METROPOLITAN HEALTH NETWORKS INC
Form 10-Q
August 09, 2012

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

FORM 10-Q

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

For the quarterly period ended June 30, 2012

OR

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

For the transition period from _____ to _____

Commission file number: 001-32361

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

Florida	65-0635748
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
777 Yamato Road, Suite 510 Boca Raton, Fl.	33431
(Address of principal executive offices)	(Zip Code)

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

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes [X] No [ ]

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes [X] No [ ]

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

Large accelerated filer [ ] Accelerated filer [X]
Non-accelerated filer [ ] (Do not check if a smaller reporting company) Smaller reporting company [ ]

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

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

Class	Outstanding at July 31, 2012
Common Stock, $.001 par value per share	44,265,552 shares

Metropolitan Health Networks, Inc.

Index

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

	June 30, 2012 (unaudited)	December 31, 2011
	(in thousands, except share data)	
ASSETS		
CURRENT ASSETS		
Cash and equivalents	$ 43,369	$ 17,277
Investments, at fair value	1,007	1,003
Due from HMOs, net	33,210	40,241
Deferred income taxes	925	949
Prepaid income taxes	191	3,717
Prepaid expense and other current assets	5,160	4,936
Current assets held for sale	5,624	4,017
TOTAL CURRENT ASSETS	89,486	72,140
PROPERTY AND EQUIPMENT, net	20,740	20,296
OTHER INTANGIBLE ASSETS, net	92,357	98,731
GOODWILL	262,610	262,610
DEFERRED FINANCING COSTS	8,348	9,882
OTHER ASSETS	1,253	1,100
NON-CURRENT ASSETS HELD FOR SALE	4,517	4,987
TOTAL ASSETS	$ 479,311	$ 469,746
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 458	$ 907
Accrued payroll and payroll taxes	3,658	6,488
Due to HMO, net	6,427	-
Accrued expenses	4,791	5,575
Accrued interest payable	6,761	2,434
Current portion of long-term debt	14,713	12,538
Current liabilities held for sale	888	956
TOTAL CURRENT LIABILITIES	37,696	28,898
LONG-TERM DEBT, net of current portion and original issue discount of $10.7 million and $12.1 million at June 30, 2012 and December 31, 2011, respectively	285,227	296,025
DEFERRED INCOME TAXES	38,219	40,175
NON-CURRENT LIABILITIES HELD FOR SALE	3	4
TOTAL LIABILITIES	361,145	365,102
COMMITMENTS AND CONTINGENCIES		
STOCKHOLDERS' EQUITY		
Preferred stock, par value $.001 per share; 10,000,000 shares authorized;		

Series A preferred stock, stated value $100 per share; 5,000 issued and outstanding	500	500
Common stock, par value $.001 per share; 80,000,000 shares authorized; 44,220,000 and 43,751,000 issued and outstanding at June 30, 2012 and December 31, 2011, respectively	44	44
Additional paid-in capital	39,610	36,740
Accumulated other comprehensive (loss)	(356)	(110)
Retained earnings	78,368	67,470
TOTAL STOCKHOLDERS' EQUITY	118,166	104,644
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 479,311	$ 469,746

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

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

	Three Months Ended June 30,	
	2012	2011
	(unaudited)	(unaudited)
	(in thousands, except per share data)	
REVENUE	$ 193,408	$ 97,320
MEDICAL EXPENSE		
Medical claims expense	150,730	76,083
Medical practice costs	14,288	4,646
Total Medical Expense	165,018	80,729
GROSS PROFIT	28,390	16,591
OPERATING EXPENSES		
Payroll, payroll taxes and benefits	7,871	3,858
General and administrative	4,731	2,201
Marketing and advertising	222	52
Amortization of intangible assets	3,187	100
Total Operating Expenses	16,011	6,211
OPERATING INCOME	12,379	10,380
OTHER (EXPENSE) INCOME:		
Interest expense	(8,134)	-
Investment income	3	281
Transaction costs	-	(1,015)
Other expense	-	(10)
Total Other (Expense) Income	(8,131)	(744)
INCOME FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	4,248	9,636
INCOME TAX EXPENSE	1,651	3,710
INCOME FROM CONTINUING OPERATIONS	2,597	5,926
INCOME FROM DISCONTINUED OPERATIONS, net of income tax expense of $209	332	-
NET INCOME	2,929	5,926
OTHER COMPREHENSIVE LOSS, net of tax benefit of $62	(99)	-
COMPREHENSIVE INCOME	$ 2,830	$ 5,926
EARNINGS PER SHARE:		
Basic		
Income from continuing operations	$ 0.06	$ 0.15

Income from discontinued operations		0.01		-
Net income	$	0.07	$	0.15
Diluted				
Income from continuing operations	$	0.06	$	0.14
Income from discontinued operations		0.01		-
Net income	$	0.07	$	0.14

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

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

	Six Months Ended June 30,	
	2012	2011
	(unaudited)	(unaudited)
	(in thousands, except per share data)	
REVENUE	$ 388,655	$ 191,986
MEDICAL EXPENSE		
Medical claims expense	293,355	147,213
Medical practice costs	28,972	9,001
Total Medical Expense	322,327	156,214
GROSS PROFIT	66,328	35,772
OPERATING EXPENSES		
Payroll, payroll taxes and benefits	16,860	7,960
General and administrative	9,077	4,343
Marketing and advertising	387	120
Amortization of intangible assets	6,374	194
Total Operating Expenses	32,698	12,617
OPERATING INCOME	33,630	23,155
OTHER (EXPENSE) INCOME:		
Interest expense	(16,362)	-
Investment income	6	464
Transaction costs	-	(1,015)
Other expense	-	(15)
Total Other (Expense) Income	(16,356)	(566)
INCOME FROM CONTINUING OPERATIONS BEFORE INCOME TAXES	17,274	22,589
INCOME TAX EXPENSE	6,679	8,697
INCOME FROM CONTINUING OPERATIONS	10,595	13,892
INCOME FROM DISCONTINUED OPERATIONS, net of income tax expense of $155	246	-
NET INCOME	10,841	13,892
OTHER COMPREHENSIVE LOSS, net of tax benefit of $155	(246)	-
COMPREHENSIVE INCOME	$ 10,595	$ 13,892
EARNINGS PER SHARE:		
Basic		
Income from continuing operations	$ 0.25	$ 0.35

Income from discontinued operations	0.01	-
Net income	$ 0.26	$ 0.35
Diluted		
Income from continuing operations	$ 0.23	$ 0.33
Income from discontinued operations	0.01	-
Net income	$ 0.24	$ 0.33

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

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

	Six Months Ended June 30,	
	2012 (unaudited) (in thousands)	2011 (unaudited)
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net income	$ 10,841	$ 13,892
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	8,168	742
Amortization of debt issuance costs and original issue discount	2,587	-
Share-based compensation expense	1,899	1,329
Excess tax benefits from stock-based compensation	(1,339)	(505)
Deferred income taxes	(1,775)	541
Other	57	(230)
Changes in operating assets and liabilities:		
Due from HMOs, net	7,031	(9,321)
Prepaid income taxes	4,865	(1,252)
Prepaid expenses and other current assets	(226)	(102)
Change in net assets held for sale	(1,206)	-
Other assets	(154)	(57)
Accounts payable	(449)	105
Accrued payroll and payroll taxes	(2,829)	(2,642)
Due to HMO, net	6,427	
Accrued expenses	(784)	835
Accrued interest payable	4,327	-
Net cash provided by operating activities	37,440	3,335
CASH FLOWS (USED IN) INVESTING ACTIVITIES:		
Capital expenditures	(2,241)	(1,472)
Cash paid for physician practices acquired, net of cash acquired	-	(975)
Restricted cash released as security for letter of credit	-	515
Purchase of short-term investments	(4)	(746)
Net cash (used in) investing activities	(2,245)	(2,678)
CASH FLOWS (USED IN) FINANCING ACTIVITIES:		
Repayments of long-term debt	(10,075)	(229)
Excess tax benefits from stock-based compensation	1,339	505
Deferred financing costs	-	(1,571)
Stock repurchases	-	(321)
Proceeds from exercise of stock options, net	(367)	(70)
Net cash (used in) financing activities	(9,103)	(1,686)
NET INCREASE (DECREASE) IN CASH AND EQUIVALENTS	26,092	(1,029)
CASH AND EQUIVALENTS - beginning of period	17,277	10,596
CASH AND EQUIVALENTS - end of period	$ 43,369	$ 9,567
Supplemental Disclosure of Non-Cash Investing and Financing Activities:		

Issuances of notes payable for physician practice acqusitions	$ -	$ 670

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

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

NOTE 1 - UNAUDITED INTERIM INFORMATION

The accompanying unaudited condensed consolidated financial statements of Metropolitan Health Networks, Inc. and subsidiaries (referred to as "Metropolitan," "the Company," "we," "us," or "our") have been prepared in accordance w accounting principles generally accepted in the United States ("U.S. GAAP") for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and footnotes required by U.S. GAAP for complete financial statements, or those normally made in an Annual Report on Form 10-K. In the opinion of management, all adjustments (consisting of normal recurring accruals) considered necessary for a fair presentation have been included. Operating results for the three and six month periods ended June 30, 2012 are not necessarily indicative of the results that may be reported for the remainder of the year ending December 31, 2012 or future periods.

The preparation of our condensed consolidated financial statements in accordance with U.S. GAAP requires us to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are medical claims payable, revenue, the existence and amount of any premium deficiency liability, the impact of risk sharing provisions related to our contracts with health maintenance organizations ("HMOs"), and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events. We adjust these estimates each period as more current information becomes available. The impact of any changes in estimates is included in the determination of earnings in the period in which the estimate is adjusted. Actual results may ultimately differ materially from those estimates.

For further information, refer to the audited consolidated financial statements and footnotes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2011. The accompanying December 31, 2011 condensed consolidated balance sheet, which has been retrospectively reclassified to reflect the assets and liabilities of the sleep diagnostic business as held for sale (See Note 4), has been derived from those audited financial statements. These interim condensed consolidated financial statements should be read in conjunction with the audited consolidated financial statements and notes to the condensed consolidated financial statements included in that report.

We have reclassified $1.0 million of transaction costs related to the Continucare acquisition from general and administrative expense to other (expense) income in the condensed consolidated statements of income and comprehensive income for the three and six months ended June 30, 2011 to conform to the presentation for the full year ended December 31, 2011.

NOTE 2 - ORGANIZATION AND BUSINESS ACTIVITY

Our primary business is the operation of our provider services network ("PSN") through our wholly owned subsidiaries, Metcare of Florida, Inc. and Continucare Corporation ("Continucare"), the latter of which we acquired on October 4, 2011. The PSN provides and arranges for the provision of healthcare services to Medicare Advantage, Medicaid and commercially insured customers in the State of Florida. At June 30, 2012, we operated the PSN through 33 wholly-owned primary care practices, a wholly-owned oncology practice and contracts with independent physician affiliates (each an "IPA"). As of June 30, 2012, the PSN operated in 20 Florida counties, including the counties in which the cities of Miami, Ft. Lauderdale, West Palm Beach, Tampa, Daytona and Pensacola are located.

