RECOM MANAGED SYSTEMS INC DE/
Form 10KSB/A
May 20, 2004

SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

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FORM 10 KSB/A
AMENDMENT NO. 1

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[X] Annual Report Under Section 13 or 15(d) of the Securities Exchange Act of 1934
For the fiscal year ended December 31, 2003

[ ] Transition Report Under Section 13 or 15(d) of the Securities Exchange Act of 1934
For the transition period from _____ to _____
Commission file number: _____

RECOM MANAGED SYSTEMS, INC.

(Exact name of small business issuer in its charter)

Delaware	**87-0441351**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

4705 Laurel Canyon Boulevard, Suite 203
Studio City, California 91607
(818) 432-4560
(Address of principal executive offices) (Zip code) (Issuer s telephone number)

Securities registered pursuant to Section 12(b) of the Exchange Act: None

Securities registered pursuant to Section 12(g) of the Exchange Act: None

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

Check if there is no disclosure of delinquent filers pursuant to Item 405 of Regulation S-B is not contained in this form, and no disclosure will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-KSB or any amendment to this Form 10-KSB: [X]

The issuer s revenues for its most recent fiscal year (fiscal 2002) was $0.

The aggregate market value of the issuer s voting and non-voting common equity held by the issuer s non-affiliates computed by reference to the price at which the common equity was sold, or the average bid and asked price of such common equity, as of a specified date within the past 60 days, was $50,765,000 as of April 30, 2004.

Check whether the issuer has filed all documents and reports required to be filed by Section 12, 13 or 15(d) of the Exchange Act after the distribution of securities under a plan confirmed by a court during the past five years: Yes [X] No [ ]

The number of shares outstanding of each of the issuer s classes of stock as of as of April 30, 2004, the latest practicable date, was 33,345,262 common shares and 1,661,305 series A convertible preferred shares.

Documents Incorporated By Reference

The issuer has not incorporated by reference into this annual report: (1) any annual report to the issuer s securities holders, (2) any proxy or information statement, or (3) any prospectus filed pursuant to Rule 424(b) or (c) of the Securities Act.

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ADVISEMENTS

The information set forth in the section of this annual report captioned "*Business*" is current as of

April 30, 2004, unless an earlier or later date is indicated in that section. The information set forth in the sections of this annual report other than "*Business*" is current as of December 31, 2003, unless an earlier or later date is indicated in those sections.

On April 11, 2003, we effected a split in our common shares on a 3:1 forward basis through the mechanism of a stock dividend. Whenever we make any reference in this annual report to the grant or issuance of common shares or options or warrants to purchase common shares, such reference shall, for comparison purposes, be made in reference to post-split numbers and, in the case of options and warrants, exercise prices, unless we state otherwise.

In this annual report we make a number of statements, referred to as "*forward-looking statements*", which are intended to convey our expectations or predictions regarding the occurrence of possible future events or the existence of trends and factors that may impact our future plans and operating results. These forward-looking statements are derived, in part, from various assumptions and analyses we have made in the context of our current business plan and information currently available to us and in light of our experience and perceptions of historical trends, current conditions and expected future developments and other factors we believe to be appropriate in the circumstances. You can generally identify forward-looking statements through words and phrases such as "*seek*", "*anticipate*", "*believe*", "*estimate*", "*expect*", "*intend*", "*plan*", "*budget*", "*project*", "*may be*", "*may likely result*" and similar expressions. When reading any forward looking statement you should remain mindful that actual results or developments may vary substantially from those expected as expressed in or implied by that statement for a number of reasons or factors, such as those relating to: (1) the success of our research and development activities, the development of a viable commercial production model, and the speed with which regulatory authorizations and product launches may be achieved; (2) whether or not a market for our products develops and, if a market develops, the pace at which it develops; (3) our ability to successfully sell our products if a market develops; (4) our ability to attract the qualified personnel to implement our growth strategies, (5) our ability to develop sales, marketing and distribution capabilities; (6) our ability to obtain reimbursement from third party payers for the products that we sell; (7) the accuracy of our estimates and projections; (8) our ability to fund our short-term and long-term financing needs; (9) changes in our business plan and corporate strategies; and (10) other risks and uncertainties discussed in greater detail in the sections of this annual report, including those captioned "*Plan of Operation*". And "*Uncertainties And Risk Factors That May Affect Our Future Results And Financial Condition*".

Each forward-looking statement should be read in context with, and with an understanding of, the various other disclosures concerning our company and our business made elsewhere in this annual report as well as other pubic reports filed with the United States Securities and Exchange Commission (the "*SEC*"). You should not place undue reliance on any forward-looking statement as a prediction of actual results or developments. We are not obligated to update or revise any forward-looking statement contained in this annual report to reflect new events or circumstances unless and to the extent required by applicable law.

BUSINESS

Overview

Recom is a development stage medical device company focused on researching, developing and marketing heart (cardiac) monitors and other diagnostic medical devices which monitor and measure the body's physiological signals in order to detect and prevent medical complications and diseases that impact an individual's health. Our products will operate using a proprietary and patented "amplification" technology which enables them to more accurately discriminate physiological signals from ambient electromagnetic background noise than existing amplification technologies. An "amplification" technology is one which enlarges or "amplifies" the body's signals of interest for diagnostic purposes while removing unwanted electromagnetic noise from other sources. Our amplification technology is an enhancement of a proven amplification technology used by the United States Air Force to record a pilot's neurological (brain) responses, and the ability of our amplification technology to more accurately discriminate physiological signals from ambient electromagnetic background noise than existing amplification technologies is based upon these proven applications and enhancements.

Corporate History

We were originally incorporated in Delaware on January 19, 1987. We had no specific business purpose on the date of incorporation and were inactive until October 30, 1998. On that date, we completed a reverse acquisition with J2 Technologies LLC, a California limited liability company formed on July 31, 1998, which was engaged in the business of developing, servicing and managing commercial computer networks both on-site and remotely. As consequence of the reverse acquisition, we engaged in J2 Technologies' business and changed our name to Recom Managed Systems, Inc. We were subsequently unsuccessful in this business and, on June 26, 2000, filed a voluntary petition for reorganization under Chapter 11 of the Federal Bankruptcy Code. Our plan of reorganization was confirmed by the Bankruptcy Court and the confirmation order became final on November 7, 2000. Subsequent to declaring bankruptcy, we ceased our business operations. The plan of reorganization provided for a total discharge of the company and our officers and directors from all pre-petition debts, expenses and legal causes of action which may have existed on or before the filing of the bankruptcy. The plan further provided for the consolidation of all previously issued common shares, and the issuance of additional common shares to various creditors of the company. As of December 31, 2000, following full implementation of the plan, there were 4,139,784 common shares (1,379,928 shares pre-split) issued and outstanding.

