

METROPOLITAN HEALTH NETWORKS INC
Form 10-K
March 22, 2004

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the Twelve Month Period Ended December 31, 2003

**TRANSITION REPORT UNDER SECTION 13 OR 15 (d)
OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 0-28456

Metropolitan Health Networks, Inc.

(Name of registrant as specified in its charter)

Florida

65-0635748

(State or other jurisdiction of

(I.R.S. Employer Identification No)

Incorporation or organization)

250 Australian Avenue South, Suite 400

West Palm Beach, Fl. 33401

(Address of principal executive offices) (Zip Code)

Registrant's telephone number: (561) 805-8500

Securities registered under Section 12(b) of the Exchange Act: none

Securities registered under Section 12(g) of the Exchange Act:

Title of Each Class

Common Stock, \$.001 par value

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

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

Revenues for the most recent fiscal year: \$143,874,488

The aggregate market value of the Registrant's voting Common Stock held by non-affiliates of the registrant was approximately \$29,281,051 (computed using the closing price of \$0.76 per share of Common Stock on December 31, 2003 as reported by OTCBB, based on the assumption that directors and officers and more than 5% stockholders are affiliates).

There were 44,912,951 shares of the registrant's Common Stock, par value \$.001 per share, outstanding on February 27, 2004.

DOCUMENTS INCORPORATED BY REFERENCE

None.

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GENERAL

Unless otherwise indicated or the context otherwise requires, all references in this Form 10-K to the "Company" or "Metcare" refers to Metropolitan Health Networks, Inc. and our consolidated subsidiaries. We disclaim and intent or obligation to update forward looking statements .

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Sections of this Annual Report contain statements that are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 (the Securities Act) and Section 21E of the Securities Exchange Act of 1934 (the Exchange Act), and we intend that such forward-looking statements be subject to the safe harbors created thereby. Statements in this Report containing the words estimate, project, anticipate, expect, intend, believe, could, should, may, and similar expressions may be deemed to create forward-looking statements. Accordingly, such statements, including without limitation, those relating to our future business, prospects, revenues, working capital, liquidity, capital needs, interest costs and income, wherever they may appear in this document or in other statements attributable to us, involve estimates, assumptions and uncertainties which could cause actual results to differ

materially from those expressed in the forward-looking statements. Specifically, this Annual Report contains forward-looking statements, including the following:

our ability to service our indebtedness, make capital expenditures and respond to capital needs;

our ability to restructure any of our debt or current liabilities;

our ability to enhance the services we provide to our members;

our ability to strengthen our medical management capabilities;

our ability to improve our physician network;

our ability to renew our managed care agreements and negotiate terms which are favorable to us and affiliated physicians;

our ability to respond to future changes in Medicare reimbursement levels and reimbursement rates from other third parties; and

our ability to establish relationships and expand into new geographic markets.

The forward-looking statements reflect our current view about future events and are subject to risks, uncertainties and assumptions. We wish to caution readers that certain important factors may have affected and could in the future affect our actual results and could cause actual results to differ significantly from those expressed in any forward-looking statement. The following important factors, in addition to factors we discuss elsewhere in this Annual Report, including the section entitled Risk Factors, could prevent us from achieving our goals, and cause the assumptions underlying the forward-looking statements and the actual results to differ materially from those expressed in or implied by those forward-looking statements:

pricing pressures exerted on us by managed care organizations and the level of payments we receive under governmental programs or from other payors;

future legislation and changes in governmental regulations;

the impact of Medicare Risk Adjustments on payments we receive for our managed care operations;

loss of significant contracts;

general economic and business conditions;

changes in estimates and judgments associated with our critical accounting policies;

federal and state investigations;

the enactment of unfavorable legislation by the Congress of the United States;

our ability to successfully recruit and retain medical professionals; and

impairment charges that could be required in future periods.

RISK FACTORS

Failure to manage our growth effectively could harm our business and results of operation.

