to a significant degree, we would be materially and adversely affected. Furthermore, there can be no assurance that our patient interventions will be successful in modifying patient behavior, improving patient health or reducing costs in any given case. Many potential customers may seek data from us with respect to the results of its programs prior to retaining us to develop new disease management or other health information programs. Our ability to market our system to new customers may be limited if we are unable to demonstrate successful results for our programs.

Our operating results have fluctuated in the past and could fluctuate in the future.

Our operating results have varied in the past and may fluctuate significantly in the future due to a variety of factors, many of which are outside of our control. These factors include:

- volume and timing of sales;

rates at which customers implement disease and care management and other health information programs within their patient populations;

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impacts of substantial divestitures and acquisitions;

loss or addition of customers and referral sources;

seasonal fluctuations in healthcare utilization;

investments required to support growth and expansion;

changes in the mix of products and customers;

changes in healthcare reimbursement policies and amounts;

increases in direct sales costs and operating expenses;

increases in selling, general and administrative expenses;

increased or more effective competition; and

regulatory changes.

Any of the above could have a material adverse impact on our business, prospects, results of operations or financial condition.

Our business is dependent on data processing and transmission capabilities.

Our business is dependent upon its ability to store, retrieve, process and manage data and to maintain and upgrade our data processing capabilities. Interruption of data processing capabilities for any extended length of time, loss of stored data, programming errors, other computer problems or interruptions of telephone service could have a material adverse effect on our business.

Any inability to adequately protect our intellectual property could harm our competitive position.

We consider our methodologies, processes and know how to be proprietary. We seek to protect our proprietary information through confidentiality agreements with our employees. Our policy is to have employees enter into confidentiality agreements that contain provisions prohibiting the disclosure of confidential information to anyone outside of our company. In addition, the policy requires employees to

acknowledge, and, if requested, assist in confirming our ownership of any new ideas, developments, discoveries or inventions conceived during employment, and requires assignment to us of proprietary rights to such matters that are related to our business. There can be no assurance that the steps we take to protect our intellectual property will be successful. If we do not adequately protect our intellectual property, competitors may be able to use our technologies and erode or negate our competitive advantage.

Acquisitions may cause integration problems, disrupt our business and strain our resources.

In the past, we have made business acquisitions, including the recent merger between CCS Consolidated and Patient Infosystems. In addition, we may make additional acquisitions in the future. Our success will depend, to a certain extent, on the future performance of these acquired business entities. These acquisitions, either individually or as a whole, could divert management attention from other business concerns and expose us to unforeseen liabilities or risks associated with entering new markets and integrating those new entities. Further, the integration of these entities may cause us to lose key

employees or key customers. Integrating newly acquired organizations and technologies could be expensive and time consuming and may strain resources. Consequently, we may not be successful in integrating these acquired businesses or technologies and may not achieve anticipated revenue and cost benefits.

If our actual financial results vary from any publicly disclosed forecasts, our stock price could decline materially.

Our actual financial results might vary from those that we anticipate, and these variations could be material. Publicly disclosed forecasts reflect numerous assumptions concerning expected performance, as well as other factors, which are beyond our control, and which might not turn out to have been correct. Although we believe that the assumptions underlying the projections are reasonable, actual results could be materially different, and to the extent actual results are materially different, our stock price could be materially adversely impacted.

We will be required to incur significant monetary penalties as a result of delays in registering the resale of shares in this prospectus.

During the months of October and December 2005, we issued an aggregate of 3,588,562 shares of our common stock in a private placement, which we refer to in this prospectus as the PIPE, at an average price of $3.49 per share for gross proceeds of approximately $12.5 million. After paying related commissions and other offering costs, the net proceeds of the PIPE were approximately $10.8 million. We used $6.0 million of the net proceeds to retire our debt obligations under a credit facility in full. Pursuant to the terms of the PIPE, we were obligated to register the resale of the shares sold in the PIPE on behalf of the investors on or before February 28, 2006. Since the effectiveness of the registration statement of which this prospectus is a part has been delayed, we are obligated to pay a financial penalty equal to 1% of the gross proceeds (approximately $120,000) per month for the period beginning March 1, 2006 and continuing through the effective date of the registration statement. This obligation could have a material adverse impact on our financial condition and liquidity position.

The sale of shares of our common stock during October 2005 may be treated as the offer and sale of ACS common stock using a non-conforming prospectus under the Securities Act for which there may be potential liability.

As part of the PIPE described in the immediately preceding risk factor, in October 2005, we sold, in a private placement to accredited investors, 3,411,512 shares of our common stock from which we received gross proceeds of approximately $12.0 million. The purchasers of the PIPE shares received shares of common stock of ACS as a result of the spin-off of ACS described elsewhere in this prospectus. To the extent that the investors in the private placement received shares of common stock of ACS in the spin-off, it may be asserted that shares of ACS common stock were offered and sold as part of the PIPE. Because the registration statement relating to the spin-off had been filed with the SEC prior to the date of the PIPE, it could therefore also be asserted that the PIPE might have been conducted using a non-conforming prospectus under the Securities Act. As a result, investors in the PIPE could assert a claim against us with respect to the sale of the ACS shares. We cannot determine whether any such claim would be valid or whether or not, or to what extent, damages could in fact be successfully asserted. There can be no assurance that we would have sufficient resources to satisfy any successful claim or that, even if it did, the damages and associated costs would not have a material adverse effect on our financial condition.

We depend on payments from customers, and cost reduction pressure on these entities may adversely affect our business and results of operations.

The healthcare industry in which we operate currently faces significant cost reduction pressures as a result of constrained revenues from governmental and private revenue sources and increasing underlying medical care costs. We believe that these pressures will continue and possibly intensify.

Our services are geared specifically to assist our customers in controlling the high costs associated with the treatment of chronic diseases; however, the pressures to reduce costs in the short term may negatively affect our ability to sign and/or retain contracts. In addition, this focus on cost reduction may cause our customers to focus on contract restructurings that reduce the fees for our services rendered. These financial pressures could have a negative impact on our operations.

We have a limited number of customers, a few of which have accounted for a substantial portion of our business.

During the years ended March 31, 2006 and 2005, 89% and 96%, respectively, of CareGuide s revenues were concentrated in two customers, Health Net, Inc. and Aetna Health Plans. The contract between CareGuide and Health Net has been terminated, and our services to Health Net generally ceased as of April 30, 2006. While we believe that the Health Net contract was not a profitable contract to us and that the termination of the Health Net contract will not adversely impact our profitability, if we are not able to execute contracts with new customers to replace Health Net, our revenues will be adversely affected. In addition, there is no guarantee that Aetna will continue to purchase our services at prior levels. If we do not generate as much revenue from our major customers as is currently expected, or if we lose Aetna as a customer, our results of operations would be materially adversely impacted.

Our contract with Health Net has been terminated, which will result in a material reduction in revenues.

Prior to May 1, 2005, our contract with Health Net, Inc. provided for our acceptance of risk in the states of Connecticut, New York and New Jersey. Effective May 1, 2005, the contract related to the business in the State of Connecticut was converted from a risk basis to an administrative services only, or ASO, basis, necessitated by a change in insurance regulations. The conversion of this contract resulted in a decrease in revenue by approximately $2 million per month. Subsequently, on February 14, 2006, we signed a transition agreement with Health Net that was effective as of January 1, 2006 and resulted in the reduction of our services to Health Net through April 30, 2006, after which time the contract was terminated. As part of the transition, the risk contracts for the states of New York and New Jersey were also converted to ASO contracts effective as of January 1, 2006. During the fiscal years ended March 31, 2006 and 2005, our contracts with Health Net represented approximately 28% and 68%, respectively, of our total revenues.

As the Health Net contracts were not profitable to us, we do not believe that our net income will be adversely impacted by their termination, even though our revenues will be significantly reduced as a result of the Health Net transition. However, there can be no guarantee that the termination of the Health Net contracts will not have a material adverse impact on our results of operations.

Reconciliations under our contract with Aetna could result in additional cash to be paid by us or result in less cash to be paid to us by Aetna than originally estimated.

Our contracts with Aetna Health Plans contain provisions whereby Aetna pays a portion of the claims and we pay the remainder, even though we recognize all of the revenue and all of the claims expense. We record a net receivable each month equal to the net of the portion of the revenues and the estimated claims to be paid by Aetna. Reconciliations are to be performed for each contract quarter

within eight months after the end of each contract quarter, but these reconciliations are still incomplete to date. During December 2005, we received a reconciliation regarding one of the two contracts for the year ending December 31, 2004, which estimated that we owe approximately $350,000 for this period. While no assurances can be given, we believe that the current calculation may be overstated in certain respects, and the reconciliation has not been finalized. Additionally, the reconciliations for 2005 have not yet been completed as of the date of this prospectus. In the event any reconciliation results in a determination that the sum of actual paid claims by Aetna plus our margin exceeds the amount of revenue retained by Aetna, we would be required to pay additional cash to Aetna. Such a result could have an adverse impact on our financial position, results of operations, and cash flows.

A majority of our revenues come from risk contracts. The claims on these risk contracts are paid over time, and the actual claims made may exceed the estimated claim liabilities.

As of March 31, 2006, we had approximately $8.3 million of claim reserve liabilities. To fund these claim liabilities and other liabilities, we had operating and restricted cash of approximately $13.3 million and accounts receivable of approximately $3.9 million at such date. These claim liabilities will be paid out over several months, and the actual claims made may exceed the estimated claim reserve liabilities. If this were to occur, we would need additional cash and would incur charges to earnings that could have a material adverse impact on our results of operations. Additionally, there may be shortfalls in cash from time to time as the timing of the claim payments may be in contrast with the collections of the accounts receivable. If this were to occur, we would be required to locate additional sources of working capital, and there can be no assurance that it would be able to do so on favorable terms or at all.

Our inability to perform well under our contracts could have a material adverse effect on our business and results of operations.

Our growth strategy focuses on developing health and care support programs to address chronic diseases and medical conditions as well as the overall health of all enrollees of a health plan. While we have considerable experience in health and care support programs with a broad range of medical conditions, any new or modified programs will involve inherent risks of execution. If we do not perform well under our contracts, or if one or more of our customers perceive that we do not perform adequately, our business reputation and results of operations could be materially adversely impacted.

An unfavorable outcome related to our dispute with Oxford Health Plans may result in additional liabilities and could result in additional reductions in cash.

We are currently disputing amounts owed under our contract with Oxford Health Plans, which we refer to in this prospectus as Oxford. Oxford has drawn on a $500,000 letter of credit that was placed under the contract and is claiming that we owe Oxford an additional $1 million in addition to replenishing the letter of credit. We believe that Oxford owes us approximately $180,000. We received a letter from Oxford dated October 25, 2005 indicating that Oxford has submitted the matter to the American Health Lawyers Association for binding arbitration, seeking to compel us to replenish the letter of credit in the amount of approximately $1.5 million and to pay Oxford an additional approximately $1.0 million. We have filed counterclaims against Oxford for amounts that we contend are owed by Oxford under the agreement. An arbitration hearing began in June 2006 and was completed in July 2006. Final briefs are due from the parties in early August 2006, after which a decision by the arbitration panel is expected. We are vigorously defending against Oxford s claims, although there can be no assurance that we will be able to resolve this matter favorably. Management s best estimate of the liability to settle this dispute was recorded as a liability as of March 31, 2006.

The profitability of certain of our contracts is dependent upon the type and number of cases that we process.

We have entered into a service agreement with a health plan under which we assist the plan with complex care management services for its customers in exchange for a fee. The profitability of the contract is dependent upon the number of cases that meet certain criteria for referral to us and agree to receive the service. Although the contract currently generates a sufficient volume of cases to make the contract profitable, if the contract fails to continue to do so in the future, the fixed costs incurred to service this contract could exceed the revenue generated from the caseload. There can be no assurance that this contract will continue to generate the required level of revenue to make the contract profitable and, if it fails to do so, this could have a material adverse impact on our results of operations and financial condition.

Our revenues are subject to seasonal pressure from the disenrollment processes of our contracted health plans.

Employers typically make decisions on which health insurance carriers they will offer to their employees and also may allow employees to switch between health plans on an annual basis. These annual membership disenrollment and re-enrollment processes of employers (whose employees are the health plan members) from health plans can result in a seasonal reduction in actual lives under management in January, during our fourth fiscal quarter.

Historically, a majority of employers and employees make these decisions effective December 31 of each year. An employer s change in health plans or employees changes in health plan elections may cause a decrease in actual lives under management for existing contracts as of January 1. Although these decisions may also cause a gain in enrollees as new employers sign on with customers, the identification of new members eligible to participate in our programs, in some products, is based on the submission of healthcare claims, which lags enrollment by an indeterminate period.

Another seasonal impact on actual lives could occur if a health plan decided to withdraw coverage altogether for a specific line of business, such as Medicare, or in a specific geographic area, thereby automatically disenrolling previously covered members. Historically, we have experienced minimal covered life disenrollment from such a decision.

Risks Related to the Merger Between CCS Consolidated and Patient Infosystems

There can be no assurance that the merger will result in any significant customer interest in the integrated service offering of the combined companies.

Historically, we have operated in the segment of the managed care business known as the population management business, where it most fundamentally is addressing its customers desire to help educate their patient populations on illness prevention and post-illness reoccurrence measures. There can be no assurance that the cross-marketing of Patient Infosystems services to CCS Consolidated s customers (and vice versa) will materialize in any material way, in which case one of the underlying rationales for the merger will fail and the outlook for the combined business would be materially adversely impacted.

We may not realize anticipated benefits from the merger.

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The integration of CareGuide will be complex, time-consuming and expensive, and may disrupt our business. We currently need to overcome significant challenges in order to realize any benefits or synergies from the merger. These challenges include the timely, efficient, and successful execution of a number of events, including the following:

- integrating the operations and technologies of the two companies;
- retaining and assimilating the key personnel of each company;
- retaining existing customers of both companies and attracting additional customers;
- retaining strategic partners of each company and attracting new strategic partners; and
- creating uniform standards, controls, procedures, policies, and information systems.

The execution of these events will involve considerable risks and may not be successful. These risks include the following:

- the potential disruption of ongoing business and distraction of the management of the combined company;
- the potential strain on financial and managerial controls and reporting systems and procedures of the combined company;
- unanticipated expenses and potential delays related to integration of the operations, technology, and other resources of the two companies;
- the impairment of relationships with employees, suppliers, and customers as a result of any integration of new management personnel;
- greater than anticipated costs and expenses related to the merger or the integration of the respective businesses of Patient Infosystems and CCS Consolidated; and
- potential unknown liabilities associated with the merger and the combined operations.

CareGuide may not succeed in addressing these risks or any other problems encountered in connection with the merger. The inability to successfully integrate the operations, technology, and personnel of Patient Infosystems and CCS Consolidated, or any significant delay in achieving integration, could have a material adverse effect on our business, prospects, financial condition and results of operations, and, as a result, on the market price of our common stock.

As a result of the merger, we are a substantially larger and broader organization, and if management is unable to sufficiently manage the combined company, operating results will suffer.

As a result of the merger, we have significantly more employees, a broader service offering, and customers in more channels than we did prior to the merger. We face challenges inherent in efficiently managing an increased number of employees over large geographic distances, including the need to implement appropriate systems, policies, benefits, and compliance programs. The inability to manage successfully the substantially larger and diverse organization, or any significant delay in achieving successful management, could have a material adverse effect on us and, as a result, on the market price of our common stock.

The merger could cause us to lose key personnel, which could materially affect the combined company s business and require the combined company to incur substantial costs to recruit replacements for lost personnel.

As a result of the merger, current and prospective employees of both companies could experience uncertainty about their future roles within the combined company. This uncertainty may adversely affect our ability to attract and retain key management, sales, marketing, and technical personnel. Any failure to retain and attract key personnel could have a material adverse effect on our business.

Risks Related to the Healthcare Industry

We are subject to extensive changes in the healthcare industry.

The healthcare industry is subject to changing political, economic and regulatory influences that may affect the procurement practices and operations of healthcare industry participants. Several lawmakers have announced that they intend to propose programs to reform the U.S. healthcare system. These programs may contain proposals to increase governmental involvement in health care, lower reimbursement rates and otherwise change the operating environment us and our targeted customers. Healthcare industry participants may react to these proposals and the uncertainty surrounding such proposals by curtailing or deferring certain expenditures, including those for our programs. We cannot predict what impact, if any, such changes in the healthcare industry might have on our business, financial condition and results of operations. In addition, many healthcare providers are consolidating to create larger healthcare delivery enterprises with greater regional market power. As a result, the remaining enterprises could have greater bargaining power, which may lead to price erosion of our programs. Our failure to maintain adequate price levels could have a material adverse effect on our business.

In recent years, the healthcare industry has undergone significant change driven by various efforts to reduce costs, including potential national healthcare reform, trends toward managed care, cuts in Medicare reimbursements, and horizontal and vertical consolidation within the healthcare industry. Our inability to react effectively to these and other changes in the healthcare industry could adversely affect our operating results. We cannot predict whether any healthcare reform efforts will be enacted and what effect any such reforms may have on us or our customers. Our inability to react effectively to changes in the healthcare industry could result in a material adverse effect on our business.

Our business is subject to extensive government regulation.

The healthcare industry, including our current business, is subject to extensive regulation by both the Federal and state governments. A number of states have extensive licensing and other regulatory requirements applicable to companies that provide healthcare services. Additionally, services provided to health benefit plans in certain cases are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended, and may be affected by other state and Federal statutes. Generally, state laws prohibit the practice of medicine and nursing without a license. Many states interpret the practice of nursing to include health teaching, health counseling, the provision of care supportive to, or restorative of, life and well being and the execution of medical regimens prescribed by a physician. Accordingly, to the extent that we assist providers in improving patient compliance by publishing educational materials or providing behavior modification training to patients, such activities could be deemed by a state to be the practice of medicine or nursing. Although we have not conducted a survey of the applicable law in all 50 states, we believe that we are not engaged in the practice of medicine or nursing. There can be no assurance, however, that our operations will not be challenged as constituting the unlicensed practice of medicine or nursing. If such a challenge were made successfully in any state,

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we could be subject to civil and criminal penalties under such state s law and could be required to restructure its contractual arrangements in that state. Such results, or the inability to successfully restructure our contractual arrangements, could have a material adverse effect on our operations.

We and our customers may also be subject to Federal and state laws and regulations that govern financial and other arrangements among healthcare providers. These laws prohibit certain fee splitting arrangements among healthcare providers, as well as direct and indirect payments, referrals or other financial arrangements that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Possible sanctions for violation of these restrictions include civil and criminal penalties. Criminal penalties range from misdemeanors, which carry fines of not more than $10,000 or imprisonment for not more than one year, or both, to felonies, which carry fines of not more than $25,000 or imprisonment for not more than five years, or both. Further, criminal violations may result in permanent mandatory exclusions and additional permissive exclusions from participation in Medicare and Medicaid programs.

Regulation in the healthcare field is constantly evolving. We are unable to predict what government regulations, if any, affecting our business may be promulgated in the future. Our business could be materially adversely affected by the failure to obtain required licenses and governmental approvals, comply with applicable regulations or comply with existing or future laws, rules or regulations or their interpretations.