On September 19, 2002, we acquired certain know how, trade secrets and other proprietary intellectual property rights relating to the development of a human biomedical signal amplification equipment and technology, referred to in this annual report as the "*Signal Technologies*", from ARC Finance Group, LLC, in exchange for 23,400,000 common shares (7,800,000 shares pre-split). The shares represented approximately 85% of our issued and outstanding common shares. We valued the Signal Technologies at $78,023 for financial accounting purposes, reflecting the ARC Finance's cost to acquire the Signal Technologies from Dr. Drakulic as discussed below. The terms of the acquisition were determined by the parties on an arms-length negotiated basis. No independent valuation was sought from a business/technology appraiser or other third party due to financial constraints. There was no relationship between Recom, including our officers, directors and shareholders, and ARC Finance Group, including its officers, directors and shareholders, prior to our acquisition of the Signal Technologies from ARC Finance Group. No finder's fees or other forms of consideration were paid by either Recom or ARC Finance Group or our respective officers, directors or shareholders in connection with our acquisition of the Signal Technologies.

The principal component of the Signal Technologies is a patented "amplification" technology which was originally invented by Dr. Budimir S. Drakulic. The underlying patent covers methods of discriminating different biomedical signals from a background of electromagnetic ambient noise. Also included in the Signal Technologies was an assignment of a license agreement dated December 9, 1993 between Dr. Drakulic and Teledyne Electronic Technologies pursuant to which Dr. Drakulic granted a limited license to Teledyne to manufacture products and use an early version of the amplification technology to manufacture devices that will analyze signals produced by the brain (EEG) in an effort to understand a patient's sleep patterns. This license agreement specified that Dr. Drakulic retained ownership of the original patent and underling technology and the right to use technology to develop new products as long as they would not infringe on Teledyne's sleep pattern recognition products. Dr. Drakulic has since received a letter from Teledyne acknowledge that Recom's products do not infringe on Teledyne's licensed applications. Additional components of the Signal Technologies include methods to automatically and remotely provide and evaluate the signals over the telephone, the Internet, or other wireless transmissions systeMs. Concurrent with our acquisition of the Signal Technologies, we obtained Dr.

Drakulic□s services as our Vice President and Chief Technology Officer to lead our product development efforts.

ARC Finance Group is a Delaware limited liability company formed in May 2002 owned and controlled by Ms. Tracy Hampton. In or about May 2002, ARC Finance Group entered an understanding with Dr. Drakulic pursuant to which it would fund a proof-of-concept or validation study and other development costs relating to the Signal Technologies and pay other expenses of Dr. Drakulic in exchange for the rights to acquire and market the Signal Technologies. Pursuant to his understanding, ARC Finance funded proof-of-concept or validation studies and other development costs relating to the Signal Technologies in the amount of $78,023 during the summer of 2002, and acquired the Signal Technologies from Dr. Drakulic. Upon its acquisition of the Signal Technologies, ARC Finance sought a third-party company to license or acquire the Signal Technologies for its commercial development. Since our acquisition of the Signal Technologies, ARC Finance Group has remained a holding company for a passive investment in our company and other properties.

On April 11, 2003, we completed a three for one forward stock split, resulting in a total of 31,510,848 common shares being outstanding as of that date.

Description Of Heart Monitors And ECGs

A heart monitor is a device used to monitor and record changes in physiological signals associated with a patient□s cardiovascular system. Heart monitors are used to collect physiological data for electrocardiogram tests, commonly known as 12-lead ECGs or EKGs, for the purpose of detecting and identifying cardiovascular disease. An ECG gives the physician important information about the heart. For example, by examining changes in waveforms in 0.67 to 40 Hz frequency range, known as the EC-38 standard, heart specialists known as cardiologists can identify irregularities in the heart□s rate and rhythm (arrhythmia). By examining changes in waveforms in the broader 0.05 Hz to 150 Hz frequency range, known as the EC-11 standard, cardiologists can identify different types of coronary artery disease, including damage to the heart muscles or tissue resulting from decreased blood flow attributable to the narrowing of the arteries (cardiac ischemia), enlargement of the heart resulting from additional effort attributable to the hardening of the heart muscle (hypertrophy), and the occurrence of prior heart attacks as well as the presence of current heart attacks.

When an ECG test is ordinarily conducted in a clinical setting, the physiological signals from the patient□s heart are acquired through twelve leads connected to ten electrodes attached to the patient□s arms, chest and legs. The placement of the ten electrodes enables each muscle or chamber of the heart to be examined for diseases specific to that muscle or chamber. These physiological signals are amplified and recorded in the form of a series of wavy lines (waveforms) that can be either displayed on a screen or printed on paper for review by the cardiologist. Any irregularity in the heart rhythm or damage or stress to the heart muscle will show up as a deviation from the normal waveform.

There are three different settings under which ECGs are normally taken, the clinical (resting) setting, the ambulatory (moving) setting and the exercise (maximum stress) setting, which are described as follows:

- ECGs administered in the clinical (resting) setting are typically given under either emergency circumstances when an individual complains of symptoms typically associated with heart disease (i.e. chest pains, shortness of breath, heart palpitations), or every year or so for older patients as part of their annual physicals. Most ECGs are given in the clinical (resting) setting.
- The principal purpose in conducting ECG tests on an ambulatory basis is that many coronary artery diseases such as cardiac ischemia and cardiac hypertrophy as well as the occurrence of past or present heart attacks can escape detection without longer-term monitoring in a more physically active or stressful setting. Requiring a patient to remain immobile in a clinical setting for the requisite period of time to identify the presence of these diseases is often impossible, impractical or unduly expensive. Thus, these diseases or conditions may go undetected. An ambulatory heart monitor, commonly known as a □holter□ monitor, allows the patient□s heart to be continuously monitored over a period of hours or days, while the patient carries out his or her daily activities under typical conditions of stress away from the physicians□ office or hospital.

- In an exercise ECG, the patient exercises on a treadmill, step machine or exercise cycle to enable the cardiologist to monitor, among other things, his heart behavior under maximum conditions of physical stress. Similar to an ambulatory ECG, this allows the cardiologist to identify many coronary artery diseases such as cardiac ischemia and cardiac hypertrophy as well as the occurrence of past or present heart attacks that may not be evident under a clinical (resting) ECG test.

