METROPOLITAN HEALTH NETWORKS INC
Form 10-Q
November 08, 2012

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

FORM 10-Q

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

For the quarterly period ended September 30, 2012

OR

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

For the transition period from _____ to _____

Commission file number: 001-32361

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

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

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

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

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

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

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

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

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

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

| Class | Outstanding at October 31, 2012 |
|---|---|
| Common Stock, $.001 par value per share | 44,250,891 shares |

Metropolitan Health Networks, Inc.

Index

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

| | September 30, 2012 (unaudited) | December 31, 2011 |
|---|---|---|
| | (in thousands, except share data) | |
| ASSETS | | |
| CURRENT ASSETS | | |
| Cash and equivalents | $ 53,785 | $ 17,277 |
| Investments, at fair value | 1,010 | 1,003 |
| Due from HMOs, net | 30,306 | 40,241 |
| Deferred income taxes | 1,358 | 949 |
| Prepaid income taxes | 4,992 | 3,717 |
| Prepaid expense and other current assets | 4,968 | 4,936 |
| Current assets held for sale | 4,552 | 4,017 |
| TOTAL CURRENT ASSETS | 100,971 | 72,140 |
| PROPERTY AND EQUIPMENT, net | 21,091 | 20,296 |
| OTHER INTANGIBLE ASSETS, net | 89,171 | 98,731 |
| GOODWILL | 262,610 | 262,610 |
| DEFERRED FINANCING COSTS | 7,735 | 9,882 |
| OTHER ASSETS | 1,350 | 1,100 |
| NON-CURRENT ASSETS HELD FOR SALE | 4,519 | 4,987 |
| TOTAL ASSETS | $ 487,447 | $ 469,746 |
| | | |
| LIABILITIES AND STOCKHOLDERS' EQUITY | | |
| | | |
| CURRENT LIABILITIES | | |
| Accounts payable | $ 774 | $ 907 |
| Accrued payroll and payroll taxes | 5,039 | 6,488 |
| Due to HMO, net | 7,265 | - |
| Accrued expenses | 4,201 | 5,575 |
| Accrued interest payable | 6,703 | 2,434 |
| Current portion of long-term debt | 16,400 | 12,538 |
| Current liabilities held for sale | 1,107 | 956 |
| TOTAL CURRENT LIABILITIES | 41,489 | 28,898 |
| LONG-TERM DEBT, net of current portion and original issue discount of $10.0 million and $12.1 million at September 30, 2012 and December 31, 2011, respectively | 280,510 | 296,025 |
| DEFERRED INCOME TAXES | 37,105 | 40,175 |
| NON-CURRENT LIABILITIES HELD FOR SALE | 2 | 4 |
| TOTAL LIABILITIES | 359,106 | 365,102 |
| COMMITMENTS AND CONTINGENCIES | | |
| | | |
| STOCKHOLDERS' EQUITY | | |
| | | |

| | | |
|---|---|---|
| Preferred stock, par value $.001 per share; 10,000,000 shares authorized; Series A preferred stock, stated value $100 per share; 5,000 issued and outstanding | 500 | 500 |
| Common stock, par value $.001 per share; 80,000,000 shares authorized; 44,206,000 and 43,751,000 issued and outstanding at September 30, 2012 and December 31, 2011, respectively | 44 | 44 |
| Additional paid-in capital | 40,498 | 36,740 |
| Accumulated other comprehensive (loss) | (378) | (110) |
| Retained earnings | 87,572 | 67,470 |
| Non-controlling interests | 105 | - |
| TOTAL STOCKHOLDERS' EQUITY | 128,341 | 104,644 |
| TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY | $ 487,447 | $ 469,746 |

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

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

| | Three Months Ended September 30, | |
|---|---|---|
| | 2012 | 2011 |
| | (unaudited) | (unaudited) |
| | (in thousands, except per share data) | |
| REVENUE | $ 191,147 | $ 92,664 |
| | | |
| MEDICAL EXPENSE | | |
| Medical claims expense | 138,312 | 69,418 |
| Medical practice costs | 14,510 | 4,947 |
| Total Medical Expense | 152,822 | 74,365 |
| GROSS PROFIT | 38,325 | 18,299 |
| | | |
| OPERATING EXPENSES | | |
| Payroll, payroll taxes and benefits | 8,688 | 4,078 |
| General and administrative | 4,604 | 2,048 |
| Marketing and advertising | 387 | 336 |
| Amortization of intangible assets | 3,186 | 96 |
| Total Operating Expenses | 16,865 | 6,558 |
| OPERATING INCOME | 21,460 | 11,741 |
| OTHER (EXPENSE) INCOME: | | |
| Interest expense | (8,072) | - |
| Investment income | 3 | 96 |
| Transaction costs | - | (2,064) |
| Other expense | | (10) |
| Total Other (Expense) Income | (8,069) | (1,978) |
| INCOME FROM CONTINUING OPERATIONS BEFORE INCOME TAXES | 13,391 | 9,763 |
| INCOME TAX EXPENSE | 4,367 | 3,767 |
| INCOME FROM CONTINUING OPERATIONS | 9,024 | 5,996 |
| | | |
| INCOME FROM DISCONTINUED OPERATIONS, net of income tax expense of $149 | 238 | - |
| NET INCOME | 9,262 | 5,996 |
| | | |
| OTHER COMPREHENSIVE LOSS, net of income tax benefit of $14 | (22) | - |
| COMPREHENSIVE INCOME | $ 9,240 | $ 5,996 |
| | | |
| EARNINGS PER SHARE: | | |
| Basic | | |
| Income from continuing operations | $ 0.21 | $ 0.15 |

| | | |
|---|---|---|
| Income from discontinued operations | 0.01 | - |
| Net income | $ 0.22 | $ 0.15 |
| Diluted | | |
| Income from continuing operations | $ 0.20 | $ 0.14 |
| Income from discontinued operations | 0.01 | - |
| Net income | $ 0.21 | $ 0.14 |

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

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

| | Nine Months Ended September 30, | |
|---|---|---|
| | 2012 | 2011 |
| | (unaudited) | (unaudited) |
| | (in thousands, except per share data) | |
| REVENUE | $ 579,805 | $ 284,650 |
| | | |
| MEDICAL EXPENSE | | |
| Medical claims expense | 431,665 | 216,630 |
| Medical practice costs | 43,489 | 13,951 |
| Total Medical Expense | 475,154 | 230,581 |
| GROSS PROFIT | 104,651 | 54,069 |
| | | |
| OPERATING EXPENSES | | |
| Payroll, payroll taxes and benefits | 25,546 | 12,039 |
| General and administrative | 13,686 | 6,389 |
| Marketing and advertising | 771 | 456 |
| Amortization of intangible assets | 9,560 | 289 |
| Total Operating Expenses | 49,563 | 19,173 |
| OPERATING INCOME | 55,088 | 34,896 |
| OTHER (EXPENSE) INCOME: | | |
| Interest expense | (24,434) | - |
| Investment income | 9 | 559 |
| Transaction costs | - | (3,079) |
| Other expense | - | (23) |
| Total Other (Expense) Income | (24,425) | (2,543) |
| INCOME FROM CONTINUING OPERATIONS BEFORE INCOME TAXES | 30,663 | 32,353 |
| INCOME TAX EXPENSE | 11,045 | 12,464 |
| INCOME FROM CONTINUING OPERATIONS | 19,618 | 19,889 |
| | | |
| INCOME FROM DISCONTINUED OPERATIONS, net of income tax expense of $305 | 484 | - |
| NET INCOME | 20,102 | 19,889 |
| | | |
| OTHER COMPREHENSIVE LOSS, net of income tax benefit of $169 | (268) | - |
| COMPREHENSIVE INCOME | $ 19,834 | $ 19,889 |
| | | |
| EARNINGS PER SHARE: | | |
| Basic | | |
| Income from continuing operations | $ 0.45 | $ 0.50 |
| Income from discontinued operations | 0.01 | - |
| Net income | $ 0.46 | $ 0.50 |
| Diluted | | |

| | | | | |
|---|---|---|---|---|
| Income from continuing operations | $ | 0.43 | $ | 0.47 |
| Income from discontinued operations | | 0.01 | | - |
| Net income | $ | 0.44 | $ | 0.47 |