We have experienced growth in our business during the last three years. Continued growth may impair our ability to provide our services efficiently and to manage our employees adequately. Our strategy is to focus on growth within geographic parameters, identifying regions throughout Florida. Future results of operations could be materially adversely affected if we are unable to manage our growth effectively.

Our quarterly results will likely fluctuate, which could cause the value of our common stock to decline.

We are subject to quarterly variations in our medical expenses due to fluctuations in patient utilization. We have significant fixed operating costs and, as a result, are highly dependent on patient utilization to sustain profitability. Our results of operations for any quarter are not necessarily indicative of results of operations for any future period or full year. We experience increased patient population and greater use of medical services in the winter months. As a result, our results of operations may fluctuate significantly from period to period. In addition, there recently has been significant volatility in the market price of securities of health care companies that in many cases we believe has been unrelated to the operating performance of these companies. We believe that certain factors, such as legislative and regulatory developments, quarterly fluctuations in our actual or anticipated results of operations, lower revenues or earnings than those anticipated by securities analysts, and general economic and financial market conditions, could cause the price of our common stock to fluctuate substantially.

The loss of certain agreements and the capitated nature of our revenues could materially affect our operations.

The majority of our revenues come from agreements with one managed care organization that provides for the receipt of capitated fees. The principal organization that we contract with is Humana. We have one-year renewable agreements with Humana to provide healthcare services to members in certain healthcare networks established or managed by Humana. For the twelve months ended December 31, 2003, approximately 99% of our revenue was obtained from these agreements. The Humana agreements may be terminated in the event we participate in activities

Humana reasonably believes may adversely affect the health or welfare of any member or other material breach, or upon 180-day notice of non-renewal by either party. Failure to maintain these agreements, or successfully develop additional sources of revenue could adversely affect our financial condition. A continuing decline in enrollees in Medicare Advantage could also have a material adverse effect on our profitability.

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

Reimbursement for Our Managed Care Operations will be affected by the Medicare Risk Adjustment

The Balanced Budget Act of 1997 directed the Health Care Financing Administration (now CMS) to replace the existing system of risk adjustment, which previously relied solely on demographic factors, with one that took enrollees' health status into account (the Medicare Risk Adjustment or MRA). The demographic-only portion of the payment was adjusted for age, gender, Medicaid eligibility, institutional status and working aged status. The revised MRA portion of the payment, however, includes these same categories but adds health status as a new criteria. Such health status is measured by the previous medical costs for inpatient hospital stays incurred by the individual. These are then used to determine each individual's expected future medical risk and, therefore, how much the health plan in which they are enrolled should be paid. To ensure that health plans had time to adjust to the new payment method, CMS built a five-year transition period into the MRA methodology it adopted. The initial data used to facilitate the transition to MRA was based solely upon inpatient hospital encounter data. For 2000 and 2001, under the Balanced Budget Refinement Act of 1999 (BBRA) the transition to risk adjustment was based upon a blend percentage consisting of 10% risk adjustment payment and 90% on the adjustment for demographic factors. For 2002, the blend percentage was adjusted to 20% risk adjustment payment and 80% on the adjustment for demographic factors. The law requires that the ambulatory data be incorporated beginning January 1, 2004, at which time the blend percentage will consist of 30% risk adjustment payment and 70% on the adjustment for demographic factors. In 2005, the blend percentage will consist of 50% risk adjustment payment and 50% on the adjustment for demographic factors. In 2006, the blend percentage will consist of 75% risk adjustment payment and 25% on the adjustment for demographic factors. In 2007, the blend percentage will consist of 100% risk adjustment payment and 0% on the adjustment for demographic factors. Through Fiscal 2003, our payments from the HMOs have substantially been based on the demographic model. However, in Fiscal 2004, we anticipate that the payments we receive from the HMOs will begin reflecting the MRA methodology. At this time, it cannot be determined if this impact will be favorable or unfavorable in future years.

