METROPOLITAN HEALTH NETWORKS INC
Form 10-K
March 27, 2007

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

FORM 10-K

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

For the fiscal year ended December 31, 2006

OR

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

For the transition period from _____ to _____

Commission file number: 0-28456

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

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

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

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

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

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

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

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes |_| No |X|

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of

1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes |X| No |_|

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act.

Large accelerated filer |_| Accelerated filer |X| Non-accelerated filer |_|

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

As of June 30, 2006, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $114,760,624 based on the closing sale price as reported on the American Stock Exchange. This calculation has been performed under the assumption that all directors, officers and stockholders who own more than 10% of our outstanding voting securities are affiliates of the Company.

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

Class	Outstanding at March 1, 2007
Common Stock, $.001 par value per share	50,270,964 shares

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant's definitive proxy statement relating to the 2007 annual meeting of shareholders, which definitive proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

METROPOLITAN HEALTH NETWORKS, INC.

FORM 10-K
For the Year Ended
December 31, 2006

TABLE OF CONTENTS

GENERAL

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

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Some of the discussion under the captions "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations," "Business" and elsewhere in this Form 10-K may include certain "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, including, without limitation, statements with respect to anticipated future operations and financial performance, growth and acquisition opportunity and other similar forecasts and statements of expectation. We intend such statements to be covered by the safe harbor provisions for forward looking statements created thereby. These statements involve known and unknown risks and uncertainties, such as our plans, objectives, expectations and intentions, and other factors that may cause us, or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by the forward-looking statements. Many of these factors are listed in Item 1A"Risk Factors" and elsewhere in this Form 10-K.

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

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

- the PSN's ability to maintain its automatic renewal status related to the Humana Agreements and do so 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, or IBNR, claims; and
- the HMO's ability to renew, maintain or to successfully rebid the agreement with the Center 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.

PART I

ITEM 1 DESCRIPTION OF BUSINESS

Overview

We operate two primary businesses in Florida, a provider service network ("PSN") that provides and arranges for medical care primarily to Humana, Inc. customers and our health maintenance organization ("HMO") which provides healthcare benefits to Medicare beneficiaries in Florida that have selected our plan. As of December 31, 2006, the PSN and the HMO provided healthcare benefits to approximately 25,600 and approximately 3,800 Medicare Advantage beneficiaries, respectively.

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 2006 was generated by providing services to Medicare beneficiaries through arrangements that require us to assume responsibility to provide and/or manage the care for all of our customers' medical needs in exchange for a monthly fee, also known as a capitated 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, especially 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.

We were incorporated in the State of Florida in January 1996, and began operations as a Physician Practice Management Group. Although we thereafter acquired a number of physician practices and ancillary service providers, we abandoned the group practice strategy in late 1999. We acquired a diagnostic laboratory and a pharmacy business in 2000 and 2001, respectively. The laboratory was shut down in 2002 and the pharmacy was sold in November 2003.

The PSN's first contract with Humana Inc. ("Humana") was secured through an acquisition in 1997, and expanded through an additional acquisition in early 1999. Pursuant to this agreement, the PSN contracted with Humana to manage certain designated Humana Medicare Advantage customers in South Florida. In

2000, an additional contract was secured to manage certain designated Humana Medicare Advantage lives in Central Florida. The PSN renegotiated its most significant contract with Humana, covering the Central Florida area, effective January 1, 2003. This renegotiation increased the percentage of Medicare premium the PSN received from Humana and resolved a number of contractual disputes between the PSN and Humana.

Effective July 1, 2005, the HMO commenced operations as a Medicare Advantage HMO. The HMO operates in twelve Florida counties where it markets its "AdvantageCare" branded health plans.

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

Provider Service Network

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 from Humana's Medicare Advantage Plan. As of December 31, 2006, the Humana Agreements covered approximately 19,200 Humana Plan Customers (as defined below) in Central Florida and 6,400 Humana Plan Customers in South Florida. Approximately 86.9% of our total 2006 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. We currently have contracts in place with twenty-eight independent primary care physician practices (individually an "IPA") and we own and operate eight primary care physician practices and one medical oncology physician practice (collectively with the IPAs, the "PSN Physicians"). In addition, 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. See "Business Model - Provider Agreements" for more information regarding the PSN's relationships with PSN Physicians, specialist physicians, ancillary service providers and hospitals.

Humana directly contracts with the Centers for Medicare and Medicaid Services ("CMS") and is paid a fixed monthly premium payment for each customer (each a "Humana Plan Customer") enrolled in Humana's Medicare Advantage Plan. 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 capitated 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 Customer. 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 expenses exceed the premiums received from Humana, our PSN experiences a gross loss.

Substantially all of our PSN's revenue comes 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. Beginning January 1, 2007, the HMO began to provide services in Polk, Glades, Manatee, Marion, Lake and Sumter. The HMO has been marketing its "AdvantageCare" branded plan since July 2005.

The HMO is required to maintain satisfactory minimum net worth requirements established by the Florida State Department of Insurance. 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. Additional information regarding our statutory requirements is set forth in Note 15 to the "Notes to Consolidated Financial Statements" contained in this Form 10-K.

We are continuing to evaluate expanding our HMO business into other counties within Florida. However, we do not intend to 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. The HMO recorded its first revenue in the third quarter of 2005.

Our HMO continues to require a considerable amount of capital. In 2006, we contributed approximately $6.8 million to the HMO to finance the operations and

growth of the HMO. During 2006 and 2005, we incurred losses before allocated overhead and income taxes of approximately $11.7 million and $6.6 million, respectively, in connection with the development and operation of the HMO. 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, 2007.

Additional information regarding our PSN and HMO segments for 2006, 2005 and 2004 is set forth in Note 18 to the "Notes to Consolidated Financial Statements" contained in this Form 10-K.

The Medicare Program and Medicare Managed Care

Medicare

In a report issued in February 2007, CMS estimated that healthcare spending in the United States was $2 trillion or approximately 17% of the gross domestic product in 2006 and would grow to $4 trillion, or 20% of the gross domestic product, by 2016. In the United States, health care outlays have grown faster than the consumer price index. According to CMS, health care outlays are projected to grow at a rate of 6.4% annually between 2007 and 2016. The projected principal drivers for this growth include continued cost-increasing medical innovation, inflation, continued strong demand for prescription drugs and the aging baby-boomer demographic.

The Medicare program has four primary components:

(i) Part A - Medicare Part A covers inpatient hospital, skilled nursing facility, and hospice care. All citizens of the United States are automatically enrolled in Medicare Part A upon reaching the age of 65.

(ii) Part B - Medicare's Part B is optional and is financed largely by monthly premiums paid by individuals enrolled in the program. Medicare Part B covers almost all reasonable and necessary medical services, including doctors' services, laboratory and x-ray services, durable medical equipment (i.e, wheelchairs, hospital beds), ambulance services, outpatient hospital care, home health care, blood and medical supplies. Participants often have the Medicare Part B monthly premium automatically deducted from their Social Security check. The monthly premium of $88.50 per month in 2006 increased to $93.50 in 2007. Medicare Part B had an annual deductible requirement of $124 in 2006; which increased to $131 in 2007. Once the deductible has been met, Medicare Part B generally pays 80% of the Medicare allowable fee schedule and beneficiaries pay the remaining 20%.

(iii) Part C - Medicare Part C is an alternative to the traditional fee-for-service Medicare program. In geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a managed care plan. The current Medicare managed care program was established in 1997 when Congress created Medicare Part C, formerly known as Medicare+Choice and now known as Medicare Advantage.

(iv) Part D - First available in 2006, Medicare Part D permits every Medicare

recipient to select a prescription drug plan. Medicare Part D replaces the transitional prescription drug discount program and replaces Medicaid prescription drug coverage for dual-eligible beneficiaries.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, an individual can choose any licensed physician and use the services of any hospital, healthcare provider, or facility certified by Medicare. CMS reimburses providers if Medicare covers the service and CMS considers it "medically necessary."

Individuals who elect to participate in the Medicare Advantage program receive greater benefits than traditional fee-for-service Medicare beneficiaries, which benefits may include eye exams, hearing aids and routine physical exams. Out-of-pocket costs for the Medicare beneficiary may also be lower. However, in exchange for these enhanced benefits, customers are generally required to use only the services and provider networks offered by the Medicare Advantage plan. This participation of private health plans in the Medicare Advantage Program under full risk contracts began in the 1980's and grew to 6.9 million customers in 1999. According to information provided by the Henry J. Kaiser Family Foundation, after a drop to 5.3 million customers in 2003, the number of enrollees in Medicare Advantage plans in the United States has increased to 8.3 million as of February 2007. Also, since 2003, the number of Medicare Advantage plans in the United States has increased from 285 to 604 as of February 2007. Medicare Advantage plans contract with CMS to provide benefits that exceed those offered under the traditional fee-for-service Medicare program by at least thirty percent in exchange for a fixed premium payment per customer per month from CMS (the "PCPM"). The monthly premium varies based on the county in which the customer resides, as adjusted to reflect the customer's demographics and the individual customer's health status.

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans' customers. CMS has phased in its risk adjustment payment system, originally implemented as part of the Balance Budget Act of 1997 and modified pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. During 2003, risk adjusted payments accounted for only 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional demographic rate book. The portion of risk adjusted payments was increased to 30% in 2004, 50%, in 2005, and 75% in 2006, and increased to 100% in 2007. The risk adjusted payment model bases the CMS reimbursement payments on various clinical and demographic factors including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age, and Medicaid eligibility. CMS requires that all managed care companies capture, collect, and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. Under this system, the risk adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan's customers average gender, age, and disability demographics.

The Medicare Modernization Act

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, known as the Medicare Modernization Act ("MMA"), signed into law in December 2003, provided sweeping changes to the Medicare program. The MMA increased the amount paid to Medicare Advantage plans such as ours and expanded Medicare beneficiary

healthcare options. We believe that the changes enacted by the MMA have enabled Medicare Advantage plans to offer more attractive and comprehensive benefits and increase preventive care to its customers, while also reducing out-of-pocket expenses for beneficiaries. We further believe that these changes will encourage increased enrollment in Medicare managed care plans in the upcoming years.

In addition to generally increasing the rates payable to Medicare Advantage plans from CMS, the MMA, among other things, (i) added the Medicare Part D prescription drug benefit beginning in January 2006, (ii) implemented a competitive bidding process for the Medicare Advantage Program and (iii) provided a limited annual enrollment period.

The MMA made favorable changes to the premium rate calculation methodology and generally provides for program rates that will better reflect the increased cost of medical services provided by managed care organizations to Medicare beneficiaries. CMS has announced that the MMA program rates for 2007 are expected to reflect an average increase of 1.1% over 2006.