7

Prior to the acquisition of Continucare, substantially all of our revenue was derived from Medicare Advantage health plans operated by Humana, one of the largest participants in the Medicare Advantage program in the United States. As a result of the acquisition of Continucare, we now have managed care agreements under the Medicare Advantage and Medicaid programs as well as commercially insured customers with several additional HMOs. Our most significant managed care agreements continue to be Medicare Advantage risk agreements with Humana. We also have agreements with United Healthcare of Florida, Inc. ("United"), Vista Healthplan of South Florida, Inc. and its affiliated companies, a subsidiary of Coventry Health Care, Inc. ("Coventry"), and Wellcare Health Plans, Inc. and its affiliated companies ("Wellcare" and together with Humana, United and Coventry, the "Contracting HMOs") as well as other HMOs. Under our HMO contracts, the substantial majority of which are risk agreements, the Contracting HMOs assign to us each member who has selected one of our physicians or IPAs as his or her primary care physician (each a "Participating Customer"). Under our risk agreements, we receive a capitated fee which is a significant percentage of the premium that the HMOs receive with respect to those Participating Customers. In return, we take full financial responsibility for the care of our Participating Customers.

We also have non-risk agreements with these HMOs. Under our non-risk agreements, we receive a monthly administrative fee based on the number of Participating Customers for which we are providing services and, under certain of these agreements, we also receive a percentage of any surplus generated as determined by the respective contract. The fees and our portion of the surplus are recorded as revenue in the period in which services are provided. Under non-risk agreements, we are not responsible for the cost of medical care provided to Participating Customers.

As of June 30, 2012, we provided services to or for approximately 69,400 Participating Customers on a risk basis and approximately 15,800 Participating Customers on a non-risk basis. We also provide services to non-Participating Customers on a fee-for-service basis.

NOTE 3 – ACQUISITIONS

We did not consummate any material acquisitions during the first six months of 2012.

In the first six months of 2011, we closed on the acquisitions of three physician practices with a total of 960 Participating Customers. The total purchase price for the three practices was $1.6 million, with a portion payable in cash at closing and the balance payable over the next 18 months. We accounted for these acquisitions as business combinations and, in accordance with U.S. GAAP, we have recorded the assets acquired and liabilities assumed at their respective fair values as of their respective acquisition dates. Our condensed consolidated financial statements include the operating results for each acquired entity from its respective date of acquisition.

The acquisition of Continucare was completed in the third quarter of 2011.

NOTE 4 – SALE OF SLEEP DIAGNOSTIC BUSINESS

The sleep diagnostic business was operated as a wholly-owned subsidiary of Continucare and was included in the acquisition of Continucare. We do not consider the sleep diagnostic business a core business of the ongoing organization and we determined that we should focus our management efforts and resources on expanding and growing our core PSN business. On February 27, 2012, the Board of Directors approved a plan to sell the sleep diagnostic business, and we have retained an investment banking firm to assist us with the sale process. We expect to complete the sale before the end of 2012.

As a result, the sleep diagnostic business is reflected as a discontinued operation in the accompanying condensed consolidated financial statements and the December 31, 2011 balance sheet has been retrospectively reclassified to reflect the assets and liabilities of this business as held for sale. We did not operate the sleep diagnostic business prior to October 4, 2011, the date of the Continucare acquisition. Therefore, the condensed consolidated statements of income and comprehensive income for the three and six month periods ended June 30, 2011 have not been retrospectively reclassified.

The current assets held for sale at June 30, 2012 consist primarily of $2.1 million in cash, accounts receivable of $2.3 million and inventory of $0.9 million. Non-current assets held for sale at June 30, 2012 consist primarily of property and equipment of $1.3 million and intangible assets of $2.9 million. Current liabilities held for sale consist primarily of accounts payable and accrued payroll and payroll taxes.

NOTE 5 – FINANCIAL INSTRUMENTS

Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions that market participants would use in pricing an asset or a liability. There is a three-tier fair value hierarchy, which prioritizes the inputs used in the valuation methodologies in measuring fair value:

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

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

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

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

The fair value of the debt outstanding under our senior secured first lien credit agreement (the “First Lien Credit Agreement”) and our senior secured second lien credit agreement (the “Second Lien Credit Agreement” and, together with the First Lien Credit Agreement, the “Credit Facilities”) is the estimated amount we would have to pay to repurchase such debt, including any premium or discount attributable to the difference between the stated interest rate and market rate of interest at the balance sheet date, but excluding any prepayment penalties. Fair values are based on quoted market prices or average valuations of similar debt instruments at the balance sheet date for those debt instruments for which quoted market prices are not available. The fair value of our long-term debt and interest rate cap are based on Level 2 inputs. The fair value of our long-term debt at June 30, 2012 was $300.9 million.

We measure our investments at fair value. Our investments are in Level 1 and Level 2. Cash and money market funds are Level 1 because these investments are valued using quoted market prices in active markets. Municipal and corporate bonds are Level 2 and are valued at the recent trading value of bonds with similar credit characteristics and rates. The fair value of our investments at June 30, 2012 was $1.0 million.

The carrying amounts of cash and cash equivalents, accounts receivable from customers, due from HMOs, accounts payable, due to HMO and accrued expenses approximate fair value due to the short-term nature of these instruments.

NOTE 6 – DERIVATIVE AND HEDGING ACTIVITIES

Our objectives in using interest rate derivatives are to add stability to interest expense and to manage our exposure to interest rate movements. To accomplish these objectives, we use an interest rate cap as our interest rate risk management strategy. We entered into an interest rate cap agreement effective December 4, 2011, which provides interest rate protection in the event LIBOR exceeds 1.5%. This interest rate cap had a notional amount of $155.1 million at June 30, 2012, which notional amount will decrease to $134.1 million over the life of the agreement, and expires on September 30, 2014. Notwithstanding this interest rate cap, we are still subject to interest rate risk with respect to indebtedness above the notional amount of the interest rate cap and, unless we extend or replace the interest rate cap, with respect to any portion of the indebtedness outstanding after September 30, 2014.

The effective portion of changes in the fair value of derivatives designated and that qualify as cash flow hedges is recorded, net of the effect of income taxes, in accumulated other comprehensive loss and is subsequently reclassified into earnings in the period that the hedged forecasted transaction affects earnings. The ineffective portion of the change in fair value of the derivatives is recognized directly in earnings. Amounts reported in accumulated other comprehensive loss related to derivatives will be reclassified to interest expense as interest payments are made on our variable-rate debt.

The fair value of our derivative financial instruments at June 30, 2012 was $0.1 million and is classified as a noncurrent asset in the condensed consolidated balance sheets. The amount of loss recognized in other comprehensive income on the effective portion of the interest rate cap for the three and six months ended June 30, 2012 was $0.1 million and $0.2 million, net of tax benefit of $0.06 million and $0.2 million, respectively. The amount of loss reclassified from other comprehensive income into interest expense in the three and six month periods ended June 30, 2012 was not material.

NOTE 7 - REVENUE

Substantially all of our revenue is derived from risk agreements with HMOs pursuant to which the Contracting HMO pays us a monthly capitation fee for each Participating Customer. The amount of this fee varies depending on the demographics and health status of each Participating Customer. Under our risk agreements, we assume the economic risk of our Participating Customers' healthcare services and related administrative costs. Revenue is recognized in the period in which our Participating Customers are entitled to receive healthcare services. Because we have the obligation to fund medical expense, we recognize revenue and medical expense for these contracts in our financial statements. Revenue from Humana accounted for 82.9% and 99.4% of our total revenue in the second quarter of 2012 and 2011, respectively. Revenue from Humana accounted for 82.9% and 99.6% of our total revenue in the first six months of 2012 and 2011, respectively.

Periodically, we receive retroactive adjustments to the capitation fees paid to us based on the updated health status of our Medicare Advantage Participating 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 Participating 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, and either the collectability of the amount is reasonably assured or the likelihood of repayment is probable.

In July 2012, we were notified by the Contracting HMOs of the amount of the retroactive mid-year MRA revenue increase from the Centers for Medicare and Medicaid Services ("CMS") for the first six months of 2012. This increase is effective July 1 and is retroactively applied to all premiums paid in the first half of 2012. The retroactive mid-year adjustment totaled $11.4 million of which $6.0 million relates to capitation fees earned in the first quarter of 2012, with the balance relating to capitation fees earned in the second quarter of 2012. At March 31, 2012, we had recorded a receivable for the estimated retroactive revenue earned during the first quarter of 2012 of $4.4 million. As a result, our revenue for the second quarter of 2012 was increased by $1.6 million, the difference between the originally estimated $4.4 million of retroactive revenue adjustment recorded during the first quarter of 2012 and the $6.0 million of retroactive revenue received for that period.

In July 2011, we were notified by Humana of the amount of the retroactive mid-year MRA revenue increase from CMS for the first six months of 2011. This increase was effective July 1 and was retroactively applied to all premiums paid in the first half of 2011. The retroactive mid-year adjustment totaled $9.5 million of which $4.9 million related to capitation fees earned in the first quarter of 2011 with the balance relating to capitation fees earned in the second quarter of 2011. At March 31, 2011, we had recorded a receivable for the estimated retroactive revenue earned during the first quarter of 2011 of $2.9 million. As a result, our revenue for the second quarter of 2011 was increased by $2.0 million, the difference between the originally estimated $2.9 million of retroactive revenue adjustment recorded during the first quarter of 2011 and the $4.9 million of retroactive revenue received for that period.

The total retroactive MRA capitation fee receivable, including the mid-year retroactive adjustment, included in due from HMOs in the accompanying condensed consolidated balance sheets was $14.1 million at June 30, 2012 and $2.6 million at December 31, 2011. We expect to collect the retroactive 2012 mid-year MRA receivable of $11.4 million in August 2012 and the $2.7 million retroactive 2011 year-end receivable in September of 2012.

Our PSN's wholly-owned medical practices also provide medical care to non-Participating Customers on a fee-for-service basis. These services are typically billed to customers, Medicare, Medicaid, HMOs and insurance companies. Fee-for-service revenue, which is less than 0.5% of total revenue for the three and six months ended June 30, 2012 and 2011, is recorded at the net amount expected to be collected from the customer or from the responsible insurance company. Often this amount is less than the charge that is billed and such discounts reduce the revenue recorded.

NOTE 8 - MEDICAL EXPENSE AND MEDICAL CLAIMS PAYABLE

Total medical expense represents the estimated total cost of providing medical care and is comprised of two components, medical claims expense and medical practice 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 Participating Customers but for which we have neither received nor processed claims. 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. Medical practice costs represent the operating costs of the physician practices owned by the PSN.

We develop our estimated medical claims expense payable using an actuarial process that is consistently applied. The actuarial process develops a range of estimated medical claims expense payable and we record the amount in the range that is our best estimate of the ultimate liability. Each period, we re-examine previously recorded medical claims expense payable estimates based on actual claim submissions and other changes in facts and circumstances. As medical claims expense payable recorded in prior periods becomes more exact, we adjust the amount of the estimate and include the change in medical claims 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 claims expense payable estimates associated with previously reported periods. While we believe our estimated medical claims expense payable is adequate to cover future claim 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 claims expense payable is included in due from HMOs or due to HMO in the accompanying condensed consolidated balance sheets.

