METROPOLITAN HEALTH NETWORKS INC
Form 10-Q
November 05, 2009

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

FORM 10-Q

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

For the quarterly period ended September 30, 2009

OR

o 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: 001-32361

METROPOLITAN HEALTH NETWORKS, INC.
(Exact name of registrant as specified in its charter)

Florida	65-0635748
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
250 Australian Avenue, Suite 400 West Palm Beach, FL (Address of principal executive offices)	33401 (Zip Code)

(561) 805-8500
(Registrant's telephone number, including area code)

None
(Former name, former address and former fiscal year, if changed since last report)

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 whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T

(§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Yes [ ] No [ ]

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of “large accelerated filer,” “accelerated filer” and “smaller reporting company” in Rule 12b-2 of the Exchange Act.

Large accelerated filer	¨	Accelerated filer	x
Non-accelerated filer (Do not check if a smaller reporting company)	¨	Smaller reporting company	¨

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

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

Class	Outstanding at October 30, 2009
Common Stock, $.001 par value per share	42,349,591 shares

Metropolitan Health Networks, Inc.

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PART 1. FINANCIAL INFORMATION
Item 1. FINANCIAL STATEMENTS

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS

ASSETS	September 30, 2009 (unaudited)	December 31, 2008
CURRENT ASSETS		
Cash and equivalents	$ 5,163,330	$ 2,701,243
Investments, at fair value	32,029,904	33,641,140
Accounts receivable, net	712,459	286,003
Due from Humana	-	2,823,355
Inventory	181,214	315,811
Prepaid expenses	632,654	570,792
Deferred income taxes	599,296	262,874
Other current assets	119,350	266,007
TOTAL CURRENT ASSETS	39,438,207	40,867,225
PROPERTY AND EQUIPMENT, net	1,623,529	1,336,094
RESTRICTED CASH	1,413,528	1,408,089
DEFERRED INCOME TAXES	1,159,293	980,842
OTHER INTANGIBLE ASSETS, net	1,027,223	1,184,142
GOODWILL, net	4,362,332	2,587,332
OTHER ASSETS	774,474	780,631
TOTAL ASSETS	$ 49,798,586	$ 49,144,355
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 451,619	$ 483,621
Due to Humana	3,776,123	-
Accrued payroll and payroll taxes	1,300,594	2,288,224
Income taxes payable	729,762	1,865,926
Current portion of long-term debt	318,182	-
Accrued termination costs of HMO administrative services agreement	-	1,080,000
Accrued expenses	634,691	621,854
TOTAL CURRENT LIABILITIES	7,210,971	6,339,625
LONG-TERM DEBT, net of current portion	556,818	-
TOTAL LIABILITIES	7,767,789	6,339,625
COMMITMENTS AND CONTINGENCIES		
STOCKHOLDERS' EQUITY		
Preferred stock, par value $.001 per share; stated value $100 per share;		

10,000,000 shares authorized; 5,000 issued and outstanding	500,000	500,000
Common stock, par value $.001 per share; 80,000,000 shares authorized;		
42,987,000 and 48,251,000 issued and outstanding at September 30, 2009 and December 31, 2008, respectively	42,987	48,251
Additional paid-in capital	27,267,735	37,649,331
Retained earnings	14,220,075	4,607,148
TOTAL STOCKHOLDERS' EQUITY	42,030,797	42,804,730
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 49,798,586	$ 49,144,355

The accompanying notes are an integral part of the condensed consolidated financial statements.

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF INCOME

	Nine Months Ended September 30,		Three Months Ended September 30,	
	2009 (unaudited)	2008 (unaudited)	2009 (unaudited)	2008 (unaudited)
REVENUE	$ 265,655,152	$ 237,175,320	$ 88,138,389	$ 78,949,785
MEDICAL EXPENSE				
Medical claims expense	227,399,839	200,522,906	76,929,010	68,072,724
Medical center costs	10,795,722	9,247,512	3,582,353	3,175,606
Total Medical Expense	238,195,561	209,770,418	80,511,363	71,248,330
GROSS PROFIT	27,459,591	27,404,902	7,627,026	7,701,455
OPERATING EXPENSES				
Payroll, payroll taxes and benefits	7,413,908	9,911,209	2,252,490	2,897,108
General and administrative	5,431,880	8,306,534	1,863,853	2,405,884
Marketing and advertising	202,092	1,739,459	118,334	138,932
Stay bonuses and termination costs	-	1,597,674	-	1,597,674
Total Operating Expenses	13,047,880	21,554,876	4,234,677	7,039,598
OPERATING INCOME BEFORE GAIN ON SALE OF HMO SUBSIDIARY	14,411,711	5,850,026	3,392,349	661,857
Gain on sale of HMO subsidiary	811,470	5,797,769	366,470	5,797,769
OPERATING INCOME	15,223,181	11,647,795	3,758,819	6,459,626
OTHER INCOME (EXPENSE)				
Investment income, net	351,301	254,547	85,838	28,630
Other income (expense)	(6,592)	(16,805)	(6,081)	(10,388)
Total other income (expense)	344,709	237,742	79,757	18,242
INCOME BEFORE INCOME TAX EXPENSE	15,567,890	11,885,537	3,838,576	6,477,868
INCOME TAX EXPENSE	5,954,963	4,250,590	1,412,095	2,209,542
NET INCOME	$ 9,612,927	$ 7,634,947	$ 2,426,481	$ 4,268,326
NET EARNINGS PER COMMON SHARE				
Basic	$ 0.21	$ 0.15	$ 0.05	$ 0.08
Diluted	$ 0.20	$ 0.14	$ 0.05	$ 0.08

The accompanying notes are an integral part of the condensed consolidated financial statements.

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

	Nine Months Ended September 30,	
	2009 (unaudited)	2008 (unaudited)
CASH FLOWS PROVIDED BY OPERATING ACTIVITIES:		
Net income	$ 9,612,927	$ 7,634,947
Adjustments to reconcile net income to net cash		
provided by/(used in) operating activities:		
Depreciation and amortization	659,989	875,369
Gain on sale of HMO subsidiary	(811,470)	(5,797,769)
Unrealized gains on short-term investments	(64,446)	-
Restricted cash from sale of HMO subsidiary	(5,439)	-
Share-based compensation expense	809,229	1,011,469
Shares issued for director fees	119,186	132,946
Excess tax benefits from share-based compensation	-	(212,000)
Deferred income taxes	(514,873)	2,749,121
Loss on sale of fixed assets	572	10,224
Changes in operating assets and liabilities:		
Accounts receivable	(426,457)	1,344,507
Due to/from Humana	6,965,948	128,473
Inventory	134,599	(18,448)
Prepaid expenses	(61,862)	(57,567)
Other current assets	146,657	(577,968)
Other assets	(6,870)	(35,695)
Accounts payable	292,998	(135,818)
Accrued payroll and payroll taxes	(987,631)	(439,939)
Income taxes payable	(1,136,164)	-
Estimated medical expenses payable	-	(1,454,591)
Due to CMS	-	261,636
Accrued expenses	(947,163)	1,403,021
Net cash provided by operating activities	13,779,730	6,821,918
CASH FLOWS (USED IN) INVESTING ACTIVITIES:		
Net proceeds from sale of HMO subsidiary	-	78,439
	-	(1,400,000)

