RadNet, Inc.
Form 10-K
February 07, 2007

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

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTIONS 13 OR 15(D) OF THE
SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended October 31, 2006

Commission File Number 0-19019

RADNET, INC.
(Exact name of registrant as specified in its charter)

NEW YORK	13-3326724
(STATE OR OTHER JURISDICTION OF INCORPORATION OR ORGANIZATION)	(I.R.S. EMPLOYER IDENTIFICATION NO.)
1510 COTNER AVENUE LOS ANGELES, CALIFORNIA	90025
(ADDRESS OF PRINCIPAL EXECUTIVE OFFICES)	(ZIP CODE)

REGISTRANT'S TELEPHONE NUMBER, INCLUDING AREA CODE: (310) 478-7808
SECURITIES REGISTERED PURSUANT TO SECTION 12(B) OF THE ACT: NONE
SECURITIES REGISTERED PURSUANT TO SECTION 12(G) OF THE ACT:
COMMON STOCK, $.0001 PAR VALUE

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes _____ No __X__

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) or the act. Yes _____ No __X__

NOTE--Checking the box above will not relieve any registrant required to file reports pursuant to section 13 or (15(d) of the exchange Act from their obligations under those Sections.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities and Exchange Act of 1934 during the preceding 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 _____

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and 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-K or any amendment to this Form 10-K. [ ]

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large Accelerated Filer [ ] Accelerated Filer [ ] Non-Accelerated Filer [X]

Indicate by check mark whether the registrant is a shell company (as defined in Exchange Act Rule 12b-2) Yes _____ No __X__

The aggregate market value of the registrant's voting and nonvoting common equity held by non-affiliates of the registrant was approximately $52,802,584 on April 30, 2006 (the last business day of the registrant's most recently completed second quarter) based on the closing price for the common stock on the Nasdaq Over-the-Counter Bulletin Board on April 28, 2006.

Indicate by check mark whether the registrant has filed all documents and reports required to be filed by Section 12, 13 or 15(d) of the Securities Exchange Act of 1934 subsequent to the distribution of securities under a plan confirmed by a court. Yes __X__ No _____

The number of shares of the registrant's common stock outstanding on January 17, 2007, was 34,158,785 shares (excluding treasury shares).

PART I

ITEM 1. BUSINESS

RADIOLOGIX ACQUISITION

On November 15, 2006, we completed the acquisition of Radiologix, Inc. Radiologix, a Delaware corporation, employing approximately 2,200 people, through its subsidiaries, was a national provider of diagnostic imaging services through the ownership and operation of freestanding, outpatient diagnostic imaging centers. Radiologix owned, operated and maintained equipment in 69 locations, with imaging centers in seven states, including primary operations in the Mid-Atlantic; the Bay-Area, California; the Treasure Coast area, Florida; Northeast Kansas; and the Finger Lakes (Rochester) and Hudson Valley areas of New York state. Under the terms of the acquisition agreement, Radiologix shareholders received an aggregate consideration of 11,310,961 shares (after giving effect to the one-for-two reverse stock split effected in November 2006) of our common stock and $42,950,000 in cash. We financed the transaction and refinanced substantially all of our outstanding debt with a $405 million senior secured credit facility with GE Commercial Healthcare Financial Services.

BUSINESS OVERVIEW

Since our acquisition of Radiologix on November 15, 2006, we operate a group of regional networks comprised of 129 diagnostic imaging facilities located in seven states with operations primarily in California, the Mid Atlantic, the Treasure Coast area of Florida, Kansas and the Finger Lakes (Rochester) and Hudson Valley areas of New York. We believe our group of regional networks is the largest of its kind in the U.S. Our facilities are strategically organized into regional networks in markets that have both high-density and expanding populations, as well as attractive payor diversity.

All of our facilities employ state-of-the-art equipment and technology in modern, patient-friendly settings. Many of our facilities within a particular

region are interconnected and integrated through our advanced information technology system. Ninety-three of our facilities are multi-modality sites, offering various combinations of magnetic resonance imaging, or MRI, computed tomography, or CT, positron emission tomography, or PET, nuclear medicine, mammography, ultrasound, diagnostic radiology, or X-ray and fluoroscopy. Thirty-six of our facilities are single-modality sites, offering either X-ray or MRI. Consistent with our regional network strategy, we locate our single-modality facilities near multi-modality sites to help accommodate overflow in targeted demographic areas.

At our facilities, we provide all of the equipment as well as all non-medical operational, management, financial and administrative services necessary to provide diagnostic imaging services. We give our facility managers authority to run our facilities to meet the demands of local market conditions, while our corporate structure provides economies of scale, corporate training programs, standardized policies and procedures and sharing of best practices across our networks. Each of our facility managers is responsible for meeting our standards of patient service, managing relationships with local physicians and payors and maintaining profitability.

We also provide administrative, management and information services to certain radiology practices that provide professional services in connection with diagnostic imaging centers and to hospitals and radiology practices with which we operate joint ventures. The services we provide leverage our existing infrastructure, and we believe the services improve the profitability, efficiency and effectiveness of the radiology practice or joint venture.

For the year ended October 31, 2006, our combined facilities, including the facilities acquired as part of our acquisition of Radiologix, performed over 2.3 million diagnostic imaging procedures.

Howard G. Berger, M.D. is our President and Chief Executive Officer, a member of our Board of Directors and owns approximately 17% of our outstanding common stock. Dr. Berger also owns, indirectly, 99% of the equity interests in Beverly Radiology Medical Group III, or BRMG. BRMG provides all of the professional medical services at 52 of our facilities located in California under a management agreement with us, and contracts with various other independent physicians and physician groups to provide the professional medical services at most of our other California facilities. We obtain professional medical services from BRMG in California, rather than provide such services directly or through subsidiaries, in order to comply with California's prohibition against the corporate practice of medicine. However, as a result of our close relationship with Dr. Berger and BRMG, we believe that we are able to better ensure that medical service is provided at our California facilities in a manner consistent with our needs and expectations and those of our referring physicians, patients and payors than if we obtained these services from unaffiliated physician groups. At eleven former Radiologix centers in California and at all of the former Radiologix centers which are located outside of California, we have entered long-term contracts with prominent radiology groups in the area to provide physician services at those facilities.

We derive substantially all of our revenue, directly or indirectly, from fees charged for the diagnostic imaging services performed at our facilities. For the year ended October 31, 2006, we performed 2,336,814 diagnostic imaging procedures (including 1,417,472 at Radiologix for its 12 months ended December 31, 2006) and generated net revenue from continuing operations of $384 million (including $223 million by Radiologix for the 12 months ended December 31,

2006).

The following table illustrates our work performed over the five-year period ended October 31, 2006:

	YEARS ENDED OCTOBER 31,			
	2002	2003	2004	200
Total number of MRI, CT and PET systems (at end of year)*	60	63	68	
Total number of procedures performed*	877,574	947,032	946,928	958,

* All procedures. Excludes discontinued operation.
**Includes 102 Radiologix MRI, CT and PET systems at October 31, 2006, and 1,417,472 Radiologix procedures for the 12 months ended December 31, 2006.

INDUSTRY OVERVIEW

Diagnostic imaging involves the use of non-invasive procedures to generate representations of internal anatomy and function that can be recorded on film or digitized for display on a video monitor. Diagnostic imaging procedures facilitate the early diagnosis and treatment of diseases and disorders and may reduce unnecessary invasive procedures, often minimizing the cost and amount of care for patients. Diagnostic imaging procedures include MRI, CT, PET, nuclear medicine, ultrasound, mammography, X-ray and fluoroscopy.

While general X-ray remains the most commonly performed diagnostic imaging procedure, the fastest growing and higher margin procedures are MRI, CT and PET. The rapid growth in PET scans is attributable to the recent introduction of reimbursement by payors of PET procedures. The number of MRI and CT scans continues to grow due to their wider acceptance by physicians and payors, an increasing number of applications for their use and a general increase in demand due to the aging population in the United States.

IMV, a provider of database and market information products and services to the analytical, clinical diagnostic, biotechnology, life science and medical imaging industries, estimates that over 24.2 million MRI procedures and 50.1 million CT procedures were conducted in the United States in 2003, representing a 10% increase over the 2002 volume of both the MRI and CT procedures, respectively. This data is particularly relevant to us, given that revenue from MRI and CT scans constituted approximately 58% of our net revenue for the year ended October 31, 2006. In addition, IMV estimates that over 706,100 clinical PET patient studies were performed in the United States in 2003, representing a 58% increase over the 2002 volume of 447,200 clinical PET patient studies. Revenue from PET scans constituted approximately 8% of our net revenue for the year ended October 31, 2006.

INDUSTRY TRENDS

We believe the diagnostic imaging services industry will continue to grow as a result of a number of factors, including the following:

ESCALATING DEMAND FOR HEALTHCARE SERVICES FROM AN AGING POPULATION

Persons over the age of 65 comprise one of the fastest growing segments of the population in the United States. According to the United States Census Bureau, this group is expected to increase as much as 14% from 2000 to 2010. Because diagnostic imaging use tends to increase as a person ages, we believe

the aging population will generate more demand for diagnostic imaging procedures.

NEW EFFECTIVE APPLICATIONS FOR DIAGNOSTIC IMAGING TECHNOLOGY

New technological developments are expected to extend the clinical uses of diagnostic imaging technology and increase the number of scans performed. Recent technological advancements include:

- MRI spectroscopy, which can differentiate malignant from benign lesions;
- MRI angiography, which can produce three-dimensional images of body parts and assess the status of blood vessels;
- Enhancements in teleradiology systems, which permit the digital transmission of radiological images from one location to another for interpretation by radiologists at remote locations; and

- The development of combined PET/CT scanners, which combine the technology from PET and CT to create a powerful diagnostic imaging system.

Additional improvements in imaging technologies, contrast agents and scan capabilities are leading to new non-invasive methods of diagnosing blockages in the heart's vital coronary arteries, liver metastases, pelvic diseases and vascular abnormalities without exploratory surgery. We believe that the use of the diagnostic capabilities of MRI and other imaging services will continue to increase because they are cost-effective, time-efficient and non-invasive, as compared to alternative procedures, including surgery, and that newer technologies and future technological advancements will continue the increased use of imaging services. In addition, we believe the growing popularity of elective full-body scans will further increase the use of imaging services. At the same time, we believe the industry has increasingly used upgrades to existing equipment to expand applications, extend the useful life of existing equipment, improve image quality, reduce image acquisition time and increase the volume of scans that can be performed. We believe this trend toward equipment upgrades rather than equipment replacements will continue, as we do not foresee new imaging technologies on the horizon that will displace MRI, CT or PET as the principal advanced diagnostic imaging modalities.

WIDER PHYSICIAN AND PAYOR ACCEPTANCE OF THE USE OF IMAGING

During the last 30 years, there has been a major effort undertaken by the medical and scientific communities to develop higher quality, cost-effective diagnostic imaging technologies and to minimize the risks associated with the application of these technologies. The thrust of product development during this period has largely been to reduce the hazards associated with conventional x-ray and nuclear medicine techniques and to develop new, harmless imaging technologies. As a result, the use of advanced diagnostic imaging modalities, such as MRI, CT and PET, which provide superior image quality compared to other diagnostic imaging technologies, has increased rapidly in recent years. These advanced modalities allow physicians to diagnose a wide variety of diseases and injuries quickly and accurately without exploratory surgery or other surgical or invasive procedures, which are usually more expensive, involve greater risk to patients and result in longer rehabilitation time. Because advanced imaging systems are increasingly seen as a tool for reducing long-term healthcare costs,

they are gaining wider acceptance among payors.

GREATER CONSUMER AWARENESS OF AND DEMAND FOR PREVENTIVE DIAGNOSTIC SCREENING

Diagnostic imaging is increasingly being used as a screening tool for preventive care such as elective full-body scans. Consumer awareness of and demand for diagnostic imaging as a less invasive and preventive screening method has added to the growth in diagnostic imaging procedures. We believe that further technological advancements will create demand for diagnostic imaging procedures as less invasive procedures for early diagnosis of diseases and disorders.

DIAGNOSTIC IMAGING SETTINGS

Diagnostic imaging services are typically provided in one of the following settings:

FIXED-SITE, FREESTANDING OUTPATIENT DIAGNOSTIC FACILITIES

These facilities range from single-modality to multi-modality facilities and are not generally owned by hospitals or clinics. These facilities depend upon physician referrals for their patients and generally do not maintain dedicated, contractual relationships with hospitals or clinics. In fact, these facilities may compete with hospitals or clinics that have their own imaging systems to provide services to these patients. These facilities bill third-party payors, such as managed care organizations, insurance companies, Medicare or Medicaid. All of our facilities are in this category.

HOSPITALS OR CLINICS

Many hospitals provide both inpatient and outpatient diagnostic imaging services, typically on site. These inpatient and outpatient centers are owned and operated by the hospital or clinic, or jointly by both, and are primarily used by patients of the hospital or clinic. The hospital or clinic bills third-party payors, such as managed care organizations, insurance companies, Medicare or Medicaid.

MOBILE FACILITIES

Using specially designed trailers, imaging service providers transport imaging equipment and provide services to hospitals and clinics on a part-time or full-time basis, thus allowing small to mid-size hospitals and clinics that do not have the patient demand to justify an on-site setting access to advanced diagnostic imaging technology. Diagnostic imaging providers contract directly with the hospital or clinic and are typically reimbursed directly by them.

DIAGNOSTIC IMAGING MODALITIES

The principal diagnostic imaging modalities we use at our facilities are:

MRI

MRI has become widely accepted as the standard diagnostic tool for a wide and fast-growing variety of clinical applications for soft tissue anatomy, such as those found in the brain, spinal cord and interior ligaments of body joints such as the knee. MRI uses a strong magnetic field in conjunction with low

energy electromagnetic waves that are processed by a computer to produce high-resolution, three-dimensional, cross-sectional images of body tissue, including the brain, spine, abdomen, heart and extremities. A typical MRI examination takes from 20 to 45 minutes. MRI systems can have either open or closed designs, routinely have magnetic field strength of 0.2 Tesla to 3.0 Tesla and are priced in the range of $0.6 million to $2.5 million.

CT

CT provides higher resolution images than conventional X-rays, but generally not as well-defined as those produced by MRI. CT uses a computer to direct the movement of an X-ray tube to produce multiple cross-sectional images of a particular organ or area of the body. CT is used to detect tumors and other conditions affecting bones and internal organs. It is also used to detect the occurrence of strokes, hemorrhages and infections. A typical CT examination takes from 15 to 45 minutes. CT systems are priced in the range of $0.3 million to $1.2 million.

PET

PET scanning involves the administration of a radiopharmaceutical agent with a positron-emitting isotope and the measurement of the distribution of that isotope to create images for diagnostic purposes. PET scans provide the capability to determine how metabolic activity impacts other aspects of physiology in the disease process by correlating the reading for the PET with other tools such as CT or MRI. PET technology has been found highly effective and appropriate in certain clinical circumstances for the detection and assessment of tumors throughout the body, the evaluation of some cardiac conditions and the assessment of epilepsy seizure sites. The information provided by PET technology often obviates the need to perform further highly invasive or diagnostic surgical procedures. PET systems are priced in the range of $0.8 million to $2.5 million. We provide PET-only services through the use of mobile equipment services at two of our sites. In addition, we have combined PET/CT systems that blend the PET and CT imaging modalities into one scanner. These combined systems are priced in the range of $1.8 million to $2.2 million.

NUCLEAR MEDICINE

Nuclear medicine uses short-lived radioactive isotopes that release small amounts of radiation that can be recorded by a gamma camera and processed by a computer to produce an image of various anatomical structures or to assess the function of various organs such as the heart, kidneys, thyroid and bones. Nuclear medicine is used primarily to study anatomic and metabolic functions. Nuclear medicine systems are priced in the range of $300,000 to $400,000.

X-RAY

X-rays use roentgen rays to penetrate the body and record images of organs and structures on film. Digital X-ray systems add computer image processing capability to traditional X-ray images, which provides faster transmission of images with a higher resolution and the capability to store images more cost-effectively. X-ray systems are priced in the range of $50,000 to $250,000.

ULTRASOUND

Ultrasound imaging uses sound waves and their echoes to visualize and locate internal organs. It is particularly useful in viewing soft tissues that do not X-ray well. Ultrasound is used in pregnancy to avoid X-ray exposure as well as in gynecological, urologic, vascular, cardiac and breast applications. Ultrasound systems are priced in the range of $90,000 to $250,000.

MAMMOGRAPHY

Mammography is a specialized form of radiology using low dosage X-rays to visualize breast tissue and is the primary screening tool for breast cancer. Mammography procedures and related services assist in the diagnosis of and treatment planning for breast cancer. Mammography systems are priced in the range of $70,000 to $100,000.

FLUOROSCOPY

Fluoroscopy uses ionizing radiation combined with a video viewing system for real time monitoring of organs. Fluoroscopy systems are priced in the range of $100,000 to $300,000.

COMPETITIVE STRENGTHS

SIGNIFICANT AND KNOWLEDGEABLE PARTICIPANT IN THE NATION'S LARGEST ECONOMY

We believe our group of regional networks of fixed-site, freestanding outpatient diagnostic imaging facilities is the largest of its kind in California, the nation's largest economy and most populous state and with the Radiologix acquisition the largest outpatient diagnostic imaging facility owner in the U.S. Our two decades of experience in operating diagnostic imaging facilities in almost every major population center in California gives us intimate, first-hand knowledge of these geographic markets, as well as close, long-term relationships with key payors, radiology groups and referring physicians within these markets. The additional Radiologix centers reflect, for the most part, a similar clustering philosophy which we believe will provide an opportunity to utilize our California model outside of California.

ADVANTAGES OF REGIONAL NETWORKS WITH BROAD GEOGRAPHIC COVERAGE

The organization of our diagnostic imaging facilities into regional networks around major population centers offers unique benefits to our patients, our referring physicians, our payors and us.

o We are able to increase the convenience of our services to patients by implementing scheduling systems within geographic regions, where practical. For example, many of our diagnostic imaging facilities within a particular region can access the patient appointment calendars of other facilities within the same regional network to efficiently allocate time available and to meet a patient's appointment, date, time or location preferences.

o We have found that many third-party payors representing large groups of patients often prefer to enter into managed care contracts with providers that offer a broad array of diagnostic imaging services at convenient locations throughout a geographic area. We believe that our regional network approach and our utilization management system make us an attractive candidate for selection as a preferred provider for these third-party payors.

o Through our advanced information technology systems, we can electronically exchange information between radiologists in real time, enabling us to cover larger geographic markets by using the specialized training of other practitioners in our networks. In addition, many of our facilities digitally transmit to our headquarters, on a daily basis, comprehensive data concerning the diagnostic imaging services performed, which our corporate management closely monitors to evaluate each facility's efficiency. Similarly, BRMG uses our advanced information technology system to closely monitor radiologists to

ensure they consistently perform at expected levels.

o The grouping of our facilities within regional networks enables us to easily move technologists and other personnel, as well as equipment, from under-utilized to over-utilized facilities on an as-needed basis. This results in operating efficiencies and better equipment utilization rates and improved response time for our patients.

COMPREHENSIVE DIAGNOSTIC IMAGING SERVICES

At each of our multi-modality facilities, we offer patients and referring physicians one location to serve their needs for multiple procedures. Furthermore, we have complemented many of our multi-modality sites with single-modality sites to accommodate overflow and to provide a full range of services within a local area consistent with demand. This can help patients avoid multiple visits or lengthy journeys between facilities, thereby decreasing costs and time delays.

STRONG RELATIONSHIPS WITH EXPERIENCED AND HIGHLY REGARDED RADIOLOGISTS

Our contracted radiologists generally have outstanding credentials and reputations, strong relationships with referring physicians, a broad mix of sub-specialties and a willingness to embrace our approach for the delivery of diagnostic imaging services. The collective experience and expertise of these radiologists translates into more accurate and efficient service to patients. Moreover, as a result of our close relationship with Dr. Berger and BRMG in California and our long-term arrangements with radiologists outside of California, we believe that we are able to better ensure that medical service is provided at our facilities in a manner consistent with our needs and expectations and those of our referring physicians, patients and payors than if we obtained these services from unaffiliated or short-term practice groups. We believe that physicians are drawn to BRMG and the other radiologist groups with whom we contract by the opportunity to work with the state-of-the-art equipment we make available to them, as well as the opportunity to receive specialized training through our fellowship programs, and engage in clinical research programs, which generally are available only in university settings and major hospitals.

DIVERSIFIED PAYOR MIX

Our revenue is derived from a diverse mix of payors, including private payors, managed care capitated payors and government payors. We believe our payor diversity mitigates our exposure to possible unfavorable reimbursement trends within any one payor class. In addition, our experience with capitation arrangements over the last several years has provided us with the expertise to manage utilization and pricing effectively, resulting in a predictable stream of profitable revenue. With the exception of Blue Cross/Blue Shield and government payors, no single payor accounted for more than 5% of our net revenue for the year ended October 31, 2006. Radiologix had two payors, Aetna (5.5%) and United Health (8.1%) which accounted for more than 5% of its net revenue for its 12 month period ended December 31, 2006.

EXPERIENCED AND COMMITTED MANAGEMENT TEAM

Dr. Howard Berger, our President and Chief Executive Officer, Norman Hames, our Chief Operating Officer, and Dr. John Crues III, medical director of our company, together have close to 75 years of healthcare management

experience. Our executive management team has created our differentiated approach based on their comprehensive understanding of the diagnostic imaging industry and the dynamics of our regional markets. Our management beneficially owns approximately 22% of our common stock.

BUSINESS STRATEGY

MAXIMIZING PERFORMANCE AT OUR EXISTING FACILITIES

We intend to enhance our operations and increase scan volume and revenue at our existing facilities by:

- Establishing new referring physician and payor relationships;
- Increasing patient referrals through targeted marketing efforts to referring physicians;
- Adding modalities and increasing imaging capacity through equipment upgrades to existing machinery, adding new machinery and relocating machinery to meet the needs of our regional markets;
- Leveraging our multi-modality offerings to increase the number of high-end procedures performed; and
- Building upon our capitation arrangements to obtain fee-for-service business.

FOCUSING ON PROFITABLE CONTRACTING

We regularly evaluate our contracts with third-party payors and radiology groups, as well as our equipment and real property leases, to determine how we may improve the terms to increase our revenues and reduce our expenses. Because many of our contracts have one-year terms, we can regularly renegotiate these contracts, if necessary. We believe our position as a leading provider of diagnostic imaging services in the areas of our concentration, our experience and knowledge of the various geographic markets in those areas, and the benefits offered by our regional networks enable us to obtain more favorable contract terms than would be available to smaller or less experienced organizations.

