UNITED AMERICAN HEALTHCARE CORP
Form 10-K
September 04, 2008

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

FORM 10-K

[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended June 30, 2008

or

[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission file number: 001-11638

UNITED AMERICAN HEALTHCARE CORPORATION
(Exact name of registrant as specified in charter)

MICHIGAN	38-2526913
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

300 RIVER PLACE, SUITE 4950
DETROIT, MICHIGAN 48207
(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code: (313) 393-4571

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

Securities registered pursuant to Section 12(g) of the Act:

COMMON STOCK, NO PAR VALUE
(Title of Class)

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) of the Act Yes [ ] No [X]

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 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. [X]

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.

Large accelerated filer	[ ]	Accelerated filer	[ ]
Non-accelerated filer	[X]	Smaller reporting company	[ ]

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes [ ] No [X].

THE AGGREGATE MARKET VALUE OF THE VOTING STOCK OF THE REGISTRANT HELD BY NON-AFFILIATES AS OF DECEMBER 31, 2007, COMPUTED BY REFERENCE TO THE NASDAQ CAPITAL MARKET CLOSING PRICE ON SUCH DATE, WAS $19,076,372

THE NUMBER OF OUTSTANDING SHARES OF REGISTRANT'S COMMON STOCK AS OF AUGUST 27, 2008 WAS 8,734,214.

Portions of the registrant's Proxy Statement for its 2008 Annual Meeting of Shareholders have been incorporated by reference in Part III of this Annual Report of Form 10-K.

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As filed with the Securities and Exchange Commission on September 4, 2008

I. UNITED AMERICAN HEALTHCARE CORPORATION

FORM 10-K

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PART I

ITEM 1. BUSINESS

GENERAL

United American Healthcare Corporation (the "Company" or "UAHC") was incorporated in Michigan on December 1, 1983 and commenced operations in May 1985. Unless the context otherwise requires, all references to the Company indicated herein shall mean United American Healthcare Corporation and its consolidated subsidiaries.

The Company provides comprehensive management and consulting services to a managed care organization in Tennessee. The Company also arranges for the financing of health care services and delivery of these services by primary care physicians and specialists, hospitals, pharmacies and other ancillary providers to commercial employer groups and government-sponsored populations in Tennessee.

Management and consulting services provided by the Company are and have been generally to health maintenance organizations with a targeted mix of Medicaid and non-Medicaid/commercial enrollment. Management and consulting services provided by the Company include feasibility studies for licensure, strategic planning, corporate governance, management information systems, human resources, marketing, pre-certification, utilization review programs, individual case management, budgeting, provider network services, accreditation preparation, enrollment processing, claims processing, member services and cost containment programs.

UAHC's efforts are concentrated on low-income families and people with disabilities in select geographic markets. The Company has specialized in the Medicaid market for over 20 years and its management team has decades of experience in this sector. Management believes the Company has gained substantial expertise in understanding and serving the particular needs of the Medicaid population. As of August 18, 2008, there were 98,976 TennCare enrollees in UAHC Health Plan of Tennessee, Inc. ("UAHC-TN"), owned by the Company's wholly owned subsidiary.

In the fiscal year ended June 30, 2008 and its two preceding fiscal years, the Company derived a majority of its revenues from UAHC-TN's managed care services in the West Grand Region of Tennessee under a contract with the State of Tennessee, Bureau of TennCare ("TennCare"). In early 2008, TennCare issued a Request for Proposals and conducted a selection process that resulted in TennCare contracts for only two other organizations to provide managed care services in the West Grand Region. Consequently, UAHC-TN will have no TennCare contract when its present contract expires on June 30, 2009. Revenue under this contract will be earned through October 31, 2008 as it is expected that UAHC-TN's TennCare members will transfer to the other organizations on November 1, 2008, and that UAHC-TN will perform its remaining TennCare obligations through the contract expiration date. Management believes that the discontinuance of the TennCare contract will have a material impact on the Company's operations.

On October 10, 2006, UAHC-TN entered into a contract with the Centers for Medicare & Medicaid Services (CMS) to act as a Medicare Advantage qualified organization. The contract authorizes UAHC-TN to serve members enrolled in both the Tennessee Medicaid and Medicare programs, commonly referred to as "dual-eligibles," specifically to offer a Special Needs Plan ("SNP") to its eligible members in Shelby County, Tennessee (including the City of Memphis), and to operate a Voluntary Medicare Prescription Drug Plan, both beginning January 1, 2007. The current contract term is through December 31, 2008, after which the contract may be renewed for successive one-year periods in accordance with its terms. As of August 18, 2008 there were approximately 845 Medicare Advantage enrollees in UAHC-TN.

INDUSTRY

In an effort to control costs while assuring the delivery of quality health care services, the public and private sectors have increasingly turned to managed care solutions. As a result, the managed care industry, which includes health maintenance organization ("HMO"), preferred provider organization ("PPO") and prepaid health service plans, has grown substantially. While the trend toward managed care solutions was traditionally pursued most aggressively by the private sector, the public sector has embraced the trend in an effort to control the costs of health care provided to Medicaid recipients. Consequently, many states are promoting managed care initiatives to contain these rising costs and supporting programs that encourage or mandate Medicaid beneficiaries to enroll in managed care plans. Under the Medicare Modernization Act of 2003 ("MMA"), the federal government expanded managed care for publicly sponsored programs by allowing Medicare Advantage plans to offer special needs plans that cover dual eligibles. These special needs plans allow for coordinated care for a specific segment of the Medicare population, thus providing the opportunity for improved quality of care and cost management.

MANAGED CARE PRODUCTS AND SERVICES

The Company owns and manages the operations of an HMO in Tennessee, UAHC-TN. The following table shows the approximate number of UAHC-TN members served by the Company in the indicated service categories as of August 18, 2008:

TennCare	Medicare	Total

98,976 845 99,821

UAHC-TN is the Company's principal revenue source. The following table shows the Company's revenues from UAHC-TN in dollar amounts and as a percentage of the Company's total revenues for the fiscal years indicated. Such data are not necessarily indicative of UAHC TN's contributions to the Company's net earnings.

	FISCAL YEAR ENDED JUNE 30,					
REVENUES	2008		2007		2006	
	(in thousands, except percentages)					
UAHC-TN	$27,756	98.4%	$17,667	97.8%	$17,923	99.7%

MANAGED PLAN

The Company has entered into a long-term management agreement, through a wholly owned subsidiary of the Company, with UAHC-TN. Pursuant to this management agreement, the Company provides to UAHC-TN management and consulting services associated with the financing and delivery of health care services.

Services provided to UAHC-TN include strategic planning; corporate governance; human resource functions; provider network services; provider profiling and credentialing; premium rate setting and review; marketing services (group and individual); accounting and budgeting functions; deposit, disbursement and investment of funds; enrollment functions; collection of accounts; claims processing; management information systems; utilization review; and quality management.

UAHC-TN has a Medicaid contract and a Medicare contract with agencies of the State of Tennessee and the United States, respectively. The amount of premiums and/or fees that UAHC TN receives is established by the contracts, although it varies according to specific government programs and may also vary according to demographic factors, including a member's age, gender and health status.

MANAGED PLAN OWNED BY THE COMPANY

MEDICAID

UAHC-TN was organized as a Tennessee corporation in October 1993, and is headquartered in Memphis, Tennessee. The Company was active in the development of UAHC-TN, and through the Company's wholly owned subsidiary, United American of Tennessee, Inc., wholly owns UAHC-TN. UAHC-TN began as a PPO contractor with the Bureau of TennCare, a State of Tennessee program that provides medical benefits to Medicaid and working uninsured and uninsurable recipients, and operated as a full-risk prepaid health services plan until it obtained its TennCare HMO license in March 1996. UAHC-TN's TennCare HMO contract was executed in October 1996, retroactive to the date of licensure.

Through an amendment with an effective date of July 1, 2005, TennCare implemented a modified risk arrangement ("MRA") with all its contracted MCOs,

including UAHC-TN, under which they became at risk for losing up to 10% of administrative fee revenue and could receive up to 15% incentive bonus revenue based on performance relative to benchmarks. UAHC-TN received notice from TennCare that it earned additional revenue of $1.1 million for its performance under the MRA for fiscal 2006, representing a 7% bonus revenue payout. Such additional revenue has been recorded, of which $0.3 million was recorded in fiscal 2006, $0.5

million was recorded in fiscal 2007, and $0.3 million was recorded in the second quarter of fiscal 2008. UAHC-TN also earned and received additional revenue of $1.4 million for fiscal 2007, representing a 9% bonus revenue payout, and the Company has recorded such additional MRA earnings in the third quarter of fiscal 2008, when UAHC-TN was notified by TennCare of the amount. Effective July 1, 2007, the evaluation period for the MRA was changed from quarterly to annually, and the incentive bonus pool was adjusted to 20% of administrative fee revenue. As of August 18, 2008, UAHC TN's total TennCare enrollment was 98,976 members.

On April 22, 2008, TennCare disclosed its decision to award new TennCare contracts to two organizations, not including the Company's subsidiary, UAHC-TN, as the culmination of TennCare's selection process pursuant to its Request for Proposals for managed care services to be provided in the West Grand Region of Tennessee. Consequently, revenue under this contract will be earned through October 31, 2008 as it is expected that UAHC -TN's TennCare members will transfer to other managed care organizations on November 1, 2008, after which UAHC-TN will perform its remaining contractual obligations through its TennCare contract expiration date of June 30, 2009. Management believes that the discontinuance of the TennCare contract will have a material impact on the Company's operations.

MEDICARE

On October 10, 2006, UAHC-TN entered into a contract with the Centers for Medicare & Medicaid Services ("CMS") to act as a Medicare Advantage qualified organization. The contract authorizes UAHC-TN to serve members enrolled in both the Tennessee Medicaid and Medicare programs, commonly referred to as "dual-eligibles," specifically to offer a Special Needs Plan ("SNP") to its eligible members in Shelby County, Tennessee (including the City of Memphis), and to operate a Voluntary Medicare Prescription Drug Plan, both beginning January 1, 2007. The current contract term is through December 31, 2008, after which the contract may be renewed for successive one-year periods in accordance with its terms.

In December 2003 Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act ("MMA"). The MMA increased the amounts payable to Medicare Advantage plans such as ours, and expanded Medicare beneficiary healthcare options by, among other things, adding a Medicare Part D prescription drug benefit beginning in 2006.

One of the goals of the MMA was to reduce the costs of the Medicare program by increasing participation in the Medicare Advantage program. Effective January 1, 2004, the MMA increased Medicare Advantage statutory payment rates, generally increasing payments per member to Medicare Advantage plans. Medicare Advantage plans are required to use these increased payments to improve the healthcare benefits that are offered, to reduce premiums or to strengthen provider networks. Management believes that these MMA reforms, including in particular the increased reimbursement rates to Medicare Advantage plans, have allowed and will continue to allow Medicare Advantage plans to offer more comprehensive and

attractive benefits, including better preventive care benefits, while also reducing out-of-pocket expenses for beneficiaries.

As part of the MMA, effective January 1, 2006, every Medicare recipient was able to select a prescription drug plan through Medicare Part D. Financing for Medicare Part D comes from beneficiary premium payments, state contributions and general revenues. The monthly premium paid by enrollees is set to cover 25.5% of the cost for standard drug coverage. CMS subsidizes the remaining 74.5%, based on bids submitted to CMS by plans for their expected benefits payments. Plans can receive additional risk-adjusted payments for high cost enrollees and reinsurance payments for 80% of costs above the catastrophic threshold. A Part D plan's total potential losses or profits are limited by risk-sharing arrangements with the federal government. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries.

Under the standard Part D drug coverage for 2007, beneficiaries enrolled in a stand-alone prescription drug plan ("PDP") pay a $265 annual deductible and 25% coinsurance up to an initial coverage limit of $2,400 in total drug costs, followed by a coverage gap (the so-called "doughnut hole") where enrollees pay 100% of their drug costs until they have spent $3,850 out of pocket. After the beneficiary has incurred $3,850 in out-of-pocket drug expenses, 95% of the beneficiary's remaining out-of-pocket drug costs for that year are covered by the plan or the federal government. Medicare Advantage prescription drug ("MA-PD") plans are not required to mirror these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to the standard drug coverage delineated in the MMA. The deductible, co-pay and coverage amounts will be adjusted by CMS on an annual basis. As additional incentive to enroll in a Part D prescription drug plan, CMS imposes a cumulative penalty added to a beneficiary's monthly Part D plan premium in an amount equal to 1% of the applicable premium for each month between the date of a beneficiary's enrollment deadline and the beneficiary's actual enrollment. This penalty amount is passed through the plan to the government. Each Medicare Advantage plan is required to offer a Part D drug prescription plan as part of its benefits. UAHC-TN currently offers prescription drug benefits through its PDP and through its MA-PD plan.

DUAL-ELIGIBLE BENEFICIARIES. A "dual-eligible" beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Medicaid, because of economic status. Health plans that serve dual-eligible beneficiaries receive a higher premium from CMS for dual-eligible members. Currently, CMS pays a higher premium for a dual-eligible beneficiary because a dual-eligible member generally has a higher risk score corresponding to his or her higher medical costs. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dual-eligible members. The MMA provides Part D subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals.

BIDDING PROCESS. Although Medicare Advantage plans have continued to be paid on a capitated, or per member per month ("PMPM") basis, as of January 1, 2006, CMS has used a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS's estimated per beneficiary fee-for-service expenses, was relabeled as

the "benchmark" amount, and local Medicare Advantage plans are required to annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that year, Medicare is required to pay the plan its bid amount, risk-adjusted based on its risk scores, plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans are required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing or reduced premiums, including premiums for MA-PD and other supplemental benefits. CMS has the right to audit the use of these proceeds. The remaining 25% of the excess amount is required to be retained in the statutory Medicare trust fund. If a Medicare Advantage plan's bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which is expected to make such plans less competitive.

ANNUAL ENROLLMENT AND LOCK-IN. Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. Since January 1, 2006, Medicare beneficiaries have had defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, stand-alone PDP or traditional fee-for-service Medicare. For 2008 and subsequent years, the annual enrollment period for a PDP is from November 15 through December 31 of each year, and enrollment in Medicare Advantage plans occurs from November 15 through March 31 of the subsequent year. Enrollment on or prior to December 31 will be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period will be effective as of the first day of the month following the date on which the enrollment occurred. After these defined enrollment periods end, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries and others who qualify for special needs plans and employer group retirees will be permitted to enroll in or change health plans during that plan year.

We are currently considering several potential strategic alternatives for UAHC-TN's Medicare Advantage plan, including partnerships or potential sale of plan assets. As of August 18, 2008 there were approximately 845 Medicare Advantage enrollees in UAHC-TN.

MANAGED PLAN PREVIOUSLY OPERATED BY THE COMPANY

For many years prior to November 1, 2002, UAHC managed a health maintenance organization in Michigan called Omni Care Health Plan ("OmniCare-MI"). OmniCare-MI ceased to be a managed plan operated by the Company effective November 1, 2002.

While managed by the Company, OmniCare-MI was a not-for-profit, tax-exempt corporation headquartered in Detroit, Michigan and serving southeastern Michigan, operating in Wayne, Oakland, Macomb, Monroe and Washtenaw counties. Its history included a number of innovations that were adopted and proved successful for the industry. While managed by the Company, it was the first network model HMO in the country and the first to capitate physician services in an IPA-model HMO (an Independent Practice Association model HMO does not

employ physicians as staff, but instead contracts with associations or groups of

independent physicians to provide services to HMO members). OmniCare-MI also created and implemented the first known mental health capitation carve out in 1983.

While managed by the Company, OmniCare-MI's enrollment was through companies that offered the health plan coverage to employees and their family members, through individual enrollment and through the State of Michigan's Medicaid program pursuant to an agreement with the Michigan Department of Community Health, which made HMO coverage available to eligible Medicaid beneficiaries in certain counties and mandatory in others.

As a Michigan HMO, OmniCare-MI was subject to oversight by the State of Michigan's Commissioner of the Office of Financial and Insurance Services (the "Commissioner"). On July 31, 2001, pursuant to a motion by the Commissioner, a State circuit court judge entered an order of rehabilitation of OmniCare-MI (the "Order") and appointed the Commissioner as Rehabilitator of OmniCare-MI. The Order directed the Rehabilitator to administer all of OmniCare-MI's assets and business while attempting to effectuate its rehabilitation, preserve its provider network and maintain uninterrupted health care services to the greatest extent possible.

The Order required the Company to continue performing all services under its OmniCare-MI management agreement, which the Company did until that agreement's termination on November 1, 2002, pursuant to OmniCare-MI's court-approved rehabilitation plan.

GOVERNMENT REGULATION

The Company is and/or has been subject to extensive federal and state health care and insurance regulations designed primarily to protect enrollees in our managed plans, particularly with respect to government sponsored enrollees. Such regulations govern many aspects of the Company's business affairs and typically empower state agencies to review management agreements with health care plans for, among other things, reasonableness of charges. Among the other areas regulated by federal and state law are licensure requirements, premium rate increases, new product offerings, procedures for quality assurance, enrollment requirements, covered benefits, service area expansion, provider relationships and the financial condition of the managed plans, including cash reserve requirements and dividend restrictions. There can be no assurances that the Company or UAHC-TN will be granted the necessary approvals for new products or will maintain federal qualifications or state licensure.

The licensing and operation of UAHC-TN are governed by the Tennessee statutes and regulations applicable to health maintenance organizations. The licenses are subject to denial, limitation, suspension or revocation if there is a determination that the plan is operating out of compliance with the state's HMO statute, failing to provide quality health services, establishing rates that are unfair or unreasonable, failing to fulfill obligations under outstanding agreements or operating on an unsound fiscal basis. UAHC-TN is not a federally-qualified HMO and, therefore, is not subject to the federal HMO Act.

Federal and state regulation of health care plans and managed care products is subject to frequent change, varies from jurisdiction to jurisdiction and generally gives responsible administrative agencies broad discretion. Laws and regulations relating to the Company's business are subject to amendment and/or interpretation in each jurisdiction. In particular, legislation mandating managed care for Medicaid recipients is often subject to change and may not

initially be accompanied by administrative rules and guidelines. Changes in federal or state governmental regulation could affect the Company's operations, profitability and business prospects. While the Company is unable to predict what additional government regulations, if any, affecting its business may be enacted in the future or how existing or future regulations may be interpreted, regulatory revisions may have a material adverse effect on the Company.