Restricted cash from sale of HMO subsidiary		
Sale of short-term investments	1,675,682	-
Cash paid for physician practice acquisition	(1,000,000)	-
Capital expenditures	(678,050)	(361,508)
Net cash (used in) investing activities	(2,368)	(1,683,069)
CASH FLOWS (USED IN) PROVIDED BY FINANCING ACTIVITIES:		
Stock repurchases	(11,315,275)	-
Proceeds from exercise of stock options	-	252,158
Excess tax benefits from share-based compensation	-	212,000
Net cash (used in) provided by financing activities	(11,315,275)	464,158
NET INCREASE IN CASH AND EQUIVALENTS	2,462,087	5,603,007
CASH AND EQUIVALENTS - beginning of period	2,701,243	38,682,186
CASH AND EQUIVALENTS - end of period	$ 5,163,330	$ 44,285,193
Supplemental Schedule of Non-Cash Financing Activities		
Issuance of note payable for physician practice acquisition	$ 875,000	$ -

The accompanying notes are an integral part of the condensed consolidated financial statements.

METROPOLITAN HEALTH NETWORKS, INC. & SUBSIDIARIES
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(UNAUDITED)

NOTE 1 UNAUDITED INTERIM INFORMATION

The accompanying unaudited condensed consolidated financial statements of Metropolitan Health Networks, Inc. and subsidiaries (referred to as "Metropolitan," "the Company," "we," "us," or "our") have been prepared in accordance w accounting principles generally accepted in the United States for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and footnotes required by accounting principles generally accepted in the United States of America for complete financial statements, or those normally made in an Annual Report on Form 10-K. In the opinion of management, all adjustments (consisting of normal recurring accruals) considered necessary for a fair presentation have been included. Operating results for the three month period and nine month period ended September 30, 2009 are not necessarily indicative of the results that may be reported for the remainder of the year ending December 31, 2009 or future periods.

The preparation of our condensed consolidated financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are medical expenses payable, premium revenue, the impact of risk sharing provisions related to our contracts with Humana, Inc. ("Humana"), the future benefit of deferred tax assets and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events. We adjust these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of earnings in the period in which the estimate is adjusted. Actual results may ultimately differ materially from those estimates.

For further information, refer to the audited consolidated financial statements and footnotes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2008. The accompanying December 31, 2008 condensed consolidated balance sheet has been derived from these audited financial statements. These interim condensed consolidated financial statements should be read in conjunction with the audited consolidated financial statements and notes to consolidated financial statements included in that report.

NOTE 2 ORGANIZATION AND BUSINESS ACTIVITY

Our business is focused on the operation of a provider services network ("PSN") in the State of Florida through our wholly-owned subsidiary, Metcare of Florida, Inc. Prior to August 29, 2008 (the "Closing Date"), we also owned and operated a health maintenance organization (the "HMO") through our wholly-owned subsidiary, Metcare Health Plans, Inc.

On the Closing Date, we completed the sale (the "Sale") of the HMO to Humana Medical Plan, Inc. (the "Humana Plan"). Concurrently with the Sale, the PSN entered into a five-year independent practice association participation agreement (the "IPA Agreement") with Humana to provide or coordinate the provision of healthcare services to the HMO's customers pursuant to a per customer fee arrangement. Under the IPA Agreement, the PSN, on a non-exclusive basis, provides and arranges for the provision of covered medical services, in all 13 Florida counties previously served by the HMO, to each customer of Humana's Medicare Advantage health plans who selects one of our PSN's primary care physicians as his or her primary care physician. The IPA Agreement has a five-year term and will renew automatically for additional one-year periods upon the expiration of the initial term and each renewal term unless terminated upon 90 days notice prior to the end of the applicable term.

Since August 30, 2008, the PSN has operated under the IPA Agreement and two other network contracts (the "Pre-Existing Humana Network Agreements" and, together with the IPA Agreement, the "Humana Agreements"), to provide medical care to Medicare beneficiaries enrolled under Humana's health plans. To deliver care, we utilize our wholly-owned medical practices and have also contracted directly or indirectly through Humana with medical practices, service providers and hospitals (collectively the "Affiliated Providers"). For the approximately 6,000 Humana Participating Customers covered under the Humana Agreement covering Miami-Dade, Broward and Palm Beach counties, our PSN and Humana share in the cost of inpatient hospital services and the PSN is responsible for the full cost of all other medical care provided to the Humana Participating Customers. For the remaining 29,500 Humana Participating Customers covered under our other two Humana Agreements, our PSN is responsible for the cost of all medical care provided.

At September 30, 2009, pursuant to the Humana Agreements, we have the contractual right to provide services to Humana customers in 27 Florida counties. We currently have operations in 19 of these counties.

The PSN also has a network agreement (the "CarePlus Agreement") with CarePlus Health Plans, Inc. ("CarePlus"), a Medicare Advantage health plan in Florida, which covers approximately 280 customers at September 30, 2009. CarePlus is a wholly-owned subsidiary of Humana. Pursuant to the CarePlus Agreement the PSN has the right to manage, on a non-exclusive basis, healthcare services to Medicare beneficiaries in 22 Florida counties who have elected to receive benefits through CarePlus' Medicare Advantage plans (each, a "CarePlus Plan Customer"). Like Humana, CarePlus directly contracts with CMS and is paid a monthly premium payment for each CarePlus Plan Customer. In return for managing these healthcare services, the PSN receives a monthly network administration fee for each CarePlus Participating Customer. For 13 of the counties covered by the CarePlus Agreement, the PSN will begin to receive a capitation fee from CarePlus and will assume full responsibility for the cost of all medical services provided to each CarePlus Participating Customer on February 1, 2010. The capitation fee will represent a substantial portion of the monthly premium CarePlus is to receive from CMS. On October 23, 2009, we and Humana agreed to delay the implementation of the capitated fee arrangement for the nine remaining counties covered by the CarePlus Agreement from September 1, 2009 to February 1, 2010.

At September 30, 2009, we operated in six of the 22 Florida counties covered by the CarePlus Agreement.

Prior to the Sale, we managed the PSN and the HMO as separate business segments. Subsequent to the Sale, we operate only the PSN business.