Total medical expense is as follows (in thousands):

	Three month period ended June 30,		Six month period ended June 30,	
	2012	2011	2012	2011
	(in thousands)			
Medical expense for the period, excluding prior period claims development	$ 162,085	$ 79,659	$ 324,770	$ 159,433
Unfavorable (Favorable) medical claims development based on actual claims submitted	2,933	1,070	(2,443)	(3,219)
Total medical expense for the period	$ 165,018	$ 80,729	$ 322,327	$ 156,214

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 in the reporting period. Unfavorable claims development is a result of actual medical claim cost for prior periods exceeding the original estimated cost which increases the total reported medical expense and the MER in the reporting period.

At June 30, 2012, we determined that the range for estimated medical claims payable was between $42.2 million and $47.1 million and we recorded a liability equal to the actuarial mid-point of the range of $44.5 million. 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.

Under our risk agreements, we are responsible for substantially all of the cost of all medical services provided to our Participating Customers. To the extent that Participating Customers require more frequent or expensive care than was anticipated, the capitation fee received may be insufficient to cover the costs of care provided. When it is probable that the expected future healthcare and maintenance costs will exceed the anticipated revenue under an agreement, we would recognize a premium deficiency liability in current operations. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as future operating losses under these contracts are charged to the liability previously established. There was no premium deficiency liability recorded at June 30, 2012 or December 31, 2011.

In the first half of 2012, we realized a pre-tax loss of $4.4 million on approximately 6,600 new Participating Customers added in 2012 under a risk agreement with a Contracting HMO other than Humana (the "Contracting HMO Agreement"). This includes a pre-tax loss in the second quarter of 2012 of $3.6 million that includes $1.6 of unfavorable claims development. The loss represents the excess of medical claims expense over revenue earned from the agreement and is the result of a number of factors including utilization that was higher than anticipated by both the Contracting HMO and us. Although we are entitled to terminate the Contracting HMO Agreement by giving the Contracting HMO 120 days' prior written notice, we are currently in discussions with the Contracting HMO to modify the contract terms to reduce the loss being incurred under this contract. While no amendment to this agreement is in place, the Contracting HMO has indicated a willingness to amend the agreement. Therefore, we anticipate that, in the last half of 2012, revenue will be sufficient to offset the projected medical costs under this contract during such period. If we are unable to amend the agreement on favorable terms or at all, the loss for the last half of 2012 is projected to be similar to the loss incurred in the first half of the year.

NOTE 9 – DUE FROM/TO HMOs

The due from HMOs account is used to record the net amount due to us as a result of activity between us and the Contracting HMOs. These transactions include, among other things, capitation fees due to us from the Contracting HMOs, retroactive capitation fee payments due to us from the Contracting HMOs, claim payments made by the Contracting HMOs on our behalf, and estimated medical claims expense payable.

Amounts due from HMOs, net consisted of the following (in thousands):

	June 30, 2012	December 31, 2011
Due from HMOs	$ 71,754	$ 80,324
Due to HMOs	(38,544)	(40,083)
Total due from HMOs	$ 33,210	$ 40,241

Under our agreements with the Contracting HMOs, we have the right to offset certain sums owed to us against certain sums we owe under the agreements and each Contracting HMO has a comparable right. In the event we owe funds after any such offset, we are required to pay the shortfall to the Contracting HMO upon notification of such deficit and the Contracting HMO may offset future payments to us under the applicable agreement by such deficit.

Although we are generally a creditor of the Contracting HMOs, as of June 30, 2012, we had a net debt owing to one Contracting HMO in the amount of $6.4 million.

NOTE 10 - INCOME TAXES

We applied an estimated effective income tax rate of 38.9% and 38.5% for the three months ended June 30, 2012 and 2011, respectively. We applied an estimated effective income tax rate of 38.7% and 38.5% for the six months ended June 30, 2012 and 2011, respectively.

We are subject to income taxes in the U.S. federal jurisdiction and the state of Florida. Tax regulations are subject to interpretation of the related tax laws and regulations and require significant judgment to apply. We have utilized all of our available net operating loss carry forwards, including net operating loss carry forwards related to years prior to 2006. These net operating losses are open for examination by the relevant taxing authorities. The statute of limitations for the federal and state 2008 tax years will expire in the next twelve months.

NOTE 11 - STOCKHOLDERS' EQUITY

During the six months ended June 30, 2012 and 2011, our Board of Directors approved the issuance to employees of 234,000 and 248,000 restricted shares of common stock and options to purchase 1.4 million and 815,000 shares of common stock, respectively. Of this amount, options to purchase 57,500 and 15,000 shares of common stock were issued to employees during the second quarter of 2012 and 2011, respectively. No restricted shares of common stock were issued to employees in the second quarter of 2012 and 8,000 restricted shares of common stock were issued to employees in the second quarter of 2011. The restricted shares and stock options vest in equal annual installments over a four year period from the date of grant. The stock options have an exercise price equal to the closing price of our common stock on the grant date. Compensation expense related to the restricted stock and options will be recognized ratably over the vesting period.

During the three and six month periods ended June 30, 2012, we issued a total of 54,000 restricted shares of common stock to the non-management members of our Board of Directors. During the three and six month periods ended June 30, 2011, we issued a total of 67,000 restricted shares of common stock to the non-management members of our Board of Directors. The restricted shares vest twelve months from the date of grant. Compensation expense related to the restricted stock will be recognized ratably over the vesting period.

We have a stock repurchase plan pursuant to which our Board of Directors authorized us to repurchase up to 25 million shares of our common stock. We did not repurchase any shares of common stock during the three and six

month periods ended June 30, 2012. During the three and six month periods ended June 30, 2011, we repurchased 71,000 shares of outstanding common stock for an aggregate purchase price of $0.3 million. From October 6, 2008 (the date of our first repurchases under the plan) through June 30, 2012, we repurchased 14.0 million shares and options to purchase 684,200 shares of our common stock for $28.3 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. The total shares that may yet be repurchased under the plan at July 31, 2012 is 10.3 million. We have the right to repurchase $15.0 million of stock during the term of the Credit Facilities generally not to exceed $5.0 million per year.

NOTE 12 - EARNINGS PER SHARE

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

Earnings per share, basic and diluted are calculated as follows (in thousands, except per share data):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
Income from continuing operations	$2,597	$5,926	$10,595	$13,892
Less: Preferred stock dividend	(13)	(13)	(25)	(25)
Income attributable to common stockholders	$2,584	$5,913	$10,570	$13,867
Income from discontinued operations	$332	$-	$246	$-
Denominator:				
Weighted average common shares outstanding	43,156	39,937	43,039	39,854
Basic earnings per share from continuing operations	$0.06	$0.15	$0.25	$0.35
Basic income per share from discontinued operations	$0.01	$-	$0.01	$-
Income attributable to common stockholders	$2,584	$5,913	$10,570	$13,867
Add: Preferred stock dividend	13	13	25	25
Income attributable to common stockholders, diluted	$2,597	$5,926	$10,595	$13,892
Denominator:				
Weighted average common shares outstanding	43,156	39,937	43,039	39,854
Common share equivalents of outstanding stock:				
Convertible preferred stock	205	306	203	301
Unvested restricted stock	480	535	507	556
Options	1,721	1,239	1,755	1,276
Weighted average common shares outstanding	45,562	42,017	45,504	41,987
Diluted earnings per share from continuing operations	$0.06	$0.14	$0.23	$0.33
Diluted income per share from discontinued operations	$0.01	$-	$0.01	$-

The following securities were not included in the computation of diluted earnings per share at June 30, 2012 and 2011 as their effect would be anti-dilutive (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
Security Excluded From Computation	2012	2011	2012	2011
Stock Options	1,309	808	855	587
Unvested restricted stock	11	138	41	111

NOTE 13 - COMMITMENTS AND CONTINGENCIES

We are party to various legal proceedings which are ordinary and routine litigation incidental to our business. We do not view any of these ordinary and routine legal proceedings as material.

We maintain professional liability policies with a captive insurance company of which we are a member, and with commercial insurance companies. At June 30, 2012, we were not aware of any claims that will exceed our coverage.

The Centers for Medicare and Medicaid Services (“CMS”) has been auditing Medicare Advantage plans for compliance by the plans and their providers with proper coding practices. The Medicare Advantage plans audited include both plans selected at random, as well as plans targeted for review based on a studied analysis of plans that have experienced significant increases in risk scores. CMS's targeted medical reviews can result in payment adjustments and in February 2012, CMS indicated that, starting with payment year 2011, 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 Medicare Advantage plan subject to a particular CMS contract. Although CMS has described its audit process as plan year specific, CMS has not specifically stated that payment adjustments as a result of one plan year's audit will not be extrapolated to prior plan years. There can be no assurance that a Contracting HMO will not be randomly selected or targeted for review by CMS. In the event that a Medicare Advantage plan of a Contracting HMO is selected for a review, there can be no assurance that the outcome of such a review will not result in a material adjustment in our revenue and profitability, even if the information we submitted to the plan is accurate and supportable. Since the CMS rules, regulations and statements regarding this audit program are still not well defined in some respects, there is also a risk that CMS may adopt new rules and regulations that are inconsistent with their existing rules, regulations and statements.

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

THE FOLLOWING DISCUSSION SHOULD BE READ IN CONJUNCTION WITH OUR ANNUAL REPORT ON FORM 10-K FOR THE YEAR ENDED DECEMBER 31, 2011, INCLUDING THE FINANCIAL STATEMENTS AND NOTES THERETO, AS WELL AS THE FINANCIAL STATEMENTS AND NOTES THAT APPEAR ELSEWHERE IN THIS REPORT.

GENERAL

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

CAUTIONARY NOTE REGARDING FORWARD LOOKING STATEMENTS

Sections of this Quarterly Report contain statements that are "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended, 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 our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by the forward-looking statements. In some cases, you can identify forward-looking statements by statements that include the words "estimate," "project," "anticipate," "expect," "intend," "n "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 ("PSN"), acting through our contracting subsidiaries, to renew its agreements with the health plans operated by Humana, Inc. and its subsidiaries ("Humana"), United Healthcare of Florida, Inc. ("United"), Vista Healthplan of South Florida, Inc. and its affiliated companies, a subsidiary of Coventry Health Care, Inc. ("Coventry"), and Wellcare Health Plans, Inc. and its affiliated companies ("Wellcare," and, together with Humana, United and Coventry, the "Contracting HMOs") that have renewable one-year terms, and to maintain all of its agreements with Contracting HMOs on favorable terms;

- our ability to increase the number of customers assigned to us by the Contracting HMOs ("Participating Customers") using our PSN, either within our current geographic markets or in additional markets, and our ability to realize the benefits of any such increases, including the anticipated benefits of economies of scale;

- our ability to amend one of our existing agreements with a Contracting HMO in order to reduce the likelihood that we will incur additional losses under such agreement in the future;

- the anticipated benefits of our acquisition of Continucare Corporation ("Continucare");

- our intention to sell the sleep diagnostic business that we acquired in the Continucare acquisition, and the expected timing and proceeds of such sale;

the factors that we believe may mitigate the impact of anticipated premium reductions;

our ability to make, and the expected timing of, payments on our senior secured first lien credit agreement (the "First Lien Credit Agreement") and our senior secured second lien credit agreement (the "Second Lien Credit Agreement" and, together with the First Lien Credit Agreement, the "Credit Facilities");

our ability to adequately predict and control medical expense and to make reasonable estimates and maintain adequate accruals for estimated medical claims expense payable; and

our ability to make reasonable estimates of Medicare retroactive capitation fee adjustments.