Medicare Part D

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

Individuals who are enrolled in a Medicare Advantage that offers drug coverage must receive their drug coverage through their Medicare Advantage prescription drug plan ("MA-PD") and may not enroll in a stand-alone PDP. For example, Humana Plan Customers and the HMO's customers were automatically enrolled in their MA-PDs as of January 1, 2006 unless they affirmatively chose to use another provider's prescription drug coverage. Any customer of a Medicare Advantage Plan that enrolls in a stand-alone PDP is automatically disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare coverage. Beneficiaries who are eligible for both Medicare and Medicaid, known as dual eligible beneficiaries (discussed in greater detail below), who have not enrolled in a MA-PD or a stand-alone PDP have been automatically enrolled by CMS with approved stand-alone PDPs in their region. Medicare Advantage customers have the right to change drug plans, either MA-PD or stand-alone PDP, one time during the open enrollment period. Dual eligible beneficiaries and other customers qualified for the low-income subsidy (LIS) may change plans throughout the year.

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

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

Competitive Bidding Process

Beginning in 2006, CMS began to use a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS's estimated per beneficiary fee-for-service expenses, has been relabeled as the "benchmark" amount, and local Medicare Advantage plans annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas.

If the bid is less than the benchmark for that year, Medicare pays the plan its bid amount, as adjusted, based on its customers risk scores plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans must use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PDs and other supplemental benefits. CMS has the right to audit the use of these proceeds. The remaining 25% of the excess amount will be retained in the statutory Medicare trust fund. If a Medicare Advantage plan's bid is greater than the benchmark, the plan will be entitled to charge a premium to enrollees equal to the difference between the bid amount and the benchmark. For 2006, the county benchmarks were 4.8% greater than the 2005 rates, which is the national growth rate in fee-for-service expenditures. County benchmarks for 2007 are anticipated to be 7.1% greater than 2006 rates.

Enrollment Period

Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. Beginning in 2006, Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, a stand-alone PDP, or traditional fee-for-service Medicare coverage. The initial enrollment period for 2006 was November 15, 2005 through May 15, 2006 for a MA-PD or stand-alone PDP. In addition, beneficiaries had an open election period from January 1, 2006 through June 30, 2006 in which they could make or change an equivalent election. Starting in November 2006 and on a going-forward basis, the annual enrollment period for a stand alone PDP will be from November 15 through December 31 of each year, and enrollment in Medicare Advantage plans will occur from November 15 through March 31 of the subsequent year. Enrollment prior to December 31 will generally be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period is effective the first day of the month following enrollment. After the defined enrollment period ends, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries, others who qualify for special needs plans, and

employer group retirees will be permitted to enroll in or change health plans during the year. In addition, in certain circumstances, such as the bankruptcy of a health plan, CMS may offer a special election period during which the customers effected are allowed to change plans.

The Florida Medicare Advantage Market

Behind only California, which has approximately 4.4 million Medicare eligible beneficiaries, Florida has the second largest Medicare population in the U.S. with an estimated 3.1 million Medicare eligible beneficiaries. At December 31, 2006, California's Medicare Advantage penetration was approximately 32% while Florida's was 22%. We believe that of the approximate 981,000 and 690,000 Medicare eligible individuals in the counties served by our PSN and HMO, approximately 38.1% and 9.6%, respectively, are customers of Medicare Advantage plans. According to the Florida Office of Economic and Demographic Research Florida's Medicare eligible population is expected to grow from 2.8 million per the 2000 census to almost 5.0 million by 2020.

According to CMS, the number of enrollees in PDPs as of January 16, 2007 was 10.98 million, compared to 10.37 million last June, an increase of 5.9%. MA-PD enrollment increased to 6.65 million from 6.04 million, a 10% increase over the same period, while Medicare-Medicaid dual eligible enrollment increased to 6.27 million from 6.07 million during this same period.

Medicare Advantage Penetration in Counties Served By PSN
(CMS data modified January 2006)

Service Area	Medicare Eligibles	Medicare Advantage Penetration	Penetration %
Central Florida	130,000	38,000	29.2%
South Florida	851,000	336,000	39.5%
Total	981,000	374,000	38.1%

Medicare Advantage Penetration in Counties Served By HMO
(Source: CMS Data Modified January 2007)

Service Area	Medicare Eligibles	Medicare Advantage Penetration	Penetration %
Treasure Coast	102,000	10,700	10.5%
Gulf Coast	367,000	29,000	7.9%
Central Florida	268,000	30,700	11.5%
Total	737,000	70,400	9.6%

The Central Florida region for the PSN includes the counties of Flagler and Volusia; the South Florida service area includes the counties of Broward, Miami-Dade and Palm Beach.

The Treasure Coast service area for the HMO includes Martin, St. Lucie, Glades and Okeechobee counties; the Gulf Coast service area includes Charlotte, Lee,

Manatee and Sarasota counties. We began marketing in the Central Florida service area in late 2006 with customers joining the plan effective January 1, 2007. The Central Florida service area includes Polk, Sumter, Lake and Marion counties.

Business Model

Provider Services Network

Our PSN provides and arranges healthcare services to Medicare Advantage beneficiaries who participate in the Medicare Advantage program through Humana. We conduct all of our PSN business operations through Metcare of Florida, Inc., our wholly owned subsidiary.

Humana Agreements

Pursuant to the Humana Agreements, the PSN provides and arranges for the provision of covered medical services to each Humana Participating Customer. Our Humana Agreement covering the Central Florida area (the "Central Florida Humana Agreement") is a global risk agreement and our Humana Agreement covering the South Florida area (the "South Florida Humana Agreement") is a full risk agreement. Pursuant to both Humana Agreements, the PSN receives a capitated fee with respect to each Humana Participating Customer, which fee represents a significant portion that Humana receives with respect to that Humana Plan Customer. Under the Central Florida Humana Agreement, the 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. Under the South Florida Humana Agreement 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 Customer. In accordance with the Humana Agreements, we are required to comply with Humana's general policies and procedures, including Humana's policies regarding referrals, approvals, utilization management and quality assurance.

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

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

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

For the term of the Central Florida Humana Agreement:

- Humana has agreed that it will not, with the exception of one existing service provider, enter into any new global risk agreements for Humana's Medicare Advantage HMO products in the Central Florida area.

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

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

Provider Agreements

Pursuant to our contracts with twenty-two of the twenty-eight IPAs, we pay such IPA providers on a set amount per customer per month and require them to provide all the necessary primary care medical services to Humana Participating Customers. The monthly amount is negotiated and is subject to change based on certain quality metrics under the PSN's Partners In Quality ("PIQ") program, a proprietary care management model that we implemented in 2002. The contracts with the other six IPAs provide for payments on a fee for service basis, pursuant to which the provider is paid only for the services provided.

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

The contracts with our IPAs generally have one-year terms and renew automatically for one-year periods unless either party provides written notice at least 120 days prior to the termination date. The IPA providers, during the

term of their contract with the PSN, and for a period of six months after the expiration or termination of such contract, are generally prohibited from participating in any other PSN, HMO or other agreement which contracts directly or indirectly with the Medicare or Medicaid Program on a capitated or risk basis. The IPA providers are further prohibited during the term and for a period of six months after the expiration of the terms from encouraging or soliciting the Humana Participating Customers to change their primary care provider, disenroll from their health plan, or leave the PSN's network.

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

Claims Processing

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

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

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

PSN Growth Strategy

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

- Increasing the volume of patients treated by the PSN Physicians through enhanced marketing efforts; and
- selectively expanding the PSN's network of providers to include additional physician practices within its existing geographic markets.

Increasing Patient Volume

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

Selectively Expanding Its Network of Physician Practices

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

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

PSN Competition

We believe that there are at least five and fifteen Medicare Advantage plans in the Central Florida and South Florida markets, respectively. It is our understanding that as of December 2006 Humana has enrolled in its Medicare Advantage Plans approximately 55% and 37% of the persons enrolled in Medicare Advantage Plans in Central Florida and South Florida, respectively. We also believe that through our PSN Physicians we provide medical services to approximately 91% and 5% of the Humana Plan Customers in the Central Florida and South Florida markets, respectively.

Some of our direct competitors in the PSN industry are Continucare Corporation, MCCI, Primary Care Associates, Inc., and Island Doctors, are all based and operating in Florida. We believe that Continucare Corporation, MCCI, and Primary Care Associates, Inc. provide PSN services to Humana in South Florida and Island Doctors provides PSN services to Humana in Central Florida. See "RISK FACTORS - Our Industry is Already Very Competitive..."

Health Maintenance Organization

Effective July 1, 2005, the HMO began offering its Medicare Advantage health plan in the Florida counties of Martin, St. Lucie, Okeechobee, Lee, Charlotte and Sarasota. Our Medicare Advantage plan covers Medicare eligible customers who reside at least six months or more in the service area and offers benefits that are better than those offered under traditional Medicare fee-for-service plans. Through our Medicare Advantage Plan, we have the flexibility to offer benefits not covered under traditional fee-for-service Medicare. These benefits are designed to be attractive to seniors and include prescription drug benefits, eye glasses, hearing aids, dental care, over-the-counter drug plans and health club memberships. In addition we offer a "special needs" zero premium, zero co-payment plan to dual-eligible individuals in our markets.

During 2006, the HMO's Medicare Advantage customers, depending on the market, paid either a $0 or $10 monthly premium. Effective January 1, 2007 this amount was reduced to $0 for all customers. In some cases, the HMO customers are subject to co-payments and deductibles, depending upon the market and benefit.

Except in limited cases, including emergencies, our HMO customers are required to use primary care physicians within the HMO's network of providers and generally must receive referrals from their primary care physician in order to see a specialist or ancillary providers.

Pursuant to the CMS Agreement, the HMO has agreed to provide services to Medicare beneficiaries pursuant to the Medicare Advantage program. Under the CMS Agreement, CMS pays the HMO a fixed capitation payment based on the number of customers enrolled, which payment is adjusted for demographic and health risk factors. Inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs are also considered in the calculation of the fixed capitation payment by CMS. The initial term of the CMS Agreement has been renewed to December 31, 2007 and is subject to annual renewal at the election of CMS. Amounts payable under the CMS Agreement are subject to annual revision by CMS. Pursuant to the CMS Agreement, the HMO is required to comply with federal Medicare laws and regulations and the CMS Agreement is subject to termination by CMS in the event of the HMO's noncompliance.