INSURANCE

The Company presently carries comprehensive general liability, directors and officers' liability, property, business automobile, and workers' compensation insurance. Management believes that coverage levels under these policies are adequate in view of the risks associated with the Company's business. In addition, UAHC-TN has (and OmniCare-MI while managed by the Company had) professional liability insurance that covers liability claims arising from medical malpractice. UAHC-TN is required to pay the professional liability insurance premiums under the terms of the Company's management agreement. There can be no assurance as to the future availability or cost of such insurance, or that the Company's business risks will be maintained within the limits of such insurance coverage.

COMPETITION

The managed care industry is highly competitive. The Company directly competes with other entities that provide health care plan management services, some of which are nonprofit corporations and others, which have significantly greater financial and administrative resources. The Company primarily competes on the basis of fee arrangements, cost effectiveness and the range and quality of services offered to prospective health care clients. While the Company believes that its experience gives it certain competitive advantages over existing and potential new competitors, there can be no assurance that the Company will be able to compete effectively in the future.

The Company competes with other HMOs, PPOs and insurance companies. The level of this competition may affect, among other things, the operating revenues of UAHC-TN and, therefore, the revenues of the Company. UAHC-TN's Medicaid primary market competitors in western Tennessee are TLC Family Health Plan, Unison Health Plan, and TennCare Select. (As stated above in the fifth paragraph under the caption "GENERAL" in this Item 1, it is expected that UAHC-TN's entire TennCare population will transfer to other MCOs on November 1, 2008 and the TennCare contract for its current Medicaid business in western Tennessee will expire on June 30, 2009 and not be extended or renewed. UAHC-TN's Medicare primary market competitors in western Tennessee are Healthspring, Unison and Windsor. UAHC-TN primarily competes on the basis of enrollment, provider networks and other related plan features and criteria. Management believes that UAHC-TN is able to compete effectively with its primary Medicare market competitors.

EMPLOYEES

The Company's ability to maintain its competitive position and expand its business into new markets depends, in significant part, upon the maintenance of its relationships with various existing senior officers, as well as its ability to attract and retain qualified health care management professionals. The Company neither has nor intends to pursue any long-term employment agreement with any of its key personnel. Accordingly, there is no assurance that the Company will be able to maintain such relationships or attract such

professionals.

The total number of employees of the Company at August 1, 2008 was 99 compared to 115 at August 1, 2007. As a result of the pending termination of the TennCare contract, Management expects a substantial decrease in the total number of employees. The Company's employees do not belong to a collective bargaining unit and management considers its relations with employees to be good.

ITEM 1A. RISK FACTORS

Set forth below and elsewhere in this Form 10-K annual report are some of the principal risks and uncertainties that could cause our actual business results to differ materially from any forward-looking statements contained in this report. These risk factors should be considered in addition to our cautionary comments concerning forward-looking statements in this report. If any of the following risks actually occurs, our business, financial condition or results of operations could be adversely affected. In such event, the trading price of our common stock could decline. In the following portion of this Item 1A, the words "we," "us" and "our" sometimes specifically mean and refer to our subsidiary UAHC-TN, when the context so indicates. Such factors potentially include, among others, the following:

WE DERIVE A SIGNIFICANT PORTION OF OUR REVENUES FROM OUR TENNCARE OPERATIONS, WHICH WILL SUBSTANTIALLY END OCTOBER 31, 2008. THE DISCONTINUANCE OF OUR TENNCARE CONTRACT WILL HAVE MATERIAL IMPACT ON OUR OPERATIONS. UNTIL THEN, LEGISLATIVE OR REGULATORY ACTIONS, ECONOMIC CONDITIONS OR OTHER FACTORS THAT ADVERSELY AFFECT THOSE OPERATIONS COULD MATERIALLY REDUCE OUR REVENUES AND PROFITS.

For the year ended June 30, 2008, our TennCare operations accounted for 57.6% of our total revenues. On April 22, 2008, the Department of Finance and Administration of the State of Tennessee, Bureau of TennCare ("TennCare"), disclosed its decision to award new TennCare contracts to two organizations, not including our subsidiary, UAHC-TN, as the culmination of TennCare's selection process pursuant to its Request for Proposals for managed care services to be provided in the West Grand Region of Tennessee. Consequently, revenue under this contract will be earned through October 31, 2008 as it is expected that UAHC-TN's TennCare members will transfer to other managed care organizations on November 1, 2008, and that UAHC-TN will perform its remaining contractual obligations through its TennCare contract expiration date of June 30, 2009. Management believes that the discontinuance of the TennCare contract will have material impact on the Company's operations.

REDUCTIONS IN FUNDING FOR GOVERNMENT HEALTHCARE PROGRAMS COULD SUBSTANTIALLY REDUCE OUR PROFITABILITY.

Substantially all of the healthcare services we offer are through government-sponsored programs, such as Medicaid and Medicare. As a result, our profitability is dependent, in large part, on continued funding for government healthcare programs at or above current levels. Future Medicaid premium rate levels may be affected by continued government efforts to contain medical costs or state and federal budgetary constraints.

Changes in Medicaid funding, for example, may lead to reductions in the number of persons enrolled in or eligible for Medicaid, reductions in the amount of reimbursement or elimination of coverage for certain benefits. Reductions in Medicaid payments could reduce our profitability if we are unable to reduce our

related expenses. Reductions in payments under Medicare or the other programs under which we offer health and prescription drug plans could similarly reduce our profitability.

CMS'S RISK ADJUSTMENT PAYMENT SYSTEM AND BUDGET NEUTRALITY FACTORS MAKE OUR REVENUE AND PROFITABILITY DIFFICULT TO PREDICT AND COULD RESULT IN MATERIAL RETROACTIVE ADJUSTMENTS TO OUR RESULTS OF OPERATIONS.

The Centers for Medicare & Medicaid Services ("CMS") has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish incentives for Medicare plans to enroll and treat less healthy Medicare beneficiaries. CMS is phasing in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors that include: hospital inpatient diagnoses; diagnosis data from ambulatory treatment settings, including hospital outpatient facilities and physician visits; gender; age; and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. As a result, it is difficult to predict with any certainty our future revenue or profitability. In addition, our SNP risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare premium revenue.

Payments to Medicare Advantage plans are also adjusted by a "budget neutrality" factor that Congress and CMS implemented in 2003 to prevent overall reductions in health plan payments while at the same time directing risk-adjusted payments to plans with more chronically ill enrollees. In general, this adjustment favorably impacted payments to Medicare Advantage plans. In February 2006, the President signed legislation that reduced federal funding for Medicare Advantage plans by approximately $6.5 billion over five years. Among other changes, the legislation provided for an accelerated phase-out of budget neutrality for risk-adjusted payments made to Medicare Advantage plans. These legislative changes will in general result in reduced payments to Medicare Advantage plans.

IF WE ARE UNABLE TO ESTIMATE INCURRED BUT NOT REPORTED MEDICAL BENEFITS EXPENSE ACCURATELY, THAT COULD AFFECT OUR REPORTED FINANCIAL RESULTS.

Our medical benefits expense includes estimates of medical claims incurred but not reported ("IBNR"). Together with our internal and consulting actuaries, we estimate our medical cost liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors. Actual conditions could, however, differ from those assumed in the estimation process. We continually review and update our estimation methods and the resulting reserves and make adjustments, if necessary, to medical benefits expense when the criteria used to determine IBNR change and when actual claim costs are ultimately determined. Due to the uncertainties associated with the factors used in these assumptions, the actual amount of medical benefits expense that we incur may be materially more than the amount of IBNR originally estimated. If our future estimates of IBNR are inadequate, our reported results of operations could be negatively impacted. Our limited ability to estimate IBNR accurately could also affect our ability to take timely corrective actions, exacerbating the extent of any adverse effect on our results.

OUR RECORDS MAY CONTAIN INACCURATE INFORMATION REGARDING THE RISK ADJUSTMENT SCORES OF OUR MEMBERS, WHICH COULD CAUSE US TO OVERSTATE OR UNDERSTATE OUR REVENUE.

We maintain claims and encounter data that support the risk adjustment scores of our members, which partly determine the revenue we are entitled to for them. These data are submitted to us based on medical charts and diagnosis codes prepared by providers of medical care. Inaccurate coding by medical providers and inaccurate records for new members in our plan could result in inaccurate premium revenue and risk adjustment payments, which are subject to correction or update in later periods. Payments that we receive in connection with such corrected or updated information may be reflected in financial statements for periods subsequent to the period in which the revenue was earned. We may also find that our data regarding our members' risk adjustment scores, when reconciled, require that we refund a portion of the revenue that we received.

THE COMPETITIVE BIDDING PROCESS MAY ADVERSELY AFFECT OUR PROFITABILITY.

Payments for local and regional Medicare Advantage plans are based on a competitive bidding process that may decrease the amount of premiums paid to us or cause us to increase the benefits we offer without a corresponding increase in premiums. As a result of the competitive bidding process, in order to maintain our current level of profitability, in the future we may need to reduce benefits or charge our members an additional premium, either of which could make our health plan less attractive to members and adversely affect our membership.

WE DERIVE ALL OF OUR MEDICARE REVENUES FROM OUR SNP OPERATIONS, AND LEGISLATIVE OR REGULATORY ACTIONS, ECONOMIC CONDITIONS OR OTHER FACTORS THAT ADVERSELY AFFECT THOSE OPERATIONS COULD MATERIALLY REDUCE OUR REVENUES AND PROFITS.

Because special needs plans (each a "SNP") are relatively new to Medicare and to the health insurance market generally, we do not know whether we will be able to sustain our SNP operation's profitability over the long-term, and our failure to do so could have an adverse effect on our results of operations. Factors that could affect our SNP operations include legislative, regulatory, intensity of competition, and utilization of benefit risks. In addition, Medicare beneficiaries who are dual-eligibles generally are able to disenroll and choose another SNP at any time, and certain Medicare beneficiaries also have a limited ability to disenroll from the SNP they initially select and choose a different SNP. We may not be able to retain the auto-assigned members or those members who affirmatively choose our SNP, and we may not be able to attract new SNP members.

FINANCIAL ACCOUNTING FOR THE MEDICARE PART D BENEFITS IS COMPLEX AND REQUIRES DIFFICULT ESTIMATES AND ASSUMPTIONS.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA") provides for "risk corridors" designed to limit to some extent the losses SNPs would incur if their actual costs are higher than estimated in their bids submitted to CMS. For example, in 2008, Medicare drug plans will bear all gains and losses of up to 5% of their expected costs and will retain 50% of the gains or be reimbursed 50% of the loss between 5% and 10% and will retain

20% of the gain or be reimbursed 20% of the loss in excess of 10%. As the risk corridors are designed to be symmetrical, a plan whose actual costs are below

its expected costs is required to reimburse CMS based on a methodology similar to that set forth above. Reconciliation payments for estimated upfront federal reinsurance payments, or in some cases the entire amount of reinsurance payments, for Medicare beneficiaries who reach the drug benefits catastrophic threshold are made retroactively on an annual basis, which could expose plans to upfront costs in providing the benefit.

The accounting and regulatory guidance regarding the proper method of accounting for Medicare Part D, particularly as it relates to the timing of revenue and expense recognition, taken together with the complexity of the Part D product may lead to variability in our reporting of quarter-to-quarter earnings related to Medicare Part D.

IF STATE REGULATORS DO NOT APPROVE PAYMENTS BY OUR HEALTH PLAN TO US, OUR BUSINESS AND GROWTH STRATEGY COULD BE MATERIALLY IMPAIRED OR WE COULD BE REQUIRED TO INCUR INDEBTEDNESS TO FUND THESE STRATEGIES.

Our health plan subsidiary, UAHC-TN, is subject to laws and regulations that limit the amount of dividends and distributions it can pay to us for purposes other than to pay income taxes related to its earnings. These laws and regulations also limit the amount of management fees UAHC-TN may pay to its affiliates, including our management subsidiary, United American of Tennessee, Inc., without prior approval of, or notification to, state regulators. If the regulators were to deny or significantly restrict our subsidiary's requests to pay dividends to us or to pay management and other fees to its affiliate, the funds available to us would be limited, which could impair our ability to implement our business and growth strategies.

WE ARE REQUIRED TO COMPLY WITH LAWS GOVERNING THE TRANSMISSION, SECURITY AND PRIVACY OF HEALTH INFORMATION THAT REQUIRE SIGNIFICANT COMPLIANCE COSTS, AND ANY FAILURE TO COMPLY WITH THESE LAWS COULD RESULT IN MATERIAL CRIMINAL AND CIVIL PENALTIES.

Regulations under the Health Insurance Portability and Accountability Act of 1996, commonly called HIPAA, require us to comply with standards regarding the exchange of health information within our Company and with third parties, including healthcare providers, business associates and our members. These regulations include standards for common healthcare transactions, including claims information, plan eligibility and payment information; unique identifiers for providers and employers; security; privacy; and enforcement. We conduct our operations in an attempt to comply with all applicable HIPAA requirements. Given the complexity of the HIPAA regulations, the possibility that the regulations may change and the fact that the regulations are subject to changing and sometimes conflicting interpretation, our ongoing ability to comply with the HIPAA requirements is uncertain. Additionally, the costs of complying with any changes to the HIPAA regulations may have a negative impact on our operations. Sanctions for failing to comply with the HIPAA health information provisions include criminal penalties and civil sanctions, including significant monetary penalties. A failure by us to comply with state health information laws that may be more restrictive than the HIPAA regulations could result in additional penalties.

IF OUR MEDICARE CONTRACT IS NOT EXTENDED OR IS TERMINATED, OUR BUSINESS WOULD BE MATERIALLY IMPAIRED.

We provide services to our Medicare eligible members through our Medicare Advantage contract with CMS. The current contract term expires December 31,

2008. UAHC-TN expects to receive notice of the extension of the terms of the Medicare Advantage contract from CMS before that date. The contract is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If the contract were terminated or not extended, or if we were unable to successfully rebid or compete for the contracts, our business would be materially impaired.

BECAUSE OUR PREMIUMS ARE ESTABLISHED BY CONTRACT AND CANNOT BE MODIFIED DURING THE CONTRACT TERM, OUR PROFITABILITY WILL LIKELY BE REDUCED OR WE COULD CEASE TO BE PROFITABLE IF WE ARE UNABLE TO MANAGE OUR MEDICAL EXPENSES EFFECTIVELY.

Our SNP revenue is generated by premiums consisting of monthly payments per member that are established by the contract with CMS for our Medicare Advantage plan. If our medical expenses exceed our estimates, except in very limited circumstances or as a result of risk score adjustments for Medicare member health acuity, we will be unable to increase the premiums we receive under the contract during its then-current term. As a result, our profitability depends, to a significant degree, on our ability to adequately predict and effectively manage our medical expenses related to the provision of healthcare services. Relatively small changes in our medical loss ratio can create significant changes in our financial results. Accordingly, failure to adequately predict and control medical expenses or to make reasonable estimates and maintain adequate accruals for incurred but not reported (IBNR) claims could have a material adverse effect on our financial condition, results of operations or cash flows.

COMPETITION IN OUR MEDICARE ADVANTAGE SERVICE AREA MAY LIMIT OUR ABILITY TO MAINTAIN OR ATTRACT MEMBERS, WHICH COULD ADVERSELY AFFECT OUR RESULTS OF OPERATIONS.

We operate in a competitive environment subject to significant changes as a result of business consolidations, evolving Medicare products, new strategic alliances and aggressive marketing practices by other managed care organizations that compete with us for members. Our principal competitors for contracts, members and providers in our local service area include national, regional and local managed care organizations that serve Medicare. Many managed care companies and other new Part D plan participants have greater financial and other resources, larger enrollments, broader ranges of products and benefits, broader geographical coverage, more established reputations in the national market and our market, greater market share, larger contracting scale and lower costs than us. Our failure to maintain or attract members to our Medicare Advantage health plan as a result of such competition could adversely affect our results of operations.

A FAILURE TO INCREASE OUR SNP MEMBERSHIP COULD ADVERSELY AFFECT OUR RESULTS OF OPERATIONS.

A failure to increase our SNP membership could adversely affect our results of operations. In addition to competition, factors that potentially could contribute to the loss of, or failure to attract and retain, members include:

- negative accreditation results or loss of licenses or contracts to offer Medicare Advantage plans;
- negative publicity and news coverage relating to us or the managed healthcare industry generally;
- litigation or threats of litigation against us;

- automatic disenrollment, whether intentional or inadvertent, as a result of members choosing another plan; and

- our inability to market to and re-enroll members who enroll with our competitors because of the new annual enrollment and lock-in provisions under the MMA.

A DISRUPTION IN OUR HEALTHCARE PROVIDER NETWORKS COULD HAVE AN ADVERSE EFFECT ON OUR OPERATIONS AND PROFITABILITY.

Our operations and profitability are dependent in part on our ability to contract with healthcare providers and provider networks on favorable terms. In any particular service area, healthcare providers or provider networks might refuse to contract with us, demand higher payments or take other actions that could result in higher healthcare costs, disruption of benefits to our members or difficulty in meeting our regulatory or accreditation requirements. If healthcare providers refuse to contract with us, use their market position to negotiate favorable contracts or place us at a competitive disadvantage, then our ability to market products or to be profitable in our service area could be adversely affected. Our provider networks could also be disrupted by the financial insolvency of a large provider group. Any disruption in our provider network could result in a loss of membership or higher healthcare costs.

WE RELY ON THE ACCURACY OF LISTS PROVIDED BY CMS REGARDING THE ELIGIBILITY OF A PERSON TO PARTICIPATE IN OUR PLAN, AND ANY INACCURACIES IN THOSE LISTS COULD CAUSE CMS TO RECOUP PREMIUM PAYMENTS FROM US WITH RESPECT TO MEMBERS WHO ARE NOT OURS, WHICH COULD REDUCE OUR REVENUE AND PROFITABILITY.

Premium payments that we receive from CMS are based upon eligibility lists produced by federal and local governments. From time to time, CMS may require us to reimburse it for any premiums that we received from CMS based on eligibility and dual-eligibility lists that CMS later discovers contained individuals who were not in fact residing in our service area or eligible for any government-sponsored program or were eligible for a different premium category or a different program. We may have already provided services to these individuals. In addition to CMS's potential recoupment of premiums previously paid, we also are at risk that CMS might fail to pay us for members for whom we are entitled to payment. Our profitability would be reduced as a result of such failure to receive payment from CMS if we had made related payments to providers and were unable to recoup such payments from them.

OUTSOURCED SERVICE PROVIDERS MAY MAKE MISTAKES AND SUBJECT US TO FINANCIAL LOSS OR LEGAL LIABILITY.

