METROPOLITAN HEALTH NETWORKS INC
Form 10-Q
May 07, 2008

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 March 31, 2008

OR

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

For the transition period from _____ to _____

Commission file number: 001-32361

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

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

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

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

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

Yes x No ¨

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or 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 April 30, 2008
Common Stock, $.001 par value per share	51,885,932 shares

Metropolitan Health Networks, Inc.

Index

PART 1. FINANCIAL INFORMATION
Item 1. Financial Statements

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

	March 31, 2008 (unaudited)	December 31, 2007
ASSETS		
CURRENT ASSETS		
Cash and equivalents, including $15.0 million in 2008 and $13.0 million in 2007 statutorily limited to use by the HMO	$ 40,669,125	$ 38,682,186
Accounts receivable, net	439,117	1,563,370
Inventory	229,173	196,154
Prepaid expenses	850,161	739,307
Deferred income taxes	2,917,755	2,905,755
Other current assets	1,046,951	676,980
TOTAL CURRENT ASSETS	46,152,282	44,763,752
PROPERTY AND EQUIPMENT, net	2,033,107	2,181,119
INVESTMENT	688,997	688,997
GOODWILL, net	2,587,332	2,585,857
DEFERRED INCOME TAXES	1,606,932	1,403,082
OTHER INTANGIBLE ASSETS, net	1,478,079	1,588,498
OTHER ASSETS	597,514	599,742
TOTAL ASSETS	$ 55,144,243	$ 53,811,047
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 1,275,804	$ 1,461,668
Estimated medical claims payable	7,286,770	7,016,632
Due to CMS	2,802,044	2,695,087
Accrued payroll and payroll taxes	1,670,543	2,546,295
Due to Humana	2,098,098	753,466
Accrued expenses	1,686,028	1,071,920
TOTAL CURRENT LIABILITIES	16,819,287	15,545,068
COMMITMENTS AND CONTINGENCIES		
STOCKHOLDERS' EQUITY		
Preferred stock, par value $.001 per share; stated value $100 per share; 10,000,000 shares authorized; 5,000 issued and outstanding, with a liquidation preference of $529,167 and $516,667 in 2008 and 2007, respectively	500,000	500,000
Common stock, par value $.001 per share; 80,000,000 shares authorized; 51,845,932 and 51,556,732 issued and outstanding at March 31, 2008 and December 31, 2007, respectively	51,846	51,557
Additional paid-in capital	43,708,330	43,311,741

Accumulated deficit		(5,935,220)		(5,597,319)
TOTAL STOCKHOLDERS' EQUITY		38,324,956		38,265,979
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$	55,144,243	$	53,811,047

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

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

	Three Months Ended March 31,	
	2008 (unaudited)	**2007 (unaudited)**
REVENUE	$ 76,014,498	$ 68,101,456
MEDICAL EXPENSE		
Medical claims expense	65,237,005	57,493,273
Medical center costs	3,151,534	2,691,072
Total Medical Expense	68,388,539	60,184,345
GROSS PROFIT	7,625,959	7,917,111
OPERATING EXPENSES		
Payroll, payroll taxes and benefits	3,752,437	3,326,970
Marketing and advertising	1,368,103	1,609,269
General and administrative	3,131,096	2,991,378
Total Operating Expenses	8,251,636	7,927,617
OPERATING (LOSS)	(625,677)	(10,506)
OTHER INCOME:		
Investment income	81,067	381,230
Other income	2,859	2,548
Total Other Income	83,926	383,778
(LOSS) INCOME BEFORE INCOME TAXES	(541,751)	373,272
INCOME TAX (BENEFIT) EXPENSE	(203,850)	145,000
NET (LOSS) INCOME	$ (337,901)	$ 228,272
NET (LOSS) EARNINGS PER COMMON SHARE:		
Basic	$ (0.01)	$ -
Diluted	$ (0.01)	$ -