The amount of premiums we receive for each Medicare customer is established by CMS, although it varies according to various demographic factors, including the customer's geographic location, age, and gender, and is further adjusted based on our plans' average risk scores. During the month of December 2006, the premiums we received from CMS across our service areas ranged from approximately $738 to $979 per customer per month. In addition to the premiums payable to us, the CMS Agreement regulates, among other matters, benefits provided, quality assurance procedures, and marketing and advertising for our Medicare products.

To successfully operate the HMO, we believe we will have to continue our development of the following capabilities, among others: medical management, sales and marketing, customer service and regulatory compliance. No assurances can be given that we will be successful in operating this segment of our business despite our allocation of a substantial amount of resources for this purpose. If the HMO does not develop as anticipated or planned, we may have to devote additional managerial and/or capital resources to the HMO, which could limit our ability to manage and/or grow the PSN. There can be no assurances that, if for any reason, we elect to discontinue the HMO business and/or seek to sell such business, we will be able to fully recoup our expenditures to date with respect to the HMO business.

Medical Health Services Management and Provider Networks

One of our primary goals is to arrange for high quality healthcare services for our HMO customers. To achieve our goal of ensuring high quality, cost-effective healthcare, we have established various quality management programs, including disease management and utilization management programs.

The disease management programs are focused on prevention and care and are designed to support the coordination of healthcare intervention, physician/patient relationships and plans of care, preventive care, and patient empowerment with the goal of improving the quality of patient care and controlling related costs. These disease management programs are focused primarily on high-risk care management and the treatment of our chronically ill customers and are designed to efficiently treat patients with specific high risk or chronic conditions such as coronary artery disease, congestive heart failure, diabetes, asthma related conditions, and certain other conditions. In addition to internal disease management efforts, the HMO has engaged disease management companies to educate customers on chronic medical conditions, help them comply

with medication regimens, and counsel customers on healthy lifestyles.

We also have implemented utilization and case management programs to provide more efficient and effective use of healthcare services by our HMO customers. The case management programs are designed to improve outcomes for customers with chronic conditions through standardization, proactive management, coordinating fragmented healthcare systems to reduce duplication, and improve collaboration with physicians. These programs monitor hospitalization, coordinate care, and ensure timely discharge from the hospital. In addition, the HMO uses internal case management programs and contracts with other third parties to manage severely and chronically ill patients. The HMO utilizes on-site critical care intensivists, hospitalists and concurrent review nurses, who manage the appropriate times for outpatient care, hospitalization, rehabilitation or home care.

Additionally, we internally monitor and evaluate, and seek to enhance, the performance of the HMO providers. Our related programs include:

- review of utilization of preventive measures and disease/case management resources and related outcomes;
- customer satisfaction surveys;
- review of grievances and appeals by customers and providers;

- orientation visits to, and site audits of, select providers;
- ongoing provider and customer education programs; and
- medical record audits.

As more fully described below under "Provider Arrangements and Payment Methods," the HMO's reimbursement methods are also designed to encourage providers to utilize preventive care, and the disease and case management services in an effort to improve clinical outcomes.

We believe strong provider relationships are essential to increasing our HMO customer base, improving the quality of care to our HMO customers and making our health plan profitable. We have established comprehensive networks of providers in each of the areas the HMO serves. The HMO seeks providers who have experience in managing the Medicare population, including experience in providing care through a risk-sharing or other relationship with a Medicare Advantage plan. Our goal is to create mutually beneficial and collaborative arrangements with our HMO providers. We believe provider incentive arrangements should not only help us attract providers, but also help align their interests with our objective of providing high-quality, cost-effective healthcare and ultimately encourage providers to deliver a level of care that promotes customer wellness, reduces avoidable catastrophic outcomes, and improves clinical outcomes.

In our efforts to improve the quality and cost-effectiveness of heath care for our HMO customers, we continue to refine and develop new methods of medical management and physician engagement. Two such initiatives are currently underway, the acute care system and post-discharge recovery plan. These initiatives focus on timely outreach and close monitoring of customers identified as high-risk or clinically unstable and the development of a comprehensive recovery plan to stabilize those types of customers.

Generally, the HMO contracts for pharmacy services through an unrelated pharmacy benefits manager, or PBM, who is reimbursed at a discount to the "average wholesale price" for the provision of covered outpatient drugs. In addition, the HMO is entitled to share in the PBM's rebates based on pharmacy utilization relating to certain qualifying medications.

We strive to be the preferred Medicare Advantage partner for providers in each market the HMO serves. In addition to risk-sharing and other incentive-based financial arrangements, we seek to promote a provider-friendly relationship by paying claims promptly, providing periodic performance and efficiency evaluations, providing convenient, web-based access to eligibility data and other information, and encouraging provider input on plan benefits. We also emphasize quality assurance and compliance by periodically reviewing our HMO's networks and providers. By fostering a collaborative, interactive relationship with our providers, we are better able to gather data relevant to improving the health of our customers.

Provider Arrangements and Payment Methods

Our HMO has primarily structured its non-exclusive provider contracts on a fee for service basis. We may also supplement provider payments with incentive arrangements based, in general, on the quality of healthcare delivery. For example, as an incentive to encourage our providers to deliver high quality care for their patients and assist us with our quality assurance and medical management programs, we often seek to implement incentive arrangements whereby we compensate our providers for "quality performance," including increased fee-for-service rates for specified preventive health services and additional payments for providing specified encounter data on a timely basis. We also seek to implement financial incentives relating to other operational matters where appropriate.

In some cases, particularly with respect to contracts between hospitals or health care systems and our HMO, we may be at risk for medical expenses above and beyond a negotiated amount (a so-called "stop loss" provision), which amount is typically calculated by reference to a percentage of billed charges, in some cases back to the first dollar of medical expense. In the case of a Medicare patient who is admitted to a non-contracting hospital, we are only obligated to pay the amount that the hospital would have received from CMS under traditional fee-for-service Medicare.

We believe our HMO's incentive and arrangements with physicians help to align their interests with us and our customers and improve both clinical and financial outcomes. We will continue to seek to implement these arrangements where possible in our HMO's existing and new service areas.

Management Services

The HMO has engaged a third party service provider, HF Administrative Services, Inc. ("HFAS"), to provide various administrative and management services, including, but not limited to, claims processing and adjudication, certain management information services, regulatory reporting and customer services pursuant to the terms of an Administrative Services Agreement (the "Services Agreement").

The HMO compensates HFAS for its management services based upon the number of customers enrolled in the HMO, subject to various monthly minimum payments. The minimum monthly fee was $25,000 per month through July 2006 this fee increased

to $60,000 per month for the remaining term of the Services Agreement. In addition, HFAS is compensated for providing additional programming services on an hourly basis. The initial term of the Services Agreement is for five years ending on June 30, 2010. Thereafter, the Services Agreement is automatically renewable for additional one-year terms unless terminated by either party for any reason upon 180 days notice. During 2006 and 2005, we paid an aggregate of $751,000 and $487,000 to HFAS for services in accordance with the Services Agreement.

Pursuant to the Services Agreements, HFAS verifies claims by the HMO's affiliated providers against the HMO's policies regarding customer eligibility, benefits, referrals and pre-authorizations and makes a determination whether and to what extent to allow such claims using the HMO's guidelines. HFAS provides notice to the HMO of claim denials. The HMO has the right and responsibility within three business days of receipt of a claim denial to independently review such claim and approve, deny or modify the claim, as appropriate. The HMO has access to the management information systems provided and maintained by HFAS for its benefit. In addition, HFAS is required under the Services Agreement to provide the HMO with reports and information regarding claim adjudication.

Either party may terminate the Services Agreement upon prior written notice (with a 30 day opportunity to cure) in the event of the other's material breach of the Services Agreement in any manner, including but not limited to, the HMO's failure to maintain sufficient funds in order for HFAS to pay claims, or in the event the HMO engages in or acquiesce to any act of bankruptcy, receivership or reorganization or in the event either party fails to secure any license, government approval or exemption required by law. See "RISK FACTORS - We Depend on Third Parties to Provide It Crucial Information and Data."

Sales and Marketing Programs

As of December 31, 2006, the HMO's sales force consists of third party agents and internally licensed sales employees. The third party agents are compensated on a commission basis. Medicare Advantage enrollment is generally an individual decision made by the customer. We regularly participate in local community health fairs and events, and seek to become involved with local senior citizen organizations to promote our products and the benefits of preventive care. Our sales and marketing programs are tailored to each of our local service areas and are designed with the goal of educating, attracting, and retaining customers and providers. In addition, the HMO's sales agents and representatives focus their efforts on in-person contacts with potential enrollees. The HMO's marketing efforts also utilize direct mail and print advertising.

Our sales and marketing activities are heavily regulated by CMS and other governmental agencies. For example, CMS has oversight over all marketing materials used by our Medicare Advantage plans and, in some cases, has imposed advance approval requirements with respect to marketing materials. Our sales activities are limited to activities such as conveying information regarding the benefits of preventive care, describing the operations of managed care plans, and providing information about eligibility requirements. The activities of our third-party brokers and agents are also heavily regulated.

Prior to 2006, Medicare beneficiaries could enroll in or change health plans at any time during the year. Commencing in 2006, Medicare beneficiaries have a limited annual enrollment period during which they can choose between a Medicare Advantage plan and traditional fee-for-service Medicare. After this annual enrollment period ends, generally only seniors turning 65 during the year, dual-eligible beneficiaries, Low-Income Subsidy (LIS) beneficiaries, others who qualify for special needs plans, Medicare beneficiaries permanently relocating to another service area, and employer group retirees will be permitted to enroll in or change health plans. See "Industry - The Medicare Modernization Act - Enrollment Period."

Quality Assurance

The HMO has implemented processes designed to ensure compliance with regulatory and accreditation standards. Internal programs that credential providers are designed to help ensure we meet the audit standards of federal and state agencies, including CMS and AHCA, as well as applicable external accreditation standards.

Our providers must satisfy specific criteria, such as licensing, credentialing, patient access, office standards, after-hours coverage, and other factors. Our participating hospitals must also meet specific criteria, including accreditation criteria established by CMS.

HMO Competition

We believe that the Medicare Advantage market is highly competitive. The recent changes in Medicare reimbursement may result in new plans entering the market or existing plans expanding in to new markets or increasing sales and marketing efforts. The new reimbursement may also result in the development of different models, such as Preferred Provider Organizations that could impact the growth of the HMO. There are a number of Medicare Advantage plans being offered to Medicare beneficiaries in the twelve Florida counties where the HMO operates including plans being offered by Vista HealthPlan, Wellcare, Universal Healthcare and Quality Health Plan. As of December 31, 2006, we estimate that we have enrolled approximately 2.8% and .3% of the Medicare eligible customers in the Treasure Coast and Gulf Coast, respectively. See "RISK FACTORS - Our Industry is Already Very Competitive..."