We outsource certain of the functions associated with providing managed care and management services, including claims processing. The service providers to whom we outsource these functions and provide data could inadvertently or incorrectly adjust, revise, omit or transmit the data in a manner that could create inaccuracies in our risk adjustment information, cause us to overstate or understate our revenue, cause us to authorize incorrect payment levels to members of our provider networks, or violate certain laws and regulations, such as HIPAA.

NEGATIVE PUBLICITY REGARDING THE MANAGED HEALTHCARE INDUSTRY GENERALLY OR THE COMPANY IN PARTICULAR COULD ADVERSELY AFFECT OUR RESULTS OF OPERATIONS OR BUSINESS.

Negative publicity regarding the managed healthcare industry generally or the Company in particular may result in increased regulation and legislative review of industry practices that further increase our costs of doing business and adversely affect our results of operations by:

- requiring us to change our products and services;
- increasing the regulatory burdens under which we operate;
- adversely affecting our ability to market our products or services; or
- adversely affecting our ability to attract and retain members.

WE ARE DEPENDENT UPON OUR EXECUTIVE OFFICERS, AND THE LOSS OF ANY ONE OR MORE OF THEM AND THEIR MANAGED CARE EXPERTISE COULD ADVERSELY AFFECT OUR BUSINESS.

Our operations are highly dependent on the efforts of William C. Brooks, our President and Chief Executive Officer, and certain other senior executives who have been instrumental in developing our business strategies and forging our business relationships. The Company neither has nor intends to pursue any long-term employment agreement with any of its key personnel. Accordingly, there is no assurance that the Company will be able to maintain such relationships or attract such professionals. Although we believe we could replace any executive we lose, the loss of the leadership, knowledge and experience of Mr. Brooks and our other executive officers could adversely affect our business. Moreover, replacing one or more of our executives may be difficult or may require an extended period of time. We do not currently maintain key man insurance on any of our executive officers.

VIOLATION OF THE LAWS AND REGULATIONS APPLICABLE TO US COULD EXPOSE US TO LIABILITY, REDUCE OUR REVENUE AND PROFITABILITY OR OTHERWISE ADVERSELY AFFECT OUR OPERATIONS AND OPERATING RESULTS.

The federal and state agencies administering the laws and regulations applicable to us have broad discretion to enforce them. We are subject on an ongoing basis to various governmental reviews, audits and investigations to verify our compliance with our contracts, licenses and applicable laws and regulations. An adverse review, audit or investigation could result in any of the following:

- loss of our right to participate in the Medicare program;
- loss of our license to act as an HMO or to otherwise provide a service;
- forfeiture or recoupment of amounts we have been paid pursuant to our contracts;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and our key employees;
- damage to our reputation in existing and potential markets;
- increased restrictions on marketing our products and services; and
- inability to obtain approval for future products and services, geographic expansions or acquisitions.

CLAIMS RELATING TO MEDICAL MALPRACTICE AND OTHER LITIGATION COULD CAUSE US TO INCUR SIGNIFICANT EXPENSES.

From time to time, we are party to various litigation matters, some of which seek monetary damages. Managed care organizations may be sued directly for alleged negligence, including in connection with the credentialing of network providers or for alleged improper denials or delay of care. In addition, our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. Although our network providers are independent contractors, claimants sometimes allege that a managed care organization should be held responsible for alleged provider malpractice, and some courts have permitted that theory of liability.

Similar to other managed care companies, we may also be subject to other claims of our members in the ordinary course of business, including claims of improper marketing practices by our independent and employee sales agents and claims arising out of decisions to deny or restrict reimbursement for services.

We cannot predict with certainty the eventual outcome of any pending litigation or potential future litigation, and there can be no assurance that we will not incur substantial expense in defending future lawsuits or indemnifying third parties with respect to the results of such litigation. The loss of even one of these claims, if it results in a significant damage award, could have a material adverse effect on our business. In addition, our exposure to potential liability under punitive damage or other theories could significantly decrease our ability to settle these claims on reasonable terms.

We maintain errors and omissions insurance and other insurance coverage that we believe are adequate based on industry standards. Potential liabilities may not be covered by insurance, our insurers may dispute coverage or may be unable to meet their obligations or the amount of our insurance coverage and related reserves may be inadequate.

There can be no assurance that we will be able to obtain insurance coverage in the future, or that insurance will continue to be available on a cost-effective basis, if at all. Moreover, even if

claims brought against us are unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly and may distract our management's attention. As a result, we might incur significant expenses and might be unable to effectively operate our business.

IF WE ARE UNABLE OR FAIL TO PROPERLY MAINTAIN EFFECTIVE AND SECURE MANAGEMENT INFORMATION SYSTEMS, SUCCESSFULLY UPDATE OR EXPAND PROCESSING CAPABILITY OR DEVELOP NEW CAPABILITIES TO MEET OUR BUSINESS NEEDS, THAT COULD RESULT IN OPERATIONAL DISRUPTIONS AND OTHER ADVERSE CONSEQUENCES.

Our business depends significantly on effective and secure information systems. The information gathered and processed by our management information systems assists us in, among other things, marketing and sales tracking, billing, claims processing, medical management, medical care cost and utilization trending, financial and management accounting, reporting, planning and analysis. These information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and handle our expansion and growth. Any inability or failure to properly maintain management information

systems or related disaster recovery programs, successfully update or expand processing capability or develop new capabilities to meet our business needs in a timely manner could result in operational disruptions, loss of existing members, difficulty in attracting new members or in implementing our growth strategies, disputes with members and providers, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate reports, and other adverse consequences. To the extent a failure in maintaining effective information systems occurs, we may need to contract for these services with third-party management companies, which could be on less favorable terms to us and could significantly disrupt our operations and information flow.

Furthermore, our business requires the secure transmission of confidential information over public networks. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation and possible liability and loss. Our security measures may be inadequate to prevent security breaches and our business operations and profitability could be adversely affected by cancellation of contracts, loss of members and potential criminal and civil sanctions if they are not prevented.

IF WE ARE UNABLE TO MAINTAIN EFFECTIVE INTERNAL CONTROLS OVER FINANCIAL REPORTING, INVESTORS COULD LOSE CONFIDENCE IN THE RELIABILITY OF OUR FINANCIAL STATEMENTS, WHICH COULD RESULT IN A DECLINE IN THE PRICE OF OUR COMMON STOCK.

Because of our status as a public company, we are required to enhance and test our financial, internal and management control systems to meet obligations imposed by the Sarbanes-Oxley Act of 2002. We have worked and are working with our independent legal, accounting and financial advisors to identify those areas in which changes should be made to our financial and management control systems. These areas include corporate governance, corporate control, internal audit, disclosure controls and procedures, and financial reporting and accounting systems. Consistent with the Sarbanes-Oxley Act and the rules and regulations of the SEC, management's assessment of our internal controls over financial reporting is required in this

Annual Report on Form 10-K and the audit opinion of the Company's independent registered accounting firm as to the effectiveness of our controls will be first required in connection with the Company's filing of its Annual Report on Form 10-K for the fiscal year ending June 30, 2010. If we are unable to timely identify, implement and conclude that we have effective internal controls over financial reporting, investors could lose confidence in the reliability of our financial statements, which could result in a decrease in the value of our common stock. Our assessment of our internal controls over financial reporting may also uncover weaknesses or other issues with these controls that could also result in adverse investor reaction.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The Company currently leases approximately 30,000 aggregate square feet in Detroit, Michigan and Memphis, Tennessee, from which it conducts its operations in Michigan and Tennessee. The principal offices of the Company are located at 300 River Place, Suite 4950, Detroit, Michigan, where it currently leases approximately 3,800 square feet of office space.

The Company believes that its current facilities provide sufficient space suitable for all of its activities and that sufficient other space will be available on reasonable terms, if needed.

ITEM 3. LEGAL PROCEEDINGS

On March 17, 2006, the United States District Court for the Eastern District of Michigan consolidated two cases collectively called "In re United American Healthcare Corporation Securities Litigation," Master File No. 2:2005cv72112(LPZ/RSW). The complaints had been filed on May 27, 2005 and June 16, 2005 by Gregory Zaluski and William Coleman, respectively, against the Company and certain of its present and past officers. The plaintiffs, each on behalf of himself and all others similarly situated, alleged that in the period from May 26, 2000 through April 22, 2005, the Company made materially false and misleading statements in violation of Section 10(b) of the Securities Exchange Act of 1934 and Rule 10b-5 thereunder, with the alleged result of artificially inflating the market price of the Company's stock during that period. Both complaints alleged that as a direct result of facts publicly disclosed by the Company in April 2005, the Company's stock price dropped by about $3.39. Each plaintiff claimed to represent a class consisting of others who purchased the Company's stock during the specified period. The plaintiffs sought to recover damages on behalf of themselves and the proposed class. Pursuant to a motion by the Company and the other defendants, the U.S. District Court dismissed the consolidated complaint against all defendants with prejudice on January 30, 2007. On March 1, 2007, the plaintiffs appealed the dismissal order to the U.S. Court of Appeals for the Sixth Circuit (the "Sixth Circuit"). On May 27, 2008, the Sixth Circuit issued an opinion and order affirming the District Court's dismissal of the

consolidated complaint. On June 10, 2008, the plaintiffs filed a petition for rehearing en banc with the Sixth Circuit. On August 22, 2008, the Sixth Circuit denied the plaintiffs' petition.

The Company is a defendant with others in a lawsuit that commenced in February 2005 in the Circuit Court for the 30th Judicial Circuit, in the County of Ingham, Michigan, Case No. 05127CK, entitled "Provider Creditors Committee on behalf of Michigan Health Maintenance Organizations Plans, Inc. v. United American Health Care Corporation and others, et al." The complaint seeks damages in excess of $62 million from the Company and other defendants based on allegations that the Company breached its management agreement with OmniCare Health Plan in Michigan ("OmniCare-MI") and that the Company's actions as the management company of OmniCare-MI resulted in such alleged damages. The Company filed an answer and affirmative defenses and a motion for partial summary disposition seeking dismissal of numerous counts; and the defendants filed a joint motion for change of venue and for partial summary disposition seeking dismissal of numerous counts. The trial judge denied the change-of-venue motion but ordered a stay of the case pending appeal of that decision to the Michigan Court of Appeals. On March 29, 2007, the Michigan Court of Appeals reversed the trial court's order that had denied the motion for change of venue. The Court of Appeals ruled in favor of the defendants, ordering the transfer of the case from the Ingham County Circuit Court to the Wayne County Circuit Court in Detroit, Michigan. After such transfer, the new trial judge dismissed some defendants from the case in May 2008. The plaintiff filed a Third Amended Complaint on August 15, 2008, detailing certain previously-pleaded allegations against the remaining defendants, including the Company. Active discovery is ongoing, and the Company continues to vigorously defend the lawsuit.

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

None.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON STOCK AND RELATED STOCKHOLDER MATTERS

Shares of the Company's common stock are traded on the NASDAQ Capital Market under the trading symbol "UAHC".

The table below sets forth for the Common Stock the range of the high and low sales prices per share on the NASDAQ Capital Market for each quarter in the past two fiscal years.

	2008 SALES PRICE		2007 SALES PRICE	
FISCAL QUARTER	HIGH	LOW	HIGH	LOW
First	$4.72	$3.42	$6.61	$2.77
Second	$4.19	$2.53	$9.50	$5.80
Third	$2.82	$2.01	$8.53	$4.65
Fourth	$3.14	$1.36	$5.30	$3.70

As of August 27, 2008, the closing price of the Common Stock was $1.68 per share and there were approximately 99 shareholders of record of the Company.

The Company has not paid any cash dividends on its Common Stock since its initial public offering in fiscal 1991 and does not anticipate paying such dividends in the foreseeable future. The Company intends to retain earnings for use in the operation and expansion of its business.

ITEM 6. SELECTED FINANCIAL DATA

The following table shows consolidated financial data for fiscal years indicated:

	2008	2007	2006	2005	2004
	(in thousands, except per share data)				
Operating Data (Year ended June 30):					
Operating revenues	$28,208	$18,065	$18,114	$22,079	$22,084
Earnings (loss) from continuing operations	(4,042)	(1,117)	1,373	5,474	7,871
Loss from discontinued operation, net of income taxes	--	--	--	(129)	(700)

Net earnings (loss)	(4,042)	(1,117)	1,373	5,345	7,171
Earnings (loss) per common share from continuing operations - basic	$ (0.47)	$ (0.14)	$ 0.18	$ 0.74	$ 1.09
Net earnings (loss) per common share - basic	$ (0.47)	$ (0.14)	$ 0.18	$ 0.72	$ 0.99
Net earnings (loss) per common share - diluted	$ (0.47)	$ (0.14)	$ 0.18	$ 0.69	$ 0.99
Weighted average common shares outstanding - diluted	8,666	8,103	7,628	7,674	7,266
Balance Sheet Data (June 30):					
Cash and investments	$19,487	$14,228	$ 6,921	$13,573	$ 8,767
Goodwill	--	3,452	3,452	3,452	3,452
Total assets	30,797	33,768	25,226	24,235	20,081
Medical claims and benefits payable	2,563	576	156	172	406
Debt	--	--	--	--	847
Shareholders' equity	24,339	27,641	22,050	20,483	14,885

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

OVERVIEW

This Financial Review discusses the Company's results of operations, financial position and liquidity. This discussion should be read in conjunction with the consolidated financial statements and related notes thereto contained elsewhere in this annual report.

This discussion and the information elsewhere in this 10-K annual report contain forward-looking statements within the meaning of the Private Securities Litigation Reform Act that are subject to the safe harbor provisions created by that Act. Forward-looking statements can be identified by the use of terms such as "expects," "could," "may," "believes," "anticipates," "will" and other future tense and forward-looking terminology. Such forward-looking statements are based on management's current expectations and involve known and unknown risks, uncertainties and other factors, many of which the Company is unable to predict or control that may cause the actual results, performance or achievements of the Company to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements.

The Company provides comprehensive management and consulting services to UAHC Health Plan of Tennessee, Inc. ("UAHC-TN"), a managed care organization ("MCO") which is a wholly owned second-tier subsidiary of United American Healthcare Corporation. Since November 1993, UAHC-TN has had a contract with the State of Tennessee for the State's "TennCare" program, to arrange for the financing and delivery of health care services on a capitated basis to eligible Medicaid beneficiaries and non-Medicaid individuals who lack access to private or employer sponsored health insurance or to another government health plan. As of June 30, 2008, UAHC-TN's total TennCare enrollment was 98,976 members, compared to 101,940 at June 30, 2007.

On April 22, 2008 we learned that UAHC-TN will cease providing managed care services as a TennCare contractor when its present TennCare contract expires. Revenue under this contract will be earned through October 31, 2008 as UAHC-TN's TennCare members are expected to transfer to other managed care organizations on November 1, 2008, after which UAHC-TN will perform its remaining contractual obligations through its TennCare contract expiration date of June 30, 2009. Revenue under this contract represented 57.6% and 88.8% of the Company's total

revenues for the fiscal year ended June 30, 2008 and 2007, respectively. Total costs related to this contract discontinuance are estimated to range between $4.6 - $6.6 million, which includes claim processing costs, employee severance, lease termination costs and other corporate general administrative expenses beginning November 2008 through June 2009.

On October 10, 2006, UAHC-TN entered into a contract with the Centers for Medicare & Medicaid Services (CMS) to act as a Medicare Advantage qualified organization. The contract authorizes UAHC-TN to serve members enrolled in both the Tennessee Medicaid and Medicare programs, commonly referred to as "dual-eligibles," specifically to offer a Special Needs Plan

("SNP") to its eligible members in Shelby County, Tennessee (including the City of Memphis), and to operate a Voluntary Medicare Prescription Drug Plan, both beginning January 1, 2007. The contract term is through December 31, 2008, after which the contract may be renewed for successive one-year periods in accordance with its terms.

REVIEW OF CONSOLIDATED RESULTS OF OPERATIONS - 2008 COMPARED TO 2007

UAHC-TN DEVELOPMENTS

UAHC-TN's results of operations for fiscal 2008 and 2007 are best understood in the context of certain earlier events involving several of TennCare's major contracted MCOs, which ceased doing business in fiscal 2002. Beginning in February, March and April 2002, UAHC-TN unexpectedly noticed increases in its claims payments, investigated, and found that approximately 9,500 new members added in September-December 2001 represented children with special needs with medical costs over 100% of the premiums received, and that many members transferred to UAHC-TN from failed MCOs also had medical costs in excess of UAHC-TN's premiums received. Beginning in April 2002, UAHC-TN wrote to TennCare seeking risk adjustments and reimbursements to compensate UAHC-TN for such medical expenses, including for actuarially estimated claims incurred but not yet reported to UAHC-TN.

TennCare responded to its MCOs' situation generally and in some instances individually. For all its contracted MCOs generally, TennCare changed its reimbursement system to an administrative services only ("ASO") program for an 18-month stabilization period (July 1, 2002 through December 31, 2003), during which the MCOs - including UAHC-TN - had no medical cost risk (i.e., no risk for medical losses), earned fixed administrative fees and were subject to increased oversight. Through successive contractual amendments, TennCare extended the ASO reimbursement system applicable to UAHC-TN, first through June 30, 2004, then through December 31, 2004, and then through June 30, 2005.

Through an amendment with an effective date of July 1, 2005, TennCare implemented a modified risk arrangement with all its contracted MCOs, including UAHC-TN, under which they became at risk for losing up to 10% of administrative fee revenue and could receive up to 15% incentive bonus revenue based on performance relative to benchmarks.

Under two escrow agreements between the Company and TennCare, on August 5, 2005 the Company funded two escrow accounts held by TennCare at the State Treasury. Both escrow agreements recited that TennCare did not at that time assert there had been any breach of UAHC TN's TennCare contract and that the Company funded the escrow accounts as a show of goodwill and good faith in working with TennCare.

The larger escrow account, which has expired, was in the original amount of $2,300,000 and was security for repayment to TennCare of any overpayments to UAHC-TN that might be determined by a state regulatory audit of all UAHC-TN processed claims. UAHC-TN was notified in late fiscal 2007 that UAHC-TN may have incorrectly received an overpayment of $1.1 million for medical claims as a result of a discrepancy in the pricing methodology. In August 2007, the Company received $1,289,851 plus accumulated interest earnings back from the $2,300,000

escrow account. In November 2007, the remaining $1,010,149 account balance was paid to TennCare for claims discrepancies found in the audit by the Tennessee Department of Commerce and Insurance.

