METROPOLITAN HEALTH NETWORKS INC
Form 10-K
March 02, 2010

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2009

OR

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

For the transition period from _____ to _____

Commission file number: 0-28456

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 South 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)

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

Title of each class	Name of each exchange on which registered
Common Stock, $.001 par value per share	NYSE Amex

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

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act.

Yes ¨ No x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ¨

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 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 ¨
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

As of June 30, 2009, the aggregate market value of the registrant’s common stock held by non-affiliates of the registrant was $91,964,322 based on the closing sale price as reported on the NYSE Amex. This calculation has been performed under the assumption that all directors, officers and stockholders who own more than 10% of our outstanding voting securities are affiliates of the Company.

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 February 25, 2010
Common Stock, $.001 par value per share	39,846,684 shares

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to the 2010 annual meeting of shareholders, which definitive proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

METROPOLITAN HEALTH NETWORKS, INC.

FORM 10-K
For the Year Ended
December 31, 2009

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GENERAL

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

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Some of the discussion under the captions "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations," "Business" and elsewhere in this Form 10-K may include certain "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. Many of these factors are listed in Item 1A"Risk Factors" and elsewhere in this Form 10-K.

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 statements regarding the following topics:

- the ability of our provider services network (the "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") 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; and
- impairment charges that could be required in future periods.

We undertake no obligation to revise or publicly release the results of any revision to any forward-looking statements.

PART I

ITEM 1 DESCRIPTION OF BUSINESS

We operate a provider services network (the "PSN"), through which we provide and arrange for medical care primarily to Medicare Advantage beneficiaries in the State of Florida who have enrolled in health plans primarily operated by Humana, Inc. ("Humana"), or subsidiaries of Humana, one of the largest participants in the Medicare Advantage program in the United States. As of December 31, 2009, our PSN operated in 16 counties in the state of Florida.

Medicare is the national, federally-administered health insurance program that covers the cost of hospitalization, medical care, and some related health services for U.S. citizens aged 65 and older, qualifying disabled persons and persons suffering from end-staged renal disease. Substantially all of our revenue in 2009 and 2008 was generated by providing services to Medicare beneficiaries through arrangements that require us to assume responsibility to provide and/or manage the care for our customers' medical needs in exchange for a monthly fee, also known as a capitation fee or capitation arrangement. To mitigate our exposure to high cost medical claims, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. See "Insurance."

Our concentration on Medicare customers provides us the opportunity to focus our efforts on understanding the specific needs of Medicare beneficiaries in our local service areas. Our management team has extensive experience developing and managing providers and provider networks.

As of December 31, 2009, the PSN provided healthcare benefits to approximately 35,500 Medicare Advantage beneficiaries, an increase of approximately 2,500 from the number of customers served by the PSN as of December 31, 2008.

Until the end of August 2008, we also operated a health maintenance organization (the "HMO") which provided healthcare benefits to Medicare Advantage beneficiaries in 13 Florida counties. As discussed in greater detail below, the HMO was sold to Humana Medical Plan, Inc. (the "Humana Plan") on August 29, 2008.

See also Note 19 to the "Notes to the Consolidated Financial Statements" contained in this Form 10-K.

Our corporate headquarters are located at 250 South Australian Avenue, Suite 400, West Palm Beach, Florida 33401 and our telephone number is (561) 805-8500. Our corporate website is www.metcare.com. Information contained on our website is not incorporated by reference into this report and we do not intend the information on or linked to our website to constitute part of this report. We make available our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and any amendments to those reports on our website, free of charge, to individuals interested in acquiring such reports. The reports can be accessed at our website as soon as reasonably practicable after they are electronically filed with, or furnished to, the Securities and Exchange Commission (the "SEC"). The public may read and copy these materials at the SEC's public reference room at 100 F Street, N.E., Washington D.C. 20549 or on their website at http://www.sec.gov. Questions regarding the operation of the public reference room may be directed to the SEC at 1-800-732-0330.

Provider Services Network

We operate the PSN through our wholly owned subsidiary, Metcare of Florida, Inc. 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"). We entered into the most recent of the Humana Agreements, a five year independent practice association participation agreement (the "IPA

Agreement"), in connection with the sale of the HMO. The IPA Agreement covers the 13 Florida counties where the HMO operated at the time of the sale.

Collectively, the Humana Agreements cover 30 counties within the State of Florida. At December 31, 2009, we have customers in 16 counties throughout Florida.

We are closely monitoring the healthcare reform debate. Until we have more clarity on the changes, if any, that are going to be legislated, we have suspended plans to expand our operations in any additional counties covered under the Humana Agreements. In the meantime, we will continue to seek opportunities to expand our operations where we already operate.

Humana directly contracts with the Centers for Medicare & Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services, which administers the Medicare program. Humana is paid a monthly premium payment for each Humana Plan Customer who selects one of the PSN physicians as his or her primary care physician (a "Humana Participating 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 Participating Customer. In return for the provision of these medical services, the PSN receives from Humana a fee for each Humana Participating Customer established pursuant to the Humana Agreements. The amount we receive from Humana represents 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 35,300 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 29,300 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.

In 2008 and 2009, substantially all of our revenue was directly or indirectly derived from premiums generated by Medicare Advantage health plans. In 2009, substantially all of our revenue was earned through our contracts with Humana.

We have built our PSN by contracting with independent primary care physician practices (each, an "IPA") for their services and 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, pharmacies and hospitals throughout the counties covered by the Humana Agreements.

Effective as of August 1, 2008, 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 manages, on a non-exclusive basis, healthcare services for Medicare beneficiaries in certain Florida counties who have elected to receive benefits through CarePlus' Medicare Advantage plans (each, a "CarePlus Plan Customer") and who have selected one of the PSN physicians as their primary care physician (each a "CarePlus Participating Customer"). At December 31, 2009, we operated in six of the 22 Florida counties covered by the CarePlus Agreement. Effective January 1, 2010 we began to operate in six additional counties and we terminated services in one county.

Like Humana, CarePlus directly contracts with CMS and is paid a monthly premium payment for each CarePlus Plan Customer, which premium varies by, among other things, customer, county, age and severity of health status. Pursuant to the CarePlus Agreement, the PSN provides or arranges for the provision of covered medical services to CarePlus Participating Customers. Since the establishment of the CarePlus Agreement, the PSN has received a monthly network administration fee for each CarePlus Participating Customer. Effective February 1, 2010, the PSN began to receive a capitation fee from CarePlus and assumed full responsibility for the cost of all medical services provided to each CarePlus Participating Customer. The capitation fee represents a substantial portion of the monthly premium CarePlus is to receive from CMS.

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 200 CarePlus Participating Customers at December 31, 2009.

The Medicare Program and Medicare Managed Care

Medicare

Medicare is a federal program that provides persons age 65 and over, qualifying disabled persons and persons suffering from end-stage renal disease with certain hospital and medical insurance benefits. The Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice, and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for paying deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium, which was $96.40 in 2009, which is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a deductible, which was $135 in 2009. To fill the gaps in traditional fee-for-service Medicare coverage, individuals may purchase Medicare supplement products, commonly known as “Medigap,” to cover deductibles, copayments, and coinsurance.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, an individual can choose any licensed physician accepting Medicare payments and use the services of any hospital, healthcare provider, or facility certified by Medicare. CMS reimburses providers if Medicare covers the service and CMS considers it “medically necessary.” Subject to limited exceptions, Medicare fee-for-service does not cover transportation, eyeglasses, hearing aids, and certain preventive services, such as annual physicals and wellness visits. However, the Medicare Improvements for Patients and Providers Act (“MIPPA”), enacted in July 2008, permits the Secretary of the Department of Health and Human Services to extend fee-for-service coverage to certain additional preventive services that are reasonable and necessary for the prevention or early detection of an illness or disability.

Medicare Advantage

As an alternative to the traditional fee-for-service Medicare program, in geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a managed care plan. Pursuant to Medicare Part C and Medicare Part D, Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a monthly per customer premium payment from CMS.

Participation of private health plans, such as Humana, in the Medicare Advantage Program under full risk contracts began in the 1980’s and grew to 6.9 million customers in 1999. According to information provided by the Henry J. Kaiser Family Foundation, after a drop to 5.3 million customers in 2003, the number of enrollees in Medicare Advantage plans in the United States has increased to 10.2 million in 2009.

The Medicare Advantage program provides a comprehensive array of health insurance benefits, including wellness programs, to Medicare eligible persons under HMO, Preferred Provider Organizations (“PPO”), and Private Fee-For-Service (“PFFS”) plans in exchange for contractual payments received from CMS, usually a per customer per month payment. Substantially all of our customers are enrolled in a Medicare Advantage HMO plan. Under a Medicare Advantage HMO plan, the beneficiary receives benefits in excess of traditional Medicare, typically including reduced cost sharing, enhanced prescription drug benefits, eye exams, hearing aids and routine physical exams, care coordination, data analysis techniques to help identify customer needs, complex case management, tools to guide customers in their health care decisions, disease management programs, wellness and prevention programs, and in some instances a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription

drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Medicare Advantage plans may charge beneficiaries monthly premiums and other co-payments for Medicare-covered services or for certain extra benefits.

Medicare Advantage HMO plans may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations, HMO plans provide no out-of-network benefits. While out-of-pocket costs for the Medicare beneficiary enrolled in a Medicare Advantage plan may be lower than under the traditional fee-for-service Medicare program, customers are generally required to use only the services and provider networks offered by the customer's Medicare Advantage plan.

CMS uses monthly rates per person for each county to determine the monthly per customer payments made to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the adequacy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 ("BBA") and the Benefits and Improvement Protection Act of 2000 ("BIPA"), generally pays more for customers with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits). Under the risk-adjustment methodology, all health benefit organizations must capture, collect, and submit the necessary diagnosis code information to CMS within prescribed deadlines.

HMO plans covered under Medicare Advantage contracts with CMS are renewed generally for a one-year term each December 31 unless CMS notifies the plan of its decision not to renew by August 1 of the year in which the contract would end, or the plan notifies CMS of its decision not to renew by the first Monday in June of the year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage business have been renewed for 2010.

Medicare Part D

Effective January 1, 2006, all Medicare beneficiaries became eligible to receive assistance paying for prescription drugs through Medicare Part D. The drug benefit is not part of the traditional fee-for-service Medicare program, but rather is offered through private insurance plans. Medicare beneficiaries are able to choose and enroll in a prescription drug plan through Medicare Part D. Prescription drug coverage under Part D is voluntary. Fee-for-service beneficiaries may purchase Part D coverage from a stand-alone prescription drug plan (a "stand-alone PDP") that is included on a list approved by CMS.

Individuals who are enrolled in a Medicare Advantage plan that offers drug coverage must receive their drug coverage through the prescription drug plan offered by their Medicare Advantage plan ("MA-PD") and may not enroll in a stand-alone PDP. Any customer of a Medicare Advantage plan that enrolls in a stand-alone PDP is automatically disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare coverage. Beneficiaries who are eligible for both Medicare and Medicaid, known as dual eligible beneficiaries (discussed in greater detail below), who have not enrolled in a MA-PD or a stand-alone PDP have been automatically enrolled by CMS with approved stand-alone PDP's in their region. Medicare Advantage customers have the right to change drug plans, either MA-PD or stand-alone PDP, one time per year, during the open enrollment period. Dual eligible beneficiaries and other customers qualified for the low-income subsidy may change plans throughout the year.

The Medicare Part D prescription drug benefit is largely subsidized by the federal government and is additionally supported by risk-sharing with the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for customer demographics and risk factor payments. If the plan bid exceeds the government subsidy the beneficiary is responsible for the difference. The beneficiary is also responsible for co-pays, deductibles and late enrollment penalties, if applicable.

All of our Humana Plan Customers receive prescription drug coverage through Medicare Part D. We are responsible for the costs of pharmaceuticals and our capitation fee from Humana is intended to cover these costs.

Dual-Eligible Beneficiaries

A "dual-eligible" beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Medicaid, because of economic status. Health plans that serve dual-eligible beneficiaries receive a higher

premium from CMS for dual-eligible customers. The additional premium for a dually-eligible beneficiary is based upon the estimated incremental cost CMS incurs, on average, to care for dual-eligible beneficiaries. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dually-eligible customers. The Medicare Modernization Act of 2003 (the "MMA") provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, since January 1, 2006, dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid program. Companies offering stand-alone PDP with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and automatic enrollment of the dual-eligible beneficiaries within their applicable region.

Enrollment Period

Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select or change a Medicare Advantage plan. The annual enrollment for a Medicare Advantage plan is from November 15 through March 31 of the subsequent year. Enrollment prior to December 31 will generally be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period is effective the first day of the month following enrollment. After the defined enrollment period ends, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries, others who qualify for special needs plans, and employer group retirees will be permitted to enroll in or change health plans during the year. In addition, in certain circumstances, such as the bankruptcy of a health plan, CMS may offer a special election period during which the customers affected are allowed to change plans.

Bidding Process.

Since January 1, 2006, CMS has used a rate calculation system for Medicare Advantage plans based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS's estimated per beneficiary fee-for-service expenses, is known as the "benchmark" amount, and local Medicare Advantage plans annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that year, Medicare will pay the plan its bid amount, adjusted based on county of residence and customers' risk scores, plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment. in reimbursement rates. Plans are required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits and CMS has the right to audit the use of these proceeds. The remaining 25% of the excess amount is retained in the statutory Medicare trust fund. If a Medicare Advantage plan's bid is greater than the benchmark, the plan is required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which has made such plans charging premiums less attractive to potential customers.

The Medicare Improvements for Patients and Providers Act of 2008

MIPPA addressed several aspects of the Medicare program. With respect to Medicare Advantage and Medicare Part D plans, MIPPA increased restrictions on marketing and sales activities, including limitations on compensation systems for agents and brokers, limitations on solicitation of beneficiaries, and prohibitions regarding many sales activities. MIPPA also imposed restrictions on special needs plans, increased penalties for reimbursement delays by Medicare Part D plans, required weekly reporting of pricing standards by Medicare Part D plans, and implemented focused cuts to certain Medicare Advantage programs. The Congressional Budget Office has estimated that the Medicare Advantage provisions of MIPPA will reduce federal spending on Medicare Advantage by $48.7 billion over the 2008-2018 period.

The Florida Medicare Advantage Market

Over the last several decades, Florida has generally been a highly attractive, rapidly growing market. In April 2009, the Office of Economic & Demographic Research of the Florida Legislature projected a total population in Florida of over 18.8 million people. Those 65 and older in Florida are projected to be 3.3 million in 2010 and are forecast to increase to 4.6 million by 2020.

Behind only California, which has approximately 4.5 million Medicare eligible beneficiaries, Florida has the second largest Medicare population in the U.S. with an estimated 3.2 million Medicare eligible beneficiaries. As of May

2009, California's Medicare Advantage penetration was approximately 34% while Florida's was 28%. Our Humana Agreements cover 30 counties throughout Florida and we have established provider networks in 16 of these counties. We believe that of the approximate 1.4 million Medicare eligible individuals in the counties in which we have established networks, approximately 28% are customers of Medicare Advantage plans.

In the fourteen counties where we do not yet have provider networks, we believe that of the approximate 1.3 million Medicare eligible individuals in these counties, approximately 30% are customers of Medicare Advantage plans.

Business Model

Provider Services Network

Our PSN provides and arranges healthcare services to Medicare Advantage beneficiaries who participate in a Medicare Advantage plan through Humana or CarePlus.