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

	Three Months Ended March 31,	
	2008 (unaudited)	2007 (unaudited)
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net (loss) income	$ (337,901)	$ 228,272
Adjustments to reconcile net (loss) income to net cash provided by/(used in) operating activities:		
Depreciation and amortization	329,105	245,905
Share-based compensation expense	290,598	156,768
Shares issued for director fees	69,280	-
Excess tax benefits from share-based compensation	(12,000)	-
Deferred income taxes	(203,850)	(147,000)
Changes in operating assets and liabilities:		
Accounts receivable	1,124,253	(2,591,550)
Inventory	(33,019)	(6,974)
Prepaid expenses	(110,854)	(188,144)
Other current assets	(369,971)	508,412
Other assets	(6,349)	27,486
Accounts payable	(185,864)	(101,495)
Accrued payroll and payroll taxes	(875,752)	619,327
Estimated medical expenses payable	270,138	740,263
Unearned premium	-	1,560,995
Due to CMS	106,957	3,131,207
Due to Humana	1,344,632	-
Accrued expenses	614,108	742,315
Net cash provided by operating activities	2,013,511	4,925,787
CASH FLOWS FROM INVESTING ACTIVITIES:		
Cash paid for physician practice acquisition	(1,475)	-
Capital expenditures	(62,097)	(96,684)
Net cash used in investing activities	(63,572)	(96,684)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from exercise of stock options	25,000	700
Excess tax benefits from share-based compensation	12,000	-
Net cash provided by financing activities	37,000	700
NET INCREASE IN CASH AND EQUIVALENTS	1,986,939	4,829,803
CASH AND EQUIVALENTS - beginning of period	38,682,186	23,110,042
CASH AND EQUIVALENTS - end of period	$ 40,669,125	$ 27,939,845

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

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

NOTE 1 UNAUDITED INTERIM INFORMATION

The accompanying unaudited condensed consolidated financial statements of Metropolitan Health Networks, Inc. and subsidiaries (referred to as "Metropolitan," "the Company," "we," "us," or "our") have been prepared in accordance w accounting principles generally accepted in the United States for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and footnotes required by accounting principles generally accepted in the United States of America for complete financial statements, or those normally made in an Annual Report on Form 10-K. In the opinion of management, all adjustments (consisting of normal recurring accruals) considered necessary for a fair presentation have been included. Operating results for the three month period ended March 31, 2008 are not necessarily indicative of the results that may be reported for the remainder of the year ending December 31, 2008 or future periods.

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

For further information, refer to the audited consolidated financial statements and footnotes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2007. The accompanying December 31, 2007 condensed consolidated balance sheet has been derived from these audited financial statements. These interim condensed consolidated financial statements should be read in conjunction with the audited consolidated financial statements and notes to consolidated financial statements included in that report.

NOTE 2 ORGANIZATION AND BUSINESS ACTIVITY

We own and operate provider service networks through our wholly owned subsidiary, Metcare of Florida, Inc. (the "PSN"). We also operate a health maintenance organization (the "HMO") through our wholly owned subsidiary, METCARE Health Plans, Inc.

The PSN operates under two agreements (the "Humana Agreements") with Humana, one of the largest participants in the Medicare Advantage program in the United States, to provide medical care to Medicare beneficiaries enrolled under Humana's health plans. To deliver care, we utilize our wholly-owned medical practices and have also contracted directly or indirectly through Humana with medical practices, service providers and hospitals (collectively the "Affiliated Providers"). The PSN operates in South Florida and Central Florida.

Effective as of August 1, 2007, the PSN entered into a network agreement (the "CarePlus Agreement") with CarePlus Health Plans, Inc., a Medicare Advantage health plan in Florida. CarePlus is a wholly-owned subsidiary of Humana. Pursuant to the CarePlus Agreement, the PSN will provide, on a non-exclusive basis, healthcare services to Medicare beneficiaries in nine Florida counties.

The HMO has a contract (the "CMS Contract") with the Centers for Medicare and Medicaid Services ("CMS") and presently offers plans in 13 Florida counties. The CMS Contract is generally automatically renewable for a one-year term each December 31 unless CMS notifies the HMO of its decision not to renew the agreement by May 1 of the contract year, or the HMO notifies CMS of its decision not to renew by the first Monday in June of the contract year. No notice of non-renewable was received from CMS in the current year.

We manage the PSN and HMO as separate business segments.

NOTE 3 RECENT ACCOUNTING PRONOUNCEMENTS

On December 4, 2007, the FASB issued FASB Statement No. 141(R) ("Statement No. 141(R)") which replaces FASB Statement No. 141, *Business Combinations* ("Statement No. 141"). Statement No. 141(R) fundamentally changes many aspects of existing accounting requirements for business combinations. It requires, among other things, the accounting for any entity in a business combination to recognize the full value of the assets acquired and liabilities assumed in the transaction at the acquisition date; the immediate expense recognition of transaction costs; and accounting for restructuring plans separately from the business combination. Statement No. 141(R) defines the acquirer as the entity that obtains control of one or more businesses in the business combination and establishes the acquisition date as the date that the acquirer achieves control. Statement No. 141(R) retains the guidance in Statement No. 141 for identifying and recognizing intangible assets separately from goodwill. If we enter into any business combination after the adoption of Statement No. 141(R), a transaction may significantly impact our financial position and earnings, but not cash flows, compared to acquisitions prior to the adoption of Statement No. 141(R). The adoption of Statement No. 141(R) is effective beginning in 2009 and both early adoption and retrospective application are prohibited.