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

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

| | Nine Months Ended September 30, | |
|---|---|---|
| | 2012 (unaudited) | 2011 (unaudited) |
| | (in thousands) | |
| CASH FLOWS FROM OPERATING ACTIVITIES: | | |
| Net income | $ 20,102 | $ 19,889 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | |
| Depreciation and amortization | 12,310 | 1,062 |
| Amortization of debt issuance costs and original issue discount | 3,877 | - |
| Share-based compensation expense | 2,749 | 1,941 |
| Excess tax benefits from stock-based compensation | (1,485) | (600) |
| Deferred income taxes | (3,308) | 300 |
| Other | 106 | 12 |
| Changes in operating assets and liabilities: | | |
| Due from HMOs, net | 9,934 | (3,751) |
| Prepaid income taxes | 210 | - |
| Prepaid expenses and other current assets | (32) | 347 |
| Change in net assets held for sale | 82 | - |
| Other assets | (250) | 111 |
| Accounts payable | (133) | 742 |
| Accrued payroll and payroll taxes | (1,448) | (2,208) |
| Due to HMO, net | 7,265 | - |
| Accrued expenses | (1,375) | 712 |
| Income taxes payable | - | 88 |
| Accrued interest payable | 4,269 | - |
| Net cash provided by operating activities | 52,873 | 18,645 |
| | | |
| CASH FLOWS (USED IN) PROVIDED BY INVESTING ACTIVITIES: | | |
| Capital expenditures | (3,548) | (3,162) |
| Cash paid for physician practices acquired, net of cash acquired | | (975) |
| Sale (purchase) of short-term investments | (7) | 37,970 |
| Net cash (used in) provided by investing activities | (3,555) | 33,833 |
| | | |
| CASH FLOWS (USED IN) PROVIDED BY FINANCING ACTIVITIES: | | |
| Repayments of long-term debt | (13,820) | (418) |
| Excess tax benefits from stock-based compensation | 1,485 | 600 |
| Deferred financing costs | - | (1,760) |

| | | | | |
|---|---|---|---|---|
| Reduction of restricted cash and investments | | - | | 1,385 |
| Stock issue costs | | - | | (127) |
| Stock repurchases | | - | | (321) |
| Proceeds from exercise of stock options, net | | (475) | | (52) |
| Net cash (used in) financing activities | | (12,810) | | (693) |
| NET INCREASE IN CASH AND EQUIVALENTS | | 36,508 | | 51,785 |
| CASH AND EQUIVALENTS - beginning of period | | 17,277 | | 10,596 |
| CASH AND EQUIVALENTS - end of period | $ | 53,785 | $ | 62,381 |
| | | | | |
| Supplemental Disclosure of Non-Cash Investing and Financing Activities: | | | | |
| Issuances of notes payable for physician practice acqusitions | $ | - | $ | 670 |

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

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

NOTE 1 - UNAUDITED INTERIM INFORMATION

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

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

For further information, refer to the audited consolidated financial statements and footnotes thereto included in the Company's Annual Report on Form 10-K for the year ended December 31, 2011. The accompanying December 31, 2011 condensed consolidated balance sheet, which has been retrospectively reclassified to reflect the assets and liabilities of the sleep diagnostic business as held for sale (See Note 5), has been derived from those audited financial statements. These interim condensed consolidated financial statements should be read in conjunction with the audited consolidated financial statements and notes to the condensed consolidated financial statements included in that report.

We have reclassified $2.1 million and $3.1 million of transaction costs related to the Continucare Corporation ("Continucare") acquisition from general and administrative expense to other (expense) income in the condensed consolidated statements of income and comprehensive income for the three and nine months ended September 30, 2011, respectively, to conform to the presentation for the full year ended December 31, 2011.

NOTE 2 – PROPOSED MERGER TRANSACTION

On November 3, 2012, we entered into an Agreement and Plan of Merger (the "Merger Agreement") with Humana Inc., a Delaware corporation ("Humana"), and Miner Acquisition Subsidiary, Inc., a Florida corporation and a wholly-owned subsidiary of Humana ("Merger Subsidiary"). The Merger Agreement provides that, upon the terms and subject to the conditions set forth in the Merger Agreement, Merger Subsidiary will merge with and into the Company (the "Merger"), with the Company surviving the Merger as a wholly-owned subsidiary of Humana.

Pursuant to the terms of the Merger Agreement, at the effective time of the Merger, each issued and outstanding share of our common stock (other than shares owned by us, Humana or Merger Subsidiary, or any of their respective subsidiaries) will be converted into the right to receive $11.25 in cash, without interest and less any required

withholding taxes. Prior to the effective time of the Merger, each outstanding option to purchase shares of our common stock will become fully vested and exercisable and will be cancelled in exchange for the right to receive an amount in cash equal to the product of (1) the total number of shares of our common stock subject to such option, multiplied by (2) the excess, if any, of $11.25 over the exercise price per share of such option, without interest and less any required withholding taxes. Immediately prior to the effective time of the Merger, each restricted share of our common stock will become fully vested and will be converted into the right to receive $11.25 in cash, without interest and less any required withholding taxes.

The Merger Agreement contains customary covenants, including covenants requiring each of the parties to use its commercially reasonable efforts to cause the transactions contemplated by the Merger Agreement to be consummated. The Merger Agreement also contains covenants requiring us to call and hold a meeting of our shareholders for the purpose of voting to adopt and approve the Merger Agreement and the Merger.

Under the Merger Agreement, if the Merger Agreement is terminated in certain circumstances, including because our Board of Directors has changed its recommendation that our shareholders approve and adopt the Merger Agreement and the Merger or because we have entered into a definitive agreement (or announced our intention to enter into a definitive agreement) to be acquired by an entity other than Humana or one of its affiliates, we will be required to pay to Humana a termination fee of $16 million and reimburse Humana for up to $5.3 million of its and Merger Subsidiary’s out-of-pocket expenses incurred in connection with the Merger.

The consummation of the Merger is subject to certain conditions, including (1) the affirmative vote of a majority of the outstanding shares of our common stock in favor of the approval and adoption of the Merger Agreement and the Merger; (2) the expiration or termination of applicable waiting periods under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended (the “HSR Act”); (3) the absence of any law, order, injunction or other prohibition that restrains, enjoins, prevents or makes illegal the consummation of the Merger; (4) subject to certain materiality exceptions, the accuracy of the representations and warranties of each party contained in the Merger Agreement; (5) the performance by each party in all material respects of its covenants in the Merger Agreement; and (6) the absence of any change, effect, development or event between November 3, 2012 and consummation of the Merger that has had or would reasonably be expected to result in a material adverse effect on the Company.

The Merger is expected to close by the end of the first quarter of 2013.

NOTE 3 - ORGANIZATION AND BUSINESS ACTIVITY

Our primary business is the operation of our provider services network ("PSN") primarily through our wholly owned subsidiaries, Metcare of Florida, Inc. and Continucare, the latter of which we acquired on October 4, 2011. Prior to 2012, the PSN provided and arranged for the provision of healthcare services to Medicare Advantage, Medicaid and commercially insured customers only in Florida. In 2012, the PSN expanded its operations to include Ohio, Kentucky and Indiana. At September 30, 2012, we operated the PSN through 33 wholly-owned primary care practices, a wholly-owned oncology practice and contracts with independent physician affiliates (each an "IPA"). As of September 30, 2012, the PSN operated throughout the Florida market including the cities of Miami, Ft. Lauderdale, West Palm Beach, Tampa, Daytona and Pensacola, as well as the Cincinnati, Ohio / Northern Kentucky and Indianapolis, Indiana markets.

In August 2012, we formed a joint venture with Humana through which we have begun to operate in the Cincinnati, Ohio / Northern Kentucky and Indianapolis, Indiana markets. The joint venture, Symphony Health Partners - Midwest, LLC ("Symphony") is owned by our wholly-owned subsidiary, Symphony Health Partners, Inc. and Humana, with Symphony Health Partners, Inc. being the majority owner.