Compliance with new federal and state legislative and regulatory initiatives could adversely affect our results of operations or may require us to spend substantial amounts acquiring and implementing new information systems or modifying existing systems.

We and our customers are subject to considerable state and federal government regulation. Many of these regulations are vaguely written and subject to differing interpretations that may, in certain cases, result in unintended consequences that could impact our ability to effectively deliver services. The current focus on regulatory and legislative efforts to protect the confidentiality and security of individually-identifiable health information, as evidenced by the Health Insurance Portability and Accountability Act of 1996, or HIPAA, is one such example.

We believe that federal regulations governing the confidentiality of individually-identifiable health information permit us to obtain individually-identifiable health information for health and care support purposes from a health plan customer; however, state legislation or regulation could preempt federal legislation if it is more restrictive. Federal regulations governing the security of electronic individually-identifiable health information became mandatory for customers in April 2005. We are contractually required to comply with certain aspects of these confidentiality and security regulations.

Although we continually monitor the extent to which specific state legislation or regulations may govern our operations, new federal or state legislation or regulation in this area that restricts our ability to obtain individually-identifiable health information would have a material negative impact on our operations.

Our subsidiaries are subject to government regulation, and the failure to comply with such regulation could adversely affect our results of operations.

Certain of our subsidiaries are licensed to take risk in certain states. These subsidiaries must meet certain minimum capital and surplus tests as well as file quarterly and annual filings with regulatory and state authorities. If one of these subsidiaries does not remain in compliance with the statutory requirements, it is possible that the regulating authorities could impose greater restrictions on the

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subsidiary, including requiring additional cash deposits, additional reporting requirements and the potential revocation of licenses, each of which could have a materially adverse impact on our results of operations, liquidity and financial condition.

Government regulators may interpret current regulations governing our operations in a manner that negatively impacts our ability to provide services.

Broadly written Medicare fraud and abuse laws and regulations that are subject to varying interpretations may expose us to potential civil and criminal litigation regarding the structure of current and past contracts entered into with our customers. We believe that our operations have not violated and do not violate the provisions of the fraud and abuse statutes and regulations; however, private individuals acting on behalf of the United States government, or government enforcement agencies themselves, could pursue a claim against us under a new or differing interpretation of these statutes and regulations.

Our participation in federal programs may result in our being subject directly to various federal laws and regulations, including provisions related to fraud and abuse, false claims and billing and reimbursement for services, and the False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to $11,000 per false claim. Actions may be brought under the False Claims Act by the government as well as by private individuals, known as whistleblowers, who are permitted to share in any settlement or judgment. Also, federal law contains various prohibitions related to false statements and false claims, some of which apply to private payors as well as federal programs.

We face competition for staffing, which may increase our labor costs and reduce profitability.

We compete with other healthcare and services providers in recruiting qualified management and staff personnel for the day-to-day operations of our business, including nurses and other healthcare professionals. In some markets, the scarcity of nurses and other medical support personnel has become a significant operating issue to healthcare businesses. This shortage may require us to enhance wages and benefits to recruit and retain qualified nurses and other healthcare professionals. A failure to recruit and retain qualified management, nurses and other healthcare professionals, or to control labor costs, could have a material adverse effect on our profitability.

We may face costly litigation that could force us to pay damages and harm our reputation.

Like other participants in the healthcare market, we are subject to lawsuits alleging negligence, product liability or other similar legal theories, many of which involve large claims and significant defense costs. Any of these claims, whether with or without merit, could result in costly litigation, and divert the time, attention, and resources of management. Although we currently maintain liability insurance intended to cover such claims, there can be no assurance that the coverage limits of such insurance policies will be adequate or that all such claims will be covered by the insurance. In addition, these insurance policies must be renewed annually. Although we have been able to obtain liability insurance, such insurance may not be available in the future on acceptable terms, or at all. A successful claim in excess of the insurance coverage could have a material adverse effect on our results of operations or financial condition.

We could share in potential liability resulting from adverse medical consequences of patients.

We provide information to healthcare providers and managed care organizations upon which determinations affecting medical care are made. As a result, we could share in potential liabilities for resulting adverse medical consequences to patients. In addition, we could have potential legal liability in the event we fail to correctly record or disseminate patient information. We maintain an errors and

omissions insurance policy with coverage of $5 million in the aggregate and per occurrence. Although we do not believe that we will directly engage in the practice of medicine or direct delivery of medical services and have not been a party to any such litigation, we maintain a professional liability policy with coverage of $5 million in the aggregate and per occurrence. There can be no assurance that our procedures for limiting liability have been or will be effective, that we will not be subject to litigation that may adversely affect our results of operations, that appropriate insurance will be available to us in the future at acceptable cost or at all, or that any insurance we maintain will cover, as to scope or amount, any claims that may be made against us.

Risks Related to our Common Stock

The market price of our common stock may be highly volatile.

The market price of our common stock has been and will likely continue to be highly volatile. From the date trading of our common stock commenced until July 18, 2006, the range of our stock price has been between $114.00 and $0.48, after giving effect to a 1-for-12 reverse stock split which became effective on January 9, 2004. Factors including announcements of technological innovations by us or other companies, regulatory matters, new or existing products or procedures, concerns about our financial position, operating results, government regulation, or developments or disputes relating to agreements or proprietary rights may have a significant impact on the market price of our common stock. In addition, potential dilutive effects of future sales of shares of our common stock us, our stockholders, or the holders of warrants and options, could have an adverse effect on the price of our common stock.

Our principal stockholders and management own a significant percentage of our outstanding common stock and will be able to exercise significant influence over our operations.

Our executive officers, directors and holders of more than 5% of our outstanding common stock, together with their respective affiliates, currently own more than 75% of our voting stock, including shares subject to outstanding options and warrants. These stockholders are able to determine the composition of our board of directors, retain the voting power to approve all matters requiring stockholder approval and will continue to have significant influence over our operations. This concentration of ownership could have the effect of delaying or preventing a change in control of us, preventing or frustrating any attempt by our stockholders to replace or remove the current management, or otherwise discouraging a potential acquirer from attempting to obtain control of us, which in turn could limit the market value of our common stock.

A large number of shares of our common stock may be sold in the market, which could depress the market price.

Sales of substantial amounts of our common stock in the public market, or the perception that these sales might occur, could materially and adversely affect the market price of our common stock or our future ability to raise capital through an offering of our equity securities. As of July 18, 2006, we had an aggregate of 67,538,976 shares of common stock outstanding. If all options and warrants currently outstanding to purchase shares of common stock were to be exercised, there would be an aggregate of 70,475,879 shares of common stock outstanding. Of the 70,475,879 shares, up to 7,933,580 shares are freely tradable without restriction or further registration under the Securities Act, unless the shares are held by one of our affiliates as such term is defined in Rule 144 of the Securities Act. The remaining shares may be sold only pursuant to a registration statement under the Securities Act or an exemption from the registration requirements of the Securities Act. The table below provides additional information on the number of shares that may be publicly sold and the dates that they become eligible for sale. The sale and distribution of these shares may cause a decline in the market price of our common stock.

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The number of shares that will become eligible for resale between the date of this prospectus and July 25, 2007 are as follows:

Date	Number of shares eligible for sale	Comment
Currently	7,933,580	Shares outstanding other than (i) the shares being sold pursuant to this prospectus, (ii) shares issued in connection with the merger with CCS Consolidated and (iii) shares held by: - John Pappajohn; - Derace Schaffer; - Principal Life Insurance Company; - Christine St. Andre; - Kent Tapper; - Psilos Group Partners, L.P., Psilos Group Partners II, L.P. and CCP/Psilos CCS, LLC (collectively, Psilos); - Essex Woodlands Health Ventures Fund IV, L.P. and Essex Woodlands Health Ventures Fund V, L.P. (collectively Essex Woodlands); - Hickory Venture Capital Corporation (Hickory); - Radius Venture Partners I, L.P. (Radius); - CCS Consolidated Holdings LLC (CCS Holdings); and - SG Cowen Securities Corp. and its affiliates (collectively, SG Cowen); and issuable upon immediately exercisable options and warrants other than options and warrants held by directors and executive officers and warrants issued as part of the 2005 PIPE financing, the shares underlying which are being registered on the registration statement of which this prospectus is a part.
Upon the effective date of the registration statement of which this prospectus is a part	3,895,598	Shares sold in Patient Infosystems PIPE offerings during October 2005 and December 2005 and shares issuable upon exercise of warrants issued in connection with such transaction.
January 25, 2007	2,142,962	Shares issued in the merger, except for shares issued to: Psilos, Essex Woodlands, Hickory, Radius, CCS Holdings, and SG Cowen.

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July 25, 2007	52,750,005	Shares (i) issued in the merger (excluding shares deposited into escrow in the merger) to Psilos, Essex Woodlands, Hickory, Radius, CCS Holdings and SG Cowen; and (ii) held by John Pappajohn, Derace Schaffer, Principal Life Insurance Company, Roger Chaufournier, Christine St. Andre and Kent Tapper (including shares underlying exercisable options and warrants). These shares will remain subject to volume limitations of Rule 144 for the following 12 month period.
Various dates	3,753,734	Shares: (i) underlying options and warrants (other than those listed above) that are immediately exercisable and that vest and become exercisable and transferable, subject to the terms thereof, at various times in the future (including options currently held by Chris Paterson, Glen Spence and Ileana Welte and warrants held by former directors); and (ii) shares deposited into escrow at the closing of the merger which, when released to former CCS Consolidated stockholders, will become transferable on January 25, 2007 or July 25, 2007, depending on which stockholders such shares are released to.

The sale and distribution of these shares, or the perception that such sales or distributions might occur, may cause a decline in the market price of our common stock.

Our common stock qualifies as a penny stock under SEC rules which may make it more difficult for stockholders to resell their shares of common stock.

Our common stock trades on the OTC Bulletin Board. As a result, the holders of our common stock may find it more difficult to obtain accurate quotations concerning the market value of the stock. Stockholders also may experience greater difficulties in attempting to sell the stock than if it were listed on a stock exchange or quoted on the NASDAQ Global Market or the NASDAQ Capital Market. Because our common stock does not trade on a stock exchange or on the NASDAQ Global Market or the NASDAQ Capital Market, and the market price of the common stock is less than $5.00 per share, the common stock qualifies as a penny stock. SEC Rule 15g-9 under the Securities Exchange Act of 1934 imposes additional sales practice requirements on broker-dealers that recommend the purchase or sale of penny stocks to persons other than those who qualify as an established customer or an accredited investor. This includes the requirement that a broker-dealer must make a determination on the appropriateness of investments in penny stocks for the customer and must make special disclosures to the customer concerning the risks of penny stocks. Application of the penny stock rules to our common stock could adversely affect the market liquidity of the shares, which in turn may affect the ability of holders of the common stock to resell the stock.

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

Statements contained in this prospectus that are not historical facts, including information about management s view of our future expectations, plans and prospects, the benefits provided by the combination of our services offered as a result of the merger with CCS Consolidated, the prospects for

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success of the merger and the combination of the two companies, such as expected synergies and expanded revenue opportunities, constitute forward-looking statements for purposes of the safe harbor provisions under the Private Securities Litigation Reform Act of 1995. When used in this prospectus, the words or phrases will likely result, expects, plans, will continue, is anticipated, estimated, project, or outlook or expressions are intended to identify forward-looking statements. Actual results may differ materially from historical results or those indicated or implied by these forward-looking statements as a result of a variety of factors including, but not limited to, risks and uncertainties associated with our financial condition, the continued use of our services by our existing customers at current or increased levels, the market acceptance of or preference for our systems and services, significant concentration of our revenues with a limited number of customers, our ability to increase and diversify our business and revenue base, including the expansion of our Care Team Connect portfolio, our ability to sell our products, our ability to compete with competitors, the growth of the healthcare market and general economic factors in the healthcare industry, the impact of and changes in governmental regulations, the failure to achieve projected operating efficiencies and unfavorable variances in interest rates and financing terms, as well as other factors that are discussed in Risk Factors section of this prospectus. We have no obligation to publicly release the result of any revisions that may be made to any forward-looking statements to reflect anticipated or unanticipated events or circumstances occurring after the date of such statements.

USE OF PROCEEDS

We will not receive any proceeds from the sale of common stock by the selling stockholders, although we would receive proceeds upon the exercise of any warrants. If all of the selling stockholders exercise all of their warrants for cash, we will receive approximately $460,554. Any proceeds we receive from the exercise of the warrants will be used for general corporate purposes, including working capital.

MARKET FOR COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

(a) Market Information

Our common stock is traded on the Over-the-Counter Bulletin Board (the OTC Bulletin Board) under the symbol PATY. The following table sets forth, for the periods indicated, the range of high and low bid quotations for our common stock as quoted on the OTC Bulletin Board. The reported bid quotations reflect inter-dealer prices without retail markup, markdown or commissions, and may not necessarily represent actual transactions.

	High	**Low**
Fiscal Year Ending December 31, 2004		
First Quarter	$6.00	$1.44
Second Quarter	$5.50	$2.00
Third Quarter	$3.60	$1.32
Fourth Quarter	$3.94	$1.66
Fiscal Year Ending December 31, 2005		
First Quarter	$6.05	$2.92
Second Quarter	$5.90	$3.80
Third Quarter	$6.30	$4.16
Fourth Quarter	$4.50	$0.91 (1)
Fiscal Year Ending March 31, 2006 (2)		
Fourth Quarter (3)	$1.53	$1.00
Fiscal Year Ending March 31, 2007		
First Quarter	$1.50	$1.05
Second Quarter (through July 17, 2006)	$1.17	$1.08

(1) On December 16, 2005, the distribution of shares of ACS to our stockholders was completed. On December 16, 2005, our common stock closed at $3.94 per share, while on December 19, 2005 the closing price was $1.36 per share.

(2) Subsequent to December 31, 2005, we changed our fiscal year end to March 31.

(3) Prior to January 25, 2006, CCS Consolidated was a private company, and accordingly there was no market for its capital stock. On January 25, 2006, CCS Consolidated merged into a subsidiary of Patient Infosystems and itself became a wholly-owned subsidiary of Patient Infosystems.

(b) Holders

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The approximate number of record holders of our common stock as of July 18, 2006 is 300. The approximate number of beneficial owners is 900.

(c) Dividends

We have not declared cash dividends on our common stock.

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Management s discussion and analysis provides a review of our operating results for the years ended March 31, 2006 and 2005 and our financial condition at March 31, 2006. The focus of this discussion and analysis is on the underlying business reasons for significant changes and trends affecting our revenues, net losses, cash flows and financial condition. This discussion and analysis should be read in conjunction with our accompanying consolidated financial statements and related notes thereto included in this prospectus. The discussion and analysis of operating results and cash flows for the fiscal year ended March 31, 2006 include the period from April 1, 2005 to January 24, 2006 for CCS Consolidated, Inc. only and include the period from the merger date of January 25, 2006 through March 31, 2006 for Patient Infosystems, Inc. and its subsidiaries, including CCS Consolidated. The discussion and analysis of our financial condition as of March 31, 2006 includes Patient Infosystems, Inc. and its consolidated subsidiaries. The discussion and analysis of the operating results, cash flows and financial condition as of and for the year ended March 31, 2005 includes CCS Consolidated, Inc. only. We and our subsidiaries collectively do business under the name CareGuide . Our board of directors has approved an amendment to our certificate of incorporation to change our name to CareGuide, Inc., which amendment has not yet been approved by our stockholders.

Overview

On January 25, 2006, a subsidiary of Patient Infosystems, Inc. merged with CCS Consolidated (the Merger). At the closing of the Merger, we issued 43,224,352 shares of common stock to the former stockholders of CCS Consolidated. This represented approximately 64% of our issued and outstanding voting shares upon the closing of the Merger, and as a result there was a change of control of our company.

In addition, under a stockholders agreement entered into at the closing of the Merger, stockholders holding approximately 65% of the outstanding voting shares of our common stock after the consummation of the Merger have agreed to vote their shares in favor of the election of John Pappajohn, a director of our company prior to the Merger, Derace Schaffer, M.D., a director of our company prior to the Merger, and three individuals designated by holders of at least a majority of our common stock held by the former stockholders of CCS Consolidated who are parties to the stockholders agreement. The three new directors appointed after the Merger were Mark L. Pacala, Daniel C. Lubin and Albert S. Waxman. As provided by the stockholders agreement, two additional directors may be added to our board of directors, which individuals must be unanimously approved by the other five members of our board of directors. These additional directors have not yet been appointed.

Because the former CCS Consolidated securityholders held approximately 63% of our fully diluted shares of common stock immediately following the Merger, CCS Consolidated s designees to our board of directors represent a majority of our directors and CCS Consolidated s executive management represent a majority of the executive management of the combined company, CCS Consolidated is deemed to be the acquiring company for accounting purposes, and the transaction has been accounted for as a reverse acquisition under the purchase method of accounting for business combinations in accordance with generally accepted accounting principles in the United States. We have adopted March 31 as our fiscal year end, which was CCS Consolidated s fiscal year end.

CareGuide is a national disease and healthcare management company that provides a full range of healthcare management services to health plans, work/life benefits companies, government entities, and self-funded employers to help them reduce health care costs while improving the quality of care for members. We believe that the steadily rising cost of healthcare for employers, increasing demands on Medicare and Medicaid funding that are outpacing resources, and an emerging interest in healthcare technology and disease management services by the federal government and large insurers creates a fertile environment for our business model.

CareGuide brings to its partnerships with private and government payors a highly specialized infrastructure and multi-disciplinary clinical care management staff to reduce the overall costs of care through identifying individuals at risk for hospitalization and other high cost services, developing care management plans centered around self-management, and ensuring that the most appropriate services are utilized. Our approach to care management is holistic in nature, recognizing that factors other than physical maladies contribute to an individual s well-being. By providing comprehensive medical and psychosocial care management services for the highest-risk, medically complex members, CareGuide enables customers to realize lower health care costs, while optimizing the quality of care and satisfaction of members.

One of our fundamental beliefs is that technology, combined with a personal touch, is an essential component of providing the most effective and efficient care management services. To that end, we are developing an integrated clinical information technology platform that we believes will lead to the next generation of care management services. Today, we utilize technology to predict members at risk for high utilization of medical services, to guide our disease management, care management, and nurse help line interventions, and to communicate with members via remote monitoring devices.

CareGuide strives to individualize and tailor every intervention to the specific needs of the individual. In doing so, our goal is to minimize unnecessary intrusiveness, maximize efficiency through the use of technology, and reserve the highest intensity care management services for those individuals who have or are about to have high medical needs and can benefit from our assistance. We recognize the need to use different channels to reach and help different members.

As a result of the Merger, we have entered into service agreements to develop, implement and operate programs for: (i) patients who have recently experienced certain cardiovascular events; (ii) patients who have been diagnosed with primary congestive heart failure; (iii) patients suffering from asthma; (iv) patients suffering from diabetes; (v) patients who are suffering from hypertension; (vi) demand management, which provides access to nurses; (vii) case and utilization management services provided by a third party; (viii) various survey initiatives which assess, among other things, satisfaction, compliance of providers or payors to national standards, health status or risk of specific health related events; and (ix) the performance of specific administrative and management functions on behalf of a customer. These contracts provide for fees paid by our customers based upon the number of patients participating in each of these programs, as well as initial program implementation and set-up fees from customers. In addition, we have a 24-hour, seven days a week nurse help line, and we also provide services to the public sector. Our customers include health plans, third party administrators, state agencies, unions, private companies and other customers.