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:

our ability to integrate the operations of Continucare or other entities, if any, that we may acquire in the future, and to realize any anticipated revenues, economies of scale, cost synergies or productivity gains in connection with our acquisition of Continucare and any other entity, if any, that we may acquire in the future, including the potential for unanticipated issues, expenses and liabilities associated with those acquisitions and the risk that Continucare or such other acquired entity, if any, fails to meet its expected financial and operating targets;

the potential for diversion of management time and resources in seeking to integrate Continucare's operations;

our potential failure to retain key employees of Continucare;

the impact of our significantly increased levels of indebtedness entered into in connection with the acquisition of Continucare on our funding costs, operating flexibility and ability to fund ongoing operations with additional borrowings, particularly in light of ongoing volatility in the credit and capital markets;

the potential for dilution to our shareholders as a result of our acquisition of Continucare;

our ability to operate pursuant to the terms of our Credit Facilities and to meet all financial covenants;

reductions in premium payments to Medicare Advantage plans;

the loss of, or a material negative amendment, to any of our significant contracts;

disruptions in the PSN's or any Contracting HMO's healthcare provider network;

failure to receive accurate and timely revenue, claim, membership and other information from the Contracting HMOs;

our ability to sell the sleep diagnostic business;

future legislation and changes in governmental regulations;

increased operating costs;

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 impact of Medicare Risk Adjustments on payments we receive from Contracting HMOs;

the impact of the Medicare prescription drug plan on our operations;

general economic and business conditions;

increased competition;

the relative health of our Participating 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.

Additional information concerning these and other risks and uncertainties is contained in our filings with the United States Securities and Exchange Commission (the "Commission"), including the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2011 and in our Quarterly Report on Form 10-Q for the quarter ended March 31, 2012.

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

We undertake no obligation to publicly update or revise any forward-looking statements to reflect events or circumstances that may arise after the date of this report unless otherwise required by law.

BACKGROUND

Our primary business is the operation of a PSN through our wholly owned subsidiaries, Metcare of Florida, Inc. and Continucare, the latter of which we acquired on October 4, 2011. The PSN provides and arranges for the provision of healthcare services to Medicare Advantage, Medicaid and commercially insured customers in the State of Florida. At June 30, 2012, we operated the PSN through our 33 wholly-owned primary care practices, a wholly-owned oncology practice, and contracts with independent physician affiliates (each an "IPA"). As of June 30, 2012, the PSN operated in 20 Florida counties, including the counties in which the cities of Miami, Ft. Lauderdale, West Palm Beach, Tampa, Daytona and Pensacola are located.

Humana Agreements

Pursuant to our agreements with Humana (the "Humana Agreements"), at June 30, 2012, the PSN provided or arranged for the provision of healthcare services to Medicare Advantage, Medicaid and commercial customers in 20 Florida counties and has contract rights to expand its service offerings to an additional 12 Florida counties. Our PSN assumes full financial responsibility for the provision or management of all necessary medical care for each Participating Customer covered by the Humana Agreements (each a "Humana Participating Customer"), even for services we do not provide directly. For approximately 25,000 Humana Participating Customers, 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 Humana Participating Customers, our PSN is responsible for the cost of all medical care provided, including the cost of inpatient hospital services. In return for the provision of these medical services, our PSN receives from Humana a capitation 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 the Centers for Medicare and Medicaid Services ("CMS") or the State of Florida with respect to Humana Participating Customers.

The Humana Agreements covering a majority of the Humana Participating Customers have one-year terms, subject to automatic renewal unless either party provides the other party notice of non-renewal 90, 120 or 180 days prior to the end of the subject agreement's term (as applicable). The remaining Humana Agreements have terms that extend to between August 31, 2013 and July 31, 2014, subject to automatic renewal for additional terms of one to three years, unless either party provides the other party notice of non-renewal 90 or 120 days prior to the end of the subject agreement's term (as applicable).

Under several of our PSN's Humana Agreements, Humana may amend the benefit and risk obligations and compensation rights from time to time by providing the PSN 30 days' prior written notice of the proposed amendment. Thereafter, the PSN will generally have 30 days to object to or be deemed to have accepted the proposed amendment. Upon receipt of such an objection, Humana may terminate the subject agreement upon 90 days' notice. In the 13 years that we have been working with Humana, after Humana and we have agreed upon the terms pursuant to which we will provide services for an upcoming year, Humana has only occasionally requested contract amendments and has never requested a contract amendment that has materially, negatively impacted our benefit obligations, risk obligations or compensation rights.

Humana may immediately terminate a Humana Agreement and/or the services of any individual physician in our primary care physician network if: (i) the PSN's or such physician's continued participation may adversely affect the health, safety or welfare of any Humana customer or bring Humana into disrepute; (ii) Humana loses its authority to do business in total or as to any limited segment or business provided that, in the event of a loss of authority with respect to a limited segment, Humana may only terminate a Humana Agreement as to that segment; (iii) the PSN or such physician violates certain provisions of Humana's policies and procedures manual; and (iv) under certain of the Humana Agreements, the PSN or any of its physicians fails to meet Humana's credentialing or re-credentialing criteria or is excluded from participation in any federal healthcare program.

In addition to the foregoing termination provisions, each of the Humana Agreements permits the PSN or Humana to terminate any such agreement upon 60 to 90 days prior written notice (subject to certain cure periods) in the event the other party breaches other provisions of the agreement.

Under most of the Humana Agreements, our subsidiary that is party to such agreement and its affiliated providers are generally prohibited, during the term of the applicable agreement plus one year, from: (i) engaging in any activities that are in competition with Humana's health insurance, HMO or benefit plans business; (ii) having a direct or indirect interest in any provider sponsored organization or network that administers, develops, implements or sells government sponsored health insurance or benefit plans; (iii) contracting or affiliating with another licensed managed care organization for the purpose of offering and sponsoring HMO, preferred provider organization ("PPO") or point of service ("POS") products where such subsidiary and/or its affiliated providers obtain an ownership interest in the HMO, PPO or POS products to be marketed; and (iv) under certain provisions of the Humana Agreements, entering into agreements with managed care entities, insurance companies, or provider sponsored networks for the provision of healthcare services to Medicare HMO, POS and/or replacement Participating Customers at the same office sites or within five miles of the office sites where services are provided to the Humana Plan Customers.

In addition, under the Humana Agreements covering a majority of the areas we serve, or are eligible to serve, our subsidiary that is party to any such agreement and/or its participating physicians and affiliated entities (including us) are prohibited from entering into a risk contract with any non-Humana Medicare Advantage HMO or provider sponsored organization in the counties subject to the agreement. These restrictions lapse between January 1, 2013 and January 1, 2015, as applicable, and are not applicable to certain previously established contracts our subsidiaries have with non-Humana HMOs with respect to a number of designated counties.

In addition, under each of our Humana Agreements, our subsidiary that is party to any such agreement and/or its participating physicians and affiliated entities (including us) are prohibited from causing groups of Medicare Participating Customers assigned to an individual physician to disenroll from a Humana plan and to enroll in a competing HMO plan.

Agreements With Other HMOs

As of June 30, 2012, the PSN also had agreements to provide or arrange for the provision of medical services to Participating Customers of other Medicare Advantage plans including those offered by United, Coventry and Wellcare. The majority of such services are provided on a risk basis pursuant to which our PSN receives a capitated fee with respect to each of these Participating Customers.

Our agreements with United, Coventry and Wellcare have one-year terms expiring between December 31, 2012 and June 30, 2013, subject to automatic renewal for an additional one-year term each unless either party provides the other with 60, 90 or 120 days' notice of its intent to terminate such agreement, as applicable. These agreements are generally subject to the same type of amendment, termination, non-solicitation and/or non-competition provisions as those included in the Humana Agreements.

Our Physician Network

At June 30, 2012, the 33 primary care practices owned and operated by the PSN were responsible for providing and arranging for medical care to 51.8% of the PSN's Participating Customers under risk agreements.

The PSN contracts with IPAs to provide and manage care for our remaining Participating Customers. Some of these contracts provide for payment to the provider of a fixed per customer per month ("PCPM") amount and require the provider to provide all the necessary primary care medical services to Participating Customers. The monthly amount is negotiated and is subject to change based on certain quality of service metrics. Other contracts provide for payments on a fee-for-service basis, pursuant to which the provider is paid only for the services provided.

Appropriate Risk Coding

We strive to ensure that our Participating Customers are assigned the proper risk scores. Our processes include ongoing training of medical staff responsible for coding and routine auditing of Participating Customers' charts to assure risk-coding compliance. Participating Customers with higher risk codes generally require more healthcare resources than those with lower risk codes. Proper coding helps to ensure that we receive capitation fees consistent with the cost of treating these Participating Customers. Our efforts related to coding compliance are ongoing and we continue to dedicate considerable resources to this important discipline.

Insurance Arrangements

To mitigate our exposure to high cost medical claims under our risk agreements, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. At June 30, 2012, for 58.2% of our Participating Customers under risk agreements, we purchase reinsurance through the HMOs with which we contract. The HMOs charge us a per customer per month fee that limits our healthcare costs for any individual Participating Customer. Healthcare costs in excess of an annual deductible, which generally ranges from $30,000 to $40,000 per Participating Customer, are paid directly by the HMOs and we are not entitled to and do not receive any related insurance recoveries.

The remaining Participating Customers are covered under one policy with an annual per customer deductible of $250,000 in 2012 and $225,000 in 2011. Reinsurance recoveries under these policies are remitted to us and are recorded as a reduction to medical claims expense.

All policies have 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.

Healthcare Reform Legislation

The healthcare reform legislation described below is not directly applicable to us since we are not a Medicare Advantage plan. However, this legislation will directly impact Medicare Advantage plans such as those offered by the Contacting HMOs, and, therefore, are expected to indirectly affect PSNs such as ours.

The United States' healthcare system, including the Medicare Advantage program, is subject to a broad array of laws and regulations as a result of the Patient Protection and Affordable Care Act, which became law on March 23, 2010 as amended by the Health Care and Education Reconciliation Act of 2010, which became law on March 30, 2010 (collectively, the "Reform Acts"). The Reform Acts are considered by some to be the most dramatic change to the country's healthcare system in decades. This legislation made significant changes to the Medicare program and to the health insurance market overall. Among other things, the Reform Acts limit Medicare Advantage payment rates, stipulate a prescribed minimum ratio for the amount of premium revenues to be expended on medical costs, give the Secretary of Health and Human Services the ability to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits, and make certain changes to Medicare Part D. Because substantially all of our revenue is directly or indirectly derived from reimbursements generated by Medicare Advantage health plans, any changes that limit or reduce Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business.