In August 2012, Symphony entered into two new agreements with Humana. Pursuant to one of these agreements, which was effective retroactive to January 1, 2012, Symphony has agreed to manage the provision of healthcare services to Humana Medicare Advantage members in the Cincinnati, Ohio / Northern Kentucky market. There were approximately 7,900 Participating Customers covered under this agreement at September 30, 2012. Through 2013, Symphony is entitled to receive a monthly administrative fee based on the number of Humana Medicare Advantage members covered under the agreement and a percentage of the surplus, if any, generated under the agreement. Symphony is expected to assume partial medical risk for the members covered under the agreement in 2014 and is expected to assume substantially all medical risk for such members in 2015 and thereafter.

Pursuant to the second agreement, which was effective as of August 1, 2012, Symphony has agreed to manage the provision of healthcare services to Humana Medicare Advantage members in the Indianapolis, Indiana market. There were approximately 2,000 Participating Customers covered under this agreement at September 30, 2012. Through 2013, Symphony is entitled to receive a monthly administrative fee based on the number of Humana Medicare Advantage members covered under the agreement and a percentage of the surplus, if any, generated under the agreement. Symphony is expected to assume partial medical risk for the members covered under the agreement in 2014 and is expected to assume substantially all medical risk for such members in 2015 and thereafter.

The other material terms of these two agreements are similar to the material terms of our other managed care agreements with Humana.

In August 2012, Metcare of Florida, Inc. entered into an agreement with Humana to manage, on a non-risk basis, the provision of healthcare services to approximately 7,000 Medicare Advantage members covered under certain Humana Medicare Advantage Preferred Provider Organization ("PPO") and Private Fee-For-Service ("PFS") plans in a three year pilot program covering the 2013 through 2015 plan years. The agreement covers members in the Daytona and Pensacola areas of Florida, including Okaloosa and Walton counties, two counties where we did not previously have operations. We receive a monthly administrative fee based on the number of Humana Medicare Advantage members covered under the agreement and a percentage of the surplus, if any, generated under the agreement.

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

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

As of September 30, 2012, we provided services to or for approximately 70,400 Participating Customers on a risk basis and approximately 17,100 Participating Customers on a non-risk basis. We also provide services to non-Participating Customers on a fee-for-service basis.

NOTE 4 – ACQUISITIONS

In October 2012, we completed the acquisition of the practice of an IPA with which we currently contract. The practice operates two primary care offices in Palm Beach County and provides medical care to approximately 1,100 Humana Participating Customers at September 30, 2012. As we currently provide services to these Participating Customers under contractual arrangements with the IPA, they are included in the total number of Participating Customers we report at September 30, 2012.

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

We closed on the acquisition of Continucare on October 4, 2011. We paid an aggregate of $404.4 million in cash and issued an aggregate of 2.5 million shares of our common stock, valued at $11.5 million, to Continucare's stockholders and option holders in consideration for their shares of Continucare common stock and options to purchase shares of Continucare common stock. At the date of acquisition, Continucare provided and managed care for approximately 36,400 Participating Customers through its 19 medical centers and contracted IPAs. Continucare also operated a sleep diagnostic business. Substantially all of Continucare's revenues were derived from managed care agreements with Humana, United, Coventry and Wellcare.

NOTE 5 – SALE OF SLEEP DIAGNOSTIC BUSINESS

The sleep diagnostic business was operated as a wholly-owned subsidiary of Continucare and was included in the acquisition of Continucare. We do not consider the sleep diagnostic business a core business of the ongoing organization and we determined that we should focus our management efforts and resources on expanding and growing our core PSN business. On February 27, 2012, the Board of Directors approved a plan to sell the sleep diagnostic business, and we have retained an investment banking firm to assist us with the sale process. We expect to complete the sale of a significant portion of this business before the end of 2012 and sell the remaining portion of the business in either the fourth quarter of 2012 or the first portion of 2013.

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

The current assets held for sale at September 30, 2012 consist primarily of $1.0 million in cash, accounts receivable of $2.3 million and inventory of $1.0 million. Non-current assets held for sale at September 30, 2012 consist primarily of property and equipment of $1.3 million and intangible assets of $2.9 million. Current liabilities held for sale consist primarily of accounts payable and accrued payroll and payroll taxes.

NOTE 6 – FINANCIAL INSTRUMENTS

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

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

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

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

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

The fair value of the debt outstanding under our senior secured first lien credit agreement (the “First Lien Credit Agreement”) and our senior secured second lien credit agreement (the “Second Lien Credit Agreement” and, together with the First Lien Credit Agreement, the “Credit Facilities”) is the estimated amount we would have to pay to repurchase such debt, including any premium or discount attributable to the difference between the stated interest rate and market rate of interest at the balance sheet date, but excluding any prepayment penalties. Fair values are based on quoted market prices or average valuations of similar debt instruments at the balance sheet date for those debt instruments for which quoted market prices are not available. The fair value of our long-term debt and interest rate cap are based on Level 2 inputs. The fair value of our long-term debt at September 30, 2012 was $297.4 million.

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

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

NOTE 7 – DERIVATIVE AND HEDGING ACTIVITIES

Our objectives in using interest rate derivatives are to add stability to interest expense and to manage our exposure to interest rate movements. To accomplish these objectives, we use an interest rate cap as our interest rate risk management strategy. We entered into an interest rate cap agreement effective December 4, 2011, which provides interest rate protection in the event LIBOR exceeds 1.5%. This interest rate cap had a notional amount of $153.3 million at September 30, 2012, which notional amount will decrease to $134.1 million over the life of the agreement, and expires on September 30, 2014. Notwithstanding this interest rate cap, we are still subject to interest rate risk with respect to indebtedness above the notional amount of the interest rate cap and, unless we extend or replace the interest rate cap, with respect to any portion of the indebtedness outstanding after September 30, 2014.

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

The fair value of our derivative financial instruments at September 30, 2012 was $30,000 and is classified as a noncurrent asset in the condensed consolidated balance sheets. The amount of loss recognized in other comprehensive income on the effective portion of the interest rate cap for the three and nine months ended September 30, 2012 was $22,000 and $0.3 million, net of tax benefit of $14,000 and $0.2 million, respectively. The amount of loss reclassified from other comprehensive income into interest expense in the three and nine month periods ended September 30, 2012 was not material.

NOTE 8 - REVENUE

Substantially all of our revenue is derived from risk agreements with HMOs pursuant to which the Contracting HMO pays us a monthly capitation fee for each Participating Customer. The amount of this fee varies depending on the demographics and health status of each Participating Customer. Under our risk agreements, we assume the economic risk of our Participating Customers' healthcare services and related administrative costs. Revenue is recognized in the period in which our Participating Customers are entitled to receive healthcare services. Because we have the obligation to fund medical expense, we recognize revenue and medical expense for these contracts in our financial statements. Revenue from Humana accounted for 82.8% and 99.4% of our total revenue in the third quarter of 2012 and 2011, respectively. Revenue from Humana accounted for 82.8% and 99.5% of our total revenue in the nine months ended September 30, 2012 and 2011, respectively.

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

There was no material difference between the estimated final settlement for 2011 of $2.7 million and the final settlement that was received in the third quarter of 2012. At December 31, 2010, we recorded a $2.2 million receivable representing our estimate of the final retroactive MRA capitation fee for 2010. In August 2011, we were notified that the final settlement was $1.0 million. The difference of $1.2 million reduced revenue in the third quarter of 2011.

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

NOTE 9 - MEDICAL EXPENSE AND MEDICAL CLAIMS PAYABLE

Total medical expense represents the estimated total cost of providing medical care and is comprised of two components, medical claims expense and medical practice costs. Medical claims expense is recognized in the period in which services are provided and includes an estimate of our obligations for medical services that have been provided to our Participating Customers but for which we have neither received nor processed claims. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by providers other than the physician practices owned by the PSN. Medical practice costs represent the operating costs of the physician practices owned by the PSN.

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

Total medical expense is as follows (in thousands):

| | Three month period ended September 30, | | Nine month period ended September 30, | |
|---|---|---|---|---|
| | 2012 | 2011 | 2012 | 2011 |
| | (in thousands) | | | |
| Medical expense for the period, excluding prior period claims development | $ 154,093 | $ 76,357 | $ 477,337 | $ 233,862 |
| (Favorable) medical claims development based on actual claims submitted | (1,271) | (1,992) | (2,183) | (3,281) |
| Total medical expense for the period | $ 152,822 | $ 74,365 | $ 475,154 | $ 230,581 |

Favorable claims development is a result of actual medical claim cost for prior periods developing lower than the original estimated cost which reduces the reported medical expense in the reporting period.