EXPANDING MRI AND CT APPLICATIONS

We intend to continue to use expanding MRI and CT applications as they become commercially available. Most of these applications can be performed by our existing MRI and CT systems with upgrades to software and hardware. We intend to introduce applications that will decrease scan and image-reading time to increase our productivity.

OPTIMIZING OPERATING EFFICIENCIES

We intend to maximize our equipment utilization by adding, upgrading and re-deploying equipment where we experience excess demand. We will continue to trim excess operating and general and administrative costs where it is feasible to do so, including consolidating, divesting or closing under-performing facilities to reduce operating costs and improve operating income. We also may continue to use, where appropriate, highly-trained radiology physician assistants to perform, under appropriate supervision of radiologists, basic services traditionally performed by radiologists. We will continue to upgrade our advanced information technology system to create cost reductions for our facilities in areas such as image storage, support personnel and financial management.

EXPANDING OUR NETWORKS

Following on with our Radiologix acquisition we intend to continue to expand our networks of facilities through new developments and acquisitions, using a disciplined approach for evaluating and entering new areas, including consideration of whether we have adequate financial resources to expand. We perform extensive due diligence before developing a new facility or acquiring an existing facility, including surveying local referral sources and radiologists, as well as examining the demographics, reimbursement environment, competitive landscape and intrinsic demand of the geographic market. We generally will only enter new markets where:

- There is sufficient patient demand for outpatient diagnostic imaging services;
- We believe we can gain significant market share;
- We can build key referral relationships or we have already established such relationships; and
- Payors are receptive to our entry into the market.

OUR SERVICES

We offer the following services: MRI, CT, PET, nuclear medicine, X-ray, ultrasound, mammography and fluoroscopy. Our facilities provide standardized services, regardless of location, to ensure patients, physicians and payors consistency in service and quality. We monitor our level of service, including patient satisfaction, timeliness of services to patients and reports to physicians.

The key features of our services include:

- Patient-friendly, non-clinical environments;
- A 24-hour turnaround on routine examinations;
- Interpretations within one to two hours, if needed;
- Flexible patient scheduling, including same-day appointments;
- Extended operating hours, including weekends;
- Reports delivered via courier, fax or email;
- Availability of second opinions and consultations;
- Availability of sub-specialty interpretations at no additional charge;
- Standardized fee schedules by region; and
- Fees that are more competitive than hospital fees.

RADIOLOGY PROFESSIONALS

In the states in which we provide services, a lay person or any entity other than a professional corporation or similar professional organization is

not allowed to practice medicine, including by employing professional persons or by having any ownership interest or profit participation in or control over any medical professional practice. This doctrine is commonly referred to as the prohibition on the "corporate practice" of medicine. In order to comply with this prohibition, we contract, directly or through BRMG, with radiologists to provide professional medical services in our facilities, including the supervision and interpretation of diagnostic imaging procedures. The radiology practice maintains full control over the physicians it employs. Pursuant to each management contract, we make available the imaging facility and all of the furniture and medical equipment at the facility for use by the radiology practice, and the practice is responsible for staffing the facility with qualified professional medical personnel. In addition, we provide management services and administration of the non-medical functions relating to the professional medical practice at the facility, including among other functions, provision of clerical and administrative personnel, bookkeeping and accounting services, billing and collection, provision of medical and office supplies, secretarial, reception and transcription services, maintenance of medical records, and advertising, marketing and promotional activities. As compensation for the services furnished under contracts with radiologists, we generally receive an agreed percentage of the medical practice billings for, or collections from, services provided at the facility, typically varying between 75% to 84% of net revenue or collections.

At 52 of our facilities, BRMG is our contracted radiology group. At October 31, 2006, BRMG employed 61 full-time and seven part-time radiologists. At the balance of our facilities we contract, directly or through BRMG, with other radiology groups to provide the professional medical services. At 18 of our imaging facilities we charge a fee for our services as manager of an entity which owns the center. Our fee is typically 10% to 15% of the collected revenue of each company after deduction of the professional fees. In addition, we generally own a percentage of the equity interests of the entity which owns the facility from which we are also entitled to a percentage of income after a deduction of all expenses, including amounts paid for medical services and medical supervision commensurate with our ownership percentage.

Under our management agreement with BRMG, in California as well as those with other radiology practices both inside and outside of California we are paid, as compensation for the use of our facilities and equipment and for our services, a percentage of the amounts collected for the professional services it renders. The percentage may be adjusted, if necessary, to ensure that the parties receive the fair value for the services they render. The following are the other principal terms of our management agreement with BRMG:

- |X| The agreement expires on January 1, 2014. However, the agreement automatically renews for consecutive 10-year periods, unless either party delivers a notice of non-renewal to the other party no later than six months prior to the scheduled expiration date. In addition, either party may terminate the agreement if the other party defaults under its obligations, after notice and an opportunity to cure, and we may terminate the agreement if Dr. Berger no longer owns at least 60% of the equity of BRMG.

- |X| At its expense, BRMG employs or contracts with an adequate number of physicians necessary to provide all professional medical services at all of our California facilities (except nine facilities acquired from Radiologix).

- |X| At our expense, we provide all furniture, furnishings and medical equipment located at the facilities and we manage and administer all non-medical functions at, and provide all nurses and other non-physician personnel required for the operation of, the facilities.

- |X| If BRMG wants to open a new facility, we have the right of first refusal to provide the space and services for the facility under the same terms and conditions set forth in the management agreement.

- |X| If we want to open a new facility, BRMG must use its best efforts to provide medical personnel under the same terms and conditions set forth in the management agreement. If BRMG cannot provide such personnel, we have the right to contract with other physicians to provide services at the facility.

- |X| BRMG must maintain medical malpractice insurance for each of its physicians with coverage limits not less than $1 million per incident and $3 million in the aggregate per year. BRMG also has agreed to indemnify us for any losses we suffer that arise out of the acts or omissions of BRMG and its employees, contractors and agents.

AT THE RADIOLOGIX LOCATIONS:

The practice at the Radiologix locations is for a Radiologix subsidiary to contract with radiology practices to provide professional services, including supervision and interpretation of diagnostic imaging procedures performed in the Radiologix diagnostic imaging centers. The contracted radiology practices generally have outstanding physician and practice credentials and reputations; strong competitive market positions; a broad sub-specialty mix of physicians; a history of growth and potential for continued growth; and a willingness to embrace our strategy for the delivery of diagnostic imaging services.

Radiologix has two models by which it contracts with radiology practices: a comprehensive services model and a technical services model. Under Radiologix's comprehensive services model, Radiologix enters into a long-term agreement with a radiology practice group (typically 40 years). Under this arrangement, in addition to obtaining technical fees for the use of Radiologix's diagnostic imaging equipment and the provision of technical services, Radiologix provides management services and receives a fee based on the practice group's professional revenue, including revenue derived outside of Radiologix's diagnostic imaging centers. Under Radiologix's technical services model, which relates primarily to six of Radiologix's subsidiary operations, Radiologix enters into a shorter-term agreement with a radiology practice group (typically 10 to 15 years) and pays a fee based on cash collections from reimbursement for imaging procedures. In both the comprehensive services and technical services models, Radiologix owns the diagnostic imaging assets and, therefore, receives 100% of the technical reimbursements associated with imaging procedures. Additionally, in most instances, both the comprehensive services and the technical services models contemplate an incentive technical bonus for the radiology group if the net technical income exceeds specific thresholds.

The agreements with the radiology practices under Radiologix's comprehensive services model contain provisions whereby both parties have agreed to certain restrictions on accepting or pursuing radiology opportunities within a five to fifteen-mile radius of any of Radiologix's owned, operated or managed

diagnostic imaging centers at which the radiology practice provides professional radiology services or any hospital at which the radiology practice provides on-site professional radiology services. Each of these agreements also restricts the applicable radiology practice from competing with Radiologix and its other contracted radiology practices within a specified geographic area during the term of the agreement. In addition, the agreements require the radiology practices to enter into and enforce agreements with their physician shareholders at each radiology practice (subject to certain exceptions) that include covenants not to compete with Radiologix for a period of two years after termination of employment or ownership, as applicable.

Under Radiologix's comprehensive services model, Radiologix has the right to terminate each agreement if the radiology practice or a physician of the contracted radiology practice engages in conduct, or is formally accused of conduct, for which the physician employee's license to practice medicine reasonably would be expected to be subject to revocation or suspension or is otherwise disciplined by any licensing, regulatory or professional entity or institution, the result of any of which (in the absence of termination of this physician or other action to monitor or cure this act or conduct) adversely affects or would reasonably be expected to adversely affect the radiology practice.

Under Radiologix's comprehensive services model, upon termination of an agreement with a radiology practice, depending upon the termination event, Radiologix may have the right to require the radiology practice to purchase and assume, or the radiology practice may have the right to require Radiologix to sell, assign and transfer to it, the assets and related liabilities and obligations associated with the professional and technical radiology services provided by the radiology practice immediately prior to the termination. The purchase price for the assets, liabilities and obligations would be the lesser of their fair market value or the return of the consideration received in the acquisition. However, the purchase price may not be less than the net book value of the assets being purchased.

The agreements with most of the radiology practices under Radiologix's technical services model contain non-compete provisions that are generally less restrictive than those provisions under Radiologix's comprehensive services model. The geographic scope of and types of services covered by the non-compete provisions vary from practice to practice. Under Radiologix's technical services model, Radiologix generally has the right to terminate the agreement if a contracted radiology practice loses the licenses required to perform the service obligations under the agreement, violates non-compete provisions relating to the modalities offered or if income thresholds are not met.

PAYORS

We derive substantially all of our revenue, directly or indirectly, from fees charged for the diagnostic imaging services performed at our facilities. These fees are paid by a diverse mix of payors, as illustrated for the year ended October 31, 2006 by the following table:

PAYOR TYPE	PERCENTAGE OF NET REVENUE(1)
Insurance(2)	41%
Managed Care Capitated Payors	27%
Medicare/Medicaid	18%
Other(3)	10%
Workers Compensation/Personal Injury	4%

1 Does not include Radiologix.
2 Includes Blue Cross/Blue Shield, which represented 14% of our net revenue for the year ended October 31, 2006.
3 Includes co-payments, direct patient payments and payments through contracts with physician groups and other non-insurance company payors.

With the exception of Blue Cross/Blue Shield and government payors, no single payor accounted for more than 5% of our net revenue (for Radiologix payors, Aetna (5.5%) and United Health (8.1%), each accounted for more than 5% of their net revenue for the year ended October 31, 2006).

We have described below the types of reimbursement arrangements we have, directly or indirectly, including through BRMG, with third-party payors.

INSURANCE

Generally, insurance companies reimburse us, directly or indirectly, including through BRMG in California or through the contracted radiology groups elsewhere, on the basis of agreed upon rates. These rates are on average approximately the same as the rates set forth in the Medicare Fee Schedule for the particular service. The patients are generally not responsible for any amount above the insurance allowable amount.

MANAGED CARE CAPITATION AGREEMENTS

Under these agreements, which are generally between BRMG in California and outside of California between the contracted radiology group and the payor, typically an independent physicians group or other medical group, the payor pays a pre-determined amount per-member per-month in exchange for the radiology group providing all necessary covered services to the managed care members included in the agreement. These contracts pass much of the financial risk of providing outpatient diagnostic imaging services, including the risk of over-use, from the payor to the radiology group and, as a result of our management agreement with the radiology group, to us.

We believe that through our comprehensive utilization management, or UM, program we have become highly skilled at assessing and moderating the risks associated with the capitation agreements, so that these agreements are profitable for us. Our UM program is managed by our UM department, which consists of administrative and nursing staff as well as BRMG medical staff who are actively involved with the referring physicians and payor management in both prospective and retrospective review programs. Our UM program includes the following features, all of which are designed to manage our costs while ensuring that patients receive appropriate care:

|X| PHYSICIAN EDUCATION

At the inception of a new capitation agreement, we provide the new referring physicians with binders of educational material comprised of proprietary information that we have prepared and third-party information we have compiled, which are designed to address diagnostic strategies for common diseases. We distribute additional material according to the referral practices of the group as determined in the retrospective analysis described below.

|X| PROSPECTIVE REVIEW

Referring physicians are required to submit authorization requests for non-emergency high-intensity services: MRI, CT, special procedures and nuclear medicine studies. The UM medical staff, according to accepted practice guidelines, considers the necessity and appropriateness of each request. Notification is then sent to the imaging facility, referring physician and medical group. Appeals for cases not approved are directed to us. The capitated payor has the final authority to uphold or deny our recommendation.

|X| RETROSPECTIVE REVIEW

We collect and sort encounter activity by payor, place of service, referring physician, exam type and date of service. The data is then presented in quantitative and analytical form to facilitate understanding of utilization activity and to provide a comparison between fee-for-service and Medicare equivalents. Our Medical Director prepares a quarterly report for each payor and referring physician, which we send to them. When we find that a referring physician is over utilizing services, we work with the physician to modify referral patterns.

MEDICARE/MEDICAID

Medicare is the national health insurance program for people age 65 or older and people under age 65 with certain disabilities. Medicaid is the state health insurance program for qualifying low income persons. Medicare and Medicaid reimburse us, directly or indirectly, including through the contracted radiology group, in accordance with the Medicare Fee Schedule, which is a schedule of rates applicable to particular services and annually adjusted upwards or downwards, typically, within a 4-8% range. Medicare patients are not responsible for any amount above the Medicare allowable amount. Medicaid patients are not responsible for any unreimbursed portion.

CONTRACTS WITH PHYSICIAN GROUPS AND OTHER NON-INSURANCE COMPANY PAYORS

These payors reimburse us, directly or indirectly, on the basis of agreed upon rates. These rates are typically set at 70-80% of the rates set forth in the Medicare Fee Schedule for the particular service. However, we often agree to a specified rate for MRI and CT procedures that is not tied to the Medicare Fee Schedule. The patients are generally not responsible for the unreimbursed portion.

FACILITIES

Through our wholly owned subsidiaries, we operate 79 fixed-site, freestanding outpatient diagnostic imaging facilities in California, 35 in the Baltimore-Washington, D.C. area and 10 in the Rochester and Hudson Valley areas of New York. We lease the premises at which these facilities are located, with the exception of two facilities located in buildings we own. We lease the land on which both of those buildings are located.

Our facilities are located in regional networks that we refer to as regions. Eighty of our facilities (including the Radiologix sites) are multi-modality sites, offering various combinations of MRI, CT, PET, nuclear medicine, ultrasound, X-ray and fluoroscopy services. Forty-nine of our facilities (including the Radiologix sites) are single-modality sites, offering either X-ray or MRI services. Consistent with our regional network strategy, we

locate our single-modality facilities near multi-modality facilities, to help accommodate overflow in targeted demographic areas.

The following table sets forth the number of our facilities for each year during the five-year period ended October 31, 2006:

	YEAR ENDED OCTOBE		
	2002	2003	2004
Total facilities owned or managed (at beginning of year)	46	58	55
Facilities added by:			
Acquisition*	1	--	--
Internal development	11	3	4
Facilities closed or sold	--	(6)	(3)
Total facilities owned (at end of year)*	58	55	56

*Includes 69 Radiologix facilities acquired on November 15, 2006.

DIAGNOSTIC IMAGING EQUIPMENT

The following table indicates, as of October 31, 2006, the quantity of principal diagnostic equipment available at our facilities, by region including the Radiologix facilities acquired on November 15, 2006:

	MRI	OPEN MRI	CT	PET/CT	MAMMO-GRAPHY	ULTRA-SOUND	X-RAY
CALIFORNIA							
Beverly Hills	4	1	2	1	3	4	3
Ventura	2	2	1	2	5	9	15
San Fernando Valley	3	3	3	1	2	6	7
Antelope Valley	1	1	1	--	1	1	2
Central California	3	3	5	--	5	10	12
Northern California	13	2	12	3	10	12	1
Orange	2	1	1	1	3	7	4
Long Beach	1	1	1	--	3	4	7
Northern San Diego	--	1	1	--	--	--	1
Palm Springs	1	1	2	--	2	7	7
Inland Empire	5	2	4	1	8	12	12
MARYLAND							
Baltimore/Washington, D.C.	18	5	21	5	22	22	1
NEW YORK							
Rochester	5	1	4	1	1	3	--
Rockland	4	1	3	2	3	3	--
FLORIDA							
Treasure Coast	2	1	3	1	3	3	--
MINNESOTA							
Duluth	--	1	--	--	--	--	--

COLORADO							
Denver	1	2	--	--	--	--	--
Total	65	29	64	18	71	103	72

The average age of our MRI and CT units is less than six years, and the average age of our PET units is less than four years. The useful life of our MRI, CT and PET units is typically ten years.

INFORMATION TECHNOLOGY

Our corporate headquarters and substantially all of our non-Radiologix facilities are interconnected through a state-of-the-art information technology system. This system, which is compliant with the Health Insurance Portability and Accountability Act of 1996, is comprised of a number of integrated applications, provides a single operating platform for billing and collections, electronic medical records, practice management and image management.

This technology has created cost reductions for our facilities in areas such as image storage, support personnel and financial management and has further allowed us to optimize the productivity of all aspects of our business by enabling us to:

- Capture all necessary patient demographic, history and billing information at point-of-service;
- Automatically generate bills and electronically file claims with third-party payors;
- Record and store diagnostic report images in digital format;
- Digitally transmit on a real time basis diagnostic images from one location to another, thus enabling networked radiologists to cover larger geographic markets by using the specialized training of other networked radiologists;
- Perform claims, rejection and collection analysis; and
- Perform sophisticated financial analysis, such as analyzing cost and profitability, volume, charges, current activity and patient case mix, with respect to each of our managed care contracts.

Currently diagnostic reports and images are accessible via the Internet to our California referring providers. We have worked with some of the larger medical groups in California with whom we have contracts to provide access to this content via their web portals.

PERSONNEL

At October 31, 2006, we had a total of 970 full-time, 52 part-time and 215 per-diem employees (additionally Radiologix had 1,196 full-time, 219 part-time and 178 per diem employees). These numbers do not include the 61 full-time and 7 part-time radiologists or the 297 full-time and 147 part-time technologists, (nor do they include Radiologix technolgists; 316 full-time, 162 part-time and 121 per diem).

We employ a site manager who is responsible for overseeing day-to-day and routine operations at each of our facilities, including staffing, modality and schedule coordination, referring physician and patient relations and purchasing of materials. In turn, our 10 regional managers and directors are responsible for oversight of the operations of all facilities within their region, including sales, marketing and contracting. The regional managers and directors, along with our directors of contracting, marketing, facilities, management/purchasing and human resources report to our chief operating officer. Our chief financial officer, director of information services and our medical director report to our chief executive officer.

None of our employees is subject to a collective bargaining agreement nor have we experienced any work stoppages. We believe our relationship with our employees is good.

EXECUTIVE OFFICERS

See Part III, Item 10 of this report for information about our executive officers.

MARKETING

Our California marketing team, which we are in the process of expanding into our Radiologix facilities, consists of one director of marketing, five territory sales managers and 18 customer service representatives. Our marketing team employs a multi-pronged approach to marketing:

PHYSICIAN MARKETING

Each customer service representative is responsible for marketing activity on behalf of one or more facilities. The representatives act as a liaison between the facility and referring physicians, holding meetings periodically and on an as-needed basis with them and their staff to present educational programs on new applications and uses of our systems and to address particular patient service issues that have arisen. In our experience, consistent hands-on contact with a referring physician and his or her staff generates goodwill and increases referrals. The representatives also continually seek to establish referral relationships with new physicians and physician groups. In addition to a base salary and a car allowance, each representative receives a quarterly bonus if the facility or facilities on behalf of which he or she markets meets specified net revenue goals for the quarter.

PAYOR MARKETING

Our marketing team regularly meets with managed care organizations and insurance companies to solicit contracts and meet with existing contracting payors to solidify those relationships. The comprehensiveness of our services, the geographic location of our facilities and the reputation of the physicians with whom we contract all serve as tools for obtaining new or repeat business from payors.

SPORTS MARKETING PROGRAM

We have a sports marketing program designed to increase our public profile. We provide X-ray equipment and a technician for all of the games of the Lakers, Clippers, Kings, Avengers and Sparks held at the Staples Center in Los

Angeles, Ducks games held at the Arrowhead Pond in Anaheim, and University of Southern California football games held in Los Angeles. In exchange for this service, we receive an advertisement in each team program throughout the season. In addition, we have a close relationship with the physicians for some of these teams.

SUPPLIERS

Historically, we have acquired almost all of our diagnostic imaging equipment from GE Medical Systems, Inc., and we purchase medical supplies from various national vendors. We believe that we have excellent working relationships with all of our major vendors. However, there are several comparable vendors for our supplies that would be available to us if one of our current vendors becomes unavailable.

We primarily acquire our equipment through various financing arrangements directly with an affiliate of General Electric Corporation, or GE, involving the use of capital leases with purchase options at minimal prices at the end of the lease term. At October 31, 2006, capital lease obligations, excluding interest, totaled approximately $6.3 million through 2011, including current installments totaling approximately $2.4 million (see Note 7). If we open or acquire additional imaging facilities, we may have to incur material capital lease obligations.

Timely, effective maintenance is essential for achieving high utilization rates of our imaging equipment. We have an arrangement with GE Medical Systems under which it has agreed to be responsible for the maintenance and repair of a majority of our equipment for a fee that is based upon a percentage of our revenue, subject to a minimum payment. Net revenue is reduced by the provision for bad debt, mobile PET revenue and other professional reading service revenue to obtain adjusted net revenue. The fiscal 2006 annual service fee was the higher of 3.62% of our adjusted net revenue, or $5,430,000. For the fiscal years 2007, 2008 and 2009, the annual service fee will be the higher of 3.62% of our adjusted net revenue, or $5,430,000. We believe this framework of basing service costs on usage is an effective and unique method for controlling our overall costs on a facility-by-facility basis. We plan to renegotiate our existing agreement with GE in early 2007 adding Radiologix to the service plan and reducing the overall service fee percentages.