We believe that our HMO has certain strengths which makes it competitive within the markets we serve. Some of the HMO's strengths include:

- Our strong network of physicians and hospitals that provide medical care to our customers.
- Our management experience in non urban Florida counties.
- Our Partners-In-Quality program which rewards physicians for providing quality care to our customers

Insurance

We rely upon insurance to protect us from many business risks, including medical malpractice, errors and omissions and certain significantly higher than average customer medical expenses. Although we maintain insurance of the types and in the amounts that we believe are reasonable, there can be no assurances that the insurance policies maintained by us will insulate us from material expenses and/or losses in the future. See "RISK FACTORS - Claims Relating to Medical Malpractice and Other Litigation...."

Employees

As of December 31, 2006, Metropolitan had 204 full-time employees, 68 of which were employed at our executive offices. Of this total, 115 and 71 were employed by the PSN and the HMO, respectively, with the balance representing corporate administrative employees. None of our employees are covered by a collective bargaining agreement or are represented by a labor union. We consider our

employee relations to be good.

Government Regulation

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

We believe that we are in material compliance with all government regulations applicable to our business. We further believe that we have implemented reasonable systems and procedures to assist us in maintaining compliance with such regulations. Nonetheless, we face a variety of regulatory related risks. See "Risk Factors - Reductions in Government Funding...", "-The MMA Will Materially Impact Our Operations...", "CMS Risk Adjustment Payment System...", "Our Business Activities Are Highly Regulated...", "The Healthcare Industry is Highly Regulated...", "If the HMO Is Required to Maintain Higher Statutory Capital Levels..." and "We Are Required to Comply with Laws..."

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

Federal and State Reimbursement Regulation

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

Federal "Fraud and Abuse" Laws and Regulations

The federal Anti-Kickback Law makes it a criminal felony offense to knowingly and willfully offer, pay, solicit or receive remuneration in order to induce business for which reimbursement is provided under federal health care programs, including without limitation, the Medicare and Medicaid programs. Violations of these laws are punishable by monetary fines, civil and criminal penalties, exclusion from care programs and forfeiture of amounts collected in violation of such laws. The scope of prohibited payments covered by the Anti-Kickback Law is broad and includes economic arrangements involving hospitals, physicians and other health care providers, including joint ventures, space and equipment rentals, purchases of physician practices and management and personal services contracts.

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

Federal False Claims Act

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

Florida Fraud and Abuse Regulations

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

Restrictions on Physician Referrals

Federal regulations under the Social Security Act that restrict physician referrals to health care entities with which they have financial relationships (commonly referred to as the "Stark Law") prohibit certain patient referrals by physicians. Specifically, the Stark Law prohibits a physician, or an immediate family customer, who has a financial relationship with a health care entity, from referring Medicare patients with limited exceptions, to that entity for certain "designated health services". A financial relationship is defined to include an ownership or investment in, or a compensation relationship with, a health care entity. The Stark Law also prohibits a health care entity receiving a prohibited referral from billing the Medicare or Medicaid programs for any services rendered to a patient as a result of the prohibited referral. The Stark Law contains certain exceptions that protect parties from liability if the parties comply with all of the requirements of the applicable exception. The sanctions under the Stark Law include denial and refund of payments, civil monetary penalties and exclusions from participation in the Medicare programs.

Privacy Laws

The privacy, security and transmission of health information is subject to federal and state laws and regulations, including the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA"). Final regulations with respect to the privacy of certain individually identifiable health information (the "Protected Health Information") became effective in April 2003 (the "Privacy Rule"). The Privacy Rule specifies authorized or required uses and disclosures of the Protected Health Information, as well as the rights patients

have with respect to their health information. HIPAA also provides that to the extent that state laws impose stricter privacy standards than the HIPAA privacy rule, such standards are not preempted, requiring compliance with any stricter state privacy law. In addition, in October 2002, the electronic data standards regulations under HIPAA became effective. The final HIPAA security rule became effective in February 2003, and established security standards with respect to Protected Health Information transmitted or maintained electronically. These regulations establish uniform standards relating to data reporting, formatting, and coding that certain health care providers must use when conducting certain transactions involving health information.

Clinic Licensure

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

Occupational Safety and Health Administration ("OSHA")

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

Medicare Marketing Restrictions

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

State Regulation

The HMO is subject to the rules, regulations and oversight by the OIR and AHCA in the areas of licensing and solvency. The HMO files reports with these state agencies describing its capital structure, ownership, financial condition, certain inter-company transactions and business operations. It also is generally required to demonstrate, among other things, that it has an adequate provider network, that its systems are capable of processing provider's claims in a timely fashion and of collecting and analyzing the information needed to manage their business. State regulations also require the prior approval or notice of acquisitions or similar transactions involving a HMO, and of certain transactions between a HMO and its parent or affiliated entities or persons. Generally, HMOs are limited in their ability to pay dividends to their stockholders.

The HMO is required to maintain a minimum level of statutory capital. These requirements assess the capital adequacy of a HMO based upon investment asset risks, insurance risks, interest rate risks and other risks associated with its business to determine the amount of statutory capital believed to be required to support the HMO's business. If the HMO's statutory capital level falls below certain required capital levels, it may be required to submit a capital corrective plan to the state department of insurance, and at certain levels may be subjected to regulatory orders, including regulatory control through rehabilitation or liquidation proceedings.

ITEM 1A. RISK FACTORS

The PSN's Operations are Dependent on Humana, Inc.

The PSN currently derives, and expects to continue to derive, the substantially all of its revenue from its Humana Agreements which provide for the receipt of capitated fees. For the twelve months ended December 31, 2006, approximately 99.2% of the PSN total revenue was obtained from these Humana Agreements. Humana may immediately terminate either of the Humana Agreements and/or any individual physician credentialed under the Humana Agreements upon the occurrence of certain events. Humana may also amend the material terms of the Humana Agreements under certain circumstances. See "ITEM 1. BUSINESS - Humana Agreements" for a detailed discussion of the Humana Agreements.

Failure to maintain the Humana Agreements on favorable terms, for any reason, would adversely affect our results of operations and financial condition. A material decline in enrollees in Humana's Medicare Advantage program could also have a material adverse effect on our results of operation.

There Can be No Assurance that We Will be Successful in Our Operation of the HMO.

Although we have operated as a risk provider since 1997, we have only operated the HMO since July 1, 2005. While the HMO's business has continued to grow, such growth has required and is expected to continue to require a considerable amount of require capital. We contributed approximately $6.8 million to the HMO during 2006 and another $6.5 million subsequent to year end to finance the operations and growth of the HMO. In the year ended December 31, 2006, the HMO's business generated an $11.7 million segment loss before allocated overhead and income taxes. We project that in 2007, the HMO's business will continue to generate a loss before allocated overhead and income taxes. The HMO's actual cash needs and losses for 2007 are expected to be strongly influenced by, among other things, the HMO's membership levels and medical expense utilization rates as wells as the scale, cost and effectiveness of various marketing programs we may undertake. We are still 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. Nonetheless, 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, 2007.

To successfully operate the HMO, we believe we will have to continue our development of the following capabilities, among others: sales and marketing, customer service and regulatory compliance. No assurances can be given that we will be successful in operating this segment of our business despite our allocation of a substantial amount of resources for this purpose. If the HMO does not develop as anticipated or planned, we would likely explore strategic alternatives for the business and/or devote additional managerial and/or capital resources to the HMO, which could limit our ability to manage and/or grow the PSN. There can be no assurances that, if for any reason, we elect to discontinue the HMO business and/or seek to sell such business, we will be able to fully recoup our expenditures to date with respect to the HMO business.

The failure of the HMO to perform as projected could also limit our ability to manage and/or grow the PSN. Most of our senior management team provides management, support and assistance to both the HMO and the PSN. To the extent one business consumes a higher than anticipated amount of our executive resources, the other business could suffer.

In our contract with CMS we commit to provide various healthcare services for a

year long period and we must notify CMS by June if we intend not to renew a contract term that commences in January. Accordingly, even if we deemed it economically necessary or desirable to scale back or discontinue operations in one or more HMO service areas, our financial and service commitments to CMS and our customers might preclude us from doing so at the desired rate, which would likely increase our losses associated with such service area. Moreover, we believe there are certain inherent economies of scale associated with our business. Accordingly, any individual decision to scale back or discontinue operations in even part of one service area could have a disproportionately large negative effect on our results of operations.

Because we must elect whether or not to renew our contracts with CMS approximately six months before a service period commences, our ability to accurately project the results of future operations for at least 18 months is very important. Because of the short history of the HMO, it is difficult to accurately make long term projections regarding the HMO business. We have found it especially difficult to precisely budget our customer growth and medical expenses. Although we have implemented a strategy to improve our ability to reduce these planning impediments, we recognize that they may remain significant obstacles to our ability to project the results of the HMO business.

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

The Humana Agreements and the CMS Agreement are risk agreements under which we receive monthly payments for each Humana Participating Customer and each customer enrolled in our HMO (collectively, the "Participating Customers") at a rate established by the agreements, also called a capitated fee. In accordance with the agreements, the total monthly payment is a function of the number of Participating Customers, regardless of the actual utilization rate of covered services. In return, the PSN or the HMO, as applicable, through its affiliated providers, assumes full financial responsibility for the provision of all necessary medical care to the Participating Customers, regardless of whether or not its affiliated providers directly provide the covered medical services.

To the extent that the Participating Customers require more care than is anticipated, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of such Participating Customers. If medical expenses exceed our estimates, except in very limited circumstances, we will be unable to increase the premiums received under these contracts during the then-current terms.

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

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

- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies,

including pharmaceuticals, whether as a result of inflation or otherwise;

- changes to mandated benefits or other changes in healthcare laws, regulations, and practices;
- Humana's periodic renegotiation of provider contracts with specialist physicians, hospitals and ancillary providers;
- periodic renegotiation of contracts with our affiliated primary care physicians;
- changes in the demographics of our customers and medical trends affecting Medicare risk scores;
- contractual or claims disputes with providers, hospitals, or other service providers within the Humana network; and
- the occurrence of catastrophes, major epidemics, or acts of terrorism.

We attempt to control these costs through a variety of techniques, including capitation and other risk-sharing payment methods, collaborative relationships with primary care physicians and other providers, advance approval for hospital services and referral requirements, case and disease management and quality assurance programs, information systems, and reinsurance. Despite our efforts and programs to manage our medical expenses, we may not be able to continue to manage these expenses effectively in the future.

If Our HMO Contracts Are Not Renewed or Are Terminated, the HMO's Business Would Be Negatively Impacted.