We have two types of revenue. First, we accept risk on the providing of post-acute services and receive a Per Member Per Month fee that is categorized as capitation revenue. Alternatively, we provide services to health plans without accepting risk, and for these types of contracts, we may receive either an administration service fee or may provide these services on a fee-for-service basis. For risk contracts, the cost of services includes the cost of providing clinical care and the incurred claims.

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

Critical Accounting Policies and Estimates

Our consolidated financial statements are prepared in accordance with generally accepted accounting principles in the United States, which require management to make estimates, judgments and assumptions that affect the reported amounts of assets, liabilities, revenue and expenses. Management bases its estimates on historical experience and on various other assumptions that it believes to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of certain assets and liabilities. Management believes that the accounting estimates employed and the resulting balances are reasonable; however, actual results may differ from these estimates under different assumptions or conditions.

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

Use of Estimates

In preparing the consolidated financial statements, we use estimates in determining the economic useful lives of our assets, provisions for doubtful accounts, claims liabilities, tax valuation allowances and various other recorded or disclosed amounts. Estimates require management to use its judgment. While we believe that our estimates for these matters are reasonable, if the actual amount is significantly different than the estimated amount, our assets, liabilities or results of operations may be overstated or understated.

Revenue Recognition

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

We recognize administrative and fee revenue for a variety of contracts. On certain contracts, we receive a fee for providing our services without accepting risk for claims. Such contracts include those that pay a set fee each month. Other contracts include a PMPM fee which include a per day per member case rate based on the number of health plan members who receive our services during the month. Such fees are negotiated with the health plan or employer group based on estimated costs and anticipated level of services. We recognize fee-for-service revenue for certain services provided for our customers and expenses paid on behalf of our customers for which we are generally reimbursed on a cost-plus basis during the period in which the services are provided.

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

Intangibles and Other Assets

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Intangible and other assets consist primarily of websites, trademarks and customer relationships. Such intangible assets are amortized to expense over the estimated life of the asset. We have preliminarily valued the customer relationships and other intangible assets of Patient Infosystems at $2.5 million as of the merger date of January 25, 2006, which is included in the intangible and other assets on the accompanying consolidated balance sheet as of March 31, 2006, less two months of amortization. We have engaged an independent valuation firm to determine the valuation of the customer relationships as of the merger date, and we will adjust the carrying value of this asset accordingly. The offset to this adjustment would be goodwill.

Goodwill

Goodwill is associated with acquisitions and is not amortized. Goodwill is tested annually for impairment, or whenever events or changes in circumstances indicate that the carrying value may not be recoverable. If the impairment test indicates impairment, the goodwill will be written down to the estimated fair value.

Direct Service Costs and IBNR Claims Payable Liability

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

The above listing is not intended to be a comprehensive list of all of our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by generally accepted accounting principles, with no need for management s judgment in their application. There are also areas in which management s judgment in selecting any available alternative would not produce a materially different result. See the notes to our consolidated financial statements included in this prospectus, which contain additional accounting policies and other disclosures required by generally accepted accounting principles.

Results of Operations

The following financial table presents data regarding our results of operations, financial position and cash flows as of and for the years ended March 31, 2006 and 2005. Such data was derived from our financial statements. This information should be read in conjunction with our consolidated financial statements as of and for the years ended March 31, 2006 and 2005 and the related notes thereto. All dollar amounts are stated in thousands of dollars:

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	Year Ended March 31,		
	2006	**2005**	**Variance Favorable (Unfavorable)**
Operating Results			
Capitated Revenue			
Health Net	$ 6,128	$ 38,990	$ (32,862)
Aetna	33,380	17,774	15,606
Total capitated revenue	**$ 39,508**	**$ 56,764**	**$ (17,256)**
Administrative and Fee Revenue			
Health Net	$ 9,328	$ 6,012	$ 3,316
Aetna	36	1,038	(1,002)
PATY customers subsequent to the Merger	1,848	-	1,848
Other	3,974	2,423	1,551
Total administrative and fee revenue	**$ 15,186**	**$ 9,473**	**$ 5,713**
Total Revenue			
Health Net	$ 15,456	$ 45,002	$ (29,546)
Aetna	33,416	18,812	14,604
PATY customers subsequent to the Merger	1,848	-	1,848
Other	3,974	2,423	1,551
Total revenue	**$ 54,694**	**$ 66,237**	**$ (11,543)**
Percentage of Revenue by Customer			
Health Net	28.3%	67.9%	(39.6)%
Aetna	61.1%	28.4%	32.7%
PATY customers subsequent to the Merger	3.4%	-	3.4%
Other	7.2%	3.7%	3.5%
Total revenue	**100.0%**	**100.0%**	

	Year Ended March 31,		Variance
	2006	**2005**	**Favorable (Unfavorable)**
Direct Service Costs			
Incurred claims	$ 35,439	$ 53,561	$ 18,122
Direct clinical expenses	11,892	8,979	(2,913)
Total direct service costs	**$ 47,331**	**$ 62,540**	**$ 15,209**
Direct Service Costs as a Percentage of Revenue			
Incurred claims as a percentage of total revenue	64.8%	80.9%	16.1%
Direct clinical expenses as a percentage of revenue	21.7%	13.5%	(8.2)%
Total direct service costs as a percentage of total revenue	**86.5%**	**94.4%**	**7.9%**
Gross profit	**$ 7,363**	**$ 3,697**	**$ 3,666**
Gross profit as a percentage of total revenue	**13.5%**	**5.6%**	**7.9%**
Selling, General & Administrative Expenses			
Selling and administrative expenses	$ 6,538	$ 6,327	$ (211)
Severance and related charges	335	558	223
Legal expenses (Lawsuit with State of Florida)	-	949	949
Unoccupied lease space write off	-	498	498
Total selling, general and administrative expenses	**$ 6,873**	**$ 8,332**	**$ 1,459**
Total depreciation and amortization expense	**$ 1,484**	**$ 1,356**	**$ (128)**
Operating loss from continuing operations	**$ (994)**	**$ (5,991)**	**$ 4,997**
Other Income (Expense)			
Interest income	$ 354	$ 187	$ 167
Interest expense:			
Interest on Line of Credit	(566)	(157)	(409)
Interest on Notes Payable	(46)	(49)	3
Interest on Capital Lease Obligations	(22)	(46)	24
Amortization of Warrants	(884)	-	(884)
Total interest expense	(1,518)	(252)	(1,266)
Other income	7	-	7
Trading portfolio loss	(16)	-	(16)
Net other income (expense)	**$ (1,173)**	**$ (65)**	**$ (1,108)**
Loss from continuing operations before income taxes	**$ (2,167)**	**$ (6,056)**	**$ 3,889**
Income tax (expense) benefit	(54)	91	(145)
Loss from continuing operations	**(2,221)**	**(5,965)**	**3,744**
Income (loss) from discontinued operations	290	(524)	814
Net loss	**$ (1,931)**	**$ (6,489)**	**$ 4,558**
EBITDA (loss) from continuing operations (1)	**$ 835**	**$ (4,448)**	**$ 5,283**

	March 31, 2006	2005	Variance Favorable (Unfavorable)
Condensed Balance Sheet Data at End of Year			
Total Assets			
Cash and cash equivalents	$ 8,399	$ 1,432	$ 6,967
Restricted cash available for current liabilities	4,894	10,541	(5,647)
Securities available for sale	99	-	99
Securities held for trading	827	-	827
Accounts receivable, net	3,859	5,161	(1,302)
Other current assets	1,131	1,197	(66)
Total current assets	**19,209**	**18,331**	**878**
Goodwill	28,666	295	28,371
Long term assets	6,348	5,309	1,039
Total assets	**$ 54,223**	**$ 23,935**	**$ 30,288**
Liabilities and Stockholders Equity (Deficit)			
Claims payable	$ 8,260	$ 15,032	$ (6,772)
Other current liabilities	8,928	6,504	2,194
Total current liabilities	**17,188**	**21,536**	**(4,578)**
Line of credit	8,000	6,150	1,850
Other long-term liabilities	328	632	(74)
Total liabilities	**25,516**	**28,318**	**(2,802)**
Stockholders equity (deficit)	**28,707**	**(4,383)**	**33,090**
Total liabilities and stockholders equity (deficit)	**$ 54,223**	**$ 23,935**	**$ 30,288**
Condensed Cash Flow Data			
Cash (used in) provided by operating activities:			
Cash received by customers	$ 35,425	$ 56,644	$ (21,219)
Direct proved costs and claims settlements paid	(19,979)	(41,329)	21,350
Salary and benefits paid	(12,400)	(9,702)	(2,698)
Other operating income (expense), net	(7,032)	(5,539)	(1,493)
Net cash (used in) provided by operating activities	**(3,986)**	**74**	**(4,060)**
Cash provided by (used in) investing activities:			
Purchases of property and equipment	(280)	(517)	237
Restricted deposits, net	5,882	(4,560)	10,442
Cash acquired in merger, net of merger costs	3,814	-	3,814
Net cash provided by (used in) investing activities	**9,416**	**(5,077)**	**14,493**
Cash provided by financing activities:			
Proceeds from borrowing under Line of Credit facility	1,850	4,650	(2,800)
Other financing activities, net	(313)	(1,029)	716
Net cash provided by financing activities	**1,537**	**3,621**	**(2,084)**
Net increase (decrease) in cash and cash equivalents	**6,967**	**(1,382)**	**8,349**
Cash and cash equivalents, beginning of period	1,432	2,814	(1,382)
Cash and cash equivalents, end of period	**$ 8,399**	**$ 1,432**	**$ 6,967**

(1) Earnings from continuing operations before interest, taxes, depreciation and amortization, or EBITDA from continuing operations, is a non-GAAP financial measure. This measure is not calculated in accordance with, or an alternative for, generally accepted accounting principles and may be different from non-GAAP measures used by other companies. We believe that the presentation of EBITDA from continuing operations, when shown in conjunction with the corresponding GAAP measure of earnings from continuing operations, provides useful information to management and investors regarding the financial and business trends relating to its results of operations. Additionally, for its internal budgeting purposes and for evaluating our performance, management uses financial statements that exclude income tax expense, interest expense and depreciation and amortization expense, as applicable, in addition to the corresponding GAAP measures. Presented below is a reconciliation of loss from continuing operations, which we believe to be the most comparable GAAP measure, to EBITDA from continuing operations (dollars in thousands):

	Year ended March 31,	
	2006	**2005**
Loss from continuing operations, GAAP basis	$ (2,221)	$ (5,965)
Income tax expense (benefit)	54	(91)
Interest expense	1,518	252
Depreciation and amortization	1,484	1,356
EBITDA (loss) from continuing operations, non-GAAP basis	**$ 835**	**$ (4,448)**

During the years ended March 31, 2006 and 2005, we accepted capitated risk from two of our customers, Health Net and Aetna.

Health Net

Our contract with Health Net, which had been in place since 1998 and represented our largest contract in terms of revenues, covered certain of our members in the states of Connecticut, New York and New Jersey. The lines of business for these members included Medicare, Medicaid and commercial members, with the vast majority of the members residing in Connecticut. Our services provided to these members included prior authorization of services to Skilled Nursing Facilities and Home Health agencies. We historically accepted capitated risk for these members. Capitated revenues related to this contract for the year ended March 31, 2004 were $43.4 million. In addition, we received a fee-for-service revenue for providing certain services that it did not receive a capitation PMPM fee. This fee for service revenue for the year ended March 31, 2004 was $8.3 million. This, the total revenues received from Health Net for the year ended March 31, 2004 was $51.7 million.

The medical loss ratio (MLR), which is defined as incurred claims divided by the related revenue, of the Health Net capitated risk business was 76.7% for the year ended March 31, 2004. We believe that this level of MLR generally produces sufficient margin to cover direct costs to administer the business and make a sufficient contribution to selling, general and administrative expenses in order to produce a profit. We realized a contribution margin from this contract for this period of $6.1 million.

Two events occurred subsequent to March 31, 2004 that resulted in the deterioration of this contract. First, the utilization rates of the Health Net members for our services increased. The average number of bed days for the biggest risk element of the Health Net contract increased 8% for the year ended March 31, 2005 as compared to the year ended March 31, 2004. Secondly, Health Net reduced the

capitated PMPM rates it paid to us as of the contract s renewal on January 1, 2005. Had the Health Net membership remained stable, the rate reduction alone would have resulted in decreased revenues of $2.25 million for the year ended March 31, 2005. However, Health Net also had a decrease in membership in certain accounts we served, which caused an even greater reduction in our revenues.

These factors resulted in the Health Net capitated MLR increasing from 76.7% for the year ended March 31, 2004 to 85.5% for the year ended March 31, 2005. Capitated revenues decreased from $43.4 million for the year ended March 31, 2004 to $39.0 million due to the declining membership base coupled with the rate decrease effective January 1, 2005. At the same time, utilization of our services increased. The contribution to overhead and profit from the Health Net contract decreased from $6.1 million for the year ended March 31, 2004 to $0.9 million for the year ended March 31, 2005.

During 2005, the Connecticut Insurance Department enacted legislation that raised capital requirements for all risk-bearing entities, which would have required us to commit approximately $13 million of capital to continue to take risk for the Health Net members in that state as of May 1, 2005. As this capital was not readily available, we and Health Net mutually agreed to convert the Connecticut contract from capitated risk to an Administrative Services Only (ASO) contract as of May 1, 2005. We continued to perform the same services under the contract as when the contract was on an at-risk basis, but we only received an administrative fee which excluded the cost of claims, causing a large reduction in its revenue.

On February 14, 2006, we signed a Transition Agreement with Health Net that was effective as of January 1, 2006. The transition, which was effectively completed as of April 30, 2006, resulted in the de-delegation of services back to Health Net. Certain of the staff who formerly serviced the Health Net contract were transferred to new contracts, and the remaining positions were eliminated.

As noted above, the Health Net Connecticut business converted to an ASO basis on May 1, 2005. As of January 1, 2006, the contracts for New York and New Jersey were also converted to ASO basis.

As part of the contract renewal as of January 1, 2005, we guaranteed to Health Net that we would reduce Health Net s hospital costs by certain amounts during the 2005 calendar year, which would entitle us to a bonus if achieved. We increased our restricted cash at March 2005 by $938 thousand in escrow. We and Health Net recently reconciled the guarantee bonus data and signed a settlement agreement where Health Net agreed to pay us a guarantee bonus of $1.2 million. The restricted cash was released back to operating cash in the year ended March 31, 2006. The $1.2 million of guarantee bonus revenue was recognized as fee-for-service revenue for the year ended March 31, 2006. We expect payment of the guarantee bonus from Health Net by September 30, 2006.

The following table represents the effects of the Health Net contract on revenues and contribution to overhead and profit for each of the three years ended March 31, 2006, 2005 and 2004:

	Year ended March 31, 2006	Year ended March 31, 2005	Year ended March 31, 2004
Health Net Revenues	$15.5 million	$45.0 million	$51.7 million
Health Net contribution to overhead and profit	$1.0 million (Includes $1.2 million of guarantee bonus revenue)	$0.9 million	$6.1 million

The contribution margins shown above are before consideration of the corporate overhead necessary to support this contract, such as executive staff, finance, actuarial, and similar costs. The contract with Health Net was terminated effective May 1, 2006. While there will be a decrease in revenues due to the termination of this contract, we expect no material adverse impact on net income.

Aetna

We entered into contracts with Aetna in July 2003 to provide post-acute services to certain of our members in the states of New York and New Jersey. We were compensated on an ASO basis when these contracts began. We received $1.8 million in ASO fees from Aetna for the period of July 2003 through March 2004.

Effective May 1, 2004, one Aetna contract converted from an ASO basis to a capitated risk basis. Another Aetna contract converted from an ASO basis to a capitated risk basis on January 1, 2005. The effects of these conversions resulted in our recording of approximately $2.8 million in monthly capitation revenue associated with the Aetna contracts, instead of approximately $200 thousand in monthly ASO revenue as originally provided for under the contracts. Because we are at-risk for the claims under the capitation risk arrangement, we record incurred claims for the estimated incurred claims.

Because we were providing services to these Aetna members on an ASO basis for several months prior to the conversion of these contracts to a capitation risk arrangement, we believe we were able to accurately price our risk services when we converted the contracts to an at-risk basis.

The following comparisons of our operating results refer to the financial data listed in the tables above.

Year ended March 31, 2006 compared to the year ended March 31, 2005

Capitation Revenue

The capitated revenue related to the Health Net contract decreased $32.9 million during the year ended March 31, 2006, when compared to the prior year, due primarily to converting from a risk contract to an ASO contract in Connecticut on May 1, 2005. Additional decreases were due to the rate decrease effective January 1, 2005 and the decrease in Health Net membership, each described above. The capitated revenue increase related to Aetna of $15.6 million was due to the conversion from an ASO basis to capitated risk for the New Jersey contract on January 1, 2005. These factors are explained in detail

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above. The net decrease in capitated revenue for the year ended March 31, 2006, when compared to the prior year, was $17.3 million.

Administrative and Fee Revenue

The increase in administration and fee revenue of $5.7 million during the year ended March 31, 2006, when compared to the prior year, was primarily the result of the conversion of the Health Net Connecticut contract from risk to Administration Services Only (ASO) on May 1, 2005, which added $6.3 million of ASO revenue that was not in the prior year. The conversion of the Aetna New Jersey contract from ASO to risk on January 1, 2005 resulted in a reduction of ASO revenue of $1.0 million. We added a new contract in July 2005 that resulted in $1.0 million of new ASO revenue during the year ended March 31, 2006. An additional new contract was also added in January 2006 that resulted in $97 thousand of new ASO revenue. Growth in other ASO contracts accounted for increased ASO revenue of $447 thousand as compared to the prior year. We realized a decrease in fee-for-service revenue of $1.1 million during the year ended March 31, 2006, when compared to the prior year primarily related to the decrease in demand related to the Health Net contract, which accounted for a decrease of $3.0 million. The revenues from Patient Infosystems customers in place prior to the Merger, from the merger date of January 25, 2006 through March 31, 2006, added $1.8 million of revenue that was not in the prior year period.

Total Revenues

Total revenues for the year ended March 31, 2006 aggregated $54.7 million, a decrease of $11.5 million, or 17.4%, from the prior year. This decrease was the net result of the $29.5 million decrease in Health Net revenues, an increase of Aetna revenues of $14.6 million, revenues from new contracts of $1.1 million, revenues from the Merger of $1.8 million and growth in other contracts of $0.5 million.