COMPETITION

The market for diagnostic imaging services is highly competitive. We compete principally on the basis of our reputation, our ability to provide multiple modalities at many of our facilities, the location of our facilities and the quality of our diagnostic imaging services. We compete locally with groups of radiologists, established hospitals, clinics and other independent organizations that own and operate imaging equipment. Our major national competitors include Alliance Imaging, Inc., Medical Resources, Inc., Healthsouth Corporation and InSight Health Services. Some of our competitors may now or in the future have access to greater financial resources than we do and may have access to newer, more advanced equipment. In addition, some physician practices have established their own diagnostic imaging facilities within their group practices to compete with us. We experience additional competition as a result of those activities.

Each of the contracted radiology practices under Radiologix's comprehensive services model has entered into agreements with its physician shareholders and full-time employed radiologists that generally prohibit those shareholders and radiologists from competing for a period of two years within defined geographic regions after they cease to be owners or employees, as applicable. In most states, a covenant not to compete will be enforced only:

- to the extent it is necessary to protect a legitimate business interest of the party seeking enforcement;
- if it does not unreasonably restrain the party against whom enforcement is sought; and
- if it is not contrary to public interest.

Enforceability of a non-compete covenant is determined by a court based on all of the facts and circumstances of the specific case at the time enforcement is sought. For this reason, it is not possible to predict whether or to what extent, a court will enforce the contracted radiology practices' covenants. The inability of the contracted radiology practices or us to enforce radiologist's non-compete covenants could result in increased competition from individuals who are knowledgeable about our business strategies and operations.

INSURANCE

We maintain insurance policies with coverage we believe is appropriate in light of the risks attendant to our business and consistent with industry practice. However, adequate liability insurance may not be available to us in the future at acceptable costs or at all. We maintain general liability insurance and professional liability insurance in commercially reasonable amounts. Additionally, we maintain workers' compensation insurance on all of our employees. Coverage is placed on a statutory basis and responds to individual state's requirements.

Pursuant to our agreements with physician groups with whom we contract, including BRMG, each group must maintain medical malpractice insurance for the group, having coverage limits of not less than $1.0 million per incident and $3.0 million in the aggregate per year.

California's medical malpractice cap further reduces our exposure. California places a $250,000 limit on non-economic damages for medical malpractice cases. Non-economic damages are defined as compensation for pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary injury. The cap applies whether the case is for injury or death, and it allows only one $250,000 recovery in a wrongful death case. No cap applies to economic damages. Other states in which we now operate do not have similar limitations and in those states we believe our insurance coverage to be sufficient.

We maintain a $5.0 million key-man life insurance policy on the life of Dr. Berger. We are the beneficiary under the policy.

REGULATION

GENERAL

The healthcare industry is highly regulated, and we can give no assurance that the regulatory environment in which we operate will not change significantly in the future. Our ability to operate profitably will depend in part upon us, and the contracted radiology practices and their affiliated physicians obtaining and maintaining all necessary licenses and other approvals, and operating in compliance with applicable healthcare regulations. We believe that healthcare regulations will continue to change. Therefore, we monitor developments in healthcare law and modify our operations from time to time as

the business and regulatory environment changes. Although we intend to continue to operate in compliance, we cannot ensure that we will be able to adequately modify our operations so as to address changes in the regulatory environment.

LICENSING AND CERTIFICATION LAWS

Ownership, construction, operation, expansion and acquisition of diagnostic imaging facilities are subject to various federal and state laws, regulations and approvals concerning licensing of facilities and personnel. In addition, free-standing diagnostic imaging facilities that provide services not performed as part of a physician office must meet Medicare requirements to be certified as an independent diagnostic testing facility to bill the Medicare program. We may not be able to receive the required regulatory approvals for any future acquisitions, expansions or replacements, and the failure to obtain these approvals could limit the market for our services.

CORPORATE PRACTICE OF MEDICINE

In the states in which we operate, a lay person or any entity other than a professional corporation or other similar professional organization is not allowed to practice medicine, including by employing professional persons or by having any ownership interest or profit participation in or control over any medical professional practice. The laws of such states also prohibit a lay person or a non-professional entity from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. We structure our relationships with the radiology practices, including the purchase of diagnostic imaging facilities, in a manner that we believe keeps us from engaging in the practice of medicine or exercising control over the medical judgments or decisions of the radiology practices or their physicians or violating the prohibitions against fee-splitting. However, because challenges to these types of arrangements are not required to be reported, we cannot substantiate our belief. There can be no assurance that our present arrangements with BRMG or the physicians providing medical services and medical supervision at our imaging facilities will not be challenged, and, if challenged, that they will not be found to violate the corporate practice prohibition, thus subjecting us to a potential combination of damages, injunction and civil and criminal penalties or require us to restructure our arrangements in a way that would affect the control or quality of our services or change the amounts we receive under our management agreements, or both.

MEDICARE AND MEDICAID FRAUD AND ABUSE

Our revenue is derived through our ownership, operation and management of diagnostic imaging centers and from service fees paid to us by contracted radiology practices. During the year ended October 31, 2006, approximately 18% of our revenue (and 29% of the Radiologix revenue) generated at our diagnostic imaging centers was derived from government sponsored healthcare programs (principally Medicare and Medicaid).

Federal law prohibits the knowing and willful offer, payment, solicitation or receipt of any form of remuneration in return for, or to induce, (i) the referral of a person, (ii) the furnishing or arranging for the furnishing of items or services reimbursable under the Medicare, Medicaid or other governmental programs or (iii) the purchase, lease or order or arranging or recommending purchasing, leasing or ordering of any item or service reimbursable under the Medicare, Medicaid or other governmental programs. Enforcement of this

anti-kickback law is a high priority for the federal government, which has substantially increased enforcement resources and is scheduled to continue increasing such resources. The applicability of the anti-kickback law to many business transactions in the healthcare industry has not yet been subject to judicial or regulatory interpretation. Noncompliance with the federal anti-kickback legislation can result in exclusion from the Medicare, Medicaid or other governmental programs and civil and criminal penalties.

We receive fees under our service agreements for management and administrative services, which include contract negotiation and marketing services. We do not believe we are in a position to make or influence referrals of patients or services reimbursed under Medicare or other governmental programs to radiology practices or their affiliated physicians or to receive referrals. However, we may be considered to be in a position to arrange for items or services reimbursable under a federal healthcare program. Because the provisions of the federal anti-kickback statute are broadly worded and have been broadly interpreted by federal courts, it is possible that the government could take the position that our arrangements with the contracted radiology practices implicate the federal anti-kickback statute. Violation of the law can result in monetary fines, civil and criminal penalties, and exclusion from participation in federal or state healthcare programs, any of which could have an adverse effect on our business and results of operations. While our service agreements with the contracted radiology practices will not meet a safe harbor to the federal anti-kickback statute, failure to meet a safe harbor does not mean that agreements violate the anti-kickback statute. We have sought to structure our agreements to be consistent with fair market value in arms' length transactions for the nature and amount of management and administrative services rendered. For these reasons, we do not believe that service fees payable to us should be viewed as remuneration for referring or influencing referrals of patients or services covered by such programs as prohibited by statute.

Significant prohibitions against physician referrals have been enacted by Congress. These prohibitions are commonly known as the Stark Law. The Stark Law prohibits a physician from referring Medicare patients to an entity providing designated health services, as defined under the Stark Law, including, without limitation, radiology services, in which the physician has an ownership or investment interest or with which the physician has entered into a compensation arrangement. The penalties for violating the Stark Law include a prohibition on payment by these governmental programs and civil penalties of as much as $15,000 for each violative referral and $100,000 for participation in a circumvention scheme. We believe that, although we receive fees under our service agreements for management and administrative services, we are not in a position to make or influence referrals of patients.

On January 4, 2001, the Centers for Medicare and Medicaid Services published final regulations to implement the Stark Law. Under the final regulations, radiology and certain other imaging services and radiation therapy services and supplies are services included in the designated health services subject to the self-referral prohibition. Under the final regulations, such services include the professional and technical components of any diagnostic test or procedure using X-rays, ultrasound or other imaging services, CT, MRI, radiation therapy and diagnostic mammography services (but not screening mammography services). The final regulations, however, exclude from designated health services: (i) X-ray, fluoroscopy or ultrasound procedures that require the insertion of a needle, catheter, tube or probe through the skin or into a body orifice; (ii) radiology procedures that are integral to the performance of, and performed during, nonradiological medical procedures; (iii) nuclear medicine procedures; and (iv) invasive or interventional radiology, because the radiology services in these procedures are merely incidental or secondary to another procedure that the physician has ordered. Beginning January 1, 2007, PET and nuclear medicine procedures are included as designated health services under the Stark Law.

The Stark Law provides that a request by a radiologist for diagnostic radiology services or a request by a radiation oncologist for radiation therapy, if such services are furnished by or under the supervision of such radiologist or radiation oncologist pursuant to a consultation requested by another physician, does not constitute a referral by a referring physician. If such requirements are met, the Stark Law self-referral prohibition would not apply to such services. The effect of the Stark Law on the radiology practices, therefore, will depend on the precise scope of services furnished by each such practice's radiologists and whether such services derive from consultations or are self-generated. We believe that, other than self-referred patients, all of the services covered by the Stark Law provided by the contracted radiology practices derive from requests for consultation by non-affiliated physicians. Therefore, we believe that the Stark Law is not implicated by the financial relationships between our operations and the contracted radiology practices.

In addition, we believe that we have structured our acquisitions of the assets of existing practices, and we intend to structure any future acquisitions, so as not to violate the anti-kickback and Stark Law and regulations. Specifically, we believe the consideration paid by us to physicians to acquire the tangible and intangible assets associated with their practices is consistent with fair market value in arms' length transactions and is not intended to induce the referral of patients. Should any such practice be deemed to constitute an arrangement designed to induce the referral of Medicare or Medicaid patients, then our acquisitions could be viewed as possibly violating anti-kickback and anti-referral laws and regulations. A determination of liability under any such laws could have an adverse effect on our business, financial condition and results of operations.

The federal government embarked on an initiative to audit all Medicare carriers, which are the companies that adjudicate and pay Medicare claims. These audits are expected to intensify governmental scrutiny of individual providers. An unsatisfactory audit of any of our diagnostic imaging facilities or contracted radiology practices could result in any or all of the following: significant repayment obligations, exclusion from the Medicare, Medicaid or other governmental programs, and civil and criminal penalties.

Federal regulatory and law enforcement authorities have recently increased enforcement activities with respect to Medicare, Medicaid fraud and abuse regulations and other reimbursement laws and rules, including laws and regulations that govern our activities and the activities of the radiology practices. Our or the radiology practices' activities may be investigated, claims may be made against us or the radiology practices and these increased enforcement activities may directly or indirectly have an adverse effect on our business, financial condition and results of operations.

STATE ANTI-KICKBACK AND PHYSICIAN SELF-REFERRAL LAWS

All of the states in which we now do business have adopted a form of anti-kickback law and a form of Stark Law. The scope of these laws and the interpretations of them are enforced by state courts and by regulatory authorities with broad discretion. Generally, state law covers all referrals by all healthcare providers for all healthcare services. A determination of liability under such laws could result in fines and penalties and restrictions on our ability to operate.

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act provides, in part, that the federal government may bring a lawsuit against any person who it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. The Federal False Claims Act further provides that a lawsuit thereunder may be initiated in the name of the United States by an individual who is an original source of the allegations. The government has taken the position that claims presented in violation of the federal anti-kickback law or Stark Law may be considered a violation of the Federal False Claims Act. Penalties include civil penalties of not less than $5,500 and not more than $11,000 for each false claim, plus three times the amount of damages that the federal government sustained because of the act of that person. We believe that we are in compliance with the rules and regulations that apply to the Federal False Claims Act. However, we could be found to have violated certain rules and regulations resulting in sanctions under the Federal False Claims Act, and if we are so found in violation, any sanctions imposed could result in fines and penalties and restrictions on and exclusion from participation in federal and California healthcare programs that are integral to our business.

HEALTHCARE REFORM INITIATIVES

Healthcare laws and regulations may change significantly in the future. We continuously monitor these developments and modify our operations from time to time as the regulatory environment changes. We cannot assure you, however, that we will be able to adapt our operations to address new regulations or that new regulations will not adversely affect our business. In addition, although we believe that we are operating in compliance with applicable federal and state laws, neither our current or anticipated business operations nor the operations of the contracted radiology practices has been the subject of judicial or regulatory interpretation. We cannot assure you that a review of our business by courts or regulatory authorities will not result in a determination that could adversely affect our operations or that the healthcare regulatory environment will not change in a way that restricts our operations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

In an effort to combat healthcare fraud, Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA. HIPAA, among other things, amends existing crimes and criminal penalties for Medicare fraud and enacts new federal healthcare fraud crimes, including actions affecting non-government payors. Under HIPAA, a healthcare benefit program includes any private plan or contract affecting interstate commerce under which any medical benefit, item or service is provided. A person or entity that knowingly and willfully obtains the money or property of any healthcare benefit program by means of false or fraudulent representations in connection with the delivery of healthcare services is subject to a fine or imprisonment, or potentially both. In addition, HIPAA authorizes the imposition of civil money penalties against entities that employ or enter into contracts with excluded Medicare or Medicaid program participants if such entities provide services to federal health program beneficiaries. A finding of liability under HIPAA could have a material adverse effect on our business, financial condition and results of operations.

Further, HIPAA requires healthcare providers and their business associates to maintain the privacy and security of individually identifiable health information. HIPAA imposes federal standards for electronic transactions with

health plans, the security of electronic health information and for protecting the privacy of individually identifiable health information. Organizations such as ours were obligated to be compliant with the initial HIPAA regulations by April 14, 2003, and with the electronic data interchange mandates by October 16, 2003. The final security regulations were issued in February 2003 with a compliance date of April 2005. We believe that we are in compliance with the current requirements, but we anticipate that we may encounter certain costs associated with future compliance. A finding of liability under HIPAA's privacy or security provisions may also result in criminal and civil penalties, and could have a material adverse effect on our business, financial condition, and results of operations.

Although our electronic systems are HIPAA compatible, consistent with the HIPAA regulations, we cannot guarantee the enforcement agencies or courts will not make interpretations of the HIPAA standards that are inconsistent with ours, or the interpretations of the contracted radiology practices or their affiliated physicians. A finding of liability under the HIPAA standards may result in criminal and civil penalties. Noncompliance also may result in exclusion from participation in government programs, including Medicare and Medicaid. These actions could have a material adverse effect on our business, financial condition, and results of operations.

COMPLIANCE PROGRAM

We maintain a program to monitor compliance with federal and state laws and regulations applicable to healthcare entities. We have a compliance officer who is charged with implementing and supervising our compliance program, which includes the adoption of (i) Standards of Conduct for our employees and affiliates and (ii) a process that specifies how employees, affiliates and others may report regulatory or ethical concerns to our compliance officer. We believe that our compliance program meets the relevant standards provided by the Office of Inspector General of the Department of Health and Human Services.

An important part of our compliance program consists of conducting periodic audits of various aspects of our operations and that of the contracted radiology practices. We also conduct mandatory educational programs designed to familiarize our employees with the regulatory requirements and specific elements of our compliance program.

U.S. FOOD AND DRUG ADMINISTRATION OR FDA

The FDA has issued the requisite premarket approval for all of the MRI and CT systems we use. We do not believe that any further FDA approval is required in connection with the majority of equipment currently in operation or proposed to be operated. Except under regulations issued by the FDA pursuant to the Mammography Quality Standards Act of 1992, where all mammography facilities are required to be accredited by an approved non-profit organization or state agency. Pursuant to the accreditation process, each facility providing mammography services must comply with certain standards including annual inspection.

Compliance with these standards is required to obtain payment for Medicare services and to avoid various sanctions, including monetary penalties, or suspension of certification. Although the Mammography Accreditation Program of the American College of Radiology currently accredits all of our facilities, which provide mammography services, and we anticipate continuing to meet the requirements for accreditation, the withdrawal of such accreditation could

result in the revocation of certification. Congress has extended Medicare benefits to include coverage of screening mammography subject to the prescribed quality standards described above. The regulations apply to diagnostic mammography and image quality examination as well as screening mammography.

RADIOLOGIST LICENSING

The radiologists providing professional medical services at our facilities are subject to licensing and related regulations by the states in which they provide services. As a result, we require BRMG and the other radiology groups with which we contract to require those radiologists to have and maintain appropriate licensure. We do not believe that such laws and regulations will either prohibit or require licensure approval of our business operations, although no assurances can be made that such laws and regulations will not be interpreted to extend such prohibitions or requirements to our operations.

INSURANCE LAWS AND REGULATION

States in which we operate have adopted certain laws and regulations affecting risk assumption in the healthcare industry, including those that subject any physician or physician network engaged in risk-based managed care to applicable insurance laws and regulations. These laws and regulations may require physicians and physician networks to meet minimum capital requirements and other safety and soundness requirements. Implementing additional regulations or compliance requirements could result in substantial costs to the contracted radiology practices, limiting their ability to enter into capitated or other risk-sharing managed care arrangements and indirectly affecting our revenue from the contracted practices.

ENVIRONMENTAL MATTERS

The facilities we operate or manage generate hazardous and medical waste subject to federal and state requirements regarding handling and disposal. We believe that the facilities that we operate and manage are currently in compliance in all material respects with applicable federal, state and local statutes and ordinances regulating the handling and disposal of such materials. We do not believe that we will be required to expend any material additional amounts in order to remain in compliance with these laws and regulations or that compliance will materially affect our capital expenditures, earnings or competitive position.

DEFICIT REDUCTION ACT OF 2005

On February 8, 2006, the President signed into law the Deficit Reduction Act of 2005, referred to as the DRA. The DRA provides that reimbursement for the technical component for imaging services (excluding diagnostic and screening mammography) in non-hospital based freestanding facilities will be capped at the lesser of reimbursement under the Medicare Part B physician fee schedule or the Hospital Outpatient Prospective Payment System (HOPPS) schedule.

Prior to January 1, 2007, the technical component of our imaging services was reimbursed under the Part B physician fee schedule, which, in most cases, allows for higher reimbursement than under the HOPPS. Under the DRA, we will be reimbursed at the lower of the two schedules, beginning January 1, 2007.

The DRA also codifies the reduction in reimbursement for multiple images on contiguous body parts previously announced by the Centers for Medicare and Medicaid Services (CMS). In November 2005, CMS announced that it will pay 100% of the technical component of the higher priced imaging procedure and 50% of the technical component of each additional imaging procedure for imaging procedures involving contiguous body parts within a family of codes when performed in the same session. Under current methodology, Medicare pays 100% of the technical

component of each procedure. CMS had indicated that it would phase in this rate reduction over two years, so that the reduction will be 25% for each additional imaging procedure in 2006 and another 25% in 2007. CMS has issued a rule that eliminates the 25% reduction in 2007.

We believe the implementation of the reimbursement reductions contained in the DRA will have a significant effect on our business, financial condition and results of operations.

ITEM 1A. RISK FACTORS

RISKS RELATING TO OUR BUSINESS

OUR FAILURE TO INTEGRATE RADIOLOGIX SUCCESSFULLY AND ON A TIMELY BASIS INTO OUR OPERATIONS COULD REDUCE OUR PROFITABILITY.

We expect that the acquisition of Radiologix will result in some synergies, business opportunities and growth prospects. We, however, may never realize these expected synergies, business opportunities and growth prospects. We may experience increased competition that limits our ability to expand our business. We may not be able to capitalize on expected business opportunities, assumptions underlying estimates of expected cost savings may be inaccurate, or general industry and business conditions may deteriorate. In addition, integrating operations will require significant efforts and expenses on our part. Personnel may leave or be terminated because of the merger. Our management may have its attention diverted while trying to integrate Radiologix. If these factors limit our ability to integrate the operations of Radiologix successfully or on a timely basis, our expectations of future results of operations, including certain cost savings and synergies expected to result from the merger, may not be met. In addition, our growth and operating strategies for Radiologix's business may be different from the strategies that Radiologix pursued prior to our acquisition. If our strategies are not the proper strategies for Radiologix, it could have a material adverse effect on the business, financial condition and results of operations of the combined company.

WE HAVE EXPERIENCED OPERATING LOSSES AND WE HAVE A SUBSTANTIAL ACCUMULATED DEFICIT. IF WE ARE UNABLE TO IMPROVE OUR FINANCIAL PERFORMANCE, WE MAY BE UNABLE TO PAY OUR OBLIGATIONS.

We have incurred net losses of $3.6 million and $6.9 million during the years ended October 31, 2005 and 2006, respectively, and at October 31, 2006 we had an accumulated stockholders' deficit of $78.8 million. Also, in recent periods, we have suffered liquidity shortfalls which have led us to, among other things, undertake and complete a "pre-packaged" Chapter 11 plan of reorganization and modify the terms of various of our financial obligations. While we believe that by taking these and other actions in the future we will be able to address these issues and solidify our financial condition, we cannot give assurances that we will be able to generate sufficient cash flow from operations to satisfy our debt obligations.

WE MAY NOT BE ABLE TO GENERATE SUFFICIENT CASH FLOW TO MEET OUR DEBT SERVICE OBLIGATIONS.

Our ability to generate sufficient cash flow from operations to make payments on our debt and other contractual obligations will depend on our future financial performance. A range of economic, competitive, regulatory, legislative and business factors, many of which are outside of our control, will affect our

financial performance. Our inability to generate sufficient cash flow to satisfy our debt and other contractual obligations would adversely impact our business, financial condition and results of operations.

OUR ABILITY TO GENERATE REVENUE DEPENDS IN LARGE PART ON REFERRALS FROM PHYSICIANS.

A significant reduction in referrals would have a negative impact on our business. We derive substantially all of our net revenue, directly or indirectly, from fees charged for the diagnostic imaging services performed at our facilities. We depend on referrals of patients from unaffiliated physicians and other third parties who have no contractual obligations to refer patients to us for a substantial portion of the services we perform. If a sufficiently large number of these physicians and other third parties were to discontinue referring patients to us, our scan volume could decrease, which would reduce our net revenue and operating margins. Further, commercial third-party payors have implemented programs that could limit the ability of physicians to refer patients to us. For example, prepaid healthcare plans, such as health maintenance organizations, sometimes contract directly with providers and require their enrollees to obtain these services exclusively from those providers. Some insurance companies and self-insured employers also limit these services to contracted providers. These "closed panel" systems are now common in the managed care environment. Other systems create an economic disincentive for referrals to providers outside the system's designated panel of providers. If we are unable to compete successfully for these managed care contracts, our results and prospects for growth could be adversely affected.

CHANGES IN THIRD-PARTY REIMBURSEMENT RATES OR METHODS FOR DIAGNOSTIC IMAGING SERVICES COULD RESULT IN A DECLINE IN OUR NET REVENUE AND NEGATIVELY IMPACT OUR BUSINESS.