The other escrow account, in the original amount of $420,500, is security for any money damages that may be awarded to TennCare in the event of any future litigation between the parties in connection with certain pending investigations by state and federal authorities. The escrow account will terminate 30 days after the conclusion of such investigations, unless the parties earlier agree otherwise. The escrow account bears interest at a rate no lower than the prevailing commercial interest rate for savings accounts at financial institutions in Nashville, Tennessee. All amounts (including interest earnings) credited to the escrow account will belong to the Company, except to the extent, if any, they are paid to TennCare to satisfy amounts determined to be owed to TennCare as provided in the escrow agreement.

In addition, based on a subsequent regulatory evaluation conducted by the Tennessee Department of Commerce and Insurance, it was determined that TennCare overpaid UAHC-TN $0.4 million in excess of UAHC-TN's statutory net worth requirement as of June 30, 2002, based on a 2002 contractual agreement. The Company recorded a reserve in fiscal 2007 and subsequently paid this amount in fiscal 2008. These items have been reflected as "Provision for claims audit and other commitment" on our Consolidated Statements of Operations.

SPECIFIC COMPARISONS OF 2008 TO 2007

Total revenues increased $10.1 million (56%) to $28.2 million for the fiscal year ended June 30, 2008 compared to $18.1 million for the fiscal year ended June 30, 2007. The increase in medical premiums revenues associated with UAHC-TN's Medicare Advantage SNP product ("MA SNP") as well as an increase in modified risk revenue were offset by a decrease in fixed administrative fees.

MA-SNP medical premiums revenues were $10.6 million for the fiscal year ended June 30, 2008 compared to $0.9 million for the fiscal year ended June 30, 2007, under UAHC-TN's contract with CMS that began January 1, 2007. The increase in medical premiums is a result of increased membership.

The net MA-SNP per member per month ("PMPM") premium rate, based on an average membership of 767 for the one year ended June 30, 2008, was $1,228 for that one-year period.

Fixed administrative fees related to the MRA program were $14.5 million for the fiscal year ended June 30, 2008, a decrease of $1.0 million (7%) from fixed administrative fees of $15.5 million for the fiscal year ended June 30, 2007. The decrease in fixed administrative fees is principally due to a decrease in members.

Variable administrative fees resulting from the MRA were $1.7 million for the

fiscal year ended June 30, 2008 compared to $0.5 million for the fiscal year ended June 30, 2007. Of the $1.7 million MRA revenue recorded in fiscal year 2008, $0.3 million MRA revenue received relates to the third quarter of fiscal 2006 and $1.4 million MRA revenue received relates to fiscal year 2007. The $0.5 million MRA revenue received in fiscal 2007 relates to the fourth quarter of fiscal 2006. Under the MRA, UAHC-TN is at risk to lose up to 10% of administrative fee

revenue and potentially could receive up to 15% incentive bonus revenue based on performance relative to benchmarks (through June 30, 2007). The Company's accounting policy is to recognize MRA revenues upon notification by TennCare that the revenue has been earned. Effective July 1, 2007, the evaluation period for the MRA was changed from quarterly to annually, and the incentive bonus pool was adjusted to 20% of administrative fee revenue.

Total expenses were $30.1 million for the fiscal year ended June 30, 2008, compared to $19.1 million for the prior fiscal year, an increase of $11.0 million (57%). The increase is principally due to a goodwill impairment charge of $3.5 million and medical expenses related to our MA-SNP, which was launched in January 2007. See Note 2 to our Consolidated Financial Statements in Item 15 below.

Medical expenses for MA-SNP (beginning January 1, 2007) were $9.6 million during the fiscal year ended June 30, 2008, an increase of $8.7 million from $0.9 million during the fiscal year ended June 30, 2007. Medical expenses generally consist of claim payments, pharmacy costs, and estimates of future payments of claims provided for services rendered prior to the end of the reporting period (such estimates of medical claims incurred but not reported are also known as "IBNR"). The IBNR was primarily based on medical cost estimates from historical data provided by CMS and emerging medical claims experience together with current factors using accepted actuarial methods. As UAHC-TN gains more claims experience for its Medicare Advantage members, less reliance will be placed on medical cost estimates based on historical data provided by CMS. The percentage of such medical expenses to medical premiums revenues for MA-SNP -- the medical loss ratio ("MLR") -- was 87.8% for the fiscal year ended June 30, 2008.

General and administrative expenses were $16.9 million for the fiscal year ended June 30, 2008, as compared with $16.6 million for the prior fiscal year, an increase of $0.3 million. The increase is principally due to marketing costs associated with the launch of our MA-SNP.

Depreciation and amortization expense increased $0.1 million to $0.2 million for the fiscal year ended June 30, 2008 compared to $0.1 million for the fiscal year ended June 30, 2007.

Loss from operations before income taxes was $1.9 million for the fiscal year ended June 30, 2008 compared to loss from operations before income taxes of $1.1 million for the fiscal year ended June 30, 2007. Such increase in loss from operations of $0.8 million, or $0.10 per basic share, is principally due to a goodwill impairment charge of $3.5 million and medical expenses related to our MA-SNP, which was launched in January 2007.

Income tax expense was $2.1 million for the fiscal year ended June 30, 2008 compared to $0.1 million for the prior fiscal year. The Company's effective tax rate for the fiscal year ended June 30, 2008 differs from the statutory rate of 34%. This difference was primarily related to the change in the valuation allowance and an impairment charge against goodwill, which is not deductible for

tax purposes. As a result of the pending expiration of the TennCare contract, the Company increased its deferred tax asset valuation allowance due to uncertainties in its expected utilization.

Net loss was $4.0 million, or $(0.47) per basic share, for the fiscal year ended June 30, 2008, compared to net loss of $1.1 million, or $(0.14) per basic share, for the fiscal year ended June 30, 2007, an increase in the net loss of $2.9 million (262%). The increased net loss is principally due to the goodwill impairment charge of $3.5 million recorded in the third quarter of fiscal 2008 and deferred tax expense resulting from the pending expiration of the TennCare contract as further discussed in Note 12 to our Consolidated Financial Statements in Item 15 below. The decrease was offset by the increase in the variable administrative fees and Medicare premiums related to our MA SNP. Excluding the goodwill impairment charge and the increase of the deferred tax asset valuation allowance, net income would have been $1.4 million for fiscal year ended June 30, 2008.

REVIEW OF CONSOLIDATED RESULTS OF OPERATIONS - 2007 TO 2006

Total revenues were unchanged at $18.1 million for the fiscal year ended June 30, 2007 compared to $18.1 million for the fiscal year ended June 30, 2006. The increase in medical premiums revenues associated with UAHC-TN's Medicare Advantage SNP product ("MA SNP") as well as an increase in modified risk revenue were offset by a decrease in fixed administrative fees.

MA-SNP medical premiums revenues were $0.9 million for the fiscal year ended June 30, 2007, under UAHC-TN's contract with CMS that began January 1, 2007. There were no TennCare medical premiums revenues for the fiscal years ended June 30, 2007 and 2006.

The net MA-SNP per member per month ("PMPM") premium rate, based on an average membership of 155 for the six months ended June 30, 2007, was $979 for that six-month period.

Fixed administrative fees related to the MRA program were $15.5 million for the fiscal year ended June 30, 2007, a decrease of $1.1 million (6%) from fixed administrative fees of $16.6 million for the fiscal year ended June 30, 2006. The decrease in fixed administrative fees is principally due to a decrease in members.

Variable administrative fees resulting from MRA were $0.5 million for the fiscal year ended June 30, 2007 compared to $0.4 million for the fiscal year ended June 30, 2006. The $0.5 million MRA revenue received in fiscal 2007 relates to the fourth quarter of fiscal 2006. UAHC-TN received notice from TennCare that it earned additional MRA revenue of $0.2 million, $0.2 million, and $0.5 million, respectively, for its performance for the first, second and fourth quarters of fiscal 2006.

Total expenses were $19.1 million for the fiscal year ended June 30, 2007, compared to $16.6 million for the prior fiscal year, an increase of $2.5 million (15%). The increase is principally due to a reserve against the restricted assets related to the claims audit escrow account and marketing costs associated with the launch of our MA-SNP. See discussion of the claims audit escrow below under "Liquidity and Capital Resources below."

Medical expenses for MA-SNP (beginning January 1, 2007) were $0.9 million during the fiscal year ended June 30, 2007. Medical expenses generally consist of claim

payments, pharmacy

costs, and estimates of future payments of claims provided for services rendered prior to the end of the reporting period (such estimates of medical claims incurred but not reported are also known as "IBNR"). The IBNR was primarily based on medical cost estimates from historical data provided by CMS and emerging medical claims experience together with current factors using accepted actuarial methods. As UAHC-TN gains more claims experience for its Medicare Advantage members, less reliance will be placed on medical cost estimates based on historical data provided by CMS. The percentage of such medical expenses to medical premiums revenues for MA-SNP -- the medical loss ratio ("MLR") -- was 90% for the fiscal year ended June 30, 2007.

General and administrative expenses were $16.6 million for the fiscal year ended June 30, 2007, as compared with $16.5 million for the prior fiscal year, an increase of $0.1 million. The increase is principally due to marketing costs associated with the launch of our MA-SNP.

Depreciation and amortization expense remained constant at $0.1 million for the fiscal years ended June 30, 2007 and June 30, 2006.

Loss from operations before income taxes was $1.1 million for the fiscal year ended June 30, 2007 compared to earnings from operations before income taxes of $1.5 million for the fiscal year ended June 30, 2006. Such decrease in earnings from operations of $2.6 million, or $0.32 per basic share, is principally due to a provision for claims audit and other commitment, a decrease in administrative fee revenue and an increase in general and administrative expenses related to the launch of our MA-SNP.

Income tax expense was $0.1 million for the fiscal year ended June 30, 2007 compared to $0.1 million for the prior fiscal year. The Company's effective tax rate for the fiscal year ended June 30, 2007 differs from the statutory rate of 34%. This difference is the result of various book-tax differences that result in taxable income that differs from the book loss.

Net loss was $1.1 million, or $(0.14) per basic share, for the fiscal year ended June 30, 2007, compared to net earnings of $1.4 million, or $0.18 per basic share, for the fiscal year ended June 30, 2006, a decrease of $2.4 million (181%). Such decrease in net earnings is principally due to a provision for claims audit and other commitment, a decrease in administrative fee revenue and an increase in general and administrative expenses as discussed above.

LIQUIDITY AND CAPITAL RESOURCES

At June 30, 2008, the Company had (i) cash and cash equivalents and short-term marketable securities of $19.5 million, compared to $14.2 million at June 30, 2007; (ii) working capital of $15.3 million, compared to working capital of $13.1 million at June 30, 2007; and (iii) a current assets-to-current liabilities ratio of 3.38 to 1, compared to 3.13 to 1 at June 30, 2007.

Net cash from operating activities was $5.5 million in fiscal 2008 compared to net cash from operating activities of $1.5 million in fiscal 2007. Investing activities in fiscal 2008 included the

purchase of $13.5 million of marketable securities and sales of $17.0 million of marketable securities.

Cash flow was $1.8 million for the fiscal year ended June 30, 2008, compared to $4.6 million for the prior fiscal year.

Cash and marketable securities increased by $5.3 million at June 30, 2008 compared to June 30, 2007 primarily due to the purchase of marketable securities.

Accounts receivable decreased by $0.4 million at June 30, 2008 compared to June 30, 2007, primarily due to timing of TennCare payments.

Property, plant and equipment increased by $0.1 million at June 30, 2008 compared to June 30, 2007, due to equipment purchases of $0.3 million offset by depreciation.

Medical claims payable increased by $2.0 million at June 30, 2008 compared to June 30, 2007, which is directly related to MA-SNP plan activity that began January 1, 2007.

Accounts payable decreased by $1.4 million at June 30, 2008 compared to June 30, 2007, principally due the payment of the claims audit and other commitments recorded in fiscal year 2007

The Company's wholly owned subsidiary, UAHC-TN, had a required minimum net worth requirement using statutory accounting practices of $7.2 million at June 30, 2008. UAHC-TN had excess statutory net worth of approximately $7.6 million at June 30, 2008. The net worth and depository requirement will be in effect through the contract termination date of June 30, 2009, or sooner, if so approved by the Tennessee Department of Commerce and Insurance. At such time, UAHC-TN, must continue to maintain net worth requirements of at least $1.5 million as statutory reserves for its ongoing Medicare operations.

UAHC-TN's application for a commercial HMO license was approved on September 7, 2001. However, management is not yet actively pursuing that commercial business.

Beginning July 1, 2002, TennCare implemented an 18-month stabilization program, which entailed changes to TennCare's contracts with MCOs, including UAHC-TN. During that period, MCOs were generally compensated for administrative services only (commonly called "ASO"), earned fixed administrative fees, were not at risk for medical costs in excess of targets established based on various factors, were subject to increased oversight, and could incur financial penalties for not achieving certain performance requirements. Through successive contractual amendments, TennCare extended the ASO reimbursement system applicable to UAHC-TN, first through June 30, 2004, then through December 31, 2004, and then through June 30, 2005.

Through an amendment with an effective date of July 1, 2005, TennCare implemented a modified risk arrangement with all its contracted MCOs, including UAHC-TN, under which they became at risk for losing up to 10% of administrative fee revenue and could receive up to 15% incentive bonus revenue based on performance relative to benchmarks.

Under two escrow agreements between the Company and TennCare, on August 5, 2005 the Company funded two escrow accounts held by TennCare at the State Treasury. Both escrow agreements recited that TennCare did not at that time assert there had been any breach of

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UAHC TN's TennCare contract and that the Company funded the escrow accounts as a show of goodwill and good faith in working with TennCare.

The larger escrow account, which has expired, was in the original amount of $2,300,000 and was security for repayment to TennCare of any overpayments to UAHC-TN that might be determined by a state regulatory audit of all UAHC-TN processed claims. UAHC-TN was notified in late fiscal 2007 that UAHC-TN may have incorrectly received an overpayment of $1.1 million for medical claims as a result of a discrepancy in the pricing methodology. In August 2007, the Company received $1,289,851 plus accumulated interest earnings back from the $2,300,000 escrow account. In November 2007, the remaining $1,010,149 account balance was paid to TennCare for claims discrepancies found in the audit by the Tennessee Department of Commerce and Insurance.

The other escrow account, in the original amount of $420,500, is security for any money damages that may be awarded to TennCare in the event of any future litigation between the parties in connection with certain pending investigations by state and federal authorities. The escrow account will terminate 30 days after the conclusion of such investigations, unless the parties earlier agree otherwise. The escrow account bears interest at a rate no lower than the prevailing commercial interest rate for savings accounts at financial institutions in Nashville, Tennessee. All amounts (including interest earnings) credited to the escrow account will belong to the Company, except to the extent, if any, they are paid to TennCare to satisfy amounts determined to be owed to TennCare as provided in the escrow agreement.

On April 22, 2008 we learned that UAHC-TN will cease providing managed care services as a TennCare contractor when its present TennCare contract expires. UAHC-TN's TennCare members are expected to transfer to other managed care organizations on November 1, 2008, after which UAHC-TN will perform its remaining contractual obligations through its TennCare contract expiration date of June 30, 2009. Revenue under this contract represented 60.5% and 93.9% of the Company's total revenues for the fiscal year ended June 30, 2008 and 2007, respectively. Management believes that the discontinuance of the TennCare contract will have a material impact on the Company's operations.

In a December 13, 2006 private placement transaction, the Company raised gross proceeds of $6.50 million through the sale of 1,000,000 newly issued shares of its common stock to certain institutional and other accredited investors at a price of $6.50 per share. The investors also received warrants to purchase 99,999 shares of the Company's common stock at an exercise price of $8.50 per share and expiring in December 2011. In addition, the Company agreed to pay the co-placement agents a transaction fee of $325,000 and warrants to purchase 50,000 shares of the Company's common stock at an exercise price of $9.01 per share. The uses of the net proceeds from the private placement have been principally for start-up costs associated with the Company's Tennessee subsidiary's new Medicare Advantage contract with the Centers for Medicare & Medicaid Services, which became effective January 1, 2007. The remainder was to be used for working capital and general corporate purposes.

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The Company's ability to generate adequate amounts of cash to meet its future cash needs depends on a number of factors, particularly including its ability to control administrative costs related to the modified risk arrangement for the

TennCare program that began July 1, 2005, and controlling corporate overhead costs. On the basis of the matters discussed above, management believes at this time that the Company has the ability to generate sufficient cash to adequately support its financial requirements through the next twelve months, and maintain minimum statutory net worth requirements of UAHC-TN. Total costs related to this contract discontinuance are estimated to range between $4.6 - $6.6 million, which includes claim processing costs, employee severance, lease termination costs and other corporate general administrative expenses beginning November 2008 through June 2009.

RECENTLY ENACTED PRONOUNCEMENTS

The following are new accounting standards and interpretations that may be applicable in the future to the Company:

In September 2006, the FASB issued Statement of Financial Accounting Standards No. 157, "Fair Value Measurements" ("FASB 157"). FASB 157 enhances existing guidance for measuring assets and liabilities using fair value. Prior to the issuance of FASB 157, guidance for applying fair value was incorporated in several accounting pronouncements. FASB 157 provides a single definition of fair value, together with a framework for measuring it, and requires additional disclosure about the use of fair value to measure assets and liabilities. FASB 157 also emphasizes that fair value is a market-based measurement, not an entity-specific measurement, and sets out a fair value hierarchy with the highest priority being quoted prices in active markets. Under FASB 157, fair value measurements are disclosed by level within that hierarchy. While FASB 157 does not add any new fair value measurements, it does change what had been current practice. Such changes include: (1) a requirement for an entity to include its own credit standing in the measurement of its liabilities; (2) a modification of the transaction price presumption; (3) a prohibition on the use of block discounts when valuing large blocks of securities for broker-dealers and investment companies; and (4) a requirement to adjust the value of restricted stock for the effect of the restriction even if the restriction lapses within one year. FASB 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years. The Company has not determined the impact of adopting FASB 157 on its financial statements.

In February 2007, the FASB issued Statement of Financial Accounting Standards No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities" ("FASB 159"). This statement permits entities to choose to measure many financial instruments and certain other items at fair value. An entity shall report unrealized gains and losses on items for which the fair value option has been elected in earnings at each subsequent reporting date. FASB 159 is effective as of the beginning of an entity's first fiscal year that begins after November 15, 2007. Early adoption is permitted as of the beginning of a fiscal year that begins on or before November 15, 2007, provided that the entity also elects to apply the provisions of FASB 157. The Company is continuing to evaluate the impact of this statement.