There are numerous steps required to implement the Reform Acts, and Congress may seek to alter or eliminate some of their provisions. In June 2012, the United States Supreme Court upheld most of the provisions of the Affordable Care Act, including the health insurance mandate. While Federal regulatory agencies are moving forward with implementation of the provisions of the Reform Act, Congress is attempting to pass legislation which would reverse the Reform Acts. Furthermore, various health insurance reform proposals are also emerging at the state level. Due to the unsettled nature of these reforms and the numerous steps required to implement them, we cannot predict to what extent (if at all) Congress will succeed in limiting or reversing the Reform Acts, whether (and if so, what) additional health insurance reforms will be implemented at the Federal or state level and/or the effect that any future legislation or regulation will have on our business.

For additional information on the Reform Acts see "Business - Healthcare Reform Legislation in 2011 and 2010" included in our Annual Report on Form 10-K for the fiscal year ended December 31, 2011 and the Risk Factor captioned "Risk Factors - Reductions in Funding for Medicare Programs and Other Provisions Under the Recent Healthcare Reform Legislation…" included in Part II, Item 1A of this Quarterly Report on Form 10-Q.

CRITICAL ACCOUNTING POLICIES

A description of our critical accounting policies is contained in our Annual Report on Form 10-K for the year ended December 31, 2011. Included within these policies are certain policies that contain critical accounting estimates and, therefore, have been deemed to be "critical accounting policies." Critical accounting estimates are those which require management to make assumptions about matters that were uncertain at the time the estimate was made and for which the use of different estimates, which reasonably could have been used, or changes in the accounting estimates that are reasonably likely to occur from period to period, could have a material impact on the presentation of our financial condition, changes in financial condition or results of operations.

COMPARISON OF RESULTS OF OPERATIONS FOR THE THREE MONTHS ENDED JUNE 30, 2012 AND JUNE 30, 2011

Summary

Net income for the second quarter of 2012 was $2.9 million compared to $5.9 million in the second quarter of 2011. Although we experienced significant growth in both revenue and gross profitability, our quarterly net income declined primarily due to the $3.6 million pre-tax loss in the second quarter of 2012 under an agreement with a Contracting HMO other than Humana (the "Contracting HMO Agreement") and an increase in professional fees of $0.9 million in the second quarter of 2012 compared to the second quarter of 2011.

In the second quarter of 2012, we realized a pre-tax loss of $3.6 million on approximately 6,600 new Participating Customers added in 2012 under the Contracting HMO Agreement. The second quarter loss for this agreement includes unfavorable claims development from the first quarter of 2012 of $1.6 million. The loss represents the excess of medical costs over revenue earned from the agreement and is the result of a number of factors including utilization that was higher than anticipated by both the Contracting HMO and us. We are currently in discussions with the Contracting HMO to modify the contract terms to reduce the loss being incurred under this agreement. While no amendment to this agreement is in place, the Contracting HMO has indicated a willingness to amend the agreement. Therefore, we anticipate that the revenue we realize under this agreement in the second half of 2012 will be sufficient to offset the projected medical costs under this agreement during the same period. If we are unable to amend the agreement, we anticipate that our losses under this agreement incurred in the second half of 2012 would be similar to or greater than the pre-tax loss of $4.4 million under this agreement in the first half of 2012. The contract can be terminated with 120 days' notice.

Basic and diluted earnings per share were $0.07 for the second quarter of 2012 as compared to $0.15, basic, and $0.14, diluted, for the same period in 2011. The after tax loss on the Contracting HMO Agreement reduced both basic and diluted earnings per share by $0.05. Basic and diluted earnings per share from income from continuing operations was $0.06 for the second quarter of 2012 as compared to $0.15, basic, and $0.14, diluted, for the same period in 2011. Basic and diluted earnings from discontinued operations for the second quarter of 2012 were $0.01 per share.

Revenue for the second quarter of 2012 was $193.4 million compared to $97.3 million for the second quarter of 2011, an increase of $96.1 million or 98.8%. The increase in revenue was primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements since December 31, 2011 and increased risk scores for our Participating Customers. Revenue for the second quarter of 2012 included $1.6 million from the mid-year retroactive adjustment that was earned in the first quarter of 2012. Revenue for the second quarter of 2011 included $2.0 million from the mid-year retroactive adjustment that was earned in the first quarter of 2011.

Total medical expense for the second quarter of 2012 was $165.0 million compared to $80.7 million for the second quarter of 2011, an increase of $84.3 million or 104.5%. This increase is primarily attributable to the additional medical claims expense associated with the Contracting HMO Agreement, the addition of the Continucare Participating Customers, the medical costs associated with the net addition of new Participating Customers under risk arrangements in 2012, the addition of the 19 Continucare medical practices, the addition of three practices we purchased in the first half of 2011, and an increase in benefits, utilization and medical cost inflation.

Gross profit was $28.4 million for the second quarter of 2012 as compared to $16.6 million for the same quarter in 2011, an increase of $11.8 million or 71.1%.

The medical expense ratio ("MER"), which is computed by dividing total medical expense by revenue, represents a statistic used to measure gross profit. In the second quarter of 2012 our MER was 85.3%, compared to 83.0% for the second quarter of 2011. The increase in MER is primarily attributable to the higher than expected medical claims expense incurred under the Contracting HMO Agreement. Excluding the revenue and medical costs associated with the Contracting HMO Agreement, our MER for the second quarter would have been 82.1%.

Operating expenses increased to $16.0 million for the second quarter of 2012 as compared to $6.2 million for the same period in 2011, an increase of $9.8 million or 158.1%. The increase in operating expenses is primarily due to the additional expenses of Continucare and an increase in amortization expense of $3.1 million, related to the amortizable intangible assets recorded in the Continucare acquisition.

Other expense increased by $7.4 million due primarily to an increase in interest expense of $8.1 million for the second quarter of 2012 related to the debt used to finance the Continucare acquisition.

Income before income taxes from continuing operations for the second quarter of 2012 was $4.2 million as compared to income before income taxes for the second quarter of 2011 of $9.6 million. The primary reasons for the decrease were the $3.6 million operating loss associated with the Contracting HMO Agreement and an increase in professional fees of $0.9 million in the second quarter of 2012 compared to the second quarter of 2011.

Income from discontinued operations for the second quarter of 2012 was $0.3 million. This amount represents the income realized by the sleep diagnostic business, net of income tax expense.

Customer Information

The table set forth below provides (i) the total number of customers to whom we were providing healthcare services as of June 30, 2012 and 2011 and (ii) the aggregate customer months for the second quarter of both 2012 and 2011. Customer months are the aggregate number of months of healthcare services we have provided to customers during a period of time.

	Participating Customers at June 30,		Participating Customer Months In The Quarter Ended June 30,		Percentage Increase In Participating Customer Months	
	2012	2011	2012	2011		
Risk arrangements	69,400	34,000	208,700	102,200	104.2	%
Non-risk arrangements	8,200	-	25,200	-	N/A	
	77,600	34,000	233,900	102,200	128.9	%

The following table sets forth the number of Participating Customers by program at June 30, 2012 and June 30, 2011:

	Participating Customers June 30,		Percentage Increase In Participating Customers	
	2012	2011		
Medicare Advantage	61,400	34,000	80.6	%
Medicaid	12,800	-	N/A	
Commercial	3,400	-	N/A	
	77,600	34,000	128.2	%

The increase in total customer months under risk arrangements for the second quarter of 2012 as compared to the same period in 2011 is primarily a result of the Participating Customers added with the Continucare acquisition and the net addition of new Participating Customers under risk arrangements in 2012. Changes in our customer base are also a result of new enrollments and/or transfers from other physician's practices and individuals aging into Medicare and becoming a Participating Customer, reduced by disenrollments, deaths, Participating Customers moving from the covered areas, Participating Customers transferring to another physician practice or Participating Customers making other insurance selections.

The increase in customer months under non-risk arrangements is a result of the Continucare acquisition.

Revenue

The most significant component of our revenue is generated from Medicare Advantage risk arrangements with the Contracting HMOs. Risk revenue increased by $87.4 million, or 90.4%, during the second quarter of 2012 as compared to the same period in 2011. The increase in revenue is primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and increased risk scores for our Participating Customers.

Our PCPM Medicare risk revenue increased by $60 for the second quarter of 2012 compared to the same period in 2011. The increase in our PCPM revenue was primarily generated by the acquisition of Continucare, which realizes higher rates in Miami-Dade County than we realize in our other service areas, and increases in our capitation payments as a result of changes in the Medicare risk adjustment scores of our Participating Customers.

In July 2012, we were notified by the Contracting HMOs of the amount of the retroactive mid-year MRA revenue increase from CMS for the first six months of 2012. This increase is effective July 1 and is retroactively applied to all premiums paid in the first half of 2012. The retroactive mid-year adjustment totaled $11.4 million of which $6.0 million relates to capitation fees earned in the first quarter of 2012 with the balance relating to capitation fees earned in the second quarter of 2012. At March 31, 2012, we had recorded a receivable for the estimated retroactive revenue earned during the first quarter of 2012 of $4.4 million. As a result, our revenue for the second quarter of 2012 was increased by $1.6 million, the difference between the originally estimated $4.4 million of retroactive revenue adjustment recorded during the first quarter of 2012 and the $6.0 million of retroactive revenue received for that period.

In July 2011, we were notified by Humana of the amount of the retroactive mid-year MRA revenue increase from CMS for the first six months of 2011. This increase is effective July 1 and was retroactively applied to all premiums paid in the first half of 2011. The retroactive mid-year adjustment totaled $9.5 million of which $4.9 million relates to capitation fees earned in the first quarter of 2011 with the balance relating to capitation fees earned in the second quarter of 2011. At March 31, 2011, we had recorded a receivable for the estimated retroactive revenue earned during the first quarter of 2011 of $2.9 million. As a result, our revenue for the second quarter of 2011 was increased by $2.0 million, the difference between the originally estimated $2.9 million of retroactive revenue adjustment recorded during the first quarter of 2011 and the $4.9 million of retroactive revenue received for that period.

Fee-for-service revenue represents amounts earned from medical services provided to non-Participating Customers in our owned medical practices. Fee-for-service revenue represents less than 0.5% of our total revenue for the three months ended June 30, 2012 and June 30, 2011.

Total Medical Expense

Total medical expense represents the estimated total cost of providing medical care and is comprised of two components, medical claims expense and medical practice 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 Participating Customers but for which we have neither received nor processed claims. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by providers other than the IPAs and physician practices owned by the PSN (collectively “Non-Affiliated Providers”). Medical practice costs represent the operating costs of the physician practices owned by the PSN.

We develop our estimated medical expense payable using an actuarial process that is consistently applied. The actuarial process develops a range of estimated medical claims expense payable and we record the amount in the range that is our best estimate of the ultimate liability. Each period, we re-examine previously recorded medical claims

expense payable estimates based on actual claim submissions and other changes in facts and circumstances. As medical claims expense payable recorded in prior periods becomes more exact, we adjust the amount of the estimate and include the change in medical claims 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 claims expense payable estimates associated with previously reported periods. While we believe our estimated medical claims expense 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.