NOTE 3 RECENT ACCOUNTING PRONOUNCEMENTS

Effective for financial statements issued for fiscal years beginning after December 15, 2008, and interim periods within those fiscal years and applied prospectively to intangible assets acquired after the effective date, in April 2008, U.S. generally accepted accounting principles ("U.S. GAAP") amended the factors that should be considered in developing renewal or extension assumptions used to determine the useful life of a recognized intangible asset. The objective is to improve the consistency between the useful life of a recognized intangible asset and the period of expected cash flows used to measure the fair value of the asset under U.S. GAAP. This applies to all intangible assets, and early adoption is not permitted. This requirement became effective for the Company's 2009 fiscal year and did not have a material impact on our consolidated financial statements.

Effective for the Company's 2009 fiscal year U.S. GAAP requires that we measure the fair value for nonfinancial assets and nonfinancial liabilities, except for items that are recognized or disclosed at fair value in the financial statements on a recurring basis (at least annually). These requirements did not have a material impact on our consolidated financial statements.

Effective January 1, 2009, U.S. GAAP requires the accounting for any entity in a business combination to recognize the full value of the assets acquired and liabilities assumed in the transaction at the acquisition date; the immediate expense recognition of transaction costs; and accounting for restructuring plans separately from the business combination. The acquirer in a business combination is defined as the entity that obtains control of one or more businesses in the business combination and establishes the acquisition date as the date that the acquirer achieves control. U.S. GAAP requires us to recognize intangible assets separately from goodwill. Any business combination entered into after January 1, 2009, could significantly impact our financial position and earnings, but not cash flows, compared to accounting for business combinations prior to the adoption of these criteria.

In addition, on April 1, 2009, U.S. GAAP was amended to require that assets acquired and liabilities assumed in a business combination that arise from contingencies (a "pre-acquisition contingency") be recognized at fair value, if the fair value can be determined during the measurement period. If the fair value of a pre-acquisition contingency cannot

be determined during the measurement period, U.S. GAAP requires that the contingency be recognized at the acquisition. This amendment is effective January 1, 2009 and could impact our accounting for future acquisitions.

In May 2009, U.S. GAAP established general standards of accounting for disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. The standard is based on the same principles that currently exist in the auditing standards. U.S. GAAP requires disclosure of the date through which subsequent events have been evaluated and for certain nonrecognized subsequent events, the nature of the event and an estimate of its financial effect or a statement that such an estimate cannot be made. We adopted this provision for the quarter ended June 30, 2009.

In June 2009, the FASB issued FASB Statement No. 168, The FASB Accounting Standards CodificationTM and the Hierarchy of Generally Accepted Accounting Principles, or SFAS 168. The FASB Accounting Standards CodificationTM (ASC) is the source of authoritative U.S. GAAP recognized by the FASB and supersedes all existing non-SEC accounting and reporting standards. All ASC content carries the same level of authority and anything outside of the ASC is nonauthoritative. SFAS 168 was effective for us beginning with our third quarter 2009 condensed consolidated financial statements. The adoption of this standard in the third quarter of 2009 only changed the way we reference accounting standards in our disclosures.

NOTE 4 REVENUE

Revenue is primarily derived from risk-based health insurance arrangements in which the premium is paid to us on a monthly basis. We assume the economic risk of funding our customers' healthcare services and related administrative costs. Premium revenue is recognized in the period in which our customers are entitled to receive healthcare services. Because we have the obligation to fund medical expenses, we recognize gross revenue and medical expenses for these contracts in our consolidated financial statements.

Periodically we receive retroactive adjustments to the premiums paid to us based on the updated health status of our customers (known as a Medicare risk adjustment or "MRA" score). The factors considered in this update include changes in demographic factors, risk adjustment scores, customer information and adjustments required by the risk sharing requirements for prescription drug benefits under Part D of the Medicare program. In addition, the number of customers for whom we receive capitation fees may be retroactively adjusted due to enrollment changes not yet processed or reported. These retroactive adjustments could, in the near term, materially impact the revenue that has been recorded. We record any adjustments to this revenue at the time the information necessary to make the determination of the adjustment is available, the collectibility of the amount is reasonably assured, or the likelihood of repayment is probable.

In August 2009, we were notified by Humana of the final retroactive MRA premium increase for services provided in 2008 based on the increased risk score of our customer base. The increase totaled $3.0 million as compared to the estimated increase of $3.8 million that we had recorded at December 31, 2008 and June 30, 2009. The difference reduced revenue and income before income taxes in the three and nine month periods ended September 30, 2009 by $800,000. In August 2008, we were notified of the final retroactive MRA premium increase for services provided in 2007. The amount of the increase was not materially different than the estimate we recorded at December 31, 2007.

Our PSN's wholly-owned medical practices also provide medical care to non-Humana customers on a fee-for-service basis. These services are typically billed to patients, Medicare, Medicaid, health maintenance organizations and insurance companies. Fee-for-service revenue is recorded at the net amount expected to be collected from the patient or third party payers paying the bill. Often this amount is less than the charge that is billed and such discounts, or contractual allowances, reduce the revenue recorded.

Investment income is recorded as earned and is included in other income.

NOTE 5 MEDICAL EXPENSE

Medical expenses are recognized in the period in which services are provided and include an estimate of our obligations for medical services that have been provided to our customers but for which we have neither received nor processed claims, and for liabilities for physician, hospital and other medical expense disputes. We develop estimates for medical expenses incurred but not reported using an actuarial process that is consistently applied. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, care provider contract rate changes, medical care consumption and other medical expense trends. The actuarial process and models develop a range for medical claims payable and we record to the amount in the range that is our best estimate of the ultimate

liability.

Each period, we re-examine previously established medical claims payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability recorded in prior periods becomes more exact, we adjust the amount of the estimates, and include the changes in medical expense in the period in which the change is identified. In each reporting period, our operating results include the effects of more completely developed medical expense payable estimates associated with previously reported periods. While we believe our medical expenses payable are adequate to cover future claims payments required, such estimates are based on the claims experience to date and various assumptions. Therefore, the actual liability could differ materially from the amounts recorded.

As claims are ultimately settled, amounts incurred related to previously reported periods will vary from the estimated medical claims payable liability that had been recorded. Favorable claims development is a result of actual medical claim cost for prior periods developing lower than the original estimated cost which reduces the reported medical expense and the Medical Expense Ratio ("MER"), which is total medical expense divided by total revenue, for the current quarter and year to date period. Unfavorable claims development is a result of actual medical claim cost for prior periods exceeding the original estimated cost which increases total reported medical expense and the MER for the current quarter and year to date period.

At September 30, 2009, we estimate that claims paid subsequent to December 31, 2008 for services provided in 2008 will approximate the estimated consolidated medical expenses payable recorded at December 31, 2008. At September 30, 2008, we estimate that, on a consolidated basis, claims paid in 2008 for services provided in 2007 would be less than the amount originally recorded as estimated medical expenses payable at December 31, 2007 by $1.2 million, decreasing medical expense by approximately 0.6% for the nine months ended September 30, 2008. The difference between the amount incurred and the estimated medical expenses payable that was recorded at December 31, 2007 was primarily a result of favorable developments in our medical claims expense.