Direct Service Costs

The decrease in direct service costs of $15.2 million for the year ended March 31, 2006, when compared to the prior year, is a net result of several factors, including:

- The Health Net capitated claims decreased $27.5 million due to the conversions from risk to ASO in Connecticut on May 1, 2005 and in New York and New Jersey on January 1, 2006, as described above. Additionally, the fee-for-service Health Net claims decreased an additional $2.7 million. Therefore, there was a total decrease in Health Net claims of $30.2 million compared to a decrease in Health Net revenues of $29.5 million. After taking into account that the revenue decrease is net of the $1.2 million of revenue recognized for the guarantee bonus discussed above, there was an improvement in the Health Net operating direct margin of revenues less claims equal to $1.9 million as a result of converting from risk to ASO.
- The conversion of the Aetna contract in New Jersey on January 1, 2005 from ASO to risk, which increased capitated revenues of $15.6 million and resulted in an $11.9 million increase in claims.
- Direct clinical expenses, which are the costs directly involved in providing clinical services to the members of our customers, increased by $2.9 million during the year ended March 31, 2006 when compared to the prior year. The majority of this increase is due to the $1.1 million of direct clinical expenses of Patient Infosystems from the merger date of January 25, 2006 through March 31, 2006. Other increases are a result of the costs of implementing of our new CCM product, which was used to manage the Health Net guarantee discussed above that resulted in a $1.2 million bonus payable to us.

Gross Profit

The net result of the contract conversions, the successful implementation of our Continuous Care Management product that resulted in the $1.2 million of guarantee bonus and the Merger was a 100% improvement, or $3.7 million, in gross profit during the year ended March 31, 2006, when compared to the prior year, as shown in the financial table above. The gross profit percentage increased from 5.6% for the year ended March 31, 2005 to 13.5% for the year ended March 31, 2006.

Selling, general and administrative expenses

SG&A decreased by $1.5 million during the year ended March 31, 2006, when compared to the prior year. This was primarily due to the following factors:

- Severance and related charges incurred in connection with a reduction in force aggregated $558 thousand for the year ended March 31, 2005. During the year ended March 31, 2006, we effected a reduction-in-force related to the termination of the Health Net contract which resulted in the recognition of severance charges of $335 thousand. Therefore, the severance charges were $223 thousand less in the current year than in the prior year.
- A total of $949 thousand of expenses were incurred in connection with a settlement with the State of Florida in the year ended March 31, 2005. No such expenses were incurred during the year ended March 31, 2006.
- During the year ended March 31, 2005, we recorded $498 thousand of future rental payments related to the unoccupied warehouse space in its headquarters in Coral Springs, Florida, which we have been unable to sublease and for which there are no plans for future use. No such expenses were incurred during the year ended March 31, 2006.
- During the year ended March 31, 2005, we entered into a separation agreement with our former president and chief operating officer. Under the terms of the separation agreement, this individual was granted a fully vested option to purchase shares of our common stock. We recognized approximately $200 thousand of compensation expense associated with this grant. We recognized $84 thousand of stock option compensation expense for certain stock options granted in the year ended March 31, 2006 for options issued with an exercise price below the fair value at grant date.
- SG&A expenses for Patient Infosystems from the merger date of January 25, 2006 through March 31, 2006 aggregated $653 thousand.

These factors resulted in a net decrease in SG&A of $1.1 million. The remaining decrease of $0.4 million is due primarily to increased control of operating expenses.

Depreciation and amortization expense

Depreciation and amortization expense related to fixed and intangible assets aggregated $1.5 million and $1.4 million for the years ended March 31, 2006 and 2005, respectively.

Interest Income (Expense), net

Interest income increased $167 thousand during the year ended March 31, 2006 when compared to the prior year due to the increase in restricted cash balances from $6.8 million at March 31, 2004 to $11.4 million at March 31, 2005 and back to $5.5 million at March 31, 2006.

Interest expense on our line of credit with Comerica Bank (the Line of Credit) increased $409 thousand during the year ended March 31, 2006 as compared to the prior year due to the increased loan balance to $8.0 million and the increase in interest rates, which increased from 6.75% at March 31, 2005 to 8.75% at March 31, 2006.

In connection with the guarantee of our obligations under the Line of Credit by certain of our major stockholders, we issued certain warrants to purchase stock. These warrants are amortized to expense over the life of the loan and this amortization is recognized as interest expense. This amortization was $884 thousand during the year ended March 31, 2006. The offset to this expense is an increase in paid-in capital. Thus, there is no impact on stockholders equity (deficit) for this expense.

Loss From Continuing Operations

The loss from continuing operations before income taxes improved from $6.0 million for the year ended March 31, 2005 to $2.2 million for the year ended March 31, 2006 for primarily the reasons described under Gross Profit above as well as the reduction in the selling, general and administration expenses.

Discontinued Operations

During the year ended March 31, 2005, we terminated our contractual relationship with Oxford Health Plans, or Oxford. Pursuant to the contract termination provisions, we performed under the terms of the contract through August 31, 2005. We has had no continuing involvement thereafter. Therefore, we account for our former contract with Oxford as discontinued operations.

The Oxford contract included risk sharing provisions and provided for an annual settlement after the conclusion of each contract year. Subsequent to March 31, 2005, Oxford submitted its calculation of the amount due from us for the contract year ended December 31, 2004, which included many matters which we believe are contrary to the terms of the contract, and we notified Oxford of the disputed items. Oxford does not agree with our position on these matters, and it drew down a $500,000 letter of credit that had been established for Oxford s benefit pursuant to this contract. At March 31, 2005, we recorded a liability based on our estimate of the potential liability in the contractual dispute with Oxford for services rendered through March 31, 2005, should we not prevail in its position on the matter. At this time, we believe that we are adequately reserved for any additional amounts due to Oxford.

We also had remaining business during the years ended March 31, 2006 and 2005 related to the cessation of operations in the State of Texas during the year ended March 31, 2003. These operations are also accounted for as discontinued operations.

During the year ended March 31, 2006, we recognized income from discontinued operations of $290 thousand and recognized a loss from discontinued operations of $524 thousand for the year ended March 31, 2005.

Net loss and EBITDA

The conversion of the Health Net contract from an unprofitable risk contract to ASO, the Health Net guarantee bonus revenue of $1.2 million, the conversion of the Aetna New Jersey contract from ASO to a profitable risk contract and the reduction in selling, general and administrative expenses resulted in a reduction of the net loss for the year ended March 31, 2006 to $1.9 million from a net loss of $6.5 million for the year ended March 31, 2005.

We realized a positive EBITDA of $835 thousand for the year ended March 31, 2006, which was

an improvement from the prior year by $5.3 million.

New Contracts

We have changed our focus from our traditional post-acute, capitated risk strategy to our new Continuous Care Management (CCM) product. It implemented its first CCM program on January 1, 2005. In July 2005, we implemented our second CCM customer.

We have already begun to experience benefits from the combined strengths and the expanded product offering of the resulting combination of CCS Consolidated with Patient Infosystems. We have signed new contracts with the combined product offerings. In addition, we have certain proposals that appear to be well-received by our potential customers, although there can be no guarantee that they will ultimately result in new customers or profitable opportunities.

Liquidity and Capital Resources

Working Capital.

We had a working capital deficit at March 31, 2005 of $3.2 million. We recognized net losses for the years ended March 31, 2006 and 2005 of $1.9 million and $6.5 million, respectively. Due to historical losses, we have depended on capital infusions from our major investors and borrowings from a financial institution to fund our operations and to fund restricted deposits. If these additional funds were not available, we would likely have been required to reduce its operations or take other measures to curtail losses. Patient Infosystems had cash and cash equivalents of $4.5 million when it merged with CCS Consolidated on January 25, 2006. On March 31, 2006, we had a surplus in working capital of $2.0 million. Accordingly, we do not believe we will need any further borrowings or raising of additional capital through March 31, 2007.

Capitated Risk Contracts.

In connection with taking capitated risk, our customers require us to provide letters of credit for their protection in case we do not have sufficient resources to pay the related claim liabilities. These letters of credit are generally collateralized by certificates of deposit and are shown on our financial statements as Restricted cash available for current liabilities. During the year ended March 31, 2005, we issued letters of credit to Aetna related to the conversions of the Aetna contracts discussed above to capitated risk and thereby increased restricted cash by $2.9 million. We also increased the restricted cash related to the Health Net contract by $1.6 million. While the Health Net contract in Connecticut converted from capitated risk to ASO on May 1, 2005 and the Health Net contracts in New York and New Jersey converted from capitated risk to ASO on January 1, 2006, we must continue to pay claims for many months after those dates for claims incurred prior to those dates. We have an arrangement with Health Net to release restricted cash as claims are paid. Accordingly, the Health Net restricted cash was reduced by $6.1 million during the year ended March 31, 2006. As of March 31, 2006, we had $1.5 million remaining in restricted cash related to the Health Net contract, which will be used to pay the remaining claim reserves related to Health Net capitated risk claims. We believe this amount is sufficient to pay these remaining claim obligations, although there can be no guarantee that the claims will not exceed our restricted cash balances.

Cash received from customers, as shown in the statement of cash flows, is generally less than revenues recorded, primarily due to the Aetna capitated risk contracts. In connection with these contracts, we record 100% of the capitated revenues and 100% of the capitated incurred claims. However, we do not pay all the claims. Aetna also pays a portion of the claims, and consequently retains cash to pay these claims. There are reconciliations to be performed for the claims Aetna paid for periods in time that is to

be compared to the cash it retained. If Aetna pays less than the cash it retained, it will owe this amount to us. If Aetna pays more than the cash it retained, we will owe Aetna this excess.

Comerica Line of Credit.

We are party to a Loan and Security Agreement with Comerica Bank (Comerica) dated October 9, 2002, as amended on October 28, 2003, November 17, 2004 and January 12, 2006 (as so amended, the Loan and Security Agreement), pursuant to which we have an $8.0 million revolving line of credit (the Line of Credit). The Line of Credit bears interest at Comerica s prime rate plus 1%, which was 8.75% and 6.75% at March 31, 2006 and 2005, respectively, and is scheduled to expire on June 30, 2007. The Line of Credit is collateralized by all of our tangible assets, including our investment in all of our subsidiaries. The satisfaction of our obligations under the Loan and Security Agreement are also guaranteed by certain of our subsidiaries. The satisfaction of our obligations under the Loan and Security Agreement are also guaranteed by certain of the former stockholders of CCS Consolidated who became stockholders of our company upon the closing of the Merger. Under the terms of the guaranties, each such stockholder unconditionally and irrevocably guarantees prompt and complete payment of its pro rata share of the amount owed under the Line of Credit.

In exchange for delivering guaranties to Comerica to satisfy our obligations, in November 2004, these former stockholders of CCS Consolidated were issued warrants to purchase shares of capital stock of CCS Consolidated, which vested over time based on the outstanding balances under the Loan and Security Agreement. As part of the Merger, the unvested portion of these warrants was terminated and replaced by warrants to purchase shares of our common stock (the Replacement Warrants). Each of the Replacement Warrants has an exercise price of $0.003172 per share of common stock. These Replacement Warrants vest through November 17, 2006 based on the outstanding balances under the Loan and Security Agreement. If the Replacement Warrants fully vest and are exercised in full for a cash payment of the aggregate exercise price, the holders of the Replacement Warrants will receive an aggregate of 3,152,141 shares of common stock. These 3,152,141 shares of common stock were issued into escrow at the closing of the merger with CCS Consolidated. To the extent that the Replacement Warrants do not vest, or are not exercised in full, the shares of common stock underlying the Replacement Warrants will be released from escrow to all former stockholders of CCS Consolidated at the effective time of the merger in accordance with the Merger Agreement.

As of March 31, 2005, the principal balance outstanding under the Line of Credit was $6.2 million. During June 2005, we borrowed an additional $1.2 million under the Line of Credit, bringing the total amount outstanding to $7.4 million, and in December 2005, we borrowed the remaining $650 thousand available under the Line of Credit, such that the maximum amount of $8.0 million was outstanding at March 31, 2006.

The Loan and Security Agreement contains representations and warranties and affirmative and negative covenants that are customary for credit facilities of this type. The Loan and Security Agreement could restrict our ability to, among other things, sell certain assets, change its business, engage in a merger or change in control transaction, incur debt, pay cash dividends, make investments and encumber its assets. The Loan and Security Agreement also contains events of default that are customary for credit facilities of this type, including payment defaults, covenant defaults, insolvency type defaults and events of default relating to liens, judgments, material misrepresentations and the occurrence of certain material adverse events.

During the months of October and December 2005, we issued an aggregate of 3,588,562 shares of its common stock in a private placement (the PIPE) at an average price of $3.49 per share for gross proceeds of approximately $12.5 million. After paying related commissions and other offering costs, the net proceeds of the PIPE were approximately $10.8 million. We used $6.0 million of the net proceeds to

retire our debt obligations under a credit facility in full. Pursuant to the terms of the PIPE, we were obligated to register the resale of the shares sold in the PIPE on behalf of the investors on or before February 28, 2006. Since the effectiveness of the registration statement of which this prospectus is a part has been delayed, we are obligated to pay a financial penalty equal to 1% of the gross proceeds (approximately $120,000) per month for the period beginning March 1, 2006 and continuing through the effective date of the registration statement.

Cash Flows.

The net cash used in operating activities for the year ended March 31, 2006 was $4 million. This was due primarily to the payment of Health Net related capitated risk claims. As noted above, there was a net reduction in restricted cash of $5.9 million, included in cash provided by investing activities, to pay for this use of cash and cash equivalents.

Patient Infosystems had cash and cash equivalents of $4.5 million when it merged with CCS Consolidated on January 25, 2006. We incurred $1.2 million of expenses related to the merger, of which $0.7 million had been paid as of March 31, 2006.

We had $8.4 million of unrestricted cash and cash equivalents at March 31, 2006. Of this amount, $1.4 million was for revenue received in advance for future periods. Future short-term cash needs related to liabilities accrued at March 31, 2006 include severance liabilities of $0.6 million, unpaid merger related costs of $0.5 million and $1.1 million of accrued payroll.

Inflation

Inflation did not have a significant impact on our operations during 2006 and 2005. We continue to monitor the impact of inflation in order to minimize its effects through pricing strategies, productivity improvements and cost reductions.

Recent Accounting Pronouncements

In May 2005, the Financial Accounting Standards Board (FASB) issued SFAS No. 154, Accounting Changes and Error Corrections a replacement of APB Opinion No. 20 and FASB Statement No. 3 (SFAS No. 154), which replaces APB Opinion No. 20, Accounting Changes, and FASB Statement No. 3, Reporting Accounting Changes in Interim Financial Statements, and changes the requirements for the accounting for and reporting of a change in accounting principle. This Statement applies to all voluntary changes in accounting principle. It also applies to changes required by an accounting pronouncement in the unusual instance that the pronouncement does not include specific transition provisions. We adopted SFAS No. 154 as of April 1, 2006. We do not expect adoption of the provisions of SFAS No. 154 to have a material impact on our consolidated financial statements, results of operations or liquidity.

In December 2004, the FASB issued Statement of Financial Accounting Standard (SFAS) No. 123(Revised), Share-Based Payment (SFAS No. 123(R)), establishing accounting standards for transactions in which an entity exchanges its equity instruments for goods or services. SFAS No. 123(R) also addresses transactions in which an entity incurs liabilities in exchange for goods or services that are based on the fair value of the entity s equity instruments, or that may be settled by the issuance of those equity instruments. SFAS No. 123(R) covers a wide range of share-based compensation arrangements including stock options, restricted stock plans, performance-based stock awards, stock appreciation rights, and employee stock purchase plans. SFAS No. 123(R) replaces existing requirements under SFAS No. 123, Accounting for Stock-Based Compensation, and eliminates the ability to account for share-based compensation transactions using APB Opinion No. 25. We adopted SFAS 123(R) as of April 1, 2006.

We do not expect the adoption of SFAS 123(R) to have a material impact on our consolidated financial statements, results of operations or liquidity.

DESCRIPTION OF BUSINESS

General

We were incorporated in the State of Delaware on February 22, 1995 under the name DSMI Corp., changed its name to Disease State Management, Inc. on October 13, 1995, and then changed its name to Patient Infosystems, Inc. on June 28, 1996. Our principal executive offices are located at 12301 N.W. 39th Street, Coral Springs, Florida 33065, and our telephone number is (954) 796-3714. Our Internet addresses are www.careguide.com and www.ptisys.com. The information contained on our websites does not constitute part of, nor is it incorporated by reference into, this prospectus. We became a public company on December 26, 1996 upon the consummation of our initial public offering. Our common stock is traded on the Over-The-Counter Bulletin Board under the stock ticker symbol PATY.

Pursuant to an Agreement and Plan of Merger dated September 19, 2005, as amended on November 22, 2005 and December 23, 2005 (as so amended, the Merger Agreement) by and among Patient Infosystems, Inc., PATY Acquisition Corp., a wholly-owned subsidiary of Patient Infosystems, Inc. (Merger Sub) and CCS Consolidated, Inc. (CCS Consolidated), Merger Sub merged with and into CCS Consolidated (the Merger), and CCS Consolidated became a wholly-owned subsidiary of Patient Infosystems, Inc. CCS Consolidated is a national care management company providing higher-risk and elderly care management services to health plans, work/life benefits companies and self-funded employers. The Merger closed and became effective on January 25, 2006. We and our subsidiaries collectively do business under the name CareGuide. Our board of directors has approved an amendment to our certificate of incorporation to change our name to CareGuide, Inc., which amendment has not yet been approved by our stockholders.

At the closing of the Merger, we issued 43,224,352 shares of our common stock to the former stockholders of CCS Consolidated. This represented approximately 64% of our issued and outstanding voting shares upon the closing of the Merger, and as a result there was a change of control of our company.

In addition, under a stockholders agreement entered into at the closing of the Merger, stockholders holding approximately 65% of our outstanding voting shares of common stock after the consummation of the Merger have agreed to vote their shares in favor of the election of John Pappajohn, a director of our company prior to the Merger, Derace Schaffer, M.D., a director of our company prior to the Merger, and three individuals designated by holders of at least a majority of our common stock held by the former stockholders of CCS Consolidated who are parties to the stockholders agreement. The three new directors appointed after the Merger were Mark L. Pacala, Daniel C. Lubin and Albert S. Waxman, Ph.D. As provided by the stockholders agreement, two additional directors may be added to our board of directors, which individuals must be unanimously approved by the other five members of our board of directors. These additional directors have not yet been appointed as of the date of this prospectus.

Because the former CCS Consolidated securityholders held approximately 63% of our fully diluted shares of common stock immediately following the Merger, CCS Consolidated s designees to our board of directors represent a majority of our directors and CCS Consolidated s executive management represent a majority of the executive management of the combined company, CCS Consolidated was deemed to be the acquiring company for accounting purposes and the transaction has been accounted for as a reverse acquisition under the purchase method of accounting for business combinations in accordance with generally accepted accounting principles in the United States. We have adopted March 31 as our fiscal year end, which was CCS Consolidated s fiscal year end.

Because the Merger between CCS Consolidated and Patient Infosystems was treated as a reverse acquisition for accounting purposes, the financial statements of the accounting acquirer, CCS Consolidated, became our historical financial statements. The financial statements included in this prospectus as of and for the year ended March 31, 2005 are those of CCS Consolidated only. The balance sheet included in this prospectus as of March 31, 2006 is a consolidated balance sheet of Patient Infosystems, Inc. and its subsidiaries after the Merger. The statement of operations and the statement of cash flows for the year ended March 31, 2006 included in this prospectus include the operations of CCS Consolidated only for the period from April 1, 2005 to January 24, 2006 and include the combined operations of Patient Infosystems, Inc. and its consolidated subsidiaries, including CCS Consolidated, for the period beginning with the merger completion date of January 25, 2006 through March 31, 2006.