In the clinical (resting) setting, ECG□s measure electronic signals in the 0.05 to 150 Hz range, known as EC 11 standard. The principal technical issue in deciphering ECG waveforms arises from the existence of ambient or background □noise□ emanating from other electromagnetic sources, including (1) signals generated by the other organs, muscles and systems of the body, whether from movement or the performance by those organs of their bodily functions, and (2) signals generated by sources external to the body, such as electronic equipment, lights or engines. This ambient noise is commonly referred to as an □artifact□. As previously discussed, cardiologists can identify irregularities in the heart□s rate and rhythm (arrhythmia) by examining changes in the 0.67 to 40 Hz EC-38 frequency range. Because of the relatively large amplitudes of these waveforms in this range, cardiologists can, as a practical matter, easily identify arrhythmia notwithstanding electromagnetic ambient or background □noise□ from other sources. However, it is very difficult for cardiologists to distinguish physiological signals from ambient □noise□ in the broader EC-11 frequency ranges used to identify different types of coronary artery disease, including damage to the heart muscles or tissue resulting from decreased blood flow attributable to the narrowing of the arteries (cardiac ischemia), enlargement of the heart resulting from additional effort attributable to the hardening of the heart muscle (hypertrophy), and the occurrence of prior heart attacks as well as the presence of current heart attacks. The principal reason for this difficulty is that the physiological signals associated with these other heart diseases are of a much lower amplitude or strength in the lower (0.05 to 0.67 Hz) and upper (40 to 150 hz) portions of the EC-11 frequency range, meaning that they do not stand-out from the ambient background noise in these portions and therefore cannot be easily discriminated from those signals. In order to minimize ambient □noise□ in the clinical setting to procure better data in these lower-amplitude ranges, ECGs are normally taken in the hospital or physician offices in rooms that have been specially constructed to filter-out or dampen external electromagagnetic sources. Further, cardiologists instruct the patient to lie in a resting position as still as possible while a reading is taken to reduce internal ambient □noise□ caused by physical movement. Another method to reduce background artifact is to reduce the sensitivity of the monitoring equipment, although this alternative results in a loss of signal quality and the ability to read certain signal intricacies.

As previously discussed, the principal purpose in conducting ECG tests on an ambulatory basis is that many types of arrhythmia and coronary artery disease such as cardiac ischemia and cardiac hypertrophy as well as the occurrence of past or present heart attacks can escape detection without longer-term monitoring in a more physically active or stressful setting than that obtained in a clinical setting. However, ambulatory heart monitors currently are unable to accurately identify most heart diseases (other than arrhythmia, which constitutes only a small percentage of heart diseases), given their inability to distinguish and discriminate the physiological signals associated with these diseases from electromagnetic ambient or background □noise□ in the lower and upper portions of the full 0.05 to 150 Hz EC-11 frequency range. Ambient or background noise are electromagnetic signals emanating from other electromagnetic sources, including signals generated by the other organs, muscles and systems of the body, whether from movement or the performance by those organs of their bodily functions, and signals generated by sources external to the body, such as electronic equipment, lights or engines. The principal reason for the inability of currently marketed ambulatory heart monitors to accurately identify heart diseases other than arrhythmia is that the physiological signals associated with these other heart diseases are of a much lower amplitude or strength in the lower (0.05 to 0.67 Hz) and upper (40 to 150 hz) portions of the EC-11 frequency range, meaning that they do not stand-out from the ambient background noise in these portions and therefore cannot be easily discriminated from those signals. Thus, these products are limited to identifying higher-amplitude signals associated with arrhythmia in the less-broad but higher-amplitude 0.67 to 40 Hz EC-38 frequency range. Current ambulatory monitors therefore generally use only three leads rather than the full twelve leads used in a clinical (resting) setting, since the extra leads will not provide additional information.

As addressed above, the principal purpose in conducting ECG tests in an exercise setting is to monitor the heart under maximum conditions of physical stress. Similar to an ambulatory ECG, this allows the cardiologist to identify many coronary artery diseases such as cardiac ischemia and cardiac hypertrophy as well as the occurrence of past or present heart attacks, that may not be evident under a clinical (resting) ECG test. However, while external sources of background artifact can be eliminated in the clinical setting when exercise ECGs are conducted, the high levels of physical activity inherent in exercise ECGs generate higher internal levels of background noise. To address this issue, exercise ECG devices are connected to computers which run sophisticated software to filter and process physiological signals and come up with "average waveforms" for analysis. According to the American Heart Association and American College of Cardiology, computer processing is not completely reliable because of software limitations in handling noise and inadequacy of the available algorithms, and cardiologists are advised to look at the raw data.

Description Of Recom's ECG Products And Services; Product Advantages

Our first product which is currently under development is a 12-lead battery-operated non-invasive ambulatory heart monitor, which we have designated as the Recom Model 100 Ambulatory, Digital, Wireless ECG Monitor System. An ambulatory heart monitor, commonly known as a "holter" monitor, allows the patient's heart to be continuously monitored over a period of 24 to 48 hours, while the patient carries out his or her daily activities away from the physicians' office or hospital. Our model 100 ambulatory heart monitor should be the first ambulatory monitor on the market with the capability to clearly identifying all types of coronary artery diseases (as well as arrhythmia) due to its ability to amplify the lower-amplitude physiological signals associated with those in the lower and upper portions of the full 0.05 to 150 Hz EC-11 frequency range. Patients using our model 100 monitor will be able to move around freely while data is sent in real time from the device to a pocket PC using Bluetooth technology. At predetermined time intervals and/or when an atypical recording is sensed, the Pocket PC will transmit data wirelessly over the Internet to our monitoring center. The physician can then access the results for analysis by simply logging into our server over the Internet. Our server and network will be compliant with the Health Insurance Portability and Accountability Act, which requires that we meet federally mandated requirements when handling patient data.

Our patented amplification technology was originally developed by our Vice President and Chief Technology Officer, Dr. Budimir S. Drakulic, to address the noise issue in response to the requirements of the United States Air Force. In an effort to explore ways to accurately and objectively monitor pilot performance, the Air Force wanted to record a pilot's neurological (brain) responses, consisting of tiny electrical impulses, to different tasks and stresses occurring in-flight using an electroencephalogram or EEG test. However, the Air Force found that the neurological signal monitoring equipment then available were not able to accurately monitor EEG in an electromagnetically-charged environment such as the cockpit of a fighter jet or a B-52 bomber. In 1992 the United States Air Force selected Dr. Drakulic to lead the effort to develop a device to solve the monitoring problem. This effort ultimately resulted in the creation by Dr. Drakulic in 1994 of his first-generation amplifier, and its use by the Air Force to monitor pilot EEG signals. This model is currently used by the National Institute of Health as well as companies such as Titan Systems and Teledyne, Inc. for purposes of monitoring different neurological biomedical signals. Dr. Drakulic has since enhanced signal processing technology and adopted it for heart monitors. These enhancements have resulted in our company filing three additional patents covering different aspects of 24/7, 12-lead ECG monitoring technology.