Humana Agreements

Two of the Humana Agreements, one covering approximately 20,400 customers and the other covering 6,000 customers at December 31, 2009, have one-year terms and renew automatically each December 31 for additional one-year terms unless terminated for cause or upon 180 days' prior notice. In addition, Humana may immediately terminate either of these agreements and/or any individual physician credentialed under these agreements upon written notice, (i) if the PSN and/or any of the PSN physician's continued participation may adversely affect the health, safety or welfare of any Humana customer or bring Humana into disrepute; (ii) in the event of one of the PSN physician's death or incompetence; (iii) if any of the PSN physicians fail to meet Humana's credentialing criteria; (iv) in accordance with Humana's policies and procedures as specified in Humana's manual, (v) if the PSN engages in or acquiesces to any act of bankruptcy, receivership or reorganization; or (vi) if Humana loses its authority to do business in total or as to any limited segment or business (but only to that segment). The PSN and Humana may also each terminate each of these Agreements upon 90 days' prior written notice (with a 60 day opportunity to cure, if possible) in the event of the other's material breach.

The IPA Agreement, which covers approximately 8,900 customers at December 31, 2009, has a five-year term that began on August 30, 2008 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. After the initial five year term, either party may terminate the agreement without cause by providing to the other party 120 days prior notice. Humana may immediately terminate the IPA Agreement and/or any individual physician credentialed under the IPA Agreement, upon written notice, (i) if the PSN and/or any of the PSN physician's continued participation may adversely affect the health, safety or welfare of any Humana customer or bring Humana into disrepute; (ii) if the PSN or any of its physicians fail to meet Humana's credentialing or re-credentialing criteria; (iii) if the PSN or any of its physicians is excluded from participation in any federal healthcare program; (iv) if the PSN or any of its physicians engages in or acquiesces to any act of bankruptcy, receivership or reorganization; or (v) if Humana loses its authority to do business in total or as to any limited segment or business (but only to that segment). The PSN and Humana may also each terminate the IPA Agreement upon 60 days' prior written notice (with a 30 day opportunity to cure, if possible) in the event of the other's material breach of the IPA Agreement.

Humana may provide 30 days notice as to certain amendments or modifications to the Humana Agreements, including but not limited to, compensation rates, covered benefits and other terms and conditions. If Humana exercises its right to amend the Humana Agreements, the PSN may object to such amendment within the 30 day notice period. If the PSN objects to such amendment within the requisite time frame, Humana may terminate the applicable Humana Agreement upon 90 days written notice.

The Humana Agreements are also subject to changes to the covered benefits that Humana elects to provide to Humana Plan Customers and other terms and conditions.

In four of the counties covered by the IPA Agreement (Martin, St. Lucie, Okeechobee and Glades), unless otherwise agreed to in writing by Humana, the PSN is restricted from entering into any risk contract with any other Medicare Advantage plan through December 31, 2013.

For the term of the Humana Agreement covering 20,400 customers:

- Humana has agreed that it will not, with the exception of one existing service provider, enter into any new global risk agreements for Humana's Medicare Advantage HMO products in Volusia and Flagler counties; and

- The PSN has agreed that it will not enter into any global, full or limited risk contracts with respect to Medicare Advantage customers with any non-Humana Medicare Advantage HMO or provider sponsored organization in Volusia and Flagler counties in which Humana has a Medicare Advantage contract.

In addition, for the term plus one year for each of the Humana Agreements, the PSN and its affiliated providers will not, directly or indirectly, engage in any activities which are in competition with Humana's health insurance, HMO or benefit plans business, including obtaining a license to become a managed healthcare plan offering HMO or point of service ("POS") products, or (ii) acquire, manage, establish or have any direct or indirect interest in any provider sponsored organization or network for the purpose of administering, developing, implementing or selling government sponsored health insurance or benefit plans, including Medicare and Medicaid, or (iii) contract or affiliate with another licensed managed care organization, where the purpose of such affiliation is to offer and sponsor a HMO or POS products and where the PSN and/or its affiliated providers obtain an ownership interest in the HMO or POS products to be marketed, and (iv) enter into agreements with other managed care entities, insurance companies or provider sponsored networks for the provision of healthcare services to Medicare HMO, Medicare POS and/or other Medicare replacement patients at the same office sites or within five miles of the office sites where services are provided to the Humana Plan Customers.

CarePlus Agreement

Pursuant to the CarePlus Agreement, the PSN provides or arranges for the provision of covered medical services to each CarePlus Participating Customer. Since the establishment of the CarePlus Agreement, the PSN has received a monthly network administration fee for each CarePlus Participating Customer in return for managing these healthcare services. Effective February 1, 2010, the PSN began receiving a capitation fee for each CarePlus Participating Customer and, in connection therewith, the PSN assumed full responsibility for the cost of all necessary medical care for each CarePlus Participating Customer, even for services the PSN does not provide directly.

Physician Network

At December 31, 2009, the PSN owned and operated ten primary care centers and an oncology practice. These centers provide and arrange for medical care to approximately 26% of the PSN's customers.

The PSN also has contracts with IPA's to provide and manage care for our remaining customers. Some of these contracts provide for payment to the provider on a fixed per customer per month amount and require the providers to provide all the necessary primary care medical services to Humana Participating Customers. The monthly amount is negotiated and is subject to change based on certain quality metrics under the PSN's Partners In Quality ("PIQ") program, our proprietary care management model. Other contracts provide for payments on a fee for service basis, pursuant to which the provider is paid only for the services provided.

PIQ is our "pay for performance" program that measures performance based on quality metrics including patient satisfaction, disease state management of high-risk, chronically ill patients, frequency of physician-patient encounters, and enhanced medical record documentation. Management believes that the PIQ program differentiates our PSN from other PSN's or Management Service Organizations ("MSO's").

The contracts with our IPA's generally have one-year terms and renew automatically for one-year periods unless either party provides written notice at least 60 days prior to the end of the term. The IPA providers, during the term of their contract with the PSN, and for a period of six months after the expiration or termination of such contract, are generally prohibited from participating in any other PSN, HMO or other agreement which contracts directly or indirectly with the Medicare or Medicaid Program on a capitated or risk basis. The IPA providers are further prohibited during the term and for a period of six months after the expiration of the terms from encouraging or soliciting the Humana Participating Customers to change their primary care provider, disenroll from their health plan, or leave the PSN's network.

The PSN has established referral relationships with a large number of specialist physicians, ancillary service providers and hospitals throughout the PSN's service area that are under contract with Humana. These providers have contracted with Humana to deliver services to our PSN patients based on certain fee schedules and care requirements. Specialist physicians, ancillary service providers and hospitals are generally paid on a contractual fee-for-service basis. Certain specialist physicians dealing with a high volume of cases are paid on a capitated basis.

The Patient Centered Medical Home

The Patient Centered Medical Home ("PCMH") is medical care delivered to a group of customers through a physician-led healthcare team which utilizes information technology and evidence-based medicine to enhance communication and customer access, improve clinical outcomes, and ensure continuity and coordination of care, thereby adding value to the healthcare consumer. We believe that our approach to care is philosophically and operationally aligned with these principles. However, to function as a true PCMH, medical practices must first develop and implement processes and systems to deliver this product consistently, efficiently, and effectively.

We have been moving our business toward the PCMH model for the past few years. In October 2009, we applied to the National Committee for Quality Assurance ("NCQA") for certification as a PCPM. The NCQA has developed a formal set of standards to certify practices as a PCMH. In February 2010, we were notified by NCQA that all eight of our owned primary care centers that applied have received level 3 certification, the highest available, as Patient Centered Medical Homes. We believe that this makes us the first PCMH in Florida. We believe the PCMH will improve our competitive position.

In coordination with our PCMH strategy, we are currently designing and testing an electronic medical records system ("EMR") to be implemented in the primary care centers which we own. We began moving toward more electronic health data in 2007 with the implementation of a basic practice management software program. In 2008 and 2009, we added telephonic messaging, the ability to prescribe pharmaceuticals electronically, a disease registry and speech recognition software. We plan to begin to install EMR at our owned centers in April 2010 and expect to have the installation completed in all of our centers in 2011. Initially, we will see some increase in cost as the installation occurs. However, we expect that as we gain more experience and efficiency with EMR, we will see costs begin to drop in the early part of 2011.

We believe it is important, in what is a highly competitive healthcare marketplace, to retain and recruit top talent. Beginning in 2009, we have entered into a formal program to better train and develop our leaders and staff. We believe this investment will have a positive return in terms of improved customer service, enhanced employee engagement and retention and, as a result, better outcomes and financial performance in future years.

Claims Processing

Pursuant to the Humana Agreements, Humana, among other things, processes claims received from providers, including from our PSN, makes a determination as to whether and to what extent to allow such claims and makes payments for covered services rendered to Humana Participating Customers using Humana's claims processing systems, policies, procedures and guidelines. Humana provides notice to the PSN upon qualification of a claim and we have the opportunity within seven days of receipt of a claim to review such claim and approve, deny or modify the claim, as appropriate. Humana provides the PSN with electronic data and reports on a monthly basis which are maintained on a server system at our executive offices. We statistically evaluate the data provided by Humana for a variety of factors including the number of customers assigned to the PSN, the reasonableness of revenue paid to us and the claims paid on our behalf. We also regularly monitor and measure Humana's estimates of claims incurred but not yet reported.

The PSN's claims suspense staff seeks to identify and correct non-qualifying claims prior to payment. After payments are made by Humana, the PSN's contestation staff is responsible for reviewing paid claims, identifying errors and seeking recoveries.

Utilization Management

Utilization review is a process whereby multiple data is analyzed to ensure that appropriate health services are provided in a cost-effective manner. Factors considered 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.

PSN Growth Strategy

We are closely monitoring the healthcare reform debate. Until we have more clarity on the changes, if any, that are going to be legislated, we have suspended plans to expand our operations in any additional counties covered under the

Humana Agreements. In the meantime, we continue to seek opportunities to expand in markets where we already operate.

Our growth strategy for the PSN includes, among other things:

- increasing the volume of patients treated by the PSN physicians through enhanced marketing efforts;
- selectively expanding the PSN's network of providers to include additional physician practices within the geographic markets in which we operate that are covered by the Humana and CarePlus Agreements;

- acquiring existing physician practices; and
- acquiring other medical service organizations.

Increasing Patient Volume

We believe the PSN's existing network of providers has the capacity to care for additional Humana Plan Customers and could realize certain additional economies of scale if the number of Humana Plan Customers utilizing the network increased. We seek to increase the number of customers using the PSN network through the general marketing efforts of Humana and through our own targeted marketing efforts towards Medicare eligible patients.

Selectively Expanding Our Network of Physician Practices Including Acquisition of Existing Physician Practices or Other Medical Services Organizations

Within our existing geographic markets, we are seeking to add additional physician practices to the PSN's existing network either through acquisition, start up or affiliation with a current PSN physician or medical service organization. We identify and select opportunities based in large part on the following broad criteria:

- a history of profitable operations or a perceived synergy such as opportunities for economies of scale through a consolidation of management or service provision functions;
- a high concentration of Medicare patients;
- a geographic proximity to underserved areas within our service regions; and
- a geographic proximity to our current operations.

PSN Competition

Some of our direct competitors in the PSN industry, all of which are operating in Florida are Continucare Corporation, MCCI, Primary Care Associates, Inc., Island Doctors and WellMed. See Item 1A "Risk Factors – Our Industry is Already Very Competitive…"

Health Maintenance Organization

Between July 2005 and August 2008, we operated the HMO through our wholly owned subsidiary, Metcare Health Plans, Inc.

On August 29, 2008 (the "Closing Date"), we completed the sale of all of the outstanding capital stock of the HMO to the Humana Plan pursuant to the terms of the Stock Purchase Agreement, dated as of June 27, 2008, by and between the Company and the Humana Plan for a cash purchase price of approximately $14.6 million (the "Purchase Price"). Upon closing, approximately ten percent of the Purchase Price was deposited in escrow to be held for 24 months to secure our payment of any post-closing adjustments, described below, and indemnification obligations. Concurrently with the sale, the PSN and Humana entered into the IPA Agreement to provide or coordinate the provision of healthcare services to the HMO's customers pursuant to a capitation arrangement.

The Purchase Price 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 as determined nine months following the Closing Date (the "Closing Net Equity"). In addition to the

Purchase Price adjustment, 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. Substantially all of the reconciliations are expected to be completed in the first half of 2010 and will be paid to us or the Humana Plan, as applicable. The ultimate settlements, if any, will increase or decrease the gain on the sale of the HMO.

In connection with the sale, we paid certain of the employees of the HMO stay bonuses or termination payments. We recognized and paid all of these costs, totaling $1.6 million, in the third quarter of 2008.

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 and providing services to 7,400 customers.

The HMO's Medicare Advantage customers did not pay a monthly premium in 2008. In most cases, the HMO 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 HMO's contract with CMS, the HMO had agreed to provide services to Medicare beneficiaries pursuant to the Medicare Advantage program. Under this contract, CMS paid the HMO a capitation payment based on the number of customers enrolled, which payment was adjusted for 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 capitation payment by CMS.

Insurance

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 was $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. See Item 1A "Risk Factors - Claims Relating to Medical Malpractice and Other Litigation...."

Employees

As of December 31, 2009, we had 209 full-time employees, 28 of which are on our corporate staff and 181 of which are employed by the PSN. None of our employees are covered by a collective bargaining agreement or are represented by a labor union. We consider our employee relations to be good.

Government Regulation

Our business is regulated by the federal government and the State of Florida. The laws and regulations governing our operations are generally intended for the benefit of health plan customers and providers and are intended to limit healthcare program expenditures. These laws and regulations, along with the terms of our contracts, regulate how we do business, what services we offer, and how we interact with Humana Participating Customers, CarePlus Participating Customers, affiliated providers and the public. The government agencies administering these laws and regulations have broad latitude to interpret and enforce them. We are subject to various governmental reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations.

We believe that we are in material compliance with all government regulations applicable to our business. We further believe that we have implemented reasonable systems and procedures to assist us in maintaining compliance with such regulations. Nonetheless, we face a variety of regulatory related risks. See "Risk Factors - Reductions in Government Funding…", "-The MMA Materially Impacted Our Operations…", "CMS Risk Adjustment Payment System…",

Business Activities Are Highly Regulated…", "The Healthcare Industry is Highly Regulated…", "" and "We Are Required Comply with Laws…"

A summary of material aspects of the government regulations to which we are subject is set forth below.

Federal and State Reimbursement Regulation

Our operations are affected on a day-to-day basis by numerous legislative, regulatory and industry-imposed operational and financial requirements, which are administered by a variety of federal and state governmental agencies as well as by self-regulating associations and commercial medical insurance reimbursement programs.

Federal “Fraud and Abuse” Laws and Regulations

Health care fraud and abuse laws at the federal and state levels regulate both the provision of services to government program beneficiaries and the submission of claims for services rendered to such beneficiaries. Individuals and organizations can be punished for submitting claims for services that were not provided, not medically necessary, provided by an improper person, accompanied by an illegal inducement to utilize or refrain from utilizing a service or product, or billed in a manner that does not comply with applicable governmental requirements. Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud and abuse, including recovery of amounts improperly paid, imprisonment, exclusion from participation in the Medicare/Medicaid programs, civil monetary penalties and suspension of payments. Fraud and abuse claims may be initiated and prosecuted by one or more government entities and/or private individuals, and more than one of the available penalties may be imposed for each violation.

Laws governing fraud and abuse apply to virtually all health care providers (including the PSN Physicians and other physicians employed or otherwise engaged by the PSN) and the entities with which a health care provider does business.

Federal Anti-Kickback Law

The federal Anti-Kickback Law prohibits the knowing and willful, offer, payment, solicitation, or receipt of any remuneration, overtly or covertly, in cash or in kind, to reduce or reward (i) referrals of goods, facilities, items or services reimbursable (in whole or in part) by a federal health care program (including, without limitation, Medicare and/or Medicaid), or (ii) the purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing or ordering of such goods, facilities, items or services.. Violations of the Anti-Kickback Law are punishable by imprisonment, criminal fines, civil monetary penalties, exclusion from care programs and forfeiture of amounts collected in violation of such laws. “Remuneration” is defined broadly and includes virtually all economic arrangements involving hospitals, physicians and other health care providers, and any third party including joint ventures, space and equipment rentals, purchases of physician practices and management and personal services contracts.