On September 22, 2004, we acquired 100% of CBCA Care Management, Inc., or CMI, a New York corporation. CMI provides case and utilization management services primarily to self insured employers and health and welfare funds. We have sold case and utilization management services since 2000 and until 2004 outsourced the operations to CMI. We intend to continue to market case and utilization management services.

On December 31, 2003, we acquired the assets of American Caresource Corporation and formed American Caresource Holdings, Inc., or ACS, to operate those assets. ACS provides ancillary benefits management services, including a network of ancillary specialty providers and value-added services that assist its clients in controlling the cost of a range of ancillary medical services. On December 16, 2005, we distributed approximately 12 million shares of common stock of ACS as a dividend to our stockholders and retained approximately 300,000 shares of ACS, of which we closed on the sale of 88,525 shares on December 30, 2005. Following the spin-off of ACS shares, ACS became an independent public company with its own management and board of directors. Two of our directors, John Pappajohn and Derace Schaffer, also serve as directors of ACS.

Business of CareGuide

CareGuide is a national disease and healthcare management company that provides a full range of healthcare management services to health plans, work/life benefits companies, government entities, and self-funded employers to help them reduce health care costs while improving the quality of care for members. We believe that the steadily rising cost of healthcare for employers, increasing demands on Medicare and Medicaid funding that are outpacing resources, and an emerging interest in healthcare technology and disease management services by the federal government and large insurers creates a fertile environment for our business model.

CareGuide brings to its partnerships with private and government payors a highly specialized infrastructure and multi-disciplinary clinical care management staff to reduce the overall costs of care through identifying individuals at risk for hospitalization and other high cost services, developing care management plans centered around self-management, and ensuring that the most appropriate services are utilized. Our approach to care management is holistic in nature, recognizing that factors other than physical maladies contribute to an individual s well-being. By providing comprehensive medical and psychosocial care management services for the highest-risk, medically complex members, we enable customers to realize lower health care costs, while optimizing the quality of care and satisfaction of members.

One of our fundamental beliefs is that technology, combined with a personal touch, is an essential component of providing the most effective and efficient care management services. To that end, we are developing an integrated clinical information technology platform that we believe will lead to the next generation of care management services. Today, we utilize technology to predict members at risk for

high utilization of medical services, to guide its disease management, care management, and nurse help line interventions, and to communicate with members via remote monitoring devices.

CareGuide strives to individualize and tailor every intervention to the specific needs of the individual. In doing so, our goal is to minimize unnecessary intrusiveness, maximize efficiency through the use of technology, and reserve the highest intensity care management services for those individuals who have or are about to have high medical needs and can benefit from our assistance. We recognize the need to use different channels to reach and help different members.

Products and Services

Our suite of care management products are marketed under the label Care Team Connect . The name stems from our objective of *connecting* all of the members of the patient s *care team*, including the family, primary care physician, other providers, and community resources. We believe that the orchestration of the various interventions, with the patient empowered to be in the lead, results in better healthcare outcomes.

Each Care Team Connect product is designed to independently yield value for clients, and additional value can be achieved by combining Care Team Connect products. Combining products yields an integrated approach to health and care management, which facilitates timely communication and coordination among patients, providers and payors. This successful care management strategy offers payors many opportunities for reducing costs and improving patient outcomes.

Care Team Connect includes the following:

Population analysis and identification. CareGuide provides comprehensive medical and pharmaceutical claims analysis that includes the administration of proprietary algorithms to identify patients with chronic disease and other high risk illnesses and conditions. We are then able to stratify individuals by level of risk for high resource utilization. This product supports the other products that follow.

Continuous Care Management (CCM). A principal service for CareGuide is the management of high-risk/high-need/high-cost populations. We believe that we are able to deliver substantial cost savings for our clients by preventing hospital admissions and readmissions among the most complex and chronically ill members. These members account for a disproportionate share of medical spending, with a much higher number of hospitalizations and episodes of emergency care than the rest of the general population. Our focus is typically on only 0.5% to 6% of a plan s membership, who are usually suffering from many illnesses simultaneously, are frail and elderly, and often have non-medical concerns as well that contribute to poor health outcomes and high costs.

CCM features evidence-based and physician-guided care management planning, remote monitoring technology, a network of skilled nursing facilities and home health providers, and a national network of specialized care managers, who provide face-to-face and in-home member assessments and care management interventions. Designed for patients with multiple co-morbidities, CCM involves the management of the full range of medical and psychosocial conditions affecting a patient, using preventative care management before, during and after a post-acute episode.

By focusing on patients with complex medical profiles who generate the majority of health care costs, our strategy combines the use of lower cost care delivered outside the hospital with

intensive patient-focused care management interventions to reduce the number of high cost hospitalizations and maximize an individual s health status and independence.

Disease management services. Our disease management services are provided for individuals with a diagnosis of asthma, diabetes, coronary heart disease, hypertension, and congestive heart failure. These services are comprehensive in approach, focusing on both the medical and behavioral aspects of chronic health care management. The programs involve clinical assessments and the provision of information on self-care, medication and treatment adherence. Through monitoring and on-going assistance, they empower the participants to become more proficient and proactive in managing their disease or condition. By including 24-hour access to our nurse help line, participants have accessible resources for questions or issues that arise with their disease. The long-term goal of the disease management services is a judicious use of health care resources through health care education, as well as reinforcement of the provider s treatment plan.

Our disease management programs are based on nationally recognized treatment guidelines for each disease state. The programs provide condition-specific assessment, support and education with behavior-based interventions according to the patient s identified risk level. Each of our chronic condition management programs is continuously reviewed and updated to assure that these programs reflect current knowledge and best practices in clinical management.

Utilization management/care management services. CareGuide has designed its care management services to ensure that participants receive high quality medical care at the best possible price at the proper time and for the appropriate duration. The programs assist in avoiding unnecessary expenditures with an objective, information-intensive approach that combines clinical judgment with accepted practice patterns. Care management services comply with Utilization Review Accreditation Commission (URAC) standards and are further developed to ensure compliance with the legislative requirements of the states in which utilization review functions are performed.

While we are experienced in and adept at reviewing and authorizing all levels of care along the continuum of inpatient to outpatient treatment, we believe that we have developed a particular expertise in managing the post-acute continuum of services, including skilled nursing care, acute rehabilitation, home healthcare, and home infusion. In managing post-acute care, CareGuide incorporates elements of its Continuous Care Management program, including post-hospital discharge planning, care management planning, and follow-up with patients in order to reduce the number of readmissions to the hospital. Because of this specialization and our actuarial experience in the post-acute arena, CareGuide is able to assume claims risk in its contracts to provide these services.

CareGuide@Home. CareGuide@Home is a national care management program that features CareGuide s national specialized care manager network to provide in-home assessments, comprehensive care plans and hands-on assistance to access community-based supportive services for homebound seniors and their families and caregivers. Clients for this program include national health plans, employee assistance programs and work-life companies.

Nurse Help Line. The Nurse Help Line is a triage, advice, referral and health-counseling service that provides individuals with around-the-clock access to registered nurses. Our nurses use algorithm-based assessment tools to recommend specific responses to medical issues and have access to provider and/or network information to direct individuals to medical resources as necessary. The Nurse Help Line provides users with information about specific health problems

or answers to their health-related questions. CareGuide s use of nationally recognized clinical algorithms allows it to assist callers in determining the most cost-effective options for acute care treatment and has effectively been able to reduce the use of emergency rooms and after-hours physician contact. Through the Nurse Help Line, individuals may also be identified for referral into disease management or care management services. The Nurse Help Line is operated from our URAC accredited call center.

InnovaCare: Provider innovation and improvement support

CareGuide, through its InnovaCare division, provides consulting and technical services to federally qualified health centers and other providers who wish to enhance their disease and care management services. These services include the following:

Population Health Disease Management Systems and Strategies. We provide technical assistance to the health centers relative to management of chronic disease. This includes organizations such as the federal government, health plans, state primary care associations, and the National Association of Community Health Centers.

Learning Organization Services. We serve as a teaching organization promoting improvement in care delivery systems. This includes logistics support for learning sessions, training, recruitment, development and support of faculty, subject matter experts in key topics, training in improvement methods and knowledge management of best practices. Topics include chronic disease management, idealized clinical practice design and the business case for planned care. We collaborate with the Institute for Healthcare Improvement on such initiatives.

Technical assistance. We assist with the development of clinical registries used to more effectively manage patients with chronic disease. Our services include (i) project management and implementation of a patient registry for federally qualified health centers through a national initiative known as the Health Disparities Collaborative and (ii) technical assistance in web-based reporting applications for clinical outcomes. This project is administered as a subcontract through the Institute for Healthcare Improvement.

Customers and Sales and Marketing

We employ a sales team that markets our Care Team Connect products to organizations that pay for healthcare services on behalf of members, employees or beneficiaries. These organizations include health insurance companies, managed care organizations, government entities, third party administrators (TPAs), health and welfare funds organized under the Taft-Hartley Labor Act, purchasing coalitions, self-funded employer groups, and work-life companies. CareGuide also uses third-party consulting services in addition to its employed sales team.

We also have agreements in place with several organizations to co-market our products and services. Agreements are in place with Loge Group, LLC, (formerly CBCA), Gilsbar, CHA Health, POMCO, A&I Benefit Plan Administrator, ppoNext, and Kelly & Associates Insurance Group, Inc. These organizations provide professional benefit administrator services, TPA services, and preferred provider services to health plan sponsors, employers, and Taft-Hartley funds. These agreements permit either company in the relationship to co-market and subcontract for the services of the other company.

For the years ended March 31, 2006 and 2005, approximately 28% and 68%, respectively, of CareGuide s revenues were earned under contracts with affiliates of a single company, Health Net, Inc. In addition, during the years ended March 31, 2006 and 2005, approximately 61% and 28% of

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CareGuide s revenues were earned under contracts with Aetna Health Plans. Effective as of January 2006, CareGuide signed a transition agreement with Health Net which resulted in the reduction of services by CareGuide to Health Net through April 30, 2006, after which time the contract with Health Net was terminated.

Competition

The healthcare industry and the market for healthcare management and healthcare information products is highly competitive and subject to continuous change in the manner in which services are provided. Other entities, whose financial, research, staff, and marketing resources may exceed our resources, are marketing care management and disease management services or have announced an intention to offer such services. These entities include disease management companies, specialty healthcare companies, major pharmaceutical companies, healthcare organizations, independent care management organizations, provider groups, pharmacy benefit management companies, healthcare information system and software vendors, and other entities that provide services to health plans, self-insured employers, government agencies and other organizations mentioned above. Many of these competitors have substantial installed customer bases in the healthcare industry and the ability to fund significant product development and acquisition efforts. We also compete against other companies that provide statistical and data management services, including clinical trial services to pharmaceutical companies. In addition, many payor organizations, including health plans, have internal network development and medical case management staff who provide services similar to those provided by us. Many of our competitors have significantly greater financial resources, and these companies also compete with us in recruiting and retaining qualified personnel. Our failure to compete effectively could have a material adverse affect on our business.

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

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

Government Regulation

The healthcare industry, including our current business, is subject to extensive regulation by both the Federal and state governments. A number of states have extensive licensing and other regulatory requirements applicable to companies that provide healthcare services. Additionally, services provided to health benefit plans in certain cases are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended, and may be affected by other state and Federal statutes. Generally, state laws prohibit the practice of medicine and nursing without a license. Many states interpret the practice of nursing to include health teaching, health counseling, the provision of care supportive to, or restorative of life and well being, and the execution of medical regimens prescribed by a physician. Accordingly, to the extent that we assist providers in improving patient compliance by publishing educational materials or providing behavior modification training to patients, such activities could be deemed by a state to be the practice of medicine or nursing. Although we have not conducted a survey of the applicable law in all 50 states, we believe that we are not engaged in the practice of medicine or

nursing. There can be no assurance, however, that businesses such as ours will not be challenged as engaging in the unlicensed practice of medicine or nursing. If such a challenge were made successfully in any state, we could be subject to civil and criminal penalties under such state s law and could be required to restructure our contractual arrangements in that state. Such results, or the inability to successfully restructure our contractual arrangements, could have a material adverse effect on our operations.

We and our customers may also be subject to Federal and state laws and regulations that govern financial and other arrangements among healthcare providers. These laws prohibit certain fee splitting arrangements among healthcare providers, as well as direct and indirect payments, referrals or other financial arrangements that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. Possible sanctions for violation of these restrictions include civil and criminal penalties. Criminal penalties range from misdemeanors, which carry fines of not more than $10,000 or imprisonment for not more than one year, or both, to felonies, which carry fines of not more than $25,000 or imprisonment for not more than five years, or both. Further, criminal violations may result in permanent mandatory exclusions and additional permissive exclusions from participation in Medicare and Medicaid programs.

Regulation in the health care field is constantly evolving. We are unable to predict what government regulations, if any, affecting our business may be promulgated in the future. Our business could be materially adversely affected by the failure to obtain required licenses and governmental approvals, comply with applicable regulations or comply with existing or future laws, rules or regulations or their interpretations.

Certain of our subsidiaries are licensed to take risk in certain states. These subsidiaries must meet certain minimum capital and surplus tests as well as file quarterly and annual filings with regulatory and state authorities. If one of these subsidiaries does not remain in compliance with the statutory requirements, it is possible that the regulating authorities could impose greater restrictions on the subsidiary, including requiring additional cash deposits, additional reporting requirements and the potential revocation of licenses, each of which could have a materially adverse impact on our results of operations, liquidity and financial condition.

Employees

As of July 18, 2006, we had 193 full time and 29 part-time employees. None of our employees is represented by a union, and we are not aware of any activities seeking such organization. We consider our relations with our employees to be good.

PROPERTIES

Our executive and corporate offices are located in Coral Springs, Florida in approximately 76,000 square feet of office space. We also lease 9,000 square feet of office space in Rochester, New York under a month-to-month arrangement which we expect to terminate in 2006. We and our subsidiaries also lease approximately 34,000 square feet of office space in New York City, of which 83% is subleased, approximately 3,300 square feet of office space in Southfield, Michigan, approximately 6,600 square feet of office space in Dallas, Texas and 6,400 square feet of office space in Las Vegas, Nevada. These operating leases expire at various times between December 31, 2006 and July 31, 2010.

These facilities are in good condition, and we believe that our and our subsidiaries offices are suitable to meet current needs.

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LEGAL PROCEEDINGS

One of our subsidiaries entered into a Health Services Agreement with Oxford Health Plans (NY) Inc., or Oxford, pursuant to which each party made payments to the other based on services provided. As permitted by the agreement, our subsidiary terminated the agreement by written notice to Oxford, which termination was effective as of August 31, 2005. Oxford contends that our subsidiary owes it approximately $1.5 million for the periods through August 31, 2005, while we believe that Oxford owes our subsidiary approximately $180,000 for the period ending December 31, 2004. We have not yet determined whether Oxford owes the subsidiary any amounts for 2005, other than an unpaid $75,000 administrative fee for the month of August 2005. Negotiations to settle the matter have been unsuccessful to date. On July 22, 2005, over our objections, Oxford drew down on a $500,000 letter of credit that had been provided under the contract. We received a letter dated September 8, 2005 from Oxford requesting that we replenish the existing letter of credit in the amount of approximately $1.5 million, but we have denied this request. We received a letter from Oxford dated September 26, 2005 indicating that Oxford has submitted the matter to the American Health Lawyers Association for binding arbitration, seeking to compel our subsidiary to replenish the letter of credit in the amount of approximately $1.5 million and to pay Oxford an additional approximately $1.0 million. We have filed counterclaims against Oxford for amounts that we contend are owed by Oxford under the agreement. An arbitration hearing began in June 2006 and was completed in July 2006. Final briefs are due from the parties in early August 2006, after which a decision by the arbitration panel is expected. We are vigorously defending this claim and are asserting our own claims in the arbitration process, although there can be no assurance regarding the ultimate outcome of this matter. Management s best estimate of the liability to settle this dispute was recorded as a liability as of March 31, 2006.

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

MANAGEMENT AND BOARD OF DIRECTORS

The names, ages and positions of our current directors and executive officers as of July 18, 2006 are as follows:

Name	Age	Position
Chris E. Paterson	45	President and Chief Executive Officer
Glen A. Spence	52	Executive Vice President and Chief Financial Officer
M. Ileana Welte	50	Senior Vice President and Chief Marketing Officer
Ann M. Boughtin	53	Executive Vice President and Chief Operating Officer
Rex M. Dendinger II	53	Senior Vice President and Chief Information Officer
Roger Louis Chaufournier	48	President and Chief Executive Officer, Provider Improvement Subsidiary
Christine St. Andre	55	Chief Operating Officer, Provider Improvement Subsidiary
Kent A. Tapper	49	Vice President, Finance, Sarbanes-Oxley and SEC Compliance
Marc L. Pacala	51	Director
Albert S. Waxman, Ph.D.	65	Chairman and Director
Daniel C. Lubin	46	Director
Derace L. Schaffer, M.D.	59	Director
John Pappajohn	77	Vice Chairman and Director

There are no familial relationships among our directors and/or officers. Directors hold office until the next annual meeting of our stockholders and until their respective successors have been elected and qualified.

Executive Officers

Chris E. Paterson, Ph.D., 45. Dr. Paterson became our President and Chief Executive Officer on January 25, 2006. Prior to that, Dr. Paterson was President and Chief Executive Officer of CCS Consolidated and a member of its board of directors since January 2005. He joined CCS Consolidated as Executive Vice President in July 2004. From 2002 to 2004, Dr. Paterson served as the President of the Central Region of UnitedHealth Group s AmeriChoice Corporation, having served as CEO of AmeriChoice health plans in Pennsylvania from 1998 to 2002. From 1990 to 1998, he worked with Merit Behavioral Care Corporation, serving in such positions as Executive Vice President of the Eastern Division and President of Tennessee Behavioral Health. Dr. Paterson has served on the boards of such entities as the City of Philadelphia Department of Health and the American Heart Association Southeastern Pennsylvania Region. Dr. Paterson received his Ph.D. in psychology from Ohio State University, interned at the University of Florida and served on the faculty of the University of Miami early in his career.

Glen A. Spence, 52. Mr. Spence became our Executive Vice President and Chief Financial Officer on January 25, 2006. Prior to that, he had served as the Executive Vice President and Chief Financial Officer of CCS Consolidated since March 2003. From 2000 to 2003, Mr. Spence was a partner in the firm of Tatum Partners, which specializes in providing Chief Financial Officers to clients in a variety of industries. Mr. Spence was employed by John Alden Financial Corporation, a publicly-held life and health insurer, from 1981 to 1999 in a variety of finance positions, including serving as the Senior

Vice President of Finance and Accounting. Mr. Spence has also functioned as a financial consultant, interim chief financial officer and an educator at CPA continuing education seminars. Mr. Spence started his career in public accounting working for Haskins & Sells, a predecessor of Deloitte and Touche, and later at KPMG. As a seasoned finance executive, Mr. Spence is versed in strategic and operational planning, rapid growth, initial public offerings, leveraged buyouts, mergers and acquisitions, regulatory affairs, underwriting, turnarounds, and SEC reporting. He holds a B.S. degree from Emporia State University, is a member of the American Institute of Certified Public Accountants and the Florida Institute of Certified Public Accountants, and holds a CPA license in the state of Florida.