In December 2007, the FASB issued SFAS No. 141(R), Business Combinations, and SFAS No. 160, Noncontrolling Interests in Consolidated Financial Statements. SFAS No. 141(R) requires an acquirer to measure the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquiree at their fair values on the acquisition date, with goodwill being the excess value over the net identifiable assets acquired. SFAS No. 160 clarifies that a noncontrolling interest in a subsidiary should be reported as equity in

the consolidated financial statements. The calculation of earnings per share will continue to be based on income amounts attributable to the parent. SFAS No. 141(R) and SFAS No. 160 are effective for financial statements issued for fiscal years beginning after December 15, 2008. Early adoption is prohibited. The Company has not yet determined the effect on our consolidated financial statements, if any, upon adoption of SFAS No. 141(R) or SFAS No. 160.

In December 2007, the FASB issued SFAS No. 160, Noncontrolling Interests in Consolidated Financial Statements - an Amendment of ARB No. 51 ("SFAS 160"), which establishes accounting and reporting standards for the noncontrolling interest in a subsidiary and for the deconsolidation of a subsidiary. SFAS No. 160 clarifies that a noncontrolling interest in a subsidiary is an ownership interest in the consolidated entity that should be reported as equity in the consolidated financial statements. SFAS No. 160 also requires consolidated net income to be reported at amounts that include the amounts attributable to both the parent and the noncontrolling interest. It also requires disclosure, on the face of the consolidated statement of income, of the amounts of consolidated net income attributable to the parent and to the noncontrolling interest. SFAS No. 160 also provides guidance when a subsidiary is deconsolidated and requires expanded disclosures in the consolidated financial statements that clearly identify and distinguish between the interests of the parent's owners and the interests of the noncontrolling owners of a subsidiary. SFAS 160 is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. The Company is currently evaluating the impact this statement will have on its financial position and results of operations.

In February 2008, the FASB issued FASB Staff Position No. 157-2, Effective Date of FASB Statement No. 157 ("FSP 157-2"), which delays the effective date of SFAS 157 for nonfinancial assets and nonfinancial liabilities. Therefore, the Company has delayed application of SFAS 157 to its nonfinancial assets and nonfinancial liabilities, which include assets and liabilities acquired in connection with a business combination, goodwill, intangible assets and asset retirement obligations, until January 1, 2009. The Company is currently evaluating the impact of SFAS 157 for nonfinancial assets and liabilities on the Company's financial position and results of operations.

In March 2008, the FASB issued SFAS No. 161, Disclosures about Derivative Instruments and Hedging Activities ("SFAS 161"), which amends and expands the disclosure requirements of FASB Statement No. 133, Accounting for Derivative Instruments and Hedging Activities ("SFAS 133"), with the intent to provide users of financial statements with an enhanced understanding of: (a) how and why an entity uses derivative instruments; (b) how derivative instruments and related hedged items are accounted for under SFAS No. 133 and its related

interpretations; and (c) how derivative instruments and related hedged items affect an entity's financial position, financial performance and cash flows. SFAS 161 requires qualitative disclosures about objectives and strategies for using derivatives, quantitative disclosures about fair value amounts of and gains and losses on derivative instruments and disclosures about credit-risk-related contingent features in derivative instruments. This statement applies to all entities and all derivative instruments. SFAS 161 is effective for financial statements issued for fiscal years and interim periods beginning after November 15, 2008. The Company has not yet determined the effect on our financial statements, if any, upon adoption of SFAS No. 161.

In May, 2008, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standard ("SFAS") No. 162, "The Hierarchy of Generally

Accepted Accounting Principles," ("SFAS No. 162"). SFAS No. 162 identifies the sources of accounting principles and the framework for selecting the principles used in the preparation of financial statements of nongovernmental entities that are presented in conformity with generally accepted accounting principles (GAAP) in the United States (the GAAP hierarchy). SFAS No. 162 will be effective 60 days following the SEC's approval of the Public Company Accounting Oversight Board's amendments to AU Section 411, "The Meaning of Present Fairly in Conformity With Generally Accepted Accounting Principles." The FASB has stated that it does not expect SFAS No. 162 will result in a change in current practice. The application of SFAS No. 162 will have no effect on the Company's financial position, results of operations or cash flows.

Also in May 2008, the FASB issued SFAS No. 163, "Accounting for Financial Guarantee Insurance Contracts--an interpretation of FASB Statement No. 60" ("SFAS 163"). SFAS 163 interprets Statement 60 and amends existing accounting pronouncements to clarify their application to the financial guarantee insurance contracts included within the scope of that Statement. SFAS 163 is effective for financial statements issued for fiscal years beginning after December 15, 2008, and all interim periods within those fiscal years. As such, the Company is required to adopt these provisions at the beginning of the fiscal year ended December 31, 2009. The Company is currently evaluating the impact of SFAS 163 on its financial statements but does not expect it to have an effect on the Company's financial position, results of operations or cash flows.

In May 2008, FASB issued FSP APB 14-1, Accounting for Convertible Debt Instruments that may be Settled in Cash upon Conversion (Including Partial Cash Settlement) ("FSP APB 14-1"). FSP APB 14-1 applies to convertible debt securities that, upon conversion, may be settled by the issuer fully or partially in cash. FSP APB 14-1 specifies that issuers of such instruments should separately account for the liability and equity components in a manner that will reflect the entity's nonconvertible debt borrowing rate when interest cost is recognized in subsequent periods. FSP APB 14-1 is effective for financial statements issued for fiscal years after December 15, 2008, and must be applied on a retrospective basis. Early adoption is not permitted. We are assessing the potential impact of this FSP on our convertible debt issuances.

In June 2008, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position ("FSP") EITF 03-6-1, Determining Whether Instruments Granted in Share-Based Payment Transactions Are Participating Securities ("FSP EITF 03-6-1"). FSP EITF 03-6-1 addresses

whether instruments granted in share-based payment transactions are participating securities prior to vesting, and therefore need to be included in the earnings allocation in computing earnings per share under the two-class method as described in SFAS No. 128, Earnings per Share. Under the guidance of FSP EITF 03-6-1, unvested share-based payment awards that contain nonforfeitable rights to dividends or dividend equivalents (whether paid or unpaid) are participating securities and shall be included in the computation of earnings-per-share pursuant to the two-class method. FSP EITF 03-6-1 is effective for financial statements issued for fiscal years beginning after December 15, 2008 and all prior-period earnings per share data presented shall be adjusted retrospectively. Early application is not permitted. We are assessing the potential impact of this FSP on our earnings per share calculation.

In June 2008, FASB ratified EITF No. 07-5, Determining Whether an Instrument (or an Embedded Feature) is Indexed to an Entity's Own Stock ("EITF 07-5"). EITF

07-5 provides that an entity should use a two-step approach to evaluate whether an equity-linked financial instrument (or embedded feature) is indexed to its own stock, including evaluating the instrument's contingent exercise and settlement provisions. EITF 07-5 is effective for financial statements issued for fiscal years beginning after December 15, 2008. Early application is not permitted. We are assessing the potential impact of this EITF on our financial condition and results of operations.

ITEM 8. CONSOLIDATED FINANCIAL STATEMENTS

Presented beginning at page F-1 of this Form 10-K.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

Under the supervision and with the participation of the Company's management, including our Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of the design and operation of our disclosure controls and procedures as defined in rule 13a-15 and 15d-15 under the Exchange Act within 90 days of the filing date of this Report. Based on their evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that these controls and procedures are effective as of June 30, 2008.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

There were no significant changes in the Company's internal controls over financial reporting during the three months ended June 30, 2008 that have materially affected, or are reasonably likely to materially effect, our internal controls over financial reporting.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15 (f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company's internal control over financial reporting as of June 30, 2008. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in Internal Control-Integrated Framework. Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of June 30, 2008 based on those criteria.

This Annual Report on Form 10-K does not include an attestation report of the Company's independent registered public accounting firm regarding internal control over financial reporting. Management's report was not subject to attestation by the Company's independent registered public accounting firm pursuant to rules of the Securities and Exchange Commission that permit the Company to provide only management's report in this Annual Report on Form 10-K.

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

Incorporated herein by reference to United American Healthcare Corporation definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the fiscal year covered by this Form 10-K with respect to its Annual Meeting of Shareholders to be held on November 7, 2008.

ITEM 11. EXECUTIVE COMPENSATION

Incorporated herein by reference to United American Healthcare Corporation definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the fiscal year covered by this Form 10-K with respect to its Annual Meeting of Shareholders to be held on November 7, 2008.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

Incorporated herein by reference to United American Healthcare Corporation definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the fiscal year covered by this Form 10-K with respect to its Annual Meeting of Shareholders to be held on November 7, 2008.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

Incorporated herein by reference to United American Healthcare Corporation definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the fiscal year covered by this Form 10-K with respect to its Annual Meeting of Shareholders to be held on November 7, 2008.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Incorporated herein by reference to United American Healthcare Corporation definitive proxy statement to be filed with the Securities and Exchange Commission within 120 days after the fiscal year covered by this Form 10-K with respect to its Annual Meeting of Shareholders to be held on November 7, 2008 is the information set forth in such proxy statement under the headings "Audit Fees" and "Audit Committee's Pre-Approval Policies and Procedures."

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES AND REPORTS ON FORM 8-K

a) (1) & (2) The financial statements listed in the accompanying Index to Consolidated Financial Statements at page F-1 are filed as part of this Form 10-K report.

(3) The Exhibit Index lists the exhibits required by Item 601 of Regulation S-K to be filed as a part of this Form 10-K report. The Exhibit Index identifies those documents which are exhibits filed herewith or incorporated by reference to (i) the Company's Form S-1 Registration Statement under the Securities Act of 1933, as amended, declared effective on April 23, 1991 (Commission File No. 33-36760); (ii) the Company's Form 10-K reports for its fiscal years ended June 30, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2001, and 2002; (iii) the Company's 10-K/A report filed October 14, 1996; (iv) the Company's Form 10-Q reports for its quarters ended March 31, 1996, September 30, 1996, December 31, 1996, March 31, 1997, March 31, 1998, December 31, 1998, December 31, 2001, September 30, 2002, December 31, 2002, March 31, 2005 and January 25, 2007; (v) the Company's Form 8-K reports filed with the Commission August 8, 1991, April 23, 1993, May 24, 1993, January 29, 1996, April 19, 1996, October 30, 1997, January 20, 1998, January 14, 2000, March 5, 2003, April 15, 2003, November 22, 2004, January 11, 2005, February 7, 2005, April 21, 2005, April 28, 2005, October 16, 2006 and December 15, 2006; or (vi) the Company's Form 8-K/A reports filed with the Commission July 21, 1993, November 12, 1997, March 10, 2003, and April 22, 2005. The Exhibit Index is hereby incorporated by reference into this Item 15.

Reports on Form 8-K

1) The Company filed a Current Report on Form 8-K on March 25, 2008 reporting that the State of Tennessee, Bureau of TennCare issued a Request for Proposals for managed care services to be provided in the East Grand Region and the West Grand Region of Tennessee.

2) The Company filed a Current Report on Form 8-K on April 22, 2008 reporting that the Department of Finance and Administration of the State of Tennessee, Bureau of TennCare publicly disclosed its decision to award new TennCare contracts to two named organizations, not including the Company's subsidiary, UAHC Health Plan of Tennessee, Inc, as the culmination of TennCare's selection process pursuant to its Request for Proposals for managed care services to be provided in the East Grand Region and the West Grand Region of Tennessee.

3) The Company filed a Current Report on Form 8-K on June 25, 2008 reporting that the Company's Board of Directors amended and restated the Company's bylaws.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

UNITED AMERICAN HEALTHCARE CORPORATION (REGISTRANT)

SIGNATURE CAPACITY

/s/ WILLIAM C. BROOKS William C. Brooks	Chairman, President and CEO (Principal Executive Officer)
/s/ STEPHEN D. HARRIS Stephen D. Harris	Executive Vice President, Chief Financial Officer, Treasurer and Director (Principal Financial Officer and Principal Accounting Officer)
/s/ EMMETT S. MOTEN, JR. Emmett S. Moten, Jr.	Secretary and Director
/s/ RICHARD M. BROWN, D.O. Richard M. Brown, D.O.	Director
/s/ DARREL W. FRANCIS Darrel W. Francis	Director
/s/ TOM A. GOSS Tom A. Goss	Director
/s/ RONALD E. HALL, SR. Ronald E. Hall, Sr.	Director
/s/ EDDIE R. MUNSON Eddie R. Munson	Director

Date: September 4, 2008

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors
United American Healthcare Corporation:

We have audited the accompanying consolidated balance sheets of United American Healthcare Corporation and Subsidiaries as of June 30, 2008 and 2007, and the related consolidated statements of operations, shareholders' equity and comprehensive income (loss), and cash flows for each of the years in the three-year period ended June 30, 2008. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. Our audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of United American Healthcare Corporation and Subsidiaries as of June 30, 2008 and 2007, and the results of their operations and their cash flows for each of the years in the three-year period ended June 30, 2008, in conformity with accounting principles generally accepted in the United States of America.

/s/ UHY LLP

Southfield, Michigan
September 4, 2008

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(IN THOUSANDS, EXCEPT SHARE DATA)

	JUNE 30,	
	2008	2007
ASSETS		
Current assets		
Cash and cash equivalents	$10,713	$ 8,932
Marketable securities	8,774	5,296
Accounts receivable - State of Tennessee, net	1,093	1,455
Interest receivable	551	578
Other receivables	374	455
Prepaid expenses and other	299	511
Deferred income taxes	--	1,950
Total current assets	21,804	19,177
Property and equipment, net	472	357
Goodwill	--	3,452
Marketable securities	7,514	7,475
Restricted assets	421	2,721
Other assets	586	586
	$30,797	$33,768
LIABILITIES AND SHAREHOLDERS' EQUITY		
Current liabilities		
Medical claims payable	$ 2,563	$ 576
Accounts payable and accrued expenses	1,726	3,142
Accrued compensation and related benefits	896	896
Accrued rent	90	135
Unearned revenue	--	279
Other current liabilities	1,183	1,099
Total current liabilities	6,458	6,127
Total liabilities	6,458	6,127
Commitments and contingencies		
Shareholders' equity		
Preferred stock, 5,000,000 shares authorized; none issued	--	--
Common stock, no par, 15,000,000 shares authorized; 8,734,214 and 8,588,211 shares issued and outstanding at June 30, 2008 and June 30, 2007, respectively	18,558	18,327
Paid-in capital - stock options	1,153	607
Warrants	444	444
Retained earnings	4,261	8,303
Accumulated other comprehensive loss, net of deferred federal income taxes	(77)	(40)
Total shareholders' equity	24,339	27,641
	$30,797	$33,768

See accompanying notes to the consolidated financial statements.

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(IN THOUSANDS, EXCEPT PER SHARE DATA)

	YEAR ENDED JUNE 30,		
	2008	2007	2006
REVENUES			
Fixed administrative fees	$14,519	$15,543	$16,628
Variable administrative fees	1,718	502	361
Medical premiums	10,596	921	--
Interest and other income	1,375	1,099	1,125
Total revenues	28,208	18,065	18,114
EXPENSES			
Medical services	9,550	891	--
Marketing, general and administrative	16,897	16,580	16,472
Depreciation and amortization	211	122	128
Goodwill impairment	3,452	--	--
Provision for claims audit and other commitment	--	1,526	--
Total expenses	30,110	19,119	16,600
Earnings (loss) from operations before income taxes	(1,902)	(1,054)	1,514
Income tax expense	2,140	63	141
Net earnings (loss)	$(4,042)	$(1,117)	$ 1,373
NET EARNINGS (LOSS) PER COMMON SHARE - BASIC			
Net earnings (loss) per common share	$ (0.47)	$ (0.14)	$ 0.18
Weighted average shares outstanding	8,666	8,103	7,478
NET EARNINGS (LOSS) PER COMMON SHARE - DILUTED			
Net earnings (loss) per common share	$ (0.47)	$(0.14)	$ 0.18
Weighted average shares outstanding	8,666	8,103	7,628

See accompanying notes to the consolidated financial statements.

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY

AND COMPREHENSIVE INCOME (LOSS)
(IN THOUSANDS)

	COMMON STOCK		PAID IN CAPITAL - STOCK			ACCUMULATED OTHER	TO
	SHARES	AMOUNT	OPTIONS	WARRANTS	RETAINED EARNINGS	COMPREHENSIVE INCOME (LOSS)	SHARE E
BALANCE AT JUNE 30, 2005	7,450	$12,476	$ --	$ --	$ 8,047	$ (40)	$2
Issuance of common stock	77	65					
Comprehensive income:							
Net earnings					1,373		
Stock option expense			259				
Unrealized loss on marketable securities						(130)	
Total comprehensive income					1,373	(130)	
BALANCE AT JUNE 30, 2006	7,527	$12,541	$ 259	$ --	$9,420	$(170)	2
Issuance of common stock	1,061	5,786					
Comprehensive income:							
Net loss					(1,117)		(
Stock option expense			348				
Issuance of warrants				444			
Unrealized gain on marketable securities						130	
Total comprehensive loss					(1,117)	130	
BALANCE AT JUNE 30, 2007	8,588	$18,327	$ 607	$444	$ 8,303	$ (40)	$2
Issuance of common stock	146	231					
Comprehensive income:							
Net loss					(4,042)		(
Stock option expense			546				
Unrealized loss on marketable securities						(37)	
Total comprehensive loss					(4,042)	(37)	(
BALANCE AT JUNE 30, 2008	8,734	$18,558	$1,153	$444	$ 4,261	$ (77)	$2

See accompanying notes to the consolidated financial statements.

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(IN THOUSANDS)

	YEAR ENDED JUNE 30,		
	2008	2007	2006
OPERATING ACTIVITIES			
Net earnings (loss)	$ (4,042)	$(1,117)	$ 1,373
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities:			
Loss on disposal of assets	--	--	4
Goodwill impairment	3,452	--	--
Depreciation and amortization	211	122	128
Deferred income taxes	1,950	--	--
Stock awards	108	108	--
Stock compensation	546	348	259
Changes in assets and liabilities			
Accounts receivable - State of Tennessee, net	362	8	(103)
Other receivables	108	(649)	199
Prepaid expenses and other	212	(246)	(93)
Medical claims payable	1,987	420	(16)
Accounts payable and accrued expenses	(1,416)	2,222	(176)
Accrued rent	(45)	(109)	9
Unearned revenue	(279)	279	--
Restricted assets	2,300		
Accrued compensation and related benefits	--	164	21
Other current liabilities	84	(25)	(414)
Net cash provided by operating activities	5,538	1,525	1,191
INVESTING ACTIVITIES			
Purchase of marketable securities	(17,049)	(4,794)	(6,688)
Proceeds from sale of marketable securities	13,495	2,100	--
Proceeds from the sale of property and equipment	--	6	--
Purchase of property and equipment	(326)	(343)	(95)
Net cash used in investing activities	(3,880)	(3,031)	(6,783)
FINANCING ACTIVITIES			
Net proceeds from sale of common stock	--	5,721	--
Proceeds from exercise of stock options	123	141	65
Proceeds for issuance of warrants	--	260	--
Net cash provided by financing activities	123	6,122	65
Net increase (decrease) in cash and cash equivalents	1,781	4,616	(5,527)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	8,932	4,316	9,843
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 10,713	$ 8,932	$ 4,316

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS - CONTINUED
(IN THOUSANDS)

	YEAR ENDED JUNE 30,		
	2008	2007	2006
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION:			
Income taxes paid	$ 20	$ --	$ 63
NON-CASH INVESTING ACTIVITY:			
Unrealized gain (loss) on investment	$(37)	$130	$(130)
NON-CASH FINANCING ACTIVITY:			
Transaction fee paid with warrants	$ --	$184	$ --

See accompanying notes to the consolidated financial statements.