The development of management information systems may involve significant time and expense.

Our management information systems are important components of the business and are becoming a more significant factor in our ability to remain competitive. We already possess a physician billing and collection system. We are participating in the development of an integrated management information system. The development and implementation of such systems involve the risk of unanticipated delay and expense, which could have an adverse

impact on our operations.

The high cost insurance could adversely effect our financial operation.

As a result of the national malpractice award trends and the significant loss of professional insurance underwriting capacity, the cost of our medical malpractice insurance has increased while the coverage afforded under the policies available has decreased. Additionally, as a result of the events of September 11, 2001, as well as recent high profile director and officer related litigation, the cost of our director and officer insurance policy has increased. We anticipate that the cost for both our medical malpractice insurance as well as our director and officer insurance will increase in 2004. We also maintain stop-loss insurance for which the premium is based on a cost per member. We may experience future increases in stop-loss insurance, which could have a material adverse effect on our business, financial condition and results of operations.

Our industry is already very competitive; increased competition could adversely affect our revenues.

The health care industry is highly competitive and subject to continual changes in the method in which services are provided and the manner in which health care providers are selected and compensated. Companies in other health care industry segments, some of which have financial and other resources greater than we do, may become competitors in providing similar services. We may not be able to continue to compete effectively in this industry. Additional competitors may enter our markets and this increased competition may have an adverse effect on our revenues.

We are dependent upon our key management personnel for our future success.

Our success depends to a significant extent on the continued contributions of our key management. We have no insurance policies for our executive officers. The loss of these key personnel could have a material adverse effect on our financial condition, results of operations and plans for future development. While we have employment contracts with certain key members of management, we compete with other companies for executive talent and there can be no assurance that highly qualified executives would be readily available.

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

The health care services that we and our affiliated professionals provide are subject to extensive federal, state and local laws and regulations governing various matters such as the licensing and certification of our facilities and personnel, the conduct of our operations, our billing and coding policies and practices, our policies and practices with regard to patient privacy and confidentiality, and prohibitions on payments for the referral of business and self-referrals. If we fail to comply with these laws, or a determination is made that in the past we have failed to comply with these laws, our financial condition and results of operations could be adversely affected. Changes to

health care laws or regulations may restrict our existing operations, limit the expansion of our business or impose additional compliance requirements. These changes, if effected, could have the effect of reducing our opportunities or continued growth and imposing additional compliance costs on us that may not be recoverable through price increases.

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

Limitations of or reduction in reimbursement amounts or rates by government-sponsored healthcare programs could adversely affect our financial condition and results of operations.

As of December 31, 2003 approximately 99% of our revenues were derived from reimbursements by various government-sponsored health care programs. These government programs, as well as private insurers, have taken and may continue to take steps to control the cost, use and delivery of health care services. The following events could result in an adverse effect on our financial condition and results of operations:

reductions in or limitations of reimbursement amounts or rates under programs,

reductions in funding of programs,

elimination of coverage for certain individuals or treatments under programs, which may be implemented as a result of increasing budgetary and cost containment pressures on the health care industry, or

new federal or state legislation reducing funding and reimbursements.

We have anti-takeover provisions which may make it difficult to replace or remove our current management.

Our Articles of Incorporation authorize the issuance of up to 10,000,000 shares of preferred stock with such rights and preferences as may be determined from time to time by the Board of Directors. Our Board of Directors may, without shareholder approval, issue preferred stock with dividends, liquidation, conversion, voting or other rights, which could adversely affect the voting power, or other rights of the holders of our common stock. The ability of our board to issue preferred stock may prevent or frustrate shareholder attempts to replace or remove current management.