M. Ileana Welte, 50. Ms. Welte became our Chief Marketing Officer and Senior Vice President on January 25, 2006. Prior to that, she was CCS Consolidated s Senior Vice President and Chief Clinical Officer. Ms. Welte joined CCS Consolidated as the executive director of CareGuide@Home in June 2001 after the acquisition of CareGuide, Inc. by CCS Consolidated. She has extensive experience in the design of programs providing care management services to the elderly and chronically ill. With a background in building sales, business development and technology operations, Ms. Welte has built a clinical organization focused on providing quality health care to the elderly and chronically ill through application of evidence based medicine and innovative technologies. Prior to joining CareGuide@Home full-time, Ms. Welte served as a senior operations and clinical consultant for business development and sales strategies for CareGuide@Home from 2000 to 2001. Before joining CCS Consolidated and CareGuide@Home, Ms. Welte served as vice president of business development for Interval Research, Electric Planet, a Paul Allen company from 1997 to 1999 and Vice President of Sales for Maxis, Inc. from 1992 to 1997. Ms. Welte holds a B.S.N. degree and has post graduate education in Geriatric Care Management.

Ann M. Boughtin, 53. Ms. Boughtin became our Executive Vice President and Chief Operating Officer on January 25, 2006. Prior to that, she had served as CCS Consolidated s Senior Vice President and Chief Marketing Officer since August 2005. From September 2003 to August 2005, Ms. Boughtin served as general manager for the TennCare Partners Program, a $450 million service operated by Magellan Health Services for the Tennessee Medicaid program. Previously, she was vice president of business development for Comprehensive Neuroscience, Inc. where she worked from June 2001 to September 2003, She was vice president of marketing and business development from June 2000 through April 2001 for Centromine, a privately held technology company, providing an ASP enterprise solution for the behavioral health industry. She was vice president of managed care for Psychiatric Solutions, Inc., a company providing behavioral healthcare management services, from July 1998 until June 2000. Ms. Boughtin began her career as assistant executive director of a large, non-profit agency, and went on to spend 15 years in the New York State Office of Mental Health, where she worked as one of the 50 top executives. Ms. Boughtin holds a Master s in Public Administration (MPA), and an MS and PS in Political Science, all from the State University of New York at Brockport.

Rex M. Dendinger II, 53. Rex Dendinger II became our Senior Vice President and Chief Information Officer on January 25, 2006. Prior to that, he had been CCS Consolidated s Senior Vice President and Chief Information Officer since November 2005. Prior to joining CCS Consolidated, from September 2003 to November 2005, Mr. Dendinger served as interim chief executive officer and chief information officer at a number of firms, providing vital expertise to start-up organizations, executive leadership to a regional claims administration firm, and supported merger and acquisition transactions. From July 1998 to September 2003, Mr. Dendinger served as chief information officer of Magellan Health Services, where he was responsible for technology strategy and operations for a $100 million leader in the managed care industry. At Saint Vincent Health System in Pennsylvania from 1996 to 1998, Mr. Dendinger directed a corporate information technology initiative to re-engineer the entire corporate network, accommodating a newly designed infrastructure and software platform. Mr. Dendinger holds a B.S. degree in Computer Science from Lockyear College.

Roger Louis Chaufournier, 48. As of January 25, 2006, Mr. Chaufournier will serve as the President and Chief Executive Officer of our provider improvement subsidiary. Mr. Chaufournier had been our Chief Executive Officer since April 1, 2000 and President between April 1, 2000 and October 27, 2004 and was a member of our Board of Directors from November 2004 to January 25, 2006. Prior to joining our company, Mr. Chaufournier was President of the STAR Advisory Group, a healthcare consulting firm he founded in 1998. From August 1996 to July 1999, Mr. Chaufournier was the Chief Operating Officer of the Managed Care Assistance Company, a company that developed and operated Medicaid health plans. Managed Care Assistance Company filed for protection under the federal bankruptcy laws in June 2000. From 1993 to 1996, Mr. Chaufournier was Assistant Dean for Strategic Planning for the Johns Hopkins University School of Medicine. In addition, Mr. Chaufournier spent twelve years in progressive leadership positions with the George Washington University Medical Center from 1981 to 1993.

Christine St. Andre, 55. As of January 25, 2006, Ms. St. Andre will serve as the Chief Operating Officer of our provider improvement subsidiary. Ms. St. Andre had been our Executive Vice President and Chief Operating Officer since June 5, 2000, and President since October 27, 2004. Ms. St. Andre has more than 20 years experience managing complex healthcare organizations. From 1994 to 2000, Ms. St. Andre was Chief Executive Officer for the University of Utah Hospitals and Clinics. Prior to 1994, Ms. St. Andre served as Chief Executive Officer of George Washington University Medical Center. Ms. St. Andre s career in healthcare began in the area of information technology at the Thomas Jefferson University.

Kent Tapper, 49. As of January 25, 2006, Mr. Tapper became our Vice President, Finance, Sarbanes-Oxley and SEC Compliance. Mr. Tapper had been our Vice President, Financial Planning since April 1999. Mr. Tapper had also served as Chief Information Officer and Vice President, Systems Engineering and has been with our company since July 1995. Mr. Tapper was our acting Chief Financial Officer from April 2000 to January 25, 2006. From 1992 to 1995, Mr. Tapper served as Product Manager, Audio Response and Call Center Platforms for Northern Telecom, Inc. From 1983 to 1992, Mr. Tapper held Product Manager, Systems Engineering Manager and various engineering management positions with Northern Telecom.

Directors

Mark L. Pacala, 51. Mr. Pacala became a member of our board of directors as a result of the merger with CCS Consolidated. He has been a director of CCS Consolidated since 2002. He has over 20 years of operational and general management experience in services, technology and healthcare companies. He has been a Managing Director of Essex Woodlands Health Ventures since January 2004 and was a Venture Partner of Essex Woodlands Health Ventures from April 2002 to December 2003. From October 2001 to January 2003, Mr. Pacala was self-employed as a venture capital consultant. He served as Chief Executive Officer of American WholeHealth, Inc., an integrative health network company that combines conventional medicine, alternative medicine, nutrition and wellness, from September 1996 to September 2001. Prior to American WholeHealth, he served as Chief Executive Officer of Forum Group, a public senior housing and healthcare company with revenues in excess of $200 million, which was later sold to Marriott Corporation. From 1989 to 1994, Mr. Pacala was a Senior Vice President and General Manager at The Walt Disney Company, and he served as Director of Corporate Planning and Vice President of Operations at Marriott Corporation from 1984 to 1989. He began his career as a banker in 1977 at Manufacturers Hanover Trust Co. and transitioned to strategic planning in healthcare at Booz, Allen and Hamilton. Mr. Pacala currently serves on the board of directors of Health Grades, Inc., a provider of proprietary healthcare provider ratings and advisory services. He received a B.A. degree from

Hamilton College where he graduated magna cum laude and Phi Beta Kappa, and later received an MBA degree from Harvard Business School, where he graduated with distinction.

Albert S. Waxman, Ph.D., 65. Dr. Waxman became a member of our board of directors as a result of the merger with CCS Consolidated and also serves as its Chairman. He has been a director of CCS Consolidated since 1998. He is a co-founder and senior managing member of Psilos Group Managers, LLC, a venture capital firm specializing in e-health and healthcare services investments since 1998. Prior to co-founding Psilos Group Managers, LLC, Dr. Waxman was, from 1993 to 1998, chairman and chief executive officer of Merit Behavioral Care Corporation, a healthcare company, and its predecessor companies, American Biodyne and Medco Behavioral Care, a subsidiary of Merck & Co., until its acquisition by Magellan Health Services in February 1998. Prior to American Biodyne, Dr. Waxman founded and served as President, Chairman and Chief Executive Officer of Diasonics, Inc. He holds several U.S. and foreign patents for display, imaging and diagnostic technologies and products. Dr. Waxman serves on the board of directors of Orthometrix, Inc. and is a director of several Psilos portfolio companies, including Comprehensive NeuroScience, HealthEdge, Health Hero Network and Active Health Management. He also serves on the Board of Directors of the New York City Investment Fund, a $100 million venture capital fund formed in 1996 by leading corporations and financial executives. Dr. Waxman received a B.S.E.E. degree from City College of New York and M.A. and Ph.D. degrees from Princeton University. He serves on the Advisor Council of Princeton University s School of Engineering and Applied Sciences.

Daniel C. Lubin, 46. Mr. Lubin became a member of our board of directors as a result of the merger with CCS Consolidated. He has been a director of CCS Consolidated since January 2005. Mr. Lubin also served as a member of the board of directors of CCS Consolidated from 1998 to 2001. Mr. Lubin has been a managing member of Radius Ventures, LLC, a New York City venture capital firm, since 1997. From 1994 to 1997, Mr. Lubin was a director in the Investment Banking Division of Schroder Wertheim & Co., where he shared responsibility for managing the firm s Health Care Group. In 1991, Mr. Lubin co-founded and was a managing director of KBL Healthcare Inc., a health and life sciences venture capital and investment banking organization, and served as president and chief operating officer of KBL Healthcare Acquisition Corp., a publicly-traded strategic acquisition fund. His prior affiliations include Manufacturers Hanover Trust, and the Center for Strategic and International Studies, where he served as Special Assistant to the Chairman. He was a founder of Cambridge Heart, Inc., a healthcare company engaged in the research, development and commercialization of products for the non-invasive diagnosis of cardiac disease. Mr. Lubin currently serves on the board of directors of BioLok International Inc., and EyeTel Imaging, Inc., each portfolio companies of Radius Ventures, LLC. He also serves on the Board of Trustees for The Haverford School. He earned a BS cum laude in Foreign Service from the Georgetown University School of Foreign Service and an MBA with honors from Harvard Business School.

Derace L. Schaffer, M.D., 59. Dr. Schaffer has been a director of our company since its inception in February 1995 and served as Chairman of the Board of Directors until November 2004. Dr. Schaffer is the founder and CEO of the Lan Group, a venture capital firm specializing in healthcare and high technology investments which position he has held for more than the last five years. He also serves as a director for the following public companies: Healthcare Acquisition Corporation, American Caresource Holdings, Inc. and Allion Healthcare, Inc. He received his postgraduate radiology training at Harvard Medical School and Massachusetts General Hospital, where he served as Chief Resident. Dr. Schaffer is Clinical Professor of Radiology at the Cornell Medical School.

John Pappajohn, 77. Mr. Pappajohn has been a director of our company since its inception in February 1995, and served as its Secretary and Treasurer from inception through May 1995. Since 1969, Mr. Pappajohn has been the sole owner of Pappajohn Capital Resources, a venture capital firm and

President of Equity Dynamics, Inc., a financial consulting firm, both located in Des Moines, Iowa. He also serves as a director for the following public companies: Healthcare Acquisition Corporation, American Caresource Holdings, Inc., Allion Healthcare, Inc., MC Informatics, Inc. and Pace Health Management Systems, Inc. He also serves as Chairman for Healthcare Acquisition Corporation.

EXECUTIVE COMPENSATION

The following table sets forth information concerning the annual and long-term compensation for services in all capacities to us for the fiscal year ended March 31, 2006 and each of the fiscal years ended December 31, 2005, 2004 and 2003 for each person who served as our Chief Executive Officer during the fiscal year ended March 31, 2006 and our executive officers who received compensation in excess of $100,000 during the fiscal year ended March 31, 2006 (collectively the Named Executive Officers), and certain of our other executive officers. Subsequent to December 31, 2005, we changed our fiscal year end to March 31. Accordingly, information for the period from April 1, 2005 to December 31, 2005 has been included in both the line items labeled 2006 and 2005 .

Summary Compensation Table

			Annual Compensation		
Name and Principal Position	**Year**		**Salary**	**Bonus**	**Securities Underlying Options / SARs**
Chris E. Paterson, President and Chief Executive Officer (*)	2006	(a)	$ 47,077	$ -	1,017,666
Roger L. Chaufournier, Former Chief Executive Officer (*)	2006	(b)	278,969	-	325,000
	2005		268,790	-	-
	2004		250,007	50,000	400,000
	2003		219,611	25,385	-
Ann M. Boughtin, Executive Vice President and Chief Operating Officer	2006	(c)	42,385	-	-
Glen A. Spence, Executive Vice President and Chief Financial Officer	2006	(d)	40,486	-	254,416
M. Ileana Welte, Senior Vice President and Chief Marketing Officer	2006	(e)	33,231	-	127,208
Rex M. Dendinger II, Senior Vice President and Chief Information Officer	2006	(f)	31,015	-	-

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Christine St. Andre, Former President and Chief Operating Officer	2006	(g)	224,888	-	150,000
	2005		217,258	-	-
	2004		200,016	40,000	200,000
	2003		184,050	22,212	-
Kent A. Tapper, Vice President, Finance	2006	(h)	172,102	-	100,000
	2005		163,697	-	-
	2004		127,934	30,000	125,000
	2003		124,154	14,913	-

(*) Named Executive Officer

(a) Dr. Paterson became our President and Chief Executive Officer on the merger date of January 25, 2006. Dr. Paterson s base pay is $250,000 per annum. Dr. Paterson held options to purchase common stock of CCS Consolidated which were assumed by us and converted into an option to purchase up to 1,017,666 shares of our common stock.

(b) Mr. Chaufournier served as our Chief Executive Officer until January 25, 2006, at which time he became President and CEO of Innovacare, our provider improvement division. On January 25, 2006, options held by Mr. Chaufournier to purchase up to 433,332 shares of our common stock were canceled in exchange for a warrant to purchase up to 325,000 shares of our common stock at an exercise price equal to $0.95 per share.

(c) Ms. Boughtin became our Executive Vice President and Chief Operating Officer on the merger date of January 25, 2006. Ms. Boughtin s base pay is $215,000 per annum.

(d) Mr. Spence became our Executive Vice President and Chief Financial Officer on the merger date of January 25, 2006. Mr. Spence s base pay is $215,000 per annum. Mr. Spence held an option to purchase common stock of CCS Consolidated which was assumed by us and converted into an option to purchase up to 254,416 shares of our common stock.

(e) Ms. Welte became our Senior Vice President and Chief Marketing Officer on the merger date of January 25, 2006. Ms. Welte s base pay is $180,000 per annum. Ms. Welte held an option to purchase common stock of CCS Consolidated which was assumed by us and converted into an option to purchase up to 127,208 shares of our common stock.

(f) Mr. Dendinger became our Senior Vice President and Chief Information Officer on the merger date of January 25, 2006. Mr. Dendinger s base pay is $168,000 per annum.

(g) Ms. St. Andre served as our President and Chief Operating Officer until January 25, 2006, at which time she became the Chief Operating Officer of Innovacare, our provider improvement division. On January 25, 2006, options held by Ms. St. Andre to purchase up to 200,000 shares of our common stock were canceled in exchange for a warrant to purchase up to 150,000 shares of our common stock an exercise price of $0.95 per share.

(h) Mr. Tapper served as our Vice President, Financial Planning until January 25, 2006, at which time he became our Vice President of Finance, Sarbanes-Oxley and SEC Compliance. On January 25, 2006, options held by Mr. Tapper to purchase up to 133,333 shares of our common stock were canceled in exchange for a warrant to purchase up to 100,000 shares of our common stock an exercise price of $0.95 per share.

Option Grants in Last Fiscal Year

The following table shows individual stock option grants made during the fiscal year ended March 31, 2006 to our executive officers:

Name	Number of Securities Underlying Options Granted (#)(1)	Percentage of Total Options Granted to Employees in Fiscal Year (%)	Exercise or Base Price ($/per Share)	Expiration Date	Market Price on Date of Grant ($/per Share)
Chris E. Paterson	1,017,666	72.7	0.2337	4/18/15	$1.06
Glen A. Spence	254,416	18.2	0.2337	4/18/15	$1.06
M. Ileana Welte	127,208	9.1	0.2337	4/18/15	$1.06

(1) Each stock option granted by us during the fiscal year ended March 31, 2006 has a maximum term of ten years from the date of grant, subject to earlier termination upon the optionee s cessation of service to us. Each such stock option granted by us represents the assumption, in connection with the merger with CCS Consolidated, of an option previously granted to the optionee to purchase common stock of CCS Consolidated. The number of shares of our common stock underlying each assumed option, and the exercise price of $0.2337 per share of our common stock, was calculated based upon the exchange ratio in connection with the merger. Each such stock option was accelerated in part so that it was 25% vested as of the merger closing date of January 25, 2006 and shall vest in 36 equal monthly installments thereafter.

Aggregated Option Exercises

and Option Values on March 31, 2006 and the Fiscal Year Then Ended

The following table sets forth certain information regarding unexercised options held by the executive officers listed in the foregoing tables at March 31, 2006 and grants of options during the fiscal year ended March 31, 2006 to these individuals. The tables do not give effect to grants of options that occurred after March 31, 2006. For additional information with respect to these grants, see Stock Option Plan, below.

	Shares acquired on exercise (#)	Value realized($)	Number of securities underlying unexercised options at March 31, 2006(#)		Value of unexercised in-the-money options at March 31, 2006($)	
Name			Exercisable	Unexercisable	Exercisable	Unexercisable
Chris E. Paterson	-	-	296,820	720,846	366,955	891,173
Roger L. Chaufournier	-	-	325,000	-	401,793	-
Ann M. Boughtin	-	-	-	-	-	-
Glen A. Spence	-	-	74,205	180,211	91,739	222,793

M. Ileana Welte	-	-	37,102	90,106	45,869	111,397
Rex M. Dendinger II	-	-	-	-	-	-
Christine St. Andre	25,000	50,125	150,000	-	185,433	-
Kent Tapper	-	-	100,000	-	123,629	-

Compensation of Directors

Our directors do not receive compensation pursuant to any standard arrangement for their services as directors. All directors are reimbursed for expenses incurred in connection with attending meetings, including travel expenses to such meetings.

Our non-employee directors were previously eligible to participate in our Stock Option Plan. However, the Stock Option Plan expired in accordance with its terms during 2005, and no further grants may be made from such plan. With respect to prior grants made pursuant to the Stock Option Plan, non-employee directors received a one-time grant of a non-qualified stock option to purchase 36,000 shares of common stock at an exercise price equal to the fair market value per share on the date of their initial election to the board of directors. Such non-qualified stock options vest as to 20% of the option grant on the first anniversary of the grant, and 20% on each subsequent anniversary. The option is exercisable only during the non-employee director s term and automatically expires on the date such director s service terminates. Upon the occurrence of a change of control, as defined in the Stock Option Plan, all outstanding unvested options immediately vest.

Employment Agreements

As part of, and effective upon, the merger with CCS Consolidated in January 2006, we entered into employment agreements with each of Chris Paterson, Glen Spence, Roger Chaufournier, Christine St. Andre and Kent Tapper. During June 2006, we entered into employment agreements with each of Ileana Welte, Ann Boughtin and Rex Dendinger. The material terms of each of these agreements are described below.