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2008, 2007 AND 2006

NOTE 1 - DESCRIPTION OF BUSINESS

United American Healthcare Corporation, together with its wholly owned subsidiaries (collectively, the "Company"), is a provider of health care services, including consulting services to managed care organizations and the provision of health care services in Tennessee.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. PRINCIPLES OF CONSOLIDATION. The consolidated financial statements include the accounts of United American Healthcare Corporation, and its wholly owned operational subsidiary: United American of Tennessee, Inc. ("UA-TN") and Subsidiary. UAHC Health Plan of Tennessee, Inc. (formerly called OmniCare Health Plan, Inc.) ("UAHC-TN") is a wholly owned subsidiary of UA-TN. All significant intercompany transactions and balances have been eliminated in consolidation.

B. USE OF ESTIMATES. The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America which require management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates as more information becomes available and any such difference could be significant. The most significant estimates that are susceptible to change in the near term relate to the determination of medical claims payable.

C. CASH AND CASH EQUIVALENTS. The Company considers all highly liquid instruments purchased with original maturities of three months or less to be cash equivalents.

D. FAIR VALUE OF FINANCIAL INSTRUMENTS. The carrying value of cash and cash equivalents, receivables, marketable securities and debt approximate fair values of these instruments at June 30, 2008 and 2007.

UNITED AMERICAN HEALTHCARE CORPORATION AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2008, 2007 AND 2006

E. MARKETABLE SECURITIES. Investments in marketable securities are primarily comprised of U.S. Treasury notes and debt issues of municipalities all carried at fair value, based upon published quotations of the underlying securities, and six-month certificates of deposit carried at cost plus interest earned, which approximates fair value. Marketable securities placed in escrow to meet statutory funding requirements, although considered available for sale, are not reasonably expected to be used in the normal operating cycle of the Company and are classified as non-current. All other securities available for sale are classified as current.

Premiums and discounts are amortized or accreted, respectively, over the life of the related debt security as adjustment to yield using the yield-to-maturity method. Interest and dividend income is recognized when earned. Realized gains and losses on investments in marketable securities are included in investment income and are derived using the specific identification method for determining the cost of the securities sold; unrealized gains and losses on marketable securities are reported as a separate component of shareholders' equity, net of the provision for deferred federal income taxes.

F. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS. Accounts receivable at June 30, 2008 and 2007 consisted primarily of State of Tennessee receivables, interest receivables and provider receivables. The Company performs an analysis of collectibility on its accounts receivables. An allowance is established for the estimated amount that may not be collectible. There was no allowance for doubtful accounts as of June 30, 2008. As of June 30, 2007, the Company had an allowance for doubtful accounts of $274,000.

G. PROPERTY AND EQUIPMENT. Property and equipment are stated at cost. Expenditures and improvements, which add significantly to the productive capacity or extend the useful life of an asset, are capitalized. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the related assets. Estimated useful lives of the major classes of property and equipment are as follows: furniture and fixtures - 5 to 13 years; equipment - 5 years; and computer software - 2 to 5 years. Leasehold improvements are included in furniture and fixtures and are amortized on a straight-line basis over the shorter of the lease term or the estimated useful life, which ranges from 5 to 13 years. The Company uses accelerated methods for income tax purposes.

H. GOODWILL. Goodwill resulting from business acquisitions was carried at cost. Effective July 1, 2001, the Company adopted Statement of Financial Accounting Standards ("SFAS") No. 142, "Goodwill and Other Intangible Assets." SFAS No. 142 eliminates the amortization of goodwill, but requires that the carrying amount of goodwill be tested for impairment at least annually at the reporting unit level, as defined, and will only be reduced if it is found to be impaired or is

associated with assets sold or otherwise disposed of. Management evaluates the carrying value of goodwill quarterly.

Management has assessed the remaining carrying amount of previously recorded goodwill of $3.5 million and determined that such amount has been impaired in accordance with SFAS No. 142 as a result of UAHC-TN's ceasing to provide managed care services in the TennCare West Grand Region of Tennessee when its present TennCare contract will expire, as further discussed in Note 12 below. Accordingly, goodwill impairment was recorded for $3.5 million during the fiscal year ended June 30, 2008. There were no goodwill impairment charges recorded during fiscal year June 30, 2007 and 2006.

I. LONG-LIVED ASSETS. Following the criteria set forth in SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets," long-lived assets and certain identifiable intangibles are reviewed by the Company for events or changes in circumstances which would indicate that the carrying value may not be recoverable. In making this determination, the Company considers a number of factors, including estimated future undiscounted cash flows associated with long-lived assets, current and historical operating and cash flow results and other economic factors. When any such impairment exists, the related assets are written down to fair value. Based upon its most recent analysis, the Company believes that long-lived assets are recorded at their net recoverable values.

J. MEDICAL CLAIMS PAYABLE. The Company provides for medical claims incurred but not reported ("IBNR") for its Medicare Advantage members and the cost of adjudicating claims primarily based on medical cost estimates from historical data provided by CMS and emerging medical claims experience together with current factors using accepted actuarial methods. As the Company gains more claims experience for our Medicare Advantage members, less reliance will be placed on medical cost estimates based on historical data provided by CMS. Although considerable variability is inherent in such estimates, management believes that these reserves are adequate.

K. REVENUE RECOGNITION. Medical premiums revenues are recognized in the month in which members are entitled to receive health care services. Medical premiums collected in advance are recorded as deferred revenues. Management fee revenues are recognized in the period the related services are performed. In accordance with generally accepted accounting principles ("GAAP"), when applicable, the Company's revenue recognition policy has been adjusted to reflect TennCare's administrative services only ("ASO") arrangement in which UAHC-TN assumed no risk for medical claims. Modified risk arrangement revenues are recognized in the period in which UAHC-TN is notified thereof by TennCare. See Note 12 for further discussion.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
JUNE 30, 2008, 2007 AND 2006

L. MEDICAL SERVICES EXPENSE RECOGNITION. The Company contracts with various health care providers for the provision of certain medical services to its members and generally compensates those providers on a capitated and fee for service basis. Such medical service expenses generally consist of claim payments, pharmacy costs, and estimates of future payments of claims provided for services rendered prior to the end of the reporting period. Pharmacy costs represent payments for members' prescription drug benefits. The estimates for medical claims payable are regularly reviewed and adjusted as necessary, with such adjustments generally reflected in current operations.

M. STOP LOSS INSURANCE. Stop loss insurance premiums are reported as medical services expense, while the related insurance recoveries are reported as deductions from medical services expense.

N. INCOME TAXES. Deferred income tax assets and liabilities are recognized for the expected future tax consequences attributable to differences between the financial statement carrying amount of existing assets and liabilities and their respective tax bases. Deferred income tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which these temporary differences are expected to be recovered or settled. The effect on deferred income tax assets and liabilities of a change in tax rates is recognized in income in the period that involves the deferred tax assets and liabilities in the amount expected to be realized. Valuation allowances are established when necessary to reduce the deferred tax assets and liabilities in the amount expected to be realized. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year. The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible for the period.

O. EARNINGS (LOSS) PER SHARE. Basic net earnings (loss) per share excluding dilution has been computed by dividing net earnings (loss) by the weighted-average number of common shares outstanding for the period. Diluted earnings (loss) per share is computed the same as basic except that the denominator also includes shares issuable upon assumed exercise of stock options or warrants. As of June 30, 2008 and 2007, the Company had outstanding stock options and warrants which were not included in the computation of loss per share because the shares would be anti-dilutive. As of June 30, 2006, the Company had outstanding stock options totaling 149,844 having a dilutive effect on earnings per share.

P. SEGMENT INFORMATION. The Company reports financial and descriptive information about its reportable operating segments. Operating segments are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision-maker in deciding how to allocate resources

and in assessing performance. Financial information is reported on the basis that it is used internally for evaluating segment performance and deciding how to allocate resources to segments.

Q. RECLASSIFICATIONS. Certain items in the prior periods consolidated financial statements have been reclassified to conform to the June 30, 2008 presentation.

NOTE 3 - MARKETABLE SECURITIES

A summary of estimated fair value, which approximates amortized cost, of marketable securities as of June 30, 2008 and 2007 is as follows (in thousands):

	2008	2007
Available for sale - Current:		
Certificates of deposit	$ 8,774	$ 5,296
Available for sale - Noncurrent:		
U.S. government obligations	7,514	7,475
	$16,288	$12,771

Certain of the Company's operations are obligated by state regulations to maintain a specified level of escrowed funds to assure the provision of healthcare services to enrollees. To fulfill these statutory requirements, the Company maintains funds in highly liquid escrowed investments, which amounted to $7.5 million at June 30, 2008 and 2007, respectively. These are different from the escrow accounts described in Note 13. Accumulated unrealized losses associated with these investments were $0.07 million and $0.04 million at June 30, 2008 and 2007, respectively. The decline is considered temporary as the investments are required to be held to maturity under current statutory deposit requirements of the State of Tennessee.

NOTE 4 - CONCENTRATION OF RISK

During the years ended June 30, 2008, 2007 and 2006, approximately 57.6%, 88.8% and 93.7%, respectively, of the Company's revenues were derived from a single customer, TennCare, a State of Tennessee program that provides medical benefits to Medicaid and Working Uninsured recipients. As discussed in Note 12 below, the non-renewal of the contract with TennCare will materially affect the profitability and financial stability of the Company.

The Company from time to time may maintain cash balances with financial institutions in excess of federally insured limits. Management has deemed this as a normal business risk.

NOTE 5 - PROPERTY AND EQUIPMENT

Property and equipment at each June 30 consists of the following (in thousands):

	2008	2007
Furniture and fixtures	$ 870	$ 868
Equipment	1,462	1,273
Computer software	376	241
	2,708	2,382
Less accumulated depreciation and amortization	(2,236)	(2,025)
	$ 472	$ 357

NOTE 6 - MEDICAL CLAIMS PAYABLE

The Company has recorded a liability of $2.6 million and $0.6 million at June 30, 2008 and 2007, respectively, for unpaid claims and medical claims incurred by enrollees. The medical claims liability incurred through fiscal 2008 represents the liability for services that have been performed by providers for the Company's Medicare Advantage members. Included in the incurred losses related to the current year are medical claims reported to UAHC-TN as well as claims that have been incurred but not yet reported to IT, or "IBNR". The IBNR component is primarily based on medical cost estimates from historical data provided by CMS and emerging medical claims experience together with current factors. As the Company gains more claims experience for our Medicare Advantage members, less reliance will be placed on medical cost estimates based on historical data provided by CMS. The IBNR reserve estimated at June 30, 2008 and 2007 was derived by an independent actuarial analysis. Each period, the Company re-examines the previously established medical claims liability estimates based on actual claim submissions and other relevant changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, the Company will increase or decrease the amount of the estimates, and include the changes in medical expenses in the period in which the change is identified. The ultimate settlement of medical claims may vary from the estimated amounts reported at June 30, 2008 and 2007.

The following table provides a reconciliation of the unpaid claims as of June 30, 2008, 2007 and 2006 (in thousands):

	2008	2007
Balance at beginning of fiscal year	$ 576	$ 156
Incurred losses related to current fiscal year	7,453	745
Incurred losses related to prior fiscal year	181	(45)

Total losses incurred	7,634	700
Paid claims related to current fiscal year	3,755	280
Paid claims related to prior fiscal year	1,892	--
Total paid claims	5,647	280
Balance at end of fiscal year	$2,563	$ 576

NOTE 7 - INCOME TAXES

The components of income tax expense (benefit) for each year ended June 30 are as follows (in thousands):

	2008	2007	2006
Income taxes:			
Current expense	$ 190	$ 63	$ 141
Deferred expense (benefit)	517	(551)	249
Change in valuation allowance	1,433	551	(249)
	$2,140	$ 63	$ 141

A reconciliation of the provision for income taxes for each year ended June 30 follows (in thousands):

	2008	2007	2006
Income tax expense at the statutory tax rate	$ (647)	$(358)	$ 515
State and city income tax, net of federal benefit	136	22	73
Permanent differences	1,186	15	9
Change in valuation allowance	1,433	551	(249)
True ups and other, net	32	(167)	(207)
	$2,140	$ 63	$ 141

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible.

Management considers the scheduled reversals of deferred taxes, projected future taxable income, and tax planning strategies in making this assessment.

Based upon the level of historical taxable income and projections for future taxable income over the periods in which the deferred tax assets are deductible, management believes it is more likely than not that the Company will not realize the benefits of these deductible differences as of June 30, 2008. The Company's valuation allowance has been increased given that its subsidiary, UAHC Health Plan of Tennessee, Inc. ("UAHC-TN"), will cease providing managed care services in the TennCare West Grand Region of Tennessee when its present TennCare contract expires as further discussed in Note 12 below. During fiscal 2008, the Company recorded deferred tax expense of $2.0 million.

As of June 30, 2008, the net operating loss carryforwards for federal income tax purposes expire from 2011 to 2021. Components of the Company's deferred tax assets and liabilities at each June 30 are (in thousands):

	2008	2007
Deferred tax assets		
Accrued rent	$ 30	$ 46
Bad debt expense	--	93
Write down of investment	--	1,360
Deferred/accrued compensation	202	185
Net operating loss carryforward of consolidated losses	1,973	2,942
Capital loss carryforward	1,360	--
Alternative minimum tax credit carryforward	677	679
Property and equipment	15	27
Medical claims payable	1,049	158
Provision for claims audit and other commitment	--	519
Stock awards	385	199
Total gross deferred tax assets	5,691	6,208
Valuation allowance	(5,691)	(4,258)
Total gross deferred tax liabilities	--	--
Net deferred tax asset	$ --	$ 1,950

NOTE 8 - PRIVATE PLACEMENT

In a December 13, 2006 private placement transaction, the Company raised gross proceeds of $6.50 million through the sale of 1,000,000 newly issued shares of its common stock to certain institutional and other accredited investors at a price of $6.50 per share. The investors also received warrants to purchase 99,999 shares of the Company's common stock at an exercise price of $8.50 per share and expiring in December 2011. In addition, the Company agreed to pay the co-placement agents a transaction fee of $325,000 and warrants to purchase

50,000 shares of the Company's common stock at an exercise price of $9.01 per share. The net proceeds from the private placement were to be used principally for start-up costs associated with the Company's Tennessee subsidiary's new Medicare Advantage contract with the Centers for Medicare & Medicaid Services, which became effective January 1, 2007. The remainder was to be used for working capital and general corporate purposes.

NOTE 9 - NON-RECURRING CHARGES

As a result of a state regulatory audit of UAHC-TN's processed claims, UAHC-TN was notified in late fiscal 2007 that UAHC-TN may have incorrectly received an overpayment of $1.1 million for medical claims as a result of a discrepancy in pricing methodology. As a result, UAHC-TN recorded a reserve of $1.1 million in the fourth quarter of fiscal 2007. In addition, based on a subsequent regulatory evaluation conducted by the Tennessee Department of Commerce and Insurance, it was determined that TennCare overpaid UAHC-TN $0.4 million in excess of UAHC-TN's statutory net worth requirement as of June 30, 2002 based on a 2002 contractual agreement further discussed in Note 12. The Company recorded a charge for this amount in the fourth quarter of fiscal 2007. These items have been reflected as "Provision for claims audit and other commitment" on our fiscal 2007 Consolidated Statement of Operations and recorded under accounts payable and accrued expenses on our Consolidated Balance Sheets. These amounts were paid during fiscal year 2008.

NOTE 10 - BENEFIT AND OPTION PLANS

The Company offers a 401(k) retirement and savings plan that covers substantially all of its employees. Effective and since April 1, 2001, the Company has matched 50% of an employee's contribution up to 4% of the employee's salary. Expenses related to the 401(k) plan were $81,190, $80,930 and $55,757 for the fiscal years ended June 30, 2008, 2007 and 2006, respectively.

The Company has reserved 200,000 common shares for its Employee Stock Purchase Plan ("ESPP"), which became effective October 1996, and enables all eligible employees of the Company to subscribe for shares of common stock on an annual offering date at a purchase price which is the lesser of 85% of the fair market value of the shares on the first day or the last day of

the annual period. Employee contributions for each of the fiscal years ended June 30, 2008, 2007 and 2006 were $0, $2,428 and $7,775, respectively.

On August 6, 1998, the Company's Board of Directors adopted the 1998 Stock Option Plan ("1998 Plan"). The 1998 Plan was approved by the Company's shareholders on November 12, 1998. The Company reserved an aggregate of 500,000 common shares for issuance upon exercise of options under the 1998 Plan. On November 14, 2003 the Company's shareholders approved an increase in the number of common shares reserved for issuance pursuant to the exercise of options granted under the amended plan from 500,000 to 1,000,000 shares, and extended the termination date of the plan by 5 years to August 6, 2013. On November 5, 2004 the Company's shareholders approved an increase in the number of common shares reserved for issuance pursuant to the exercise of options granted under the amended plan from 1,000,000 to 1,500,000 shares. On September 9, 1998, December 15, 1998, February 3, 1999, November 10, 1999, May 3, 2001 November 30,

2001, May 8, 2003, December 4, 2003, April 29, 2004, November 5, 2004, December 2, 2004, November 5, 2004, December 2, 2004, November 4, 2005, April 24, 2006, November 3, 2006, February 22, 2007, November 2, 2007 and March 11, 2008 nonqualified options for a total of 325,000, 26,000, 5,000, 8,000, 50,000, 75,000, 25,000, 196,500, 280,000, 45,000, 153,000, 45,000, 153,000, 15,000, 200,500, 95,000, 50,600, 45,000 and 155,000 common shares, respectively, were granted under the amended and restated 1998 Plan. The exercise prices of the options range from $0.63 to $6.24.