At September 30, 2012, we determined that the range for estimated medical claims payable was between $44.1 million and $45.6 million and we recorded a liability equal to the actuarial mid-point of the range of $44.7 million. Based on historical results, we believe that the approximate actuarial mid-point of the range continues to be the best estimate within the range of the PSN's ultimate liability.

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

In the third quarter of 2012, we realized a loss of $0.6 million, including a premium deficiency reserve of $1.1 million, on an agreement with a Contracting HMO other than Humana (the "Contracting HMO Agreement") covering approximately 6,600 new Participating Customers added in 2012. Included in the third quarter was favorable claims development from the first half of 2012 of $1.6 million which reduced medical claims expense. On November 6, 2012, we provided written notice to the Contracting HMO terminating this agreement effective March 5, 2013 as we

were unable to reach more favorable contract terms with the Contracting HMO. As a result, we recorded in medical claims expense in the third quarter of 2012 a premium deficiency of $1.1 million, which is our estimate of the loss that we will incur under the Contracting HMO Agreement through March 5, 2013. For the nine months ended September 30, 2012, our loss under the Contracting HMO Agreement was $5.0 million.

NOTE 10 – DUE FROM/TO HMOs

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

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

| | September 30, 2012 | December 31, 2011 |
|---|---|---|
| Due from HMOs | $ 70,358 | $ 80,324 |
| Due to HMOs | (40,052) | (40,083) |
| Total due from HMOs | $ 30,306 | $ 40,241 |

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

Although we are generally a creditor of the Contracting HMOs, as of September 30, 2012, we had a net debt owing to one Contracting HMO in the amount of $7.3 million.

NOTE 11 - INCOME TAXES

We applied an estimated effective income tax rate of 32.6% and 38.6% for the three months ended September 30, 2012 and 2011, respectively. We applied an estimated effective income tax rate of 36.0% and 38.5% for the nine months ended September 30, 2012 and 2011, respectively. In the third quarter of 2012, we realized the tax benefits related to the elimination of $0.8 million of prior years' accrued uncertain tax positions, for years that are no longer subject to audit, which lowered our effective income tax rate.

We are subject to income taxes in the U.S. federal jurisdiction and the state of Florida. Tax regulations are subject to interpretation of the related tax laws and regulations and require significant judgment to apply. We have utilized all of our available net operating loss carry forwards, including net operating loss carry forwards related to years prior to 2006. These net operating losses are open for examination by the relevant taxing authorities. The statute of limitations for the federal and state 2009 tax years will expire in the next twelve months.

NOTE 12 - STOCKHOLDERS' EQUITY

On November 2, 2012, we delivered a notice of redemption to the holder (the "Series A Holder") of all 5,000 of the outstanding shares of our Series A Preferred Stock. Pursuant to the notice of redemption, we notified the Series A Holder that we are exercising our right to redeem all of the outstanding shares of Series A Preferred Stock held by him at a redemption price of $105 per share ($525,000) in accordance with the provisions of our Articles of Incorporation, as amended to date. Subject to certain conditions, the redemption of the Series A Preferred Stock is expected to occur on November 16, 2012.

During the nine months ended September 30, 2012 and 2011, our Board of Directors approved the issuance to employees of 234,000 and 248,000 restricted shares of common stock and options to purchase 1.4 million and 815,000 shares of common stock, respectively. No restricted shares of common stock or options were issued to employees in

the third quarter of either 2012 or 2011. Restricted shares and stock options vest in equal annual installments over a four year period from the date of grant. The stock options have an exercise price equal to the closing price of our common stock on the grant date. Compensation expense related to the restricted stock and options will be recognized ratably over the vesting period.

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

We have a stock repurchase plan pursuant to which our Board of Directors authorized us to repurchase up to 25 million shares of our common stock. We did not repurchase any shares of common stock during the three and nine month periods ended September 30, 2012. During the three and nine month periods ended September 30, 2011, we repurchased 71,000 shares of outstanding common stock for an aggregate purchase price of $0.3 million. From October 6, 2008 (the date of our first repurchases under the plan) through September 30, 2012, we repurchased 14.0 million shares and options to purchase 684,200 shares of our common stock for $28.3 million. The number of shares to be repurchased and the timing of the purchases are influenced by a number of factors, including the then prevailing market price of our common stock, other perceived opportunities that may become available to us and regulatory requirements. The total shares that may yet be repurchased under the plan at September 30, 2012 is 10.3 million. We have the right to repurchase $15.0 million of stock during the term of the Credit Facilities generally not to exceed $5.0 million per year.

NOTE 13 - EARNINGS PER SHARE

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

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

| | Three Months Ended September 30, | | Nine Months Ended September 30, | |
|---|---|---|---|---|
| | 2012 | 2011 | 2012 | 2011 |
| Income from continuing operations | $ 9,024 | $ 5,996 | $ 19,618 | $ 19,889 |
| Less: Preferred stock dividend | (13) | (13) | (38) | (38) |
| Income attributable to common stockholders | $ 9,011 | $ 5,983 | $ 19,580 | $ 19,851 |
| | | | | |
| Income from discontinued operations | $ 238 | $ - | $ 484 | $ - |
| Denominator: | | | | |
| Weighted average common shares outstanding | 43,263 | 40,035 | 43,126 | 39,917 |
| Basic earnings per share from continuing operations | $ 0.21 | $ 0.15 | $ 0.45 | $ 0.50 |
| | | | | |
| Basic earnings per share from discontinued operations | $ 0.01 | $ - | $ 0.01 | $ - |
| | | | | |
| Income attributable to common stockholders | $ 9,011 | $ 5,983 | $ 19,580 | $ 19,851 |
| Add: Preferred stock dividend | 13 | 13 | 38 | 38 |
| Income attributable to common stockholders, diluted | $ 9,024 | $ 5,996 | $ 19,618 | $ 19,889 |
| | | | | |
| Denominator: | | | | |
| Weighted average common shares outstanding | 43,263 | 40,035 | 43,126 | 39,917 |

| | | | | |
|---|---|---|---|---|
| Common share equivalents of outstanding stock: | | | | |
| Convertible preferred stock | 207 | 291 | 203 | 301 |
| Unvested restricted stock | 479 | 528 | 498 | 547 |
| Options | 1,688 | 1,313 | 1,733 | 1,288 |
| Weighted average common shares outstanding | 45,637 | 42,167 | 45,560 | 42,053 |
| Diluted earnings per share from continuing operations | $ 0.20 | $ 0.14 | $ 0.43 | $ 0.47 |
| Diluted earnings per share from discontinued operations | $ 0.01 | $ - | $ 0.01 | $ - |

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

| | Three Months Ended September 30, | | Nine Months Ended September 30, | |
|---|---|---|---|---|
| Security Excluded From Computation | 2012 | 2011 | 2012 | 2011 |
| Stock Options | 1,276 | 797 | 995 | 657 |
| Unvested restricted stock | - | - | 28 | 74 |

NOTE 14 - COMMITMENTS AND CONTINGENCIES

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

We maintain professional liability policies with a captive insurance company of which we are a member and with commercial insurance companies. Except as set forth below, we are not aware of any other claims that may exceed our coverage.

On October 25, 2012, a jury returned a verdict of $9.5 million in a professional liability case against the Company. The Court has reserved ruling on the case which provides the opportunity for both parties to file motions. A judgment has not yet been filed against the Company in connection with this verdict. We believe that the amount awarded was in excess of Florida statutes and will be significantly reduced to comply with the law. If reduced in accordance with Florida law, we expect that our liability, if any in respect of this award, will approximate our insurance coverage. We intend to vigorously contest this verdict and believe that the outcome of this matter will not have a material impact on our financial condition or results of operations however, the ultimate outcome of this case is uncertain.