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements*. This standard provides guidance for using fair value to measure assets and liabilities. The standard also responds to investors' requests for expanded information about the extent to which companies measure assets and liabilities at fair value, the information used to measure fair value, and the effect of fair value measurements on earnings. The standard applies whenever other standards require (or permit) assets or liabilities to be measured at fair value, but does not expand the use of fair value in any new circumstances. There are numerous previously issued statements dealing with fair values that are amended by SFAS No. 157. SFAS No. 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007. In February 2008, the FASB issued Staff Position ("FSP") FAS 157-1, *Application of FASB Statement No. 157 to FASB Statement No. 13 and Other Accounting Pronouncements That Address Fair Value Measurements for Purposes of Lease Classification or Measurement under Statement 13,* which scopes out leasing transactions accounted for under SFAS No. 13, *Accounting for Leases*. In February 2008, FSP FAS 157-2, *Effective Date of FASB Statement No. 157*, was issued, which delays the effective date of SFAS No. 157 to fiscal years and interim periods within those fiscal years beginning after November 15, 2008 for non-financial assets and non-financial liabilities, except for items that are recognized or disclosed at fair value in the financial statements on a recurring basis (at least annually). The implementation of SFAS No. 157 for financial assets and financial liabilities, effective January 1, 2008, did not have a material impact on the Company's condensed consolidated financial statements. The Company is currently assessing the impact of SFAS No. 157 for non-financial assets and non-financial liabilities on its consolidated financial statements.

SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities, Including an Amendment of FASB Statement No. 115,* was issued in February 2007. SFAS No. 159 allows entities to voluntarily choose to measure many financial assets and financial liabilities at fair value through earnings. Upon initial adoption, SFAS No. 159 provides entities with a one-time chance to elect the fair value option for existing eligible items. The effect of the first measurement to fair value is reported as a cumulative-effect adjustment to the opening balance of retained earnings in the year SFAS No. 159 is adopted. SFAS No. 159 is effective as of the beginning of fiscal years starting after November 15, 2007. Currently, we have not elected to account for any of our eligible items using the fair value option under SFAS No. 159. As a result, our adoption of SFAS No. 159, effective January 1, 2008, did not have a material impact on our condensed consolidated financial position, results of operations or cash flows.

In December 2007, FASB Statement No. 160, *Noncontrolling Interests in Consolidated Financial Statements: an amendment of ARB No. 51*, was issued by the FASB. Statement No. 160 amends ARB 51 to establish accounting and reporting standards for the noncontrolling interest in a subsidiary and for the deconsolidation of a subsidiary. It also amends certain of ARB No. 51's consolidation procedures for consistency with the requirements of Statement No.

141(R), *Business Combinations*. Statement No. 160 is effective for fiscal years beginning on or after December 15, 2008. The adoption of Statement No. 160 is not expected to have any impact on our financial statements.

NOTE 4 REVENUE

Our Medicare premium revenue is adjusted periodically to give effect to a risk component. Risk adjustment uses health status indicators to improve the accuracy of payments and establish incentives for plans to enroll and treat less healthy Medicare beneficiaries. Under the risk adjustment methodology, managed care plans must capture, collect, and submit diagnosis code information to CMS. After reviewing the respective submissions, CMS generally adjusts the premium payments to Medicare plans at the beginning and middle of the calendar year and performs a final settlement in the subsequent year.

NOTE 5 MEDICAL EXPENSE

Total medical expense for both the PSN and HMO is recognized in the period in which services are provided and includes an estimate of our obligations for medical services that have been provided to our customers but for which we have either not yet received or processed claims, and for liabilities for physician, hospital and other medical expense disputes. We develop our estimated medical claims payable by using an actuarial process that is consistently applied. The actuarial process and models develop a range of estimated medical claims payable and we record to the amount in the range that is our best estimate of the ultimate liability.

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

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

As of March 31, 2008, we estimate that our medical claims cost for services provided prior to December 31, 2007 will be approximately $1.1 million less than the amount originally estimated, resulting in a favorable development. This reduces the medical expense ratio for the three month period ended March 31, 2008 by 1.5%. Of this amount, $86,000 of favorable development related to the PSN and $1.1 million of favorable development related to the HMO.

As of March 31, 2007, we had estimated that our medical claim cost for services provided prior to December 31, 2006 would exceed our estimated medical claims payable at December 31, 2006 by approximately $563,000, resulting in an unfavorable development in such period.. This increases the MER for the three month period ended March 31, 2007 by .8%. The $563,000 difference in the amount incurred was a result of net unfavorable developments in our consolidated medical claims expense, with $1.6 million unfavorable to the PSN and $1.0 million favorable to the HMO.