Total medical expense and the MER are as follows (in thousands):

	Three Months Ended March 31,	
	2012	2011
Estimated medical expense for the period, excluding prior period claims development	$ 162,085	$ 79,659
(Favorable) unfavorable prior period medical claims development in current period based on actual claims submitted	2,933	1,070
Total medical expense for period	$ 165,018	$ 80,729
Medical Expense Ratio for period	85.3 %	83.0 %

Unfavorable claims development is a result of actual medical claim cost for prior periods exceeding the original estimated cost which increases the total reported medical expense and the MER in the reporting period.

The reported MER is impacted by both revenue and expense. Periodically we receive retroactive adjustments of the capitation fees paid to us. Retroactive adjustments of prior periods' capitation fees that are recorded in the current period impact the MER of that period. If the retroactive adjustment increases 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 retroactive MRA capitation fee adjustments and settlement of Part D program capitation fees. Actual medical claims expense usually develops differently than originally estimated.

Because the risk agreements provide that the PSN is financially responsible for all medical services provided to the Participating Customers, medical claims expense includes the cost of medical services provided to Participating Customers by providers other than the physician practices owned by the PSN.

Total medical expense for the second quarter of 2012 increased by $84.3 million, or 104.4%, to $165.0 million from $80.7 million for the second quarter of 2011. Medical claims expense, which is the largest component of medical services expense, increased by $74.6 million, or 98.0%, to $150.7 million for the second quarter of 2012 from $76.1 million for the same period in 2011, primarily due to the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and higher than expected medical claims expense under the Contracting HMO Agreement.

Our PCPM Medicare risk expense increased by $45 for the second quarter of 2012 compared to the same period in 2011. The increase in our PCPM expense was primarily generated by the acquisition of Continucare. The counties in which Continucare operates, particularly Miami-Dade County, have higher costs than those in most of the counties in which we had operated. The increase was also a result of the higher than average medical claims expense associated with the Contracting HMO Agreement.

The MER for the second quarter of 2012 was 85.3%, compared to 83.0% for the second quarter of 2011. The increase in MER is primarily attributable to the higher than expected medical claims expense incurred under the Contracting HMO Agreement. Excluding the revenue and medical costs associated with the Contracting HMO Agreement our MER in the second quarter of 2012 would have been 82.1%. As discussed above, we are currently seeking to negotiate an amendment to the Contracting HMO Agreement.

Medical practice costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services and the costs associated with the operations of our wholly-owned medical

practices. Medical practice costs increased by $9.7 million, or 210.9%, to $14.3 million for the second quarter of 2012 from $4.6 million for the second quarter of 2011. The increase in medical practice costs was primarily a result of our acquisition of Continucare, with its 19 wholly-owned centers, and the three medical practices we purchased in the first half of 2011.

At June 30, 2012, we determined that the range for estimated medical claims payable was between $42.2 million and $47.1 million and we recorded a liability of $44.5 million. 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.

Operating Expenses

The following table provides information regarding the various items which comprise operating expenses (dollar amounts in thousands).

	Three Months Ended June 30,					
	2012		2011		Increase	% Change
Payroll, payroll taxes and benefits	$7,871		$3,858		$4,013	104.0 %
Percentage of total revenue	4.1	%	4.0	%		
General and administrative	4,731		2,201		2,530	114.9 %
Percentage of total revenue	2.4	%	2.3	%		
Marketing and advertising	222		52		170	326.9 %
Percentage of total revenue	0.1	%	0.1	%		
Amortization of intangible assets	3,187		100		3,087	3087.0 %
Percentage of total revenue	1.6	%	0.1	%		
Total operating expenses	$16,011		$6,211		$9,800	157.8 %

Payroll, Payroll Taxes and Benefits

Payroll, payroll taxes and benefits include salary and related costs associated with our corporate level executives, administrative, transportation and call center personnel. The increase in 2012 is primarily a result of the inclusion of Continucare's executive, administrative, transportation and call center payroll, payroll taxes and benefits of $3.3 million. We also realized an increase in stock-based compensation of $0.5 million for the second quarter of 2012 compared to the same period in 2011 primarily due to the addition of certain Continucare employees to the plan.

General and Administrative

This increase in general and administrative expenses for the second quarter of 2012 is primarily a result of the inclusion of $1.6 million of Continucare's general and administrative costs. Legal and accounting fees increased by $0.9 million for the second period of 2012 compared to the second quarter of 2011 primarily as a result of the preparation and filing of a "shelf" registration statement and related materials and non-recurring projects.

Marketing and Advertising

Marketing and advertising costs increased for the second quarter of 2012 compared to the second quarter of 2011 due primarily to the inclusion of Continucare's marketing and advertising costs.

Amortization of Intangibles

The increase in amortization is a result of the intangible assets acquired in connection with the acquisition of Continucare.

Other Expense

We recognized other expense of $8.1 million for the second quarter of 2012 compared to other expense of $0.7 million for the same period in 2011. For the second quarter of 2012, we incurred $8.1 million of interest expense related to the debt incurred in connection with the Continucare acquisition. For the second quarter of 2011, we recorded transaction costs associated with the Continucare transaction of $1.0 million.

Income taxes

Our estimated effective income tax rate was 38.9% and 38.5% for the second quarter of 2012 and 2011, respectively.

COMPARISON OF RESULTS OF OPERATIONS FOR THE SIX MONTHS ENDED JUNE 30, 2012 AND JUNE 30, 2011

Summary

Net income for the first six months of 2012 was $10.8 million compared to $13.9 million for the first six months of 2011. Although we experienced significant growth in both revenue and gross profitability, net income for the first six months of 2012 declined primarily due to the $4.4 million pre-tax loss from the Contracting HMO Agreement for the six months ended June 30, 2012, the $0.8 million decrease in the favorable claims variance in the first six months of 2012 compared to 2011, and an increase in professional fees of $1.4 million in the first six months of 2012 compared to the same period in 2011.

Basic and diluted earnings per share were $0.26 and $0.24, respectively, for the first six months of 2012 as compared to $0.35 and $0.33, respectively, for the same period in 2011. The after tax loss on the Contracting HMO Agreement reduced both basic and diluted earnings per share by $0.06. Basic and diluted earnings from continuing operations for the first six months of 2012 were $0.25 and $0.23 a share, respectively. Basic and diluted earnings from discontinued operations for the first six months of 2012 were $0.01 per share.

Revenue for the first six months of 2012 was $388.7 million compared to $192.0 million for the first six months of 2011, an increase of $196.7 million or 102.4%. The increase in revenue was primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and increased risk scores for our Participating Customers.

Total medical expense for the first six months of 2012 was $322.3 million compared to $156.2 million for the first six months of 2011, an increase of $166.1 million or 106.3%. This increase is primarily attributable to the additional medical claims expense associated with the Contracting HMO Agreement, the addition of the Continucare Participating Customers, the medical costs associated with the net addition of new Participating Customers under risk arrangements in 2012, the addition of the 19 Continucare medical practices, the addition of three medical practices we purchased in the first half of 2011, and an increase in benefits, utilization and medical cost inflation.

Gross profit was $66.3 million for the first six months of 2012 as compared to $35.8 million for the same period in 2011, an increase of $30.5 million or 85.2%.

Our MER was 82.9% for the first six months of 2012, as compared to MER of 81.4% for the first six months of 2011. The increase in MER is primarily attributable to the higher than expected expenses incurred under the Contracting HMO Agreement during the first six months of 2012. Excluding the revenue and medical costs associated with the Contracting HMO Agreement, our MER for the first six months of 2012 would have been 80.3%. As discussed above, we are currently seeking to negotiate an amendment to the Contracting HMO Agreement.

Operating expenses increased to $32.7 million for the first six months of 2012 as compared to $12.6 million for the same period in 2011, an increase of $20.1 million or 159.5%. The increase in operating expenses is primarily due to the additional expenses of Continucare and an increase in amortization expense of $6.2 million, related to the amortizable intangible assets recorded in the Continucare acquisition.

Other expense increased by $15.8 million due primarily to an increase in interest expense of $16.4 million for the first six months of 2012 related to the debt used to finance the Continucare acquisition.

Income before income taxes from continuing operations for the first six months of 2012 and 2011 was $17.3 million and $22.6 million, respectively. The primary reasons for the decrease were the $4.4 million operating loss associated with the Contracting HMO Agreement, the $0.8 million decrease in the favorable claims variance in the first six months of 2012 compared to 2011, and an increase in professional fees of $1.4 million in the first six months of 2012 compared to the same period in 2011.

Income from discontinued operations was $0.2 million for the first six months of 2012. This amount represents income realized by the sleep diagnostic business during the first six months of 2012, net of income tax expense.

Customer Information

The table set forth below provides (i) the total number of customers to whom we were providing healthcare services as of June 30, 2012 and 2011 and (ii) the aggregate customer months for the first six months of both 2012 and 2011. Customer months are the aggregate number of months of healthcare services we have provided to customers during a period of time.

	Participating Customers at June 30,		Participating Customer Months For The Six Months Ended June 30,		Percentage Increase In Participating Customer Months	
	2012	2011	2012	2011		
Risk arrangements	69,400	34,000	419,200	205,100	104.4	%
Non-risk arrangements	8,200	-	50,900	-	N/A	
	77,600	34,000	470,100	205,100	129.2	%

The increase in total customer months under risk arrangements for the first six months of 2012 as compared to the same period in 2011 is primarily a result of the Participating Customers added with the Continucare acquisition and the net addition of new Participating Customers under risk arrangements in 2012. Changes in our customer base are also a result of new enrollments and/or transfers from other physician's practices, and individuals aging into Medicare and becoming a Participating Customer, reduced by disenrollments, deaths, Participating Customers moving from the covered areas, Participating Customers transferring to another physician practice or Participating Customers making other insurance selections.

The increase in customer months under non-risk arrangements is a result of the Continucare acquisition.

Revenue

The most significant component of our revenue is the revenue generated from Medicare Advantage risk arrangements with the Contracting HMOs. Risk revenue increased by $178.5 million, or 93.3%, during the first six months of 2012 as compared to the same period in 2011. The increase in revenue is primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and increased risk scores for our Participating Customers.

Our PCPM Medicare risk revenue increased by $77 for the first six months of 2012 compared to the same period in 2011. The increase in our PCPM revenue is primarily generated by the acquisition of Continucare, which realizes higher rates in Miami-Dade County than we realize in our other service areas, and increases in our capitation payments as a result of changes in the Medicare risk adjustment scores of our Participating Customers.

Fee-for-service revenue represents amounts earned from medical services provided to non-Participating Customers in our owned medical practices. Fee-for-service revenue represented less than 0.5% of our total revenue for the six months ended June 30, 2012 and June 30, 2011.