We have recently completed development of the "front-end" or hardware portion of our model 100 heart monitor, and received FDA 510(k) marketing approval on January 28, 2004 to market that portion of the device in the United States on the basis of it being substantially equivalent to other devices on the market. The "front-end" portion of the heart monitor amplifies, collects, processes and records data. We are currently developing the "back-end" or software portion of our model 100 heart monitor, which allows the management and interpretation of the data. We intend to use and integrate into our system commercially available software for which FDA approval has already been received by original manufacturer, to manage and interpret this data. We do not believe that integration of this software into our system will require additional FDA approval. Once we have completed these steps, we must design and engineer a "production" model for mass manufacturing which will be durable, reliable and maintenance-free, and competitively priced. We anticipate that we will complete a production model of our model 100 heart monitor, integrating both back-end and front-end functions, by the end of fiscal 2005, and will have also commenced commercial marketing efforts by the end of that period.

In the longer-term, we will also market heart monitors for each of the exercise and clinical (resting) segments of the ECG market. We have initially chosen to target the ambulatory market segment with our initial product since our product advantages discussed above will have the most impact on this market segment, and to then leverage our success in this market to penetrate the exercise and clinical (resting) market segments. We believe that our amplification technology will give our monitors products advantages in both of these ECG market segments insofar as it not only separates or distinguishes low-amplitude signals from background noise, but it produces a more clear and consistent signal than that produced by monitors currently on the market. This higher signal quality will allow the cardiologist to more accurately identify the specific cardiovascular disease.

Due to the higher signal quality generated by our amplification technology, as well as the compact design of that technology, particularly in an ambulatory setting, we believe that our heart monitor can be used to create a more efficacious continuous preventive monitoring program. Specifically, we believe that individuals could periodically use our ambulatory device to not only measure their heart functions, but to create a "baseline" of historical data relating to their individualized signals using mathematical or "algorithmic" waveform pattern recognition programs we are developing. The physician can then not only compare these signals and baseline with our known database of irregular or "anomalous" ECG waveforms indicative of particular forms of heart disease, but also identify fluctuations from the individual's unique baseline. To support this theory, our scientists are currently undertaking focused research studies to categorize physiological baselines and their correlation to heart disease. If we can verify that deviations from a patient's baseline can serve as a marker of disease or life-threatening conditions, these events could be treated earlier, thereby resulting in decreased medical expenses, reduced hospitalization and fewer incidences of death and disability.

Other Products

Our amplification technology is also extremely effective when used for other biomedical signals such as electroencephalogram or EEG tests used to measure neurological (brain) responses. Indeed, as discussed above, the technology was originally developed by Dr. Drakulic expressly for this purpose, and the enhancements Dr. Drakulic has since made to the technology should give it a competitive advantage over other technologies on the market. We intend in the future to devote a portion of our development activities to EEG-related applications of our technology, such as Alzheimer's and other neurological diseases.

Competition

Our principal competitors in the ambulatory heart monitor markets are as follows::

- CardioNet, Inc., located in San Diego, California, sells an ambulatory ECG monitor system which records and wirelessly transmits physiological data by an RF to a handheld PDA for later modem or Internet transmission. We believe that CardioNet's system is closest to our product in terms of operations and features. The CardioNet monitor is only certified under EC 38, and only uses three leads. As a consequence, CardioNet's system can only identify irregularities in the heart's rate and rhythm (arrhythmia).
- Cardiac Telecom, located outside Pittsburgh, Pennsylvania, sells an ambulatory heart monitor system which transmits wirelessly from the chest to a data processor/phone-connected station. The data is then sent over a hard line to the Internet. This system is only ambulatory when in 30/60 feet of the base unit. The base unit is the size of a desk-top PC and runs on line current. Hence it is only used as a home unit. The Cardiac Telecom monitor is only certified under EC 38, and only uses three leads. As a consequence, Cardiac Telecom's system can only identify irregularities in the heart's rate and rhythm (arrhythmia).

- Raytel Medical, located in Windsor, Connecticutt, is a division of SHL Telemedicine based in Israel. Raytel Medical is the largest provider in the United States for holter monitoring and cardiac event devices. All of their systems are transtelephonic and not wireless. They have a 12 lead ECG system but we believe that the electrode system is poor and is put on the chest by the patient to record 30 to 120 sec strip when they feel an event occurring. Then the patient must bring the device to a phone and transmit it to a monitoring center. Our system requires no patient effort to record the signal and when an abnormal signal is recorded, it is sent wirelessly to a monitoring center. The Raytel Medical monitor is only certified under EC 38.
- Mortara Instrument, located in Milwaukee, Wisconsin, manufacturers a 12 lead ECG ambulatory system. The Mortara Instrument monitor is only certified under EC 38.
- Card Guard, located in Switzerland, has two divisions in the United States, Instromedix and Lifewatch. Presently, they market event recorders as well as operating monitoring centers. They are looking to move into the wireless monitoring space but today they are all transtelephonic.

Market Size

Cardiovascular disease is the leading cause of death in the industrialized world. According to the American Heart Association's *Heart Disease and Stroke Statistics 2004 Update*:

- Heart disease and stroke, the principal components of cardiovascular disease, claim more lives in the United States each year than the next five leading causes of death combined;
- Approximately 61,800,000 people in the United States suffer from one or more types of cardiovascular disease each year;
- Approximately 950,000 lives were claimed by cardiovascular diseases in the United States in 1999;
- Patients who have suffered heart attacks in the United States number 7.3 million, congestive heart failure 4.7 million, arrhythmia 2.0 million, and angina 6.4 million;
- Approximately one-sixth of all people in the United States killed by cardiovascular disease are under the age of 65; and
- In 2004 the estimated direct and indirect healthcare cost of cardiovascular disease in the United States will be $368.4 billion.

The Center for Disease Control has stated that, if all forms of major cardiovascular disease were eliminated, life expectancy would rise by almost 7 years while, in comparison, if all forms of cancer were eliminated, the gain in life expectancy would only be 3 years.

Based upon the foregoing statistics, we believe that patients with any of these health problems would probably benefit in some manner from improved heart monitoring.