The fees charged for the diagnostic imaging services performed at our facilities are paid by insurance companies, Medicare and Medicaid, workers compensation, private and other payors. Any change in the rates of or conditions for reimbursement from these sources of payment could substantially reduce the amounts reimbursed to us or to our contracted radiology practices for services provided, which could have an adverse effect on our net revenue. For example, recent legislative changes in California's workers compensation rules had a negative impact on reimbursement rates for diagnostic imaging services, and federal Medicare changes taking effect beginning January 1, 2007 are expected to have a negative impact on the rates paid for MRI services.

PRESSURE TO CONTROL HEALTHCARE COSTS COULD HAVE A NEGATIVE IMPACT ON OUR RESULTS.

One of the principal objectives of health maintenance organizations and preferred provider organizations is to control the cost of healthcare services. Managed care contracting has become very competitive, and reimbursement schedules are at or below Medicare reimbursement levels. The development and expansion of health maintenance organizations, preferred provider organizations and other managed care organizations within the geographic areas covered by our network could have a negative impact on the utilization and pricing of our services, because these organizations will exert greater control over patients' access to diagnostic imaging services, the selections of the provider of such services and reimbursement rates for those services.

IF BRMG OR ANY OF OUR OTHER CONTRACTED RADIOLOGY PRACTICES TERMINATE THEIR

AGREEMENTS WITH US, OUR BUSINESS COULD SUBSTANTIALLY DIMINISH.

Our relationship with BRMG is an integral part of our business. Through our management agreement, BRMG provides all of the professional medical services at 52 of our 79 California facilities (including the Radiologix facilities acquired on November 15, 2006) with the balance of our other facilities through management contracts with other radiology groups. BRMG and these other radiology groups contract with various other independent physicians and physician groups to provide all of the professional medical services at most of our facilities, and must use their best efforts to provide the professional medical services at any new facilities that we open or acquire in their areas of operation. In addition, the radiology groups' strong relationships with referring physicians are largely responsible for the revenue generated at the facilities they service. Although our management agreement with BRMG runs until 2014, and with the other groups for terms as long, if not longer, BRMG and the other radiology groups have the right to terminate the agreements if we default on our obligations and fail to cure the default. Also, the various radiology groups' ability to continue performing under the management agreements may be curtailed or eliminated due to the groups' financial difficulties, loss of physicians or other circumstances. If the radiology groups cannot perform their obligations to us, we would need to contract with one or more other radiology groups to provide the professional medical services at the facilities serviced by the group. We may not be able to locate radiology groups willing to provide those services on terms acceptable to us, if at all. Even if we were able to do so, any replacement radiology group's relationships with referring physicians may not be as extensive as those of the terminated group. In any such event, our business could be seriously harmed. In addition, the radiology groups are party to substantially all of the managed care contracts from which we derive revenue. If we were unable to readily replace these contracts, our revenue would be negatively affected.

IF OUR CONTRACTED RADIOLOGY PRACTICES, INCLUDING BRMG, LOSE A SIGNIFICANT NUMBER OF THEIR RADIOLOGISTS, OUR FINANCIAL RESULTS COULD BE ADVERSELY AFFECTED.

Recently, there has been a shortage of qualified radiologists in some of the regional markets we serve. In addition, competition in recruiting radiologists may make it difficult for our contracted radiology practices to maintain adequate levels of radiologists. If a significant number of radiologists terminate their relationships with our contracted radiology practices and those radiology practices cannot recruit sufficient qualified radiologists to fulfill their obligations under our agreements with them, our ability to maximize the use of our diagnostic imaging facilities and our financial results could be adversely affected. For example, in fiscal 2002, due to a shortage of qualified radiologists in the marketplace, BRMG experienced difficulty in hiring and retaining physicians and thus engaged independent contractors and part-time fill-in physicians. Their cost was double the salary of a regular BRMG full-time physician. Increased expenses to BRMG will impact our financial results because the management fee we receive from BRMG, which is based on a percentage of BRMG's collections, is adjusted annually to take into account the expenses of BRMG. Neither we, nor our contracted radiology practices, maintain insurance on the lives of any affiliated physicians.

WE MAY NOT BE ABLE TO SUCCESSFULLY GROW OUR BUSINESS.

As part of our business strategy, we intend to increase our presence in the areas we serve through selectively acquiring facilities, developing new facilities, adding equipment at existing facilities, and directly or indirectly entering into contractual relationships with high-quality radiology practices.

However, our ability to successfully expand depends upon many factors, including our ability to:

- Identify attractive and willing candidates for acquisitions;
- Identify locations in existing or new markets for development of new facilities;
- Comply with legal requirements affecting our arrangements with contracted radiology practices, including state prohibitions on fee-splitting, corporate practice of medicine and self-referrals;
- Obtain regulatory approvals where necessary and comply with licensing and certification requirements applicable to our diagnostic imaging facilities, the contracted radiology practices and the physicians associated with the contracted radiology practices;
- Recruit a sufficient number of qualified radiology technologists and other non-medical personnel;
- Expand our infrastructure and management; and
- Compete for opportunities. We may not be able to compete effectively for the acquisition of diagnostic imaging facilities. Our competitors may have more established operating histories and greater resources than we do. Competition also may make any acquisitions more expensive.

Acquisitions involve a number of special risks, including the following:

- Obtain adequate financing.
- Possible adverse effects on our operating results;
- Diversion of management's attention and resources;
- Failure to retain key personnel;
- Difficulties in integrating new operations into our existing infrastructure; and
- Amortization or write-offs of acquired intangible assets.

WE MAY BECOME SUBJECT TO PROFESSIONAL MALPRACTICE LIABILITY.

Providing medical services subjects us to the risk of professional malpractice and other similar claims. The physicians that our contracted radiology practices employ are from time to time subject to malpractice claims. We structure our relationships with the practices under our management agreements with them in a manner that we believe does not constitute the practice of medicine by us or subject us to professional malpractice claims for acts or omissions of physicians employed by the contracted radiology practices. Nevertheless, claims, suits or complaints relating to services provided by the contracted radiology practices have been asserted against us in the past and may be asserted against us in the future. In addition, we may be subject to professional liability claims, including, without limitation, for improper use or malfunction of our diagnostic imaging equipment. We may not be able to maintain adequate liability insurance to protect us against those claims at acceptable costs or at all.

Any claim made against us that is not fully covered by insurance could be costly to defend, result in a substantial damage award against us and divert the attention of our management from our operations, all of which could have an adverse effect on our financial performance. In addition, successful claims against us may adversely affect our business or reputation. Although California places a $250,000 limit on non-economic damages for medical malpractice cases, no limit applies to economic damages and no such limits exist in the other states in which we now provide services.

SOME OF OUR IMAGING MODALITIES USE RADIOACTIVE MATERIALS, WHICH GENERATE REGULATED WASTE AND COULD SUBJECT US TO LIABILITIES FOR INJURIES OR VIOLATIONS OF ENVIRONMENTAL AND HEALTH AND SAFETY LAWS.

Some of our imaging procedures use radioactive materials, which generate medical and other regulated wastes. For example, patients are injected with a radioactive substance before undergoing a PET scan. Storage, use and disposal of these materials and waste products present the risk of accidental environmental contamination and physical injury. We are subject to federal, state and local regulations governing storage, handling and disposal of these materials. We could incur significant costs and the diversion of our management's attention in order to comply with current or future environmental and health and safety laws and regulations. Also, we cannot completely eliminate the risk of accidental contamination or injury from these hazardous materials. In the event of an accident, we could be held liable for any resulting damages, and any liability could exceed the limits of or fall outside the coverage of our insurance.

WE EXPERIENCE COMPETITION FROM OTHER DIAGNOSTIC IMAGING COMPANIES AND HOSPITALS. THIS COMPETITION COULD ADVERSELY AFFECT OUR REVENUE AND BUSINESS.

The market for diagnostic imaging services is highly competitive. We compete principally on the basis of our reputation, our ability to provide multiple modalities at many of our facilities, the location of our facilities and the quality of our diagnostic imaging services. We compete locally with groups of radiologists, established hospitals, clinics and other independent organizations that own and operate imaging equipment. Our major national competitors include Alliance Imaging, Inc., Medical Resources, Inc., Healthsouth Corporation and InSight Health Services. Some of our competitors may now or in the future have access to greater financial resources than we do and may have access to newer, more advanced equipment. In addition, some physician practices have established their own diagnostic imaging facilities within their group practices and compete with us. We are experiencing increased competition as a result of such activities.

STATE AND FEDERAL ANTI-KICKBACK AND ANTI-SELF-REFERRAL LAWS MAY ADVERSELY AFFECT INCOME.

Various federal and state laws govern financial arrangements among healthcare providers. The federal anti-kickback law prohibits the knowing and willful offer, payment , solicitation or receipt of any form of remuneration in return for, or to induce, the referral of Medicare, Medicaid, or other federal healthcare program patients, or in return for, or to induce, the purchase, lease or order of items or services that are covered by Medicare, Medicaid, or other federal healthcare programs. Similarly, many state laws prohibit the solicitation, payment or receipt of remuneration in return for, or to induce the referral of patients in private as well as government programs. Violation of these anti-kickback laws may result in substantial civil or criminal penalties

for individuals or entities and/or exclusion from federal or state healthcare programs. We believe we are operating in compliance with applicable law and believe that our arrangements with providers would not be found to violate the anti-kickback laws. However, these laws could be interpreted in a manner inconsistent with our operations.

Federal law prohibiting physician self-referrals (the "Stark Law") prohibits a physician from referring Medicare or Medicaid patients to an entity for certain "designated health services" if the physician has a prohibited financial relationship with that entity, unless an exception applies. Certain radiology services are considered "designated health services" under the Stark Law. Although we believe our operations do not violate the Stark Law, our activities may be challenged. If a challenge to our activities is successful, it could have an adverse effect on our operations. In addition, legislation may be enacted in the future that further addresses Medicare and Medicaid fraud and abuse or that imposes additional requirements or burdens on us.

All of the states in which our diagnostic imaging centers are located have adopted a form of anti-kickback law and almost all of those states have also adopted a form of Stark Law. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. A determination of liability under the laws described in this risk factor could result in fines and penalties and restrictions on our ability to operate in these jurisdictions.

TECHNOLOGICAL CHANGE IN OUR INDUSTRY COULD REDUCE THE DEMAND FOR OUR SERVICES AND REQUIRE US TO INCUR SIGNIFICANT COSTS TO UPGRADE OUR EQUIPMENT.

The development of new technologies or refinements of existing modalities may require us to upgrade and enhance our existing equipment before we may otherwise intend. Many companies currently manufacture diagnostic imaging equipment. Competition among manufacturers for a greater share of the diagnostic imaging equipment market may result in technological advances in the speed and imaging capacity of new equipment. This may accelerate the obsolescence of our equipment, and we may not have the financial ability to acquire the new or improved equipment. In that event, we may be unable to deliver our services in the efficient and effective manner that payors, physicians and patients expect and thus our revenue could substantially decrease. During fiscal 2005, we traded-in and upgraded our existing MRI at Tarzana Advanced to increase throughput and patient volume and compete in the marketplace. We incurred a loss on disposal of equipment of approximately $696,000 for the upgrade.

A FAILURE TO MEET OUR CAPITAL EXPENDITURE REQUIREMENTS COULD ADVERSELY AFFECT OUR BUSINESS.

We operate in a capital intensive, high fixed-cost industry that requires significant amounts of capital to fund operations, particularly the initial start-up and development expenses of new diagnostic imaging facilities and the acquisition of additional facilities and new diagnostic imaging equipment. We incur capital expenditures to, among other things, upgrade and replace existing equipment for existing facilities and expand within our existing markets and enter new markets. To the extent we are unable to generate sufficient cash from our operations, funds are not available from our lenders or we are unable to structure or obtain financing through operating leases, long-term installment notes or capital leases, we may be unable to meet our capital expenditure requirements.

BECAUSE WE HAVE HIGH FIXED COSTS, LOWER SCAN VOLUMES PER SYSTEM COULD ADVERSELY AFFECT OUR BUSINESS.

The principal components of our expenses, excluding depreciation, consist of compensation paid to technologists, salaries, real estate lease expenses and equipment maintenance costs. Because a majority of these expenses are fixed, a relatively small change in our revenue could have a disproportionate effect on our operating and financial results depending on the source of our revenue. Thus, decreased revenue as a result of lower scan volumes per system could result in lower margins, which would adversely affect our business.

OUR SUCCESS DEPENDS IN PART ON OUR KEY PERSONNEL AND WE MAY NOT BE ABLE TO RETAIN SUFFICIENT QUALIFIED PERSONNEL. IN ADDITION, FORMER EMPLOYEES COULD USE THE EXPERIENCE AND RELATIONSHIPS DEVELOPED WHILE EMPLOYED WITH US TO COMPETE WITH US.

Our success depends in part on our ability to attract and retain qualified senior and executive management, managerial and technical personnel. Competition in recruiting these personnel may make it difficult for us to continue our growth and success. The loss of their services or our inability in the future to attract and retain management and other key personnel could hinder the implementation of our business strategy. The loss of the services of Dr. Howard G. Berger, our President and Chief Executive Officer, or Norman R. Hames, our Chief Operating Officer, could have a significant negative impact on our operations. We believe that they could not easily be replaced with executives of equal experience and capabilities. We do not maintain key person insurance on the life of any of our executive officers with the exception of a $5.0 million policy on the life of Dr. Berger. Also, if we lose the services of Dr. Berger, our relationship with BRMG could deteriorate, which would adversely affect our business.

Many of the states in which we operate do not enforce agreements that prohibit a former employee from competing with a former employer. As a result, many of our employees whose employment is terminated are free to compete with us, subject to prohibitions on the use of confidential information and, depending on the terms of the employee's employment agreement, on solicitation of existing employees and customers. A former executive, manager or other key employee who joins one of our competitors could use the relationships he or she established with third party payors, radiologists or referring physicians while our employee and the industry knowledge he or she acquired during that tenure to enhance the new employer's ability to compete with us.

CAPITATION FEE ARRANGEMENTS COULD REDUCE OUR OPERATING MARGINS.

For fiscal 2006, we derived approximately 27% of our net revenue from capitation arrangements, and we intend to increase the revenue we derive from capitation arrangements in the future. Under capitation arrangements, the payor pays a pre-determined amount per-patient per-month in exchange for us providing all necessary covered services to the patients covered under the arrangement. These contracts pass much of the financial risk of providing diagnostic imaging services, including the risk of over-use, from the payor to the provider. Our success depends in part on our ability to negotiate effectively, on behalf of the contracted radiology practices and our diagnostic imaging facilities, contracts with health maintenance organizations, employer groups and other third-party payors for services to be provided on a capitated basis and to efficiently manage the utilization of those services. If we are not successful in managing the utilization of services under these capitation arrangements or if patients or enrollees covered by these contracts require more frequent or extensive care than anticipated, we would incur unanticipated costs not offset by additional revenue, which would reduce operating margins.

WE MAY BE UNABLE TO EFFECTIVELY MAINTAIN OUR EQUIPMENT OR GENERATE REVENUE

WHEN OUR EQUIPMENT IS NOT OPERATIONAL.

Timely, effective service is essential to maintaining our reputation and high use rates on our imaging equipment. Although we have an agreement with GE Medical Systems pursuant to which it maintains and repairs the majority of our imaging equipment, this agreement does not compensate us for loss of revenue when our systems are not fully operational and our business interruption insurance may not provide sufficient coverage for the loss of revenue. Also, GE Medical Systems may not be able to perform repairs or supply needed parts in a timely manner. Therefore, if we experience more equipment malfunctions than anticipated or if we are unable to promptly obtain the service necessary to keep our equipment functioning effectively, our ability to provide services would be adversely affected and our revenue could decline.

DISRUPTION OR MALFUNCTION IN OUR INFORMATION SYSTEMS COULD ADVERSELY AFFECT OUR BUSINESS.

Our information technology system is vulnerable to damage or interruption from:

- Earthquakes, fires, floods and other natural disasters;
- Power losses, computer systems failures, internet and telecommunications or data network failures, operator negligence, improper operation by or supervision of employees, physical and electronic losses of data and similar events; and

- Computer viruses, penetration by hackers seeking to disrupt operations or misappropriate information and other breaches of security.

We rely on this system to perform functions critical to our ability to operate, including patient scheduling, billing, collections, image storage and image transmission. Accordingly, an extended interruption in the system's function could significantly curtail, directly and indirectly, our ability to conduct our business and generate revenue.

OUR ACTUAL FINANCIAL RESULTS MAY VARY SIGNIFICANTLY FROM THE PROJECTIONS WE FILED WITH THE BANKRUPTCY COURT.

In connection with our "pre-packaged" Chapter 11 plan of reorganization that was confirmed by the Bankruptcy Court on October 20, 2003, we were required to prepare projected financial information to demonstrate to the Bankruptcy Court the feasibility of the plan of reorganization and our ability to continue operations upon our emergence from bankruptcy. As indicated in the disclosure statement with respect to the plan of reorganization and the exhibits thereto, the projected financial information and various estimates of value discussed therein should not be regarded as representations or warranties by us or any other person as to the accuracy of that information or that those projections or valuations will be realized. We, and our advisors, prepared the information in the disclosure statement, including the projected financial information and estimates of value. This information was not audited or reviewed by our independent accountants. The significant assumptions used in preparation of the information and estimates of value were included as an exhibit to the disclosure statement.

Those projections are not included in this report and you should not rely

upon them in any way or manner. We have not updated, nor will we update, those projections. At the time we prepared the projections, they reflected numerous assumptions concerning our anticipated future performance with respect to prevailing and anticipated market and economic conditions which were and remain beyond our control and which may not materialize. Projections are inherently subject to significant and numerous uncertainties and to a wide variety of significant business, economic and competitive risks and the assumptions underlying the projections may be wrong in many material respects. Our actual results may vary significantly from those contemplated by the projections. As a result, we caution you not to rely upon those projections.

WE ARE VULNERABLE TO EARTHQUAKES AND OTHER NATURAL DISASTERS.

Our headquarters and 79 of our facilities are located in California, an area prone to earthquakes and other natural disasters. Three of our facilities are located in an area of Florida which has suffered from hurricanes. An earthquake or other natural disaster could seriously impair our operations, and our insurance may not be sufficient to cover us for the resulting losses.

COMPLYING WITH FEDERAL AND STATE REGULATIONS IS AN EXPENSIVE AND TIME-CONSUMING PROCESS, AND ANY FAILURE TO COMPLY COULD RESULT IN SUBSTANTIAL PENALTIES.

We are directly or indirectly through the radiology practices with which we contract subject to extensive regulation by both the federal government and the state governments in which we provide services, including:

- The federal False Claims Act;
- The federal Medicare and Medicaid anti-kickback laws, and state anti-kickback prohibitions;
- Federal and state billing and claims submission laws and regulations;
- The federal Health Insurance Portability and Accountability Act of 1996;
- The federal physician self-referral prohibition commonly known as the Stark Law and the state equivalent of the Stark Law;
- State laws that prohibit the practice of medicine by non-physicians and prohibit fee-splitting arrangements involving physicians;
- Federal and state laws governing the diagnostic imaging and therapeutic equipment we use in our business concerning patient safety, equipment operating specifications and radiation exposure levels; and
- State laws governing reimbursement for diagnostic services related to services compensable under workers compensation rules.

If our operations are found to be in violation of any of the laws and regulations to which we or the radiology practices with which we contract are subject, we may be subject to the applicable penalty associated with the violation, including civil and criminal penalties, damages, fines and the curtailment of our operations. Any penalties, damages, fines or curtailment of

our operations, individually or in the aggregate, could adversely affect our ability to operate our business and our financial results. The risks of our being found in violation of these laws and regulations is increased by the fact that many of them have not been fully interpreted by the regulatory authorities or the courts, and their provisions are open to a variety of interpretations. Any action brought against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses and divert our management's attention from the operation of our business. For a more detailed discussion of the various federal and state laws and regulations to which we are subject, see "Business - Government Regulation."

IF WE FAIL TO COMPLY WITH VARIOUS LICENSURE, CERTIFICATION AND ACCREDITATION STANDARDS, WE MAY BE SUBJECT TO LOSS OF LICENSURE, CERTIFICATION OR ACCREDITATION, WHICH WOULD ADVERSELY AFFECT OUR OPERATIONS.

Ownership, construction, operation, expansion and acquisition of our diagnostic imaging facilities are subject to various federal and state laws, regulations and approvals concerning licensing of personnel, other required certificates for certain types of healthcare facilities and certain medical equipment. In addition, freestanding diagnostic imaging facilities that provide services independent of a physician's office must be enrolled by Medicare as an independent diagnostic testing facility to bill the Medicare program. Medicare carriers have discretion in applying the independent diagnostic testing facility requirements and therefore the application of these requirements may vary from jurisdiction to jurisdiction. We may not be able to receive the required regulatory approvals for any future acquisitions, expansions or replacements, and the failure to obtain these approvals could limit the opportunity to expand our services.

Our facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensure and certification. If any facility loses its certification under the Medicare program, then the facility will be ineligible to receive reimbursement from the Medicare and Medicaid programs. For the year ended October 31, 2006, approximately 18% of our net revenue (and 29% of Radiologix net revenue for the 12 months ended December 31, 2006) came from the Medicare and Medicaid programs. A change in the applicable certification status of one of our facilities could adversely affect our other facilities and in turn us as a whole.

OUR AGREEMENTS WITH THE CONTRACTED RADIOLOGY PRACTICES MUST BE STRUCTURED TO AVOID THE CORPORATE PRACTICE OF MEDICINE AND FEE-SPLITTING.

State law prohibits us from exercising control over the medical judgments or decisions of physicians and from engaging in certain financial arrangements, such as splitting professional fees with physicians. These laws are enforced by state courts and regulatory authorities, each with broad discretion. A component of our business has been to enter into management agreements with radiology practices. We provide management, administrative, technical and other non-medical services to the radiology practices in exchange for a service fee typically based on a percentage of the practice's revenue. We structure our relationships with the radiology practices, including the purchase of diagnostic imaging facilities, in a manner that we believe keeps us from engaging in the practice of medicine or exercising control over the medical judgments or decisions of the radiology practices or their physicians or violating the prohibitions against fee-splitting. However, because challenges to these types of arrangements are not required to be reported, we cannot substantiate our belief. There can be no assurance that our present arrangements with BRMG or the physicians providing medical services and medical supervision at our imaging facilities will not be challenged, and, if challenged, that they will not be found to violate the corporate practice prohibition, thus subjecting us to potential damages, injunction and/or civil and criminal penalties or require us

to restructure our arrangements in a way that would affect the control or quality of our services and/or change the amounts we receive under our management agreements. Any of these results could jeopardize our business.