A new CMS Agreements was entered into effective January 1, 2007 and expires on December 31, 2007. Pursuant to the CMS Agreement, the HMO is required to comply with federal Medicare laws and regulations, and the CMS Agreement is subject to termination by CMS in the event of the HMO's noncompliance. If the HMO is unable to renew or to successfully rebid for the CMS Agreement, or if the CMS Agreement is terminated, its business would be negatively impacted.

Reductions in Government Funding for Medicare Programs Could Adversely Affect Our Results of Operations

Substantially all of our revenue is directly or indirectly derived from reimbursements generated by Medicare Advantage health plans. As a result, our revenue and profitability are dependent on government funding levels for Medicare Advantage programs. The Medicare programs are subject to statutory and regulatory changes, retroactive and prospective rate adjustments, administrative rulings, and funding restrictions, any of which could have the effect of limiting or reducing reimbursement levels. These government programs, as well as private insurers such as Humana, have taken and may continue to take steps to control the cost, use and delivery of health care services. Any changes that limit or reduce Medicare reimbursement levels could have a material adverse effect on our business. For example, the following events could result in an adverse effect on our results of operations:

- 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.

The MMA Will Materially Impact Our Operations and Could Reduce Our Profitability and Increase Competition for Customers.

The MMA substantially changed the Medicare program and is complex and wide-ranging. While many of these changes will generally benefit the Medicare Advantage sector, certain provisions of the MMA may increase competition, create challenges with respect to educating the PSN's and the HMO's existing and potential customers about the changes, and create other risks and substantial and potentially adverse uncertainties, including the following:

- Increased reimbursement rates for Medicare Advantage plans could result in a further increase in the number of plans that participate in the Medicare program. This could create new competition that could adversely affect the number of customers the PSN or the HMO serve and their respective results of operations.
- Managed care companies began offering various new products in 2006 pursuant to the MMA, including regional preferred provider organizations, or PPOs, and private fee-for-service plans. Medicare PPOs and private fee-for-service plans allow their customers more flexibility in selecting physicians than Medicare Advantage HMOs, which typically require customers to coordinate with a primary care physician. The MMA has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost-reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. It is too early to determine whether the formation of regional Medicare PPOs and private fee-for-service plans will affect our PSN's or HMO's relative attractiveness to existing and potential Medicare customers in their service areas.
- The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may directly or indirectly cause the PSN and/or the HMO to decrease the amount of premiums paid to it or cause it to increase the benefits it offers.
- Medicare beneficiaries generally have a more limited annual enrollment period during which they can choose to participate in a Medicare Advantage plan or receive benefits under the traditional fee-for-service Medicare program. After the annual enrollment period, most Medicare beneficiaries will not be permitted to change their Medicare benefits. This "lock-in" may make it difficult for the HMO to retain an adequate sales force. The new annual enrollment process and subsequent "lock-in" provisions of the MMA may adversely affect our level of revenue growth as it will limit the HMO's ability to market to and enroll new customers in its established service areas outside of the annual enrollment period. Such limitations could adversely and materially affect our profitability and results of operations.
- Managed care companies that offer Medicare Advantage plans are

required to offer prescription drug benefits as part of their Medicare Advantage plans. Managed care plans offering drug benefits are, under the new law, called MA-PDs. There is insufficient information to determine whether the governmental payments will be adequate to cover the actual costs for these new MA-PD benefits or whether we will be able to profitably or competitively manage our MA-PDs. Individuals who are enrolled in a Medicare Advantage plan must receive their drug coverage through their Medicare Advantage prescription drug plan. Enrollees may prefer a stand-alone drug plan and may cease to be a Medicare Advantage customer in order to participate in a stand-alone PDP. Accordingly, the new Medicare Part D prescription drug benefit could reduce Participating Customer enrollment and revenue.

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

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish incentives for Medicare plans to enroll and treat less healthy Medicare beneficiaries. CMS is phasing-in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors including hospital inpatient diagnoses, diagnostic data from ambulatory treatment settings, including hospital outpatient facilities and physician visits, gender, age, and Medicaid eligibility. CMS requires that all managed care companies capture, collect, and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. As part of the phase-in, during 2003, risk adjusted payments accounted for 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional CMS demographic rate books. The portion of risk adjusted payments was increased to 30% in 2004, 50% in 2005, and 75% in 2006 and to 100% in 2007. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. In addition, the HMO's and/or Humana's risk scores for any period may result in favorable or unfavorable adjustments to the payments directly or indirectly received from CMS and our Medicare premium revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of related recording diagnostic code information and thereby enhancing its risk scores.

Since 2003, payments to Medicare Advantage plans have also been adjusted by a "budget neutrality" factor that was implemented by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing higher, risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. The Deficit Reduction Act of 2005 which, among other changes, provides for an accelerated phase-out of budget neutrality for risk adjustment of payments made to Medicare Advantage plans. This legislation will have the effect of reducing payments to Medicare Advantage plans in general. Consequently, we expect the premiums we receive could be reduced, dependent upon the HMO's and Humana's risk scores.

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

Our operations and profitability are dependent, in part, upon our ability to contract with healthcare providers and provider networks on favorable terms. In

any particular service area, healthcare providers or provider networks could refuse to contract with us, demand higher payments, or take other actions that could result in higher healthcare costs, disruption of benefits to our customers, or difficulty in meeting our regulatory or accreditation requirements. In some service areas, healthcare providers may have significant market positions. If healthcare providers refuse to contract with us, use their market position to negotiate favorable contracts, or place us at a competitive disadvantage, then our ability to market products or to be profitable in those service areas could be adversely affected. Our provider networks could also be disrupted by the financial insolvency of a large provider group. Any disruption in our provider network could result in a loss of customers or higher healthcare costs.

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

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

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

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

The HMO relies on HFAS, a third party service provider, to provide various administrative and management services, including, but not limited to, claims processing and adjudication, certain management information services, regulatory reporting and customer services pursuant to the terms of the Services Agreement.

Because these services are outsourced as opposed to performed internally, we have less control over the manner in which these matters are handled and the accuracy and timeliness of the data provided to us than if we handled these functions internally. Additionally, any loss of information by Humana or HFAS could have a material adverse effect on our business and the results of its operations.

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

From time to time, we are a party to various litigation matters, some of which seek monetary damages. Managed care organizations may be sued directly for alleged negligence, including in connection with the credentialing of network providers or for alleged improper denials or delay of care. In addition, providers affiliated with the PSN or the HMO involved in medical care decisions

may be exposed to the risk of medical malpractice claims. A small percentage of these providers do not have malpractice insurance. As a result of increased costs or inability to secure malpractice insurance, the percentage of physicians who do not have malpractice insurance may increase. Although most of its network providers are independent contractors, claimants sometimes allege that a PSN and/or HMO should be held responsible for alleged provider malpractice, particularly where the provider does not have malpractice insurance, and some courts have permitted that theory of liability. Similar to other managed care companies, the HMO may also be subject to other claims of its customers in the ordinary course of business, including claims arising out of decisions to deny or restrict reimbursement for services.

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

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

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

We compete in the highly competitive and regulated health care industry, which is subject to continuing changes with respect to the provisioning of services and the selection and compensation of providers. In 2006, approximately 86.9% of our revenue was generated pursuant to the Humana Agreements. Humana competes with other HMOs and PPOs in securing and serving patients in the Medicare Advantage Program. Companies in other health care industry segments, some of which have financial and other resources comparable to or greater than Humana, may become competitors to Humana. The market in Florida may become increasingly attractive to HMOs and PPOs that may compete with Humana or the HMO. Humana and the HMO may not be able to continue to compete effectively in the health care industry if additional competitors enter the same market.

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

Competitors of our PSN vary in size and scope, in terms of products and services

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

We believe that many of our competitors and potential competitors are substantially larger than our PSN and/or the HMO and have significantly greater financial, sales and marketing, and other resources. We believe that most of our competitors also have more experience operating as an HMO and that these competitors may be able to respond more rapidly to changes in the regulatory environment in which they operate and changes in managed care organization business or to devote greater resources to the development and promotion of their services than we can. Furthermore, it is our belief that some of our competitors may make strategic acquisitions or establish cooperative relationships among themselves.

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

Our success depends, to a significant extent, on the continued contributions of certain of our executive officers and key management personnel. The loss of these individuals could have a material adverse effect on our business, results of operations, financial condition and plans for future development. While we have employment contracts with certain executive officers and key customers of management, these agreements may not provide sufficient incentive for these persons to continue their employment with us. We compete with other companies in the industry for executive talent and there can be no assurance that highly qualified executives would be readily and easily available without delay, given the limited number of individuals in the industry with expertise particular to our business operations.

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

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

- imposing additional license, registration, or capital reserve requirements;
- increasing our administrative and other costs;
- forcing us to undergo a corporate restructuring;
- increasing mandated benefits without corresponding premium increases;

- limiting our ability to engage in inter-company transactions with our affiliates and subsidiaries;
- forcing us to restructure our relationships with providers; or
- requiring us to implement additional or different programs and systems.

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

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

The health care services that we and our affiliated professionals provide are subject to extensive federal, state and local laws and regulations governing various matters such as the licensing and certification of our facilities and personnel, the conduct of our operations, billing and coding policies and practices, policies and practices with regard to patient privacy and confidentiality, and prohibitions on payments for the referral of business and self-referrals. These laws are generally aimed at protecting patients and not our shareholders, and the agencies charged with the administration of these laws have broad authority to enforce them. See "ITEM 1. BUSINESS - Government Regulation" for a discussion of the various federal government and the State laws and regulations to which we are subject.

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

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

geographic expansions, or acquisitions.

The U.S. Department of Health and Human Services Office of the Inspector General, Office of Audit Services, or OIG, conducts reviews of Medicare Advantage plans to determine whether they used payment increases consistent with the requirements of the MMA. Under the MMA, when a Medicare Advantage plan receives a payment increase, it must reduce beneficiary premiums or cost sharing, enhance benefits, put additional payment amounts in a benefit stabilization fund, or use the additional payment amounts to stabilize or enhance access. There can be no assurances that the findings of an audit or investigation of our business would not have an adverse effect on us or require substantial modifications to our operations. In addition, private citizens, acting as whistleblowers, are entitled to bring enforcement actions under a special provision of the federal False Claims Act.

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

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

If the HMO Is Required to Maintain Higher Statutory Capital Levels for Our Existing Operations or if We Are Subject to Additional Capital Reserve Requirements as We Pursue New Business Opportunities, Our Liquidity May Be Adversely Affected.

The HMO is subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, or net worth, and restrict the payment of dividends without appropriate regulatory notification and approvals.