At September 30, 2009, we estimate that, on a consolidated basis, claims paid subsequent to June 30, 2009 for services provided prior to that date will be less than the consolidated estimated medical expenses payable recorded at June 30, 2009 by approximately $694,000 or approximately 0.9% of consolidated total medical expense recorded for the quarter ended September 30, 2009. The difference between the amount incurred and the estimated medical expenses payable that was recorded at June 30, 2009 was primarily a result of favorable developments in our medical claims expense. At September 30, 2008, we estimate that claims paid for the PSN and HMO subsequent to June 30, 2008 for services provided prior to that date would approximate the estimated consolidated medical expenses payable recorded at that date.

At September 30, 2009, we determined that the range for estimated medical claims payable was between $24.7 million and $31.1 million and we recorded a liability at the actuarial mid-range of $26.7 million. Based on historical results, we believe that the actuarial mid-range represents the best estimate of the ultimate liability. This amount is included in the Due from/to Humana in the accompanying condensed consolidated balance sheets.

Medical expenses also include, among other things, the expense of operating our wholly-owned practices, capitated payments made to affiliated primary care physicians and specialists, hospital costs, outpatient costs, pharmaceutical expense and premiums we pay to reinsurers net of the related reinsurance recoveries. Capitation payments represent monthly contractual fees disbursed to physicians and other providers who are responsible for providing medical care to customers. Pharmacy expense represents payments for customers' prescription drug benefits, net of rebates from drug manufacturers. Rebates are recognized when the rebates are earned according to the contractual arrangements with the respective vendors.

NOTE 6 PRESCRIPTION DRUG BENEFITS UNDER MEDICARE PART D

We provide prescription drug benefits to our Humana Participating Customers in accordance with the requirements of Medicare Part D. The benefits covered under Medicare Part D are in addition to the benefits covered by the PSN under Medicare Parts A and B. We recognize premium revenue for the provision of Part D insurance coverage ratably.

The Part D Payment is subject to adjustment, positive or negative, based upon the application of risk corridors that compare the estimated prescription drug benefit costs (“Estimated Costs”) to actual prescription drug benefit incurred costs (the "Actual Costs"). To the extent the Actual Costs exceed the Estimated Costs by more than the risk corridor, we may receive additional payments. Conversely, to the extent the Estimated Costs exceed the Actual Costs by more than the risk corridor, we may be required to refund a portion of the Part D Payment. We estimate and recognize an adjustment to premium revenue based upon pharmacy claims experience to date as if the contract to provide Part D coverage were to end at the end of each reporting period. Accordingly, this estimate does not take into consideration projected future pharmacy claims experience. It is reasonably possible that this estimate could change in the near term by an amount that could be material. Since these amounts represent additional premium or premium that is to be returned, any adjustment is recorded as an increase or decrease to revenue. The final settlement for the Part D program occurs in the subsequent year.

At September 30, 2009, we estimate that there will be no liability for excess Part D payments related to premiums earned in the third quarter of 2009 or premiums earned during the nine months ended September 30, 2009. In the third quarter of 2008, we determined that the final Part D repayment for prescription drug coverage in 2007 was approximately $1 million higher than we had estimated. This amount reduced revenue in the third quarter of 2008. No adjustment was required during the third quarter of 2009.

NOTE 7 INCOME TAXES

We applied an estimated effective income tax rate of 36.8% and 38.3% for the three month and nine month periods ended September 30, 2009, respectively. For the three month and nine month periods ended September 30, 2008, the effective income tax rate for each period was 34.1% and 35.8%, respectively. The lower effective income tax rate in 2008 is a result of tax benefits that had been reserved but were recognized upon the expiration of the statute of limitations for the tax period to which the benefits relate.

We are subject to income taxes in the U.S. federal jurisdiction and the State of Florida. Tax regulations are subject to interpretation of the related tax laws and regulations and require significant judgment to apply. We have utilized all of our available net operating loss carryforwards, including net operating loss carryforwards related to years prior to 2005. These net operating losses are open for examination by the relevant taxing authorities. The statute of limitations for the federal and Florida 2006 tax years will expire in the next twelve months.

NOTE 8 EARNINGS PER SHARE

Net earnings per common share, basic is computed using the weighted average number of common shares outstanding during the period. Net earnings per common share, diluted is computed using the weighted average number of common shares outstanding during the period, adjusted for incremental shares attributed to outstanding options, convertible preferred stock and unvested shares of restricted stock.

Net earnings per common share, basic and diluted, are calculated as follows:

	For the nine months ended September 30,		For the three months ended September 30,	
	2009	2008	2009	2008
Basic				
Net income	$ 9,613,000	$ 7,635,000	$ 2,426,000	$ 4,268,000
Less: Preferred stock dividend	(38,000)	(38,000)	(13,000)	(13,000)
Income available to common stockholders	$ 9,575,000	$ 7,597,000	$ 2,413,000	$ 4,255,000
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Weighted average common shares outstanding	45,588,000	51,359,000	44,038,000	51,578,000
Basic earnings per common share	$ 0.21	$ 0.15	$ 0.05	$ 0.08
Diluted				
Net income	$ 9,613,000	$ 7,635,000	$ 2,426,000	$ 4,268,000
Denominator:				
Weighted average common shares outstanding	45,588,000	51,359,000	44,038,000	51,578,000
Common share equivalents of outstanding stock:				
Convertible preferred stock	881,000	517,000	646,000	698,000
Restricted stock	239,000	177,000	307,000	154,000
Options	290,000	679,000	514,000	598,000
Weighted average common shares outstanding	46,998,000	52,732,000	45,505,000	53,028,000
Diluted earnings per common share	$ 0.20	$ 0.14	$ 0.05	$ 0.08

The following securities were not included in the computation of diluted earnings per share for the three month and nine month periods ended September 30, 2009 and 2008, as their effect would be anti-dilutive:

	For the nine months ended September 30,		For the three months ended September 30,	
Security Excluded From Computation	2009	2008	2009	2008
Stock Options	3,217,000	1,277,000	1,498,000	1,542,000
Unvested restricted stock	119,000	-	-	-

NOTE 9 STOCKHOLDERS' EQUITY

In October 2008, we announced that the Board of Directors authorized the repurchase of up to 10 million shares of our outstanding common stock. On August 3, 2009, the Board of Directors approved a 5 million share increase to the share repurchase program bringing the total number of shares of common stock authorized for repurchase under the program to 15 million shares. During the three and nine month periods ended September 30, 2009, we repurchased 3.3 million and 6.3 million shares for $6.4 million and $11.3 million, respectively. From October 6, 2008 (the date of our first repurchases under the plan) through September 30, 2009, we have repurchased 10.5 million shares for $19.0

million, at an average price of $1.81 per share. We cancel the stock that has been repurchased and reduce common stock and additional paid-in capital for the acquisition price of the stock. The number of shares to be repurchased and the timing of the purchases are influenced by a number of factors, including the then prevailing market price of our common stock, other perceived opportunities that may become available to us and regulatory requirements.