FUTURE FEDERAL LEGISLATION COULD LIMIT THE PRICES WE CAN CHARGE FOR OUR SERVICES, WHICH WOULD REDUCE OUR REVENUE AND ADVERSELY AFFECT OUR OPERATING RESULTS.

In addition to extensive existing government healthcare regulation, there are numerous initiatives affecting the coverage of and payment for healthcare services, including proposals that would significantly limit reimbursement under the Medicare and Medicaid programs. Limitations on reimbursement amounts and other cost containment pressures have in the past resulted in a decrease in the revenue we receive for each scan we perform.

THE REGULATORY FRAMEWORK IN WHICH WE OPERATE IS UNCERTAIN AND EVOLVING.

Healthcare laws and regulations may change significantly in the future. We continuously monitor these developments and modify our operations from time to time as the regulatory environment changes. We cannot assure you, however, that we will be able to adapt our operations to address new regulations or that new regulations will not adversely affect our business. In addition, although we believe that we are operating in compliance with applicable federal and state laws, neither our current or anticipated business operations nor the operations of the contracted radiology practices have been the subject of judicial or regulatory interpretation. We cannot assure you that a review of our business by courts or regulatory authorities will not result in a determination that could adversely affect our operations or that the healthcare regulatory environment will not change in a way that restricts our operations.

Certain states have enacted statutes or adopted regulations affecting risk assumption in the healthcare industry, including statutes and regulations that subject any physician or physician network engaged in risk-based managed care contracting to applicable insurance laws and regulations. These laws and regulations, if adopted in the states in which we operate, may require physicians and physician networks to meet minimum capital requirements and other safety and soundness requirements. Implementing additional regulations or compliance requirements could result in substantial costs to us and the contracted radiology practices and limit our ability to enter into capitation or other risk sharing managed care arrangements.

OUR SUBSTANTIAL DEBT COULD ADVERSELY AFFECT OUR FINANCIAL CONDITION AND PREVENT US FROM FULFILLING OUR OBLIGATIONS.

Our current substantial indebtedness and any future indebtedness we incur could have important consequences by adversely affecting our financial condition, which could make it more difficult for us to satisfy our obligations to our creditors. Our substantial indebtedness could also:

- |X| Require us to dedicate a substantial portion of our cash flow from operations to payments on our debt, reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate purposes;

- |X| Increase our vulnerability to adverse general economic and industry conditions;

- |X| Limit our flexibility in planning for, or reacting to, changes in our business and the industry in which we operate;

- |X| Place us at a competitive disadvantage compared to our competitors that have less debt; and

- |X| Limit our ability to borrow additional funds on terms that are satisfactory to us or at all.

WE PREVIOUSLY IDENTIFIED INEFFECTIVE DISCLOSURE CONTROLS AND PROCEDURES THAT IF UNSUCCESSFULLY REMEDIATED COULD ADVERSELY AFFECT OUR ABILITY TO REPORT OUR FINANCIAL RESULTS ON A TIMELY AND ACCURATE BASIS.

We determined that our disclosure controls and procedures were ineffective for the fiscal year ended October 31, 2005 and for the subsequent quarters ended January 31, 2006, April 30, 2006 and July 31, 2006. With respect to our ineffective disclosure controls and procedures, we determined that we had insufficient personnel resources and technical accounting expertise within the accounting function to resolve the following non-routine accounting matters: the recording of non-typical cost-based investments and unusual debt-related transactions and the appropriate analysis of the amortization lives of leasehold improvements in accordance with GAAP.

In connection with the preparation of this Annual Report on Form 10-K, our management on February 2, 2007, in consultation with our independent registered public accounting firm, Moss Adams LLP, determined that we had ineffective disclosure controls and procedures which would require us to restate certain of our previously issued financial statements. The adjustments result from management's historical treatment of depreciation expense related to the depreciation of leasehold improvements of our facilities. Although, the adjustments to certain prior period financial statements are all non-cash, and do not affect our historical reported revenues, cash flows or cash position for any of the affected fiscal or quarterly periods, the adjustments resulted in:

- a one-time adjustment to decrease retained earnings as of October 31, 2003 by $2,859,595;
- an adjustment to increase fiscal 2004 depreciation expense and decrease retained earnings by $154,707;
- an adjustment to increase fiscal 2005 depreciation expense and decrease retained earnings by $434,442; and
- an adjustment to increase depreciation expense and decrease retained earnings by $33,215 for our first quarter ended January 31, 2006.

The restated consolidated financial statements are for the fiscal years ended October 31, 2005 and 2004, and the quarterly unaudited financial statements for these years and for the first quarter ended January 31, 2006.

As a result, the consolidated financial statements, as previously filed, contain errors related to the recording of the depreciation expense of leasehold improvements and should, therefore, not be relied upon. The related auditor reports of Moss Adams LLP with respect to these consolidated financial statements should also no longer be relied upon.

We believe that we have adequately remediated the material weaknesses we have identified by restating our financial statements for the 2005 and 2004 fiscal years in this report and by entering into a consulting agreement on August 1, 2006 with Morgan Franklin Corporation to advise us with respect to

non-routine accounting matters. However, if we have not effectively remediated the material weakness, such material weakness could result in non-timely filing of periodic reports or accounting deficiencies in our financial reporting.

We may identify additional material weaknesses or other deficiencies in our internal controls in the future. Any material weaknesses or other deficiencies in our control systems may affect our ability to comply with SEC reporting requirements and listing standards or cause our financial statements to contain material misstatements which could negatively affect market price and trading liquidity of our common stock. In addition, there are inherent limitations in all control systems, and misstatements due to error or fraud may occur and not be detected.

ITEM 1B. UNRESOLVED STAFF COMMENTS

Inapplicable.

ITEM 2. PROPERTIES

Our corporate headquarters is located in adjoining premises at 1510 and 1516 Cotner Avenue, Los Angeles, California 90025, in approximately 16,500 square feet occupied under leases, which expire (with options to extend) on June 30, 2017. In addition, we lease 52,941square feet of warehouse and other space under leases, which expire at various dates between February 2006 and January 2018. The Radiologix corporate headquarters are located in 26,000 square feet in Dallas, Texas pursuant to a lease which expires on September 30, 2011. We are in the process of attempting to sublease this space. Radiologix also has a regional office of approximately 39,000 square feet in Baltimore, Maryland under a lease which expires September 30, 2012. Our facility lease terms vary in length from month to month to 15 years with renewal options upon prior written notice, from 1 year to 10 years depending upon the agreed upon terms with the local landlord. Facility lease amounts generally increase from 1% to 6% on an annual basis. We do not have options to purchase the facilities we rent.

ITEM 3. LEGAL PROCEEDINGS

We are involved in the following litigation:

(a) In Re DVI, Inc. Securities Litigation. UNITED STATES DISTRICT COURT, EASTERN DISTRICT OF PA, DOCKET NO. 2:03-CV-05336-LDD

This is a class action securities fraud case under Section 10(b) of the Securities Exchange Act and Rule 10b-5. It was brought by shareholders of DVI, Inc. ("DVI"), one of our former major lenders, against DVI officers and directors and a number of third party defendants, including us. The case arises from bankruptcy proceedings instituted by DVI in August 2003. We were named as a defendant in the Third Amended Complaint filed in July 2004.

The putative plaintiff class consists of those persons who purchased or otherwise acquired DVI, Inc. securities between August of 1999 and August of 2003. Plaintiffs allege that in 2000, we acquired from a third party one or more unprofitable imaging centers in order to help DVI conceal the fact that existing DVI loans on the centers were delinquent. Plaintiffs argue that we should have known that DVI was engaging in fraudulent practices to conceal losses, and our alleged "lack of due diligence" in investigating DVI's finances in the course of these acquisitions amounted to complicity in deceptive and misleading practices.

We have answered the complaint. The matter is still in its initial stages with discovery just beginning in that the court has stayed the proceedings for many months. We intend to vigorously contest the allegations.

(b) FLEET NAT'L BANK V. BOYLE ET. AL., U.S. DISTRICT COURT FOR THE

EASTERN DISTRICT OF PENNSYLVANIA, DOCKET NO. 04-CV-1277

This case is related to In re DVI Securities Litigation, but was filed by several of DVI's lenders. It, too, arises from the DVI bankruptcy (referenced in the matter above) and was brought against DVI officers and directors and a number of third party defendants, including us. We were named in the First Amended Complaint filed in this action in September 2004.

The plaintiff alleges violations of the Racketeering Influenced and Corrupt Organizations Act, 18 U.S.C. 1961 et seq., ("RICO"), and common-law claims, including conspiracy to commit fraud, tortious interference with a contract, conspiracy to commit tortious interference with a contract, conspiracy to commit conversion and aiding and abetting fraud. Plaintiffs allege that in 2000, we acquired from a third party one or more unprofitable imaging centers in order to help DVI conceal the fact that existing DVI loans on the centers were delinquent.

We filed a motion to dismiss the complaint that was granted as to all claims except the RICO claim. We have filed an answer to the complaint. The case is in its initial stages in that the court has stayed the proceedings for many months. We intend to vigorously contest the remaining claims.

(c) SIEMENS MEDICAL SOLUTIONS USA, INC. V. RADNET, INC., US DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS, DALLAS DIVISION CASE NO. 3-06CY2316-R.

The action, filed in December 2006, arises out of Radiologix notifying Siemens of its revocation of certain equipment purchase orders. Siemens contends there was a breach of contract and seeks damages of approximately $3.5 million.

We responded to the complaint on January 10, 2007. We intend to pursue our defense vigorously.

GENERAL

We are engaged from time to time in the defense of lawsuits arising out of the ordinary course and conduct of our business. We believe that the outcome of our current litigation will not have a material adverse impact on our business, financial condition and results of operations. However, we could be subsequently named as a defendant in other lawsuits that could adversely affect us.

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

During the fourth fiscal quarter of fiscal 2006 we submitted the following matters to security holders which were approved at a special meeting of stockholders held November 15, 2006 (the below numbers have been adjusted to reflect the one-for-two reverse stock split effected in November 2006):

1) With respect to the adoption of the Merger Agreement with Radiologix and approval of the merger and issuance of our common stock pursuant to the Merger Agreement, 14,075,078 shares voted in favor of the proposal, 21,112 shares voted against the proposal, and 8,140 shares abstained. There were 7,523,680 broker non-votes. The shares voted in favor of the proposal constituted a majority of the outstanding shares of common stock. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

2) With respect to an amendment to our Certificate of Incorporation to change our corporate name to "RadNet, Inc.", 14,057,094 shares voted in favor of the proposal, 31,811 shares voted against the proposal, and 15,925 shares abstained. There were 7,523,180 broker non-votes. The shares voted in favor of the proposal constituted a majority of the outstanding shares of common stock. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

3) With respect to an amendment to our Certificate of Incorporation to increase the authorized number of shares from 100,000,000 to 200,000,000 and reduce the par value, 13,630,731 shares voted in favor of the proposal, 456,914 shares voted against the proposal, and 17,185 shares abstained. There were 7,523,180 broker non-votes. The shares voted in favor of the proposal constituted a majority of the outstanding shares of common stock. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

4) With respect to an amendment to our Certificate of Incorporation to implement transfer restrictions to protect our net operating loss carry forwards, 14,038,275 shares voted in favor of the proposal, 48,155 shares voted against the proposal, and 17,900 shares abstained. There were 7,523,680 broker non-votes. The shares voted in favor of the proposal constituted a majority of the outstanding shares of common stock. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

5) With respect to the approval of the 2006 Stock Incentive Plan, 13,652,512 shares voted in favor of the proposal, 418,918 shares voted against the proposal, and 62,550 shares abstained. There were 7,525,305 broker non-votes. The shares voted in favor of the proposal constituted a majority of the outstanding shares of common stock. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

6) With respect to the election of directors, the five nominees for director received the number of votes set forth opposite their respective names:

NAME	FOR	WITHHELD
Howard G. Berger, M.D.	21,168,272	459,738
John V. Crues, III, M.D.	21,198,885	429,126
Norman R. Hames	21,196,497	431,513
Lawrence L. Levitt	21,612,033	15,978
David L. Swartz	21,609,783	18,228

No other persons received any votes. The following nominees received the highest number of votes cast for their election, and were therefore elected as directors of the Company in accordance with New York law and the procedures set forth in the proxy statement: Howard

G. Berger, M.D., John V. Crues, III, M.D., Norman R. Hames, Lawrence L. Levitt and David L. Swartz.

7) With respect to an amendment to our Certificate of Incorporation to effect a one-for-two reverse stock split, 21,487,777 shares voted in favor of the proposal, 126,310 shares voted against the proposal, and 12,297 shares abstained. There were 1,625 broker non-votes. The shares voted in favor of the proposal constituted a majority of the outstanding shares of common stock. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

8) With respect to the ratification of Moss Adams LP as the Company's independent registered public accounting firm, 21,578,763 shares voted in favor of the proposal, 28,827 shares voted against the proposal, and 18,795 shares abstained. There were 1,625 broker non-votes. The shares voted in favor of the proposal constituted a majority of the votes cast. The proposal was therefore approved in accordance with New York law and the procedures set forth in the proxy statement.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our common stock is quoted on the Nasdaq Over-the-Counter, or OTC, Bulletin Board under the symbol "RDNT.OB". The following table indicates the high and low prices for our common stock for the periods indicated based upon information supplied by the National Quotation Bureau, Inc. Such quotations have been adjusted to reflect our reverse one-for-two stock split effected in November 2006 and reflect interdealer prices without adjustment for retail mark-up, markdown or commission, and may not necessarily represent actual transactions.

QUARTER ENDED	LOW	HIGH
January 31, 2006	$0.52	$1.12
April 30, 2006	0.74	2.78
July 31, 2006	2.36	3.80
October 31, 2006	3.04	5.66
January 31, 2005	0.82	1.20
April 30, 2005	0.48	0.98
July 31, 2005	0.52	0.86
October 31, 2005	0.52	0.86

The last low and high prices for our common stock on the OTC Bulletin Board (subsequent to the one-for-two reverse stock split effected in November 2006) on January 16, 2007 were $4.82 and $5.07, respectively. As of January 16, 2007, the number of holders of record of our common stock was 3,917. However, Cede & Co., the nominee for The Depository Trust Company, the clearing agency for most broker-dealers, owned a substantial number of our outstanding shares of common stock of record on that date. Our management believes that customers of these broker-dealers beneficially own these shares and that the number of beneficial owners of our common stock is substantially greater than 3,917.

We did not pay dividends in fiscal 2005 or 2006 and we do not expect to pay any dividends in the foreseeable future.

CONVERTIBLE SUBORDINATED DEBENTURES

At October 31, 2006, we had $16.1 million convertible subordinated debentures outstanding which mature June 30, 2008 and bear interest, payable quarterly, at an annual rate of 11.5%. The debentures were convertible into our common stock at a price of $5.00 per share ($2.50 per share prior to the one-for-two reverse stock split effected in November 2006). On December 15, 2006, we redeemed these debentures.

RECENT SALES OF UNREGISTERED SECURITIES

During the fiscal year ended October 31, 2006, we sold the following securities (all of which have been adjusted to reflect our reverse one-for-two stock split effected in November 2006) pursuant to an exemption from registration provided under Section 4(2) of the Securities Act of 1933, as amended:

- In November 2005, we issued to a party who had loaned us $1,000,000, who agreed to extend his obligation which was then due and to waive his right to convert the obligation into our common stock at $1.00 per share, a five-year warrant exercisable at a price of $1.00 per share, which was the public market closing price for our common stock on the transaction date, to purchase 150,000 shares of our common stock.

- In February 2006, we issued to one of BRMG's radiologists in order to retain his services, a five-year warrant exercisable at a price of $0.80 per share, which was the public market closing price for our common stock on the transaction date, to purchase 100,000 shares of our common stock.

- In March 2006, we issued to each of our two independent directors five-year warrants exercisable at $1.00 per share, which was the public market price closing price for our common stock on the transaction date, for each to purchase 25,000 shares of our common stock.

- In March 2006, we issued to one of BRMG's radiologists, in order to retain his services and to another radiologist in order to obtain her services, a five-year warrant exercisable at a price of $0.80 per share, which was the public market closing price for our common stock on the transaction date, to purchase 50,000 shares and 100,000 shares, respectively, of our common stock.

- In March 2006, we issued to one of our key employees a seven-year warrant exercisable at a price of $1.12 per share, which was the public market closing price for our common stock on the transaction date, to purchase 1,500,000 shares of our common stock.

- In April 2006, we issued to one of our key employees a six-year warrant exercisable at a price of $2.52 per share, which was the public market closing price of our common stock on the transaction date, to purchase 250,000 shares of our common stock.

- In June 2006, we issued to one of BRMG's radiologists, in order to retain his services, a five year warrant exercisable at a price of $2.68 per share, which was the public market closing price of our common stock on the transaction date, to purchase 25,000 shares of our stock.

- In July 2006, we issued to one of our key employees a five-year warrant exercisable at a price of $3.10 per share, which was the public market closing price of our common stock on the transaction date, to purchase 100,000 shares of our common stock.

EQUITY COMPENSATION PLAN INFORMATION

The following table summarizes information with respect to options, warrants and other rights under our equity compensation plans at October 31, 2006 (as adjusted to reflect the reverse one-for-two stock split effected November 2006):

PLAN CATEGORY	NUMBER OF SECURITIES TO BE ISSUED UPON EXERCISE OF OUTSTANDING OPTIONS WARRANTS AND RIGHTS	WEIGHTED-AVERAGE EXERCISE PRICE OF OUTSTANDING OPTIONS WARRANTS AND RIGHTS	NU RE FO C
Equity compensation plans approved by security holders	353,750	$ 1.01	
Equity compensation plans not approved by security holders*	4,628,167	$ 1.20	
Total	4,981,917	$ 1.19	

* These represent warrants issued in connection with securing the services of various parties for instances they were issued in connection with obtaining financing.

ITEM 6. SELECTED CONSOLIDATED FINANCIAL DATA

The following table sets forth our selected historical consolidated financial data. The selected consolidated statements of operations data set forth below for each of the years in the three year period ended October 31, 2006 and the consolidated balance sheet data set forth below as of October 31, 2005 and 2006 are derived from our audited consolidated financial statements and notes thereto included elsewhere herein, as restated. The selected historical consolidated statements of operations data set forth below for the years ended October 31, 2002 and 2003, and the consolidated balance sheet data set forth below as of October 31, 2002, 2003 and 2004 are derived from our audited consolidated financial statements not included herein, as restated. The selected historical consolidated financial data set forth below have been restated to reflect adjustments that are discussed further in Note 2 "Restatement of Financial Statements" in the Notes to the consolidated financial statements. This data should be read in conjunction with and is qualified in its entirety by reference to the audited consolidated financial statements and the related notes included elsewhere in this Form 10-K and "Management's Discussion and Analysis of Financial Condition and Results of Operations."

The financial data set forth below and discussed in this Annual Report are derived from the consolidated financial statements of RadNet, its subsidiaries and certain affiliates. As a result of the contractual and operational

relationship among BRMG, Dr. Berger and us, we are considered to have a controlling financial interest in BRMG pursuant to guidance issued by the Emerging Issues Task Force, or EITF, of the Financial Accounting Standards Board, or FASB, in EITF's release 97-2. Due to the deemed controlling financial interest, we are required to include BRMG as a consolidated entity in our consolidated financial statements. This means, for example, that revenue generated by BRMG from the provision of professional medical services to our patients, as well as BRMG's costs of providing those services, are included as net revenue in our consolidated statement of operations, whereas the management fee that BRMG pays to us under our management agreement with BRMG is eliminated as a result of the consolidation of our results with those of BRMG. Also, because BRMG is a consolidated entity in our financial statements, any borrowings or advances we have received from or made to BRMG are not reflected in our consolidated balance sheet. If BRMG were not treated as a consolidated entity in our consolidated financial statements, the presentation of certain items in our income statement, such as net revenue and costs and expenses, would change but our net income would not, because in operation and historically, the annual revenue of BRMG from all sources closely approximates its expenses, including Dr. Berger's compensation, fees payable to us and amounts payable to third parties.

	YEAR ENDED OCTOBER		
	2002 (AS RESTATED)	2003 (AS RESTATED)	2004 (AS RESTATED)
STATEMENT OF OPERATIONS DATA:			(DOLLARS IN THOUSAN
Net revenue	$ 134,078	$ 140,259	$ 137,277
Operating expenses:			
Operating expenses	102,286	106,078	105,828
Depreciation and amortization	15,757	16,979	17,917
Provision for bad debts	6,892	4,944	3,911
Loss on disposal of equipment, net	--	--	--
Income (loss) from continuing operations	(7,182)	(5,569)	(14,731)
Income from discontinued operation	884	3,197	--
Net income (loss)	(6,298)	(2,372)	(14,731)
BALANCE SHEET DATA:			
Cash and cash equivalents	$ 36	$ 30	$ 1
Total assets	148,885	139,176	124,437
Total long-term liabilities	121,830	122,096	139,980
Total liabilities	202,560	195,122	195,006
Working capital (deficit)	(44,668)	(44,615)	(32,172)
Stockholders' equity (deficit)	(53,675)	(55,946)	(70,569)

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

OVERVIEW

Since our acquisition of Radiologix on November 15, 2006, we operate a group of regional networks comprised of 129 diagnostic imaging facilities located in seven states with operations primarily in California, the Mid

Atlantic, the Treasure Coast area of Florida, Kansas and the Finger Lakes (Rochester) and Hudson Valley areas of New York. We believe our group of regional networks is the largest of its kind in the U.S. Our facilities are strategically organized into regional networks in markets that have both high-density and expanding populations, as well as attractive payor diversity.

All of our facilities employ state-of-the-art equipment and technology in modern, patient-friendly settings. Many of our facilities within a particular region are interconnected and integrated through our advanced information technology system. Ninety-three of our facilities are multi-modality sites, offering various combinations of magnetic resonance imaging, or MRI, computed tomography, or CT, positron emission tomography, or PET, nuclear medicine, mammography, ultrasound, diagnostic radiology, or X-ray and fluoroscopy. Thirty-six of our facilities are single-modality sites, offering either X-ray or MRI. Consistent with our regional network strategy, we locate our single-modality facilities near multi-modality sites to help accommodate overflow in targeted demographic areas.