Total Medical Expense

Total medical expense and the MER are as follows (in thousands):

	Six Months Ended June 30,	
	2012	2011
Estimated medical expense for the period, excluding prior period claims development	$ 324,770	$ 159,433
Unfavorable (favorable) prior period medical claims development in current period based on actual claims submitted	(2,443)	(3,219)
Total medical expense for period	$ 322,327	$ 156,214
Medical Expense Ratio for period	82.9%	81.4%

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 in the reporting period.

Total medical expense for the first six months of 2012 increased by $166.1 million, or 106.3%, to $322.3 million from $156.2 million for the first six months of 2011. Medical claims expense, which is the largest component of medical services expense, increased by $146.2 million, or 99.3%, to $293.4 million for the first six months of 2012 from $147.2 million for the same period in 2011, primarily due to the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements added in 2012 and the higher than expected medical claims expense under the Contracting HMO Agreement.

Our PCPM Medicare risk expense increased by $48 for the first six months of 2012 compared to the same period in 2011. The increase in our PCPM expense was primarily generated by the acquisition of Continucare. The counties in which Continucare operates, particularly Miami-Dade County, have higher costs than those in most of the counties in which we had operated. The increase was also a result of the higher than average medical claims expense associated with the Contracting HMO Agreement.

The MER for the first six months of 2012 was 82.9%, compared to MER of 81.4% for the first six months of 2011. The increase in MER is primarily attributable to the higher than expected expenses incurred under the Contracting HMO Agreement during the first six months of 2012. Excluding the revenue and medical costs associated with the Contracting HMO Agreement our MER for the first six months of 2012 would have been 80.3%.

Medical practice costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services, and the costs associated with the operations of our wholly-owned medical practices. Medical practice costs increased by $20.0 million, or 222.2%, to $29.0 million for the first six months of 2012 from $9.0 million for the first six months of 2011. The increase in medical practice costs was primarily a result of our acquisition of Continucare, with its 19 wholly-owned centers, and the three medical practices we purchased in the first half of 2011.

Operating Expenses

The following table provides information regarding the various items which comprise operating expenses (dollar amounts in thousands).

	2012		2011		Increase	Change	
Payroll, payroll taxes and benefits	$16,860		$7,960		$8,900	111.8	%
Percentage of total revenue	4.3	%	4.1	%			
General and administrative	9,077		4,343		4,734	109.0	%
Percentage of total revenue	2.3	%	2.3	%			
Marketing and advertising	387		120		267	222.5	%
Percentage of total revenue	0.1	%	0.1	%			
Amortization of intangible assets	6,374		194		6,180	3185.6	%
Percentage of total revenue	1.6	%	0.1	%			
Total operating expenses	$32,698		$12,617		$20,081	159.2	%

Payroll, Payroll Taxes and Benefits

Payroll, payroll taxes and benefits include salary and related costs associated with our corporate level executives, administrative, transportation and call center personnel. The increase in 2012 is primarily a result of the inclusion of Continucare's executive, administrative, transportation and call center payroll, payroll taxes and benefits of $7.4 million. We also realized an increase in stock-based compensation of $0.6 million, primarily due to the addition of certain Continucare employees to the plan and an increase in payroll expense of $0.7 million for the first half of 2012 compared to the same period in 2011.

General and Administrative

This increase in general and administrative expenses for the first six months of 2012 is primarily a result of the inclusion of $3.1 million of Continucare's general and administrative costs. Legal and accounting fees increased by $1.4 million for the first half of 2012 when compared to the same period in 2011 primarily as a result of the preparation and filing of a "shelf" registration statement and related materials and non-recurring projects.

Marketing and Advertising

Marketing and advertising costs increased in the first six months of 2012 compared to the first six months of 2011 due primarily to the inclusion of Continucare's marketing and advertising costs.

Amortization of Intangibles

The increase in amortization is a result of the intangible assets acquired in connection with the acquisition of Continucare.

Other Expense

We recognized other expense of $16.4 million and $0.6 million for the first six months of 2012 and 2011, respectively. The increase in other expense is primarily due to $16.4 million of interest expense related to the debt incurred in connection with the Continucare acquisition. For the first six months of 2011, we recorded transaction costs associated with the Continucare transaction of $1.0 million.

Income taxes

Our estimated effective income tax rate was 38.7% for the first six months of 2012 and 38.5% for the first six months of 2011.

LIQUIDITY AND CAPITAL RESOURCES

Cash and Cash Equivalents

Cash, cash equivalents and short-term investments at June 30, 2012 totaled $44.4 million as compared to $18.3 million at December 31, 2011, an increase of $26.1 million. As of June 30, 2012, we had working capital of $51.8 million as compared to working capital of $43.2 million at December 31, 2011, an increase of $8.6 million or 19.9%. Our total stockholders' equity was $118.2 million at June 30, 2012 and $104.6 million at December 31, 2011.

Net cash provided by operating activities during the first six months of 2012 was $37.4 million. The most significant sources of cash from operating activities were:

- net income, excluding non-cash items, of $23.5 million;
- a decrease in due from HMOs, net, of $7.0 million;
- an increase in due to HMO, net, of $6.4 million; and
- a decrease in prepaid income taxes of $4.9 million.

These sources of cash were partially offset by a decrease in accrued payroll and payroll taxes of $2.8 million as a result of the payment for the first six months of 2012 of the employee bonuses which were accrued at December 31, 2011.

Net cash used in investing activities for the six months ended June 30, 2012 was $2.2 million which primarily related to capital expenditures.

Net cash used by financing activities for the six months ended June 30, 2012 was $9.1 million. This was primarily a result of the repayment of the $5.0 million of borrowings under the revolving loan facility and payments made of $4.8 million under our First Lien Term Loan Facility (see below). These uses were partially offset by the excess tax benefits from stock based compensation of $1.3 million.

We expect to collect the retroactive 2012 mid-year MRA receivable of $11.4 million in August 2012 and the $2.7 million retroactive 2011 year-end receivable in September of 2012.

Adjusted EBITDA From Continuing Operations

The following table presents our Adjusted EBITDA from continuing operations (Non-GAAP measure) for the six months ended June 30, 2012 and 2011, as well as a reconciliation of Adjusted EBITDA from continuing operations to the reported income from continuing operations for such periods (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2012	2011	2012	2011
Income from continuing operations	$ 2,597	$ 5,926	$ 10,595	$ 13,892
Income tax expense	1,651	3,710	6,679	8,697
Net interest expense (income)	8,131	(281)	16,356	(464)
Depreciation and amortization	4,104	311	8,168	742
Stock-based compensation	1,135	629	1,899	1,329
Adjusted EBITDA From Continuing Operations	$17,618	$ 10,295	$ 43,697	$ 24,196

Adjusted EBITDA from continuing operations is not defined under U.S. GAAP and it may not be comparable to similarly titled measures reported by other companies. We use Adjusted EBITDA from continuing operations, along with other U.S. GAAP measures, as a measure of profitability because Adjusted EBITDA from continuing operations helps us to compare our performance on a consistent basis by removing from our operating results from continuing operations the impact of our capital structure, the accounting methods used to compute depreciation and amortization and the effect of non-cash stock-based compensation expense. We believe Adjusted EBITDA from continuing operations is useful to investors as it is a widely used measure of performance and the adjustments we make to Adjusted EBITDA from continuing operations provide further clarity on our profitability. We remove the effect of non-cash stock-based compensation from our income which can vary based on share price, share price volatility and expected life of the equity instruments we grant. In addition, this stock-based compensation expense does not result in cash payments by us. Adjusted EBITDA from continuing operations has limitations as a profitability measure in that it does not include the interest expense on our debt, our provisions for income taxes, the effect of our expenditures for capital assets, and the effect of non-cash stock-based compensation expense.

Credit Facilities

We entered into a senior secured First Lien Credit Agreement and a secured Second Lien Credit Agreement on October 4, 2011. These facilities are guaranteed jointly and severally by substantially all of our existing and future subsidiaries (the "Guarantors") and are secured by a first-priority and second-priority security interest, respectively, in substantially all of our and the Guarantors' existing and future assets

First Lien Credit Agreement

The First Lien Credit Agreement provides for a $240.0 million first lien term loan facility and a $40.0 million revolving loan facility (including subfacilities for up to $15.0 million for letters of credit and $5.0 million for same day, "swingline," borrowings). These loans bear interest at a variable rate that is currently equal to 7.0% for term loan borrowings and 6.5% for revolving loan borrowings. As of June 30, 2012, we had $235.2 million outstanding under our first lien term loan facility. While no amount was outstanding under our revolving loan facility, letters of credit against the revolving loan facility. As of June 30, 2012, we had $33.4 million available for borrowing under our revolving loan facility.

Borrowings under the First Lien Term Loan Facility are subject to quarterly principal amortization at the following rates: 5.0% of the $240.0 million principal amount the first year, 7.5% the second year, 10.0% the third year, and 12.5% for each of the fourth and fifth years. The balance of all borrowings under the first lien term loan facility is due and payable on the maturity date of October 4, 2016.

We may prepay the term loans or permanently reduce the revolver commitment under the First Lien Facilities at any time without penalty. Commencing for the year ended December 31, 2012, we will also be required to make prepayments on an annual basis (subject to certain basket amounts and exceptions), in an amount equal to 75.0% of our excess cash flow (defined as cash flow less scheduled principal and interest payments, cash taxes, and any increase in working capital, plus any decrease in working capital) less any voluntary prepayments made during the applicable year, with a reduction to 50.0% based on achievement of a total leverage ratio (defined as the ratio of our aggregate outstanding indebtedness to our adjusted income before stock-based compensation, interest, taxes, depreciation and amortization) not exceeding 2.00x as of the last day of each year. We also must make prepayments of 25-50% of the net proceeds from publicly offered equity issuances as well as 100% of the net proceeds from asset sales, debt issuances (other than to the extent permitted under the First Lien Credit Agreement) and extraordinary receipts, as defined.

The First Lien Credit Agreement includes customary restrictive covenants, subject to certain basket amounts and exceptions, including covenants limiting our ability to incur or amend certain types of indebtedness and liens; merge with, make an investment in or acquire any property or assets of another company; make capital expenditures; pay cash dividends; repurchase shares of our outstanding stock; make loans; dispose of assets (including the equity securities of our subsidiaries); or prepay the principal on any subordinate indebtedness. Subject to certain terms and conditions, we have the right to make up to $15.0 million of stock repurchases during the term of the credit facilities, generally not to exceed $5.0 million in any year, and make up to $100.0 million of acquisitions, generally not to exceed $50.0 million in any one year. The First Lien Credit Agreement also requires us to maintain certain total leverage ratios (defined above), senior leverage ratios (defined above) and fixed charge coverage ratios (defined as the ratio of our free cash flow to our fixed charges (interest, scheduled principal payments, earnout, stock repurchases from officers, directors and employees) during the term of the agreement, tested quarterly.

Second Lien Credit Agreement

The Second Lien Credit Agreement provides for a $75.0 million second lien term loan facility. This loan bears interest at a variable rate that is currently equal to 13.5%. As of June 30, 2012, we had $75.0 million outstanding under our second lien term loan facility. Borrowings under the Second Lien Credit Agreement are generally due and payable on the maturity date, October 4, 2017.