Chris Paterson

Under the terms of Dr. Paterson s employment agreement, he is employed in the capacity of our president and chief executive officer. His employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Dr. Paterson. Dr. Paterson s base salary under the employment agreement is $250,000 per year, and Dr. Paterson is eligible for a discretionary calendar year bonus in an amount up to 50% of his base salary, subject to his achievement of mutually agreed upon performance goals. In addition, Dr. Paterson is eligible for any other bonus payments as may be awarded by our board of directors. Dr. Paterson s options to purchase shares of CCS Consolidated common stock were assumed by us at the closing of the Merger, and the vesting of such options was partially accelerated so that one quarter of the shares underlying the options were vested as of the closing of the Merger, with the remainder vesting in 36 equal monthly installments over the next three years. Dr. Paterson is also eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Dr. Paterson s employment is terminated by us without cause or by Dr. Paterson for good reason (each as defined in his employment agreement), subject to Dr. Paterson s entering into and not revoking a separation agreement and release in a form acceptable to us, Dr. Paterson will be entitled to receive: (i) severance payments equal to his then applicable base salary for a period of twelve months; (ii) a pro rated portion of any annual bonus that he would have received had he remained employed through the calendar year for which the bonus is calculated; and (iii) if he timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as he is receiving severance payments under the

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employment agreement (or until he is eligible for health care coverage under another employer s plan, whichever period is shorter).

Glen Spence

Under the terms of Mr. Spence s employment agreement, he is employed in the capacity of our chief financial officer. His employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Mr. Spence. Mr. Spence s base salary under the employment agreement is $215,000 per year, and Mr. Spence is eligible for a discretionary calendar year bonus in an amount up to 20% of his base salary, subject to his achievement of mutually agreed upon performance goals. In addition, Mr. Spence is eligible for any other bonus payments as may be awarded by our board of directors. Certain of Mr. Spence s options to purchase shares of CCS Consolidated common stock were assumed by us at the closing of the Merger, and the vesting of such options was partially accelerated so that one quarter of the shares underlying the options were vested as of the closing of the Merger, with the remainder vesting in 36 equal monthly installments over the next three years. Mr. Spence is also eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Mr. Spence s employment is terminated by us without cause or by Mr. Spence for good reason (each as defined in his employment agreement), subject to Mr. Spence s entering into and not revoking a separation agreement and release in a form acceptable to us, Mr. Spence will be entitled to receive: (i) severance payments equal to his then applicable base salary for a period of six months; (ii) a pro rated portion of any annual bonus that he would have received had he remained employed through the calendar year for which the bonus is calculated; and (iii) if he timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as he is receiving severance payments under the employment agreement (or until he is eligible for health care coverage under another employer s plan, whichever period is shorter).

Ileana Welte

Under the terms of Ms. Welte s employment agreement, she is employed in the capacity of our chief clinical officer and senior vice president. Her employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Ms. Welte. Ms. Welte s base salary under the employment agreement is $180,000 per year, and Ms. Welte is eligible for a discretionary calendar year bonus in an amount up to 20% of her base salary, subject to her achievement of mutually agreed upon performance goals. In addition, Ms. Welte is eligible for any other bonus payments as may be awarded by our board of directors. Ms. Welte s options to purchase shares of CCS Consolidated common stock were assumed by us at the closing of the Merger, and the vesting of such options was partially accelerated so that one quarter of the shares underlying the options were vested as of the closing of the Merger, with the remainder vesting in 36 equal monthly installments over the next three years. Ms. Welte is also eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Ms. Welte s employment is terminated by us without cause or by Ms. Welte for good reason (each as defined in her employment agreement), subject to Ms. Welte s entering into and not revoking a separation agreement and release in a form acceptable to us, Ms. Welte will be entitled to receive: (i) severance payments equal to her then applicable base salary for a period of six months; (ii)

a pro rated portion of any annual bonus that she would have received had she remained employed through the calendar year for which the bonus is calculated; and (iii) if she timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as she is receiving severance payments under the employment agreement (or until she is eligible for health care coverage under another employer s plan, whichever period is shorter).

Ann Boughtin

Under the terms of Ms. Boughtin s employment agreement, she is employed in the capacity of our chief operating officer and executive vice president. Her employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Ms. Boughtin. Ms. Boughtin s base salary under the employment agreement is $215,000 per year, and Ms. Boughtin is eligible for a discretionary calendar year bonus in an amount up to 20% of her base salary, subject to her achievement of mutually agreed upon performance goals. In addition, Ms. Boughtin is eligible for any other bonus payments as may be awarded by our board of directors. Ms. Boughtin is also eligible to receive commissions pursuant to our commission plan, in accordance with the terms and conditions of that plan. Ms. Boughtin is also eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Ms. Boughtin s employment is terminated by us without cause or by Ms. Boughtin for good reason (each as defined in her employment agreement), subject to Ms. Boughtin s entering into and not revoking a separation agreement and release in a form acceptable to us, Ms. Boughtin will be entitled to receive: (i) severance payments equal to her then applicable base salary for a period of six months; (ii) a pro rated portion of any annual bonus that she would have received had she remained employed through the calendar year for which the bonus is calculated; and (iii) if she timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as she is receiving severance payments under the employment agreement (or until she is eligible for health care coverage under another employer s plan, whichever period is shorter).

Rex Dendinger III

Under the terms of Mr. Dendinger s employment agreement, he is employed in the capacity of our chief information officer and senior vice president. His employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Mr. Dendinger. Mr. Dendinger s base salary under the employment agreement is $168,000 per year, and Mr. Dendinger is eligible for a discretionary calendar year bonus in an amount up to 20% of his base salary, subject to his achievement of mutually agreed upon performance goals. In addition, Mr. Dendinger is eligible for any other bonus payments as may be awarded by our board of directors. Mr. Dendinger is also eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Mr. Dendinger s employment is terminated by us without cause or by Mr. Dendinger for good reason (each as defined in his employment agreement), subject to Mr. Dendinger s entering into and not revoking a separation agreement and release in a form acceptable to us, Mr. Dendinger will be entitled to receive: (i) severance payments equal to his then applicable base salary for a period of six months; (ii) a pro rated portion of any annual bonus that he would have received had he

remained employed through the calendar year for which the bonus is calculated; and (iii) if he timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as he is receiving severance payments under the employment agreement (or until he is eligible for health care coverage under another employer s plan, whichever period is shorter).

Roger Chaufournier

Under the terms of Mr. Chaufournier s employment agreement, he is employed in the capacity of President of our provider improvement division, reporting to our chief executive officer. His employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Mr. Chaufournier. Mr. Chaufournier s base salary under the employment agreement is $262,500 per year, and Mr. Chaufournier is eligible for a calendar year bonus if our board of directors determines in its sole reasonable discretion that the earnings before charges for interest, taxes, depreciation and amortization (EBITDA) for our provider improvement division for the year has exceeded $1,000,000, and Mr. Chaufournier remains employed by us through the end of the calendar year. If both these conditions are met, Mr. Chaufournier s bonus shall be equal to a percentage of such EBITDA as follows:

12% of the EBITDA of the provider improvement division over $1,000,000 but less than $2,000,000;

18% of the EBITDA of the provider improvement division over $2,000,000 but less than $3,000,000;

24% of the EBITDA of the provider improvement division over $3,000,000 but less than $4,000,000; and

30% of the EBITDA of the provider improvement division over $4,000,000.

In addition, Mr. Chaufournier is eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Mr. Chaufournier s employment is terminated by us without cause or by Mr. Chaufournier for good reason (each as defined in his employment agreement), subject to Mr. Chaufournier s entering into and not revoking a separation agreement and release in a form acceptable to us, Mr. Chaufournier will be entitled to receive: (i) severance payments equal to his then applicable base salary for a period of twelve months; (ii) a pro rated portion of any annual bonus that he would have received had he remained employed through the calendar year for which the bonus is calculated; and (iii) if he timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as he is receiving severance payments under the employment agreement (or until he is eligible for health care coverage under another employer s plan, whichever period is shorter).

Christine St. Andre

Under the terms of Ms. St. Andre s employment agreement, she is employed in the capacity of Chief Operating Officer of our provider improvement division. Her employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us

or Ms. St. Andre. Ms. St. Andre s base salary under the employment agreement is $210,000 per year, and Ms. St. Andre will be eligible for a calendar year bonus if our board of directors determines in its sole reasonable discretion that the EBITDA for the provider improvement division for the year has exceeded $1,000,000, and Ms. St. Andre remains employed by us through the end of the calendar year. If both these conditions are met, Ms. St. Andre s bonus shall be equal to a percentage of such EBITDA as follows:

8% of the EBITDA of the provider improvement division over $1,000,000 but less than $2,000,000;

12% of the EBITDA of the provider improvement division over $2,000,000 but less than $3,000,000;

16% of the EBITDA of the provider improvement division over $3,000,000 but less than $4,000,000; and

20% of the EBITDA of the provider improvement division over $4,000,000.

In addition, Ms. St. Andre is eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors.

In the event that Ms. St. Andre s employment is terminated by us without cause or by Ms. St. Andre for good reason (each as defined in her employment agreement), subject to Ms. St. Andre s entering into and not revoking a separation agreement and release in a form acceptable to us, Ms. St. Andre will be entitled to receive: (i) severance payments equal to her then applicable base salary for a period of twelve months; (ii) a pro rated portion of any annual bonus that she would have received had she remained employed through the calendar year for which the bonus is calculated; and (iii) if she timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as she is receiving severance payments under the employment agreement (or until she is eligible for health care coverage under another employer s plan, whichever period is shorter).

Kent Tapper

Under the terms of Mr. Tapper s employment agreement, he is employed in the capacity of our Vice President of Finance, Sarbanes-Oxley and SEC Compliance, reporting to our chief financial officer. His employment agreement has an initial one year term, which automatically renews for additional one-year periods unless earlier terminated by us or Mr. Tapper. Mr. Tapper s base salary under the employment agreement is $175,000 per year, and Mr. Tapper is eligible for any other bonus payments as may be awarded by our board of directors. In addition, Mr. Tapper is eligible to receive options to purchase shares of our common stock under our stock option plans on the same basis as similarly situated employees. The decision to grant any such options and the terms of such options will be within the discretion of our board of directors. Mr. Tapper will be responsible for temporary living accommodations in the Coral Springs, Florida area by the end of July 2006, and we have agreed to pay travel and commuting expenses. In addition, we will pay up to $10,000 in expenses for temporary living accommodations plus amounts associated with income taxes thereon. In the event that Mr. Tapper terminates his employment with us within one year after his relocation to Florida, Mr. Tapper will be required to repay a prorated portion of such relocation costs.

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In the event that Mr. Tapper s employment is terminated by us without cause or by Mr. Tapper for good reason (each as defined in his employment agreement), subject to Mr. Tapper s entering into and not revoking a separation agreement and release in a form acceptable to us, Mr. Tapper will be entitled to receive: (i) severance payments equal to his then applicable base salary for a period of six months; (ii) a pro rated portion of any annual bonus that he would have received had he remained employed through the calendar year for which the bonus is calculated; and (iii) if he timely elects and remains eligible for continued coverage under COBRA, that portion of the COBRA premiums that we were paying prior to the date of termination for as long as he is receiving severance payments under the employment agreement (or until he is eligible for health care coverage under another employer s plan, whichever period is shorter).

STOCK OPTION PLANS

All stock options outstanding as of March 31, 2006 were granted under our Amended and Restated Stock Option Plan adopted by the board of directors and stockholders in 1995, which expired in 2005 on the tenth anniversary of its adoption (the Original Plan) or the CCS Consolidated, Inc. 2005 Equity Incentive Plan, which was assumed by us on January 25, 2006 as part of the Merger (the CCS Plan and collectively the Plans). As of March 31, 2006, 1,847,367 shares of our common stock are reserved for issuance under the Plans. No new grants can be made under the Original Plan.

As of March 31, 2006, options to acquire 1,847,367 shares of common stock were outstanding to our employees and directors. The following table sets forth information regarding the number of options outstanding and the exercise price of these options.

Number of Options Outstanding at March 31, 2006	**Exercise Price**
1,399,290	$ 0.23
4,166	2.25
315,000	2.28
118,700	2.80
6,297	16.50
2,500	22.56
706	29.26
708	33.00
1,847,367	

Under the terms of the Original Plan, all outstanding options immediately vest upon a change of control event. A qualifying change of control event did occur on January 25, 2006, and all options granted under the Original Plan became vested on that date.

All outstanding options granted under the CCS Plan were 25% vested as of January 25, 2006, the date of the Merger, and vest monthly thereafter in 36 equal installments.

SECURITY OWNERSHIP OF CERTAIN BENEFICIAL

OWNERS AND MANAGEMENT

The following table sets forth certain information regarding the beneficial ownership of our common stock as of July 18, 2006, by

- each person we know to be the beneficial owner of 5% or more of our outstanding shares of common stock;
- each person who served as our Chief Executive Officer during the fiscal year ended March 31, 2006, and our other executive officers who received compensation in excess of $100,000 during the fiscal year ended March 31, 2006, whom we refer to as the Named Executive Officers;
- each of our current directors and executive officers; and
- all executive officers and directors as a group.

Percentages are based on a total of 67,538,976 shares of common stock outstanding as of July 18, 2006. Unless otherwise indicated, the address of each listed stockholder is c/o Patient Infosystems, Inc., 12301 N.W. 39th Street, Coral Springs, Florida, 33065.

Beneficial Owner	Shares Beneficially Owned	Percentage Beneficially Owned
Executive Officers and Directors		
Marc L. Pacala(2) (15)	15,009,324	22.0%
Albert S. Waxman(3)	9,447,075	14.0%
John Pappajohn(4)(15)	8,419,957	12.5%
Daniel C. Lubin(5)(15)	6,540,131	9.7%
Derace L. Schaffer, M.D.(6)	1,169,947	1.7%
Chris E. Paterson(8)**	1,017,666	1.5%
Roger L. Chaufournier(7)**	325,000	(1)
Glen A. Spence(11)*	254,416	(1)
Christine St. Andre(9)	175,000	(1)
M. Ileana Welte(12)*	127,208	(1)
Kent A. Tapper(10)	103,008	(1)
Ann M. Boughtin*	-	(1)
Rex M. Dendinger II*	-	(1)
All directors and executive officers as a group (13 persons) (16)	41,764,841	60.0%
Five Percent Stockholders of Common Stock		
Principal Life Insurance 801 Grand Ave. Des Moines, IA 50392	3,745,350	5.5%
Entities affiliated with Essex Woodlands Health Ventures (2) (15) 190 South LaSalle Street, Suite 2800	15,009,324	22.0%

Chicago, IL 60603		
Hickory Venture Capital Corporation (13) (15)	8,642,454	12.7%

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301 Washington Street, NW, Suite 301 Huntsville, AL 35801		
Radius Venture Partners I, L.P. (5) (15) 400 Madison Avenue, 8th Floor New York, NY 10017	6,540,131	9.7%
Entities affiliated with Psilos Group Partners (14) (15) 625 Avenue of the Americas, 4th Floor New York, NY 10011	6,101,233	9.0%

* Became an executive officer effective January 25, 2006 upon completion of the merger with CCS Consolidated.
** Named Executive Officer.

(1) Less than 1%.

(2) Consists of 1,615,589 shares of common stock held of record by Essex Woodlands Health Ventures Fund V, L.P. and 12,678,199 shares of common stock held of record by CCS Consolidated Holdings, LLC. Mr. Pacala is a general partner of Essex Woodlands Health Ventures Fund V, L.P. and is a manager of CCS Consolidated Holdings, LLC and shares voting and dispositive power with respect to the shares held by each of these entities and disclaims beneficial ownership of the shares in which he has no pecuniary interest. Amount also includes 715,536 shares of common stock issuable upon exercise of a warrant held by Essex Woodlands Health Ventures Fund V, L.P. and exercisable within 60 days of July 18, 2006.

(3) Consists of 729,503 shares of common stock held of record by Psilos Group Partners II, L.P., 5,013,169 shares of common stock held of record by CCS Consolidated Holdings, LLC, 35,466 shares of common stock held of record by CCP/Psilos CCS, LLC and 3,668,937 shares of common stock currently held by an escrow agent for the benefit of certain former stockholders of CCS Consolidated, over which Dr. Waxman exercises voting power. Dr. Waxman is a managing member of, or managing member of the general partner of, Psilos Group Partners, L.P., Psilos Group Partners II, L.P. and CCP/Psilos CCS, LLC. Dr. Waxman is also a manager of CCS Consolidated Holdings, LLC. As a result, Dr. Waxman shares voting and dispositive power with respect to the shares held by these entities and disclaims beneficial ownership of the shares in which he has no pecuniary interest. Shares of common stock issuable upon exercise of a warrant held by Psilos Group Partners II, L.P. and exercisable within 60 days of July 18, 2006 are included in the number of shares set forth above over which Dr. Waxman exercises voting power in his capacity as party to the escrow agreement.

(4) Consists of 6,625,521 shares held of record by Mr. Pappajohn, 30,000 shares held of record by Halkis, Ltd., a sole proprietorship owned by Mr. Pappajohn, 30,000 shares held of record by Thebes, Ltd., a sole proprietorship owned by Mr. Pappajohn s spouse, 30,000 shares held directly by Mr. Pappajohn s spouse, 1,666,936 shares held by a voting trust and a fully vested and exercisable warrant to purchase 37,500 shares of common stock. Mr. Pappajohn disclaims beneficial ownership of the shares owned by Thebes, Ltd., by his spouse and by the voting trust.

(5) Consists of 244,647 shares of common stock held of record by Radius Venture Partners I, L.P. and 6,187,129 shares held of record by CCS Consolidated Holdings, LLC. Mr. Lubin is a general partner of Radius Venture Partners I, L.P., shares voting and dispositive power with respect to the shares held by Radius Venture Partners I, L.P. and disclaims beneficial ownership of the shares in which he has no pecuniary interest. Jordan Davis, another general partner of Radius Venture Partners I, L.P., is a manager of CCS Consolidated Holdings, LLC and shares voting and dispositive power with respect to the shares held by Radius Venture Partners I, L.P. and disclaims beneficial ownership of the shares in which he has no pecuniary interest. Amount also includes 108,355 shares of common stock issuable

upon exercise of a warrant held by Radius Venture Partners I, L.P. and exercisable within 60 days of July 18, 2006.

(6) Consists of 1,120,447 shares held of record by Dr. Schaffer, 12,000 shares held of record by Dr. Schaffer s children and a fully vested and exercisable warrant to purchase 37,500 shares of common stock.

(7) Consists of a fully vested and exercisable warrant to purchase 325,000 shares of common stock.

(8) Consists of 1,017,666 shares of common stock issuable pursuant to early exercise features of an option exercisable within 60 days. Of these shares, 636,043 shares underlying this option are not vested and would not be transferable by Dr. Paterson until vested. Accordingly, Dr. Paterson is not deemed to have investment power over such shares.

(9) Consists of 25,000 shares held of record by Ms. St. Andre and a fully vested and exercisable warrant to purchase 150,000 shares of common stock.

(10) Consists of 3,008 shares held of record by Mr. Tapper and a fully vested and exercisable warrant to purchase 100,000 shares of common stock.