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

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

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

## GENERAL

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

## CAUTIONARY NOTE REGARDING FORWARD LOOKING STATEMENTS

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

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

the ability of our provider services network ("PSN"), acting through our contracting subsidiaries, to renew its agreements with the health plans operated by Humana, Inc. and its subsidiaries ("Humana"), United Healthcare of Florida, Inc. ("United"), Vista Healthplan of South Florida, Inc. and its affiliated companies, a subsidiary of Coventry Health Care, Inc. ("Coventry"), and Wellcare Health Plans, Inc. and its affiliated companies ("Wellcare," and, together with Humana, United and Coventry, the "Contracting HMOs") that have renewable one-year terms, and to maintain all of its agreements with Contracting HMOs on favorable terms;

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

our ability to accurately estimate the premium deficiency for the remaining term of one existing agreement with a Contracting HMO other than Humana (the "Contracting HMO Agreement") covering approximately 6,600 new Participating Customers added in 2012;

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

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

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

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

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

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

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

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

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

our potential failure to retain key employees of Continucare;

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

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

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

reductions in premium payments to Medicare Advantage plans;

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

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

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

our ability to sell the sleep diagnostic business;

future legislation and changes in governmental regulations;

increased operating costs;

reductions in government funding of the Medicare program and changes in the political environment that may affect public policy and have an adverse impact on the demand for our services;

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

17

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

general economic and business conditions;

increased competition;

the relative health of our Participating Customers;

changes in estimates and judgments associated with our critical accounting policies;

federal and state investigations;

our ability to successfully recruit and retain key management personnel and qualified medical professionals; and

impairment charges that could be required in future periods.

Additional information concerning these and other risks and uncertainties is contained in our filings with the United States Securities and Exchange Commission (the "Commission"), including the section entitled "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2011 and in our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2012 and June 30, 2012.

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

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

BACKGROUND

Merger Agreement

On November 3, 2012, we entered into an Agreement and Plan of Merger (the "Merger Agreement") with Humana and Miner Acquisition Subsidiary, Inc., a Florida corporation and a wholly-owned subsidiary of Humana ("Merger Subsidiary"). The Merger Agreement provides that, upon the terms and subject to the conditions set forth in the Merger Agreement, Merger Subsidiary will merge with and into the Company (the "Merger"), with the Company surviving the Merger as a wholly-owned subsidiary of Humana.

Pursuant to the terms of the Merger Agreement, at the effective time of the Merger, each issued and outstanding share of our common stock (other than shares owned by us, Humana or Merger Subsidiary, or any of our respective subsidiaries) will be converted into the right to receive $11.25 in cash, without interest and less any required withholding taxes. Prior to the effective time of the Merger, each outstanding option to purchase shares of our common stock will become fully vested and exercisable and will be cancelled in exchange for the right to receive an amount in cash equal to the product of (1) the total number of shares of our common stock subject to such option, multiplied by (2) the excess, if any, of $11.25 over the exercise price per share of such option, without interest and less any required withholding taxes. Immediately prior to the effective time of the Merger, each restricted share of our common stock will become fully vested and will be converted into the right to receive $11.25 in cash, without interest and less any required withholding taxes.

The Merger Agreement contains customary covenants, including covenants requiring each of the parties to use its commercially reasonable efforts to cause the transactions contemplated by the Merger Agreement to be consummated. The Merger Agreement also contains covenants requiring us to call and hold a meeting of our shareholders for the purpose of voting to adopt and approve the Merger Agreement and the Merger.

Under the Merger Agreement, if the Merger Agreement is terminated in certain circumstances, including because our Board of Directors has changed its recommendation that our shareholders approve and adopt the Merger Agreement and the Merger or because we have entered into a definitive agreement (or announced our intention to enter into a definitive agreement) to be acquired by an entity other than Humana or one of its affiliates, we will be required to pay to Humana a termination fee of $16 million and reimburse Humana for up to $5.3 million of its and Merger Subsidiary's out-of-pocket expenses incurred in connection with the Merger.

The consummation of the Merger is subject to certain conditions, including (1) the affirmative vote of a majority of the outstanding shares of our common stock in favor of the approval and adoption of the Merger Agreement and the Merger; (2) the expiration or termination of applicable waiting periods under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended (the "HSR Act"); (3) the absence of any law, order, injunction or other prohibition that restrains, enjoins, prevents or makes illegal the consummation of the Merger; (4) subject to certain materiality exceptions, the accuracy of the representations and warranties of each party contained in the Merger Agreement; (5) the performance by each party in all material respects of its covenants in the Merger Agreement; and (6) the absence of any change, effect, development or event between November 3, 2012 and consummation of the Merger that has had or would reasonably be expected to result in a material adverse effect on the Company.

The Merger is expected to close by the end of the first quarter of 2013.

Redemption of Series A Preferred Stock

On November 2, 2012, we delivered a notice of redemption to the holder (the "Series A Holder") of all 5,000 of the outstanding shares of our Series A Preferred Stock. Pursuant to the notice of redemption, we notified the Series A

Holder that we are exercising our right to redeem all of the outstanding shares of Series A Preferred Stock held by him at a redemption price of $105 per share ($525,000) in accordance with the provisions of our Articles of Incorporation, as amended to date. Subject to certain conditions, the redemption of the Series A Preferred Stock is expected to occur on November 16, 2012.

Business

Our primary business is the operation of our provider services network ("PSN") primarily through our wholly owned subsidiaries, Metcare of Florida, Inc. and Continucare Corporation ("Continucare"), the latter of which we acquired on October 4, 2011. Prior to 2012, the PSN provided and arranged for the provision of healthcare services to Medicare Advantage, Medicaid and commercially insured customers only in Florida. In 2012, the PSN expanded its operations to include Ohio, Kentucky and Indiana. At September 30, 2012, we operated the PSN through 33 wholly-owned primary care practices, a wholly-owned oncology practice and contracts with independent physician affiliates (each an "IPA"). As of September 30, 2012, the PSN operated throughout the Florida market including the cities of Miami, Ft. Lauderdale, West Palm Beach, Tampa, Daytona and Pensacola, as well as the Cincinnati, Ohio / Northern Kentucky and the Indianapolis, Indiana markets.

In August 2012, we formed a joint venture with Humana, Inc. (together with its subsidiaries, "Humana") through which we have begun to operate in the Cincinnati, Ohio / Northern Kentucky and Indianapolis, Indiana markets. The joint venture, Symphony Health Partners - Midwest, LLC ("Symphony"), is owned by our wholly-owned subsidiary, Symphony Health Partners, Inc. and Humana, with Symphony Health Partners, Inc. being the majority owner.

In August 2012, Symphony entered into two new agreements with Humana. Pursuant to one of these agreements, which was effective retroactive to January 1, 2012, Symphony has agreed to manage the provision of healthcare services to Humana Medicare Advantage members in the Cincinnati, Ohio/Northern Kentucky market. There were approximately 7,900 Participating Customers covered under this agreement at September 30, 2012. Through 2013, Symphony is entitled to receive a monthly administrative fee based on the number of Humana Medicare Advantage members covered under the agreement and a percentage of the surplus, if any, generated under the agreement. Symphony is expected to assume partial medical risk for the members covered under the agreement in 2014 and is expected to assume substantially all medical risk for such members in 2015 and thereafter.

Pursuant to the second agreement, which was effective as of August 1, 2012, Symphony has agreed to manage the provision of healthcare services to Humana Medicare Advantage members in the Indianapolis, Indiana market. There were approximately 2,000 Participating Customers covered under this agreement at September 30, 2012. Through 2013, Symphony is entitled to receive a monthly administrative fee based on the number of Humana Medicare Advantage members covered under the agreement and a percentage of the surplus, if any, generated under the agreement. Symphony is expected to assume partial medical risk for the members covered under the agreement in 2014 and is expected to assume substantially all medical risk for such members in 2015 and thereafter.

The other material terms of these two agreements are similar to the material terms of our other managed care agreements with Humana.

In August 2012, Metcare of Florida, Inc. entered into an agreement with Humana to manage, on a non-risk basis, the provision of healthcare services to approximately 7,000 Medicare Advantage members covered under certain Humana Medicare Advantage Preferred Provider Organization ("PPO") and Private Fee-For-Service ("PFS") plans in a three year pilot program covering the 2013 through 2015 plan years. The agreement covers members in the Daytona and Pensacola areas of Florida, including Okaloosa and Walton counties, two counties where we did not previously have operations. We will receive a monthly administrative fee based on the number of Humana Medicare Advantage members covered under the agreement and a percentage of the surplus, if any, generated under the agreement.