At March 31, 2008, we determined that the range for estimated medical claims payable for the PSN was between $14.2 million and $15.3 million and we recorded a liability at the actuarial mid-range of $14.6 million. Based on historical results, we believe that, for the PSN, the actuarial mid-range represents the best estimate of the ultimate liability. This amount is included within the Due to Humana in the accompanying condensed consolidated balance sheets.

At March 31, 2008, we estimated that the range for estimated medical claims payable for the HMO was between $7.3 million and $8.0 million and we recorded a liability of $7.3 million. Based on historical results, we believe that, for the HMO, the low end of the range continues to be the best estimate of the ultimate liability.

NOTE 6 PRESCRIPTION DRUG BENEFITS UNDER MEDICARE PART D

The HMO, through CMS, and the PSN, through the Humana Agreements, provides prescription drugs coverage under Medicare Part D to the HMO’s and PSN's Medicare Advantage customers, respectively. The benefits covered under Medicare Part D are in addition to the benefits covered by the HMO and the PSN under Medicare Parts A and B.

In general, pursuant to Medicare Part D, pharmacy benefits may vary in terms of coverage levels and out-of-pocket costs for beneficiary premiums, deductibles and co-insurance. However, all Part D plans must offer either "standard coverage" or its actuarial equivalent (with out-of-pocket threshold and deductible amounts that do not exceed those of standard coverage). These "standard" benefits represent the minimum level of benefits mandated by federal law. In addition to the defined standard plans offered by the HMO, the PSN, through the Humana Agreements, offers certain prescription drug plans containing benefits in excess of the standard coverage limits.

The payment our HMO receives monthly from CMS for coverage under Medicare Part D (the "CMS Payment") generally represents the HMO's bid amount for providing Part D insurance coverage. We recognize premium revenue for the HMO's provision of Part D insurance coverage ratably over the term of the CMS Contract. However, as discussed below, the ultimate amount of the CMS Payment is subject to 1) risk corridor adjustments and 2) subsidies provided by CMS in order for the HMO and CMS to share the risk associated with financing the ultimate costs of the Medicare Part D benefit.

The CMS payment is subject to positive or negative adjustment based upon the application of risk corridors that compare the prescription drug benefit costs estimated by the HMO in making its bid to CMS (the "Estimated Costs") to actual incurred prescription drug benefit costs (the "Actual Costs"). In accordance with federal regulations, in 2008, the HMO bears all gains and losses that fall within 5% of its Estimated Costs. For 2007, the HMO bore all gains and losses that fell within 2.5% of its Estimated Costs. To the extent the Actual Costs exceed Estimated Costs by more than these percentage corridors; CMS may make additional payments to the HMO. Conversely, to the extent the Estimated Costs exceed the Actual Costs by more than the percentage corridors, the HMO may be required to refund to CMS a portion of the CMS Payment. Actual Costs subject to risk sharing with CMS are limited to the costs that are, or would have been, incurred under the CMS standard benefit plan. We estimate and recognize an adjustment to premium revenue from CMS related to the risk corridor payment adjustment based upon pharmacy claims experience to date as if the CMS Agreement were to end at the end of each reporting period. Accordingly, this estimate does not take into consideration projected future pharmacy claims experience. It is reasonably possible that this estimate could change in the near term by an amount that could be material. Since these amounts represent additional premium or premium that is to be returned, any adjustment is recorded as an increase or decrease to revenue. The final settlement for the Part D program occurs in the year subsequent to the year during which coverage was provided. We record a receivable/payable in our financial statements for this amount.

Certain subsidies represent reimbursements from CMS for claims the HMO paid even though it is not ultimately required to bear the risk in connection with such claims. These include federally reinsured claims where an HMO customer's actual drug spending reaches Part D's annual catastrophic threshold and certain deductible, coinsurance and co-payment amounts for low-income beneficiaries. We account for these subsidies as current liabilities in our consolidated balance sheets and as an operating activity in our consolidated statements of cash flows. We do not recognize premium revenue or claims expense for these subsidies.

We also receive Medicare Part D revenue pursuant to the applicable percent of premium provided for in the Humana Agreements. As with the HMO, we estimate the pharmacy benefit costs as such costs are incurred by the PSN. With regards to the estimated amount of any risk corridor adjustments, we have utilized estimates provided to us by Humana and have performed a separate calculation of any risk corridor adjustments. We have adjusted our premium revenue based on these estimates. It is reasonably possible that this estimate could change in the near term by an amount that could be material.