Marketing And Distribution Strategy

Our current plans are to license our heart monitor technologies for stationary heart monitor applications to established medical-device manufacturers and distributors, who will most likely incorporate them into their own products. In the case of the market for ambulatory heart monitors, we anticipate that we will delegate most of our sales, marketing and distribution activities to third party medical-device marketing and distribution companies on a regional basis, while creating a small internal sales, marketing and distribution staff to monitor and manage those activities and to directly market and distribute our products to doctors, hospitals and distributors on a selected basis. We will also probably explore joint venture relationships.

Manufacturing Capacity

We currently fabricate our heart monitors either in-house or through engineering consultants. Given the limitations in our internal manufacturing capability, we anticipate that we will rely upon third party contract manufacturers or joint-venture partners to satisfy future production requirements when we are able to introduce our products to market. Most of the components of our products are standard parts which will be available from multiple supply sources at competitive prices.

Research And Development

We currently conduct research and development activities either in-house or through engineering consultants. Our research and development expenses for fiscal 2003 and 2002 was $497,631 and $67,500, respectively. None of these expenditures were borne by customers. We have budgeted $1,000,000 for research and development for fiscal 2004.

Regulatory Overview

The Medical Device Amendments of 1976 (the "*Medical Device Act*"), a section of the Federal Food, Drug & Cosmetic Act, establishes complex procedures for compliance based upon FDA regulations that designate devices as Class I (general controls, such as compliance with labeling and record-keeping requirements), Class II (performance standards in addition to general controls) or Class III (pre-market approval application before commercial marketing).

A medical device that is substantially equivalent to a directly related medical device previously in commerce may be eligible for the FDA's abbreviated pre-market notification "510(k) review" process. FDA 510(k) clearance is a "grandfather" process. As such, FDA clearance does not imply that the safety, reliability and effectiveness of the medical device has been approved or validated by the FDA, but merely means that the medical device is substantially equivalent to a previously cleared commercially-related medical device. The review period and FDA determination as to substantial equivalence should be made within 90 days of submission of a 510(k) application, unless additional information or clarification or clinical studies are requested or required by the FDA. As a practical matter, the review process and FDA determination often take significantly longer than 90 days.

Our heart monitor is a Class II product. In September 2003, we submitted an application to the FDA for the "front-end" or data collection, processing and recording functions of our monitor on form 510(k), and received FDA approval to market this portion of the device in the United States on January 28, 2004. We are currently developing the "back-end" or software portion of our monitor, which allows the management and interpretation of the data, and for which FDA approval generally is not required.

Patents And Licenses

We hold patent number 5,678,559 issued by the United States Patent and Trademark Office for our core technology, our amplification device. This patent, labeled "*A Method And System Of Recording Different Physiological Signal From A Human Body*", was granted on October 21, 1997. This patent, which was assigned to us by ARC Finance Group as part of our acquisition of the Signal Technologies, expires on October 21, 2014.

We also hold the following three patent applications filed with the United States Patent and Trademark Office: (1) number 10/293,105 captioned "*System for, and Method of, Acquiring Physiological Signals of a Patient*" filed on November 13, 2002, (2) number 10/611,696 captioned "*Amplified System for Determining Parameters of a Patient*"

filed July 1, 2003; and (3) number 10/664,711 captioned "*Apparatus for, and Method of, Determining the Characteristics of a Patient's Heart*" filed September 17, 2003. Each of these patent applications covers aspects of our core technology that enhances the operation of our heart monitor. Dr. Drakulic is the inventor named in our core patent and each of the patent applications. We are currently waiting for comment from the United States Patent and Trademark Office on each of these patent applications.

Also included in the Signal Technologies was an assignment of a license agreement dated December 9, 1993 between Dr. Drakulic and Teledyne Electronic Technologies, pursuant to which Dr. Drakulic granted a limited license to use an early version of the amplification technology to analyze signals produced by the brain (EEG) in an effort to understand a patient□s sleep patterns. We do not expect to earn significant revenues from this license. This license will not prevent Recom from competing in the broader market for EEG amplification products.

Competition

Because we do not yet have a saleable product, we have no competitive presence in the medical monitoring device market. Even if our heart monitor is approved for sale, we do not expect to establish a competitive presence in this market for several years, if at all. There are numerous suppliers of heart monitoring products, all of which have established products and methods of distribution as well as more money than we do. We may never be able to compete successfully in this or any other medical device market.

Costs And Effects Of Compliance With Environmental Laws

There are no special or unusual environmental laws or regulations that will require us to make material expenditures or that can be expected to materially impact on the operation of our business.

Employees

We currently have seven full-time employees, and engage the services of eight engineering, marketing and financial consultants on a part-time basis. None of our employees is represented by a labor union and we consider our relationships with our employees to be good.

PROPERTIES

Our executive offices are located at 4705 Laurel Canyon Boulevard, Suite 203, Studio City, California. These facilities, consisting of approximately 3,550 square feet and encompassing four suites including our administrative offices and research and development/laboratory facilities**,** are leased through August 30, 2005. We pay approximately $8,100 per month in base rent for these facilities, which we believe reflected market value on the date the lease was executed, and are also required to pay our share of any increase in operating expenses after August 2002. Operating expenses include expenses for maintenance of common areas, heating, air conditioning, plumbing, trash disposal, janitorial and security services and other like expenses. The leased premises are in good condition and we believe they will be suitable for our purposes for at least twelve months.

FINANCIAL STATEMENTS AND SUMMARY FINANCIAL DATA

Our financial statements and notes thereto are filed in a separate section at the end of this annual report. The following tables summarize the consolidated statements of operations and balance sheet data for our company for the periods or as of the dates indicated, respectively:

	Year Ended December 31,	
	2003	**2002**
Consolidated Statements of Operations Data:		
Revenue	$	$
Research and development expenses	$ (497,631)	$ (67,500)
General and administrative expenses	$ (4,813,746)	$ (144,454)
Net loss	$ (5,311,377)	$ (211,954)
Preferred dividend	$ (1,975,170)	$
Net loss attributed to common stockholders	$ (7,264,547)	$ (211,954)
Basic and diluted loss per share	$ (0.17)	$ (0.02)
Basic and diluted loss per share attributed to common stockholders	$ (0.23)	$ (0.02)
Weighted average shares outstanding, basic and diluted	31,765,404	11,609,162

	Year Ended December 31, 2003
Consolidated Balance Sheet Data:	
Current assets	$ 4,088,469
Total assets	$ 4,415,596
Current liabilities	$ 590,856
Total liabilities	$ 590,856
Total stockholders equity	$ 3,824,740
Total liabilities and stockholders equity	$ 4,415,596