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

These factors could also make it more difficult for us to raise funds through future offerings of our common stock. As of December 31, 2003, there were 38,527,699 shares of our common stock outstanding, all of which are freely tradable without restriction with the exception that approximately 7,000,000 shares, which are owned by certain of our officers, directors, affiliates and third parties, and may be sold publicly at any time subject to the volume and other restrictions under Rule 144 of the Securities Act of 1933.

In addition, as of December 31, 2003, approximately 10,400,000 shares of our common stock were reserved for issuance upon the exercise of warrants and options which have been previously granted.

Our common stock has experienced in the past, and is expected to experience in the future, significant price and volume volatility, which substantially increase the risk of loss to persons owning common stock.

Because of the limited trading market for our common stock, and because of the possible price volatility, you may not be able to sell your shares of common stock when you desire to do so. The inability to sell your shares in a rapidly declining market may substantially increase your risk of loss because of such illiquidity and because the price for our common stock may suffer greater declines because of its price volatility.

PART I

Item 1.

Description of Business

Introduction

Metropolitan Health Networks, Inc. provides healthcare benefits to over 25,000 Medicare Advantage members (formerly Medicare+Choice) in Central and South Florida under full-risk contracts with Humana, Inc., the second largest participant in this Medicare program. Metcare entered into this business in 1999, operating a Provider Service Network (PSN), also known as a Managed Service Organization (MSO).

The PSN includes thirty-three (33) primary care physician practices. Metcare owns six of these practices; the balance are independently owned and operated under capitation contracts with the Company. In addition to the primary care practices, the PSN contracts with specialists, ancillary service providers, and hospitals. The Company also owns and operates an oncology practice, which is part of the network.

Under its risk agreements, Metropolitan receives credit for a significant percentage of the monthly Medicare premiums received by Humana from the Centers for Medicare and Medicaid Services (CMS) and is obligated to provide all of the covered healthcare benefits for the member lives. To the extent the costs of providing such benefits is less than the related premiums received, Metropolitan profits. Conversely, if the costs exceed related premiums, the Company loses money. The Company re-insures against catastrophic losses and certain diseases annually on a per member basis. The annual stop-loss limits are \$100,000 and \$40,000 per member in the Daytona and South Florida markets, respectively.

The Medicare Advantage business accounts for the majority of the Company's revenues. In addition, Metcare cares for commercial insurance members and fee for service patients in its wholly owned practices.

Background

The Company was incorporated in the State of Florida in January 1996, and began operations as a physician practice group. During the late 1990's Metcare acquired a number of physician practices and ancillary service providers. In

late 1999, the group practice strategy was abandoned in connection with a change in the senior management team.

The first managed care risk contract was secured with Humana in 1999. In 2000 an additional contract was subsequently secured to manage all of Humana's Medicare Advantage lives in the Daytona, Florida area (Flagler and Volusia Counties). The Daytona contract currently accounts for over 19,000 lives or 77% of the Company's total Medicare Advantage lives. The balance of the Company's Humana lives resides in South Florida (Palm Beach, Broward and Miami-Dade Counties).

Metropolitan renegotiated its most significant contract with Humana, in Daytona, effective January 1, 2003. This renegotiation increased the percentage of Medicare premium received by Metcare and resolved a number of contractual disputes.

Metcare acquired a diagnostic laboratory business, renamed Metlabs, Inc., in 2000. This operation was subsequently shut down in 2002. The Company formed Metcare Rx, a pharmacy business, in 2001. This business was sold in November 2003.

Metropolitan's Board of Directors replaced the Company's President and CEO in March 2003, and subsequently adopted a strategy to focus its resources and energies on its core managed care business. In December 2003, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the Medicare Modernization Act or MMA) was signed into law, which, among other changes, is significantly increasing funding for the Medicare Advantage program beginning in 2004. Included in the MMA was the establishment of a significant federal marketing budget to promote the Medicare Advantage program. The stated goal is to triple enrollment in this program over the next several years.