On September 10, 2009 (the "Repurchase Closing Date"), we repurchased 500,000 shares of our common stock from certain of our directors and executive officers for approximately $1.1 million. The shares were repurchased at a per share price of $2.1462, which was 2% below the closing price of our common stock on September 8, 2009, the date we entered into definitive repurchase agreements with such officers and directors. In addition, on the Repurchase Closing Date, we repurchased options exercisable for an aggregate of 567,500 shares of our common stock from certain of our executive officers for approximately $332,000, which represents the difference between the exercise price of the options and $2.1462. The shares underlying the options repurchased are also included in the number of shares repurchased during the third quarter of 2009 and deplete the repurchase authority granted by our Board.

No restricted stock or options were issued to our Board of Directors during the three month period ended September 30, 2009. During the nine month period ended September 30, 2009, we issued a total of 101,000 restricted shares of common stock and options to purchase 50,000 shares of common stock to the non-management members of our Board of Directors. The restricted shares and stock options vest one year from date of grant. The stock options have an exercise price equal to the closing price of our common stock on the grant date. Compensation expense related to the restricted stock and options is recognized ratably over the vesting period.

No restricted shares or options were issued to our employees in the third quarter of 2009. During the nine month period ended September 30, 2009, we issued to our employees 367,000 restricted shares of common stock and options to purchase 1.4 million shares of common stock. The restricted shares and stock options vest in equal annual installments over a four year period from the date of grant. The stock options have an exercise price equal to the closing price of our common stock on the grant date. Compensation expense related to the restricted stock and options is recognized ratably over the vesting period.

NOTE 10 - INVESTMENTS

Investments at September 30, 2009 consisted of U.S. Treasury securities, municipal bonds and corporate debt. We classify our debt securities as trading securities and do not classify any securities as available-for-sale or held to maturity. Trading securities are bought and held principally for the purpose of selling them in the near term. Available-for-sale securities are all securities not classified as trading or held to maturity. Cash and cash equivalents that have been set aside to invest in trading securities are classified as investments.

Trading securities are recorded at fair value based on the closing market price of the security. Unrealized gains and losses on trading securities are included in operations.

Effective January 1, 2008, U.S. GAAP clarified that, except for certain nonfinancial assets and nonfinancial liabilities, fair value is based on exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions that market participants would use in pricing an asset or a liability. As a basis for considering such assumptions, a three-tier value hierarchy was established, which prioritizes the inputs used in the valuation methodologies in measuring fair value:

Level 1—Observable inputs that reflect quoted prices (unadjusted) for identical assets or liabilities in active markets.

Level 2—Include other inputs that are directly or indirectly observable in the marketplace.

Level 3—Unobservable inputs which are supported by little or no market activity.

The fair value hierarchy also requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

In accordance with U.S. GAAP, we measure our investments at fair value. Our investments are classified as Level 1 because our investments are valued using quoted market prices for identical securities in active markets.

Premiums and discounts are amortized or accreted over the life of the security as an adjustment to yield using the effective interest method. Dividend and interest income is recognized when earned.

The carrying amounts of cash and cash equivalents, accounts receivable, accounts payable and accrued expenses approximate fair value due to the short-term nature of these instruments. At September 30, 2009, the carrying value of the Company's long-term debt obligation approximates fair value based on the terms of the obligation.

NOTE 11 COMMITMENTS AND CONTINGENCIES

Sale of HMO

The sale price of the HMO is subject to positive or negative post-closing adjustment based upon the difference between the HMO's estimated closing net equity, which was approximately $5.1 million and the HMO's actual net equity as of the Closing Date (the "Closing Net Equity"). The settlement period for determining the HMO's actual net equity is December 31, 2010. In addition to this settlement, the Stock Purchase Agreement requires that the Humana Plan reconcile any changes in CMS Part D payments and Medicare payments received by the HMO after the Closing Date for services provided prior to the Closing Date to the amounts recorded for such items as part of the Closing Net Equity determination. The ultimate settlements, if any, will increase or decrease the gain on the sale of the HMO. At September 30, 2009 we have adjusted the net equity settlement for any additional significant adjustments that have been identified subsequent to August 29, 2008, that would impact the recorded gain. These adjustments have been recorded as a gain on the sale of HMO subsidiary.

Included in the Gain on Sale of the HMO for the nine month period ended September 30, 2009 is the net effect of the settlement of certain obligations related to the HMO that were retained by us and amounts due to the HMO, in excess of the estimated amount, as a result of the final 2008 retroactive MRA Premium adjustment in the third quarter of 2009.

Guarantees

In connection with the sale of the assets of our pharmacy division in 2003, the purchaser of the pharmacy assets agreed to assume our obligation under a lease which ran through 2012. In the event of the purchaser's default, we could be responsible for future lease payments totaling approximately $359,000 at September 30, 2009. We are not currently aware of any defaults.

Commitment

In July 2009, we entered into a contract to install unified electronic medical records ("EMR") and practice management solutions for our wholly-owned medical offices. The EMR is expected to equip our physicians with paperless patient information that can be securely accessed anytime, anywhere. The estimated cost of installation of the EMR and practice management system is approximately $1 million. We are projecting that the installation will be completed within two years.

NOTE 12 PHYSICIAN PRACTICE ACQUISITION

Effective July 31, 2009, we acquired certain assets of one of our contracted independent primary care physician practices for approximately $1.9 million. This transaction has been accounted for under the acquisition method. Approximately $1.8 million of the purchase price has been allocated to goodwill while approximately $76,000 has been allocated to the non-compete agreement and $24,000 has been allocated to patient records. The amount allocated to the non-compete is being amortized over two years and the cost associated with the patient records is being amortized over one year.

Effective as of July 24, 2009, Metcare of Florida, Inc. entered into a definitive agreement to acquire the assets and assume certain liabilities of an unaffiliated independent primary care physician practice in the South Florida market with approximately 550 active patients including 150 Humana Plan Customers for approximately $600,000. This transaction is expected to close during the fourth quarter of 2009.

NOTE 13 BUSINESS SEGMENT INFORMATION

Prior to the Sale, we managed the PSN and HMO as separate business segments. We identified our segments in accordance with U.S. GAAP, which is consistent with information used by our Chief Executive Officer in managing our business. The segment information aggregates products with similar economic characteristics. These characteristics include the nature of customer groups and the nature of the services and benefits provided. The results of each segment were measured by income before income taxes. We allocated all selling, general and administrative expenses, investment and other income, interest expense, goodwill and certain other assets and liabilities to our segments. Our segments shared overhead costs.