However, in response to the breadth of the Anti-Kickback Law and a concern that it prohibited some common and appropriate arrangements, regulatory “safe harbors” were established such that if a particular transaction or relationship satisfied all of the requirements of a particular safe harbor, the transaction or relationship will be protected from prosecution under the Anti-Kickback Law. Further, the Anti-Kickback Law is an intent-based statute, meaning that the failure of an arrangement to meet all of the requirements of a safe harbor does not render such arrangement illegal per se. Rather, those arrangements that do not satisfy the requirements of a safe harbor will be subject to review on a case-by-case basis to determine whether the parties involved possessed the requisite improper intent.

Physician Incentive Plan Regulations

CMS has promulgated regulations that prohibit health plans with Medicare contracts from making any direct or indirect payment to physicians or other providers as an inducement to reduce or limit medically necessary services to a Medicare beneficiary. These regulations also impose disclosure, patient satisfaction monitoring and other requirements relating to physician incentive plans including requirements that govern incentive plans involving bonuses or withholdings that could result in a physician being at “substantial financial risk” as defined in Medicare regulations.

Federal False Claims Act

We are subject to a number of laws that regulate the presentation of false claims or the submission of false information to the federal government. For example, the federal False Claims Act prohibits any party from knowingly presenting, or causing to be presented, a false or fraudulent request for payment from the federal government, or making a false statement or using a false record to get a claim approved. The federal government has taken the position that claims presented in violation of the federal Anti-Kickback Law or the Stark Law may be considered a violation of the federal False Claims Act as well as by imprisonment for up to five years. Violations of the False Claims Act are punishable by treble damages and penalties of up to $11,000 per false claim. In addition to suits filed by the government, a special provision under the False Claims Act allows a private individual (e.g., a “whistleblower” such as a disgruntled former employee, competitor or patient) to bring an action under the False Claims Act on behalf of the government alleging that an entity has defrauded the federal government and permits the whistleblower to share in any settlement or judgment that may result from that lawsuit.

Florida Fraud and Abuse Regulations

Florida enacted "The Patient Brokering Act" which imposes criminal penalties, including jail terms and fines, for offering, soliciting, receiving or paying any commission, bonus, rebate, kickback, or bribe, directly or indirectly in cash or in kind, or engaging in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage from a healthcare provider or healthcare facility. The Florida statutory provisions regulating the practice of medicine include similar language as grounds for disciplinary action against a physician.

Restrictions on Physician Referrals

The federal Ethics on Patient Referrals Law (the "Stark Law"), enacted as part of the Social Security Act, prohibits a physician from referring Medicare or Medicaid beneficiaries to an entity for the furnishing of "designated health services," which includes a broad range of inpatient and outpatient health care services, if the physician (or the physician's immediate family member) has a direct or indirect "financial relationship" with the entity. The Stark Law also prohibits an entity from billing Medicare or Medicaid for services furnished pursuant to a prohibited referral. A financial relationship is defined broadly to include a direct or indirect ownership or investment in, or compensation relationship with, a health care entity. The Stark Law, and the regulations promulgated thereunder, contains certain exceptions that permit referrals that would otherwise be prohibited if the parties comply with all of the requirements of the applicable exception. The sanctions under the Stark Law include denial of claims and repayment of claims previously paid, civil monetary penalties and exclusions from participation in the Medicare programs.

Privacy Laws

The privacy, security, and use and disclosure of patient health information is subject to federal and state laws and regulations, including the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations. Final regulations with respect to the privacy of certain individually identifiable health information (the "Protected Health Information") became effective in April 2003 (the "Privacy Rule"). The Privacy Rule specifies authorized or required uses and disclosures of the Protected Health Information, as well as the rights patients have with respect to their health information. The Privacy Rule also provides that to the extent that state laws impose stricter privacy standards than the HIPAA privacy rule, such standards are not preempted, requiring compliance with any stricter state privacy law. In addition, in October 2002, the electronic data standards regulations under HIPAA became effective. The final HIPAA security rule became effective in February 2003, and established security standards with respect to Protected Health Information transmitted or maintained electronically. These regulations establish uniform standards relating to data reporting, formatting, and coding that many health care providers and health plans must use when conducting certain transactions involving health information.

HIPAA added a new provision to an existing criminal statute that prohibits the knowing and willful falsification or concealment of a material fact or the making of a materially false, fictitious or fraudulent statement in connection with the delivery of or payment for health care benefits, items or services. HIPAA established criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also imposes sanctions and fines for unintentional disclosure of Protected Health Information.

Clinic Licensure

AHCA requires us to license each of our physician practices individually as health care clinics. Each physician practice must renew its health care clinic licensure biennially.

Occupational Safety and Health Administration ("OSHA")

In addition to OSHA regulations applicable to businesses generally, we must comply with, among other things, the OSHA directives on occupational exposure to blood borne pathogens, the federal Needlestick Safety and Prevention Act, OSHA injury and illness recording and reporting requirements, federal regulations relating to proper handling of laboratory specimens, spill procedures and hazardous waste disposal, and patient transport safety requirements.

Medicare Marketing Restrictions

We are subject to federal marketing rules and regulations that limit, among other things, offering any gift or other inducement to Medicare beneficiaries to encourage them to come to us for their healthcare.

Our Executive Officers

Set forth below are: (1) the names and ages of our executive officers at February 1, 2010, (2) all positions with the Company presently held by each such person and (3) the positions held by, and principal areas of responsibility of, each such person during the last five years.

Name	Age	Position
Michael M. Earley*	54	Chief Executive Officer
Jose A. Guethon, M.D.	47	Chief Operating Office and President
Robert J. Sabo, CPA.	59	Chief Financial Officer
Roberto L. Palenzuela, Esq.	46	General Counsel and Secretary

* On December 7, 2009, we announced that Mr. Earley plans to step down as Chief Executive Officer upon the earlier of March 31, 2010 or the employment of his successor. On March 1, 2010, Mr. Earley agreed to continue to serve as our CEO until the earlier of June 30, 2010 or the employment of his successor. We are currently in the process of searching for a successor.

MICHAEL M. EARLEY has served as our Chief Executive Officer since March 2003. He also served as Chairman of the Board from September 2004 through December 2009. He previously served as a member on our Board of Directors from June 2000 to December 2002. From January 2002 until February 2003, Mr. Earley was self-employed as a corporate consultant. Previously, from January 2000 through December 2002, he served as Chief Executive Officer of Collins Associates, an institutional money management firm. From 1997 through December 1999, Mr. Earley served as Chief Executive Officer of Triton Group Management, a corporate consulting firm. From 1986 to 1997, he served in a number of senior management roles, including CEO and CFO of Intermark, Inc. and Triton Group Ltd., both publicly traded diversified holding companies and from 1978 to 1983, he was an audit and tax staff member of Ernst & Whinney. From 2002 until its sale in 2008, Mr. Earley served as a director and member of the audit committee of MPower Communications, a publicly traded telecommunications company. Mr. Earley received his undergraduate degrees in Accounting and Business Administration from the University of San Diego.

JOSE A. GUETHON, M.D. has served as our Chief Operating Officer and President since September 2008. Prior to his appointment, he served as President of the PSN since January 2007. Dr. Guethon initially joined us in October 2001 and has served in a variety of positions, including as Medical Director and Staff Physician from October 2001 through June 2004, as Senior Vice President of Utilization and Quality Improvement from June 2004 through January 2006 and as Chief Medical Officer of our HMO from January 2006 through December 2006. Dr. Guethon has approximately 15 years of healthcare experience both in clinical and administrative medicine, and is board-certified in family practice. Prior to joining us, Dr. Guethon served as the Regional Medical Director for JSA Healthcare Corporation, a provider services network located in Tampa, Florida from April 2001 through October 2001 and as the Medical Director of Humana's Orlando market operations from April 1998 through April 2001. Dr. Guethon earned his undergraduate degree from the University of Miami, his doctorate in medicine degree from the University of South Florida College of Medicine, and completed an MBA program at Tampa College.

ROBERT J. SABO, C.P.A. has served as our Chief Financial Officer since November 15, 2006. Mr. Sabo has over 35 years of financial expertise focused substantially in the Florida healthcare industry. From November 2003 to October 2006, he was the Chief Financial Officer of Hospital Partners of America, LLC, a privately held North Carolina healthcare services and hospital partnership company, where his duties included the day to day financial operations of the organization as well as the company's significant business development and merger and acquisition work. He began his career as a CPA in South Florida with Ernst & Young in 1972, and was admitted to the partnership in 1984, with his most recent responsibility from January 1999 until June 2003 as Market Leader of the Health Science Practice of the Carolinas. Mr. Sabo graduated with a B.B.A. in Accounting from the University of Miami. He is a Certified Public Accountant and a member of the American Institute of Certified Public Accountants.

ROBERTO L. PALENZUELA, ESQ. has served as General Counsel and Secretary since March 2004. Prior to joining us, Mr. Palenzuela served as General Counsel and Secretary of Continucare Corporation, a publicly traded primary care physician services company, from May 2002 through March 2004. From 1994 to 2002, Mr. Palenzuela served as an officer and director of Community Health Plan of the Rockies, Inc., a privately owned health maintenance organization based in Denver, Colorado. Community Health Plan of the Rockies, Inc. filed for protection under Chapter 11 of the federal bankruptcy laws on November 15, 2002, and was released from Chapter 11 on December 16, 2002. From March 1999 through June 2001, Mr. Palenzuela served as General Counsel of Universal Rehabilitation Centers of America, Inc. (n/k/a Universal Medical Concepts, Inc.), a privately owned physician practice management company. Mr. Palenzuela received his Bachelors Degree in Business Administration from the University of Miami in 1985 and his law degree from the University of Miami School of Law in 1988.

ITEM 1A. RISK FACTORS

Our Operations are Dependent on Humana and, At Times, Their and Our Economic Interests May Diverge.

For the twelve months ended December 31, 2009, approximately 99.6% of our revenue was earned through the Humana Agreements. We expect that, going forward, substantially all of our revenue will continue to be derived under the Humana Agreements. Humana may immediately terminate any of the Humana Agreements and/or any individual physician credentialed under the Humana Agreements upon the occurrence of certain events. Humana may also amend the material terms of the Humana Agreements under certain circumstances. See “Item 1. Business-Humana Agreements” for a detailed discussion of the Humana Agreements. Failure to maintain the Humana Agreements on favorable terms, for any reason, would materially adversely affect our results of operations and financial condition. A material decline in enrollees in Humana’s Medicare Advantage program could also have a material adverse effect on our results of operations.

Notwithstanding Humana and our current shared interest in providing service to Humana Participating Customers enrolled in Humana’s Medicare Advantage Plans, Humana and we have different and, at times, opposing economic interests. Humana provides a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, Humana and we may have different views regarding the proper pricing of our services and/or the proper pricing of the various service providers in Humana’s provider networks, the cost of which we bear to the extent we utilize such service providers. Similarly, as a result of changes in laws, regulations, consumer preferences or other factors, Humana may find it in its best interest to provide health insurance services in Florida pursuant to another payment or reimbursement structure. In the event our interests diverge, we may have limited recourse or alternative options in light of our dependence on Humana. There can be no assurances that Humana and we will continue to find it mutually beneficial to work together.

Because we operate exclusively as a PSN in Florida, primarily pursuant to the Humana Agreements, our exposure to many of the risks described herein are not mitigated by a diversification of our lines of business, geographic focus or sources of revenue. While there are no restrictions to pursuing such diversification we would have to establish new relationships with physicians and other health care providers. In addition, if we were to seek expansion into new geographic markets we would be required to comply with laws and regulations of states that differ from the ones in which we currently operate, and may face competitors with greater knowledge of such local markets.

Reductions in Funding for Medicare Programs and other Healthcare Reform Initiatives Could Adversely Affect Our Profitability

Substantially all of our revenue is directly or indirectly derived from reimbursements generated by Medicare Advantage health plans. As a result, our revenue and profitability are dependent on government funding levels for Medicare Advantage programs.

The Medicare programs are subject to statutory and regulatory changes, prospective and retroactive rate adjustments, administrative rulings, and funding restrictions, any of which could have the effect of limiting or reducing reimbursement levels. These government programs, as well as private insurers have taken and continue to take steps to control the cost, use and delivery of healthcare services.

For instance, CMS has announced that in 2010, the premiums paid to Medicare Advantage Plans will decrease as a result of a 0.5% decrease in the base rate and a recalibration of risk scores that will decrease the base rate by an additional 4.5%. Although we believe that the impact on us of the premium reduction will be mitigated by, among other things, reduced benefit offerings, increased customer co-pays and deductibles and improved risk score compliance, we have limited ability to influence the benefits offered or co-pays and deductibles set by Humana.

CMS announced that it would audit Medicare Advantage plans, primarily targeted based on risk score growth, for compliance by the plans and their providers with proper coding practices. CMS began targeted medical record reviews and adjustment payment validations in late 2008, focusing on risk adjustment data from 2006 dates of service, which were the basis for premium payments for the 2007 plan year. CMS has indicated that payment adjustments will not be limited to risk scores for the specific beneficiaries for which errors are found but may be extrapolated to the entire plan. There can be no assurance that Humana's Medicare Advantage plans will not be randomly selected or targeted for review by CMS or, in the event that a Humana Medicare Advantage plan is selected for a review, that the outcome of such a review will not result in a material adjustment in our revenue and profitability.

The President has expressed support for healthcare reform and each house of the U.S. Congress has passed a bill pertaining to the structure and funding for the U.S. healthcare system, including the Medicare program. Various items of the two bills would, if adopted, have a material adverse impact on Medicare Advantage customers and Medicare Advantage plans, including without limitation, provisions reducing Medicare Advantage payment rates. More specifically, the House of Representative's bill would phase down the current payment system to benchmark rates that are 100% of average Medicare fee-for-service costs. Plans with high "quality rankings" would be eligible for a benchmark increase. The Senate bill, in contrast, would set benchmark rates at the area-wide average of plan bids. Plans meeting certain performance benchmarks would be eligible for bonus payments. In addition, the House of Representatives bill would also authorize the termination of Medicare Advantage plans which, for five consecutive years, use less than 85% of health insurance premiums to provide health care to their customers

Although the Senate's bill and the House of Representative's bill contain some comparable provisions regarding restrictions on plan cost-sharing and changes to the annual enrollment period, it is impossible to predict with any reasonable certainty what items of the two bills or of any future legislative proposals, if any, will become law or the impact of any new law on our profitability.

Any of the following changes, among others, could have a material adverse effect on our business:

- reductions in or limitations of reimbursement amounts or rates under programs;
- reductions in funding of programs;
- expansion of benefits without adequate funding; or
- elimination of coverage for certain individuals, benefits or treatments under programs.

Any of the foregoing changes could compel Medicare Advantage plan providers to increase member premiums, compel them to reduce the benefits they offer, or some combination thereof, thereby making Medicare Advantage plans potentially less attractive to Medicare customers relative to other insurance or care options.

Because Substantially All of Our Revenue Is Established by Contract and Cannot Be Modified During the Contract Terms, Our Operating Margins Could be Negatively Impacted if We Are Unable to Manage Our Medical Expenses Effectively.

The Humana Agreements are risk agreements under which we receive monthly payments for each Humana Participating Customer at a rate established by the agreements, also called a capitation fee. In accordance with the agreements, the total monthly payment is a function of the number of Humana Participating Customers, regardless of the actual utilization rate of covered services. In return, the PSN assumes financial responsibility for the provision of all necessary medical care to the Humana Participating Customers, regardless of whether or not its affiliated providers directly provide the covered medical services.

To the extent that the Humana Participating Customers require more care than is anticipated, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of such Humana Participating Customers. If

medical expenses exceed our estimates, except in very limited circumstances, we will be unable to increase the premiums received under these contracts during the then-current terms.