PLAN OF OPERATION

Results Of Operations

Prior to On September 19, 2002 we were an inactive shell company with no revenues and minimal expenses. On September 19, 2002 we acquired the Signal Technologies, adopted a new business plan to develop that technology, and commenced hiring staff and commencing research and development activities. As a consequence of these activities, our net loss (before preferred dividends) increased from $211,954 in fiscal 2002, most of which occurred in the fourth quarter of that year, to $5,311,377 for fiscal 2003. Research and development expenditures increased from $67,500 in fiscal 2002 to $497,631 in fiscal 2003, reflecting the ramp-up in our research and development activities. General and administrative expenses increased from $144,454 to $4,813,746, reflecting the ramp-up in our overall operations. The primary components of the increased general and administrative expenses were (1) professional fees (legal, accounting, investment banking, medical product and regulatory consulting, and general consulting for management and marketing), and (2) premiums for directors and officers insurance. We also incurred a preferred dividend of $1,953,170 in fiscal 2003, which was attributable to a combination of (i) the value of the beneficial conversion feature of the preferred shares ($896,474), (ii) the fair value of the warrants ($949,121), and (iii) accrued dividends payable on the preferred

shares ($107,575).

Plan Of Business Through End Of Fiscal 2005

Our plan of operation until the end of fiscal 2005 is to complete the development of our first product, our model 100 ambulatory heart monitor.

As discussed earlier in this annual report, we have recently completed development of the "front-end" or hardware portion of our model 100 heart monitor, and submitted it to the FDA for marketing approval on a 510(k) basis as being substantially similar to other devices on the market. The "front-end" portion of the device collects, processes and records data. FDA 510(k) approval to market this "front-end" portion of our device in the United States was subsequently granted by the FDA on January 28, 2004. We are currently developing the "back-end" or software portion of our model 100 heart monitor, which allows the management and interpretation of the data. We intend to use and modify commercially available software for which FDA approval has already been received to manage and interpret this data. We do not believe that our modification of this software will require additional FDA approval. Once we have completed these steps, we must design and engineer a "production" model for mass manufacturing which will be durable, reliable and maintenance-free, and competitively priced. We anticipate that we will complete a production model of our model 100 heart monitor, integrating both back-end and front-end functions, by the end of fiscal 2005, and will have also commenced commercial marketing efforts by the end of that period.

We have currently budgeted $3,600,000 to complete the development of our non-invasive ambulatory heart monitor through the end of fiscal 2005, including $2,300,000 to cover our projected general and administrative and marketing expenses during this period, and $1,300,000 to cover our projected research and development, and product testing and development costs during this period.

The steps we need to take to complete our research and development, product development and testing activities include the following:

- We need to finalize the remaining development work on the "front-end" portion of the device, which consists of designing the device to meet the ANSI/AAMI EC-38 standard for ambulatory electrocardiographs adopted by the FDA for clinical (resting) diagnostic heart monitors (i.e., ability to interpret physiological signals throughout the entire 0.7HZ to 150 HZ range), as well as satisfying applicable performance, safety and environmental standards such as those relating to electromagnetic interference, electromagnetic susceptibility, shock and current leakage. These latter standards include the IEC60601-2-27 requirements for the safety of electrocardiograph devices; the IEC 60601-1-2 requirements for safety and electromagnetic compatibility; the UL2601-1 medical equipment general requirements for safety; and FCC regulations under part 15, subpart C, governing allowable frequency ranges for different types of devices, including medical devices. None of this work needs to be approved by the FDA, however, before we can commence marketing our model 100 monitor, we must not only satisfactory complete the performance testing of our monitor to establish that it satisfies the requirements described above, but must also conduct user preference tests measuring our device against other ambulatory monitors. This latter testing will be conducted at our laboratory facilities as well as at selected hospitals and university sites. A minor expense in the testing will be the cost to acquire competitor's devices. We anticipate that we will complete this work by the end of the fourth quarter of 2004. We have budgeted $280,000 for this phase.
- We also need to complete the "back-end" portion of the device. To do so, we anticipate spending $250,000 to purchase off-the-shelf software which we can use with only minor modifications, and spending an additional $200,000 to develop proprietary software and algorithMs. We anticipate that we will complete this work by the end of the first quarter of 2005.
- Once we have fully designed the "front-end" portion of our device, we intend to submit test protocols in the third quarter of 2005 to several institutional review boards to review. We will coordinate the writing of a number of "white papers" relating to effectives of our device and published results in peer review journals. The term "white paper" is used to describe articles written by recognized experts in the field and presented at technical conferences or published in scientific journals. During this period, we also intend to make arrangements with four or more hospitals or clinics to test our device. We anticipate that we will complete this process by the third quarter of 2005. During the course of this period we should complete the "back-end" portion of the device, and we will then have the opportunity to use it during the clinical testing with the "front-end" portion. Our anticipated budget for these activities is $300,000.
- We need to design a vest which can be used on a 24/7 basis for extended periods of time, while being taken off by the patient intermittently for showers, etc. We must address two engineering issues in developing this vest. First, we need to develop an electrode which can be incorporated into the vest to monitor the patient's heart signal, thus replacing the use of leads and gels currently used in recording ECGs. Second, we need to design the vest in such a fashion that it not only holds the electrode against the body at the correct locations and in the proper manner, but it also can be adapted to fit patients with different heights, weights and physiques. We project that we will spend approximately $230,000 to conduct these development activities, and expect to complete them by the last quarter of 2005.

- We have also budgeted $60,000 to purchase various items of equipment to test the operation of the device over different phases.

Marketing activities included in our general and administrative expenses will include (1) hiring three sales managers by the end of 2005 for the east coast, Midwest, and south, respectively; (2) exhibiting at various trade shows, including shows for the North American Society for Pacing and Electrophysiology, American College of Cardiology and American Heart Association to be held in 2005; (3) commencing an advertising program in cardiology journals in 2005, and (4) providing sample heart monitors to key cardiologists, hospitals and monitoring centers in early to mid 2005.

We anticipate that we will convert one current consultant to an employee, and add four additional employees, to our staff through the end of fiscal of 2005.

Liquidity And Capital Resources

For the period January 1, 2002 through December 31, 2003, we principally financed our operations through a combination of (1) the sale of our common shares, series A preferred shares and common share purchase warrants for cash ($6,101,650); and (2) the issuance of common shares or common share purchase warrants in payment of the provision of services ($3,666,861).