Industry

A report issued in early 2004 by CMS estimated that national healthcare spending in the United States was nearly \$1.7 trillion, or \$5,800 for every American, in 2003. The CMS report projected that healthcare spending, which today accounts for more than 15% of the national economy, would grow to \$3.4 trillion by 2013, more than 18% of projected Gross Domestic Product. The principal drivers for this growth include continued cost-increasing medical innovation, rising price inflation, continued strong demand for prescription drugs and the aging baby-boomer demographics. The CMS projections did not give effect to the December 2003 Medicare Modernization Act, other than to note that new legislation is not anticipated to have a large impact on overall spending but is expected to cause sizable shifts in payment sources.

Medicare currently provides healthcare benefits to 41 million elderly and disabled Americans, and was established in 1965. This number is expected to more than double by 2030. The newly renamed Medicare Advantage program

(formerly Medicare+Choice) represents private health plans' participation in the Medicare program. Under Medicare Advantage plans, private insurers provide care under contracts with Medicare. These plans represent an alternative to traditional fee-for-service Medicare and by definition must provide enhanced benefits in exceeding traditional Medicare by at least 30%. Some of these enhancements include prescription drugs, eye exams, hearing aids and routine physical exams. Out-of-pocket cost for the beneficiary may be lower and choice of physicians is typically restricted to the plan's network.

This participation of private health plans under risk contracts began in the 1980's and grew to a peak membership in 2000 when Medicare HMOs covered 6.3 million lives. Today, private plans account for slightly more than 10% of Medicare members, down from a peak penetration of 18%. The Balanced Budget Act of 1997 resulted in significant funding decreases causing the number of participating plans to drop from 346 in 1998 to 151 in 2003. The exodus of managed care companies from Medicare left many of its beneficiaries without a private plan option.

The Medicare Modernization Act, or MMA, was signed into law in December 2003, and provides sweeping changes to the Medicare program. At an estimated cost of over \$400 billion for the next ten years, the new law provides for a Medicare prescription drug offering beginning in 2006, establishes new tax-advantaged Health Savings Account regulation and makes significant changes to the old Medicare+Choice (now Medicare Advantage) program. The changes to the Medicare Advantage program were a response to the decreased managed care participation in Medicare and the resulting lack of choice for Medicare beneficiaries. The MMA made favorable changes to the premium rate calculation methodology and generally provides for program rates that will better reflect the increased cost of medical services provided to Medicare beneficiaries. The new rates for 2004 were announced in January 2004 reflecting an average increase of 10.6%, which will be reflected in funding beginning in March 2004.

The funding increases are intended to both offset medical cost inflation and to allow enhanced plan benefit design to encourage increased participation in Medicare Advantage plans.

Markets

Metcare currently provides healthcare services to nearly 6,000 Medicare Advantage beneficiaries in South Florida (Palm Beach, Broward and Miami-Dade Counties) and to over 19,000 members in the Daytona area (Flagler and Volusia Counties). Behind only California, which has nearly 4 million Medicare eligibles, Florida has the second largest Medicare population in the U.S. with almost 3 million lives. However, California's Medicare Advantage penetration is approximately 30% while Florida's is only 20%. The most significant counties in terms of Medicare Advantage membership currently include Palm Beach, Broward, Miami-Dade and Volusia. Florida's Medicare population is expected to grow to 4 million by 2015.

Business Model

Metcare provides turnkey healthcare services to Medicare Advantage beneficiaries who participate in the Medicare Advantage program through Humana, Inc. Our current agreements with Humana have one-year terms and renew automatically for additional one-year terms unless terminated for cause or on 180-days prior notice. Humana is paid a certain premium per member, per month, for its Medicare Advantage members by Medicare under its contract with CMS. The monthly amount varies by patient, county and severity of health status. Humana, in turn, allocates a majority of this amount to Metcare for all patients cared for by Metcare.