Since we do not negotiate with CMS or Humana regarding the benefits to be provided under Humana's Medicare Advantage plans, we often have just a few months to familiarize ourselves with each new, annual package of benefits we are expected to offer. If Humana exercises its right to amend the benefits offered, we may object to such amendment within 30 days. If we object to such amendment, Humana may terminate the applicable Humana Agreement upon 90 days written notice. Aside from the foregoing, we have limited ability to negotiate with Humana regarding the scope of benefits we will be directly or indirectly responsible for providing. While the Humana Agreements covering the Central Florida and South Florida service areas have one-year renewable terms, the term of the IPA Agreement is five years. Accordingly, even if the Humana Agreements covering the Central Florida and South Florida service areas were terminated, we could still have an obligation to provide services under the IPA Agreement for a number of years, potentially at a loss.

Relatively small changes in our ratio of medical expense to revenue can create significant changes in our financial results. Accordingly, the failure to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported, claims, may have a material adverse effect on our financial condition, results of operations, or cash flows.

Historically, our medical expenses as a percentage of revenue have fluctuated. Factors that may cause medical expenses to exceed estimates include:

- the health status of our customers;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations, and practices;
- Humana's periodic renegotiation of provider contracts with specialist physicians, hospitals and ancillary providers;
- periodic renegotiation of contracts with our affiliated primary care physicians;
- changes in the demographics of our customers and medical trends affecting Medicare risk scores;
- contractual or claims disputes with providers, hospitals, or other service providers within the Humana network; and
- the occurrence of catastrophes, major epidemics, or acts of terrorism.

A Failure to Estimate Incurred But Not Reported Medical Benefits Expense Accurately Could Affect Our Profitability.

Medical claims expense includes estimates of future medical claims that have been incurred by the customer but for which the provider has not yet billed us ("IBNR claims"). IBNR claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon our historical claims experience and other factors. Adjustments, if necessary, are made to medical claims expense when the assumptions used to determine our IBNR claims liability changes and when actual claim costs are ultimately determined. Due to the inherent uncertainties associated with the factors used in these estimates and changes in the patterns and rates of medical utilization, materially different amounts could be reported in our financial statements for a particular period under different conditions or using different, but still reasonable, assumptions. Although our past estimates of IBNR have typically been adequate, they may be inadequate in the future, which would adversely affect our results of operations. Further, the inability to estimate IBNR accurately may also affect our ability to take timely corrective actions, further exacerbating the extent of any adverse effect on our results.

We Face Certain Competitive Threats Which Could Reduce Our Profitability and Increase Competition for Customers.

We face certain competitive threats based on certain features of the Medicare programs, including the following:

- Managed care companies began offering various new products in 2006, including regional PPOs and private fee-for-service plans. Medicare PPOs and private fee-for-service plans allow their customers more flexibility in selecting physicians than Medicare Advantage HMOs, which typically require customers to coordinate care with a primary care physician. The Medicare Modernization Act has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost-reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private fee-for-service plans has affected our PSN's relative attractiveness to existing and potential Medicare customers in their service areas.

- The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of premiums paid to the PSN or cause the PSN to increase the benefits it offers.

- Medicare beneficiaries generally have a more limited annual enrollment period during which they can choose between participating in a Medicare Advantage plan or receiving benefits under the traditional fee-for-service Medicare program. After the annual enrollment period, most Medicare beneficiaries will not be permitted to change their Medicare benefits. The annual enrollment process and subsequent "lock-in" provisions of the MMA may adversely affect our level of revenue growth as it will limit Humana's ability to market to and enroll new customers in its established service areas outside of the annual enrollment period.

- Managed care companies that offer Medicare Advantage plans are required to offer prescription drug benefits as part of their Medicare Advantage plans. Individuals who are enrolled in a Medicare Advantage plan that offers qualified Part D coverage must receive their drug coverage through their Medicare Advantage prescription drug plan, with the exception of those Medicare Advantage enrollees who are also enrolled in a Medical Savings Account plan, who may choose a stand-alone PDP. Enrollees may prefer a stand-alone drug plan and may cease to be a Medicare Advantage customer in order to participate in a stand-alone PDP. Accordingly, the Medicare Part D prescription drug benefit could reduce Humana Participating Customer enrollment and revenue.

CMS's Risk Adjustment Payment System and Budget Neutrality Payment Adjustments Could Result In Material Retroactive Adjustments to Our Results of Operations.

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish appropriate compensation for Medicare plans that enroll and treat less healthy Medicare beneficiaries. CMS establishes premium payments to Medicare plans based on the plans' approved bids at the beginning of the calendar year. Based on the customers' known demographic and risk information, CMS then adjusts premium levels on two separate occasions during the year on a retroactive basis to take into account additional customer risk data. The first such adjustment updates the risk scores for the current year based on prior year's dates of service. The second such adjustment is a final retroactive risk premium settlement for the prior year. As a result of the variability of factors impacting risk scores, the actual amount of CMS's retroactive payment could be materially more or less than our estimates. Consequently, our estimate of our plans' aggregate customer risk scores for any period, and our accrual of premiums related thereto, may result in favorable or unfavorable adjustments to our Medicare premium revenue and, accordingly, our profitability.

Since 2003, payments to Medicare Advantage plans have also been adjusted by a "budget neutrality" factor that was implemented by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing higher, risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. The Deficit Reduction Act of 2006, among other changes, provides for an accelerated phase-out of budget neutrality for risk adjustment of payments made to Medicare Advantage plans. The phase out began in 1997 and will be complete by 2011, when Medicare Advantage plans will no longer receive any budget neutrality payment adjustment. As a result of this phase-out, we expect the premiums we receive could be reduced, depending on the risk scores of Humana Participating Customers.

A Disruption in Our Health Care Provider Networks Could Have an Adverse Effect on Our Operations and Profitability.

Our operations and profitability are dependent, in part, upon our ability to contract with healthcare providers and provider networks on favorable terms. In any particular service area, healthcare providers or provider networks could refuse to contract with us, demand higher payments, or take other actions that could result in higher healthcare costs, disruption of benefits to our customers, or difficulty in meeting our regulatory or accreditation requirements. In some service areas, healthcare providers may have significant market positions. If healthcare providers refuse to contract with us, use their market position to negotiate favorable contracts, or place us at a competitive disadvantage, then our ability to market products or to be profitable in those service areas could be adversely affected. Our provider networks

could also be disrupted by the financial insolvency of a large provider group. Any disruption in our provider network could result in a loss of customers or higher healthcare costs.

A Disruption in Humana's Healthcare Provider Networks Could Have an Adverse Effect on Our Operations and Profitability.

A significant portion of the PSN's total medical expenses are payable to entities that are not directly contracted with the PSN. Although virtually all of such entities are Humana approved service providers, and although the PSN can provide Humana input with respect to Humana's service providers, the PSN does not control the process by which Humana negotiates and/or contracts with service providers in the Humana Medicare Advantage network.

We Depend on Humana to Provide Us with Crucial Information and Data.

Humana provides a significant amount of information and services to the PSN, including claims processing, billing services, data collection and other information, including reports and calculations of costs of services provided and payments to be received by the PSN. The PSN does not own or control such systems and, accordingly, has limited ability to ensure that these systems are properly maintained, serviced and updated. In addition, information systems such as these may be vulnerable to failure, acts of sabotage and obsolescence. The PSN's business and results of operations could be materially and adversely affected by its inability, for any reason, to receive timely and accurate information from Humana.

Competition For Physician Practice Group Acquisition and Other Factors May Impede Our Ability to Acquire Other Physician Practices and May Inhibit Our Growth.

We anticipate that a portion of the future growth of our PSN may be accomplished through acquisitions of physician practices or other medical service organizations with Humana or CarePlus contracts. The success of this strategy depends upon our ability to identify suitable acquisition candidates, reach agreements to acquire these companies, obtain necessary financing on acceptable terms and successfully integrate the operations of these businesses. In pursuing acquisition opportunities, we may compete with other companies that have similar growth strategies. Some of these competitors are larger and have greater financial and other resources then we have. This competition may prevent us from acquiring businesses that could improve our growth or expand our operations.

Claims Relating to Medical Malpractice and Other Litigation Could Cause Us to Incur Significant Expenses.

From time to time, we are a party to various litigation matters, some of which seek monetary damages. Managed care organizations may be sued directly for alleged negligence, including in connection with the credentialing of network providers or for alleged improper denials or delay of care. In addition, providers affiliated with the PSN involved in medical care decisions may be exposed to the risk of medical malpractice claims. Some of these providers do not have malpractice insurance. As a result of increased costs or inability to secure malpractice insurance, the percentage of physicians who do not have malpractice insurance may increase. Although most of its network providers are independent contractors, claimants sometimes allege that a PSN should be held responsible for alleged provider malpractice, particularly where the provider does not have malpractice insurance, and some courts have permitted that theory of liability.

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

We maintain errors and omissions insurance and other insurance coverage that we believe are adequate based on industry standards. Nonetheless, potential liabilities may not be covered by insurance, insurers may dispute coverage or may be unable to meet their obligations or the amount of insurance coverage and/or related reserves may be inadequate. There can be no assurances that we will be able to obtain insurance coverage in the future, or that insurance will continue to be available on a cost-effective basis, if at all. Moreover, even if claims brought against us are unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly and may distract management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Our Industry is Already Very Competitive; Increased Competition Could Adversely Affect Our Revenue; the PSN Competes with Other Service Providers for Humana's Business.

We compete in the highly competitive and regulated healthcare industry, which is subject to continuing changes with respect to the provisioning of services and the selection and compensation of providers. Substantially all of our revenue was directly or indirectly derived from premiums generated by Medicare Advantage health plans. In 2009, substantially all of our revenue was earned through the Humana Agreements. Humana competes with other health plans in securing and serving patients in the Medicare Advantage Program. Companies in other healthcare industry segments, some of which have financial and other resources comparable to or greater than Humana, are competitors to Humana. The market in Florida has become increasingly attractive to health plans that may compete with Humana. For example, HealthSpring and Coventry Health Plans, both based outside of Florida, have in recent years announced acquisitions of health plans in Florida. Humana may not be able to continue to compete profitably in the healthcare industry if additional competitors enter the same market.

The PSN competes with other service providers for Humana's business and Humana competes with other health plans in securing and serving patients in the Medicare Advantage Program. Failure to maintain favorable terms in the Humana Agreements would adversely affect our results of operations and financial condition.

Competitors of our PSN vary in size and scope and in terms of products and services offered. Our PSN competes directly with various regional and local companies that provide similar services. Some of the PSN's direct competitors are WellCare, Continucare Corporation, Primary Care Associates, Inc., MCCI and Island Doctors, all based or operating in Florida. Additionally, companies in other healthcare industry segments, some of which have financial and other resources greater than ours, may become competitors in providing similar services at any given time. The market in Florida has become increasingly attractive to competitors of the PSN due to the large population of Medicare participants. We and Humana may not be able to continue to compete effectively in the healthcare industry if additional competitors enter the same markets.

We believe that many of our competitors and potential competitors are substantially larger than our PSN and have significantly greater financial, sales and marketing, and other resources. Furthermore, it is our belief that some of our competitors may make strategic acquisitions or establish cooperative relationships among themselves.

The Failure to Implement a CEO Succession Plan Could Be Disruptive to Our Business.

In December 2009, we announced that Mr. Earley plans to step down as Chief Executive Officer upon the earlier of March 31, 2010 or the employment of his successor. On March 1, 2010, Mr. Earley agreed to continue to serve as our CEO until the earlier of June 30, 2010 or the employment of his successor. We are in the process of searching for a new Chief Executive Officer. However, there can be no assurances that we will be able to locate and retain a suitable candidate in a timely manner or that any new Chief Executive Officer will lead us as desired. We face significant competition for an executive with the qualifications and experience we are seeking. If we do not locate and engage a Chief Executive Officer that meets our search criteria prior to Mr. Earley's departure, we may seek to appoint an interim Chief Executive Officer. Any failure to implement a CEO succession as planned could have a material adverse effect on our business.

We are Dependent upon Certain Executive Officers and Key Management Personnel for Our Future Success.

Our success depends, to a significant extent, on the continued contributions of certain of our executive officers and key management personnel. The loss of these individuals could have a material adverse effect on our business, results of operations, financial condition and plans for future development. While we have a retention plan and employment contracts with certain executive officers and key management personnel, there can be no assurance that these persons will continue their employment with us. We compete with other companies in the industry for executive talent and there can be no assurance that highly qualified executives would be readily and easily available without delay, given the limited number of individuals in the industry with expertise particular to our business operations.

Our Business Activities Are Highly Regulated and New and Proposed Government Regulation or Legislative Reforms Could Increase Our Cost of Doing Business, and Reduce Our Customer Base, Profitability, and Liquidity.

Our business is subject to substantial federal and state regulation. These laws and regulations, along with the terms of our contracts and licenses, directly or indirectly regulate how we do business, what services we offer, and how we interact with our customers, providers, and the public. Healthcare laws and regulations are subject to frequent change and varying interpretations. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or the issuance of new regulations could adversely affect our business by, among other things:

- reducing the capitation payments we receive;

- imposing additional license, registration, or capital reserve requirements;
- increasing our administrative and other costs;
- forcing us to undergo a corporate restructuring;

- increasing mandated benefits without corresponding premium increases;
- limiting our ability to engage in inter-company transactions with our affiliates and subsidiaries;
- forcing us to restructure our relationships with providers; or
- requiring us to implement additional or different programs and systems.

It is possible that future legislation and regulation and the interpretation of existing and future laws and regulations could have a material adverse effect on our ability to operate under the Medicare program and to continue to serve and attract new customers.

The Healthcare Industry is Highly Regulated. Our or Humana's Failure to Comply with Laws or Regulations, or a Determination that in the Past We Had Failed to Comply with Laws or Regulations, Could Have an Adverse Effect on Our Business, Financial Condition and Results of Operations.

The healthcare services that we and our affiliated professionals, including the PSN physicians, 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, billing and coding policies and practices, policies and practices with regard to patient privacy and confidentiality, and prohibitions on payments for the referral of business and physician self-referrals. These laws and regulations generally aimed at protecting patients and federal healthcare programs, and the agencies charged with the administration of these laws and regulations have broad authority to enforce them. See Item 1. Business - Government Regulation for a discussion of the various federal government and state laws and regulations to which we are subject.

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

- loss of the PSN's right to directly or indirectly participate in the Medicare program;
- loss of one or more of the PSN's licenses to act as a service provider or third party administrator or to otherwise provide or bill for a service;
- forfeiture or recoupment of amounts the PSN has been paid pursuant to its contracts;
- imposition of significant civil or criminal penalties, fines, or other sanctions on us and/or our affiliated professionals and employees, including the PSN physicians;
- damage to our reputation in existing and potential markets;
- increased restrictions on marketing of the PSN's services; and
- inability to obtain approval for future products and services, geographic expansions, or acquisitions.

Humana is also subject to substantial federal and state government regulation as well as governmental reviews, audits and investigations. Humana's failure to comply with applicable regulations and/or maintain its licensure and rights to participate in the Medicare program would have a materially adverse effect on our business.

We Are Required to Comply With Laws Governing the Transmission, Security and Privacy of Health Information That Require Significant Compliance Costs, and Any Failure to Comply With These Laws Could Result in Material Criminal and Civil Penalties.

Regulations under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, require us to comply with standards regarding the exchange of health information within our company and with third parties, including healthcare providers, designated "business associates" and customers. These regulations include standards for common

healthcare transactions, including claims information, plan eligibility, and payment information; unique identifiers for providers and employers; security; privacy; and enforcement. HIPAA also provides that to the extent that state laws impose stricter privacy standards than HIPAA privacy regulations, the stricter state law requirements are not preempted by HIPAA. HIPAA does, however, preempt more lenient state law requirements and thus, unless a state seeks and receives an exception from the Department of Health and Human Services regarding certain state laws, or state laws concerning certain specified areas, such state standards and laws will be preempted by any contrary provision of HIPAA.