Effective with the Sale, we operate only the PSN segment and, since we operated in only one segment during the three and nine month periods ended September 30, 2009 segment information is not presented for those periods. Segment information as of and for the three and nine month periods ended September 30, 2008 is as follows:

NINE MONTHS ENDED SEPTEMBER 30, 2008	PSN (1)	HMO (1)	Total
Revenues from external customers	$185,542,000	$51,633,000	$237,175,000
Segment gain (loss) before allocated overhead, gain on sale of HMO and income taxes	17,958,000	(4,526,000)	13,432,000
Allocated corporate overhead	4,120,000	3,224,000	7,344,000
Segment gain (loss) after allocated overhead and before gain on sale of HMO and income taxes	13,838,000	(7,750,000)	6,088,000
Segment assets	51,985,000	-	51,985,000
Goodwill	2,587,000	-	2,587,000
THREE MONTHS ENDED SEPTEMBER 30, 2008	PSN (2)	HMO (2)	Total
Revenues from external customers	$65,623,000	$13,327,000	$78,950,000
Segment gain (loss) before allocated overhead, gain on sale of HMO and income taxes	4,311,000	(1,185,000)	3,126,000
Allocated corporate overhead	1,462,000	984,000	2,446,000
Segment gain (loss) after allocated overhead and before gain on sale of HMO and income taxes	2,849,000	(2,169,000)	680,000

(1) Beginning September 1, 2008, the HMO members are included in the activity of the PSN under the IPA Agreement with Humana. The information presented in this table represents the eight months of activity for the HMO prior to its Sale on August 29, 2008.

(2) Beginning September 1, 2008, the HMO members are included in the activity of the PSN under the IPA Agreement with Humana. The information presented in this table represents the two months of activity for the HMO prior to its Sale on August 29, 2008.

Segment assets at September 30, 2008 exclude general corporate assets of $2.9 million including deferred tax assets of $1.8 million.

NOTE 14 SUBSEQUENT EVENTS

The Company has evaluated subsequent events through the time the financial statements were issued upon filing its Quarterly Report on Form 10-Q on November 5, 2009.

Between October 1, 2009 and November 2, 2009, we repurchased approximately 687,000 shares for $1.5 million.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

THE FOLLOWING DISCUSSION SHOULD BE READ IN CONJUNCTION WITH OUR ANNUAL REPORT ON FORM 10-K FOR THE YEAR ENDED DECEMBER 31, 2008, AS WELL AS THE FINANCIAL STATEMENTS AND NOTES THERETO.

Unless otherwise indicated or the context otherwise requires, all references in this Form 10-Q to "we," "us," "our," "Metropolitan" or the "Company" refers to Metropolitan Health Networks, Inc. and its consolidated subsidiaries.

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Sections of this Quarterly Report contain statements that are "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, including, without limitation, statements with respect to anticipated future operations and financial performance, growth and acquisition opportunities and other similar forecasts and statements of expectation. We intend such statements to be covered by the safe harbor provisions for forward looking statements created thereby. These statements involve known and unknown risks and uncertainties, such as our plans, objectives, expectations and intentions, and other factors that may cause us, or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by the forward-looking statements.

In some cases, you can identify forward-looking statements by statements that include the words "estimate," "project," "anticipate," "expect," "intend," "may," "should," "believe," "seek" or other similar expressions.

Specifically, this report contains forward-looking statements, including the following:

- the ability of our PSN to renew those Humana Agreements (as defined below) with one-year renewable terms and maintain all of the Humana Agreements on favorable terms;
- our ability to make reasonable estimates of Medicare retroactive premium adjustments; and
- our ability to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported ("IBNR") medical claims.

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 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:

- reductions in government funding of the Medicare program and changes in the political environment that may affect public policy and have an adverse impact on the demand for our services;
- the loss of or material, negative price amendment to significant contracts;
- disruptions in the PSN's or Humana's healthcare provider networks;

- failure to receive accurate and timely claims processing, billing services, data collection and other information from Humana;
- future legislation and changes in governmental regulations;
- increased operating costs;
- reductions in premium payments to Medicare Advantage plans;
- the impact of Medicare Risk Adjustments on payments we receive from Humana;

- the impact of the Medicare prescription drug plan on our operations;
- general economic and business conditions;
- increased competition;
- the relative health of our customers;
- changes in estimates and judgments associated with our critical accounting policies;
- federal and state investigations;
- our ability to successfully recruit and retain key management personnel and qualified medical professionals;
- impairment charges that could be required in future periods; and
- our ability to successfully integrate and retain the customers of any physician practices that we acquire.

Additional information concerning these and other risks and uncertainties is contained in our filings with the Securities and Exchange Commission (the "Commission"), including the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2008.

Forward-looking statements should not be relied upon as a prediction of actual results. Subject to any continuing obligations under applicable law or any relevant listing rules, we expressly disclaim any obligation to disseminate, after the date of this Quarterly Report on Form 10-Q, any updates or revisions to any such forward-looking statements to reflect any change in expectations or events, conditions or circumstances on which any such statements are based.

BACKGROUND

Through our provider services network ("PSN"), we provide and arrange for medical care primarily to Medicare Advantage beneficiaries in 19 counties in the State of Florida who have enrolled in health plans primarily operated by Humana, Inc. ("Humana") and/or its subsidiaries, one of the largest participants in the Medicare Advantage program in the United States. We operate the PSN through our wholly-owned subsidiary, Metcare of Florida, Inc. As of September 30, 2009, the PSN provided healthcare benefits to approximately 35,800 Medicare Advantage beneficiaries (including 280 beneficiaries covered under our agreement with CarePlus). Until the end of August 2008, we also operated a health maintenance organization (the "HMO") which provided healthcare benefits to approximately 7,400 Medicare Advantage beneficiaries in 13 Florida counties. The HMO was sold to Humana Medical Plan, Inc. on August 29, 2008.

Our Agreements with Humana

The PSN currently operates under three network agreements with Humana (collectively, the "Humana Agreements") pursuant to which the PSN provides, on a non-exclusive basis, healthcare services to Medicare beneficiaries in certain Florida counties who have elected to receive benefits under a Humana Medicare Advantage HMO Plan ("Humana Plan Customers") and who have selected a primary care physician employed by or contracted with us. Collectively, the Humana Agreements cover 27 counties within the State of Florida and, at September 30, 2009, we serve Humana Plan Customers in 19 counties. We entered into the most recent of these Humana Agreements ("the IPA Agreement") in connection with the sale of the HMO. The IPA Agreement has a five-year term and covers the 13 Florida counties where the HMO operated at the time of its sale to the Humana Plan. As a result of the sale of the HMO and the IPA Agreement, the customer base of the PSN grew by approximately 7,400 customers upon the closing of the transaction.