Metcare serves over 25,000 patients enrolled by Humana, Inc. in South and Central Florida. Metcare's Provider Service Network (PSN) operates predominantly as an affiliated model as contrasted with a staff model in which the physician practices are owned and operated by the risk provider. Under the Company's model, the physicians maintain their independence but are aligned with a professional staff that assists in providing high quality, cost effective health care. Metcare's PSN is comprised of 33 primary care physician practices, six of which the Company owns. The others are independent practices that are contracted with on a capitated-basis. Under these agreements, Metcare pays the physician a set amount per member, per month, to provide the necessary primary care services on a risk basis. The monthly amount is negotiated and is subject to change based on certain quality metrics under the Company's Partners In Quality (PIQ) program. In addition to primary care physicians, the Company's PSN contracts with specialists, ancillary service providers and hospitals. These providers deliver services to the Company's patients based on certain fee schedules and care requirements. Metcare has capitated (fixed cost) certain high volume specialties, averaging the cost on a per member, per month basis; the others are paid on a contractual fee-for-service basis.

Metropolitan does not pay or process any of the payments to its PSN physicians or other providers. All claims processing is handled directly by Humana. The Company does review and approve claims in advance of payment (prospective payment review). Incorrect claims are identified and corrected prior to payment by the Company's claims suspense staff. Paid claims are reviewed again and errors are handled and recovered by Metcare's contestation staff. The Company regularly monitors and measures Humana's claims escrow pools, or allocations for claims incurred but not yet reported (IBNR), for accuracy and underfunding.

Metropolitan is certified as a Utilization Review Agent by Florida's Agency for Health Care Administration. Utilization review is a process whereby multiple data are analyzed and considered to ensure that appropriate health services are provided in a cost-effective manner. Factors include the risks and benefits of a medical procedure, the cost of providing those services, specific payer coverage guidelines, and historical outcomes of healthcare providers such as physicians and hospitals.

The Company has developed a proprietary care management model, Partners In Quality (PIQ), which was implemented in 2002. PIQ is based on the principle that optimal clinical outcomes depend on multiple factors including perceptions of care, efficient utilization of healthcare resources, evidence-based medical treatment and appropriate follow-up. This model is used to manage and compensate the Company's primary care physicians in caring for Metcare's patients. The PIQ program measures performance based on quality metrics including patient satisfaction, disease state management of high-risk, chronically ill patients, increased frequency of physician-patient encounters, and enhanced medical record documentation. Metropolitan believes this focus provides a competitive advantage as a provider service network.

Competition

The healthcare industry is highly competitive and is subject to continuing changes in the provisioning of services and the selection and compensation of providers. The Company competes with national, regional and local companies in providing its services. Metcare competes with other risk providers for Humana's business, and Humana competes with other HMO's in securing and serving patients in the Medicare Advantage program.

Growth Initiatives

Membership in Medicare Advantage programs (previously Medicare +Choice) has declined as a percentage of Medicare eligible lives over the last several years, principally the result of decreased funding which has negatively impacted plan benefits. Although the Company has seen growth in its membership through its expansion of its relationship with Humana, Metcare has experienced gradual attrition in membership commensurate with the industry. Net membership decreases from attrition were approximately 1,200 or 4.4% in 2003. The Company expects this trend to reverse with the passage of the Medicare Modernization Act in late 2003. With operations focused in Florida, the nation's second largest Medicare market, the Company expects incremental membership growth in its current markets. Among a number of sweeping changes to Medicare, the legislation is intended to substantially increase participation in Medicare Advantage through increased funding commitments. Beginning with an average increase of 10.6% in 2004, this stimulus allows plans to improve benefits and attract new enrollees. The Company's 2004 premium increases are approximately 9.8% in Daytona and 17.8% in South Florida, a significant portion of which will be utilized to enhance plan benefits. As well, Metcare expects that opportunities to expand into other Florida markets will develop as Humana and other Medicare HMO's grow their respective businesses.