In October 2012, we completed the acquisition of the practice of an IPA with which we currently contract. The practice operates two primary care offices in Palm Beach County, Florida and provides medical care to approximately 1,100 Humana Participating Customers at September 30, 2012. As we currently provide services to these Participating Customers under contractual arrangements with the IPA, they are included in the total number of Participating Customers we report at September 30, 2012.

Humana Agreements

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

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

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

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

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

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

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

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

The foregoing discussion relates only to our risk agreements with Humana and does not include the Cincinnati agreement, the Indianapolis agreement or the new PPO and PFS agreement with Humana, each of which is described under the heading "Background." Except as described under the heading "Background," the material terms of those agreements are similar to the material terms of the Humana Agreements as described above.

Agreements With Other HMOs

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

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

In the third quarter of 2012, we realized a loss of $0.6 million, including a premium deficiency reserve of $1.1 million, (under the "Contracting HMO Agreement"). Included in the third quarter was favorable claims development from the first half of 2012 of $1.6 million which reduced medical claims expense. On November 6, 2012, we provided written notice to the Contracting HMO terminating this agreement effective March 5, 2013 as we were unable to reach more favorable contract terms with the Contracting HMO. As a result, we recorded in medical claims expense in the third quarter of 2012 a premium deficiency of $1.1 million, which is our estimate of the loss that we will incur under the Contracting HMO Agreement through March 5, 2013. For the nine months ended September 30, 2012, our loss under the Contracting HMO Agreement was $5.0 million.

Our Physician Network

At September 30, 2012, the 33 primary care practices owned and operated by the PSN were responsible for providing and arranging for medical care to 51.9% of the PSN's Participating Customers under risk agreements.

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

Appropriate Risk Coding

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

Insurance Arrangements

To mitigate our exposure to high cost medical claims under our risk agreements, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. At September 30, 2012, for 59.2% of our Participating Customers under risk agreements, we purchase reinsurance through the HMOs with which we contract. The HMOs charge us a per customer per month fee that limits our healthcare costs for any individual Participating Customer. Healthcare costs in excess of an annual deductible, which generally ranges from $30,000 to $40,000 per Participating Customer, are paid directly by the HMOs and we are not entitled to and do not receive any related insurance recoveries.

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

All policies have a maximum annual benefit per customer of $1.0 million. Although we maintain insurance of the types and in the amounts that we believe are reasonable, there can be no assurances that the insurance policies maintained by us will insulate us from material expenses and/or losses in the future.

Healthcare Reform Legislation

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

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

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

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

CRITICAL ACCOUNTING POLICIES

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

ACQUISITION OF CONTINUCARE

We closed on the acquisition of Continucare on October 4, 2011. We paid an aggregate of $404.4 million in cash and issued an aggregate of 2.5 million shares of our common stock, valued at $11.5 million, to Continucare's stockholders and option holders in consideration for their shares of Continucare common stock and options to purchase shares of Continucare common stock. At the date of acquisition, Continucare provided and managed care for approximately 36,400 Participating Customers through its 19 medical centers and contracted IPAs. Continucare also operated a sleep diagnostic business. Substantially all of Continucare's revenues were derived from managed care agreements with Humana, United, Coventry and Wellcare.

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

Summary

Net income for the third quarter of 2012 was $9.3 million compared to $6.0 million in the third quarter of 2011, an increase of $3.3 million or 55.0%. In the third quarter of 2012, we realized the tax benefits related to the elimination of $0.8 million of prior years' accrued uncertain tax positions for years that are no longer subject to audit. In the third quarter of 2011, we incurred pre-tax expenses of $2.1 million associated with the Continucare acquisition.

Basic and diluted earnings per share were $0.22 and $0.21, respectively, for the third quarter of 2012 as compared to $0.15, basic, and $0.14, diluted, for the same period in 2011. Diluted and basic earnings per share in 2012 were increased by $0.02 per share as a result of the elimination of prior years' accrued uncertain tax positions for years that are no longer subject to audit. The after tax impact of the Continucare transaction costs reduced basic and diluted earnings per share by $0.03 in 2011. Basic and diluted earnings per share from income from continuing operations was $0.21 and $0.20 for the third quarter of 2012 as compared to $0.15, basic, and $0.14, diluted, for the same period in 2011. Basic and diluted earnings from discontinued operations for the third quarter of 2012 were $0.01 per share.

In the third quarter of 2012, we realized a loss of $0.6 million, including a premium deficiency reserve of $1.1 million, on an agreement with a Contracting HMO (the "Contracting HMO Agreement") covering approximately 6,600 new Participating Customers added in 2012. Included in the third quarter was favorable claims development from the first half of 2012 of $1.6 million which reduced medical claims expense. On November 6, 2012, we provided written notice to the Contracting HMO terminating this agreement effective March 5, 2013 as we were unable to reach more favorable contract terms with the Contracting HMO. As a result, we recorded in medical claims expense in the third quarter of 2012 a premium deficiency of $1.1 million, which is our estimate of the loss that we will incur under the Contracting HMO Agreement through March 5, 2013. For the nine months ended September 30, 2012, our loss under the Contracting HMO Agreement was $5.0 million.

Revenue for the third quarter of 2012 was $191.1 million compared to $92.7 million for the third quarter of 2011, an increase of $98.4 million or 106.1%. The increase in revenue was primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements since December 31, 2011 and an increase in the average risk scores of our Participating Customers.

Total medical expense for the third quarter of 2012 was $152.8 million compared to $74.4 million for the third quarter of 2011, an increase of $78.4 million or 105.4%. This increase is primarily attributable to the addition of the Continucare Participating Customers, the medical costs associated with the net addition of new Participating Customers under risk arrangements in 2012, the addition of the 19 Continucare medical practices and an increase in benefits, utilization and medical cost inflation. Total medical expense was partially offset by favorable prior period medical claims development of $1.3 million and $2.0 million in the third quarter of 2012 and 2011, respectively, as well as the impact of the decrease in the aggregate customer months during the third quarter of 2011.

Gross profit was $38.3 million for the third quarter of 2012 as compared to $18.3 million for the same quarter in 2011, an increase of $20.0 million or 109.3%.

The medical expense ratio ("MER"), which is computed by dividing total medical expense by revenue, represents a statistic used to measure gross profit. In the third quarter of 2012 our MER was 79.9%, compared to 80.3% for the third quarter of 2011.Excluding the revenue and medical costs associated with the Contracting HMO Agreement our MER for the third quarter of 2012 would have been 77.9%.

Operating expenses increased to $16.9 million for the third quarter of 2012 as compared to $6.6 million for the same period in 2011, an increase of $10.3 million or 156.1%. The increase in operating expenses is primarily due to the additional expenses of Continucare and an increase in amortization expense of $3.1 million, related to the amortizable intangible assets recorded with the Continucare acquisition.

Other expense increased by $6.1 million due primarily to an increase in interest expense of $8.1 million for the third quarter of 2012 related to the debt used to finance the Continucare acquisition. We expensed $2.1 million of transaction costs in the third quarter of 2011 that were associated with our acquisition of Continucare.

Income before income taxes from continuing operations for the third quarter of 2012 was $13.4 million as compared to income before income taxes for the third quarter of 2011 of $9.8 million. The primary reasons for the increase are discussed above.

In the third quarter of 2012, we realized the tax benefits related to the elimination of $0.8 million of prior years' accrued uncertain tax positions for years that are no longer subject to audit, which lowered our effective income tax rate.

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

Customer Information

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

| | Participating Customers at September 30, | | Participating Customer Months In The Quarter Ended September 30, | | Percentage Increase In Participating Customer Months |
|---|---|---|---|---|---|
| | 2012 | 2011 | 2012 | 2011 | |
| Risk arrangements | 70,400 | 34,400 | 211,400 | 102,600 | 106.0% |
| Non-risk arrangements | 17,100 | - | 51,000 | - | N/A |
| | 87,500 | 34,400 | 262,400 | 102,600 | 155.8% |

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

| | Participating Customers at September 30, | | Percentage Increase In Participating Customers |
|---|---|---|---|
| | 2012 | 2011 | |
| Medicare Advantage | 71,600 | 34,400 | 108.1% |
| Medicaid | 13,400 | - | N/A |
| Commercial | 2,500 | - | N/A |
| | 87,500 | 34,400 | 154.4% |

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

The increase in customer months under non-risk arrangements is a result of the Continucare acquisition and the addition of the Cincinnati and Indianapolis contracts with Humana.