With the ongoing debate on healthcare reform, we have decided to, at least temporarily, suspend plans to expand our operations in any additional counties covered under the Humana Agreements except those where we already operate, until we have more clarity on the changes, if any, that are going to be legislated. In the meantime, we are continuing to seek opportunities to expand our business in our existing markets.

Humana directly contracts with the Centers for Medicare & Medicaid Services ("CMS") and is paid a monthly premium payment for each Humana Plan Customer. Among other factors, the monthly premium varies by customer, county, age and severity of health status. Pursuant to the Humana Agreements, the PSN provides or arranges for the provision of covered medical services to each Humana Plan Customer who selects one of the PSN physicians as his or her primary care physician (a "Humana Participating Customer"). In return for the provision of these medical services, the PSN receives from Humana a fee for each Humana Participating Customer. The fee rates are established by the Humana Agreements and represent a substantial percentage of the monthly premiums received by Humana from CMS with respect to Humana Participating Customers.

Our PSN assumes full responsibility for the provision or management of all necessary medical care for each of the approximately 35,500 Humana Participating Customers covered by the Humana Agreements, even for services we do not provide directly. For the approximately 6,000 Humana Participating Customers covered under our network agreement covering Miami-Dade, Broward and Palm Beach counties, our PSN and Humana share in the cost of inpatient hospital services and the PSN is responsible for the full cost of all other medical care provided to the Humana Participating Customers. For the remaining 29,500 Humana Participating Customers covered under our other two network agreements, our PSN is responsible for the cost of all medical care provided. To the extent the costs of providing such medical care are less than the related fees received from Humana; our PSN generates a gross profit. Conversely, if medical expenses exceed the fees received from Humana, our PSN experiences a deficit in gross profit.

Substantially all of our PSN's revenue is generated from the Humana Agreements. We do receive additional revenue pursuant to the CarePlus Agreement (described below) and, in the medical practices we own and operate, by providing primary care services to non-Humana or CarePlus Participating Customers on a fee-for-service basis.

CMS recently announced that it will reduce the premiums paid to Medicare Advantage Plans by between 4% and 5% starting in 2010. In addition, in February 2009, CMS announced its expectation that annual health spending will increase by 6.2% between 2008 and 2018. We believe that the impact of the anticipated premium reduction and increased costs will be, to some degree, mitigated by, among other things, reduced benefit offerings, increased co-pays and deductibles, and improved risk score compliance.

The President and both houses of Congress are currently engaged in active debate concerning the reformation of the structure and funding for the U.S. healthcare system, including the Medicare program. Although none of the bills currently being considered have become law, various proposals contain items that would have a material adverse impact on Medicare Advantage members and Medicare Advantage plans including, without limitation, provisions reducing Medicare funding, requiring "competitive bidding" against a reduced plan benefit design, legally-imposed minimum medical loss ratios, and further limitations on Medicare Advantage marketing and enrollment periods. We are not able to predict with any certainty what provisions will become law, if any.

While we are unable to predict what impact the 2010 premium decrease, coupled with the uncertainties of broader healthcare reform efforts that have been initiated by the current administration, will have on our consolidated results of operations in the future, these uncertainties are causing us to more sharply focus on the profitability of our existing markets and operations and to re-evaluate various growth initiatives and strategies.

Our Agreement with CarePlus

Effective as of August 1, 2007, our PSN entered into a network agreement (the "CarePlus Agreement") with CarePlus Health Plans, Inc. ("CarePlus"), a Medicare Advantage HMO in Florida. CarePlus is a wholly-owned subsidiary of Humana. Pursuant to the CarePlus Agreement the PSN has the right to manage, on a non-exclusive basis, healthcare services to Medicare beneficiaries in 22 Florida counties who have elected to receive benefits through CarePlus' Medicare Advantage plans (each, a "CarePlus Plan Customer") and who have selected a primary care physician employed by or contracted with us. Like Humana, CarePlus directly contracts with CMS and is paid a monthly premium payment for each CarePlus Plan Customer. In return for managing these healthcare services, the PSN receives a monthly network administration fee for each CarePlus Participating Customer. For 13 of the counties covered by the CarePlus Agreement, the PSN will begin to receive a capitation fee from CarePlus and will assume full responsibility for the cost of all medical services provided to each CarePlus Participating Customer on February 1, 2010. The capitation fee will represent a substantial portion of the monthly premium CarePlus is to receive from CMS. On October 23, 2009, we and Humana agreed to delay the implementation of the capitated fee arrangement for the nine remaining counties covered by the CarePlus Agreement to February 1, 2010.

In nine of the counties covered by the CarePlus Agreement the PSN physicians who provide services to the Humana Participating Customers are not allowed to provide services to CarePlus Participating Customers. In these counties, the PSN must (i) locate and contract with new independent primary care physician practices and/or (ii) acquire or establish and operate its own physician practices to service the CarePlus Participating Customers. In the remaining counties covered by the CarePlus Agreement, the PSN is allowed to use the PSN physicians who provide services to the Humana Participating Customers.

The CarePlus Agreement covered approximately 280 CarePlus Participating Customers at September 30, 2009. We have operations in six of the counties covered by the CarePlus Agreement as of September 30, 2009.

Our Physician Network

We have built our PSN physician network by contracting with independent primary care physician practices (each, an "IPA") for their services and by acquiring and operating our own physician practices. Through the Humana Agreements, we have established referral relationships with a large number of specialist physicians, ancillary service providers and hospitals throughout the counties covered by the Humana Agreements.

Effective July 31, 2009, Metcare of Florida, Inc., our wholly-owned subsidiary, acquired the assets and assumed certain liabilities of one of our contracted independent primary care physician practices with approximately 1,100 of our current customers in the Central Florida market for approximately $1.9 million.

Effective as of July 24, 2009, Metcare of Florida, Inc. entered into a definitive agreement to acquire the assets and assume certain liabilities of an unaffiliated independent primary care physician practice in the South Florida market with approximately 550 active patients including 150 Humana Plan Customers for approximately $600,000. This transaction is expected to close in the fourth quarter of 2009.

Health Maintenance Organization

As discussed above, on the Closing Date, we completed the sale of all of the outstanding capital stock of the HMO to the Humana Plan. The following discussion generally summarizes the HMO's business as operated by us prior to its sale.

At the time of its sale, the HMO was offering its Medicare Advantage health plan in 13 Florida counties. Our Medicare Advantage plan covered Medicare eligible customers who resided at least nine months or more in the service area and offered more expansive benefits than those offered under the traditional Medicare fee-for-service plan. Through our Medicare Advantage plan, we had the flexibility to offer benefits not covered under traditional fee-for-service Medicare. These benefits were designed to be attractive to seniors and included prescription drug benefits, eye glasses, hearing aids, dental care, over-the-counter drug plans and health club memberships. In addition we offered a "special needs" zero premium, zero co-payment plan to dual-eligible individuals (as that term is defined by CMS) in our markets.