At December 31, 2006, all of the HMO's cash and cash equivalents are subject to the restriction on the payment of dividends. The State of Florida may raise the statutory capital level from time to time. Other states have adopted risk-based capital requirements based on guidelines adopted by the National Association of Insurance Commissioners, which tend to be, although are not necessarily, higher than existing statutory capital requirements. Regardless of whether Florida adopts risk-based capital requirements, the Florida Department of Insurance can require the HMO to maintain minimum levels of statutory capital in excess of amounts required under the applicable state laws if it determines that maintaining additional statutory capital is in the best interests of the HMO's customers. Any increases in these requirements could materially increase our reserve requirements. In addition, as we continue to expand plan offerings in Florida or pursue new business opportunities, the HMO may be required to maintain additional statutory capital reserves. In either case, available funds could be materially reduced, and we could have less capital available to our PSN business operations, both of which could harm our ability to implement our business strategy.

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

Regulations under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, require us to comply with standards regarding the exchange of health information within our company and with third parties, including healthcare providers, business associates and customers. These regulations include standards for common healthcare transactions, including claims information, plan eligibility, and payment information; unique identifiers for providers and employers; security; privacy; and enforcement. HIPAA also provides that to the extent that state laws impose stricter privacy standards than HIPAA privacy regulations, a state seeks and receives an exception from the Department of Health and Human Services regarding certain state laws, or state laws concerning certain specified areas, such state standards and laws are not preempted.

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

Recent Challenges Faced by CMS Related to Implementation of Part D May Temporarily Disrupt or Adversely Affect the PSN's and the HMO's Relationships with their Respective Customers.

Partially in anticipation of the implementation of Part D, CMS transitioned to new information and reporting systems, which has generated confusing and, we believe in some cases, erroneous customer and payment reports concerning Medicare eligibility and enrollment, most of which we believe reflects inadvertently disenrolled dual-eligible and other beneficiaries who were already customers of our PSN or HMO. In addition, recent media reports are prevalent concerning the confusion caused by failures in systems and reporting for Part D, particularly as these failures adversely affect the access of dual-eligibles and low-income beneficiaries to their prescription drugs. These developments could cause us to experience short-term disruptions in our operations and challenge our information and communications systems which could temporarily disrupt or adversely affect the PSN's or the HMO's relationships with their respective customers, resulting in a reduction of our customer base and adversely affecting our operating results.

We May Be Unsuccessful in Implementing Our Growth Strategy If We Are Unable to Expand into New Service Areas in a Timely Manner in Accordance with Our Strategic Plans.

Our strategy is to continue to focus on growth within certain geographic regions of Florida. Continued growth may impair our ability to manage existing operations and provide services efficiently and to manage our employees adequately. Future results of operations could be materially adversely affected if we are unable to manage growth efforts effectively.

We are seeking to continue to increase the PSN and the HMO customer base and to expand to new service areas within our existing markets and in other markets.

We are likely to incur additional costs if the PSN or the HMO enters service areas where it does not currently operate. Our rate of expansion into new geographic areas may also be limited by:

- the time and costs associated with obtaining an HMO license to operate in a new area or expanding the HMO's licensed service area, as the case may be;

- the PSN and/or the HMO's inability to develop a network of physicians, hospitals, and other healthcare providers that meets their respective requirements and those of the applicable regulators;

- competition, which could increase the costs of recruiting customers, reduce the pool of available customers, or increase the cost of attracting and maintaining providers;

- the cost of providing healthcare services in those areas;

- demographics and population density; and

- the new annual enrollment period and lock-in provisions of the MMA.

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

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

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

- special meetings of shareholders may be called only by the Chairman of the Board of Directors, the President or by the Board of Directors pursuant to a resolution adopted by a majority of the directors;

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

- the Board of Directors has the ability to issue up to 10,000,000 shares of preferred stock, with such rights and preferences as may be determined from time to time by the Board of Directors, without shareholder approval.

Our Quarterly Results Will Likely Fluctuate, Which Could Cause the Value of Our Common Stock to Decline.

We are subject to quarterly variations in medical expenses due to sometimes pronounced fluctuations in patient utilization. We have significant fixed operating costs and, as a result, are highly dependent on patient utilization to sustain profitability. Our results of operations for any quarter are not necessarily indicative of results of operations for any future period or full year. For example, we usually experience a greater use of medical services in the winter months. As a result, our results of operations may fluctuate significantly from period to period, which could cause the value of our Common Stock to decline.

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

We cannot predict the effect, if any, that future sales or the possibility of future sales may have on the market price of our Common Stock. As of December 31, 2006, there were approximately 50.3 million shares of our Common Stock outstanding, all of which are freely tradable without restriction or tradable in accordance with Rule 144 of the Securities Act with the exception of approximately 15.9 million shares, owned by certain of our officers, directors and affiliates which may be sold publicly at any time subject to the volume and other restrictions promulgated pursuant to Rule 144 of the Securities Act. In addition, as of December 31, 2006, approximately 5.2 million shares of our Common Stock were reserved for issuance upon the exercise of options which were previously granted and 355,000 shares of our Common Stock were reserved for future issuance upon conversion of the Series A Preferred Stock.

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

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

increase our shareholders' risk of loss because of such illiquidity and because the price for our Common Stock may suffer greater declines because of our price volatility.

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

Our Common Stock is listed on the AMEX. To maintain listing of securities, the AMEX requires satisfaction of certain maintenance criteria that we may not be able to continue to be able to satisfy. If we are unable to satisfy such maintenance criteria in the future and we fail to comply, our Common Stock may be delisted from trading on AMEX. If our Common Stock is delisted from trading on AMEX, then trading, if any, might thereafter be conducted in the over-the-counter market in the so-called "pink nt style="DISPLAY: inline; FONT-SIZE: 10pt; FONT-F

30

32

Net loss

$
(226
)

$
(56
)

$
(473
)

$
(525
)

Net loss per share, basic and diluted	$ (.07)	$ (.02)	$ (.15)	$ (.17)
Weighted average shares, basic	3,091,000	3,091,000	3,091,000	3,091,000
Weighted average shares, diluted	3,091,000			

3,091,000

3,091,000

3,091,000

See accompanying notes.

ARC Wireless Solutions, Inc.
Condensed Consolidated Statements of Cash Flows
(Unaudited, in thousands)

	Nine Months Ended September 30,	
	2011	2010
Operating activities		
Net loss from operations	$(473)	$(525)
Adjustments to reconcile net loss from operations to net cash provided by (used in) operating activities:		
Depreciation and amortization	142	154
Non-cash stock compensation	24	24
Provision for doubtful accounts	5	-
Changes in operating assets and liabilities:		
Accounts receivable, trade	196	88
Inventory	19	252
Prepaids and other current assets	7	16
Other assets	(4)	(13)
Accounts payable and accrued expenses	(255)	(360)
Net cash used in operating activities	(339)	(364)
Investing activities		
Patent acquisition costs	(12)	(10)
Purchase of plant and equipment	(87)	(83)
Proceeds from sale of plant and equipment	-	18
Net cash used in investing activities	(99)	(75)
Financing activities		
Net repayment of line of credit and capital lease obligations	(29)	-
Net cash used in financing activities	(29)	-
Net decrease in cash	(467)	(439)
Cash and cash equivalents, beginning of year	11,643	11,785
Cash and cash equivalents, end of quarter	$11,176	$11,346

See accompanying notes.

ARC Wireless Solutions, Inc.
Notes to Condensed Consolidated Financial Statements
September 30, 2011

Note 1. Basis of Presentation

The accompanying unaudited condensed consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States for interim financial information and pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, they do not include all of the information and footnotes required by accounting principles generally accepted in the United States for complete financial statements. In the opinion of management, the accompanying unaudited consolidated condensed financial statements contain all of the normal recurring adjustments necessary to present fairly the financial position of the Company as of September 30, 2011, the results of its operation and its cash flows for the three months and nine months then ended. For further information, refer to the financial statements and footnotes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2010.

During the periods presented in the unaudited consolidated condensed financial statements, the Company operated in one business segment which is identified as Manufacturing which offers a wide variety of wireless components and network solutions to service providers, systems integrators, value added resellers, businesses and consumers, primarily in the United States.

Operating results for the three months and nine months ended September 30, 2011 are not necessarily indicative of the results to be expected for the full year or any future period.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of ARC Wireless Solutions, Inc. ("ARC"), and its wholly-owned subsidiary corporations, Starworks Wireless Inc. ("Starworks" or "Kit") and ARC Wireless Hong Kong Limited ("ARCHK"). All material intercompany accounts, transactions, and profits have been eliminated in consolidation. In 2010 management determined ARCHK, our wholly-owned subsidiary, was no longer necessary and operations were terminated. ARCHK primarily managed our own China production operations which was no longer required when we transitioned to utilizing the manufacturing, product sourcing, and outsourcing services of Rainbow Industrial Limited ("RIL") during the third quarter of 2010, as described in Note 5.

Basis of Presentation

The Company has experienced recurring losses and has accumulated a deficit of approximately $9 million since inception in 1989. There can be no assurance that the Company will achieve the desired result of net income and positive cash flow from operations in future years. Management believes that current working capital will be sufficient to allow the Company to maintain its operations through September 30, 2012 and into the foreseeable future.

Use of Estimates

The preparation of the Company's consolidated condensed financial statements in accordance with generally accepted accounting principles of the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from these estimates.

Cash and Cash Equivalents

We consider all highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents. From time to time we have cash balances in excess of federally insured amounts. We maintain our cash balances with several financial institutions.

Fair Value of Financial Instruments

The Company's short-term financial instruments consist of cash, money market accounts, accounts receivable, accounts payable and accrued expenses. The carrying amounts of these financial instruments approximate fair value because of their short-term maturities. Financial instruments that potentially subject the Company to a concentration of credit risk consist principally of cash and accounts receivable.

The Company does not hold or issue financial instruments for trading purposes nor does it hold or issue interest rate or leveraged derivative financial instruments.

Accounts Receivable

Trade receivables consist of uncollateralized customer obligations due under normal trade terms which normally require payment within 30 days of the invoice date. Management reviews trade receivables periodically and reduces the carrying amount by a valuation allowance that reflects management's best estimate of the amount that may not be collectible. The provision for doubtful accounts was $0 at December 31, 2010 and $5 thousand at September 30, 2011. Bad debt expense for the three months and nine months ended September 30, 2011 was $5 thousand and $0 for the three months and nine months ended September 30, 2010.

Income Taxes

The Company accounts for income taxes pursuant to Accounting Standards Codification ("ASC") 740, Income Taxes, which utilizes the asset and liability method of computing deferred income taxes. The objective of this method is to establish deferred tax assets and liabilities for any temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities at enacted tax rates expected to be in effect when such amounts are realized or settled. The current and deferred tax provision is allocated among the members of the consolidated group on the separate income tax return basis.