We conduct our operations in an attempt to comply with all applicable HIPAA requirements. Given the complexity of the HIPAA regulations, the possibility that the regulations may change, and the fact that the regulations are subject to changing and, at times, conflicting interpretation, our ongoing ability to comply with applicable HIPAA requirements is uncertain. Furthermore, a state's ability to promulgate stricter laws, and uncertainty regarding many aspects of such state requirements, make compliance more difficult. To the extent that we submit electronic healthcare claims and payment transactions that do not comply with the electronic data transmission standards established under HIPAA, payments may be delayed or denied. Additionally, the costs of complying with any changes to the HIPAA regulations may have a negative impact on operations. Sanctions for failing to comply with the HIPAA provisions include criminal penalties and civil sanctions, including significant monetary penalties. In addition, failure to comply with state health information laws that may be more restrictive than the regulations issued under HIPAA could result in additional penalties.

Our Exploration of Various Forms of Business Proposals Could be Disruptive to Our Business and We May Never Recover Our Investment in Such Efforts.

From time to time we do explore various business proposals that we believe have the promise of resulting in a transaction or relationship that could be beneficial to us. Such proposals may relate to new service areas, new businesses, new services and/or strategic alternatives. Such perceived opportunities may be presented to us by third parties without solicitation and, in other instances, we may take certain actions to generate and/or gauge an expression of interest or an offer. The exploration of such proposals is an inherently uncertain process, not uniquely within our control and subject to unpredictable developments and set-backs. We may incur substantial expenses and consume considerable management and employee time, exploring whether or not to even conditionally advance one or more business proposals. The diversion of our management's and employees' attention can be disruptive to our on-going business. Although our Board of Directors can commit to act in our best interest when making and/or evaluating any communications regarding business proposals, we can not assure you that any series of conversations, expressions of interest or offers will ever result in an offer that is deemed to be in our best interest by our Board of Directors and/or shareholders, which may be asked to pass upon an offer in certain circumstances. Accordingly, we are also subject to the risk that we may never recoup the investment of money and/or management time that we devote to business proposals.

We have Anti-Takeover Provisions Which May Make it Difficult to Acquire Us or Replace or Remove Current Management.

Provisions in our Articles of Incorporation and Bylaws may delay or prevent our acquisition, a change in our management or similar change in control transaction, including transactions in which our shareholders might otherwise receive a premium for their shares over then current prices or that shareholders may deem to be in their best interests. In addition, these provisions may frustrate or prevent any attempts by our shareholders to replace or remove current management by making it more difficult for shareholders to replace members of the Board of Directors. Because the Board of Directors is responsible for appointing the members of the management team, these provisions could in turn affect any attempt by our shareholders to replace the current members of the management team. These provisions provide, among other things, that:

- any shareholder wishing to properly bring a matter before a meeting of shareholders must comply with specified procedural and advance notice requirements;

- the authorized number of directors may be changed only by resolution of the Board of Directors; and

- the Board of Directors has the ability to issue 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, without shareholder approval.

Our Quarterly Results Will Likely Fluctuate, Which Could Impact the Value of Our Common Stock.

We are subject to quarterly variations in revenue and medical expenses due to, among other things, our ever evolving estimates of reimbursement rates and incurred but not reported medical expenses, as well as fluctuations in patient utilization. For example, our estimates of reimbursement rates are often materially impacted when CMS announces past and future year reimbursement rates and we generally experience a greater use of medical services in some months than others. Accordingly, our results of operations fluctuate from period to period and our results of operations for any quarter are not necessarily indicative of results of operations for any future period or full year, which could impact the value of our Common Stock.

The Market Price of Our Common Stock Could Fall as a Result of Sales of Shares of Common Stock in the Market or the Price Could Remain Lower because of the Perception that Such Sales May Occur.

We cannot predict the effect, if any, that future sales or the possibility of future sales may have on the market price of our Common Stock. As of December 31, 2009, there were approximately 40.9 million shares of our Common Stock outstanding, all of which are freely tradable without restriction or tradable in accordance with Rule 144 of the Securities Act with the exception of approximately 5.2 million shares owned by certain of our officers, directors and affiliates which may be sold publicly at any time subject to the volume and other restrictions promulgated pursuant to Rule 144 of the Securities Act and subject to legal restrictions such as insider trading laws and (ii) approximately 719,000 restricted shares of our Common Stock owned by certain of our employees and directors at December 31, 2009, which are subject to forfeiture until vested in accordance with their terms. In addition, as of December 31, 2009, approximately 4.2 million shares of our Common Stock were reserved for issuance upon the exercise of options which were previously granted and 881,000 shares of our Common Stock were reserved for future issuance upon conversion of the Series A Preferred Stock.

Sales of substantial amounts of our Common Stock or the perception that such sales could occur could adversely affect prevailing market prices which could impair our ability to raise funds through future sales of Common Stock.

The market price and trading volume of our Common Stock could fluctuate significantly and unexpectedly as a result of a number of factors, including factors beyond our control and unrelated to our business. Some of the factors related to our business include termination of the Humana Agreements, announcements relating to our business or that of our competitors, adverse publicity concerning organizations in our industry, changes in state or federal legislation and programs, general conditions affecting the industry, performance of companies comparable to us, and changes in the expectations of analysts with the respect to our future financial performance. Additionally, our Common Stock may be affected by general economic conditions or specific occurrences such as epidemics (such as influenza), natural disasters (including hurricanes), and acts of war or terrorism. Because of the limited trading market for our Common Stock, and because of the possible price volatility, our shareholders may not be able to sell their shares of Common Stock when they desire to do so. The inability to sell shares in a rapidly declining market may substantially increase our shareholders' risk of loss because of such illiquidity and because the price for our Common Stock may suffer greater declines because of our price volatility.

Delisting of Our Common Stock from NYSE Amex Would Adversely Affect Us and Our Shareholders.

Our Common Stock is listed on the NYSE Amex. To maintain listing of securities, the NYSE Amex requires satisfaction of certain maintenance criteria that we may not be able to continue to be able to satisfy. If we are unable to satisfy such maintenance criteria in the future and we fail to comply, our Common Stock may be delisted from trading on NYSE Amex. If our Common Stock is delisted from trading on NYSE Amex, then trading, if any, might thereafter be conducted in the over-the-counter market in the so-called "pink sheets" or on the "Electronic Bulletin Board" of the National Association of Securities Dealers, Inc. and consequently an investor could find it more difficult to dispose of, or to obtain accurate quotations as to the price of, our Common Stock.

Our Common Stock May Not be Excepted from "Penny Stock" Rules, Which May Adversely Affect the Market Liquidity of Our Common Stock.

The Securities Enforcement and Penny Stock Reform Act of 1990 requires additional disclosure relating to the market for penny stocks in connection with trades in any stock defined as a "penny stock". The Securities and Exchange Commission's (the "Commission" or the "SEC") regulations generally define a penny stock to be an equity security that has a market price of less than $5.00 per share, subject to certain exceptions. For example, such exceptions include any equity security listed on a national securities exchange such as the NYSE Amex. Currently, our Common Stock meets this exception. Unless an exception is available, the regulations require the delivery, prior to any transaction involving a penny stock, of a disclosure schedule explaining the penny stock market and the risks associated therewith. In addition, if our Common Stock becomes delisted from the NYSE Amex and we do not meet another exception to the penny stock regulations, trading in our Common Stock would be covered by the Commission's Rule 15g-9 under the Exchange Act for non-national securities exchange listed securities. Under this rule, broker/dealers who recommend such securities to persons other than established customers and accredited investors must make a special written suitability determination for the purchaser and receive the purchaser's written agreement to a transaction prior to sale. Securities also are exempt from this rule if the market price is at least $5.00 per share. If our Common Stock becomes subject to the regulations applicable to penny stocks, the market liquidity for our Common Stock could be adversely affected. In such event, the regulations on penny stocks could limit the ability of broker/dealers to sell our Common Stock and thus the ability of purchasers of our Common Stock to sell their shares in the secondary market.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None

ITEM 2 PROPERTIES

Our principal executive office is located at 250 South Australian Avenue, Suite 400, West Palm Beach, Florida where we occupy 18,100 square feet at a current monthly rent of approximately $26,500 pursuant to a lease expiring March 31, 2011.

We have a satellite office in Daytona Beach, Florida where we occupy 5,700 square feet at a monthly rent of $9,700 pursuant to a lease expiring in January 2012.

The PSN leases eleven offices serving patients in Central Florida and South Florida with aggregate monthly rental payments of $51,000 pursuant to lease agreements with remaining noncancellable terms ranging from two to seven years after December 31, 2009.

ITEM 3 LEGAL PROCEEDINGS

We are a party to various legal proceedings which are either immaterial in amount to us or involve ordinary routine litigation incidental to our business and the business of our subsidiaries. There are no material pending legal proceedings, other than routine litigation incidental to our business to which we are a party or of which any of our property is the subject.

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 quarter ended December 31, 2009.

PART II

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

Our Common Stock is currently traded on the NYSE Amex Exchange under the symbol "MDF". The following table sets forth the high and low sales prices for our Common Stock, as reported by NYSE Amex, for each full quarterly period within the two most recent years:

	High ($)	Low ($)
Quarter ended March 31, 2008	$ 2.48	$ 2.18
Quarter ended June 30, 2008	$ 2.28	$ 1.66
Quarter ended September 30, 2008	$ 2.28	$ 1.69
Quarter ended December 31, 2008	$ 2.07	$ 1.30
Quarter ended March 31, 2009	$ 1.78	$ 1.20
Quarter ended June 30, 2009	$ 2.19	$ 1.46
Quarter ended September 30, 2009	$ 2.49	$ 2.01
Quarter ended December 31, 2009	$ 2.21	$ 1.85

At February 16, 2010, we believe we had approximately 3,440 beneficial shareholders.

Issuer Purchases of Equity Securities

Common stock repurchases during the fourth quarter of 2009 were as follows:

Period	Total Number of Shares Purchased	Average Price Paid Per Share, Including Commission	Total Number of Shares Purchased as Part of Publicly Announced Plans (1)	Maximum Number of Shares That May Yet Be Purchased Under the Plan (2)
October 1, 2009 - October 31, 2009	637,250	$ 2.21	637,250	3,871,224
November 1, 2009 - November 30, 2009	668,000	$ 2.07	668,000	3,203,224
December 1, 2009 - December 31, 2009	895,867	$ 1.98	895,867	2,307,357

(1) On October 3, 2008, we announced a stock repurchase plan pursuant to which our Board of Directors authorized us to repurchase up to 10 million shares of our common stock. On August 3, 2009, the Board of Directors approved a 5 million share increase to the share repurchase program. On February 24, 2010, the Board approved an increase to the share repurchase program of an additional 5 million shares, bringing the total number of shares of common stock authorized for repurchase under the program to 20 million shares. 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. The plan does not have a scheduled expiration date.

(2) Maximum number of shares that may yet be purchased under the plan at December 31, 2009 excludes the additional 5 million shares of common stock authorized by the Board on February 24, 2010.

Dividends

We have never declared or paid any cash dividends on our Common Stock and do not intend to pay cash dividends in the foreseeable future. Pursuant to Florida law, we are prohibited from paying dividends or otherwise distributing funds to our shareholders, except out of legally available funds. The declaration and payment of dividends on our Common Stock and the amount thereof will be dependent upon our results of operations, financial condition, cash requirements, future prospects and other factors deemed relevant by the Board of Directors. No assurance can be given that we will pay any dividends on our Common Stock in the future.

Equity Compensation Plans

The following table provides certain information regarding our existing equity compensation plans as of December 31, 2009:

	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for issuance under equity compensa-tion plans
Equity compensation plans approved by security holders	4,202,098(1)	$ 1.85	3,236,284

(1)

The table above does not include awards of 719,000 shares of unvested restricted common stock. For information concerning these awards see Note 15 to the Consolidated Financial Statements.

Performance Graph

The following graph depicts our cumulative total return for the last five fiscal years relative to the cumulative total returns of the NASDAQ Stock Market Index and a group of peer companies (the "Peer Group"). All indices shown in the graph have been reset to a base of $100 as of December 31, 2004 and assume an investment of $100 on that date and the reinvestment of dividends paid since that date.

	December 31, 2005	December 31, 2006	December 31, 2007	December 31, 2008	December 31, 2009
Metropolitan Health Networks, Inc.	$ 85	$ 108	$ 84	$ 57	$ 70
NASDAQ Composite	102	113	125	75	109
NASDAQ Health Services	137	137	179	131	173
SIC Code 8000-8099 Health Services	112	120	112	82	110

ITEM 6 SELECTED FINANCIAL DATA

Set forth below is our selected historical consolidated financial data for the five years ended December 31, 2009. The selected historical consolidated financial data should be read in conjunction with the consolidated financial statements and accompanying notes and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Item 7 of this Annual Report. The consolidated statement of operations data and balance sheet data as of and for the years ended December 31, 2006, 2007, 2008 and 2009 are derived from our audited consolidated financial statements which have been audited by Grant Thornton LLP, our independent registered public accounting firm. The consolidated statement of operations data and balance sheet data as of and for the year ended December 31, 2005 are derived from our audited consolidated financial statements which have been audited by Kaufman, Rossin & Co., P.A.

	For the years ended December 31,				
	2009 (5)	2008 (4)	2007 (3)	2006 (2)	2005 (1)
Statement of Operations Data					
Revenue	$ 354,407,100	$ 317,211,727	$ 277,577,289	$ 228,216,073	$ 183,765,191
Operating income (loss)	$ 22,981,103	$ 16,540,974	$ 8,071,571	$ (232,952)	$ 3,232,678
Income from continuing operations before income taxes	$ 23,348,679(8)	$ 16,618,535(6) (7)	$ 9,440,738(6)	$ 825,561(6)	$ 3,849,549
Net income	$ 14,448,566	$ 10,204,467	$ 5,913,998	$ 472,561	$ 2,381,743
Basic earnings per share	$ 0.32	$ 0.21	$ 0.12	$ 0.01	$ 0.05
Diluted earnings per share	$ 0.31	$ 0.20	$ 0.11	$ 0.01	$ 0.05
Weighted average common shares outstanding-basic	44,496,487	49,093,039	50,573,349	50,032,555	48,975,803
Weighted average common shares outstanding-diluted	45,940,636	50,353,644	51,796,185	51,472,616	51,007,396
Cash dividend declared	-	-	-	-	-
Balance Sheet Data					
Cash and equivalents	$ 6,794,809	$ 2,701,243	$ 38,682,186	$ 23,110,042	$ 15,572,862
Short-term investments	$ 27,036,310	$ 33,641,140	$ -	$ -	$ -
Total current assets	$ 35,715,053	$ 40,867,225	$ 44,763,752	$ 30,464,838	$ 24,479,528
Total assets	$ 51,332,242	$ 49,144,355	$ 53,811,047	$ 41,841,033	$ 33,115,106
Total current liabilities	$ 8,008,609	$ 6,339,625	$ 15,545,068	$ 10,911,770	$ 3,416,244
Total liabilities	$ 8,406,336	$ 6,339,625	$ 15,545,068	$ 10,911,770	$ 3,416,244
Total working capital	$ 27,706,444	$ 34,527,600	$ 29,218,684	$ 19,553,068	$ 21,063,284
Long - term obligations, including current portion	$ 715,909	$ -	$ -	$ -	$ -
Total stockholders' equity	$ 42,925,906	$ 42,804,730	$ 38,265,979	$ 30,929,263	$ 29,698,862

(1) The financial data for 2005 includes a deferred tax asset of $7,993,000 and an income tax expense of $1,468,000.
(2) The financial data for 2006 includes a deferred tax asset of $7,367,000 and an income tax expense of $353,000.
(3) The financial data for 2007 includes a deferred tax asset of $4,309,000 and an income tax expense of $3,527,000.
(4) The financial data for 2008 includes a deferred tax asset of $1,244,000 and an income tax expense of $6,414,000.
(5) The financial data for 2009 includes a deferred tax asset of $1,678,000 and an income tax expense of $8,900,000.
(6)

In accordance with U.S. GAAP, 2009, 2008, 2007 and 2006 results of operations include stock based compensation expense of $1,355,000, $1,229,000, $616,000 and $736,000, respectively.