The HMO's Medicare Advantage customers did not pay a monthly premium in 2008. The HMO's customers were subject to co-payments and deductibles, depending upon the market and benefit. Except in limited cases, including emergencies, our HMO customers were required to use primary care physicians within the HMO's network of providers and generally received referrals from their primary care physician in order to see a specialist or ancillary provider.

Pursuant to the agreement between the HMO and CMS (the "CMS Contract"), the HMO had agreed to provide services to Medicare beneficiaries pursuant to the Medicare Advantage program. Under the CMS Contract, CMS paid the HMO a capitation payment based on the number of customers enrolled, which payment was adjusted for, among others, demographic and health risk factors. Inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs were also considered in the calculation of the fixed capitation payment by CMS.

The amount of premiums we received for each Medicare customer was established by the CMS Contract through the competitive bidding process. The premium varied according to various demographic factors, including the customer's geographic location, age, and gender, and was further adjusted based on our plans' average risk scores. In addition to the premiums paid to us, the CMS Contract regulated, among other matters, benefits provided, quality assurance procedures, and marketing and advertising for our Medicare products.

Insurance Arrangements

We rely upon insurance to protect us from many business risks, including medical malpractice, errors and omissions and certain significantly higher than average customer medical expenses. For example, to mitigate our exposure to high cost medical claims, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. For 2009, our deductible per customer per year for the PSN is $40,000 in Miami-Dade, Broward and Palm Beach counties and $200,000 in the other counties in which we operate, with a maximum annual benefit per customer of $1.0 million. Although we maintain insurance of the types and in the amounts that we believe are reasonable, there can be no assurances that the insurance policies maintained by us will insulate us from material expenses and/or losses in the future.

CRITICAL ACCOUNTING POLICIES

Critical Accounting Policies

A description of our critical accounting policies is contained in our Annual Report on Form 10-K for the year ended December 31, 2008.

COMPARISON OF RESULTS OF OPERATIONS FOR THE THREE MONTHS ENDED SEPTEMBER 30, 2009 AND SEPTEMBER 30, 2008

During the three months ended September 30, 2009, we operated only the PSN business segment as we sold the HMO on August 29, 2008. The operating results for the three months ended September 30, 2008 include the results of operations of the HMO through August 29, 2008. After that date, as a result of the IPA Agreement, the customers of the HMO became customers of the PSN. Similar to the Humana Agreements, under the IPA Agreement, the PSN is paid by Humana a percentage of the premium paid by CMS for each member of Humana's Medicare Advantage Plans who selects one of the PSN's Physicians as his or her primary care physician. Medical costs incurred under the IPA Agreement are included in the medical expenses of the PSN.

Income before income tax expense was $6.5 million for the third quarter of 2008 and included a $5.8 million gain on the sale of our HMO which was offset by related stay bonuses and termination costs of $1.6 million. Excluding these amounts, income before income taxes for the third quarter of 2008 was $2.3 million. In the third quarter of 2009 income before income tax expense was $3.8 million. Excluding the gain on sale of $366,000, income before income taxes for the third quarter of 2009 was $3.5 million.

Revenue increased $9.2 million or 11.6% between the third quarter of 2008 and the third quarter of 2009. The improvement between these periods is primarily attributable to:

- a 7.6% increase in our consolidated customer base
- a 3.5% increase in the base premium; and
- an approximate 8.7% increase in the weighted average risk score of our customers.

Our increase in revenue in the third quarter of 2009 was partially offset by the impact of the sale of our HMO and the IPA Agreement. More specifically, prior to the sale of the HMO in August 2008, we received 100% of the premium paid by CMS for the HMO's customers. Following the sale of the HMO and under the related IPA Agreement, we receive a percentage of the CMS premium received by Humana for care for these customers through our PSN.

Our medical expense increased $9.3 million or 13.0% between the third quarter of 2008 and the third quarter of 2009. This increase primarily resulted from a 7.6% increase in customer months and a 5.0% increase in per customer medical costs between the two periods.

Our Medical Expense Ratio ("MER"), which is our total medical expense divided by our total revenue, of 91.3% in the third quarter of 2009 compared to a MER of 90.2% in the third quarter of 2008. The reduction in the premium we receive for providing services to our former HMO customers under the IPA Agreement increased our MER by approximately 3.2% in the 2009 third quarter as compared to 0.9% in the third quarter of 2008.

Net income for the third quarter of 2009 was $2.4 million or $0.05 per basic and diluted share compared to net income of $4.3 million or $0.08 per basic and diluted share for the third quarter of 2008. Impacting net income in the third quarter of 2008 was the gain on the sale of our HMO subsidiary and the related one time termination and stay bonus costs. Excluding these items, net income for the three months ended September 30, 2008 would have been $1.7 million or $0.03 per basic and diluted share. The gain on sale in the third quarter of 2009 of $366,000 does not change the reported earnings per share.

Customer Information

The table set forth below provides (i) the total number of customers to whom we were providing healthcare services through the PSN as of September 30, 2009 and through the PSN and the HMO as of September 30, 2008 and (ii) the aggregate customer months of the PSN for the third quarter of 2009 and for the PSN and the HMO for the third quarter of 2008. Customer months is the aggregate number of months of healthcare service provided to our customers during the applicable period, with one month of service to one customer counting as one customer month,

Through the IPA Agreement, our PSN began providing services to the customers of our HMO following its sale to the Humana Plan.

	September 30, 2009		September 30, 2008		
	Customers at End of Period	Customer Months For Quarter	Customers at End of Period	Customer Months for Quarter	Percentage Change in Customer Months Between Quarters
PSN	35,800	106,800	33,100	84,500	
HMO	-	-	-	14,800	
Total	35,800	106,800	33,100	99,300	7.6 %

The increase in total customer months for 2009 as compared to 2008 is primarily a result of the net effect of new enrollments and disenrollments, deaths, customers moving from the covered areas, customers transferring to another physician practice or customers making other insurance selections.

Revenue

The following table provides a breakdown of our sources of revenue by segment for the 2009 and 2008 third quarters:

	Three Months Ended September 30		$	
	2009	2008	Increase (Decrease)	% Change
PSN revenue from Humana	$ 87,427,000	$ 65,226,000	$ 22,201,000	34.0 %
PSN fee-for-service revenue	711,000	397,000	314,000	79.1 %
Total PSN revenue	88,138,000	65,623,000	22,515,000	34.3 %
Percentage of total revenue	100.0 %	83.1 %		
HMO revenue	-	13,327,000	(13,327,000)	-100.0 %
Percentage of total revenue	0.0 %	16.9 %		
Total revenue	$ 88,138,000	$ 78,950,000	$ 9,188,000	11.6 %
Revenue PCPM	$ 825	$ 795		