Prior to the repayment of all borrowings under the First Lien Credit Agreement, we may not prepay any borrowings under the Second Lien Credit Agreement without the prior consent of the First Lien Lenders. To the extent a prepayment of borrowings under the Second Lien Credit Agreement is permitted, we will be required to pay prepayment penalties of 2-5% and, if the prepayment is made prior to May 4, 2013, we will be required to pay a make-whole payment equal to the estimated, discounted net present value of any interest payments that would have been made on or prior to such date but are avoided as a result of the prepayment.

After May 4, 2013, and provided all borrowings under the First Lien Credit Agreement have been repaid and the facility has been terminated, we will, subject to certain basket amounts and exceptions, be required to make mandatory prepayments to the Second Lien Lenders on substantially the same terms and conditions as mandatory prepayments are required under the First Lien Credit Agreement. Mandatory prepayments as a result of asset sales or debt or equity issuances will be subject to the prepayment charges described in the preceding paragraph.

The Second Lien Credit Agreement contains substantially the same negative covenants and financial covenants (other than the senior leverage ratio) as the First Lien Credit Agreement, except that the permitted basket amounts in the Second Lien Credit Agreement are generally higher than under the First Lien Credit Agreement and the financial covenants ratios are 10-15% less restrictive than under the First Lien Credit Agreement.

Interest Rate Cap

Effective December 4, 2011, we entered into an interest rate cap agreement pursuant to which we will be entitled to receive certain payments in the event the LIBOR rate on the First and Second Lien Credit Agreements exceeds 1.5%. The notional amount of the interest rate cap, which expires on September 30, 2014, is $155.1 million at June 30, 2012 and will decrease to $134.1 million over the life of the agreement. The effect of this interest rate cap is to hedge our risk of a rise in the LIBOR rate above 1.5% with respect to a portion of the outstanding indebtedness under the First Lien Credit Agreement and the Second Lien Credit Agreement equal to the notional amount of the cap.

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, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources that are material to investors.

ITEM 3. 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. Our market risk profile has not changed significantly during the first six months of 2012.

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 reduce our exposure to any one of these entities or investments. 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 municipal bonds. 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. Our interest rate risk relative to our investments has decreased significantly with the sale of substantially all our investments in the third quarter of 2011.

The interest rate on our borrowings under the Credit Agreements can fluctuate based on both the interest rate option (i.e., base rate or LIBOR rate plus applicable margins) and the interest period. As of June 30, 2012, the total amount of outstanding debt subject to interest rate fluctuations was $310.2 million. A hypothetical 100 basis point change in LIBOR as of the date of the Agreement would have no impact on interest expense due to the LIBOR floor contained in the Credit Agreement. Effective December 4, 2011, we entered into an interest rate cap which provides protection against increases in the LIBOR rate above 1.5%. The notional amount of the cap is $155.1 million at June 30, 2012, decreasing to $134.1 million over the life of the agreement. The interest rate cap expires on September 30, 2014.

Intangible Asset Risk

We have intangible assets and perform goodwill impairment tests annually and whenever events or changes in 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. At June 30, 2012, we believe our intangible assets 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 4. CONTROLS AND PROCEDURES

Under the supervision and with the participation of our Chief Executive Officer and our Chief Financial Officer we carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures for the period ended June 30, 2012.

Based on our evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective to ensure that the information required to be disclosed by us in the reports that we file or submit under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported within the time periods specified in SEC 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.

There have been no changes in our internal control over financial reporting that occurred during our last fiscal quarter that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. 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.

35

ITEM 1A. RISK FACTORS

There has been no material changes in our risk factors from those disclosed in our Annual Report on Form 10-K for the fiscal year ended December 31, 2011 and our quarterly report for the quarter ended March 31, 2012 other than the following

Reductions in Funding for Medicare Programs and Other Provisions Under the Recent Healthcare Reform Legislation and Future Related Regulations Could Have a Material Adverse Effect on Our Business, Revenue and Profitability

The Reform Acts made significant changes to the Medicare program and to the health insurance market overall. A number of provisions of healthcare reform legislation have been implemented, and other provisions are scheduled to take effect between now and 2018. Potentially adverse provisions include:

Medicare Advantage benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates are being phased down from current levels to levels that are between 95% and 115% of fee-for-service costs, depending on a plan's geographic area. Plans receiving certain quality ratings by CMS will be eligible for bonus rate increases.

Rebates received by Medicare Advantage plans that "underbid" based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.

The Secretary of HHS is granted explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits.

Beginning in 2014, Medicare Advantage plans with medical loss ratios below 85% will be required to pay a rebate to the Secretary of HHS. The Secretary will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years.

Since January 1, 2011, cost-sharing for certain services (such as chemotherapy and skilled nursing care) have been limited to the cost-sharing permitted under Original Medicare.

Prescription drug plans are now required to cover all drugs on a list developed by the Secretary of HHS, and the Part D premium subsidy for high-income beneficiaries has been reduced by 25%.

Substantially all of our revenue is directly or indirectly derived from the monthly premium payments paid by CMS to the Contracting HMOs. As a result, our business and results of operations are dependent on government funding levels for Medicare Advantage programs. Any changes that limit or reduce Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business.

Due to the Reform Acts' recent passage, scope and complexity, the unsettled nature of the reforms and the numerous steps required to implement them, and our inability to predict or dictate how the Contracting HMO's Participating Customers and/or our various direct and indirect competitors will react to the Reform Acts, we believe that we have limited ability to predict the direct and indirect effects of the Reform Acts upon the Medicare Advantage industry and us. For instance, although we anticipate that we will experience a decline in per beneficiary payment rates under the Reform Acts, we also anticipate the impact of such reduction on us will be mitigated, by some indeterminate amount by some of the following factors: enhanced medical management that will reduce the cost of care, reduced plan benefit offerings, increased customer co-pays and deductibles, the potential for plan quality bonuses, improved plan

risk score compliance and/or other factors. We note that, although we are seeking to implement various operational and strategic initiatives with respect to the Reform Acts, our ability to anticipate and effectuate certain initiatives is significantly restricted since we have limited ability to influence, among other things, the Contracting HMOs' marketing efforts to increase enrollment in the plans that we serve, the plan benefits offered by the Contracting HMOs, the plan co-pays and deductibles set by the Contracting HMOs and/or the quality ratings received by the Contracting HMO plans that we serve. If we fail to realize our operational and strategic objectives with respect to the Reform Acts for any reason, it is reasonably possible that our business may be materially adversely affected by the Reform Acts and related regulations.

As a result, changes to Medicare Advantage health plan reimbursement rates stemming from the Reform Acts as well as newly enacted and future regulations adopted in connection therewith may negatively impact our business, revenue and profitability. In addition, the Reform Acts established a Medicare shared savings program for Accountable Care Organizations (ACOs) which took effect in January 2012. Under this shared savings program, the Secretary of HHS may contract with eligible organizations, including group medical practices, to be accountable for the quality, cost and overall care of Medicare beneficiaries assigned to the ACO. Participating ACOs that meet specified quality performance standards will be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. The development and expansion of ACOs has the potential to adversely impact our business, revenue and profitability.

There are numerous steps required to implement the Reform Acts, and Congress may seek to alter or eliminate some of their provisions. In June, 2012, the United States Supreme Court upheld most of the provisions of the Affordable Care Act, including the health insurance mandate. While Federal regulatory agencies are moving forward with implementation of the provisions of the Reform Act, Congress is attempting to pass legislation which would reverse the Reform Acts. Furthermore, various health insurance reform proposals are also emerging at the state level. . Due to the unsettled nature of these reforms and the numerous steps required to implement them, we cannot predict to what extent (if at all) Congress will succeed in limiting or reversing the Reform Acts, whether (and if so, what) additional health insurance reforms will be implemented at the Federal or state level and/or the effect that any future legislation or regulation will have on our business. However, the enacted reforms as well as future legislative and/or regulatory changes may have a material adverse effect on our results of operations, including by decreasing our reimbursement rates and increasing our expenses.

Our Discussions to Amend the Contracting HMO Agreement May Not be Successful

We entered into the Contracting HMO Agreement, effective January 1, 2012, pursuant to which are currently providing services to approximately 6,600 Participating Customers on a risk basis. The cost of providing medical care to such Participating Customers has been higher than the average cost of providing medical care to the remainder of the Participating Customers for whom we are responsible and significantly higher than we expected when we entered into the Contracting HMO Agreement. As a result, we have realized losses under the Contracting HMO Agreement for the three and six months ended June 30, 2012. Although we are entitled to terminate the Contracting HMO Agreement by giving the Contracting HMO party thereto 120 days' prior written notice, we are currently seeking to amend the Contracting HMO Agreement in a manner that we believe will reduce the likelihood that we will incur additional losses under such agreement in the future. While the contracting HMO has indicated a willingness to amend the Contracting HMO Agreement we may not be successful in negotiating and entering into an amendment to the Contracting HMO Agreement that will materially reduce the likelihood that we will incur additional losses under such agreement in the future. If our discussions to amend the contract are not successful, we project a loss for the last half of 2012 under the Contracting HMO Agreement that will be similar to or greater than the $4.4 million loss realized in the first half of the year.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

Issuer Purchases of Equity Securities

We have a stock repurchase plan pursuant to which our Board of Directors authorized us to repurchase up to 25 million shares of our common stock. We did not repurchase any stock during 2012. During the three and six month period ended June 30, 2011, we repurchased 71,000 shares of our common stock for an aggregate purchase price of $0.3 million. From October 6, 2008 (the date of our first repurchases under the plan) through June 30, 2012, we have repurchased 14.0 million shares and options to purchase 684,200 shares of our common stock for $28.3 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. The total shares that may yet be repurchased under the plan at May 2, 2012 is 10.3 million.

Under the First and Second Lien Credit Facilities we have the right to make up to $15 million of stock repurchases during the term of the Credit Facilities, generally not to exceed $5 million in any year.

ITEM 6. EXHIBITS

3.1	Articles of Incorporation, as amended (1)
3.2	Amended and Restated Bylaws (2)
31.1	Certification of the Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2	Certification of the Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1	Certification of the Chief Executive Officer and the Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**
101.INS	XBRL Instance Document***
101.SCH	XBRL Schema Document***
101.CAL	XBRL Calculation Linkbase Document***
101.LAB	XBRL Label Linkbase Document***
101.PRE	XBRL Presentation Linkbase Document***
101.DEF	XBRL Definition Linkbase Document***

* filed herewith

** furnished herewith

*** The interactive files on Exhibit 101 hereto are deemed not filed or part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act of 1933, as amended, are deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, and otherwise are not subject to liability under those sections.

(1) Incorporated by reference to our Registration Statement on Form 8-A filed with the SEC on November 19, 2004 (No. 001-32361).

(2) Incorporated by reference to our Current Report on Form 8-K filed with the SEC on September 30, 2004.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the Undersigned thereunto duly authorized.

METROPOLITAN HEALTH NETWORKS, INC.

Date: August 9, 2012

/s/ Michael M. Earley
Michael M. Earley
Chief Executive Officer

/s/ Robert J. Sabo
Robert J. Sabo
Chief Financial Officer
(Principal Financial and Accounting Officer)