At March 31, 2008, we estimated the PSN would have a $500,000 liability for excess Part D payments related to 2008’s first quarter premiums. At December 31, 2007, we recognized a liability for the PSN of approximately $4 million related to premiums received in 2007 that we estimate will be refunded during 2008. These amounts are included within Due to Humana in the accompanying condensed consolidated balance sheets.

At March 31, 2008, based on year to date drug costs and utilization patterns and changes in actuarial assumptions underlying future drug costs projections, we determined that a liability for Part D premium payments in excess of drug costs for the HMO of approximately $2.8 million should be recorded. Of this amount, $2.7 million relates to 2007 and was recorded at December 31, 2007. These amounts are included in Due to CMS in the accompanying condensed consolidated balance sheets.

NOTE 7 INCOME TAXES

The effective income tax rate was 37.6% for the three months ended March 31, 2008 compared to 38.8% for the three months ended March 31, 2007.

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 net operating loss carry forwards related to years prior to 2003. To the extent such net operating losses are utilized, the years from

which the loss carryforwards originate are open for examination by the relevant taxing authorities. Upon adoption of Interpretation No. 48, we evaluated our tax positions with regard to these years. The statute of limitations for the federal and Florida 2004 tax years will expire in the next twelve months.

The Internal Revenue Service has concluded its examination of our 2005 Federal income tax return. We did not recognize a change to the total amount of unrecognized tax benefit as a result of the examination. Tax years subsequent to 2003 remain subject to federal and state examination.

We recognize interest related to unrecognized tax benefits in interest expense, which is included in other income in the condensed consolidated statements of operations, and penalties in operating expenses for all periods presented. Interest expense of $25,000 was accrued in the first quarter of 2007. No penalties have been accrued in any period presented.

The amount of unrecognized tax benefits at March 31, 2008 includes $260,000 of unrecognized tax benefits which, if ultimately recognized, will reduce our annual effective tax rate.

NOTE 8 EARNINGS (LOSS) PER SHARE

Earnings (loss) per common share, basic is computed using the weighted average number of common shares outstanding during the period. Earnings (loss) per common share, diluted is computed using the weighted average number of common shares outstanding during the period adjusted for incremental shares attributed to outstanding options and warrants, nonvested stock and preferred stock convertible into shares of common stock, if such incremental shares have a dilutive effect.

	Three months ended March 31,	
	2008	**2007**
Net (loss) income	$ (338,000)	$ 228,000
Less: Preferred stock dividend	(13,000)	(13,000)
(Loss) income available to common stockholders	$ (351,000)	$ 215,000
Denominator:		
Weighted average common shares outstanding	51,185,000	50,270,000
Basic (loss) earnings per common share	$ (0.01)	$ 0.00
(Loss) income available to common stockholders, diluted	$ (351,000)	$ 215,000
Denominator:		
Weighted average common shares outstanding	51,185,000	50,270,000
Common share equivalents of outstanding stock: Options and warrants	-	1,495,000
Weighted average common shares outstanding	51,185,000	51,765,000
Diluted (loss) earnings per common share	$ (0.01)	$ 0.00

The following securities were not included in the computation of diluted loss per share at March 31, 2008, as their effect would be anti-dilutive:

- Stock options – 4,360,000
- Convertible preferred stock – 5,000
- Unvested restricted stock – 636,000

Options to purchase 200,000 shares of common stock with exercise prices ranging between $2.69 and $6.50 per share were outstanding during the three months ended March 31, 2007, but were not included in the computation of diluted earnings per share because the options' exercise price was greater than the average market price of the common shares and, therefore, the effect would be anti-dilutive. In addition, there were 5,000 shares of convertible preferred stock at a conversion price of $2.72 that were not included in the computation of diluted earnings per share because the effect

would be anti-dilutive.

NOTE 9 STOCKHOLDERS' EQUITY

During the three months ended March 31, 2008, we issued 25,000 shares of common stock in connection with the exercise of stock options. During the three month period ended March 31, 2007, we issued 2,000 shares of common stock in connection with the exercise of stock options.

During the first quarter of 2008, we issued 268,200 restricted shares of common stock and options to purchase 982,000 shares of common stock to employees. 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 day preceding the grant date. Compensation expense related to the restricted stock and options is recognized ratably over the vesting period.

During the first quarter of 2008 we extended the expiration date from June 30, 2008 to September 30, 2008 for 100,000 options issued to a consultant in 2007. In accordance with FAS 123(R), *Share-Based Payment,* we revalued the options and accounted for the increase in value as additional expense which is being amortized ratably over the vesting period.