On March 1, 2003, the Company granted nonqualified stock options for 100,000 common shares (outside the 1998 Plan) to the Company's President and CEO and reserved that number of common shares for issuance upon exercise of such options. Such options were fully exercised in November 2007.

Information regarding the stock options outstanding at June 30, 2008, 2007 and 2006 are as follows (shares in thousands):

	OPTIONS OUTSTANDING			OPTIONS EXERCISABLE	
	SHARES	WEIGHTED AVERAGE EXERCISE PRICE	AVERAGE REMAINING CONTRACTUAL LIFE	NUMBER OF SHARES EXERCISABLE	WEIGHTED AVERAGE EXERCISE PRICE
Options outstanding at June 30, 2005	902	$3.30	7.32 years	628	$2.84
Granted	216	2.89	9.80 years	3	2.10
Exercisable	--	--	--	115	4.11
Exercised	(40)	1.64	--	(40)	1.64
Expired	--	--	--	--	--
Forfeited	(124)	4.73	--	--	--
Options outstanding at June 30, 2006	954	$3.09	6.79 years	706	$3.12
Granted	146	5.98	8.10 years	16	6.05
Exercisable	--	--	--	76	3.14
Exercised	(44)	2.74	--	(44)	2.74
Expired	--	--	--	--	--
Forfeited	(42)	5.92	--	--	--
Options outstanding at June 30, 2007	1,014	$3.40	6.18 years	754	$3.20
Granted	200	1.94	9.64 years	4	2.85
Exercisable	--	--		123	3.05
Exercised	(102)	1.18	--	(102)	1.18
Expired					
Forfeited	(10)	2.95	--	--	--

Options outstanding at June 30, 2008	1,102	$3.35	6.46 years	779	$3.06

Options for 15,300 common shares were available for grant under the amended and restated 1998 Plan at the end of fiscal 2008.

The Company has adopted SFAS No. 123(R), "Share-Based Payment," which is a revision of SFAS No. 123, "Accounting for Stock Based Compensation," and supersedes APB Opinion No. 25, "Accounting for Stock Issued to Employees," which was issued in December 2004. The revisions are intended to provide investors and other users of financial statements with more complete and neutral financial information by requiring that the compensation cost relating to share-based payment transactions be recognized in financial statements. That cost is measured based on the fair value of the equity or liability instruments issued. The Company recorded stock option expense of $0.5 million, $0.3 million and $0.3 million for fiscal 2008, 2007 and 2006, respectively.

The fair value of options at date of grant was estimated using the Black-Scholes option pricing model with the following weighted average assumptions used for grants in fiscal 2008, 2007, and 2006, depending on the date of issuance: dividend yield of 0%; expected volatility ranging from 29% to 66%; risk free interest rate ranging from 3.44% to 4.81%; and expected life ranging from 5.0 to 10.0 years. The options have terms ranging from 5.0 to 10.0 years and typically vest quarterly over 3 years. Through March 2012, the total compensation expense is expected to be $0.7 million related to these options. The weighted average fair value for options granted during fiscal 2008 is $1.54.

NOTE 11 - LEASES

The Company leases its facilities and certain furniture and equipment under operating leases expiring at various dates through December 2010. Terms of the facility leases generally provide that the Company pay its pro rata share of all operating expenses, including insurance, property taxes and maintenance.

Rent expense for the years ended June 30, 2008, 2007 and 2006 totaled $0.3 million, $0.4 million and $0.4 million, respectively. Based on the current commitments, the Company estimates rent expense of $0.4 million for each of its fiscal years through 2011.

NOTE 12 - CONTRACTUAL RISK AGREEMENT

Beginning July 1, 2002, TennCare, a State of Tennessee program that provides medical benefits to Medicaid and working uninsured recipients, implemented an 18-month stabilization program, which entailed changes to TennCare's contracts with managed care organizations ("MCOs"), including the Company's subsidiary, UAHC-TN. During that period, MCOs were generally compensated for administrative services only (commonly called "ASO"), earned fixed administrative fees, were not at risk for medical costs in excess of targets established based on various factors, were subject to increased oversight, and could incur financial penalties for not achieving certain performance requirements. Through successive contractual amendments, TennCare extended the ASO reimbursement system applicable to UAHC-TN, first through June 30, 2004, then through December 31, 2004, and then through June 30, 2005.

Through an amendment with an effective date of July 1, 2005, TennCare extended its contract with UAHC-TN through June 30, 2006 and implemented a modified risk arrangement ("MRA") with all its contracted MCOs, including UAHC-TN, which became at risk for losing up to 10% of administrative fee revenue and could receive up to 15% incentive bonus revenue based on performance relative to benchmarks. UAHC-TN received notice from TennCare that it earned additional revenue of $1.1 million for its performance under the MRA for fiscal 2006, representing a 7% bonus revenue payout. Such additional revenue has been recorded, of which $0.3 was recorded in fiscal 2006, $0.5 million was recorded in fiscal 2007, and $0.3 million was recorded in the second quarter of fiscal 2008. UAHC-TN also earned and received additional revenue of $1.4 million for fiscal 2007, representing a 9% bonus revenue payout, and the Company has recorded such additional MRA earnings in the third quarter of fiscal 2008, when UAHC-TN was notified by TennCare of the amount. Effective July 1, 2007, the evaluation period for the MRA was changed from quarterly to annually, and the incentive bonus pool was adjusted to 20% of administrative fee revenue.

In September 2002, UAHC-TN and the State of Tennessee, doing business as TennCare, amended the Contractor Risk Agreement between them. Pursuant to the amendment, the State of Tennessee agreed to pay UAHC-TN up to $7.5 million as necessary to meet its statutory net worth requirement as of June 30, 2002. Pursuant to a further agreement with UAHC-TN in

October 2002, the State of Tennessee agreed to pay additional funds to UAHC-TN if future certified actuarial data confirm they are needed by UAHC-TN to meet its statutory net worth requirement as of June 30, 2002. Under generally accepted accounting principles, the $7.5 million receivable and additional funds were not recorded in fiscal 2002 financial statements but have been recorded in subsequent fiscal years as fiscal 2002 claims were processed. Based on a subsequent regulatory evaluation, it was determined that TennCare paid UAHC-TN $0.4 million in excess of UAHC-TN's statutory net worth requirement as of June 30, 2002. The Company recorded a charge for this amount in the fourth quarter of fiscal year 2007 and reflected it as "Provision for claims audit and other commitment" on our Consolidated Statements of Operations.

On April 22, 2008 we learned that UAHC-TN will cease providing managed care services as a TennCare contractor when its present TennCare contract expires. UAHC-TN's TennCare members are expected to transfer to other managed care organizations on November 1, 2008, after which UAHC-TN will perform its

remaining contractual obligations through its TennCare contract expiration date of June 30, 2009. However, revenue under this contract will only be earned through October 31, 2008. Revenue under this contract represented 57.6% and 88.8% of the Company's total revenues for the fiscal year ended June 30, 2008 and 2007, respectively. Management believes that the discontinuance of the TennCare contract will have a material impact on the Company's operations.

NOTE 13 - RESTRICTED ASSETS

Under two escrow agreements between the Company and TennCare on August 5, 2005 the Company funded two escrow accounts held by TennCare at the State Treasury. Both escrow agreements recited that TennCare did not assert there had been any breach of UAHC-TN's TennCare contract and that the Company funded the escrow accounts as a show of goodwill and good faith in working with TennCare.

The larger escrow account, which has expired was in the original amount of $2,300,000 and was security for repayment to TennCare of any overpayments to UAHC-TN that might be determined by an audit of all UAHC-TN processed claims. In August 2007, the Company received $1,289,851 plus accumulated interest earnings back from that account. In November 2007, the remaining $1,010,149 account balance was paid to TennCare for claims discrepancies found in the review by the Tennessee Department of Commerce and Insurance.

The other escrow account, in the original amount of $420,500, is security for any money damages that may be awarded to TennCare in the event of any future litigation between the parties in connection with certain pending investigations by state and federal authorities. The escrow account will terminate 30 days after the conclusion of such investigations, unless the parties earlier agree otherwise. The escrow account bears interest at a rate no lower than the prevailing commercial interest rate for savings accounts at financial institutions in Nashville, Tennessee. All amounts (including interest earnings) credited to the escrow account will belong

to the Company, except to the extent, if any, they are paid to TennCare to satisfy amounts determined to be owed to TennCare as provided in the escrow agreement.

NOTE 14 - UNAUDITED SELECTED QUARTERLY FINANCIAL DATA

The following table presents selected quarterly financial data for the fiscal years ended June 30, 2008 and 2007 (in thousands, except per share data):

	THREE MONTHS ENDED				
	SEPT. 30,	DEC. 31,	MARCH 31,	JUNE 30,	TOTAL
2008					
Total revenues	$6,188	$7,048	$ 8,275	$ 6,697	$28,208
Net earnings (loss)	73	256	(3,770)	(601)	(4,042)
Net earnings (loss)					

per common share assuming dilution	$ 0.01	$ 0.03	$ (0.43)	$ (0.08)	$ (0.47)
2007					
Total revenues	$4,174	$4,223	$ 4,550	$ 5,118	$18,065
Net earnings (loss)	332	228	(39)	(1,638)	(1,117)
Net earnings (loss) per common share assuming dilution	$ 0.04	$ 0.03	$ (0.00)	$ (0.19)	$ (0.14)

The net loss in the third quarter of fiscal 2008 is primarily attributable to the goodwill impairment charge and increase in the deferred tax asset valuation allowance recorded during the quarter. Please refer to Note 2 for further discussion.

The net loss in the fourth quarter of fiscal 2007 is primarily attributable to non-recurring charges recorded in the fourth quarter of fiscal 2007. Please refer to Note 9 for further discussion.

NOTE 15 - SEGMENT FINANCIAL INFORMATION

Summarized financial information for the Company's principal operations for fiscal 2008, 2007 and 2006 is as follows (in thousands):

	MANAGEMENT COMPANIES (1)	HMO & MANAGED PLAN (2)	CORPORATE & ELIMINATIONS	CONSOLIDATED COMPANY
2008				
Revenues - external customers	$ --	$26,833	$ --	$ 26,833
Revenues - intersegment	15,696	--	(15,696)	--
Interest and other income	452	923	--	1,375
Total revenues	$ 16,148	$27,756	$(15,696)	$ 28,208
Interest expense	$ --	$ --	$ --	$ --
Earnings (loss) from operations	(5,228)	1,186	--	(4,042)
Segment assets	63,423	21,518	(54,144)	30,797
Purchase of equipment	326	--	--	326
Depreciation and amortization	211	--	--	211
2007				
Revenues - external customers	$ --	$16,966	$ --	$ 16,966
Revenues - intersegment	14,162	--	(14,162)	--
Interest and other income	398	701	--	1,099
Total revenues	$ 14,560	$17,667	$(14,162)	$ 18,065

Interest expense	$ --	$ --	$ --	$ --
Earnings (loss) from operations	(1,532)	415	--	(1,117)
Segment assets	64,273	20,017	(50,522)	33,768
Purchase of equipment	343	--	--	343
Depreciation and amortization	122	--	--	122
2006				
Revenues - external customers	$ --	$16,989	$ --	$ 16,989
Revenues - intersegment	15,161	--	(15,161)	--
Interest and other income	191	934	--	1,125
Total revenues	$ 15,352	$17,923	$(15,161)	$ 18,114
Interest expense	$ --	$ --	$ --	$ --
Earnings from operations	342	1,031	--	1,373
Segment assets	60,386	16,116	(51,276)	25,226
Purchase of equipment	95	--	--	95
Depreciation and amortization	128	--	--	128

(1) Management Companies: United American Healthcare Corporation, United American of Tennessee, Inc.

(2) HMO and Managed Plan: UAHC Health Plan of Tennessee, Inc.

NOTE 16 - RECENTLY ENACTED PRONOUNCEMENTS

The following are new accounting standards and interpretations that may be applicable in the future to the Company:

In September 2006, the FASB issued Statement of Financial Accounting Standards No. 157, "Fair Value Measurements" ("FASB 157"). FASB 157 enhances existing guidance for measuring assets and liabilities using fair value. Prior to the issuance of FASB 157, guidance for applying fair value was incorporated in several accounting pronouncements. FASB 157 provides a single definition of fair value, together with a framework for measuring it, and requires additional disclosure about the use of fair value to measure assets and liabilities. FASB 157 also emphasizes that fair value is a market-based measurement, not an entity-specific measurement, and sets out a fair value hierarchy with the highest priority being quoted prices in active markets. Under FASB 157, fair value measurements are disclosed by level within that hierarchy. While FASB 157 does not add any new fair value measurements, it does change what had been current practice. Such changes include: (1) a requirement for an entity to include its own credit standing in the measurement of its liabilities; (2) a modification of the transaction price presumption; (3) a prohibition on the use of block discounts when valuing large blocks of securities for broker-dealers and investment companies; and (4) a requirement to adjust the value of restricted stock for the effect of the restriction even if the restriction lapses within one year. FASB 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years. The Company has not determined the impact of adopting FASB

157 on its financial statements.

In February 2007, the FASB issued Statement of Financial Accounting Standards No. 159, "The Fair Value Option for Financial Assets and Financial Liabilities" ("FASB 159"). This statement permits entities to choose to measure many financial instruments and certain other items at fair value. An entity shall report unrealized gains and losses on items for which the fair value option has been elected in earnings at each subsequent reporting date. FASB 159 is effective as of the beginning of an entity's first fiscal year that begins after November 15, 2007. Early adoption is permitted as of the beginning of a fiscal year that begins on or before November 15, 2007, provided that the entity also elects to apply the provisions of FASB 157. The Company is continuing to evaluate the impact of this statement.

In December 2007, the FASB issued SFAS No. 141(R), Business Combinations, and SFAS No. 160, Noncontrolling Interests in Consolidated Financial Statements. SFAS No. 141(R) requires an acquirer to measure the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquiree at their fair values on the acquisition date, with goodwill being the excess value over the net identifiable assets acquired. SFAS No. 160 clarifies that a noncontrolling interest in a subsidiary should be reported as equity in the consolidated financial statements. The calculation of earnings per share will continue to be based on income amounts attributable to the parent. SFAS No. 141(R) and SFAS No. 160 are effective for financial statements issued for fiscal years beginning after December 15, 2008. Early adoption is

prohibited. The Company has not yet determined the effect on our consolidated financial statements, if any, upon adoption of SFAS No. 141(R) or SFAS No. 160.

In December 2007, the FASB issued SFAS No. 160, Noncontrolling Interests in Consolidated Financial Statements - an Amendment of ARB No. 51 ("SFAS 160"), which establishes accounting and reporting standards for the noncontrolling interest in a subsidiary and for the deconsolidation of a subsidiary. SFAS No. 160 clarifies that a noncontrolling interest in a subsidiary is an ownership interest in the consolidated entity that should be reported as equity in the consolidated financial statements. SFAS No. 160 also requires consolidated net income to be reported at amounts that include the amounts attributable to both the parent and the noncontrolling interest. It also requires disclosure, on the face of the consolidated statement of income, of the amounts of consolidated net income attributable to the parent and to the noncontrolling interest. SFAS No. 160 also provides guidance when a subsidiary is deconsolidated and requires expanded disclosures in the consolidated financial statements that clearly identify and distinguish between the interests of the parent's owners and the interests of the noncontrolling owners of a subsidiary. SFAS 160 is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. The Company is currently evaluating the impact this statement will have on its financial position and results of operations.

In February 2008, the FASB issued FASB Staff Position No. 157-2, Effective Date of FASB Statement No. 157 ("FSP 157-2"), which delays the effective date of SFAS 157 for nonfinancial assets and nonfinancial liabilities. Therefore, the Company has delayed application of SFAS 157 to its nonfinancial assets and nonfinancial liabilities, which include assets and liabilities acquired in connection with a

business combination, goodwill, intangible assets and asset retirement obligations, until January 1, 2009. The Company is currently evaluating the impact of SFAS 157 for nonfinancial assets and liabilities on the Company's financial position and results of operations.

In March 2008, the FASB issued SFAS No. 161, Disclosures about Derivative Instruments and Hedging Activities ("SFAS 161"), which amends and expands the disclosure requirements of FASB Statement No. 133, Accounting for Derivative Instruments and Hedging Activities ("SFAS 133"), with the intent to provide users of financial statements with an enhanced understanding of: (a) how and why an entity uses derivative instruments; (b) how derivative instruments and related hedged items are accounted for under SFAS No. 133 and its related interpretations; and (c) how derivative instruments and related hedged items affect an entity's financial position, financial performance and cash flows. SFAS 161 requires qualitative disclosures about objectives and strategies for using derivatives, quantitative disclosures about fair value amounts of and gains and losses on derivative instruments and disclosures about credit-risk-related contingent features in derivative instruments. This statement applies to all entities and all derivative instruments. SFAS 161 is effective for financial statements issued for fiscal years and interim periods beginning after November 15, 2008. The Company has not yet determined the effect on our financial statements, if any, upon adoption of SFAS No. 161. In May, 2008, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standard ("SFAS") No. 162, "The Hierarchy of Generally Accepted

Accounting Principles," ("SFAS No. 162"). SFAS No. 162 identifies the sources of accounting principles and the framework for selecting the principles used in the preparation of financial statements of nongovernmental entities that are presented in conformity with generally accepted accounting principles (GAAP) in the United States (the GAAP hierarchy). SFAS No. 162 will be effective 60 days following the SEC's approval of the Public Company Accounting Oversight Board's amendments to AU Section 411, "The Meaning of Present Fairly in Conformity With Generally Accepted Accounting Principles." The FASB has stated that it does not expect SFAS No. 162 will result in a change in current practice. The application of SFAS No. 162 will have no effect on the Company's financial position, results of operations or cash flows.

Also in May 2008, the FASB issued SFAS No. 163, "Accounting for Financial Guarantee Insurance Contracts--an interpretation of FASB Statement No. 60" ("SFAS 163"). SFAS 163 interprets Statement 60 and amends existing accounting pronouncements to clarify their application to the financial guarantee insurance contracts included within the scope of that Statement. SFAS 163 is effective for financial statements issued for fiscal years beginning after December 15, 2008, and all interim periods within those fiscal years. As such, the Company is required to adopt these provisions at the beginning of the fiscal year ended December 31, 2009. The Company is currently evaluating the impact of SFAS 163 on its financial statements but does not expect it to have an effect on the Company's financial position, results of operations or cash flows.