At our facilities, we provide all of the equipment as well as all non-medical operational, management, financial and administrative services necessary to provide diagnostic imaging services. We give our facility managers authority to run our facilities to meet the demands of local market conditions, while our corporate structure provides economies of scale, corporate training programs, standardized policies and procedures and sharing of best practices across our networks. Each of our facility managers is responsible for meeting our standards of patient service, managing relationships with local physicians and payors and maintaining profitability.

We derive substantially all of our revenue, directly or indirectly, from fees charged for the diagnostic imaging services performed at our facilities. For the year ended October 31, 2006, we derived 58% of our net revenue from MRI and CT scans. Over the past three fiscal years, we have increased net revenue primarily through improvements in net reimbursement, expansions of existing facilities, upgrades in equipment and development of new facilities.

The fees charged for diagnostic imaging services performed at our facilities are paid by a diverse mix of payors, as illustrated for the year ended October 31, 2006 (pre-Radiologix acquisition) by the following table:

PAYOR TYPE	PERCENTAGE OF NET REVENUE
Insurance(1)	41%
Managed Care Capitated Payors	27
Medicare/Medi-Cal	18
Other(2)	10
Workers Compensation/Personal Injury	4

1 Includes Blue Cross/Blue Shield, which represented 14% of our net revenue for the year ended October 31, 2006.

2 Includes co-payments, direct patient payments and payments through contracts with physician groups and other non-insurance company payors.

Our eligibility to provide service in response to a referral often depends on the existence of a contractual arrangement between the radiologists providing the professional medical services or us and the referred patient's insurance

carrier or managed care organization. These contracts typically describe the negotiated fees to be paid by each payor for the diagnostic imaging services we provide. With the exception of Blue Cross/Blue Shield and government payors, no single payor accounted for more than 5% of our net revenue for the year ended October 31, 2006. Under our capitation agreements, we receive from the payor a pre-determined amount per member, per month. If we do not successfully manage the utilization of our services under these agreements, we could incur unanticipated costs not offset by additional revenue, which would reduce our operating margins.

The principal components of our fixed operating expenses, excluding depreciation, include professional fees paid to radiologists, except for those radiologists who are paid based on a percentage of revenue, compensation paid to technologists and other facility employees, and expenses related to equipment rental and purchases, real estate leases and insurance, including errors and omissions, malpractice, general liability, workers' compensation and employee medical. The principal components of our variable operating expenses include expenses related to equipment maintenance, medical supplies, marketing, business development and corporate overhead. Because a majority of our expenses are fixed, increased revenue as a result of higher scan volumes per system or improvements in net reimbursement can significantly improve our margins.

BRMG strives to maintain qualified radiologists and technologists while minimizing turnover and salary increases and avoiding the use of outside staffing agencies, which are considerably more expensive and less efficient. In recent years, there has been a shortage of qualified radiologists and technologists in some of the regional markets we serve. As turnover occurs, competition in recruiting radiologists and technologists may make it difficult for our contracted radiology practices to maintain adequate levels of radiologists and technologists without the use of outside staffing agencies. At times, this has resulted in increased costs for us.

For a discussion of other factors that may have an impact on our business and our future results of operations, see "Risks Related to our Business."

OUR RELATIONSHIP WITH BRMG

Howard G. Berger, M.D. is our President and Chief Executive Officer, a member of our Board of Directors, and owned approximately 30% of RadNet's outstanding common stock at October 31, 2006. Dr. Berger also owns, indirectly, 99% of the equity interests in BRMG. BRMG provides all of the professional medical services at 52 of our facilities under a management agreement with us, and contracts with various other independent physicians and physician groups to provide all of the professional medical services at most of our other facilities. We obtain professional medical services from BRMG, rather than providing such services directly or through subsidiaries, in order to comply with California's prohibition against the corporate practice of medicine. However, as a result of our close relationship with Dr. Berger and BRMG, we believe that we are able to better ensure that professional medical services are provided at our facilities in a manner consistent with our needs and expectations and those of our referring physicians, patients and payors than if we obtained these services from unaffiliated practice groups.

Under our management agreement with BRMG, which expires on January 1, 2014, BRMG pays us, as compensation for the use of our facilities and equipment and for our services, a percentage of the gross amounts collected for the professional services it renders. The percentage, which was 79% at October 31, 2006, is adjusted annually, if necessary, to ensure that the parties receive fair value for the services they render. In operation and historically, the annual revenue of BRMG from all sources closely approximates its expenses, including Dr. Berger's compensation, fees payable to us and amounts payable to third parties. For administrative convenience and in order to avoid

inconveniencing and confusing our payors, a single bill is prepared for both the professional medical services provided by the radiologists and our non-medical, or technical, services, generating a receivable for BRMG. Historically, BRMG financed these receivables under a working capital facility with Bridge Healthcare Finance LLC and regularly advanced to us the funds that it draws under this working capital facility, which we used for our own working capital purposes. We repaid or offset those advances with periodic payments from BRMG to us under the management agreement. We guaranteed BRMG's obligations under this working capital facility.

As a result of our contractual and operational relationship with BRMG and Dr. Berger, we are required to include BRMG as a consolidated entity in our consolidated financial statements. See "Selected Consolidated Financial Data."

RESTATEMENT OF FINANCIAL STATEMENTS

On February 7, 2005, the Office of the Chief Accountant of the SEC (the "OCA") issued a letter to the American Institute of Certified Public Accountants regarding lease accounting which identified lease accounting issues including amortization of leasehold improvements.

The OCA believes that leasehold improvements in an operating lease should be amortized by the lessee over the shorter of their economic lives or the lease term, as defined in paragraph 5 (f) of FASB Statement 13 ("SFAS 13"), Accounting for Leases, as amended. The OCA believes amortizing leasehold improvements over a term that includes assumption of lease renewals is appropriate only when the renewals have been determined to be "reasonably assured," as that term is contemplated by SFAS 13.

Our Management and the Audit Committee of our Board of Directors in consultation with Moss Adams LLP determined that our accounting for leases was not consistent with the accounting principle described in the OCA's letter. Similar to many other companies with multiple sites including outpatient medical service companies, retailers and restaurants, we have corrected our error in accounting for leases.

Generally we have amortized leasehold improvements over the shorter of the assets' estimated useful lives or the initial lease terms including renewal options which are reasonably assured. This is consistent with our utilization of initial lease terms including renewal options in our calculation of straight line rent expense, however, in some situations the Company depreciated leasehold improvements over a 15-year period while the straight line rent expense in those same years was computed over the initial lease terms including renewal options, which were less than 15 years. Therefore, to ensure compliance with generally accepted accounting principles, we are correcting our calculation of the amortization of leasehold improvements to utilize the shorter of the assets' estimated useful lives or the initial terms including renewal options of the related leases.

See Note 2: "Restatement of Financial Statements" under Notes to Consolidated Financial Statements of this Form 10-K for a summary of the effect of these changes on our consolidated financial statements as of October 31, 2004 and 2005, respectively.

FINANCIAL CONDITION

LIQUIDITY AND CAPITAL RESOURCES

At October 31, 2006, our working capital was $1.8 million. At October 31, 2005, our working capital deficit was approximately $143.4 million due to the reclassification of approximately $109 million in notes and capital lease obligations as current liabilities expected to be refinanced and the classification of approximately $13.3 million in line of credit liabilities as current. At October 31, 2005, we were subject to financial covenants under our debt agreements and believed we may have been unable to continue to be in compliance with our existing financial covenants during fiscal 2006. As such, the associated debt was reclassified as a current liability. Previously, our line of credit was collateralized by accounts receivable and given the majority of accounts receivable was classified as a current liability so was the related liability.

On November 15, 2006, we completed our acquisition of Radiologix, Inc. (AMEX: RGX). Under the terms of the acquisition agreement, Radiologix shareholders received an aggregate consideration of 11,310,961 shares (or 22,621,922 shares before the one-for-two reverse stock split) of our common stock and $42,950,000 in cash.

On November 15, 2006, we entered into a $405 million senior secured credit facility with GE Commercial Finance Healthcare Financial Services. This facility was used to finance our acquisition of Radiologix, refinance existing indebtedness, pay transaction costs and expenses relating to our acquisition of Radiologix, and to provide financing for working capital needs post-acquisition. Debt issue costs related to the March 2006 refinancing and line of credit of approximately $5.0 million will be written off and we will recognize a loss on the extinguishments of debt with the transaction. The facility consists of a revolving credit facility of up to $45 million, a $225 million term loan and a $135 million second lien term loan. The revolving credit facility has a term of five years, the term loan has a term of six years and the second lien term loan has a term of six and one-half years. Interest is payable on all loans initially at an Index Rate plus the Applicable Index Margin, as defined. The Index Rate is initially a floating rate equal to the higher of the rate quoted from time to time by The Wall Street Journal as the "base rate on corporate loans posted by at least 75% of the nation's largest 30 banks" or the Federal Funds Rate plus 50 basis points. The Applicable Index Margin on each of the revolving credit facility and the term loan is 2% and on the second lien term loan is 6%. We may request that the interest rate instead be based on LIBOR plus the Applicable LIBOR Margin, which is 3.5% for the revolving credit facility and the term loan and 7.5% for the second lien term loan. The credit facility includes customary covenants for a facility of this type, including minimum fixed charge coverage

ratio, maximum total leverage ratio, maximum senior leverage ratio, limitations on indebtedness, contingent obligations, liens, capital expenditures, lease obligations, mergers and acquisitions, asset sales, dividends and distributions, redemption or repurchase of equity interests, subordinated debt payments and modifications, loans and investments, transactions with affiliates, changes of control, and payment of consulting and management fees.

As part of the financing, we were required to swap at least 50% of the aggregate principal amount of the facilities to a floating rate within 90 days of the close of the agreement on November 15, 2006. On April 11, 2006, effective April 28, 2006, we entered into an interest rate swap on $73.0 million fixing the LIBOR rate of interest at 5.47% for a period of three years. This swap was made in conjunction with the $161.0 million credit facility closed on March 9, 2006. In addition, on November 15, 2006, we entered into an interest rate swap

on $107.0 million fixing the LIBOR rate of interest at 5.02% for a period of three years, and on November 28, 2006, we entered into an interest rate swap on $90.0 million fixing the LIBOR rate of interest at 5.03% for a period of three years. Previously, the interest rate on the above $270.0 million portion of the credit facility was based upon a spread over LIBOR which floats with market conditions.

We document our risk management strategy and hedge effectiveness at the inception of the hedge, and, unless the instrument qualifies for the short-cut method of hedge accounting, over the term of each hedging relationship. The Company's use of derivative financial instruments is limited to interest rate swaps, the purpose of which is to hedge the cash flows of variable-rate indebtedness. The Company does not hold or issue derivative financial instruments for speculative purposes. In accordance with Statement of Financial Accounting Standards No. 133, derivatives that have been designated and qualify as cash flow hedging instruments are reported at fair value. The gain or loss on the effective portion of the hedge (i.e., change in fair value) is initially reported as a component of other comprehensive income in the Company's Consolidated Statement of Stockholders' Equity. The remaining gain or loss, if any, is recognized currently in earnings. At October 31, 2006, there were no derivatives that were designated as cash flow hedging instruments. Of the derivatives that were not designated as cash flow hedging instruments, we recorded interest expense of approximately $920,000 classified as accrued expenses on the Company's balance sheet at October 31, 2006.

Effective March 2006, we completed the issuance of a $161 million senior secured credit facility that we used to refinance substantially all of our existing indebtedness (except for $16.1 million of outstanding subordinated debentures and approximately $5 million of capital lease obligations). We incurred fees and expenses for the transaction of approximately $5.6 million. Debt issue costs are being amortized on a straight-line basis over 65 months and are classified as deferred financing costs. In addition, we recorded a net loss on extinguishments of debt of $2.1 million, which includes $1.2 million in pre-payment penalty fees that were unpaid as of October 31, 2006 and classified as accrued expenses under current liabilities. The facility provided for a $15 million five-year revolving credit facility, an $86 million term loan due in five years and a $60 million second lien term loan due in six years. The loans were subject to acceleration on December 27, 2007, unless we made arrangements to discharge or extend our outstanding subordinated debentures by that date. Under the terms and conditions of the Second Lien Term Loan, subject to achieving certain leverage ratios, we had the right to raise up to $16.1 million in additional funds as part of the Second Lien Term Loan for the purposes of redeeming the subordinated debentures. Additionally, under the current facilities, we have the ability to pursue other funding sources to refinance the subordinated debentures. The loans were payable interest only monthly except for the $86 million term loan that required amortization payments of 1.0% per annum, or $860,000, paid quarterly.

The revolving credit facility and the $86 million term loan bear interest at a base rate ("base rate" means corporate loans posted by at least 75% of the nation's 30 largest banks as quoted by the Wall Street Journal) plus 2.5%, or at our election, the LIBOR rate plus 4.0% per annum, payable monthly. The $60 million second lien term loan bears interest at the base rate plus 7.0%, or at our election, the LIBOR rate plus 8.5% per annum, payable monthly. The $86 million term loan included amortization payments of 1.0% per annum, payable in quarterly installments of $215,000. Upon the close of the refinancing on March 9, 2006, we utilized approximately $1.5 million of the new $15 million revolving credit facility.

Under the new facility, we were subject to various financial covenants including a limitation on capital expenditures, maximum days sales outstanding, minimum fixed charge coverage ratio, maximum leverage ratio and maximum senior

leverage ratio. Availability under our $15 million revolving credit facility was governed by the margins calculated under the maximum senior leverage ratio and maximum total leverage ratio covenants. As of October 31, 2006, we had approximately $2.6 million of availability based upon our borrowing base formula.

Prior to November 2005, we entered into various other financing arrangements over the periods reported in this Form 10-K in order to improve our working capital and meet our obligations as they became due (see Note 7).

We operate in a capital intensive, high fixed-cost industry that requires significant amounts of capital to fund operations. In addition to operations, we require significant amounts of capital for the initial start-up and development expense of new diagnostic imaging facilities, the acquisition of additional facilities and new diagnostic imaging equipment, and to service our existing debt and contractual obligations. Because our cash flows from operations have been insufficient to fund all of these capital requirements, we have depended on the availability of financing under credit arrangements with third parties. Historically, our principal sources of liquidity have been funds available for borrowing under our existing lines of credit, now with General Electric Capital Corporation. We finance the acquisition of equipment mainly through capital and operating leases. As of October 31, 2006 and October 31, 2005, our line of credit liabilities were $12.4 million and $13.3 million, respectively.

Our business strategy with regard to operations will focus on the following:

- Maximizing performance at our existing facilities;
- Focusing on profitable contracting;
- Expanding MRI and CT applications
- Optimizing operating efficiencies; and
- Expanding our networks

Our ability to generate sufficient cash flow from operations to make payments on our debt and other contractual obligations will depend on our future financial performance. A range of economic, competitive, regulatory, legislative and business factors, many of which are outside of our control, will affect our financial performance. Taking these factors into account, including our historical experience and our discussions with our lenders to date, although no assurance can be given, we believe that through implementing our strategic plans and continuing to restructure our financial obligations, we will obtain sufficient cash to satisfy our obligations as they become due in the next twelve months.

SOURCES AND USES OF CASH

Cash increased for fiscal 2005 by $1,000. There was no increase or decrease in cash for fiscal 2006.

Cash provided by operating activities for the year ended October 31, 2005 was $11.1 million compared to $10.3 million for the same period in 2006. The primary reason for the fiscal 2006 decrease in cash provided by operating activities was due to the increase in accounts receivable. Accounts receivable increased by approximately 7.8% from fiscal 2005 to fiscal 2006 due to an increase in same store net revenue less provision for bad debts, a build-up in accounts receivable related to the five new facilities added during fiscal 2006

by approximately $1.1 million, and a Medicare and Medi-Cal provider number delay for new physicians and sites added during the fiscal period.

Cash used by investing activities for fiscal 2005 was $4.0 million compared to $13.5 million for the same period in 2006. For fiscal 2005 and 2006, we purchased property and equipment for approximately $4.1 million and $9.5 million, respectively, and received proceeds from the sale of medical equipment of $65,000 and $47,000, respectively. In addition, during fiscal 2006, we acquired the assets and businesses of centers in Fresno and San Francisco for $1,500,000 and $1,650,000, respectively, invested in a PET center in Palm Desert for $237,500, and paid $704,000 in transaction fees related to the acquisition of Radiologix effective November 15, 2006.

Cash used for financing activities for fiscal 2005 was $7.1 million compared to cash provided by financing activities of $3.2 million for the same period in 2006. For fiscal 2005 and 2006, we made principal payments on capital leases, notes payable and lines of credit of approximately $14.1 million and $7.0 million, respectively, and received proceeds from borrowings under existing lines of credit, refinancing arrangements and related parties of approximately $6.1 million and $12.2 million, respectively. During fiscal 2005, we also increased our cash disbursements in transit by $0.9 million compared to a decrease in cash disbursements of $2.8 million in fiscal 2006. In addition, as part of the March 2006 debt restructuring, we repaid existing debt of $141.2 million and debt issue costs of $5.6 million with proceeds from borrowings on notes payable of $146.5 million and cash. Debt issue costs of approximately $0.3 million related to the upcoming Radiologix acquisition were also paid during fiscal 2006. During the year ended October 31, 2006, we received proceeds from the issuance of common stock of $1.5 million.

CONTRACTUAL COMMITMENTS

Our future obligations for notes payable, equipment under capital leases, lines of credit, subordinated debentures, equipment and building operating leases and purchase and other contractual obligations for the next five years and thereafter include (dollars in thousands):

	2007	2008	2009	2010	2011	THERE-AFTER	
Notes payable*	$ 1,303	$144,939	$ 443	$ 444	408	30	$
Capital leases*	2,955	2,120	1,753	388	105	--	
Lines of credit	--	12,437	--	--	--	--	
Subordinated debentures	--	16,031	--	--	--	--	
Operating leases(1)	9,086	8,453	8,220	8,065	7,747	74,100	
Purchase obligations(2)	1,467	--	--	--	--	--	
TOTAL(3)	$ 14,811	$183,980	$ 10,416	$ 8,897	$ 8,260	$ 74,130	$

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* Includes interest.

1 Includes all existing options to extend lease terms

2 Includes a two-year obligation to purchase imaging film from Fuji. We must purchase an aggregate of $4.4 million of film at a rate of approximately $2.2 million per year over the term of the agreement which will be completed on

June 30, 2007.

3 Does not include our obligation under our maintenance agreement with GE Medical Systems described below.

We have an arrangement with GE Medical Systems under which it has agreed to be responsible for the maintenance and repair of a majority of our equipment for a fee that is based upon a percentage of our revenue, subject to a minimum payment. Net revenue is reduced by the provision for bad debt, mobile PET revenue and other professional reading service revenue to obtain adjusted net revenue. The fiscal 2006 annual service fee was the higher of 3.62% of our adjusted net revenue, or $5,393,800. For the fiscal years 2007, 2008 and 2009, the annual service fee will be the higher of 3.62% of our adjusted net revenue, or $5,430,000. We believe this framework of basing service costs on usage is an effective and unique method for controlling our overall costs on a facility-by-facility basis. We plan to renegotiate our existing agreement with GE in early 2007 adding Radiologix to the service plan and reducing the overall service fee percentage.

CRITICAL ACCOUNTING ESTIMATES

Our discussion and analysis of financial condition and results of operations are based on our consolidated financial statements that were prepared in accordance with generally accepted accounting principles, or GAAP. Management makes estimates and assumptions when preparing financial statements. These estimates and assumptions affect various matters, including:

- Our reported amounts of assets and liabilities in our consolidated balance sheets at the dates of the financial statements;
- Our disclosure of contingent assets and liabilities at the dates of the financial statements; and
- Our reported amounts of net revenue and expenses in our consolidated statements of operations during the reporting periods.

These estimates involve judgments with respect to numerous factors that are difficult to predict and are beyond management's control. As a result, actual amounts could materially differ from these estimates.

The Securities and Exchange Commission, or SEC, defines critical accounting estimates as those that are both most important to the portrayal of a company's financial condition and results of operations and require management's most difficult, subjective or complex judgment, often as a result of the need to make estimates about the effect of matters that are inherently uncertain and may change in subsequent periods. In Note 2 to our consolidated financial statements, we discuss our significant accounting policies, including those that do not require management to make difficult, subjective or complex judgments or estimates. The most significant areas involving management's judgments and estimates are described below.

REVENUE RECOGNITION

Revenue is recognized when diagnostic imaging services are rendered. Revenue is recorded net of contractual adjustments and other arrangements for providing services at less than established patient billing rates. We estimate contractual allowances based on the patient mix at each diagnostic imaging

facility, the impact of managed care contract pricing and historical collection information. We operate 129 facilities, each of which has multiple managed care contracts and a different patient mix. We review the estimated contractual allowance rates for each diagnostic imaging facility on a monthly basis. We adjust the contractual allowance rates, as changes to the factors discussed above become known. Depending on the changes we make in the contractual allowance rates, net revenue may increase or decrease.

ACCOUNTS RECEIVABLE

Substantially all of our accounts receivable are due under fee-for-service contracts from third party payors, such as insurance companies and government-sponsored healthcare programs, or directly from patients. Services are generally provided pursuant to one-year contracts with healthcare providers. Receivables generally are collected within industry norms for third-party payors. We continuously monitor collections from our clients and maintain an allowance for bad debts based upon any specific payor collection issues that we have identified and our historical experience. For fiscal 2004, 2005 and 2006 our provision for bad debts as a percentage of net revenue (pre-Radiologix acquisition) was 2.8%, 3.4% and 4.7%, respectively.

DEFERRED TAX ASSETS

We evaluate the realizability of the net deferred tax assets and assess the valuation allowance periodically. If future taxable income or other factors are not consistent with our expectations, an adjustment to our allowance for net deferred tax assets may be required. Even though we expect to utilize our net operating loss carry forwards in the future, the last three fiscal year losses and available evidence cause the valuation of our net deferred tax assets to be uncertain in the near term. As of October 31, 2006, we have fully allowed for our net deferred tax assets.