Revenue

The most significant component of our revenue is generated from Medicare Advantage risk arrangements with the Contracting HMOs. Medicare risk revenue increased by $88.5 million, or 96.1%, during the third quarter of 2012 as compared to the same period in 2011. The increase in revenue is primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and increased risk scores for our Participating Customers.

Our PCPM Medicare risk revenue increased by $82 for the third quarter of 2012 compared to the same period in 2011. The increase in our PCPM revenue was primarily generated by the acquisition of Continucare, which realizes higher rates in Miami-Dade County, Florida than we realize in our other service areas, and increases in our capitation payments as a result of changes in the Medicare risk adjustment scores of our Participating Customers.

There was no material difference between the estimated final settlement for 2011 of $2.7 million and the final settlement that was received in the third quarter of 2012. At December 31, 2010, we recorded a $2.2 million receivable representing our estimate of the final retroactive MRA capitation fee for 2010. In August 2011, we were notified that the final settlement was $1.0 million. The difference of $1.2 million reduced revenue in the third quarter of 2011.

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

Total Medical Expense

Total medical expense represents the estimated total cost of providing medical care and is comprised of two components, medical claims expense and medical practice costs. Medical claims expense is recognized in the period in which services are provided and includes an estimate of our obligations for medical services that have been provided to our Participating Customers but for which we have neither received nor processed claims. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by providers other than the IPAs and physician practices owned by the PSN (collectively "Non-Affiliated Providers"). Medical practice costs represent the operating costs of the physician practices owned by the PSN.

We develop our estimated medical expense payable using an actuarial process that is consistently applied. The actuarial process develops a range of estimated medical claims expense payable and we record the amount in the range that is our best estimate of the ultimate liability. Each period, we re-examine previously recorded medical claims expense payable estimates based on actual claim submissions and other changes in facts and circumstances. As medical claims expense payable recorded in prior periods becomes more exact, we adjust the amount of the estimate

and include the change in medical claims expense in the period in which the change is identified. In each reporting period, our operating results include a change in medical expense from the effects of more completely developed medical claims expense payable estimates associated with previously reported periods. While we believe our estimated medical claims expense payable is adequate to cover future claims payments required, such estimates are based on our claims experience to date and various management assumptions. Therefore, the actual liability could differ materially from the amount recorded.

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

| | Three Months Ended September 30, | |
|---|---|---|
| | 2012 | 2011 |
| Estimated medical expense for the period, excluding prior period claims development | $ 154,093 | $ 76,357 |
| (Favorable) prior period medical claims development in current period based on actual claims submitted | (1,271) | (1,992) |
| Total medical expense for period | $ 152,822 | $ 74,365 |
| | | |
| Medical Expense Ratio for period | 79.9 % | 80.3 % |

Favorable claims development is a result of actual medical claim cost for prior periods being less than the original estimated cost which reduces the total reported medical expense and the MER in the reporting period.

The reported MER is impacted by both revenue and expense. Periodically we receive retroactive adjustments of the capitation fees paid to us. Retroactive adjustments of prior periods' capitation fees that are recorded in the current period impact the MER of that period. If the retroactive adjustment increases revenue then the impact reduces the MER for the period. Conversely, if the retroactive adjustment reduces revenue, then the MER for the period is higher. These retroactive adjustments include, among other things, the mid-year and annual retroactive MRA capitation fee adjustments and settlement of Part D program capitation fees. Actual medical claims expense usually develops differently than originally estimated.

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

Total medical expense for the third quarter of 2012 increased by $78.4 million, or 105.4%, to $152.8 million from $74.4 million for the third quarter of 2011. Medical claims expense, which is the largest component of medical services expense, increased by $68.9 million, or 99.3%, to $138.3 million for the third quarter of 2012 from $69.4 million for the same period in 2011, primarily due to the acquisition of Continucare and the net addition of new Participating Customers under risk arrangements in 2012.

Our PCPM Medicare risk expense increased by $38 for the third quarter of 2012 compared to the same period in 2011. The increase in our PCPM expense was primarily generated by the acquisition of Continucare. The counties in which Continucare operates, particularly Miami-Dade County, Florida, have higher costs than those in most of the counties in which we had operated prior to the acquisition of Continucare.

The MER for the third quarter of 2012 was 79.9%, compared to 80.3% for the third quarter of 2011. Excluding the revenue and medical costs associated with the Contracting HMO Agreement, our MER for the third quarter of 2012 would have been 77.9%.

Medical practice costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services and the costs associated with the operations of our wholly-owned medical practices. Medical practice costs increased by $9.6 million, or 195.9%, to $14.5 million for the third quarter of 2012 from $4.9 million for the third quarter of 2011. The increase in medical practice costs was primarily a result of our acquisition of Continucare, which has 19 wholly-owned centers.

At September 30, 2012, we determined that the range for estimated medical claims payable was between $44.1 million and $45.6 million and we recorded a liability of $44.7 million. Based on historical results, we believe that the approximate actuarial mid-point of the range continues to be the best estimate within the range of the PSN's ultimate liability.

Operating Expenses

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

| | Three Months Ended September 30, | | | | | |
|---|---|---|---|---|---|---|
| | 2012 | | 2011 | | Increase | % Change |
| Payroll, payroll taxes and benefits | $ 8,688 | | $ 4,078 | | $ 4,610 | 113.0% |
| Percentage of total revenue | 4.5 | % | 4.4 | % | | |
| General and administrative | 4,604 | | 2,048 | | 2,556 | 124.8% |
| Percentage of total revenue | 2.4 | % | 2.2 | % | | |
| Marketing and advertising | 387 | | 336 | | 51 | 15.2% |
| Percentage of total revenue | 0.2 | % | 0.4 | % | | |
| Amortization of intangible assets | 3,186 | | 96 | | 3,090 | 3218.8% |
| Percentage of total revenue | 1.7 | % | 0.1 | % | | |
| Total operating expenses | $ 16,865 | | $ 6,558 | | $ 10,307 | 157.2% |

Payroll, Payroll Taxes and Benefits

Payroll, payroll taxes and benefits include salary and related costs associated with our corporate level executives, administrative, transportation and call center personnel. The increase in 2012 is primarily a result of the inclusion of Continucare's executive, administrative, transportation and call center payroll, payroll taxes and benefits of $3.7 million and an increase in payroll expense of $0.7 million for the three months ended September 30, 2012 compared to the same period in 2011.

General and Administrative

This increase in general and administrative expenses for the third quarter of 2012 is primarily a result of the inclusion of $1.7 million of Continucare's general and administrative costs. Legal and accounting fees increased by $0.5 million for the third quarter of 2012 compared to the third quarter of 2011 primarily as a result of increased professional fees associated with the larger combined organization.

Marketing and Advertising

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

Amortization of Intangibles

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

Other Expense

We recognized other expense of $8.1 million for the third quarter of 2012 compared to other expense of $2.0 million for the same period in 2011. For the third quarter of 2012, we incurred $8.1 million of interest expense related to the debt incurred in connection with the Continucare acquisition. For the third quarter of 2011, we recorded transaction costs associated with the Continucare transaction of $2.1 million.

Income taxes

Our estimated effective income tax rate was 32.6% and 38.6% for the third quarter of 2012 and 2011, respectively. In the third quarter of 2012, we realized the tax benefits related to the elimination of $0.8 million of prior years' accrued uncertain tax positions for years that are no longer subject to audit, which lowered our effective income tax rate.

COMPARISON OF RESULTS OF OPERATIONS FOR THE NINE MONTHS ENDED SEPTEMBER 30, 2012 AND SEPTEMBER 30, 2011

Summary

Net income for the nine months ended September 30, 2012 was $20.1 million compared to $19.9 million for the nine months ended September 30, 2011. Net income for 2012 was positively impacted by the elimination of $0.8 million of prior years' accrued uncertain tax positions for years that are no longer subject to audit. Net income for the nine months ended September 30, 2012 was negatively impacted by the $5.0 million pre-tax loss from the Contracting HMO Agreement. Net income in 2011 was reduced by CNU pre-tax transaction costs of $3.1 million.