ASC 740 also provides detailed guidance for the financial statement recognition, measurement and disclosure of uncertain tax positions recognized in the financial statements. Tax positions must meet a "more-likely-than-not" recognition threshold at the effective date to be recognized. During the three months and nine months ended September 30, 2011 and 2010, the Company recognized no adjustments for uncertain tax positions.

The Company recognizes interest and penalties related to uncertain tax positions in income tax expense. No interest and penalties related to uncertain tax positions were recognized at September 30, 2011 and December 31, 2010. The Company expects no material changes to unrecognized tax positions within the next twelve months.

Reclassifications

Certain balances in the prior year consolidated financial statements have been reclassified in order to conform to the current year presentation. The reclassifications had no effect on financial condition, gross profit, or net loss.

Note 2. Share-Based Compensation

The Company accounts for share-based payments pursuant to ASC 718, Stock Compensation and, accordingly, the Company records compensation expense for share-based awards based upon an assessment of the grant date fair value for stock options and restricted stock awards.

Stock compensation expense for stock options is recognized on a straight-line basis over the vesting period of the award. The Company accounts for stock options as equity awards.

The following table summarizes share-based compensation expense recorded in selling, general and administrative expenses during each period presented (in thousands):

	Three Months Ended		Nine Month Ended	
	September 30, 2011	September 30, 2010	September 30, 2011	September 30, 2010
Stock options	$ 8	$ 8	$ 24	$ 24
Total share-based compensation expense	$ 8	$ 8	$ 24	$ 24

Stock option activity was as follows:

	Number of Shares	Weighted Average Exercise Price ($)
Balance at January 1, 2011	40,000	$ 5.40
Granted	-	-
Exercised	-	-
Forfeited or expired	(40,000)	$ (5.40)
Balance at September 30, 2011	-	-

The following table presents information regarding options outstanding and exercisable as of September 30, 2011:

Weighted average contractual remaining term - options outstanding	-
Aggregate intrinsic value - options outstanding	-
Options exercisable	-
Weighted average exercise price – options exercisable	-
Aggregate intrinsic value - options exercisable	-
Weighted average contractual remaining term - options exercisable	-

There were no options granted or exercised during the three months or nine months ended September 30, 2011.

As of September 30, 2011, there was no future compensation costs related to nonvested stock options.

Note 3. Earnings Per Share

Basic earnings (loss) per share includes no dilution and is computed by dividing income available to common stockholders by the weighted average number of common shares outstanding for the period. Diluted earnings (loss) per share, reflects the potential dilution of securities that could share in the earnings of the entity. For periods where

the Company has incurred a net loss, stock options were not included in the computation of diluted loss per share because their effect was anti-dilutive, therefore, basic and fully diluted loss per share are the same for those periods.

The following table represents a reconciliation of the shares used to calculate basic and diluted earnings (loss) per share for the respective periods indicated (in thousands, except per share amounts):

	For the Three Months Ended September 30,					
	2011			2010		
	Net Loss Attributed to Common Stock	Weighted Average Shares	Per Share Loss	Net Loss Attributed to Common Stock	Weighted Average Shares	Per Share Loss
Basic EPS:						
Net Loss	$(226)	3,091	$(.07)	$(56)	3,091	$(.02)
Effect of Dilutive Securities						
Employee stock options	-	-	-	-	-	-
Diluted loss per share	$(226)	3,091	$(.07)	$(56)	3,091	$(.02)

	For the Nine Months Ended September 30,					
	2011			2010		
	Net Loss Attributed to Common Stock	Weighted Average Shares	Per Share Loss	Net Loss Attributed to Common Stock	Weighted Average Shares	Per Share Loss
Basic EPS:						
Net Loss	$(473)	3,091	$(.15)	$(525)	3,091	$(.17)
Effect of Dilutive Securities						
Employee stock options	-	-	-	-	-	-
Diluted loss per share	$(473)	3,091	$(.15)	$(525)	3,091	$(.17)

Note 4. Inventory

Commencing January 1, 2011, inventory is valued at the lower of cost or market using first in first out (FIFO) which approximate average cost, due to the rapid turnover of inventory. The Company previously valued its inventory at lower of cost or market using standard cost which approximated average cost, and as such, the change is not considered a change in accounting. Inventories are reviewed periodically and items considered to be slow-moving or obsolete are reduced to estimated net realizable value through an appropriate reserve. At September 30, 2011 and December 31, 2010, the inventory reserve was $72 and $64 thousand, respectively. Inventory consists of the following amounts (in thousands):

	September 30, 2011	December 31, 2010
Raw materials	$ 52	$ 58
Work in progress	-	-
Finished goods	548	554
Subtotal	600	612
Inventory reserve	(72)	(64)
Net inventory	$ 528	$ 548

Note 5. Related Party Transactions

In 2009, the Company entered into a financial advisory engagement (the "Agreement") with Quadrant Management, Inc. (the "Advisor"). Quadrant Management, Inc. is under common control with Brean Murray Carret Group, Inc. ("Brean"), an entity that, together with a current director of the Company, beneficially owns approximately 1,121,354 shares, or approximately 36.3%, of the Company's common stock at September 30, 2011. The Company's former Chief Executive Officer has been a Managing Director at Quadrant Management, Inc. since 2005. The Company's current Chief Executive Officer is a Managing Director at Quadrant Management, Inc. since January 2008.

Pursuant to the Agreement, the Advisor provides to ARC financial advisory and business consulting services, including restructuring services. In consideration for the restructuring services which have been provided by the Advisor and for the ongoing services to be provided, ARC agreed to pay the following: 1) an initial cash fee of $250 thousand upon signing the Agreement in January 2009; 2) during 2009 and future years, ARC will pay an annual fee of the greater of (i) $250 thousand or (ii) 20% of any increase in reported earnings before interest, taxes, depreciation and amortization after adjusting for one-time and non-recurring items ("EBITDA") for the current financial year over preceding year, or (iii) 20% of reported EBITDA for the current financial year, and; 3) all reasonable out-of-pocket expenses incurred by Advisor in performing services under the Agreement. The 2010 annual fee of $250 thousand is included in accrued liabilities at December 31, 2010. Approximately $187 thousand of the 2011 annual fee was included in accrued liabilities at September 30, 2011. The Agreement will expire on December 31, 2013.

During the third quarter of 2010, we began utilizing the manufacturing, product sourcing, and outsourcing services of Rainbow Industrial Limited ("RIL") which is based in China. RIL is wholly owned by an affiliate of Quadrant Management, Inc., which is affiliated with us and our Chief Executive Officer. We purchase goods and services from RIL valued at approximately $200 thousand per month, however the actual dollar amount can vary significantly with normal fluctuations in business activity. At September 30, 2011 we had payables to RIL of approximately $16 thousand.

Note 6. Recent Accounting Pronouncements

In May 2011, the FASB issued ASU No. 2011-04, Fair Value Measurement (ASC Topic 820) — Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs. The amendments in this ASU result in common fair value measurement and disclosure requirements in U.S. GAAP and IFRS. Consequently, the amendments change the wording used to describe many of the requirements in U.S. GAAP for measuring fair value and for disclosing information about fair value measurements. To improve consistency in application across jurisdictions some changes in wording are necessary to ensure that U.S. GAAP and IFRS fair value measurement and disclosure requirements are described in the same way. The ASU also provides for certain changes in current GAAP disclosure requirements, for example with respect to the measurement of level 3 assets and for measuring the fair value of an instrument classified in a reporting entity's shareholders' equity. The amendments in this ASU are to be applied prospectively. For public entities, the amendments are effective during interim and annual periods beginning after December 15, 2011. The adoption of this guidance is not anticipated to have a material impact on our consolidated financial position, results of operations or cash flows.

In May 2011, the FASB issued ASU No. 2011-05, Comprehensive Income (ASC Topic 220) — Presentation of Comprehensive Income. The amendments from this update will result in more converged guidance on how comprehensive income is presented under both U.S. GAAP and IFRS. With this update to ASC 220, an entity has the option to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in a single continuous statement of comprehensive income or in two separate but consecutive statements. In both choices, an entity is required to present each component of net income along with total net income, each component of other comprehensive income along with a total for other comprehensive income, and a total amount for comprehensive income. The amendments in this update do not change the items that must be reported in other comprehensive income or when an item of other comprehensive income must be reclassified to net income, nor does it affect how earnings per share is calculated or presented. Current U.S. GAAP allows reporting entities three alternatives for presenting other comprehensive income and its components in financial statements. One of those presentation options is to present the components of other comprehensive income as part of the statement of changes in stockholders equity. This update eliminates that option. The amendments in this ASU should be applied retrospectively. For public entities, the amendments are effective for fiscal years, and interim periods within those years, beginning after December 15, 2011. The adoption of this guidance is not anticipated to have a material impact on our consolidated financial position, results of operations or cash flows.

In September 2011, the FASB issued amendments to the goodwill impairment guidance which provides an option for companies to use a qualitative approach to test goodwill for impairment if certain conditions are met. The amendments are effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011 (early adoption is permitted). The implementation of amended accounting guidance is not expected to have a material impact on our consolidated financial position and results of operations.

Note 7. Concentration of Credit Risk

One customer accounted for approximately 30% and 23% of the Company’s net sales for the nine months ended September 30, 2011 and 2010, respectively. A reduction, delay or cancellation of orders from this customer or the loss of this customer could significantly reduce the Company’s revenues and operating results. We cannot provide assurance that this customer or any of our current customers will continue to place orders, that orders by existing customers will continue at current or historical levels or that we will be able to obtain orders from new customers.

Note 8. Industry Segment Information

ASC 280, Segment Reporting, requires that the Company disclose certain information about its operating segment where operating segments are defined as components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. Generally, financial information is required to be reported on the basis that is used internally for evaluating segment performance and deciding how to allocate resources to segments. The Company has one reportable segment, Manufacturing, which is a separate business unit that offers a variety of wireless components and network solutions to service providers, system integrators, value added resellers, businesses and consumers, primarily in the United States.

Note 9. Subsequent Events

Management has evaluated the impact of events occurring after September 30, 2011 up to the date of the filing of these condensed consolidated financial statements. These statements contain all necessary adjustments and disclosures resulting from that evaluation.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion is intended to assist you in understanding our business and the results of our operations. It should be read in conjunction with the Consolidated Condensed Financial Statements and the related notes that appear elsewhere in this report as well as our Annual Report on Form 10-K for the year ended December 31, 2010. Certain statements made in our discussion may be forward looking. Forward-looking statements involve risks and uncertainties and a number of factors could cause actual results or outcomes to differ materially from our expectations. These risks, uncertainties, and other factors include, among others, the risks described in our Annual Report on Form 10-K for the fiscal year ended December 31, 2010 filed with the Securities and Exchange Commission, as well as other risks described in this Quarterly Report. Unless the context requires otherwise, when we refer to "we," "us" and "our," we are describing ARC Wireless Solutions, Inc. and its consolidated subsidiaries on a consolidated basis.