VALUATION OF GOODWILL AND LONG-LIVED ASSETS

Our net goodwill at October 31, 2006 was $23.1 million. Goodwill is recorded as a result of our acquisition of operating facilities. The operating facilities are grouped by region into reporting units. We evaluate goodwill, at a minimum, on an annual basis and whenever events and changes in circumstances suggest that the carrying amount may not be recoverable in accordance with Statement of Financial Accounting Standards, or SFAS, No. 142, "Goodwill and Other Intangible Assets." Impairment of goodwill is tested at the reporting unit level by comparing the reporting unit's carrying amount, including goodwill, to the fair value of the reporting unit. The fair values of the reporting units are estimated using a combination of the income or discounted cash flows approach and the market approach, which uses comparable market data. If the carrying amount of the reporting unit exceeds its fair value, goodwill is considered impaired and a second step is performed to measure the amount of impairment loss, if any.

Our long-lived assets at October 31, 2006 consist primarily of net property and equipment of $64.6 million. We evaluate long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable in accordance with SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets." An asset is considered impaired if its carrying amount exceeds the future net cash flow the asset is expected to generate. If such asset is considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the asset exceeds its fair market value. We assess the recoverability of our long-lived and intangible assets by determining whether the unamortized balances can be recovered through undiscounted future net cash flows of the related assets.

For each of the three years in the period ended October 31, 2006, we recorded no impairment of goodwill or property and equipment. However, if our estimates or the related assumptions change in the future, we may be required to record impairment charges to reduce the carrying amount of these assets.

DERIVATIVE FINANCIAL INSTRUMENTS

The Company holds derivative financial instruments for the purpose of hedging the risks of certain identifiable and anticipated transactions. In general, the types of risks hedged are those relating to the variability of cash flows caused by movements in interest rates. The Company documents its risk management strategy and hedge effectiveness at the inception of the hedge, and, unless the instrument qualifies for the short-cut method of hedge accounting, over the term of each hedging relationship. The Company's use of derivative financial instruments is limited to interest rate swaps, the purpose of which is to hedge the cash flows of variable-rate indebtedness. The Company does not hold or issue derivative financial instruments for speculative purposes.

In accordance with Statement of Financial Accounting Standards No. 133, derivatives that have been designated and qualify as cash flow hedging instruments are reported at fair value. The gain or loss on the effective portion of the hedge (i.e., change in fair value) is initially reported as a component of other comprehensive income in the Company's Consolidated Statement of Stockholders' Equity. The remaining gain or loss, if any, is recognized currently in earnings.

SIGNIFICANT EVENTS

RADIOLOGIX

On November 15, 2006, we completed our previously announced acquisition of Radiologix, Inc. (AMEX: RGX). Under the terms of the acquisition agreement, Radiologix shareholders received an aggregate consideration of 11,310,961 shares (or 22,621,922 shares before the one-for-two reverse stock split) of our common stock and $42,950,000 in cash.

On November 15, 2006, we entered into a $405 million senior secured credit facility with GE Commercial Finance Healthcare Financial Services. This facility was used to finance our acquisition of Radiologix, refinance existing indebtedness, pay transaction costs and expenses relating to our acquisition of Radiologix, and to provide financing for working capital needs post-acquisition. Debt issue costs related to the March 2006 refinancing and line of credit of approximately $5.0 million will be written off and we will recognize a loss on the extinguishments of debt with the transaction. The facility consists of a revolving credit facility of up to $45 million, a $225 million term loan and a $135 million second lien term loan. The revolving credit facility has a term of five years, the term loan has a term of six years and the second lien term loan has a term of six and one-half years. Interest is payable on all loans initially at an Index Rate plus the Applicable Index Margin, as defined. The Index Rate is initially a floating rate equal to the higher of the rate quoted from time to time by The Wall Street Journal as the "base rate on corporate loans posted by at least 75% of the nation's largest 30 banks" or the Federal Funds Rate plus 50 basis points. The Applicable Index Margin on each the revolving credit facility and the term loan is 2% and on the second lien term loan is 6%. We may request that the interest rate instead be based on LIBOR plus the Applicable LIBOR Margin, which is 3.5% for the revolving credit facility and the term loan and 7.5% for the second lien term loan. The credit facility includes customary

covenants for a facility of this type, including minimum fixed charge coverage ratio, maximum total leverage ratio, maximum senior leverage ratio, limitations on indebtedness, contingent obligations, liens, capital expenditures, lease obligations, mergers and acquisitions, asset sales, dividends and distributions, redemption or repurchase of equity interests, subordinated debt payments and modifications, loans and investments, transactions with affiliates, changes of control, and payment of consulting and management fees.

The estimated purchase price and the allocation of the estimated purchase price discussed below are preliminary based on management's best estimate because the final valuation has not been completed. The preliminary estimated total purchase price of the merger is as follows:

(in thousands)	
Value of stock given by RadNet to Radiologix*	$ 39,400*
Cash	42,950
Estimated transaction fees and expenses	15,208**
Total Purchase Price	$ 97,558

(*) Calculated as 11,310,961 shares multiplied by $3.48 (average closing price of $1.74 from June 28, 2006 to July 13, 2006 adjusted for the one-for-two reverse stock split).

Per FAS 141 Paragraph 22, the fair value of securities traded in the market is generally more clearly evident than the fair value of an acquired entity. Thus, the quoted market price of an equity security issued to effect a business combination generally should be used to estimate the fair value of an acquired entity after recognizing possible effects of price fluctuations, quantities traded, issue costs, and the like. The market price for a reasonable period before and after the date that the terms of the acquisition are agreed to and announced (or in the case of the acquisition of Radiologix, July 6, 2006) shall be considered in determining the fair value of securities issued (Opinion 16, paragraph 74).

(**) Includes $8,274,000 in assumed liabilities of Radiologix, including $3,210,000 in merger and acquisition fees and $5,064,000 in bond prepayment penalties.

Under the purchase method of accounting, the total estimated purchase price as shown above is allocated to Radiologix's net tangible and intangible assets based on their estimated fair values as of the date of the completion of the merger. The preliminary allocation of the pro forma purchase price is as follows:

(in thousands)	
Current assets	$ 116,788
Property and equipment, net	76,802
Identifiable intangible assets	58,739
Goodwill	46,178
Investments in joint ventures	9,481
Other assets	585
Current liabilities	(24,145)
Accrued restructuring charges	(314)

Assumption of Debt	(177,358)
Long-term liabilities	(7,989)
Minority interests in consolidated subsidiaries	(1,209)
Total purchase price	$ 97,558

We have estimated the fair value of tangible assets acquired and liabilities assumed. Some of these estimates are subject to change, particularly those estimates relating to the valuation of property and equipment and identifiable intangible assets. The allocation of the purchase price is preliminary and based upon management's best estimate because the final valuation has not been completed. The final allocation of the purchase price will be based upon Radiologix's assets and liabilities on the closing date and the allocation of the purchase price will be reviewed by an external valuation expert.

CASH, MARKETABLE SECURITIES, INVESTMENTS AND OTHER ASSETS: RadNet valued cash, marketable securities, investments and other assets at their respective carrying amounts as RadNet believes that these amounts approximate their current fair values or the fair values.

IDENTIFIABLE INTANGIBLE ASSETS. RadNet expects identifiable intangible assets acquired to include management service agreements. Management service agreements represent the underlying relationships and agreements with certain professional radiology groups.

Identifiable intangible assets consist of:

(IN THOUSANDS)	ESTIMATED FAIR VALUE	AMORTIZATION PERIOD	ESTIMATED ANNUAL AMORTIZATION
Management service agreements	$ 58,739	25 years	$ 2,350

RadNet has determined the preliminary fair value of intangible assets with limited discussions with Radiologix management and a review of certain transaction-related documents prepared by Radiologix management.

Estimated useful lives for the intangible assets were based on the average contract terms, which are greater than the amortization period that will be used for management contracts. Intangible assets are being amortized using the straight-line method, considering the pattern in which the economic benefits of the intangible assets are consumed.

GOODWILL. Approximately $46,178,000 has been allocated to goodwill. Goodwill represents the excess of the purchase price over the fair value of the underlying net tangible and intangible assets. In accordance with SFAS No. 142, GOODWILL AND OTHER INTANGIBLE ASSETS, goodwill will not be amortized but instead will be tested for impairment at least annually. In the event that the management of the combined company determines that the value of goodwill has become impaired, the combined company will incur an accounting charge for the amount of impairment during the fiscal quarter in which the determination is made.

FACILITY OPENINGS

In September 2006, we acquired the assets and business of Fresno Imaging Center for $1,500,000 in cash utilizing our existing line of credit. The center provides MRI, CT, ultrasound and x-ray services. The center is 14,470 square feet with a monthly rental of approximately $20,000 per month through December 31, 2013. No goodwill was recorded in the transaction.

In September 2006, we acquired the assets and business of Irvine Imaging Services for $500,000 in assumed liabilities. The center provides MRI, CT, ultrasound and x-ray services. The monthly rental is approximately $14,560 per month. No goodwill was recorded in the transaction.

In September 2006, we acquired the net assets and business of San Francisco Advanced Imaging Center, in San Francisco, California, for $1,650,000 paid from working capital. The center provides MRI, CT and x-ray services. The center is 7,115 square feet with a monthly rental of approximately $29,000 with an initial lease term through April 2017. No goodwill was recorded in the transaction.

On August 25, 2006, we acquired the assets and business of Corona Imaging Center, in Corona, California, for $1,500,000 financed through a third party lender over five years at 8.5%. In addition, we financed certain medical equipment for approximately $243,000 as part of the transaction. The center provides MRI, CT, ultrasound, and x-ray services. The center is 2,133 square feet with a monthly rental of approximately $3,839 per month with an initial lease term through November 2011. No goodwill was recorded in the transaction.

On May 15, 2006, we opened an additional multi-modality site in Emeryville, California that provides MRI, CT and x-ray services. Ultrasound services will be added in the near future. We entered into a new building lease for 6,500 square feet with a beginning monthly rental of $9,754 and invested approximately $1.7 million in leasehold improvements for the new center. The improvements were paid for from working capital.

Effective February 1, 2006, upon the inception of a new capitation arrangement, we opened two additional satellite offices in Yucaipa and Moreno Valley, California that provide x-ray services for our Riverside location. In addition, in February 2006, we opened one additional satellite office providing x-ray services in Temecula, California.

Effective February 1, 2006, we invested $237,000 for a 47.5% membership interest in an entity that operates a PET center in Palm Springs, California. We account for this investment under the equity method of accounting. Income in earnings of this equity method investment was approximately $83,000. The center will provide PET services for our existing facilities in the area replacing a prior arrangement where PET services were provided by a mobile unit for a "per use" fee. We have an option to purchase the other 52.5% interest subsequent to November 1, 2006 and prior to February 29, 2008 for $512,500.

Effective February 1, 2006, we entered into a facility use agreement for an open MRI center in Vallejo, California. The agreement provides for the use of the equipment and facility for a monthly fee.

In December 2005, we entered into a new building lease in Encino, California for approximately 10,425 square feet to begin the development of a new center, San Fernando Interventional Radiology and Imaging Center, which is expected to open by March 2007. The center will offer MRI, CT, ultrasound and x-ray services as well as biopsy, angiography, shunt, and pain management procedures. The monthly rent is approximately $19,600 and the first month's rent was due in August 2006.

In March 2005, we opened a new center with approximately 3,533 square feet of space in Westlake, California, near Thousand Oaks that offers MRI,

mammography, ultrasound and x-ray services. During fiscal 2005, we used existing lines of credit for the payment of approximately $873,000 in leasehold improvements for the new facility.

Effective July 31, 2004, we purchased the 25% minority interest in Rancho Bernardo Advanced Imaging from two physicians for $200,000 that consisted of an $80,000 down payment and monthly payments of $10,000 due from September 2004 to August 2005. All payments were made during fiscal 2005. There was no goodwill recorded in the transaction.

In January 2004, we entered into a new building lease for approximately 3,963 square feet of space in Murrieta, California, near Temecula. The center opened in December 2004 and offers MRI, CT, PET, nuclear medicine and x-ray services. The equipment was financed by GE. During fiscal 2004, we had used existing lines of credit for the payment of approximately $840,000 in leasehold improvements for Murrieta.

In addition, during fiscal 2004, we opened an additional three satellite facilities servicing our Northridge, Rancho Cucamonga and Thousand Oaks centers.

At various times, we may open small x-ray facilities acquired primarily to service larger capitation arrangements over a specific geographic region.

FACILITY CLOSURES

Upon the acquisition of Fresno Imaging Center in September 2006, we closed our existing Woodward Park facility and incurred a loss on the disposal of leasehold improvements in that center of approximately $55,000. All of the business of the old Fresno site transferred to the new location.

Upon the acquisition of Irvine Imaging Services in September 2006, we closed our existing Tustin Imaging facility. There was no loss on the disposal of leasehold improvements in that center. All of the business of the old Tustin site transferred to the new Irvine location.

After the opening of a new site in Emeryville, California, we closed our existing Emeryville MRI only facility and incurred a loss on the disposal of leasehold improvements in that center of approximately $143,000. All of the business of the old Emeryville site transferred to the new location.

In early fiscal 2004, we first downsized and later closed our San Diego facility. The center's location was no longer productive and business could be sent to our new facility in Rancho Bernardo. The equipment was moved to other locations and our leasehold improvements were written off. During the year ended October 31, 2004, the center generated net revenue of $49,000 and incurred a net loss of $122,000.

In addition, during fiscal 2004, we closed two satellite facilities servicing our Antelope Valley and Lancaster regions.

At various times, we may close small x-ray facilities acquired primarily to service larger capitation arrangements over a specific geographic region. Over time, patient volume from these contracts may vary, or we may end the arrangement, resulting in the subsequent closures of these smaller satellite facilities.

DEBT RESTRUCTURING

During fiscal 2005 and 2006, we continued our focused efforts to improve our financial position and liquidity by restructuring and reducing our indebtedness on favorable terms. For a discussion of these efforts, see "Financial Condition - Liquidity and Capital Resources."

YEAR ENDED OCTOBER 31, 2006 COMPARED TO THE YEAR ENDED OCTOBER 31, 2005

RESULTS OF OPERATIONS

The following table sets forth, for the periods indicated, the percentage that certain items in the statement of operations bears to net revenue.

	YEAR ENDED OCTOBER 31,		
	2004 (AS RESTATED)	2005 (AS RESTATED)	2006
Net revenue	100.0%	100.0%	100.0%
Operating expenses:			
Operating expenses	77.1	74.9	74.7
Depreciation and amortization	13.1	12.0	10.2
Provision for bad debts	2.8	3.4	4.7
Loss on disposal of equipment, net	--	0.5	0.2
Total operating expense	93.0	90.8	89.8
Income from operations	7.0	9.2	10.2
Other expense (income):			
Interest expense	12.6	12.0	12.7
Loss (gain) on debt extinguishments, net	--	(0.3)	1.3
Other income	(0.1)	(0.3)	--
Other expense	1.2	0.2	0.5
Total other expense	13.7	11.6	14.5
Loss before equity in income of investee, income taxes and minority interest	(6.7)	(2.4)	(4.3)
Equity in income of investee	--	--	--
Loss before income taxes and minority interest	(6.7)	(2.4)	(4.3)
Income tax expense	(3.8)	--	--
Loss before minority interest	(10.5)	(2.4)	(4.3)
Minority interest in earnings of subsidiaries	0.2	--	--
Net loss	(10.7)	(2.4)	(4.3)

During fiscal 2006, we continued our efforts to enhance our operations and expand our network, while improving our financial position. Our results for fiscal 2006 were aided by the opening and integration of new facilities, increases in PET volume, and improvements in reimbursement from managed care capitated contracts and other payors.

During fiscal 2006, we made more progress in solidifying our financial condition. Effective March 9, 2006, we completed the issuance of a $161 million senior secured credit facility which we used to refinance substantially all of our existing indebtedness (except for $16.1 million of outstanding subordinated debentures and approximately $5 million of capital lease obligations). We incurred fees and expenses for the transaction of approximately $5.6 million. Debt issue costs were being amortized on a straight-line basis over 65 months and were classified as debt issue costs. In addition, we recorded a net loss on extinguishments of debt of $2.1 million, which included $1.2 million in pre-payment penalty fees that are unpaid as of October 31, 2006 and classified as accrued expenses under current liabilities. See "Financial Condition - Liquidity and Capital Resources."

At October 31, 2005 and October 31, 2006, we performed an evaluation, under the supervision and with the participation of our management, including our Chief Executive Officer and our Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)). Based upon that evaluation, our Chief Executive Officer and our Chief Financial Officer concluded that our disclosure controls and procedures are not effective in alerting them prior to the end of a reporting period to all material information required to be included in our periodic filings with the SEC because we identified the following material weakness in the design of internal control over financial reporting: We concluded that we had insufficient personnel resources and technical accounting expertise within the accounting function to resolve the following non-routine accounting matters, the recording of non-typical cost-based investments and unusual debt-related transactions and the appropriate analysis of the amortization lives of leasehold improvements in accordance with generally accepted accounting principles. The incorrect accounting for the foregoing was sufficient to lead management to conclude that a material weakness in the design of internal control over the accounting for non-routine transactions existed at October 31, 2005 and October 31, 2006.

Subsequent to October 31, 2005, we determined to change the design of our internal controls over non-routine accounting matters by the identification of an outside resource at a recognized professional services company that we can consult with on non-routine transactions or the employment of qualified accounting personnel to deal with this issue together with the utilization of other senior corporate accounting staff, who are responsible for reviewing all non-routine matters and preparing formal reports on their conclusions, and conducting quarterly reviews and discussions of all non-routine accounting matters with our independent public accountants. On August 1, 2006, we entered into an agreement with MorganFranklin Corporation, a professional service company we believe capable of providing the necessary consulting services which we believe address the identified weakness. We engaged MorganFranklin, a consulting firm with the requisite accounting expertise, to assist us, from time to time, in the evaluation and application of the appropriate accounting treatment, to provide support in the form of technical analysis related to accounting and financial reporting matters that may arise, and to provide management advice with respect to their preliminary conclusions regarding issues we wish to bring to their attention. To the extent our Chief Financial Officer identifies any non-routine accounting matters which require resolution, he will contact MorganFranklin and work closely with them, our audit committee and our auditors to resolve any issues. We are continuing to evaluate additional controls and procedures that we can implement and may add additional accounting personnel during early fiscal 2007 to enhance our technical accounting resources. We do not anticipate that the cost of this remediation effort will be material to our financial statements. We believe that the engagement of

MorganFranklin and use of their services should adequately address the identified weakness. With the acquisition of Radiologix, we have added additional technical accounting staff from their organization which we believe will further reduce any material weakness.

The above identified material weakness in internal control was determined by management during our year-end audit to be a material change in our internal control over financial reporting during the quarter ended October 31, 2005.

In connection with the preparation of this Annual Report on Form 10-K, our management on February 2, 2007, in consultation with our independent registered public accounting firm, Moss Adams LLP, determined we would restate certain of our previously issued financial statements. The adjustments result from management's historical treatment of depreciation expense related to the depreciation of leasehold improvements of our facilities. Although the adjustments to certain prior period financial statements are all non-cash, and do not affect our historical reported revenues, cash flows or cash position for any of the affected fiscal or quarterly periods, the adjustments resulted in:

- a one-time adjustment to decrease retained earnings as of October 31, 2003 by $2,859,595;
- an adjustment to increase fiscal 2004 depreciation expense and decrease retained earnings by $154,707;
- an adjustment to increase fiscal 2005 depreciation expense and decrease retained earnings by $434,442; and
- an adjustment to increase depreciation expense and decrease retained earnings by $33,215 for our first quarter ended January 31, 2006.

The consolidated financial statements have been adjusted for the fiscal years ended October 31, 2005 and 2004, and are adjusted for the quarterly unaudited financial statements for these years and for the first quarter ended January 31, 2006.

As a result, the consolidated financial statements, as previously filed, contain errors related to the recording of the depreciation expense of leasehold improvements and should, therefore, not be relied upon. The related auditor reports of Moss Adams LLP with respect to these consolidated financial statements should also no longer be relied upon.

We have remediated the matter and included the restated financial statements for the 2005 and 2004 fiscal years in this report. Our Audit Committee and management have discussed the matters associated with the restatements with Moss Adams LLP.

NET REVENUE

Net revenue from continuing operations for fiscal 2006 was $161.0 million compared to $145.6 million for fiscal 2005, an increase of approximately $15.4 million, or 10.6%. The largest net revenue increases were at the following facilities:

	Fiscal 06 Increase	%
Temecula (5 sites)	$3,433,000	45.2%
Tarzana (2 sites)	$2,301,000	25.2%
Palm Springs (6 sites)	$1,557,000	17.1%

Palm Springs' net revenue increase was primarily due to increased patient volume, improved contracting and increases in reimbursement from its managed care capitated payors. Temecula's net revenue increase was primarily due to the return of a managed care capitated contract and the opening and ramp-up in business of an additional facility in Murrieta providing MRI, CT, PET, nuclear medicine and x-ray services in December 2004. Tarzana's net revenue increase was primarily due to increased PET volume with the hiring of a new physician and the upgrade of one of its MRI machines that increased throughput and patient volume.

In addition, we acquired five new facilities that generated net revenues of $1.9 million for the fiscal year ended October 31, 2006 with the majority of new sites added in the fourth quarter.

Managed care capitated payor revenue increased from 26% of net revenue, or approximately $38 million, to 27% of net revenue, or approximately $43 million, for the years ended October 31, 2005 and 2006, respectively. We have been successful in retaining existing contracts while obtaining increases in reimbursement from the payors coupled with receiving increases in co-payments from the individual patients upon service. We anticipate maintaining a similar mix of managed care capitated payor business in fiscal 2007.

OPERATING EXPENSES

Operating expenses from continuing operations for fiscal 2006 increased approximately $12.5 million, or 9.5%, from $132.2 million in fiscal 2005 to $144.7 million in fiscal 2006. The following table sets forth our operating expenses for fiscal 2005 and 2006 (dollars in thousands):

	Year Ended October 31,	
	2005 (as restated)	2006
Salaries and professional reading fees	$ 66,674	$ 75,522
Building and equipment rental	7,919	8,811
General administrative expenses	34,419	36,009
Total operating expenses	109,012	120,342
Depreciation and amortization	17,536	16,394
Provision for bad debt	4,929	7,626
Loss on disposal of equipment, net	696	373

- SALARIES AND PROFESSIONAL READING FEES

  Salaries and professional reading fees increased $8.8 million, or 13.3%, from fiscal 2005 to 2006. The majority of the increase is due to the increase in net revenue from $145.6 million to $161.0 million, or 10.6%, in fiscal 2005 and 2006, respectively. In addition to the hiring of additional employees to staff new centers, professional fees increased at certain sites due to contracts where compensation to the professionals is based upon a percentage of net revenue.