We currently have approximately $3,100,00 of cash on hand, which we project will fund our projected product development and operating costs through the October 2005. Once we commence marketing our heart monitor, we project that we will not be cash flow positive based solely on projected sales and service revenues less manufacturing, general and administrative, marketing expenses and other operating costs for at least eight months. We will need to raise additional cash and working capital to cover an expected shortfall in our cash and working capital until we become cash-flow positive. Should our costs and expenses prove to be greater than we currently anticipate, or should we change our current business plan in a manner that will increase or accelerate our anticipated costs and expenses, such as through an acquisition of new products, the depletion of our working capital could occur sooner than projected. For example, we are currently considering the acquisition of a non-prescription heart monitor from TZ Medical, Inc. which would increase our projected marketing costs, although it is probably less probable than more probable that we will consummate the transaction. Should we determine it to be necessary to raise additional cash in the future as our current cash and working capital resources are depleted, we will seek to raise it through the public or private sales of debt or equity securities, the procurement of advances on contracts or licenses, funding from joint-venture or strategic partners, debt financing or short-term loans, or a combination of the foregoing. We may also seek to satisfy indebtedness without any cash outlay through the private issuance of debt or equity securities. We currently do not have any binding commitments for, or readily available sources of, additional financing. We cannot give you any assurance that we will be able to secure the additional cash or working capital we may require to continue our operations.

MANAGEMENT

Identity

The following table identifies our current executive officers and directors, their respective offices and positions, and their respective dates of election or appointment:

Name And Municipality Of Residence	Age	Office	Initial Election Or Appointment Date
Marvin H. Fink Los Angeles, California	67	Chief Executive Officer, President, Secretary, and Chairman of the Board	October 12, 2002
Budimir S. Drakulic, Ph.D. Los Angeles, California	54	Vice President and Chief Technology Officer	October 15, 2002
Charles Dargan Los Angeles, California	48	Interim Chief Financial Officer	December 18, 2003
Ellsworth Roston Los Angeles, California	81	Director	November 1, 2002
Robert Koblin, M.D. Los Angeles, California	72	Director	February 6, 2003
Lowell T. Harmison, Ph.D. Washington, D.C.	66	Director	June 6, 2003
Jennifer Black Lake Oswego, Oregon	48	Director	January 20, 2004

Messrs. Fink and Drakulic provide their services as executive officers on a full-time permanent basis. Mr. Dargan provides his services as an executive officer on a part-time interim basis through an agency that specializes in providing financial management personnel to businesses on a temporary basis.

There are no family relationships between any two or more of our directors or executive officers. There is no arrangement or understanding between any of our directors or executive officers and any other person pursuant to which any director or officer was or is to be selected as a director or officer, and there is no arrangement, plan or understanding as to whether non-management shareholders will exercise their voting rights to continue to elect the current board of directors. There are also no arrangements, agreements or understandings to our knowledge between non-management shareholders that may directly or indirectly participate in or influence the management of our affairs.

Business Experience

Marvin H. Fink has served as our Chief Executive Officer, President and Chairman of the Board since October 12, 2002, and our Secretary since November 2003. Prior to joining us, Mr. Fink was president of his own management consulting group from August 2001 until he joined Recom in October 2002. Mr. Fink has 45 years of experience in the management of high technology programs from development stage through production including projects for the Department of Defense, NASA, Teledyne Systems, Litton Industries and Hughes Aircraft. Until his retirement in August 2001, Mr. Fink served as President of Teledyne Electronic Technologies from 1993, which was then a subsidiary of Teledyne Technologies, Inc. (NYSE:TDY). From 1986 until 1993, he served as President of Teledyne Microelectronics. Mr. Fink has served as a director of RF Industries (Nasdaq:RFIL), a manufacturer of coaxial connectors used for communication applications, since October 2001. Mr. Fink holds a bachelors of science degree in electronic engineering from City College of New York, a Masters of Science degree in Electronic Engineering from the University of Southern California, and a Juris Doctor degree from the San Fernando Valley College of Law.

Dr. Budimir S. Drakulic has served as our Vice President and Chief Technology Officer since October 15, 2002. Dr. Drakulic has more than 25 years of experience in the design, development and integration of hardware and software modules for biomedical microelectronics circuits and systeMs. From 1997 through February of 2002, Dr. Drakulic was involved directly and indirectly with Advanced Heart Technologies, Inc., a corporation controlled by Dr. Drakulic. Dr. Drakulic was the Consultant and Chief Scientist, Medical Device Business Unit for Teledyne Electronic Technologies from 1992 through 1997. Before that, he held numerous positions affiliated with the University of California at Los Angeles, including Visiting Assistant Professor with the Electrical Engineering Department and Director of the Microelectronics Development Lab at the Crump Institute for Medical Engineering. He holds a Bachelor of Science degree in electrical engineering from the University of Belgrade, Yugoslavia. He also holds a Masters degree and a Ph.D. in Electronic and Biomedical Engineering from the same university. Dr. Drakulic was the recipient of the Ralph and Marjorie Crump Prize for Excellence in Medical Engineering from UCLA in 1985, and was a Research Fellow with the Crump Institute for Medical Engineering at UCLA. Dr. Drakulic filed a petition for bankruptcy in November 2001.

Mr. Charles Dargan has providing his services as our interim Chief Financial Officer since December 18, 2003 on a leased basis through CFO 911, an agency that specializes in providing financial management personnel to businesses on a temporary basis. We are actively recruiting a permanent full-time Chief Financial Officer. Mr. Dargan is also currently employed as the Chief Financial and Accounting Officer of Semotus Solutions, Inc. (AMEX:DLK). From April 2000 until his appointment as Chief Financial and Accounting Officer in January 2001, Mr. Dargan served as Semotus Solutions Executive Vice President of Operations. Mr. Dargan was also a director of Semotus Solutions from March 1999 to July 2002. Prior to joining Semotus Solutions, Mr. Dargan served as a Managing Director of Corporate Finance for The Seidler Companies Incorporated, a private brokerage, investment banking and public finance firm. In addition, he was a partner and Chief Financial Officer of the investment banking firm of Ambient Capital; a Managing Director of Corporate Finance at L.H. Friend, Weinress, Frankson & Presson, Inc.; and a First Vice President at Drexel Burnham Lambert, Incorporated. His accounting and financial industry experience has made him an expert in public and private debt and equity finance, mergers and acquisitions and financial management of and planning for emerging growth companies. Mr. Dargan graduated from the University of Southern California with an MBA and an MS in Finance, and possesses an A.B. in Government and Economics from Dartmouth College. He also holds accounting and finance industry certifications of Chartered Financial Analyst (CFA) and Certified Public Accountant (CPA).