In May 2008, FASB issued FSP APB 14-1, Accounting for Convertible Debt Instruments that may be Settled in Cash upon Conversion (Including Partial Cash Settlement) ("FSP APB 14-1"). FSP APB 14-1 applies to convertible debt

securities that, upon conversion, may be settled by the issuer fully or partially in cash. FSP APB 14-1 specifies that issuers of such instruments should separately account for the liability and equity components in a manner that will reflect the entity's nonconvertible debt borrowing rate when interest cost is recognized in subsequent periods. FSP APB 14-1 is effective for financial statements issued for fiscal years after December 15, 2008, and must be applied on a retrospective basis. Early adoption is not permitted. We are assessing the potential impact of this FSP on our convertible debt issuances.

In June 2008, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position ("FSP") EITF 03-6-1, Determining Whether Instruments Granted in Share-Based Payment Transactions Are Participating Securities ("FSP EITF 03-6-1"). FSP EITF 03-6-1 addresses whether instruments granted in share-based payment transactions are participating securities prior to vesting, and therefore need to be included in the earnings allocation in computing earnings per share under the two-class method as described in SFAS No. 128, Earnings per Share. Under the guidance of FSP EITF 03-6-1, unvested share-based payment awards that contain nonforfeitable rights to dividends or dividend equivalents (whether paid or unpaid) are participating securities and shall be included in the computation of earnings-per-share pursuant to the two-class method. FSP EITF 03-6-1 is effective for financial statements issued for fiscal years beginning after December 15, 2008 and all prior-period earnings per share data presented shall be adjusted retrospectively. Early application is not permitted. We are assessing the potential impact of this FSP on our earnings per share calculation.

In June 2008, FASB ratified EITF No. 07-5, Determining Whether an Instrument (or an Embedded Feature) Is Indexed to an Entity's Own Stock ("EITF 07-5"). EITF 07-5 provides that an entity should use a two-step approach to evaluate whether an equity-linked financial instrument (or embedded feature) is indexed to its own stock, including evaluating the instrument's contingent exercise and settlement provisions. EITF 07-5 is effective for financial statements issued for fiscal years beginning after December 15, 2008. Early application is not permitted. We are assessing the potential impact of this EITF on our financial condition and results of operations.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION OF DOCUMENT	INCORPORATED HEREIN BY REFERENCE TO	H
3.1	Restated Articles of Incorporation of Registrant	Exhibit 3.1 to the Registrant's Form S-1 Registration Statement under the Securities Act of 1933, as amended, declared effective on April 23, 1991 ("1991 S-1")	

3.1(a)	Certificate of Amendment to the Articles of Incorporation of Registrant	Exhibit 3.1(a) to 1991 S-1
3.2	Amended and Restated Bylaws of Registrant	Exhibit 3.2 to the Registrant's 1993 Form 10-K
3.3	Amended and Restated Bylaws of Registrant	Exhibit 3.1 to Form 8-K filed June 25, 2008
4.1	Incentive and Non-Incentive Stock Option Plan of Registrant effective March 25, 1991, as amended	Exhibit 4.1 to the Registrant's 1995 Form 10-K
4.2	Form of Common Share Certificate	Exhibit 4.2 to the Registrant's 1995 Form 10-K
4.3	Form of Common Stock Purchase Warrant dated as of December 13, 2006, issued by the Company	Exhibit 4.1 to Form 8-K filed December 15, 2006
4.4	Form of Registration Rights Agreement dated as of December 13, 2006 among United American Healthcare Corporation and certain investors	Exhibit 10.2 to Form 8-K filed December 15, 2006
10.1	Employees' Retirement Plan for Registrant dated May 1, 1985, with First Amendment thereto and Summary Plan Description therefore	Exhibit 10.1 to 1991 S-1
10.2	Management Agreement between Michigan Health Maintenance Organization Plans, Inc. and Registrant dated March 15, 1985, as amended June 12, 1985	Exhibit 10.2 to 1991 S-1
10.3	Management Agreement between U.A. Health Care Corporation and Personal Physician Care, Inc. dated March 18, 1987	Exhibit 10.3 to 1991 S-1
10.4	Amendment dated February 16, 1993 to Management Agreement between United American Healthcare Corporation and Personal Physician Care, Inc. dated March 18, 1987	Exhibit 10.5 to the Registrant's 1995 Form 10-K
10.5	Amendment dated June 16, 1994 to Management Agreement between U.A. Health Care Corporation and Personal Physician Care, Inc. dated March 18, 1987	Exhibit 10.4 to the Registrant's 1994 Form 10-K
10.6	Management Agreement between OmniCare Health Plan, Inc. and United American of Tennessee, Inc. dated February 2, 1994	Exhibit 10.5 to Registrant's 1994 Form 10-K
10.7	Management Agreement between UltraMedix Health Care Systems, Inc. and United American of Florida, Inc. dated February 1, 1994	Exhibit 10.6 to Registrant's 1994 Form 10-K
10.8	Amendment dated September 4, 1995	Exhibit 10.9 to the Registrant's 1995

	to Management Agreement between UltraMedix Healthcare Systems, Inc. and United American of Florida, Inc. dated February 1, 1995	Form 10-K
10.9	Amendment dated September 20, 1995 to Management Agreement between UltraMedix Health Care Systems, Inc. and United	Exhibit 10.10 to Registrant's 1995 Form 10-K

EXHIBIT NUMBER	DESCRIPTION OF DOCUMENT	INCORPORATED HEREIN BY REFERENCE TO	H
	American of Florida, Inc. dated February 1, 1995		
10.10	Lease Agreement between 1155 Brewery Park Limited Partnership and Registrant dated July 24, 1991, effective May 1, 1992	Form 8-K filed August 8, 1991	
10.11	Amendment dated December 8, 1993 to Lease agreement between 1155 Brewery Park Limited Partnership and Registrant dated July 24, 1991	Exhibit 10.8 to the Registrant's 1994 Form 10-K	
10.12	Amendment dated April 15, 1993 to Lease Agreement between 1155 Brewery Park Limited Partnership and Registrant dated July 24, 1991	Exhibit 10.13 to Registrant's 1995 Form 10-K	
10.13	Lease Agreement between Baltimore Center Associates Limited Partnership and Corporate Healthcare Financing, Inc. dated August 24, 1988, as amended April 12, 1993, effective the later of May 1, 1993 or the date premises are ready for occupancy	Exhibit 10.7 to the Registrant's 1993 Form 10-K	
10.14	Amendment dated May 11, 1994 (effective June 30, 1994) to Lease agreement between Baltimore Center Associates Limited Partnership and Corporate Healthcare Financing, Inc	Exhibit 10.11 to the Registrant's 1994 Form 10-K	
10.15	Lease Agreement between CLW Realty Asset Group, Inc., as agent for The	Exhibit 10.2 to Registrant's 1994 Form 10-K	

EXHIBIT NUMBER	DESCRIPTION OF DOCUMENT	INCORPORATED HEREIN BY REFERENCE TO	H
	Prudential Insurance Company of America and United American of Florida dated May 31, 1994, effective June 1, 1994		
10.16	Lease Agreement between Fleming	Exhibit 10.3 to Registrant's 1994 Form 10-K	

	Companies, Inc. and United American of Tennessee dated June 30, 1994, effective the date premises are ready for occupancy	
10.17	Lease Agreement between International Business Machines Corporation and Registrant dated August 29, 1994	Exhibit 10.19 to Registrant's 1995 Form 10-K
10.18	Amended and Restated Line of Credit Facility Agreement between Michigan National Bank and Registrant dated March 14, 1995	Exhibit 10.20 to Registrant's 1995 Form 10-K
10.19	Promissory notes between Michigan National Bank and Registrant dated August 26, 1993	Exhibit 10.9 to the Registrant's 1993 Form 10-K
10.20	Asset Purchase Agreement between CHF, Inc., Healthcare Plan Management, Inc., CHF-HPM Limited Partnership, Louis J. Nicholas and Keith B. Sullivan and Registrant dated May 7, 1993	Form 8-K filed May 24, 1993 and Form 8-K/A filed July 21, 1993
10.21	Loan and Security Agreement between UltraMedix Health Care Systems, Inc. and United American of Florida dated February 1, 1994	Exhibit 10.18 to Registrant's 1994 Form 10-K
10.22	Amendment dated June 13, 1995 to the Loan and Security Agreement between	Exhibit 10.26 to Registrant's 1995 Form 10-K

EXHIBIT NUMBER	DESCRIPTION OF DOCUMENT	INCORPORATED HEREIN BY REFERENCE TO	H
	UltraMedix Care Systems, Inc. and United American of Florida, Inc. dated February 1, 1994		
10.23	Form of Stock Transfer Services Agreement between Huntington National Bank and Registrant	Exhibit 10.19 to Registrant's 1994 Form 10-K	
10.24	Employment Agreement between Julius V. Combs, M.D. and Registrant dated March 15, 1991	Exhibit 10.15 to 1991 S-1	
10.25	Employment Agreement between Ronald R. Dobbins and Registrant dated March 15, 1991	Exhibit 10.16 to 1991 S-1	
10.26	Employment Agreement between Louis J. Nicholas and Corporate Healthcare Financing, Inc. dated May 7, 1993	Exhibit 10.22 to Registrant's 1994 Form 10-K	
10.27	First Amendment to Contingent Note Promissory Note between CHF-HPM Limited Partnership and the Registrant	Form 10-Q for the Quarter Ended March 31, 1996, filed May 14, 1996	
10.28	Acquisition of majority interest in OmniCare Health Plan, Inc. of Tennessee and UltraMedix Healthcare Systems, Inc.	Form 8-K filed April 19, 1996	

10.29	Injured Workers' Insurance Fund Contract No. IWIF 9-96 Managed Care Contract with Statutory Benefits Management Corporation dated June 19, 1996	Form 10-K/A filed October 14, 1996, as amended
10.30	Ernst & Young LLP Report of Independent Auditors as of June 30, 1996	Exhibit 10.30 to Registrant's 1998 Form 10-K

EXHIBIT NUMBER	DESCRIPTION OF DOCUMENT	INCORPORATED HEREIN BY REFERENCE TO	H
10.31	Renaissance Center Office Lease between Renaissance Center Venture and Registrant	Form 10-Q for the Quarter Ended September 30, 1996, filed November 13, 1996	
10.32	Purchase Agreement between Statutory Benefits Management Corporation and Spectera, Inc.	Form 10-Q for the Quarter Ended December 31, 1996, filed February 10, 1997	
10.33	Agreement of Purchase and Sale of Stock, between CHF Acquisition, Inc. and the Registrant dated September 12, 1997	Form 10-K filed October 14, 1997	
10.34	Ernst & Young LLP Report of Independent Auditors as of June 30, 1997	Form 10-K filed October 14, 1997	
10.35	Amended and Restated Business Loan Agreement between Michigan National Bank and Registrant dated March 12, 1998 (effective as of February 1, 1998)	Form 10-Q for the Quarter Ended March 31, 1998, filed May 15, 1998	
10.36	Business Loan Agreement Addendum between Michigan National Bank and Registrant dated March 12, 1998 (effective as of February 1, 1998)	Form 10-Q for the Quarter Ended March 31, 1998, filed May 15, 1998	
10.37	Promissory Note from Registrant to Michigan National Bank dated March 12, 1998 (effective as of February 1, 1998)	Form 10-Q for the Quarter Ended March 31, 1998, filed May 15, 1998	
10.38	Employment Agreement between Gregory H. Moses, Jr. and Registrant dated May 11, 1998	Exhibit 10.38 to Registrant's 1998 Form 10-K	
10.39	Amendment dated as of June 30, 1998 to Lease Agreement between 1155 Brewery Park Limited Partnership and Registrant dated June 24, 1991	Exhibit 10.39 to Registrant's 1998 Form 10-K	
10.40	Termination of Lease between Renaissance Holdings, Inc. (successor to Renaissance Center Venture) and Registrant dated June 24, 1998	Exhibit 10.40 to Registrant's 1998 Form 10-K	

10.41	United American Healthcare Corporation 1998 Stock Option Plan	Exhibit 10.41 to Registrant's 1998 Form 10-K
10.42	Stock Purchase Agreement among Registrant, CHFA, Inc. and Corporate Healthcare Financing, Inc. dated August 31, 1998	Exhibit 10.42 to Registrant's 1998 Form 10-K
10.43	Secured Promissory Note from CHFA, Inc. to Registrant dated August 31, 1998	Exhibit 10.43 to Registrant's 1998 Form 10-K
10.44	Unsecured Promissory Note from CHFA, Inc. to Registrant dated August 31, 1998	Exhibit 10.44 to Registrant's 1998 Form 10-K
10.45	Guaranty Agreement of Louis J. Nicholas dated August 31, 1998	Exhibit 10.45 to Registrant's 1998 Form 10-K
10.46	Pledge Agreement between CHFA, Inc. and Registrant dated August 31, 1998	Exhibit 10.46 to Registrant's 1998 Form 10-K
10.47	Amendment of Business Loan Agreement between Registrant and Michigan National Bank dated September 1, 1998	Exhibit 10.47 to Registrant's 1998 Form 10-K
10.48	Promissory Note of Registrant to Michigan National Bank dated September 1, 1998	Exhibit 10.48 to Registrant's 1998 Form 10-K
10.49	Pledge Agreement from Registrant to Michigan National Bank dated September 1, 1998	Exhibit 10.49 to Registrant's 1998 Form 10-K
10.50	Promissory Note from Registrant to UAH Securities Litigation Fund dated December 11, 1998	Form 10-Q for the Quarter Ended December 31, 1998, filed February 16, 1999
10.51	Amendment of Promissory Note and Business Loan Agreement from Michigan National Bank dated May 6, 1999	Exhibit 10.51 to Registrant's 1999 Form 10-K
10.52	Provider Contract between Urban Hospital Care Plus and Registrant dated April 1, 1999	Exhibit 10.52 to Registrant's 1999 Form 10-K
10.53	Assignment and Assumption of Subleases and Security Deposits between International Business Machines Corporation and Registrant dated September 9, 1999	Exhibit 10.53 to Registrant's 1999 Form 10-K
10.54	Business Loan Agreement between Registrant and Michigan National Bank dated September 25, 2000	Exhibit 10.54 to Registrant's 2001 Form 10-K
10.55	Promissory Note of Registrant to Michigan National Bank dated September 25, 2000	Exhibit 10.55 to Registrant's 2001 Form 10-K
10.56	Security Agreement between Registrant and Michigan National Bank dated September 25, 2000	Exhibit 10.56 to Registrant's 2001 Form 10-K
10.57	Amendment of Business Loan Agreement with Standard Federal Bank N.A., dated November 29, 2001 and effective September 30, 2001.	Form 10-Q for the Quarter Ended December 31, 2001, filed February 14, 2002
10.58	Amended and Restated Promissory Note to Standard Federal Bank N.A., dated November 29, 2001 and effective	Form 10-Q for the Quarter Ended December 31, 2001, filed February 14, 2002

	September 30, 2001.	
10.59	Amendment to Management Agreement with OmniCare Health Plan dated December 14, 2001 and effective August 1, 2001.	Form 10-Q for the Quarter Ended December 31, 2001, filed February 14, 2002
10.60	Amendment of Business Loan Agreement with Standard Federal Bank N.A., dated October 11, 2002	Exhibit 10.60 to Registrant's 2002 Form 10-K
10.61	Amendment of Business Loan Agreement with Standard Federal Bank N.A., dated October 11, 2002 and effective September 30, 2002	Form 10-Q for the Quarter Ended September 30, 2002, filed November 13, 2003
10.62	Letter amendment of Business Loan Agreement with Standard Federal Bank N.A., dated February 5, 2003	Form 10-Q for the Quarter Ended December 31, 2002, filed May 13, 2003
10.63	United American Healthcare Corporation Supplemental Executive Retirement Plan	Form 8-K filed January 11, 2005
10.64	Severance Agreement dated as of April 15, 2005 between United American of Tennessee, Inc and Osbie L. Howard	Form 10-Q filed April 28, 2005
10.65	Contract #H6934 effective September 29, 2006 between Centers for Medicare & Medicaid Services and UAHC Health Plan of Tennessee, Inc. with its Attachment A and Addendum D	Exhibit 10.1 to Form 8-K filed October 16, 2006
10.66	Form of Purchase Agreement dated as of December 13, 2006 among United American Healthcare Corporation and certain investors	Exhibit 10.1 to Form 8-K filed December 15, 2006
10.67	United American Healthcare Corporation Supplemental Executive Retirement Plan, as amended and restated effective as of January 1, 2005, signed on November 9, 2006	Exhibit 10.1 to Form 10-Q filed January 25, 2007
16.1	Concurring Letter regarding change in Certifying Accountants dated October 30, 1997, from Grant Thornton LLP	Form 8-K filed October 30, 1997
16.2	Concurring Letter regarding change in Certifying Accountants dated November 12, 1997, from Grant Thornton LLP	Form 8-K/A filed November 12, 1997
16.3	Concurring Letter regarding change in Certifying Accountants dated November 12, 1997, from Ernst & Young LLP	Form 8-K/A filed November 12, 1997
16.4	Concurring Letter regarding change in Certifying Accountants dated	Form 8-K filed January 20, 1998

	January 16, 1998, from Arthur Andersen LLP	
16.5	Letter of KPMG LLP dated March 5, 2003 to the Securities and Exchange Commission.	Form 8-KA filed March 10, 2003
16.6	Letter dated November 22, 2004, from Follmer Rudzewicz PLC to the Securities and Exchange Commission	Form 8-K filed November 22, 2004
21	Subsidiaries of the Registrant	
23.1	Consent of Registered Independent Public Accounting Firm	
31.1	Certification of Chief Executive Officer under Section 302 of the Sarbanes-Oxley Act of 2002	
31.2	Certification of Chief Financial Officer under Section 302 of the Sarbanes-Oxley Act of 2002	
32.1	Certification of Chief Executive Officer Pursuant to 18 U.S.C. Section 1350	
32.2	Certification of Chief Financial Officer Pursuant to 18 U.S.C. Section 1350	
99.1	Press Release dated January 12, 1998	Form 8-K filed January 20, 1998
99.2	Press Release dated January 6, 2000	Form 8-K filed January 14, 2000
99.3	Press release dated April 15, 2005.	Form 8-K filed April 15, 2005
99.3	Press release dated April 21, 2005.	Form 8-K filed April 21, 2005
99.4	Notice of Administrative Supervision issued by the Commissioner of the State of Tennessee Department of Commerce and Insurance, dated April 20, 2005.	Form 8-K/A filed April 21, 2005