NOTE 10 COMMITMENTS AND CONTINGENCIES

Legal Proceedings

On March 13, 2007, a complaint was filed by Mr. Noel Guillama, who served as our President, Chairman of the Board and Chief Executive Officer from January 1996 through February 2000, in the Circuit Court of the Fifteenth Judicial Circuit in and for Palm Beach County, naming us as a defendant. The dispute involves 1,500,000 restricted shares of common stock issued to Mr. Guillama in connection with his personal guarantee of a Company line of credit in 1999. We repaid the line of credit and expected, based on documentation signed by Mr. Guillama, the 1,500,000 shares issued as collateral to be returned to us. Mr. Guillama alleges that we have breached an agreement to remove the transfer restrictions from these shares and is seeking damages for breach of contract and specific performance. We believe this lawsuit is without merit and intend to assert an appropriate defense. We filed a motion to dismiss the complaint in May 2007. On April 22, 2008, Mr. Guillama filed a First Amended Complaint and Request for Jury Trial. Our response is due on May 16, 2008 and we anticipate defending this action vigorously. These shares have not been reflected as issued or outstanding in the accompanying condensed consolidated balance sheets or in the computations of earnings per share.

We are also a party to certain other claims arising in the ordinary course of business. We believe that the outcome of these matters will not have a material adverse effect on our financial position or the results of our operations.

Guarantees

In connection with the sale of the assets of our pharmacy division in 2003, the purchaser of the pharmacy assets agreed to assume our obligation under a lease which ran through 2012. In the event of the purchaser's default, we could be responsible for future lease payments totaling approximately $527,000 at March 31, 2008. We are not currently aware of any defaults.

NOTE 11 BUSINESS SEGMENT INFORMATION

We manage the PSN and HMO as separate business segments. We identified our segments in accordance with the aggregation provisions of SFAS No. 131, *Disclosures about Segments of an Enterprise and Related Information,* which is consistent with information used by our Chief Executive Officer in managing our business. The segment information below aggregates services with similar economic characteristics. These characteristics include the nature

of customer groups and the nature of the services and benefits provided. The results of each segment are measured by income before income taxes. We allocate all selling, general and administrative expenses, investment and other income, interest expense, goodwill and certain other assets and liabilities to our segments. Our segments share overhead costs.

THREE MONTHS ENDED MARCH 31, 2008	PSN	HMO	Total
Revenues from external customers	$ 57,719,000	$ 18,295,000	$ 76,014,000
Segment gain (loss) before allocated overhead and income taxes	4,741,000	(2,652,000)	2,089,000
Allocated corporate overhead	1,298,000	1,333,000	2,631,000
Segment gain (loss) after allocated overhead and before income taxes	3,443,000	(3,985,000)	(542,000)
Segment assets	32,237,000	17,321,000	49,558,000
Goodwill	2,587,000	-	2,587,000

THREE MONTHS ENDED MARCH 31, 2007	PSN	HMO	Total
Revenues from external customers	$ 57,093,000	$ 11,009,000	$ 68,102,000
Segment gain (loss) before allocated overhead and income taxes	6,499,000	(3,867,000)	2,632,000
Allocated corporate overhead	1,015,000	1,244,000	2,259,000
Segment gain (loss) after allocated overhead and before income taxes	5,484,000	(5,111,000)	373,000
Segment assets	23,372,000	16,836,000	40,208,000
Goodwill	1,992,000	-	1,992,000

Segment assets at March 31, 2008 exclude general corporate assets of $5.6 million including deferred tax assets of $4.5 million.

Segment assets at March 31, 2007 exclude general corporate assets of $8.3 million including deferred tax assets of $7.1 million.

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

THE FOLLOWING DISCUSSION SHOULD BE READ IN CONJUNCTION WITH OUR ANNUAL REPORT ON FORM 10-K FOR THE YEAR ENDED DECEMBER 31, 2007, AS WELL AS THE FINANCIAL STATEMENTS AND NOTES THERETO.

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

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

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

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

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

- the PSN's ability to renew the Humana Agreements and maintain such agreements on favorable terms;
- our ability to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported ("IBNR") claims; and
- the HMO's ability to renew, maintain and/or successfully rebid for the agreement with the Centers for Medicare and Medicaid Services ("CMS").

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

- reductions in government funding of Medicare programs;
- disruptions in the PSN's, the HMO's or Humana's healthcare provider networks;
- failure to receive claims processing, billing services, data collection and other information on a timely basis from Humana or HF Administrative Services;

- failure to receive, on a timely or accurate basis, customer information from CMS;
- future legislation and changes in governmental regulations;
- increased operating costs;
- the impact of Medicare Risk Adjustments on payments we receive from CMS or Humana;

- the impact of the Medicare prescription drug plan on our operations;
- loss of significant contracts;
- general economic and business conditions;
- increased competition;
- the relative health of our patients;
- changes in estimates and judgments associated with our critical accounting policies;
- federal and state investigations;
- our ability to grow our HMO customers in our current geographic markets and our ability to expand our HMO into new geographic markets;
- 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 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, 2007.