(7) Includes a gain on the sale of our HMO of $5.9 million and related stay bonuses and termination costs of $1.6 million.

(8) Includes an incremental gain on the sale of our HMO of $1.3 million.

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

Overview

During 2009 and the last four months of 2008, we operated only our PSN business, having sold our HMO on August 29, 2008. During 2007 and through August 28, 2008, we operated two financial reporting segments, the PSN business and the HMO business. The sale allowed us to focus solely on our core PSN business in 2009 and to significantly reduce general and administrative costs.

Our results are impacted by many factors, but most notably are influenced by our ability to establish and maintain a competitive and efficient cost structure and to accurately and consistently negotiate competitive payments from Humana. Benefit costs are subject to a high rate of inflation due to many forces, including new higher priced technologies and medical procedures, new prescription drugs and therapies, an aging population, lifestyle challenges including obesity and smoking, the tort liability system, and government regulation.

We rely on a key statistical performance measure, the medical expense ratio ("MER"), which is computed by taking total medical expenses as a percentage of revenue. This measure represents a statistic used to measure gross profit.

Critical Accounting Policies

Our significant accounting policies are more fully described in Note 2 of the "Notes to Consolidated Financial Statements" included in this Form 10-K. As disclosed in Note 2, the preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the accompanying financial statements. Actual results may ultimately differ materially from those estimates. We believe that the following discussion addresses our most critical accounting policies, including those that are perceived to be the most important to the portrayal of our financial condition and results of operations and that require complex and/or subjective judgments by management.

We believe that our most critical accounting policies include "Use of Estimates, Revenue, Expense and Receivables."

Use of Estimates, Revenue, Expense and Receivables

Our revenue is primarily derived from risk-based health insurance arrangements in which the premium is paid to us monthly and varies depending on the county, age and severity of illness of the Humana Participating Customer. We assume the economic risk of funding our customers' healthcare services and related administrative costs. Premium revenue is recognized in the period in which eligible individuals are entitled to receive healthcare services. Because we have the obligation to fund medical expenses, we recognize gross revenue and medical expenses associated with the Humana Agreements in our consolidated financial statements. We record healthcare premium payments we receive in advance of the service period as unearned premiums.

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 not yet reported. These retroactive adjustments could, in the near term, materially impact the revenue that has been recorded. We record any adjustments to revenue at the time that the information necessary to make the determination of the adjustment is available and the collectibility of the amount is reasonably assured, or the

likelihood of repayment is probable.

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 our estimated medical claims payable by 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 of projected medical claims payable and we record to the amount within the range that is our best estimate of the ultimate liability. The actual liability incurred could differ materially from the amount recorded.

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 estimate of medical claims payable recorded in prior periods become more exact, we adjust the amount of our liability estimates, and include the changes in such estimates 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 claims experience to date and various assumptions. Therefore, the actual liability could differ materially from the amounts recorded. See Notes 2 and 8 to the Consolidated Financial Statements and Item 1A Risk Factors - "A Failure To Estimate Incurred But Not Reported…"

Pending Adoption of an Accounting Pronouncement

There are no pending accounting pronouncements that are expected to have a significant impact on our financial statements.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements that have or are reasonably likely to have a current or future effect on our financial condition, changes in financial condition, revenue or expenses, results of operations, liquidity, capital expenditures or capital resources that are material to investors.

Contractual Obligations and Other Contractual Commitments

The following table summarizes our significant contractual obligations and commercial commitments as of December 31, 2009.

		Payment Due by Period			
Contractual Obligations	Total	Less Than 1 Year	1 - 3 Years	3 - 5 Years	More Than 5 years
Operating lease obligations	$ 5,693,000	$ 1,398,000	$ 2,042,000	$ 1,176,000	$ 1,077,000
Service Agreements	1,443,000	987,000	456,000	-	-
Employment obligations	3,313,000	3,313,000	-	-	-
	$ 10,449,000	$ 5,698,000	$ 2,498,000	$ 1,176,000	$ 1,077,000

As of December 31, 2009, our long-term debt totaled $716,000 (including current portion) and we had no payment obligations that would constitute capital lease obligations.

We utilized vendors during the year to assist us with the implementation of the EMR system as well as other initiatives. Payments under these service contracts for the years subsequent to December 31, 2009 are approximately $987,000, $305,000 and $151,000 in the years 2010, 2011 and 2012, respectively. Some contracts will automatically renew unless written notice is provided to the vendor within the stated period of time prior to the end of the contract period.

Impact of Inflation

In February of 2010, CMS announced that Medicare program spending is projected to increase by 8.1% in 2009. CMS also projects that the Medicare spending growth rate from 2009 to 2019 will increase by an average of 7.5%. The principal projected drivers for this growth include continued cost-increasing medical innovation, inflation, continued strong demand for prescription drugs and the aging baby-boomer demographic.

Comparison of 2009 and 2008

Summary

In 2009, income before income taxes increased by 40.4% over 2008 from $16.6 million in 2008 to $23.3 million in 2009, an increase of $6.7 million. Excluding the gain on sale of our HMO of $5.9 million and $1.3 million in 2008 and 2009, respectively, and the stay bonuses and termination costs related to the sale that were expensed in 2008 of $1.6 million, our income before income taxes would have been $22.0 million in 2009 compared to $12.3 million in 2008, an increase of $9.7 million or 78.9%.

Net income in 2009 was $14.4 million compared to $10.2 million in 2008, an increase of $4.2 million or 41.2%. Basic earnings per share were $0.32 in 2009 and $0.21 in 2008. Diluted earnings per share were $0.31 in 2009 compared to $0.20 in 2008. The increase in earnings per share was primarily a result of our increased net income and the impact of our share buyback program that began in October 2008. We repurchased an aggregate of 7,816,678 shares in 2009 and 4,191,798 shares in 2008. The gain on the sale of the HMO, net of the related stay bonuses and termination costs in 2008, increased net income in 2009 by $0.01 per basic and diluted share and by $0.06 per basic and diluted share in 2008.

Revenue increased to $354.4 million in 2009 from $317.2 million in 2008, an increase of $37.2 million or 11.7%. See “Item 1 – Description of Business – Medicare,” “The Medicare Modernization Act.”

Our customer months, which are the aggregate number of months of healthcare services we have provided to customers during a period of time, increased to 425,100 in 2009 from 396,400 in 2008, an increase of 7.2%. Our per customer per month (“PCPM”) revenue increased from $800 in 2008 to $834 in 2009, an increase of 4.3%. The increase in PCPM revenue in 2009 was reduced by the IPA Agreement entered into as a result of the sale of the HMO. More specifically, while we owned the HMO in 2008, we received 100% of the premium paid by CMS for the HMO’s customers. Since the sale of the HMO, we receive, pursuant to the IPA Agreement, less than 100% of the CMS premium paid to Humana with respect to customers in the HMO’s former counties of operation.

Our PCPM medical expense increased, from $708 in 2008 to $738 in 2009, an increase of 4.2%. Our MER increased by one basis point to 88.5% in 2009 as compared to 88.4% in 2008. The reduction in Medicare premiums we received under the IPA Agreement increased our MER in 2009 compared to 2008.

The sale of the HMO enabled us to reduce our operating expenses. In 2009, operating expenses decreased to $19.2 million compared to $26.1 million in 2008. Included in 2008 operating expenses is $1.6 million of stay bonuses and termination costs associated with the sale of the HMO. Excluding these bonuses and termination costs, operating costs in 2008 (which exclude approximately four months of the HMO’s 2008 operations) would have been $24.5 million, which is $5.3 million or 21.6% higher than operating costs for 2009.

CMS has announced that in 2010, the premiums paid to Medicare Advantage plans will decrease as a result of a 0.5% decrease in the base rate and a recalibration of risk scores that will decrease the base rate by an additional 4.5%. We believe that the impact on us of the foregoing premium reduction and increased costs will be mitigated by, among other things, reduced benefit offerings, increased customer co-pays and deductibles and improved risk score compliance by us.

See “Item 1A. Risk Factors” for further discussion of the most significant risks that affect our business, financial condition, results of operations and/or cash flows.

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 December 31, 2009 and 2008 and (ii) the aggregate customer months for the PSN in 2009 and 2008 and the HMO in 2008.

Following the sale of the HMO and contemporaneous execution of the IPA Agreement, the PSN assumed responsibility for providing medical services to the customer base of the HMO.

	Customers at December 31	Customer Months In	Percentage Change in Customer Months

	2009	2008	2009	2008	Between Years
PSN	35,500	33,000	425,100	338,300	25.7%
HMO	-	-	-	58,100	-100.0%
Total	35,500	33,000	425,100	396,400	7.2%

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 caused by deaths, customers moving from the covered areas, customers transferring to another physician practice or customers making other insurance selections.

At February 1, 2010, the PSN was providing services to approximately 35,300 customers. This amount will change as customers may enroll and disenroll through March 31, 2010.

Revenue

The following table provides a breakdown of our sources of revenue.

	Year Ended December 31		$ Increase (Decrease)	% Change
	2009	2008		
PSN revenue from Humana	$ 352,993,000	$ 263,268,000	$ 89,725,000	34.1%
PSN fee-for-service revenue	1,414,000	1,570,000	(156,000)	-9.9%
Total PSN revenue	354,407,000	264,838,000	89,569,000	33.8%
Percentage of total revenue	100.0%	83.5%		
HMO revenue	-	52,374,000	(52,374,000)	-100.0%
Percentage of total revenue	0.0%	16.5%		
Total revenue	$ 354,407,000	$ 317,212,000	$ 37,195,000	11.7%

The PSN's most significant source of revenue during both 2009 and 2008 was the premium revenue generated pursuant to the Humana Agreements (the "Humana Related Revenue"). The Humana Related Revenue increased from $263.3 million in 2008 to $353.0 million in 2009, an increase of approximately $89.7 million or 34.1%.

Approximately $77.1 million of the increase in the Humana Related Revenue is attributable to the IPA Agreement pursuant to which we began providing services to the customers of the HMO following its sale to the Humana Plan. The balance of the increase is primarily attributable to a 4.3% increase in our PCPM premium in 2009 as compared to 2008 and the increase in our customer base.

The average premium we received per customer per month ("PCPM") for 2009 was approximately $834 as compared to $800 for 2008. This PCPM premium increase is primarily a result of a 3.5% increase in the base premium in 2009 as compared to 2008, comprised of an industry-wide increase in the base premium in 2009, as well as a company specific increase in the base premium based upon an increase in the average Medicare risk score of our customers.

Periodically, we receive retroactive adjustments to the premiums paid to us based on the updated MRA scores of our customers. 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.

At December 31, 2009, we recorded a $1.4 million receivable representing our estimate of the retroactive MRA premium for services provided in 2009 that we expect to receive in the summer of 2010. In 2009, we received the final MRA premium payment for services provided in 2008 in the amount of $3.0 million. At December 31, 2008, we had recorded a $3.8 million estimated MRA receivable for services provided in 2008. The difference of $800,000

reduced revenue in 2009. The final retroactive MRA premium adjustment for services provided in 2007, which was received in 2008, was not materially different than the estimate we recorded at December 31, 2007.

We continue to invest resources in people and processes to assure that our customers are assigned the proper risk scores. These processes include ongoing training of medical staff responsible for coding and routine auditing of patient charts to assure risk-coding compliance. Customers with higher risk codes generally require more healthcare resources than those with lower risk codes. Proper coding helps to assure that we receive premiums consistent with the cost of treating these customers. Our efforts related to coding compliance are ongoing and we continue to commit additional resources to this important discipline.

The payment we receive for providing prescription drug benefits (the “Medicare 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 (the "Estimated Costs") to actual incurred prescription drug benefit 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 Medicare Part D payment. The final settlement for the Part D program occurs in the subsequent year.

At December 31, 2009 we recorded a receivable of $961,000, the amount we estimate 2009 Actual Costs exceeded the revenue received. At December 31, 2008, we estimated that we would be required to refund $100,000 related to Medicare Part D payments received and recorded a liability for this amount. The 2008 amount settled at the approximate amount that was estimated. In 2008, we determined that the final Part D settlement payable for prescription drug coverage in 2007 was over accrued by approximately $1 million and we increased revenue in 2008 by this amount.

The fee-for-service revenue represents amounts earned from medical services provided to non-Humana customers in our owned physician practices.

Total Medical Expense

Total medical expense represents the estimated total cost of providing patient care and is comprised of two components, medical claims expense and medical center costs. Medical claims expense is recognized in the period in which services are provided and includes 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. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by providers other than the physician practices owned by the PSN (collectively “Non-Affiliated Providers”). Medical center costs represent the operating costs of the physician practices owned by the PSN.

We develop our estimated medical expenses payable by using an actuarial process that is consistently applied. The actuarial process develops a range of estimated medical expenses 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 recorded medical claims payable estimates based on actual claim submissions and other changes in facts and circumstances. As medical expenses recorded in prior periods becomes more exact, we adjust the amount of the estimate, and include the change in medical expense in the period in which the change is identified. In each reporting period, our operating results include a change in medical expense from the effects of more completely developed medical expense payable estimates associated with previously reported periods. While we believe our estimated medical expenses payable is adequate to cover future claims payments required, such estimates are based on our claims experience to date and various management assumptions. Therefore, the actual liability could differ materially from the amount recorded.

Medical expense and MER for 2008 and 2009 are as follows:

	2009 Consolidated	2008 HMO	2008 PSN	2008 Consolidated
Estimated medical expense for the year, excluding prior period claims development	$ 313,532,000	$ 46,826,000	$ 234,799,000	$ 281,625,000
(Favorable) unfavorable prior period medical claims development in current year based on actual claims submitted	20,000	(780,000)	(373,000)	(1,153,000)
Total reported medical expense for the year	$ 313,552,000	$ 46,046,000	$ 234,426,000	$ 280,472,000
Medical Expense Ratio for year	88.5%	87.9%	88.5%	88.4%
Medical Expense PCPM	$ 738	$ 793	$ 693	$ 708

In the table above, favorable adjustments to amounts we recorded in prior periods for estimated claims payable appear in parentheses while unfavorable adjustments do not appear in parentheses. Favorable adjustments reduce total medical expense for the respective applicable period and unfavorable claims development increases total medical expense for the applicable period.

The reported MER is impacted by both revenue and expense. Periodically we receive retroactive adjustments to the premiums paid to us based on the updated MRA score. Retroactive adjustments of prior period's premiums that are recorded in the current period impact the MER of that period. If the retroactive adjustment increases premium revenue then the impact reduces the MER for the period. Conversely, if the retroactive adjustment reduces revenue, then the MER for the period is higher. These retroactive adjustments include, among other things, the mid-year and annual MRA premium adjustments and settlement of Part D program premiums. In addition, actual medical claims expense usually develops differently than estimated during the period. Therefore, the reported MER shown in the above table will likely change as additional claim development occurs. 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 MER for the current 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 period.

A change in either revenue or medical claims expense of approximately $3.8 million would have impacted the MER by 1% in 2009 while a change in either revenue or medical claims expense of approximately $3.4 million would have impacted our MER by 1% in 2008.

Because the Humana Agreements provide that the PSN is financially responsible for all medical services provided to the Humana Participating Customers, medical claims expense includes the cost of medical services provided to Humana Participating Customers by Non-Affiliated Providers.