Mr. Ellsworth Roston has served as a director since November 1, 2002. Mr. Roston has practiced patent law since 1943, and currently serves as Of Counsel to the patent firm of Fulwider Patton Lee & Utecht since 1997. Mr. Roston has a history of assisting technology companies during their development stages. Most recently, Mr. Roston has served as a director of Natgram, Inc., an internet software developer, since 1998, Amerlin Inc., a pet house/kennel manufacturer, since 1996, and American Legal Net, a provider of legal forms, since April 2004. Mr. Roston also served as a director of Rokenbok Corporation, a toy manufacturer, from 1996 through February 2004, and of Dome Industries, an electronic hardware manufacturer, from 1991 through 2002. Mr. Roston was one of three founders of Brooktree Corporation, and served on its board of directors for 15 years until it was purchased by Rockwell Corporation in 1998. Mr. Roston received his undergraduate degree and his law degree from Yale University.

Dr. Robert Koblin has served as a director since February 6, 2003. Dr. Koblin, a cardiologist, has more than 30 years of medical experience beginning during the time he served in the United States Army as a medic and continuing most recently as a staff physician and instructor at the Cedars-Sinai Medical Center in Los Angeles since 1966. He has also served as the Managing Director of the Robertson Diagnostic Center in Beverly Hills, California since April 2002, and as an assistant clinical professor of medicine at the University of California, Los Angeles (UCLA), since 1982. Dr. Koblin received his undergraduate degree from New York University, his medical degree from Stanford University.

Dr. Lowell T. Harmison has served as a director since June 6, 2003 and as a Senior Advisor since February of 2003. Dr. Harmison has a very distinguished 35 year career in the field of biomedicine. Most recently, Dr. Harmison has served as a director and as chairman of the board of World Doc Foundation, a private foundation promoting health education and expanded knowledge of telemedicine, since June 2002. Dr. Harmison has also served as a director and chief executive officer of ProCell Corporation, a cancer research company, since June 2000, and as a director of pHA Bio Remediation, an environmental restoration company, since 1997. Dr. Harmison also served as chairman of Sequella Foundation, which promotes research into tuberculosis, from 1997 to 2001, and served as a director of Sequella Inc., a research and development company for tuberculosis products, from 1997 to 2000. Dr. Harmison is the holder of the first domestic and foreign patents on the fully implantable artificial heart; and served as Chief Executive Officer of USET, Inc. from 1987 to 1989. Dr. Harmison also served as the Director of the Robert Maxwell Foundation, a private foundation operating internationally and consisting of 21 operating companies, from 1987 to 1989. He also served as the Principal Deputy Assistant Secretary for Health of the U.S. Public Health Service, Department of Health and Human Services. Dr. Harmison has a Ph.D. from the University of Maryland and a B.S. and M.S. from West Virginia University. He was also given an honorary Doctor of Science degree from the West Virginia University.

Ms. Jennifer Black has served as a director since January 20, 2004. Ms. Black has been President of her own business, Jennifer Black & Associates, since September 2003. Her firm provides independent research for institutional clients. Previously, Ms. Black was with Black & Co. (since 1979), where she was responsible for research coverage on the apparel and specialty retail industries. Ms. Black was President of Black & Co. when it was acquired by First Security Van Kasper in April 2000. Subsequently, Wells Fargo Securities acquired First Security Van Kasper in September 2000. Ms. Black left Wells Fargo Securities in September 2003. Ms. Black serves on the Governors Council of Economic Advisors for the State of Oregon, where she has been re-appointed to a second three-year term. Ms. Black attended Washington State and Portland State Universities.

Board Of Directors

Our bylaws set the authorized number of directors on our board of directors at not less than three nor more than nine, with the actual number fixed by a resolution of our board. As noted above, there are currently five directors serving on our board, Messrs. Fink, Roston, Koblin and Harmison and Ms. Black. All of the directors will serve until the next annual meeting of shareholders and until their successors are elected and qualified by our shareholders, both common and preferred, voting on a cumulative basis as one class, or until their earlier death, retirement, resignation or removal.

Board Committees And Independence

Our board of directors has established two committees to date, an audit committee comprised of Dr. Koblin and Ms. Black, and a compensation committee comprised of Messrs. Fink and Roston and Dr. Koblin.

Mr. Roston, Dr. Koblin and Ms. Black are each "independent" directors as that term is defined by the SEC. None of our current directors, including Dr. Koblin and Ms. Black who serve on our audit committee, have the requisite public company accounting background or experience to be considered an "audit committee financial expert" as that term is defined by the SEC. Due to our development stage status, we believe that both members of the Audit Committee have the requisite financial background and experience to carry out their duties.

Shareholder Nomination Procedures

Approximately 66% of our voting shares are held by a single shareholder which, in view of the cumulative voting provision in our bylaws, effectively allows that shareholder to elect at least three of our five directors. Since that shareholder already has ready access to our board of directors and in view of this voting power, our board has not to date adopted formal procedures by which other shareholders could recommend nominees for election or appointment to our board.

Board Compensation

Our current compensation policy for our directors for service on the full board is to compensate them through stock grants under our 2002 Stock Plan pursuant to a director's compensation policy adopted on February 6, 2003. Upon joining our board of directors, each member is granted an option to purchase 50,000 (pre-split and post-split) common shares, exercisable at its then trading price. These options are fully vested upon grant, and lapse in five years if not exercised. Each director will thereafter be granted options on an annual basis entitling him to purchase an additional 28,000 (post-split) common shares, which options will vest quarterly based upon the continued provision of services as a director, and lapse in five years if not exercised. The exercise price for these options will be fixed at current market price as of the date of grant. Following our April 11, 2003 stock split, our board determined to maintain the grants at 50,000 common shares post-split for grants to new directors insofar as it believed such number was an appropriate number of option shares after taking into consideration factors it deemed relevant.

Our current compensation policy for our directors for serving on our various committees to the board is to compensate them through the grant of common share purchase options. Upon his or her appointment to a committee, each committee member is granted an option to purchase 2,000 common shares, exercisable at its then trading price. These options vest in four quarterly installments, and lapse in five years if not exercised.

The following table described the common share purchase options granted to our directors as of April 30, 2004 as compensation for serving on our board and, if applicable, committees of our board.

Name	Grant Date	Common Shares Purchasable	Exercise Price	Expiration Date
Marvin H. Fink	2/6/2003	150,000(3)	$ 0.88	2/5/2008
	11/3/2003	28,000	$ 4.40	11/2/2008
	4/1/2004	2,000	$ 6.00	3/31/2009