BUSINESS OVERVIEW

We focus on wireless broadband technology related to propagation and optimization. We design and develop antennas that extend the reach of broadband and other wireless networks and that simplify the implementation of those networks. We supply our products to public and private carriers, wireless infrastructure providers, wireless equipment distributors, value added resellers and other original equipment manufacturers. Our strategy is focused on enhancing value for our stockholders by increasing revenues while at the same time reducing our overhead.

Growth in product revenue is dependent both on gaining further traction with current and new customers for the existing product portfolio as well as further acquisitions to support our wireless initiatives. Revenue growth for antenna products is correlated to overall global wireless market growth and a portion of our growth in this market has slowed due to the increasing use of fully integrated solutions and the current global economic conditions. We continue to focus on keeping our operational and general costs down in order to improve our gross margins until demand rebounds.

Specific growth areas are last mile wireless broadband Internet delivered over standards-based solutions such as Worldwide Interoperability for Microwave Access ("WiMAX"), WiFi or vendor specific proprietary solutions for point-to-point and point-to-multipoint applications, and industrial automation markets; Global Positioning Systems ("GPS") and Mobile SATCOM solutions for network timing, fleet and asset tracking and monitoring; Machine to machine ("M2M") communications for controlling or monitoring data from devices; and cellular base station antennas to build out or optimize carrier networks.

During the third quarter of 2010, we began utilizing the manufacturing, product sourcing, and outsourcing services of Rainbow Industrial Limited ("RIL") which is based in China. RIL is wholly owned by an affiliate of Quadrant Management, Inc., which is affiliated with us and our Chief Executive Officer. We purchase goods and services from RIL valued at approximately $200 thousand per month; however the actual dollar amount can vary significantly with normal fluctuations in business activity. We use RIL's services because we believe in doing so it may lower our costs and simplify our internal accounting procedures.

Financial Condition

At September 30, 2011, we had approximately $11.5million in working capital, which represents a decrease of approximately $400 thousand from working capital at December 31, 2010 of $11.9 million.

We have seen a decline in orders from customers, both domestically and internationally, as a result of the current economic environment and due to the increasing use of fully integrated solutions rather than the component solutions we offer. While we do not expect this trend to reverse in 2011, we continue our efforts to acquire new customers and update our product portfolio.

Management believes that current working capital will be sufficient to allow us to maintain our operations through September 30, 2012 and into the foreseeable future.

Results of Continuing Operations for the Three Months Ended September 30, 2011 and 2010

Total revenues were approximately $629 thousand for the three months ended September 30, 2011 and $968 thousand for the three months ended September 30, 2010. The decrease in revenues during the three months ended September 30, 2011 compared to the three months ended September 30, 2010 is primarily attributable to general decrease in sales across all product lines.

Gross profit margins were 39% and 38% for the three months ended September 30, 2011 and 2010, respectively. The slight increase in gross margin is primarily due to product mix.

Selling, general and administrative expenses (SG&A) increased 9% to $482 thousand for the three months ended September 30, 2011 as compared to $441 thousand for the three months ended September 30, 2010. SG&A as a percent of total revenues increased from 46% for the three months ended September 30, 2010 to 77% for the three months ended September 30, 2011. The primary reason for the increase in the % of SG&A compared to revenues is the 35% decrease in revenues comparing the three months ended September 30, 2011 to September 30, 2010. Salaries and wages, remains the largest component of SG&A costs, constituting 26% of the total SG&A costs for the three months ended September 30, 2011 and 2010. The majority of the overall increase in SG&A is related to a increase in research and development costs and salary costs. We are continuing our efforts to streamline our operations and reduce costs in other areas.

Other income decreased during the third quarter 2011 to approximately $10 thousand as compared to $12 thousand in the third quarter 2010. The decline is primarily due to decreased interest income as a result of the decline in our cash balances in addition to a decline in interest rates on money market funds where a significant portion of the funds are invested.

There is no provision for income taxes for both the three months ended September 30, 2011 and 2010 due to our net losses for both periods.

Results of Continuing Operations for the Nine Months Ended September 30, 2011 and 2010

Total revenues were approximately $2.3 million for the nine months ended September 30, 2011 and approximately $3.1 million for the nine months ended September 30, 2010. The decrease in revenues during the nine months ended September 30, 2011 compared to the nine months ended September 30, 2010 is primarily attributable to general decrease in broadband wireless sales which was partially offset by an increase in our GPS antenna sales.

Gross profit margins were 34% and 33% for the nine months ended September 30, 2011 and 2010, respectively. The slight increase in gross margin is primarily due to product mix.

Selling, general and administrative expenses (SG&A) decreased 18% to approximately $1.3 million for the nine months ended September 30, 2011 as compared to approximately $1.58 million for the nine months ended September 30, 2010. SG&A as a percent of total revenues increased from 52% for the nine months ended September 30, 2010 to

56% for the nine months ended September 30, 2011. Salaries and wages, remains the largest component of SG&A costs, constituting 28% of the total SG&A costs for the nine months ended September 30, 2011 and 2010. The majority of the overall decrease in SG&A is related to a decrease in salary costs and decreases in US facility costs. We are continuing our efforts to streamline our operations and reduce costs in other areas.

Other income decreased during the nine months ended September 30, 2011 to approximately $30 thousand as compared to $32 thousand in the nine months ended September 30, 2010. The decline is primarily due to decreased interest income as a result of the decline in our cash balances in addition to a decline in interest rates on money market funds where a significant portion of the funds are invested.

There is no provision for income taxes for both the nine months ended September 30, 2011 and 2010 due to our net losses for both periods.

Financial Condition (in thousands of dollars)

	September 30, 2011	December 31, 2010
Current ratio (1)	27.89 to 1	17.72 to 1
Working capital (2)	$ 11,484	$ 11,894
Total debt	$ 427	$ 711
Total cash less debt	$ 10,749	$ 10,932
Stockholders equity	$ 11,833	$ 12,282
Total liabilities to equity	.036 to 1	.05 to 1

(1) Current ratio is calculated as current assets divided by current liabilities.

(2) Working capital is the difference between current assets and current liabilities.

We have a cash balance of $11.176 million at September 30, 2011 and hold no long-term debt outstanding. We believe that we have the ability to provide for operational needs through projected operating cash flow and cash on hand through September 30, 2012.

The net cash used by operating activities was $339 thousand for the nine months ended September 30, 2011 compared to net cash used by operating activities of $364 thousand for the nine months ended September 30, 2010. The primary reason for the change is a reduction in the net loss from operations of $52 thousand comparing the nine months ended September 30, 2011 compared to the nine months ended September 30, 2010.

The net cash used in investing activities was $99 thousand for the nine months ended September 30, 2011 compared to $75 thousand for the nine months ended June 30, 2010, primarily the result of capital expenditures for molds and machinery.

Net cash used in financing activities was $29 thousand for the nine months ended September 30, 2011 and $0 for the nine months ended September 30, 2010.

Off Balance Sheet Arrangements

The Company does not have any off balance sheet arrangements that have or are reasonably likely to have a current or future effect on the Company's financial condition, changes in financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources.

Item 3: Quantitative and Qualitative Disclosures About Market Risk

Pursuant to permissive authority under Regulation S-K, Rule 305, we have omitted Quantitative and Qualitative Disclosures About Market Risk.

Item 4. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

We maintain disclosure controls and procedures that are designed to ensure that information required to be disclosed in our filings with the Securities and Exchange Commission (SEC) is recorded, processed, summarized and reported within the time period specified in the SEC's rules and forms, and that such information is accumulated and communicated to management, including our chief executive and acting chief financial officer, or persons performing similar functions, as appropriate, to allow timely decisions regarding required disclosure based on the definition of "disclosure controls and procedures" as defined in Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the "Exchange Act").

As of the end of the period covered by this report, and under the supervision and with the participation of our management, including our interim Chief Executive Officer and the person performing the similar function as acting Chief Financial Officer, we evaluated the effectiveness of the design and operation of these disclosure controls and procedures. Based on this evaluation and subject to the foregoing, our interim Chief Executive Officer and acting Chief Financial Officer concluded that our disclosure controls and procedures were effective.

Changes in Internal Control over Financial Reporting

There were no changes in the Company's internal control over financial reporting during the quarter ended September 30, 2011 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

None

Item 6. Exhibits

EXHIBIT INDEX

Exhibit Number	Description
3.1	Amended and Restated Articles of Incorporation dated October 11, 2000 (1)
3.2	Bylaws of the Company as amended and restated on March 25, 1998 (2)
10.2	Stock Purchase Agreement, by and among Bluecoral limited, Winncom Technologies Corp. and the Company dated as of July 28, 2006 (3)
10.3	Escrow Agreement, dated July 28, 2006, by and among the Company, Bluecoral Limited and Consumer Title Services, LLC (3)
10.4	Employment Agreement effective January 31, 2008 between the Company and Randall P. Marx (4)
10.5	Employment Agreement effective November 1, 2007 between the Company and Monty R. Lamirato (5)
10.6	Employment Agreement effective November 1, 2007 between the Company and Steve C. Olson (5)
10.7	Employment Agreement effective November 1, 2007 between the Company and Richard L. Anderson (5)
10.8	Separation Agreement effective August 16, 2011 between the Company and Steven C. Olson
31.1 *	Officers' Certifications of Periodic Report pursuant to Section 302 of Sarbanes-Oxley Act of 2002
32.1 *	Officers' Certifications of Periodic Report pursuant to Section 906 of Sarbanes-Oxley Act of 2002

(1) Incorporated by reference from the Company's Form 10-KSB for December 31, 2000 filed on April 2, 2001.
(2) Incorporated by reference from the Company's Form 10-KSB for December 31, 1997 filed on March 31, 1998.
(3) Incorporated by reference from the Company's Form 8-K/A filed on August 2, 2006.
(4) Incorporated by reference from the Company's Form 8-K filed on February 7, 2008.
(5) Incorporated by reference from the Company's Form 8-K filed on November 8, 2007.

* filed herewith

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.

ARC WIRELESS SOLUTIONS, INC.

Date: November 14, 2011

By: /s/ Ted Deinard
Ted Deinard
Interim Chief Executive Officer
Acting Principal Financial Officer