The underlying economics of the Medicare Modernization Act may also provide sufficient incentive for companies such as Metcare to directly enter the Medicare Advantage business. The Company is currently evaluating its opportunities in the Florida, particularly in underserved markets, and may file for its own Medicare HMO license in 2004. The decision to enter this business would necessarily be based on a number of factors including analysis of the opportunity, consideration of alternative strategies and availability of necessary capital.

Employees

As of December 31, 2003, the Company had approximately 100 full-time employees, of which 31 were employed at the Company's executive offices. No employees of the Company are covered by a collective bargaining agreement or are represented by a labor union. The Company considers its employee relations to be good.

Item 2.

Description of Property

Our offices are located at 250 Australian Avenue South, Suite 400, West Palm Beach, Florida where we occupy 13,211 square feet at a current monthly rent of \$15,700 pursuant to a lease expiring March 31, 2008.

The Company has a satellite office in Daytona Beach with 5,700 square feet and monthly rent of \$8,600. The lease expires September 30, 2006.

The managed care division leases 6 offices in Florida with an aggregate monthly rental of \$28,800 with expiration dates ranging from one to five years.

None of the Company's properties are leased from affiliates.

Item 3.

Legal Proceedings

The Company is a party to various claims arising in the ordinary course of business. Management believes that the outcome of these matters will not have a materially adverse effect on the financial position or the results of operations of the Company.

In June 2003, the Company was informed that the U.S. Attorneys' Office in Wilmington, Delaware was conducting an investigation of the Company. The Company fully cooperated with the U.S. Attorneys' Office and on February 9, 2004 the investigation was terminated.

Item 4.

Submission of Matters to a Vote of Security Holders

No matter was submitted to a vote of the security holders, through the solicitation of proxies or otherwise, during the twelve months ended December 31, 2003.

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PART II

Item 5.

Market for Common Equity and Related Stockholder Matters

The Company's Common Stock is currently traded on the OTCBB under the symbol "MDPA". The Company's Warrants traded under the symbol "MDPAW" until March 15, 2001 when they expired. The following table sets forth the high and low closing bid prices for the common stock, as reported by OTCBB:

	High	Low
	<u>(\$)</u>	<u>(\$)</u>
COMMON STOCK		
Quarter ended March 31, 2002	1.40	0.67
Quarter ended June 30, 2002	0.83	0.45
Quarter ended September 30, 2002	0.46	0.18
Quarter ended December 31, 2002	0.47	0.17
Quarter ended March 31, 2003	0.27	0.14
Quarter ended June 30, 2003	0.20	0.07
Quarter ended September 30, 2003	0.34	0.13
Quarter ended December 31, 2003	0.79	0.26

The foregoing bid prices reflect inter-dealer prices, without retail mark-up, mark-down or commission, and may not necessarily represent actual transactions.

As of the date of this filing there were approximately 1,200 holders of our common stock.

The Company has not declared or paid any dividends on its common stock. The Company presently intends to invest its earnings, if any, in the development and growth of its operations and the reduction of debt.

Equity Compensation Plan

A table detailing the Company's existing equity compensation plans as of December 31, 2003 is included in Item 12.

Item 6.

Selected Financial Data

Set forth below is our selected historical consolidated financial data for the five fiscal years ended December 31, 2003. The selected historical consolidated financial data should be read in conjunction with our consolidated financial statements and accompanying notes.

	For the Years Ended December 31,				
	2003	2002	2001	2000*	1999
Net revenues	\$143,874,488	\$140,063,566	\$128,186,307	\$119,047,520	\$18,501,497
Income (Loss) from continuing Operations	\$ 5,861,303	\$ (13,865,800)	\$ 997,990	\$ 4,417,862	\$ (7,841,805)
Income (Loss) from continuing operations per share - basic	\$ 0.17	\$ (0.46)	\$ 0.04	\$ 0.26	\$ (1.09)