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

BACKGROUND

We operate two primary businesses in Florida, a provider service network ("PSN") that provides and arranges for medical care primarily to customers of Humana, Inc. (each a "Humana Plan Customer") and our health maintenance organization ("HMO") which provides healthcare benefits to Medicare beneficiaries in Florida that have selected our plan.

As of March 31, 2008, the PSN and the HMO provided healthcare benefits to approximately 25,800 and approximately 7,200 Medicare Advantage beneficiaries, respectively. At April 1, 2008, the customer base of the PSN was approximately 25,700 and the customer base of the HMO was approximately 7,400.

Both our PSN and HMO operations primarily focus on individuals covered by Medicare, the national, federally-administered health insurance program that covers the cost of hospitalization, medical care, and some related health services for U.S. citizens aged 65 and older, qualifying disabled persons and persons suffering from end-staged renal disease. Substantially all of our revenue in the first quarter of 2008 and 2007 was generated by providing services to Medicare beneficiaries through arrangements that require us to assume responsibility to provide and/or manage the care for our customers' medical needs in exchange for a monthly fee, also known as a capitation fee or capitation arrangement.

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

To mitigate our exposure to high cost medical claims, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. Our deductible per customer per year was $125,000 for the HMO for the first 6 months of 2007 and $150,000 thereafter, with a maximum benefit per customer per policy period of $1,000,000. For the PSN the deductibles for 2007 were $40,000 in South Florida and $140,000 in Central Florida, with a maximum benefit per customer per policy period of $1,000,000. The deductible for the PSN in Central Florida increased to $200,000 as of January 1, 2008.

Provider Service Network

We operate the PSN through Metcare of Florida, Inc., our wholly owned subsidiary.

We have two network contracts (the "Humana Agreements") with Humana. Humana is one of the largest participants in the Medicare Advantage program in the United States. Our PSN provides, on a non-exclusive basis, healthcare services to Medicare beneficiaries in Flagler and Volusia counties ("Central Florida") and Palm Beach, Broward and Miami-Dade counties ("South Florida") who have elected to receive benefits under a Humana Medicare Advantage HMO Plan. As of March 31, 2008, the Humana Agreements covered approximately 19,300 Humana Plan Customers in Central Florida and 6,500 Humana Plan Customers in South Florida. Approximately 75.9% of our first quarter 2008 revenue was generated through the Humana Agreements.

We have built our PSN physician network by contracting with primary care physicians for their services and acquiring and operating our own physician practices. Through our Humana Agreements we have established referral relationships with a large number of specialist physicians, ancillary service providers and hospitals throughout South Florida and Central Florida.

Humana directly contracts with CMS and is paid a monthly premium payment for each customer enrolled in a Humana Medicare Advantage Plan. Among other factors, the monthly premium varies by patient, county, age and

severity of health status. Pursuant to the Humana Agreements, the PSN provides or arranges for the provision of covered medical services to each Humana Plan Customer who selects one of the PSN Physicians as his or her primary care physician (a “Humana Participating Customer”). In return for the provision of these medical services, the PSN receives from Humana a fee for each Humana Participating Customer. The fee rates are established by the Humana Agreements and comprise a substantial portion of the monthly premiums received by Humana from CMS with respect to Humana Participating Customers.

In Central Florida, our PSN assumes full responsibility for the provision of all necessary medical care for each Humana Participating Customer, even for services we do not provide directly. In South Florida, the PSN and Humana share in the cost of inpatient hospital services and the PSN assumes full responsibility for the provision of all other medical care provided to the Humana Participating Customers. To the extent the costs of providing such medical care are less than the related premiums received from Humana, our PSN generates a gross profit. Conversely, if medical expense exceeds the premiums received from Humana, our PSN experiences a gross loss.

Effective as of August 1, 2007, the PSN entered into a network agreement (the “CarePlus Agreement”) with CarePlus Health Plans, Inc., a Medicare Advantage HMO in Florida. CarePlus Health Plans, Inc. is a wholly-owned subsidiary of Humana. Pursuant to the CarePlus Agreement, the PSN provides, on a non-exclusive basis, healthcare services to Medicare beneficiaries in nine Florida counties who have elected to receive benefits through CarePlus’ Medicare Advantage plans. The counties covered by the CarePlus Agreement include the South Florida counties in which we provide services to Humana Plan Customers (Palm Beach, Broward and Miami-Dade) as well as Orange, Osceola, Seminole, Pasco, Pinellas and Hillsborough counties. As of March 31, 2008, the CarePlus Agreement covered approximately 85 CarePlus Participating Customers (as defined below).