- BUILDING AND EQUIPMENT RENTAL

Building and equipment rental expenses increased $0.9 million in fiscal year 2006 when compared to the same period last year. The increase is primarily due to cost of living rental increases within existing building lease agreements, the addition of new facilities and the related rental expense, and temporary equipment rental for MRI and CT equipment at two of our imaging centers.

- GENERAL AND ADMINISTRATIVE EXPENSES

  General and administrative expenses include billing fees, medical supplies, office supplies, repairs and maintenance, insurance, business tax and license, outside services, utilities, marketing, travel and other expenses. Many of these expenses are variable in nature including medical supplies and billing fees which increase with volume and repairs and maintenance under our GE service agreement at 3.62% of net revenue. Overall, general and administrative expenses increased $1.6 million, or 4.6%, in fiscal 2006 compared to the previous period primarily due to the increase in net revenue.

- DEPRECIATION AND AMORTIZATION

  Depreciation and amortization decreased by $1.1 million in fiscal year 2006 when compared to the same period last year. The decrease in depreciation and amortization was primarily related to aging property and equipment fully depreciating during the period not offset by the addition of new property and equipment.

- PROVISION FOR BAD DEBT

  The $2.7 million increase in the provision for bad debt was primarily a result of increased net revenue and the increase in bad debts as a percentage of net revenue from 3.4% to 4.7% in fiscal 2005 and 2006, respectively. The bad debt percentage increased due to maturing accounts receivable, the write-off of receivables due to incomplete demographic information and billing statute issues, and the faster write-off of slower-paying receivables to collection agencies to expedite cash receipts.

- LOSS ON DISPOSAL OF EQUIPMENT, NET

  During fiscal 2006, losses on disposal or sale of equipment were $0.4 million and were primarily due to the write-off of leasehold improvements at our Emeryville and Woodward Park facilities, and the sale of certain medical equipment at a loss. During fiscal 2005, losses on disposal of equipment were $0.7 million and were primarily due to the trade-in and upgrade of an MRI at our Tarzana Advanced facility that was initiated to improve the existing equipment increasing throughput and patient volume at the site.

INTEREST EXPENSE

Interest expense for fiscal 2006 increased approximately $2.9 million, or 16.4%, from the same period in fiscal 2005. Interest expense is primarily from our outstanding notes payable and capital lease obligations, subordinated bond debentures, related party payables and our outstanding line of credit. The increase was primarily the result of increases in notes payable and capital lease obligations and our mark to market interest rate adjustment of $0.9 million for fiscal 2006 related to the swap arrangement. As part of the March 2006 refinancing, we were required to swap at least 50% of the aggregate principal amount of the facilities to a floating rate within 90 days of the close of the agreement on March 9, 2006. On April 11, 2006, effective April 28,

2006, on $73.0 million (one half of our First and Second Lien Term Loans of $146.0 million), we entered into an interest rate swap fixing the LIBOR rate of interest at 5.47% for a period of three years. Previously, the interest rate on the $73.0 million was based upon a spread over LIBOR which floats with market conditions. The amount is classified in long-term accrued expenses.

LOSS (GAIN) ON DEBT EXTINGUISHMENTS, NET

For the year ended October 31, 2005, we recognized gains from extinguishments of debt for $0.5 million for the write-off of certain notes payable past the statute of limitations for $475,000 and the settlement of other notes payable at a discount of $40,000. For the year ended October 31, 2006, due to the March 2006 debt restructuring, we recognized a net loss on extinguishment of debt of $2.1 million. The loss is comprised of a gain of $2.1 million for a discount on notes payable, offset by $2.1 million in pre-payment penalties and $2.1 million for the write-off of capitalized debt issue costs.

OTHER INCOME

For the year ended October 31, 2005, we earned other income of $0.4 million. During fiscal 2005, we recognized gains from write-off of liabilities previously expensed in fiscal 2004 for approximately $210,000, deferred rental income of $90,000, and record copy income of $57,000. We had no other income during the year ended October 31, 2006.

OTHER EXPENSE

In the years ended October 31, 2005 and 2006, we incurred other expense of $349,000 and $788,000, respectively. During the twelve months ended October 31, 2005, we recognized losses on the write-off of loan fees and other assets of $349,000. During the twelve months ended October 31, 2006, we recorded expenses of $788,000 that included the $500,000 settlement payment to Broadstream and related legal fees.

EQUITY IN INCOME OF INVESTEE

In the year ended October 31, 2006, we earned income for our 47.5% investment in a PET center of approximately $83,000. The investment of $237,000 was made in February 2006.

INCOME TAX EXPENSE

In fiscal 2005 and 2006, the valuation allowance was fully reserved.

YEAR ENDED OCTOBER 31, 2005 COMPARED TO THE YEAR ENDED OCTOBER 31, 2004

During fiscal 2005, we continued our efforts to enhance our operations and expand our network, while improving our financial position and significantly reducing our net loss. Our results for fiscal 2005 were aided by the opening and integration of new facilities in prior periods, increases in PET volume, and improvements in reimbursement from managed care capitated contracts and other payors. As a result of these factors and the other matters discussed below, we experienced an increase in income from operations of $4.1 million.

During fiscal 2005, we made more progress in solidifying our financial condition. Effective November 30, 2004, we issued $4.0 million in principal amount of notes to Post and Post repurchased the DVI affiliate's line of credit

facility with the residual funds utilized by us as working capital. The new note payable has monthly interest only payments at 12% per annum until its maturity in July 2008. In addition, Post acquired $15.2 million of our notes payable from an affiliate of DVI and the indebtedness was restructured by Post and us. The new note payable has monthly interest only payments at 11% per annum until its maturity in June 2008. The assignment of the note payable to Post will not result in any actual total dollar savings to us over the term of the new obligation, but it will defer cash flow outlays of approximately $1.3 million per year until maturity. See "Financial Condition - Liquidity and Capital Resources."

NET REVENUE

Net revenue from continuing operations for fiscal 2005 was $145.6 million compared to $137.3 million for fiscal 2004, an increase of approximately $8.3 million, or 6.0%. The largest net revenue increases were at the following facilities:

	Fiscal 05 Increase	%
Orange (4 sites)	$2,383,000	17.6%
Tarzana (2 sites)	$1,775,000	24.2%
Palm Springs (5 sites)	$1,618,000	21.7%
Temecula (4 sites)	$1,366,000	21.9%

Orange's and Palm Springs' net revenue increases were primarily due to increased patient volume, improved contracting and increases in reimbursement from its managed care capitated payors. Temecula's net revenue increase was primarily due to the return of a managed care capitated contract and the opening of an additional facility in Murrieta providing MRI, CT, PET, nuclear medicine and x-ray services in December 2004. Tarzana's net revenue increase was primarily due to increased PET volume with the hiring of a new physician and the upgrade of one of its MRI machines that increased throughput and patient volume.

Managed care capitated payor revenue increased from 25% of net revenue, or approximately $34 million, to 26% of net revenue, or approximately $38 million, for the years ended October 31, 2004 and 2005, respectively. We have been successful in retaining existing contracts while obtaining increases in reimbursement from the payors coupled with receiving increases in co-payments from the individual patients upon service. We anticipate maintaining a similar mix of managed care capitated payor business in fiscal 2006.

OPERATING EXPENSES

Operating expenses from continuing operations for fiscal 2005 increased approximately $4.5 million, or 3.5%, from $127.7 million in fiscal 2004 to $132.2 million in fiscal 2005. The following table sets forth our operating expenses for fiscal 2004 and 2005 (dollars in thousands):

	Year Ended October 31,	
	2004	2005
Salaries and professional reading fees	$ 64,932	$ 66,674
Building and equipment rental	7,804	7,919
General administrative expenses	33,092	34,419

Total operating expenses	105,828	109,012
Depreciation and amortization	17,917	17,536
Provision for bad debt	3,911	4,929
Loss on disposal of equipment, net	--	696

o SALARIES AND PROFESSIONAL READING FEES

Salaries and professional reading fees increased $1.7 million from fiscal 2004 to 2005. The majority of the increase is due to the increase in net revenue from $137.3 million to $145.6 million in fiscal 2004 and 2005, respectively. In addition to the hiring of additional employees to staff two new centers in Murrieta and Westlake, California, professional fees increased at certain sites due to contracts where compensation to the professionals is based upon a percentage of net revenue.

o BUILDING AND EQUIPMENT RENTAL

Building and equipment rental expenses increased $0.1 million in fiscal year 2005 when compared to the same period last year. The increase is primarily due to cost of living rental increases within existing building lease agreements and the addition of new facilities and the related rental expense.

o GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses include billing fees, medical supplies, office supplies, repairs and maintenance, insurance, business tax and license, outside services, utilities, marketing, travel and other expenses. Many of these expenses are variable in nature. These expenses increased $1.3 million, or 4.0%, in fiscal 2005 compared to the previous period primarily due to the increase in net revenue. The largest fiscal 2005 increases were expenditures for billing fees and medical supplies that increased $711,000 and $635,000, respectively, when compared to the same period last year.

o DEPRECIATION AND AMORTIZATION

Depreciation and amortization decreased by $0.4 million in fiscal year 2005 when compared to the same period last year. The primary reason for the decrease is the reduction in capital expenditures. During fiscal 2004 and 2005, capital expenditures were $13.1 million and $8.8 million, respectively.

o PROVISION FOR BAD DEBT

The $1.0 million increase in provision for bad debt was primarily a result of increased net revenue and the increase in bad debts as a percentage of net revenue from 2.8% to 3.4% in fiscal 2004 and 2005, respectively. The bad debt percentage increased due to maturing accounts receivable and the faster write-off of slower-paying receivables to collection agencies to expedite cash receipts and accounts receivable turnover.

o LOSS ON DISPOSAL OF EQUIPMENT, NET

The $0.7 million increase in losses on disposal of equipment is primarily due to the trade-in and upgrade of an MRI at our Tarzana Advanced facility that was initiated to improve the existing equipment increasing throughput and patient volume at the site.

INTEREST EXPENSE

Interest expense for fiscal 2005 increased approximately $0.2 million, or 1.2%, from the same period in fiscal 2004. Interest expense is primarily from our outstanding notes payable and capital lease obligations, subordinated bond debentures, related party payables and our outstanding line of credit.

LOSS (GAIN) ON DEBT EXTINGUISHMENTS, NET

For the year ended October 31, 2005, we recognized gains from extinguishments of debt for $0.5 million for the write-off of certain notes payable past statute for $475,000 and the settlement of other notes payable at a discount of $40,000. For the year ended October 31, 2004, there were no gain or losses from debt extinguishments.

OTHER INCOME

In fiscal 2004 and 2005, we earned other income of $0.2 million and $0.4 million, respectively, principally comprised of sublease income, medical record copying income, deferred rent income, and business interruption and insurance refunds.

OTHER EXPENSE

In fiscal 2004 and 2005, we incurred other expense of $1.7 million and $0.3 million, respectively, principally comprised of write-offs of miscellaneous receivables and other assets, losses on disposal of equipment, forgiveness of notes, losses on the sale or disposal of assets, and costs related to bond offerings and debt restructures. During fiscal 2004, we incurred approximately $1.6 million of legal and professional service costs related to our earlier attempts to solidify financing and the related bond offering that was not completed.

INCOME TAX EXPENSE

In fiscal 2004, we increased the valuation allowance for the net deferred tax asset by $5.2 million due to our recurring losses from continuing operations over the prior three fiscal years. In fiscal 2005, the valuation allowance was fully reserved.

MINORITY INTEREST IN EARNINGS OF SUBSIDIARIES

Minority interest in earnings of subsidiaries represents the minority investors' 25% share of the income from the Burbank Advanced Imaging Center LLC and 25% share of the Rancho Bernardo Advanced LLC for the period. Both center's residual interests were purchased by us in September and July 2004, respectively. We now own 100% of all our locations and our minority interest liabilities have been eliminated. Minority interest expense was $351,000 in fiscal 2004.

SUMMARY OF OPERATIONS BY QUARTER

The following table presents unaudited quarterly operating results for each of our last eight fiscal quarters. We believe that all necessary adjustments have been included in the amounts stated below to present fairly the quarterly results when read in conjunction with the consolidated financial statements as restated. The selected quarterly financial data in 2005 and the first quarter of 2006 below have been restated to reflect adjustments that are discussed further in Note 2 "Restatement of Financial Statements" in the Notes to the consolidated financial statements. Results of operations for any particular quarter are not necessarily indicative of results of operations for a full year or predictive of future periods.

	2005 QUARTER ENDED (AS RESTATED)				20
	JAN 31	APR 30	JUL 31 (1)	OCT 31	JAN 31 (AS RESTATED)
	(dollars in thousands)				
STATEMENT OF OPERATIONS DATA:					
Net revenue	$34,110	$35,190	$36,178	$40,095	$38,538
Operating expenses	32,206	32,168	32,088	35,711	34,638
Total other expense	4,211	3,727	4,236	4,796	4,410
Equity in income of investee	--	--	--	--	--
Income tax expense	--	--	--	--	--
Net income (loss)	(2,307)	(705)	(146)	(412)	(510)
Basic earnings per share:					
Basic net loss per share 1	(.11)	(.03)	(.01)	(.02)	(.02)
Diluted earnings per share:					
Diluted net loss per share 1	(.11)	(.03)	(.01)	(.02)	(.02)

1 Effective November 28, 2006, the Company completed a one-for-two reverse stock split. The historical earnings per share and shares outstanding information have been updated for the change in the number of shares.

See Note 2: "Restatement of Financial Statements" under Notes to Consolidated Financial Statements of this Form 10-K for a summary of the effect of these changes on our consolidated financial statements as of October 31, 2004 and 2005, respectively.

The following is a summary of the significant effects of these corrections on our summary of operations by quarter for all four quarters of fiscal 2005 and the first quarter of fiscal 2006.

CONSOLIDATED STATEMENTS OF OPERATIONS

QUARTER ENDED JANUARY 31, 2005	AS PREVIOUSLY REPORTED	ADJUSTMENTS	AS RESTATED
Net revenue	$ 34,110	$ --	$ 34,110

Operating expenses	32,097	109	32,206
Total other expense	4,211	--	4,211
Equity in income of investee	--	--	--
Income tax expense	--	--	--
Net income (loss)	(2,198)	(109)	(2,307)
Basic earnings per share:			
Basic net loss per share (1)	(0.11)	--	(0.11)
Diluted earnings per share:			
Diluted net loss per share (1)	(0.11)	--	(0.11)

(1) Effective November 28, 2006, the Company completed a one-for-two reverse stock split. The historical earnings per share and shares outstanding information have been updated for the change in the number of shares.

CONSOLIDATED STATEMENTS OF OPERATIONS

QUARTER ENDED APRIL 30, 2005	AS PREVIOUSLY REPORTED	ADJUSTMENTS	AS RESTATED
Net revenue	$ 35,190	$ --	$ 35,190
Operating expenses	32,059	109	32,168
Total other expense	3,727	--	3,727
Equity in income of investee	--	--	--
Income tax expense	--	--	--
Net income (loss)	(596)	(109)	(705)
Basic earnings per share:			
Basic net loss per share (1)	(0.03)	--	(0.03)
Diluted earnings per share:			
Diluted net loss per share (1)	(0.03)	--	(0.03)

(1) Effective November 28, 2006, the Company completed a one-for-two reverse stock split. The historical earnings per share and shares outstanding information have been updated for the change in the number of shares.

CONSOLIDATED STATEMENTS OF OPERATIONS

QUARTER ENDED JULY 31, 2005	AS PREVIOUSLY REPORTED	ADJUSTMENTS	AS RESTATED
Net revenue	$ 36,178	$ --	$ 36,178

Operating expenses	31,979	109	32,088
Total other expense	4,236	--	4,236
Equity in income of investee	--	--	--
Income tax expense	--	--	--
Net income (loss)	(37)	(109)	(146)
Basic earnings per share:			
Basic net loss per share (1)	--	(0.01)	(0.01)
Diluted earnings per share:			
Diluted net loss per share (1)	--	(0.01)	(0.01)

(1) Effective November 28, 2006, the Company completed a one-for-two reverse stock split. The historical earnings per share and shares outstanding information have been updated for the change in the number of shares.

CONSOLIDATED STATEMENTS OF OPERATIONS

QUARTER ENDED OCTOBER 31, 2005	AS PREVIOUSLY REPORTED	ADJUSTMENTS	AS RESTATED
Net revenue	$ 40,095	$ --	$ 40,095
Operating expenses	35,603	108	35,711
Total other expense	4,796	--	4,796
Equity in income of investee	--	--	--
Income tax expense	--	--	--
Net income (loss)	(304)	(108)	(412)
Basic earnings per share:			
Basic net loss per share (1)	(0.02)	--	(0.02)
Diluted earnings per share:			
Diluted net loss per share (1)	(0.02)	--	(0.02)

(1) Effective November 28, 2006, the Company completed a one-for-two reverse stock split. The historical earnings per share and shares outstanding information have been updated for the change in the number of shares.

CONSOLIDATED STATEMENTS OF OPERATIONS

QUARTER ENDED JANUARY 31, 2005	AS PREVIOUSLY REPORTED	ADJUSTMENTS	AS RESTATED

Net revenue	$ 38,538	$ --	$ 38,538
Operating expenses	34,605	33	34,638
Total other expense	4,410	--	4,410
Equity in income of investee	--	--	--
Income tax expense	--	--	--
Net income (loss)	(477)	(33)	(510)
Basic earnings per share:			
Basic net loss per share (1)	(0.02)	--	(0.02)
Diluted earnings per share:			
Diluted net loss per share (1)	(0.02)	--	(0.02)

(1) Effective November 28, 2006, the Company completed a one-for-two reverse stock split. The historical earnings per share and shares outstanding information have been updated for the change in the number of shares.

RELATED PARTY TRANSACTIONS

We describe certain transactions between us and certain related parties under "Certain Relationships and Related Transactions" below.

RECENT ACCOUNTING PRONOUNCEMENTS

In December 2004, the FASB issued SFAS No. 123 (Revised 2004), "Share-Based Payment" which was amended effective April 2005. The new rule requires that the compensation cost relating to share-based payment transactions be recognized in financial statements based on the fair value of the equity or liability instruments issued. We applied Statement 123R on November 1, 2005. We routinely use share-based payment arrangements as compensation for our employees. During fiscal 2004 and 2005, had this rule been in effect, we would have recorded the non-cash expense of $379,000 and $341,000, respectively.

In June 2006, FASB issued FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes--an interpretation of FASB Statement No. 109" ("FIN 48"). FIN 48 prescribes a recognition threshold and measurement process for recording in the financial statements uncertain tax positions taken or expected to be taken in a tax return in accordance with SFAS No. 109, "Accounting for Income Taxes." Tax positions must meet a more-likely-than-not recognition threshold at the effective date to be recognized upon the adoption of FIN 48 and in subsequent periods. The accounting provision of FIN 48 will be effective for the Company beginning January 1, 2007. The Company has not yet completed its evaluation of the impact of adoption on the Company's financial position or results of operations.

In September 2006, the FASB issued SFAS No. 157, "Fair Value Measurements," which defines fair value, establishes a framework for measuring fair value in generally accepted accounting principles, and expands disclosures about fair value measurements. SFAS No. 157 applies under most other accounting pronouncements that require or permit fair value measurements and does not require any new fair value measurements. This Statement is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years, with earlier application encouraged. The provisions of SFAS No. 157 should be applied prospectively as of the beginning of the fiscal year in which the Statement is initially applied,

except for a limited form of retrospective application for certain financial instruments. The Company will adopt this statement for fiscal year 2009. Management has not determined the effect the adoption of this statement will have on its consolidated financial position or results of operations.

In September 2006, the Securities and Exchange Commission ("SEC") issued Staff Accounting Bulletin No. 108 ("SAB 108"), which provides interpretive guidance on how the effects of the carryover or reversal of prior year misstatements should be considered in quantifying a current year misstatement. SAB 108 is effective for fiscal years ending after November 15, 2006. The Company will adopt this statement for fiscal 2007. Management has not determined the effect the adoption of this statement will have on its consolidated financial position or results of operations.

In October 2006, the Company adopted FASB Interpretation No. 47, "Accounting for Conditional Asset Retirements -- an interpretation of SFAS No. 143" ("FIN 47"). FIN 47 clarifies that uncertainty about the timing and (or) method of settlement of a conditional asset retirement obligation should be factored into the measurement of the liability when sufficient information exists to make a reasonable estimate of the fair value of the obligation. The provisions of this interpretation were effective for the Company's fiscal year ended October 31, 2006 and did not have a material impact on its consolidated financial position or results of operations. See discussion above under Long-Lived Assets.

FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. These forward-looking statements reflect, among other things, management's current expectations and anticipated results of operations, all of which are subject to known and unknown risks, uncertainties and other factors that may cause our actual results, performance or achievements, or industry results, to differ materially from those expressed or implied by such forward-looking statements. Therefore, any statements contained herein that are not statements of historical fact may be forward-looking statements and should be evaluated as such. Without limiting the foregoing, the words "believes," "anticipates," "plans," "intends," "will," "expects," "should" and similar words and expressions are intended to identify forward-looking statements. Except as required under the federal securities laws or by the rules and regulations of the SEC, we assume no obligation to update any such forward-looking information to reflect actual results or changes in the factors affecting such forward-looking information. The factors included in "Risks Relating to Our Business," among others, could cause our actual results to differ materially from those expressed in, or implied by, the forward-looking statements.

Specific factors that might cause actual results to differ from our expectations, include, but are not limited to:

- economic, competitive, demographic, business and other conditions in our markets;
- a decline in patient referrals;
- changes in the rates or methods of third-party reimbursement for diagnostic imaging services;
- the enforceability or termination of our contracts with radiology practices;

- the availability of additional capital to fund capital expenditure requirements;
- burdensome lawsuits against our contracted radiology practices and us;
- reduced operating margins due to our managed care contracts and capitated fee arrangements;
- any failure on our part to comply with state and federal anti-kickback and anti-self-referral laws or any other applicable healthcare regulations;
- our substantial indebtedness, debt service requirements and liquidity constraints;
- the interruption of our operations in certain regions due to earthquake or other extraordinary events;
- the recruitment and retention of technologists by us or by radiologists of our contracted radiology groups;
- successful integration of Radiologix operations;
- and other factors discussed in the "Risk Factors" section or elsewhere in this report.

All future written and verbal forward-looking statements attributable to us or any person acting on our behalf are expressly qualified in their entirety by the cautionary statements contained or referred to in this section. In light of these risks, unc