Total medical expense was $313.6 million and $280.5 million for the years ended December 31, 2009 and 2008, respectively. The increase in total medical expense in 2009 was primarily due to the increase in the number of customer months and increasing medical costs. Approximately $299.0 million or 95.4% of our total medical expenses in 2009 are attributable to medical claims expense. In 2008, approximately $268.0 million or 95.5% of our total medical expenses were attributable to medical claims expense. The balance was the expenses associated with

operating our medical centers.

Medical expense on a PCPM basis was $708 in 2008 as compared to $738 in 2009. This increase of 4.2% is primarily a result of increasing medical costs and utilization during 2009.

Our MER increased by one basis point from 88.4% in 2008 to 88.5% in 2009. 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 MER in 2008 would have been 90.7% if the HMO had been sold on January 1, 2008.

At December 31, 2009, we estimate that claims paid subsequent to December 31, 2008 for services provided prior to that date was not substantially different than the amount that we had estimated and accrued at December 31, 2008. At December 31, 2008, we estimated that claims paid subsequent to December 31, 2007 for services provided prior to that date were $1.2 million or approximately 0.4% of total medical expense lower than the estimated medical expenses payable recorded at December 31, 2007.

At December 31, 2009, we determined that the range for estimated medical claims payable was between $25.8 million and $29.4 million and we recorded a liability of $27.4 million, the actuarial mid-point of the range. Based on historical results, we believe that the actuarial mid-point of the range continues to be the best estimate within the range of the PSN's ultimate liability.

Medical center costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services, as well as the costs associated with the operations of those practices. Approximately $14.5 million of our total medical expenses in 2009 related to physician practices we own as compared to $12.5 million in 2008. Approximately $1.2 million of the increase in medical center costs is attributable to payroll costs, $500,000 is related to a medical center that was acquired in July 2008 and $200,000 is related to increased medical supply costs.

Other Operating Expenses

	Year Ended December 31		(Decrease)	%
	2009	2008	Increase	Change
Administrative payroll, payroll taxes and benefits	$ 11,287,000	$ 12,537,000	$ (1,250,000)	-10.0%
Percentage of total revenue	3.2%	4.0%		
General and administrative	7,565,000	10,071,000	(2,506,000)	-24.9%
Percentage of total revenue	2.1%	3.2%		
Marketing and advertising	359,000	1,865,000	(1,506,000)	-80.8%
Percentage of total revenue	0.1%	0.6%		
Stay bonuses and termination costs	-	1,598,000	(1,598,000)	-100.0%
Percentage of total revenue	0.0%	0.5%		
Total other operating expenses	$ 19,211,000	$ 26,071,000	$ (6,860,000)	-26.3%

Administrative Payroll, Payroll Taxes and Benefits

Administrative payroll, payroll taxes and benefits include salaries and related costs for our executive, administrative and the sales staff of the HMO in 2008. For 2009, administrative payroll, payroll taxes and benefits were $11.3 million, compared to the $12.5 million for 2008, a decrease of $1.3 million. The decrease is primarily a result of a $1.8 million decrease in payroll cost associated with the HMO following the sale of the HMO primarily offset by the costs related to the amount expensed under the Amended Employment Agreement of our CEO.

General and Administrative

General and administrative expenses decreased to $7.6 million in 2009 as compared to $10.1 million in 2008, a decrease of $2.5 million, or 24.9%. General and administrative costs associated with the HMO decreased $3.3 million as a result of the sale of the HMO partially offset by increased costs of the PSN associated with the number of customers cared for under the IPA Agreement.

Marketing and Advertising

Marketing and advertising expense primarily consists of advertising expenses and, in 2008, brokerage commissions paid to independent sales agents of the HMO. Marketing and advertising expense was $359,000 in 2009 as compared to $1.9 million in 2008, a decrease of 80.8%. The primary reason for this decrease is the elimination of these costs upon the sale of the HMO as a significant portion of our marketing costs were incurred during the open enrollment period, which occurred in the first and last quarter of the year.

Stay Bonuses and Termination Costs

In connection with the sale of the HMO, we paid certain employees of the HMO stay bonuses and termination payments. We recognized and paid all of these costs, totaling $1.6 million, in the third quarter of 2008. We incurred no such costs in 2009.

Gain on Sale of HMO Subsidiary

On August 29, 2008, we completed the sale of all of the outstanding capital stock of our HMO to the Humana Plan for a cash purchase price of approximately $14.6 million. We recognized a gain on the sale of the HMO in the third quarter of 2008 of approximately $5.9 million.

The gain on sale in 2009 of $1.3 million includes additional gain from the closing net equity settlement for the HMO and the settlement of certain liabilities of the HMO that we settled in 2009 at amounts lower than the liability recorded at the time of the sale.

Other Income

We realized other income of $368,000 in 2009 compared to $78,000 in 2008. We realized investment income in 2009 of $390,000 as compared to $108,000 in 2008.

Income taxes

Our effective income tax rate was 38.1% in 2009 and 38.6% in 2008. The decrease in 2009 was a result of an increase in our investment in tax-exempt securities.

Comparison of 2008 and 2007

Summary

Income before income taxes for 2008 was $16.6 million compared to $9.4 million in 2007. Income before income taxes in 2008 includes a gain on the sale of the HMO of $5.9 million and stay bonus and terminations costs associated with the sale of $1.6 million. The PSN reported a segment gain before income taxes and allocated overhead of $24.8 million for 2008, compared to $29.2 million for 2007, a decrease of $4.4 million or 15.1%. The HMO segment incurred a loss before income taxes and allocated overhead of $2.2 million for 2008, compared to a loss of $10.5 million in 2007, a decrease of 79.0%. Allocated overhead was $10.2 million and $9.3 million for 2008 and 2007, respectively. The 2008 segment information above excludes the gain on the sale of the HMO and the related stay bonus and termination costs.

Net income for 2008 was $10.2 million compared to $5.9 million for 2007. Earnings per share, basic was $0.21 and earnings per share, diluted was $0.20 for 2008 compared to earnings per share, basic of $0.12 and earnings per share, diluted of $0.11 for 2007. The gain on sale of the HMO, net of the stay bonus and termination costs, of $4.3 million is equivalent to approximately $0.06 per share, basic and diluted, of our outstanding common stock.

For 2008, we realized revenue of $317.2 million compared to $277.6 million in the prior year, an increase of approximately $39.6 million or 14.3%. Medical expenses for 2008 were $280.5 million, an increase of $39.8 million or 16.5% over 2007.

Our customer months increased to 396,400 in 2008 from 367,200 in 2007, an increase of 8.0%. Our PCPM revenue increased from $759 in 2007 to $800 in 2008, an increase of 5.4%. Our PCPM revenue included 100% of the

premium from CMS when we operated the HMO and was reduced under the IPA Agreement upon the sale of the HMO. Our PCPM medical costs also increased, from $658 in 2007 to $708 in 2008, an increase of 7.6%. Our MER increased by 1.7% to 86.7% in 2007 as compared to 88.4% in 2008.

Customer Information

The table set forth below provides (i) the total number of customers to whom we were providing healthcare services through the PSN and HMO as of December 31, 2008 and 2007 and (ii) the aggregate customer months for the PSN and the HMO during 2008 and 2007.

Following the sale of the HMO and consummation of the related IPA Agreement, the customer base of the HMO was assumed by the PSN.

	Customers at December 31		Customer Months In		Percentage Change in Customer Months
	2008	2007	2008	2007	Between Years
PSN	33,000	25,400	338,300	302,100	12.0%
HMO	-	6,200	58,100	65,100	-10.8%
Total	33,000	31,600	396,400	367,200	8.0%

The increase in total customer months for 2008 as compared to 2007 is primarily a result of the following:

- growth in the number of HMO customers, resulting primarily from the enrollment of new customers during the enrollment period that commenced November 15, 2007 and ended March 31, 2008;
- the assumption by our PSN, on December 1, 2007, of the management of five South Florida physician practices not previously affiliated with the PSN, which included approximately 1,000 Humana Medicare Advantage customers;
- HMO enrollments during a special enrollment period that occurred in the summer of 2007 for customers of a competing Medicare Advantage plan that had its contract terminated by CMS in July 2007; and
- 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;

The increase was partially offset by a reduction of approximately 450 customers in South Florida from a PSN practice that we closed in August 2007, all of which were moved to other providers outside of the PSN.

Revenue

The following table provides a breakdown of our sources of revenue.

	Year Ended December 31		$ Increase	%
	2008	2007	(Decrease)	Change
PSN revenue from Humana	$ 263,268,000	$ 221,255,000	$ 42,013,000	19.0%
PSN fee-for-service revenue	1,570,000	1,257,000	313,000	24.9%
Total PSN revenue	264,838,000	222,512,000	42,326,000	19.0%
Percentage of total revenue	83.5%	80.2%		
HMO revenue	52,374,000	55,065,000	(2,691,000)	-4.9%
Percentage of total revenue	16.5%	19.8%		
Total revenue	$ 317,212,000	$ 277,577,000	$ 39,635,000	14.3%

The PSN's most significant source of revenue during both 2008 and 2007 was the premium revenue generated pursuant to the Humana Agreements (the "Humana Related Revenue"). The Humana Related Revenue increased from $221.3 million in 2007 to $263.3 million in 2008, an increase of approximately $42.0 million or 19.0%.

Approximately $21.5 million of the increase in the Humana Related Revenue is attributable to the IPA Agreement pursuant to which we began providing services to the customers of the HMO following its sale to the Humana Plan. The balance of the increase is primarily attributable to a 6.5% increase in the PSN's PCPM premium in 2008 as compared to 2007.

This PCPM premium increase is primarily a result of an increase in the base premium in 2008 and an additional premium as a result of an increase in the average Medicare risk score of our customers.

At December 31, 2008, we recorded a $3.8 million receivable representing our estimate of the retroactive MRA premium for 2008 that we expected to receive in the summer of 2009. The final 2007 and 2006 retroactive MRA premium adjustments, which were received in 2008 and 2007, respectively, were not materially different than the estimates we had recorded for those years.

At December 31, 2008, we estimated that we may be required to refund approximately $100,000 related to Medicare Part D payments received and recorded a liability for this amount. Based upon CMS' final determination of the Actual Costs of the PSN for providing prescription drug benefits in 2007 and 2006, we recorded additional revenue in the third quarter of both 2008 and 2007 of approximately $1.0 million, representing the amount by which our 2007 and 2006 year-end estimated Part D refund liability exceeded the final amount.

The fee-for-service revenue represents amounts earned from medical services provided to non-Humana customers in our owned physician practices.

Total Medical Expense

Total medical expense represents the estimated total cost of providing patient care and is comprised of two components, medical claims expense and medical center costs. Medical claims expense is recognized in the period in which services are provided and includes 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. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by Non-Affiliated Providers. Medical center costs represent the operating costs of the physician practices owned by the PSN.

Medical costs and MER are as follows:

	2008			2007		
	HMO	PSN	Consolidated	HMO	PSN	Consolidated
Estimated medical expense for the year, excluding prior period claims development	$ 46,826,000	$ 234,800,000	$ 281,626,000	$ 51,813,000	$ 187,456,000	$ 239,269,000
(Favorable) unfavorable prior period medical claims development in current year based on actual claims submitted	(780,000)	(373,000)	(1,153,000)	(638,000)	2,065,000	1,427,000
Total reported medical expense for the year	$ 46,046,000	$ 234,427,000	$ 280,473,000	$ 51,175,000	$ 189,521,000	$ 240,696,000

Medical Expense Ratio for year	87.9%	88.5%	88.4%	92.9%	85.2%	86.7%
Medical Expense PCPM	$ 793	$ 693	$ 708	$ 787	$ 628	$ 656

In the table above, favorable adjustments to amounts we recorded in prior periods for estimated claims payable appear in parentheses while unfavorable adjustments do not appear in parentheses. Favorable adjustments reduce total medical expense for the respective applicable period and unfavorable claims development increases total medical expense for the applicable period.

Because the Humana Agreements provide that the PSN is financially responsible for all medical services provided to the Humana Participating Customers, medical claims expense includes the cost of medical services provided to Humana Participating Customers by Non-Affiliated Providers. During 2008, the PSN's medical claims expense increased by approximately $39.8 million or 16.5%, primarily as a result of the PSN's provision of services to the HMO's customers under the IPA Agreement and higher medical costs associated with our PSN customers' increasing medical needs as reflected in the higher average risk scores of our customers in 2008.

For the PSN, a change in either revenue or medical claims expense of approximately $2.6 million impacts the PSN's MER by 1% in 2008 and a change of approximately $2.0 million impacts the PSN's MER by 1% in 2007.

Because the Humana Agreements provide that the PSN is financially responsible for all medical services provided to the Humana Participating Customers, medical claims expense includes the cost of medical services provided to Humana Participating Customers by Non-Affiliated Providers.

Total medical expenses were $280.5 million and $240.7 million for the years ended December 31, 2008 and 2007, respectively. Our reported MER increased from 86.7% in 2007 to 88.4% in 2008. Approximately $268.0 million or 95.5% of our total medical expenses in 2008 are attributable to medical claims expense. In 2007, approximately $229.4 million or 95.3% of our total medical expenses were attributable to medical claims expense. The balance was the expenses associated with operating our medical centers.

Medical expense on a PCPM basis was $708 in 2008 as compared to $658 in 2007. This increase of 7.6% is primarily a result of increasing medical costs and utilization during 2008.

The MER for the PSN increased to 88.5% in 2008 as compared to 85.2% in 2007. During the period subsequent to the sale of the HMO, we did not realize an immediate reduction in medical costs for services provided under the IPA Agreement. This negatively impacted our gross profit and our MER for the period subsequent to the sale since, under the IPA Agreement, we receive a percentage of the CMS premium received by Humana (instead of the entire amount we were receiving when operating the HMO). As a result, we realized less revenue in the last four months following the sale of the HMO than we would have if we had continued to operate the HMO. The combination of these factors increased our MER in 2008 by 0.9%.

Medical center costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services, as well as the costs associated with the operations of those practices. Approximately $12.5 million of our total medical expenses in 2008 related to physician practices we own as compared to $11.3 million in 2007.

The MER for the HMO declined to 87.9% in 2008 from 92.9% in 2007. This decline is primarily a result of our ability to renegotiate certain contracts with hospitals and outpatient service providers in 2008, which reduced the amount we paid for services, improvements in our medical management techniques, and higher premiums from CMS attributable to an increase in the 2008 base rate and increased risk scores. Total medical expense for the HMO in 2008 decreased by $5.1 million over that incurred in 2007 primarily due to the fact that the HMO was sold effective August 29, 2008 and, accordingly, the results of operations for 2008 include only eight months of total medical expense.

The estimated medical expense payable for the PSN at December 31, 2008 was determined to be between $22.7 million and $24.5 million and, as is our policy, we recorded a liability of $23.1 million, which approximates the actuarial mid-point of the range. At December 31, 2007, our estimated medical expenses payable for the PSN was $14.7 million. Claims paid in 2008 for 2007 totaled $14.3 million, a favorable variance of $374,000. This $374,000 difference decreased the PSN's medical expense in 2008 and decreased the PSN's MER by .2%.

At December 31, 2007, our estimated medical expense payable for the HMO was $7.0 million. Claims paid in 2008 for 2007 totaled $6.2 million which was less than the estimated accrual by $780,000. This difference was recorded as a reduction in claims expense in 2008 and reduced the HMO's MER by 1.5%.