Under the CarePlus Agreement, with certain limited exceptions, we are precluded from using the PSN Physicians who provide services to the Humana Participating Customers to provide services to CarePlus Participating Customers. Accordingly, the PSN must (i) locate and contract with new independent primary care physician practices and/or (ii) acquire or establish and operate its own physician practices to service the CarePlus Participating Customers.

CarePlus directly contracts with CMS and is paid a monthly premium payment for each customer (each a “CarePlus Plan Customer”) enrolled in a CarePlus Medicare Advantage Plan. Among other things, the monthly premium varies by patient, county, age and severity of health status. Pursuant to the CarePlus Agreement, the PSN provides or arranges for the provision of covered medical services to each CarePlus Plan Customer who selects one of the PSN Physicians as his or her primary care physician (each a “CarePlus Participating Customer”). In return for the provision of these medical services, the PSN receives a monthly network administration fee for each CarePlus Participating Customer. The PSN will assume full responsibility for the provision of all necessary medical care for each CarePlus Participating Customer, even for services we do not provide directly, effective March 31, 2009.

Substantially all of our PSN’s revenue is generated from the Humana Agreements. We do receive additional revenue in the medical practices we own and operate by providing primary care services to non-Humana Participating Customers on a fee-for-service basis.

Health Maintenance Organization

We operate the HMO through METCARE Health Plans, Inc., our wholly owned subsidiary that was issued a Health Care Provider Certificate ("HCPC") by Florida's Agency for Health Care Administration ("AHCA") on March 16, 2005. The Department of Financial Services, Office of Insurance Regulation ("OIR") approved the HMO's application and a Certificate of Authority to operate a HMO in the State of Florida (“COA”) on April 22, 2005.

Effective July 1, 2005, the HMO entered into a contract with CMS (the “CMS Contract”) to begin offering Medicare Advantage plans to Medicare beneficiaries in six Florida counties - Lee, Charlotte, Sarasota, Martin, St. Lucie and Okeechobee. The HMO began marketing its "AdvantageCare" branded plan in July 2005. Beginning January 1, 2007, the HMO began to provide services in Polk, Glades, Manatee, Marion, Lake and Sumter counties. Effective January 1, 2008, the HMO began to operate in Collier County.

The HMO is required to maintain satisfactory minimum net worth requirements established by the Florida State Office of Insurance Regulation. The HMO is restricted from making dividend payments without appropriate regulatory notifications and approvals or to the extent such dividends would put us out of compliance with statutory capital requirements.

We are continuing to evaluate expanding our HMO business into other counties within Florida. We presently do not provide HMO services in the geographic markets covered by the Humana Agreements. We view our HMO business as an extension of our existing core competencies.

The HMO's revenue is generated by premiums consisting of monthly payments per customer that are established by the CMS Contract through the competitive bidding process. The HMO contracts directly with CMS and is paid a monthly premium payment for each customer enrolled in our Plan. Among other things, the monthly premium varies by patient, county, age and severity of health status. The HMO recorded its first revenue in the third quarter of 2005.

Our HMO continues to require a considerable amount of capital. During 2007, we incurred losses before allocated overhead and income taxes of approximately $10.5 million in connection with the development and operation of the HMO. We contributed approximately $14.2 million to the HMO during 2007, including $6.5 million relating to 2006 operations. In addition, we contributed another $4.5 million to the HMO in the first quarter of 2008 to finance the operations and growth of the HMO. Included in this $4.5 million was $1.9 million related to 2007 operations. We are continuing to commit resources in an effort to increase our HMO customer base. Our future operating results will be impacted by the effectiveness of our sales and marketing efforts in enrolling customers and the HMO's ability to manage medical expenses. We are not in a position to meaningfully estimate when, if ever, the HMO's business will become profitable and/or generate cash from operations and we may be required to fund the development and expansion of the HMO business, including any associated losses, for an extended period of time. We anticipate that the on-going development efforts, reserve requirements and operating costs for our still developing HMO business can be funded by our current resources and projected cash flows from operations until at least December 31, 2008.

CRITICAL ACCOUNTING POLICIES

Critical Accounting Policies

A description of our critical accounting policies is contained in our Annual Report on Form 10-K for the year ended December 31, 2007.

COMPARISON OF RESULTS OF OPERATIONS FOR THE THREE MONTHS ENDED MARCH 31, 2008 AND MARCH 31, 2007

Summary