(11) Consists of 254,416 shares of common stock issuable pursuant to early exercise features of an option exercisable within 60 days. Of these shares, 159,012 shares underlying this option are not vested and would not be transferable by Mr. Spence until vested. Accordingly, Mr. Spence is not deemed to have investment power over such shares.

(12) Consists of 127,208 shares of common stock issuable pursuant to early exercise features of an option exercisable within 60 days. Of these shares, 79,506 shares underlying this option are not vested and would not be transferable by Ms. Welte until vested. Accordingly, Ms. Welte is not deemed to have investment power over such shares.

(13) Consists of 968,814 shares of common stock held of record by Hickory Venture Capital Corporation and 7,244,557 shares held of record by CCS Consolidated Holdings, LLC. Amount also includes 429,085 shares of common stock issuable upon exercise of a warrant held by Hickory Venture Capital Corporation and exercisable within 60 days of July 18, 2006.

(14) Consists of 729,503 shares of common stock held of record by Psilos Group Partners II, L.P., 5,013,169 shares of common stock held of record by CCS Consolidated Holdings, LLC and 35,466 shares of common stock held of record by CCP/Psilos CCS, LLC. Albert S. Waxman, a director of, Psilos Group Partners, L.P., Psilos Group Partners II, L.P. and CCP/Psilos CCS, LLC. Amount also includes 323,095 shares of common stock issuable upon exercise of a warrant held by Psilos Group Partners II, L.P. and exercisable within 60 days of July 18, 2006.

(15) As described in greater detail in footnotes 2, 3, 5 and 13, certain of these entities are members of CCS Consolidated Holdings, LLC. CCS Consolidated Holdings owns of record an aggregate of 31,123,053 shares of common stock. The managers of CCS Consolidated Holdings, who share voting and investment power over the securities held of record by CCS Consolidated Holdings, are Albert Waxman, Mark Pacala, Jordan Davis and Thomas Noojin. Each of these individuals disclaims beneficial ownership of the shares in which he has no pecuniary interest. The shares of common stock held by CCS Consolidated Holdings, LLC will be distributed to its members pursuant to a limited liability company agreement.

(16) Consists of 34,379,678 shares held of record, 1,666,936 shares held by a voting trust, 3,668,937 shares held by an escrow agent, 650,000 shares issuable upon exercise of fully vested warrants, and 1,399,290 shares pursuant to early exercise features of the stock options. Of these shares underlying stock options, 874,561 shares are not vested and would not be transferable until vested.

CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Between April 2003 and January 2004, we issued 840,118 shares of Series D 9% Cumulative Convertible Preferred Stock (Series D Preferred Stock) under the terms of the Note and Stock Purchase Agreement dated April 11, 2003 and amended on September 10, 2003. John Pappajohn and Derace Schaffer, M.D., two of our directors, purchased 435,233 and 5,318 shares, respectively, of Series D Preferred Stock. The shares of Series D Preferred Stock have been converted into common stock on a 10-for-1 basis in accordance with their terms.

In January 2004, we borrowed $200,000 for working capital from Mr. Pappajohn which was repaid in March 2004 using the proceeds of the sale of our common stock. During the three month period ended September 30, 2004, we borrowed $570,000 of working capital from Mr. Pappajohn which was repaid in September 2004 using the proceeds of a line of credit with Wells Fargo Bank Iowa, N.A. (Wells Fargo) which indebtedness was guaranteed by Mr. Pappajohn.

On December 31, 2003, we entered into the Third Addendum to the Second Amended and Restated Credit Agreement with Wells Fargo, which extended the term of the $3,000,000 credit facility from January 2, 2004 to July 31, 2005. Dr. Schaffer and Mr. Pappajohn guaranteed this extension. In consideration of their guarantees, in February 2004, we granted to Dr. Schaffer and Mr. Pappajohn warrants to purchase an aggregate of 47,500 shares of Series D Preferred Stock, which warrants have been exercised and the underlying shares have been converted to common stock. We valued these warrants at $1,085,375 using the Black-Scholes method.

On September 21, 2004, we entered into the Fourth Addendum to the Second Amended and Restated Credit Agreement with Wells Fargo, which increased the amount of the credit facility to $7,000,000 and extended the term to July 31, 2006. Dr. Schaffer and Mr. Pappajohn guaranteed these extensions. In consideration of their guarantees, in September 2004 we granted to Dr. Schaffer and Mr. Pappajohn warrants to purchase an aggregate of 1,000,000 shares of our common stock for $1.68 per share. We valued these warrants at $1,416,500 using the Black-Scholes method.

On February 2, 2005, our wholly owned subsidiary ACS entered into the First Addendum to the Credit Agreement with Wells Fargo, which increased the amount of ACS s credit facility to $3,000,000. Dr. Schaffer and Mr. Pappajohn, directors of both us and ACS, guaranteed this extension. Also on February 2, 2005, we entered into the Fifth Addendum to the Second Amended and Restated Credit Agreement with Wells Fargo, which decreased the amount of our credit facility to $6,000,000. ACS repaid $1,000,000 of debt to us using its credit facility, which we used to retire $1,000,000 of our credit facility. In consideration of the guarantees, ACS issued warrants to Mr. Pappajohn and Dr. Schaffer to purchase 974,950 shares of ACS common stock at the fair market value per share on the date of grant.

On October 31, 2005, we issued 547,224 shares of common stock valued at $3.44 per share and paid $17,351 in cash to the holders of our preferred stock in lieu of accrued dividends which we were obligated to pay upon conversion of such preferred stock into common stock. John Pappajohn and Derace Schaffer, M.D., two of our directors, received 279,465 and 40,694 shares of our common stock, respectively, and Principal Life Insurance Company, a beneficial owner of more than 5% of our outstanding common stock, received 193,860 shares of our common stock in satisfaction of the accrued dividends.

On January 25, 2006, we paid dividends in arrears totaling $192,785 to the holders of our Series C and D Preferred Stock. In lieu of $178,036 of cash, John Pappajohn and Derace Schaffer, M.D., two of

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our directors, received 23,733 and 2,387 shares of ACS common stock, respectively, and Principal Life Insurance Company, a beneficial owner of more than 5% of our outstanding common stock, received 18,390 shares of ACS common stock in satisfaction of the accrued dividends. Such shares of ACS common stock were held by us as available-for-sale securities.

As described elsewhere in this prospectus, in connection with the Merger with CCS Consolidated, on January 25, 2006, we assumed obligations under a line of credit arrangement with Comerica Bank. The satisfaction of our obligations under the line of credit are also guaranteed by certain of the former stockholders of the CCS Consolidated who became our stockholders upon the closing of the Merger. These stockholders, which are entities affiliated with Essex Woodlands Health Ventures, Hickory Venture Capital Corporation, Radius Venture Partners and Psilos Group Partners, are each beneficial owners of 5% or more of our common stock. Certain individuals associated with these entities, Mark Pacala, Daniel Lubin and Albert Waxman, are also current directors of our company.

In exchange for delivering guaranties to Comerica Bank to satisfy the obligations under the line of credit, these former stockholders of CCS Consolidated were issued warrants to purchase shares of capital stock of CCS Consolidated, which vested over time based on the outstanding balances under the line of credit. As part of the Merger, the unvested portion of these warrants was terminated and replaced by warrants to purchase shares of our common stock (the Replacement Warrants). Each of the Replacement Warrants has an exercise price of $0.003172 per share of our common stock. These Replacement Warrants vest through November 17, 2006 based on the outstanding balances under the line of credit. If the Replacement Warrants fully vest and are exercised in full for a cash payment of the aggregate exercise price, the holders of the Replacement Warrants will receive an aggregate of 3,152,141 shares of common stock. These 3,152,141 shares of common stock were issued into escrow at the closing of the Merger. To the extent that the Replacement Warrants do not vest, or are not exercised in full, the shares of common stock underlying the Replacement Warrants will be released from escrow to all former stockholders of CCS Consolidated at the effective time of the Merger in accordance with the Merger Agreement. Dr. Waxman is the representative of the former stockholders of CCS Consolidated and is a party to the escrow agreement between us and the escrow agent.

In September 2005, we entered into a letter agreement with Psilos Group Partners II, L.P. (Psilos) regarding a success fee payable to Psilos by us upon the occurrence of certain events or the passage of time. The letter agreement was contingent upon and effective only at completion of the Merger. Psilos and its affiliated entities beneficially own more than 5% of our outstanding common stock, and Albert Waxman, a director of Psilos, is also a director of our company. Such a fee would be payable to Psilos upon the earliest to occur of the following:

- any consolidation or merger of us with or into any other corporation or other entity or person, or any other corporate reorganization, in which our capital stock immediately prior to such consolidation, merger or reorganization, represents less than 50% of the voting power of the surviving entity (or, if the surviving entity is a wholly owned subsidiary, its parent) immediately after such consolidation, merger or reorganization;
- any transaction or series of related transactions to which we are a party in which in excess of fifty percent (50%) of our voting power is transferred;
- a sale, lease, exclusive license or other disposition of all or substantially all of our assets;
- the filing of a registration statement under the Securities Act of 1933, as amended, relating to an underwritten public offering of common stock to be issued by us in which Psilos is permitted to participate as a selling stockholder; or
- July 25, 2007, being the expiration date of the eighteen month lock-up period following the date of the Merger.

The amount of the fee, if any, is dependent upon the value of our common stock issued to the former CCS Consolidated stockholders in the Merger as determined in the letter agreement between us and Psilos. In the event that such valuation is less than $35,000,000, no fee will be paid. In the event that such valuation exceeds $35,000,000, Psilos will be entitled to 10% of such excess; provided that in no event shall the fee exceed $500,000. At the closing of the Merger, we issued 516,796 shares of common stock into escrow to be used for satisfaction of the fee, if any. The fee, if any, will be payable by releasing a number of these escrowed shares of our common stock with a fair market value equal to the bonus payment.

In addition, under a stockholders agreement entered into at the closing of the Merger, stockholders holding approximately 65% of the outstanding voting shares of our common stock after the consummation of the Merger have agreed to vote their shares in favor of the election of John Pappajohn, a director of our company prior to the Merger, Derace Schaffer, a director of our company prior to the Merger, and three individuals designated by holders of at least a majority of our common stock held by the former stockholders of CCS Consolidated who are parties to the stockholders agreement. The three new directors appointed after the Merger were Mark L. Pacala, Daniel C. Lubin and Albert S. Waxman, Ph.D., who are representatives of Essex Woodlands Health Ventures, Radius Venture Partners and Psilos Group Partners, respectively.

Lock-Up Agreements

In connection with the closing of the Merger, we entered into lockup agreements with our largest stockholders. Lockup agreements were signed and delivered by stockholders holding approximately 75% of our issued and outstanding shares as of the closing of the Merger, including all stockholders beneficially owning 5% or more of our outstanding common stock. Each stockholder signing a lockup agreement agreed not to sell, transfer, make any short sale of, grant any option for the purchase of, or enter into any hedging or similar transaction with the same economic effect as a sale with respect to any of our securities held by such stockholder for a period of eighteen (18) months following the closing of the Merger, or until July 25, 2007, subject to certain limited exceptions. After the expiration of this 18-month period ending on July 25, 2007, and during each 3-month period thereafter until June 30, 2008, each stockholder may sell a number of our securities equal to the greater of:

1% of the number of shares of our common stock outstanding as of the date of determination; or

the average weekly reported volume of trading of our common stock on all national securities exchanges and/or reported through the automated quotation system of a registered securities association during the four calendar weeks preceding the date of determination.

After June 30, 2008, all securities held by such stockholders shall no longer be subject to the lockup agreements.

In addition, in the event that after July 25, 2007, there is either a change of control transaction involving us, or a primary offering of shares of our common stock (or securities convertible into shares of our common stock for no additional consideration) constituting at least 25% of the shares of our common stock then outstanding, then in each such case all securities held by such stockholders will no longer be subject to the restrictions contained in the lockup agreement.

With respect to the lockup agreements signed by Roger Chaufournier, Christine St. Andre and Kent Tapper, each of whom were our executive officers immediately prior to the closing of the Merger, in the event that any of such individuals ceases to be an employee of us or any of our affiliates, for any reason or no reason, then the securities held by such individual will be released from the restrictions

contained in their lockup agreements thirty (30) days after the date the employment relationship ends, unless earlier released as described above.

DESCRIPTION OF SECURITIES

We are authorized to issue 100,000,000 shares of capital stock, divided into (i) 80,000,000 shares of common stock, par value $0.01 per share and (ii) 20,000,000 shares of preferred stock, par value $0.01 per share. As of July 18, 2006, there are 67,538,976 shares of common stock outstanding, held of record by approximately 300 stockholders. There are no shares of our preferred stock outstanding.

Common Stock

The holders of common stock are entitled to one vote for each share held of record in the election of directors and in all other matters to be voted on by the stockholders. There is no cumulative voting with respect to the election of directors. As a result, the holders of more than 50% of the shares voting for the election of directors can elect all of the directors. Holders of common stock are entitled:

- to receive any dividends as may be declared by the board of directors out of funds legally available for such purpose after payment of accrued dividends on the outstanding shares of preferred stock; and

- in the event of our liquidation, dissolution, or winding up, to share ratably in all assets remaining after payment of liabilities and after provision has been made for each class of stock having preference over the common stock.

All of the outstanding shares of common stock are validly issued, fully paid and nonassessable. Holders of common stock have no preemptive right to subscribe for or purchase additional shares of any class of our capital stock.

Authorized Preferred Stock

Our board of directors has the authority within the limitations set forth in our certificate of incorporation to provide by resolution for the issuance of preferred stock, in one or more classes or series, and to fix the rights, preferences, privileges and restrictions thereof, including dividend rights, conversion rights, voting rights, terms of redemption, liquidation preferences and the number of shares constituting any series or the designation of such series.

Warrants

As of July 18, 2006, there are outstanding warrants to purchase 1,089,536 shares of our common stock. All of such warrants are fully vested. This excludes the Replacement Warrants issued as part of the merger with CCS Consolidated to certain former holders of CCS Consolidated capital stock who are guarantors of CCS Consolidated s obligations under its line of credit with Comerica Bank. The shares underlying the Replacement Warrants have been deposited into escrow and may be acquired by such former CCS Consolidated stockholders based upon the outstanding balance of the line of credit. To the extent that the Replacement Warrants do not vest, or are not exercised in full, the shares of our

common stock underlying the Replacement Warrants will be released from escrow to all former stockholders of CCS Consolidated in accordance with the Merger Agreement.

Of the 1,089,536 shares underlying outstanding warrants described above, 307,036 shares are being registered in the registration statement of which this prospectus is a part and are issuable upon exercise of warrants that we have issued to the selling stockholders.

Market for Common Stock

Shares of our common stock are listed on the OTC Bulletin Board under the symbol PATY.

Transfer Agent and Registrar

Our transfer agent and registrar is Continental Stock Transfer and Trust Company, 17 Battery Place, New York, New York 10004.

Shares Eligible for Future Sale

As of July 18, 2006, we had an aggregate of 67,538,976 shares of common stock outstanding. If all options and warrants currently outstanding to purchase shares of common stock were to be exercised, there would be an aggregate of 70,475,879 shares of common stock outstanding. Of the 70,475,879 shares, up to 7,933,580 shares are freely tradable without restriction or further registration under the Securities Act, except for any shares purchased by an affiliate, which will be subject to the resale limitations of Rule 144 promulgated under the Securities Act.

All of the remaining shares of common stock currently outstanding are restricted securities or owned by affiliates, as those terms are defined in Rule 144, and may not be sold publicly unless they are registered under the Securities Act or are sold pursuant to Rule 144 or another exemption from registration. The restricted securities are not eligible for sale without registration under Rule 144. The table below provides additional information on the number of shares that may be publicly sold and the dates that they become eligible for sale. As of July 18, 2006, there were outstanding options to purchase 1,850,070 shares of our common stock.

The number of shares that will become eligible for resale between the date of this prospectus and July 25, 2007 are as follows:

Date	Number of shares eligible for sale	Comment
-		-

Currently	7,933,580	Shares outstanding other than (i) the shares being sold pursuant to this prospectus, (ii) shares issued in connection with the merger with CCS Consolidated and (iii) shares held by: - John Pappajohn; - Derace Schaffer; - Principal Life Insurance Company; - Christine St. Andre; - Kent Tapper; - Psilos Group Partners, L.P., Psilos Group Partners II, L.P. and CCP/Psilos CCS, LLC (collectively, Psilos); - Essex Woodlands Health Ventures Fund IV, L.P. and Essex Woodlands Health Ventures Fund V, L.P. (collectively Essex Woodlands); - Hickory Venture Capital Corporation (Hickory); - Radius Venture Partners I, L.P. (Radius); - CCS Consolidated Holdings LLC (CCS Holdings); and - SG Cowen Securities Corp. and its affiliates (collectively, SG Cowen); and
		issuable upon immediately exercisable options and warrants other than options and warrants held by directors and executive officers and warrants issued as part of the 2005 PIPE financing, the shares underlying which are being registered on the registration statement of which this prospectus is a part.
Upon the effective date of the registration statement of which this prospectus is a part	3,895,598	Shares sold in our PIPE offerings during October 2005 and December 2005 and shares issuable upon exercise of warrants issued in connection with such transaction.
January 25, 2007	2,142,962	Shares issued in the merger, except for shares issued to: Psilos, Essex Woodlands, Hickory, Radius, CCS Holdings, and SG Cowen.
July 25, 2007	52,750,005	Shares (i) issued in the merger (excluding shares deposited into escrow in the merger) to Psilos, Essex Woodlands, Hickory, Radius, CCS Holdings and SG Cowen; and (ii) held by John Pappajohn, Derace Schaffer, Principal Life Insurance Company, Roger Chaufournier, Christine St. Andre and Kent Tapper (including shares underlying exercisable options

		and warrants).
		These shares will remain subject to volume limitations of Rule 144 for the following 12 month period.
Various dates	3,753,734	Shares (i) underlying options and warrants (other than those listed above) that are immediately exercisable and that vest and become exercisable and transferable, subject to the terms thereof, at various times in the future (including options currently held by Chris Paterson, Glen Spence and Ileana Welte and warrants held by former directors); and (ii) shares deposited into escrow at the closing of the merger which, when released to former CCS Consolidated stockholders, will become transferable on January 25, 2007 or July 25, 2007, depending on which stockholders such shares are released to.

The sale and distribution of these shares, or the perception that such sales or distributions might occur, may cause a decline in the market price of our common stock.

Rule 144

Generally, under Rule 144 as currently in effect, subject to the satisfaction of certain other conditions, a person, including any of our affiliates or persons whose shares are aggregated with an affiliate, who has owned restricted shares of common stock beneficially for at least one year, is entitled to sell, within any three-month period, a number of shares that does not exceed the greater of:

1% of the then outstanding shares of common stock; or

the average weekly trading volume of shares of common stock during the four calendar weeks preceding such sale.

A person who is not an affiliate, has not been an affiliate within three months prior to sale, and has beneficially owned the restricted shares for at least two years is entitled to sell such shares under Rule 144(k) without regard to any of the limitations described above.

Charter and Bylaws Provisions and Delaware Anti-Takeover Statute