For the nine months ended September 30, 2012, our loss under the Contracting HMO Agreement was $5.0 million which included a premium deficiency of $1.1 million recorded in the third quarter as described below. On November 6, 2012, we provided written notice to the Contracting HMO terminating this agreement effective March 5, 2013 as we were unable to reach more favorable contract terms with the Contracting HMO. As a result, we recorded in medical claims expense in the third quarter of 2012 a premium deficiency of $1.1 million, which is our estimate of the loss that we will incur under the Contracting HMO Agreement through March 5, 2013.

Basic and diluted earnings per share were $0.46 and $0.44, respectively, for the nine months ended September 30, 2012 as compared to $0.50 and $0.47, respectively, for the same period in 2011. Basic and diluted earnings from continuing operations for the nine months ended September 30, 2012 were $0.45 and $0.43 per share, respectively. The after tax impact of the $5.0 million loss from the Contracting HMO Agreement reduced basic and diluted earnings per share in 2012 by $0.06. The after tax impact of the Continucare transaction costs reduced basic and diluted earnings per share by $0.05 in 2011. Basic and diluted earnings from discontinued operations for the nine months ended September 30, 2012 were $0.01 per share.

Revenue for the nine months ended September 30, 2012 was $579.8 million compared to $284.7 million for the nine months ended September 30, 2011, an increase of $295.1 million or 103.7%. The increase in revenue was primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and an increase in the average risk scores of our Participating Customers. Revenue in 2011 was reduced by the final estimated retroactive MRA premium receivable for 2010 being $1.2 million lower than had been estimated.

Total medical expense for the nine months ended September 30, 2012 was $475.2 million compared to $230.6 million for the nine months ended September 30, 2011, an increase of $244.6 million or 106.1%. This increase is primarily attributable to the medical costs associated with the net addition of new Participating Customers under risk arrangements in 2012, the higher than expected medical claims expense under the Contracting HMO Agreement, the addition of the 19 Continucare medical practices and an increase in benefits, utilization and medical cost inflation.

Gross profit was $104.7 million for the nine months ended September 30, 2012 as compared to $54.1 million for the same period in 2011, an increase of $50.6 million or 93.5%.

Our MER was 82.0% for the nine months ended September 30, 2012, as compared to MER of 81.0% for the nine months ended September 30, 2011. Excluding the revenue and medical costs associated with the Contracting HMO Agreement, our MER for the first nine months of 2012 would have been 79.6%.

Operating expenses increased to $49.6 million for the nine months ended September 30, 2012 as compared to $19.2 million for the same period in 2011, an increase of $30.4 million or 158.3%. The increase in operating expenses is primarily due to the additional expenses of Continucare and an increase in amortization expense of $9.3 million related to the amortizable intangible assets recorded in the Continucare acquisition.

Other expense increased by $21.9 million due primarily to an increase in interest expense of $24.4 million for the nine months ended September 30, 2012 related to the debt used to finance the Continucare acquisition. We expensed $3.1 million of transaction costs in the nine months ended September 30, 2011 that were associated with our acquisition of Continucare.

Income before income taxes from continuing operations for the nine months ended September 30, 2012 and 2011 was $30.7 million and $32.4 million, respectively. The primary reasons for the decrease are discussed above.

In the third quarter of 2012, we realized the tax benefits related to the elimination of $0.8 million of prior years' accrued uncertain tax positions for years that are no longer subject to audit, which lowered our effective income tax rate.

Income from discontinued operations was $0.5 million for the nine months ended September 30, 2012. This amount represents income realized by the sleep diagnostic business during the nine months ended September 30, 2012, net of income tax expense.

Customer Information

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

| | Participating Customers at September 30, | | Participating Customer Months For The Nine Months Ended September 30, | | Percentage Increase In Participating Customer Months |
|---|---|---|---|---|---|
| | 2012 | 2011 | 2012 | 2011 | |
| Risk arrangements | 70,400 | 34,400 | 630,700 | 307,600 | 105.0% |
| Non-risk arrangements | 17,100 | - | 148,400 | - | N/A |
| | 87,500 | 34,400 | 779,100 | 307,600 | 153.3% |

The increase in total customer months under risk arrangements for the nine months ended September 30, 2012 as compared to the same period in 2011 is primarily a result of the Participating Customers added with the Continucare acquisition and the net addition of new Participating Customers under risk arrangements in 2012. Changes in our customer base are also a result of new enrollments and/or transfers from other physician's practices, and individuals aging into Medicare and becoming a Participating Customer, reduced by disenrollments, deaths, Participating Customers moving from the covered areas, Participating Customers transferring to another physician practice or Participating Customers making other insurance selections.

The increase in customer months under non-risk arrangements is a result of the Continucare acquisition and the addition of the Cincinnati and Indianapolis contracts with Humana. The Participating Customer months for the nine months ended September 30, 2012 include the retroactive impact on customer months as a result of the retroactive

effective date of the Cincinnati contract with Humana.

Revenue

The most significant component of our revenue is the revenue generated from Medicare Advantage risk arrangements with the Contracting HMOs. Medicare risk revenue increased by $266.6 million, or 94.1%, during the nine months ended September 30, 2012 as compared to the same period in 2011. The increase in revenue is primarily attributable to Participating Customers added with the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements in 2012 and increased risk scores for our Participating Customers.

Our PCPM Medicare risk revenue increased by $78 for the nine months ended September 30, 2012 compared to the same period in 2011. The increase in our PCPM revenue is primarily generated by the acquisition of Continucare, which realizes higher rates in Miami-Dade County, Florida than we realize in our other service areas, and increases in our capitation payments as a result of changes in the Medicare risk adjustment scores of our Participating Customers.

There was no material difference between the estimated final settlement for 2011 of $2.7 million and the final settlement that was received in the third quarter of 2012. At December 31, 2010, we recorded a $2.2 million receivable representing our estimate of the final retroactive MRA capitation fee for 2010. In August 2011, we were notified that the final settlement was $1.0 million. The difference of $1.2 million reduced revenue in the third quarter of 2011.

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

Total Medical Expense

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

| | Nine Months Ended September 30, | |
|---|---|---|
| | 2012 | 2011 |
| Estimated medical expense for the period, excluding prior period claims development | $ 477,337 | $ 233,862 |
| (Favorable) prior period medical claims development in current period based on actual claims submitted | (2,183) | (3,281) |
| Total medical expense for period | $ 475,154 | $ 230,581 |
| | | |
| Medical Expense Ratio for period | 82.0 % | 81.0 % |

Favorable claims development is a result of actual medical claim cost for prior periods developing lower than the original estimated cost which reduces the reported medical expense and the MER in the reporting period.

Total medical expense for the nine months ended September 30, 2012 increased by $244.6 million, or 106.1%, to $475.2 million from $230.6 million for the nine months ended September 30, 2011. Medical claims expense, which is the largest component of medical services expense, increased by $215.1 million, or 99.3%, to $431.7 million for the nine months ended September 30, 2012 from $216.6 million for the same period in 2011, primarily due to the acquisition of Continucare, the net addition of new Participating Customers under risk arrangements added in 2012 and the higher than expected medical claims expense under the Contracting HMO Agreement.

Our PCPM Medicare risk expense increased by $45 for the nine months ended September 30, 2012 compared to the same period in 2011. The increase in our PCPM expense was primarily generated by the acquisition of Continucare and the higher than expected medical claims expense under the Contracting HMO Agreement. The counties in which Continucare operates, particularly Miami-Dade County, Florida, have higher costs than those in most of the counties in which we had operated prior to the acquisition of Continucare.

The MER for the nine months ended September 30, 2012 was 82.0%, compared to MER of 81.0% for the nine months ended September 30, 2011. Excluding the revenue and medical costs associated with the Contracting HMO Agreement our MER for the first nine months of 2012 would have been 79.6%.

Medical practice costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services, and the costs associated with the operations of our wholly-owned medical practices. Medical practice costs increased by $29.5 million, or 210.7%, to $43.5 million for the nine months ended September 30, 2012 from $14.0 million for the nine months ended September 30, 2011. The increase in medical

practice costs was primarily a result of our acquisition of Continucare, which has 19 wholly-owned centers.

Operating Expenses

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

| | Nine Months Ended September 30, | | % |
|---|---|---|---|
| | 2012 | 2011 | Increase |