Other Operating Expenses

	Year Ended December 31		(Decrease)	%
	2008	2007	Increase	Change
Administrative payroll, payroll taxes and benefits	$ 12,537,000	$ 13,108,000	$ (571,000)	-4.4%
Percentage of total revenue	4.0%	4.7%		
General and administrative	10,071,000	11,158,000	(1,087,000)	-9.7%
Percentage of total revenue	3.2%	4.0%		
Marketing and advertising	1,865,000	3,959,000	(2,094,000)	-52.9%
Percentage of total revenue	0.6%	1.4%		
Stay bonuses and termination costs	1,598,000	-	1,598,000	100.0%
Percentage of total revenue	0.5%	0.0%		
Restructuring expense	-	584,000	(584,000)	-100.0%
Percentage of total revenue	0.0%	0.2%		
Total other operating expenses	$ 26,071,000	$ 28,809,000	$ (2,738,000)	-9.5%

Administrative Payroll, Payroll Taxes and Benefits

Administrative payroll, payroll taxes and benefits include salaries and related costs for our executive, administrative and sales staff. For 2008, administrative payroll, payroll taxes and benefits were $12.5 million, compared to the $13.1 million for 2007, a decrease of $571,000. The decrease is primarily a result of a $1.9 million decrease in payroll cost associated with the HMO, primarily as a result of the sale of the HMO. The decrease was partially offset primarily by an increase in the PSN's payroll costs, most of which related to the increase in personnel that was needed to manage the increased number of customers serviced under the IPA Agreement.

General and Administrative

General and administrative expenses decreased to $10.1 million in 2008 as compared to $11.2 million in 2007, a decrease of $1.1 million, or 9.7%. General and administrative costs associated with the HMO decreased $2.2 million in 2008 as compared to 2007, primarily as a result of the sale of the HMO. The decrease was partially offset by an increase in the general and administrative costs of the PSN, most of which related to the increase in the number of customers serviced under the IPA Agreement.

Marketing and Advertising

Marketing and advertising expense, which primarily consists of advertising expenses and brokerage commissions paid to independent sales agents of the HMO, was $1.9 million in 2008 as compared to $4.0 million in 2007, a decrease of 52.9%. The primary reason for this decrease is the elimination of these costs upon the sale of the HMO, as a significant portion of our marketing costs were incurred during the open enrollment period, which occurs in the last quarter of the year.

Stay Bonuses and Termination Costs

In connection with the sale of the HMO, we paid the employees of the HMO stay bonuses and termination payments. We recognized and paid all of these costs, totaling $1.6 million, in the third quarter of 2008.

Restructuring Expense

In July 2007, we implemented a restructuring plan designed to reduce costs and improve operating efficiencies. The restructuring plan, completed by the end of August 2007, resulted in the closure of two of the HMO's office locations, one PSN medical practice, and a workforce reduction involving 16 employees. In connection with this plan, we recorded approximately $584,000 of restructuring costs during the third quarter of 2007, including approximately $147,000 for severance payments, approximately $365,000 for continuing lease obligations on closed locations and approximately $72,000 for the write-off of certain leasehold improvements and equipment. At the time of its closure on July 31, 2007, the PSN medical practice served approximately 450 customers in South Florida, all of which were moved to other providers outside of the PSN. Prior to its closing on July 31, this PSN medical practice generated approximately $2.6 million of revenue in 2007 and had a negative gross margin. Of the $584,000 restructuring charge, approximately $400,000 related to the HMO with the balance of $184,000 associated with the PSN.

Gain on Sale of HMO Subsidiary

In 2008, we recognized a gain on the sale of the HMO of approximately $5.9 million.

Other Income

We realized other income of $78,000 in 2008 compared to $1.4 million in 2007. Although we did realize positive investment income in 2008, investment income did decrease by $1.3 million compared to 2007. This was a result of a significant decline in interest rates and realized and unrealized losses in our investment portfolio of approximately $811,000 during 2008.

Income taxes

Our effective tax rate was 38.6% in 2008 and 37.4% in 2007. The higher effective income tax rate in 2008 is a result of adjusting deferred tax estimates related to the HMO.

Liquidity and Capital Resources

Cash, cash equivalents and short-term investments at December 31, 2009 totaled approximately $33.8 million as compared to approximately $36.3 million at December 31, 2008. This reduction is primarily a result of posting $5.0 million of short-term investments to secure a $3.0 million line of credit, and classifying this collateral as a non-current asset at December 31, 2009, and the repurchase of shares discussed below.

As of December 31, 2009, we had a working capital surplus of approximately $27.7 million as compared to a working capital surplus of approximately $34.5 million as of December 31, 2008, a decrease of approximately $6.8 million or 19.7%. This decrease in working capital is primarily attributable to the posting of the collateral under the letter of credit agreement discussed above and our repurchase of $15.9 million of our common stock in 2009, both of which were partially offset by cash flow from operations.

We have an investment policy with respect to the investment of our cash and equivalents. The goal of the investment policy is to obtain the highest yield possible while investing only in highly rated instruments or investments with nominal risk of loss of principal. The investment policy sets forth a list of “Permitted Investments” and provides that any exceptions to the policy must be approved by the Chief Financial Officer or the Chief Executive Officer. We anticipate that we will continue to invest our funds in highly liquid securities.

In December 2009, we entered into a one year commercial line of credit agreement with a bank, which provides for borrowings and issuance of letters of credit of up to $3.0 million. The line of credit is secured by investments of $5.0 million. Under this line of credit, as of December 31, 2009, we had a $3.0 million letter of credit issued in favor of Humana.

At December 31, 2009, we had $716,000 of debt related to the acquisition of a physician practice.

In October 2008, we announced authorization for 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. On February 24, 2010, the Board approved an increase to the share repurchase program of an additional 5 million shares, bringing the total number of shares of common stock authorized for repurchase under the program to 20 million shares. In 2009, we repurchased 7.8 million shares and options exercisable to purchase 684,200 shares of our common stock for an aggregate of $15.9 million. In 2008, we repurchased 4.2 million shares for an aggregate of $7.6 million. Between January 1, 2010 and February 25, 2010, we repurchased an additional 1.6 million shares for

$3.7 million. 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.

Our total stockholders' equity increased approximately $100,000 or 0.2%, from approximately $42.8 million at December 31, 2008 to approximately $42.9 million at December 31, 2009. This increase was primarily a result of our net income reduced primarily offset by the shares acquired under our stock repurchase plan.

Net cash provided by operating activities for 2009 was approximately $20.4 million. In addition to net income of $14.4 million our significant sources of cash from operating activities were:

- an increase in due from (to) Humana of $5.1 million;
- stock based compensation expense of $1.2 million; and
- non-cash depreciation and amortization expense of $884,000.

The cash provided by operating activities was partially offset by the following uses of cash:

- the gain on the sale of the HMO of $1.3 million; and
- a decrease in accrued termination costs related to the HMO administrative services agreement of $960,000.

Net cash used in investing activities for 2009 was approximately $472,000. During 2009, we sold short-term investments of $1.6 million, acquired $1.1 million of fixed assets and invested $1.0 million in the purchase of a physician practice.

Net cash used in financing activities for 2009 was approximately $15.8 million. Approximately $15.9 million of which was used to repurchase our common stock, in accordance with the stock repurchase program discussed above.

ITEM 7A QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Market risk generally represents the risk of loss that may result from the potential change in value of a financial instrument as a result of fluctuations in interest rates and market prices. We do not currently have any trading derivatives nor do we expect to have any in the future. We have established policies and internal processes related to the management of market risks, which we use in the normal course of our business operations.

Interest Rate Risk

We monitor the third-party depository institutions that hold our cash, cash equivalents and investments. We diversify our cash, cash equivalents and investments among counterparties and investment positions to minimize exposure to any one of these entities or investments. As of December 31, 2009, other than one of our investment positions which represented 5.5% of our total investment portfolio, none of our other investment positions represented more than 5.0% of our total investment portfolio. Our emphasis is primarily on safety of principal while maximizing yield on those funds. To achieve this objective, we maintain our portfolio of cash equivalents and investments in a variety of securities, including U.S. Treasury securities, municipal bonds and corporate debt. As of December 31, 2009, the fair value of our investment positions was approximately $27.0 million, over 37.8% of which had a term to maturity of less than two years and a credit rating by a major rating agency of A or higher. Our investments are classified as trading securities. Investments in both fixed rate and floating rate interest earning securities carry a degree of interest rate risk. Fixed rate securities may have their fair market value adversely impacted due to a rise in interest rates, while floating rate securities may produce less income than predicted if interest rates fall. Due in part to these factors, the value of our investments and/or our income from investments may decrease in the future.

Intangible Asset Risk

We have intangible assets and perform goodwill impairment tests (apart from the required annual impairment test of goodwill) whenever events or circumstances indicate that the carrying value may not be recoverable from estimated future cash flows. As a result of our periodic evaluations, we may determine that the intangible asset values need to be written down to their fair values, which could result in material charges that could be adverse to our operating results and financial position. We evaluate the continuing value of goodwill by using valuation techniques based on multiples

of earnings, revenue and EBITDA (i.e., earnings before interest, taxes, depreciation and amortization), particularly with regard to entities similar to us that have recently been acquired. We also consider the market value of our own stock and those of companies similar to ours. As of December 31, 2009 we believe our intangible assets, including goodwill are recoverable, however, changes in the economy, the business in which we operate and our own relative performance could change the assumptions used to evaluate intangible asset recoverability. We continue to monitor those assumptions and their effect on the estimated recoverability of our intangible assets.

Equity Price Risk

We do not own any equity investments, other than in our subsidiaries. As a result, we do not currently have any direct equity price risk.

Commodity Price Risk

We do not enter into contracts for the purchase or sale of commodities. As a result, we do not currently have any direct commodity price risk.

ITEM 8 FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The financial statements and supplementary data required by this Item are set forth in the accompanying audited financial statements.

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

None

ITEM 9A. CONTROLS AND PROCEDURES

(a) Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as of December 31, 2009. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

(b) Management's Annual Report on Internal Control over Financial Reporting

Management, with the participation of the Chief Executive Officer and the Chief Financial Officer, is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers and effected by the company's board of directors, management and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles and includes those policies and procedures that:

- pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the company;

- provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and

- provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the company's assets that could have a material effect on the financial statements.

Because of inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Projections of any evaluation of effectiveness to future periods are subject to the risks that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2009. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in Internal Control-Integrated Framework.

Based on our assessment, management believes that, as of December 31, 2009, the Company's internal control over financial reporting is effective.

Grant Thornton LLP, the registered public accounting firm that audited the consolidated financial statements included in this Annual Report on Form 10-K, has issued an attestation report on our internal control over financial reporting.

(c) Attestation Report of Independent Registered Public Accounting Firm

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders
Metropolitan Health Networks, Inc.

We have audited Metropolitan Health Networks, Inc. and subsidiaries (the Company) internal control over financial reporting as of December 31, 2009, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2009, based on criteria established in Internal Control—Integrated Framework issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of the Company as of December 31, 2009 and 2008, and the related consolidated statements of income, changes in stockholders' equity and cash flows for each of the three years ended December 31, 2009 and our report dated March 2, 2010 expressed an unqualified opinion on those financial statements.

/s/ GRANT THORNTON LLP

Miami, Florida
March 2, 2010

(d) Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting during the fourth quarter of 2009 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

PART III

ITEM 10 DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Code of Ethics

As part of our system of corporate governance, our Board of Directors has adopted a code of ethics that is specifically applicable to our Chief Executive Officer and senior financial officers. This Code of Ethics for Senior Financial Officers, as well as our Code of Business Conduct and Ethics, applicable to all directors, officers and employees, are available on our web site at http://www.metcare.com. Shareholders may request a free copy of these documents from:

Metropolitan Health Networks, Inc.
Attn: Roberto L. Palenzuela, General Counsel and Secretary
250 South Australian Avenue, Suite 400
West Palm Beach, Florida 33401
(561)805-8500.

If we make substantive amendments to this Code of Business Conduct and Ethics or grant any waiver, including any implicit waiver, we will disclose the nature of such amendment or waiver on our website or in a report on Form 8-K within four days of such amendment or waiver.

Corporate Governance Guidelines — Certain Committee Charters

We have adopted Corporate Governance Guidelines as well as charters for our Audit, Compensation and Governance and Nominating Committees. These documents are available on our web site at http://www.metcare.com. Shareholders may request a free copy of any of these documents from the address and phone number set forth above under "Code of Ethics." The information contained on our web site is not incorporated by reference into this Annual Report on Form 10-K.

The information required by this item about our Executive Officers is included in Part I, "Item 1. Business" of this Annual Report on Form 10-K under the caption "Our Executive Officers." All other information required by this item is incorporated herein by reference from our definitive Proxy Statement for the 2010 Annual Meeting of Shareholders to be filed with the Commission pursuant to Regulation14A no later than April 30, 2010 (the "2010 Proxy Statement").

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is included in our 2010 Proxy Statement and is incorporated herein by reference.

ITEM 12 SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this item is included in our 2010 Proxy Statement and is incorporated herein by reference.

ITEM 13 CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

The information required by this item is included in our 2010 Proxy Statement and is incorporated herein by reference.

ITEM 14 PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this item is included in our 2010 Proxy Statement and is incorporated herein by reference.

PART IV

ITEM 15 EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The following documents are filed as a part of this Form 10-K:

(1) Consolidated Financial Statements.

(2) All financial schedules required to be filed by Item 8 of this form, and by Item 15(d) have been omitted as the required information is inapplicable or has been included in the Notes to Consolidated Financial Statements.

METROPOLITAN HEALTH
NETWORKS, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

DECEMBER 31, 2009

CONTENTS

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders
Metropolitan Health Networks, Inc.

We have audited the accompanying consolidated balance sheets of Metropolitan Health Networks, Inc. and subsidiaries (the Company) as of December 31, 2009 and 2008, and the related consolidated statements of income, changes in stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2009. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Metropolitan Health Networks, Inc. and subsidiaries as of December 31, 2009 and 2008, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2009 in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Metropolitan Health Networks, Inc. and subsidiaries internal control over financial reporting as of December 31, 2009, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated March 2, 2010 expressed an unqualified opinion thereon.

/s/ GRANT THORNTON LLP
Miami, Florida
March 2, 2010

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2009	2008
ASSETS		
CURRENT ASSETS		
Cash and equivalents	$ 6,794,809	$ 2,701,243
Investments, at fair value	27,036,310	33,641,140
Accounts receivable from patients, net of allowance of $583,000 and $490,000 in 2009 and 2008, respectively	517,314	286,003
Due from Humana, net	-	2,823,355
Inventory	216,170	315,811
Prepaid expenses	427,985	570,792
Deferred income taxes	510,816	262,874
Other current assets	211,649	266,007
TOTAL CURRENT ASSETS	35,715,053	40,867,225
PROPERTY AND EQUIPMENT, net of accumulated depreciation and amortization of $2,809,000 and $2,324,000 in 2009 and 2008, respectively	1,909,635	1,336,094
RESTRICTED CASH AND INVESTMENTS	6,444,678	1,408,089
DEFERRED INCOME TAXES, net of current portion	1,167,475	980,842
OTHER INTANGIBLE ASSETS, net of accumulated amortization of $877,000 and $524,000 in 2009 and 2008, respectively	930,569	1,184,142
GOODWILL	4,362,332	2,587,332
OTHER ASSETS	802,500	780,631
TOTAL ASSETS	$ 51,332,242	$ 49,144,355
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 455,306	$ 483,621
Accrued payroll and payroll taxes	2,959,708	2,288,224
Income taxes payable	2,271,638	1,865,926
Due to Humana, net	1,385,200	-
Accrued termination costs of HMO administrative services agreement	-	1,080,000
Accrued expenses	618,575	621,854
Current portion of long-term debt	318,182	-
TOTAL CURRENT LIABILITIES	8,008,609	6,339,625
LONG-TERM DEBT, net of current portion	397,727	-
TOTAL LIABILITIES	8,406,336	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;	40,902	48,251

40,902,391 and 48,251,395 issued and outstanding at December 31, 2009 and 2008, respectively		
Additional paid-in capital	23,329,290	37,649,331
Retained earnings	19,055,714	4,607,148
TOTAL STOCKHOLDERS' EQUITY	42,925,906	42,804,730
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 51,332,242	$ 49,144,355

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

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

Years End