BANK OF NOVA SCOTIA /
Form 424B5
March 07, 2014

The information in this Preliminary Pricing Supplement is not complete and may be changed. We may not sell these Notes until the Pricing Supplement is delivered in final form. We are not selling these Notes, nor are we soliciting offers to buy these Notes, in any State where such offer or sale is not permitted.

PRELIMINARY PRICING SUPPLEMENT
Subject to Completion
Dated March 7, 2014

Filed Pursuant to Rule 424(b)(5)
Registration No. 333-185049

Pricing Supplement dated l to the
Prospectus dated August 1, 2013
Prospectus Supplement dated August 8, 2013 and Product Prospectus Supplement (Rate Linked Notes, Series A) dated August 8, 2013

The Bank of Nova Scotia

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Capped Fixed-to-Floating Rate Notes, Series A

Due March 28, 2019

- 100% repayment of principal at maturity, subject to the credit risk of the Bank
- 5-year stated term
- Quarterly interest payments
- Fixed Interest Rate of 1.25% per annum for the first eight quarterly Interest Periods
- Floating Interest Rate of 3-Month USD LIBOR plus 0.30% per annum, subject to a cap of 5.00%

The Capped Fixed-to-Floating Rate Notes, Series A Due March 28, 2019 (the "Notes") offered hereunder are unsecured obligations of The Bank of Nova Scotia and are subject to investment risks including possible loss of the Principal Amount invested due to the credit risk of The Bank of Nova Scotia. As used in this pricing supplement, the "Bank," "we," "us" or "our" refers to The Bank of Nova Scotia.

The Notes will not be listed on any securities exchange or automated quotation system.

NEITHER THE UNITED STATES SECURITIES AND EXCHANGE COMMISSION ("SEC") NOR ANY STATE SECURITIES COMMISSION HAS APPROVED OR DISAPPROVED OF THE NOTES OR PASSED UPON THE ACCURACY OR THE ADEQUACY OF THIS DOCUMENT, THE ACCOMPANYING PROSPECTUS, PROSPECTUS SUPPLEMENT OR PRODUCT PROSPECTUS SUPPLEMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE. THE NOTES ARE NOT

INSURED BY THE CANADA DEPOSIT INSURANCE CORPORATION PURSUANT TO THE CANADA DEPOSIT INSURANCE CORPORATION ACT, THE UNITED STATES FEDERAL DEPOSIT INSURANCE CORPORATION, OR ANY OTHER GOVERNMENTAL AGENCY OF CANADA, THE UNITED STATES OR ANY OTHER JURISDICTION.

Scotia Capital (USA) Inc., our affiliate, will purchase the Notes from us for distribution to agents or other registered broker-dealers or will offer the Notes directly to investors. Scotia Capital (USA) Inc. or any of its affiliates or agents may use the final pricing supplement to which this preliminary pricing supplement relates in market-making transactions in the Notes after their initial sale. Unless we, Scotia Capital (USA) Inc. or another of its affiliates or agents selling such Notes to you informs you otherwise in the confirmation of sale, the final pricing supplement to which this pricing supplement relates is being used in a market-making transaction. See "Supplemental Plan of Distribution (Conflicts of Interest)" in this pricing supplement and "Supplemental Plan of Distribution" on page PS-32 of the accompanying product prospectus supplement.

Investment in the Notes involves certain risks. You should refer to "Additional Risk Factors" in this pricing supplement and "Additional Risk Factors Specific to the Notes" beginning on page PS-5 of the accompanying product prospectus supplement and "Risk Factors" beginning on page S-2 of the accompanying prospectus supplement.

	Per Note	Total
Price to public	100.00%	$
Underwriting commissions[1]	Variable	Variable
Proceeds to The Bank of Nova Scotia[2]	Variable	Variable

The difference between the estimated value of your Notes and the original issue price reflects costs that the Bank or its affiliates expect to incur and profits that the Bank or its affiliates expect to realize in connection with hedging activities related to the Notes. These costs and profits will likely reduce the secondary market price, if any secondary market develops, for the Notes. As a result, you may experience an immediate and substantial decline in the market value of your Notes on the Trade Date and you may lose all or a substantial portion of your initial investment. The Bank's profit in relation to the Notes will vary based on the difference between (i) the amounts received by the Bank in connection with the issuance and the reinvestment return received by the Bank in connection with those funds and (ii) the costs incurred by the Bank in connection with the issuance of the Notes and the hedging transactions. The Bank will also realize a profit that will be based on the (i) cost of creating and maintaining the hedging transactions minus (ii) the payments received on the hedging transactions.

We will deliver the Notes in book-entry form through the facilities of The Depository Trust Company ("DTC") on or about March 28, 2014 against payment in immediately available funds.

Scotia Capital (USA) Inc.

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1 Scotia Capital (USA) Inc. or one of our affiliates will purchase the Notes at the Principal Amount and as part of the distribution, if the Notes priced today, would pay varying discounts and underwriting commissions of $6.50 (0.65%) per $1,000 Principal Amount of the Notes in connection with the distribution of the Notes. The actual discounts and underwriting commissions that Scotia Capital (USA) Inc. or one of our affiliates will pay may be more or less than 0.65% and will depend on market conditions. Certain accounts may pay a purchase price of at least $985.00 (98.50%) per $1,000 Principal Amount of the Notes and third party distributors involved in such transactions may charge a discretionary fee with respect to such sales. In no event will Scotia Capital (USA) Inc. or one of our affiliates pay varying discounts and underwriting commissions in excess of $15.00 (1.50%) per $1,000 Principal Amount of the Notes in connection with the distribution of the Notes. Scotia Capital (USA) Inc. may also receive a structuring and development fee of up to $0.50 (0.05%) per $1,000 Principal Amount of the Notes. See "Supplemental Plan of Distribution (Conflicts of Interest)" in this pricing supplement.

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Excludes potential profits from hedging. For additional considerations relating to hedging activities see “Additional Risk Factors - The Inclusion of Dealer Spread and Projected Profit from Hedging in the Original Issue Price is Likely to Adversely Affect Secondary Market Prices” in this pricing supplement.

SUMMARY

The information in this "Summary" section is qualified by the more detailed information set forth in this pricing supplement, the prospectus, the prospectus supplement and the product prospectus supplement, each filed with the SEC. See "Additional Terms of Your Notes" in this pricing supplement.

Issuer:	The Bank of Nova Scotia (the "Issuer" or the "Bank")
CUSIP/ISIN:	CUSIP 064159DY9 / ISIN US064159DY93
Type of Note:	Capped Fixed-to-Floating Rate Notes, Series A
Minimum Investment:	$1,000
Denominations:	$1,000 and integral multiples of $1,000 in excess thereof
Principal Amount:	$1,000 per Note
Currency:	U.S. Dollars
Trade Date:	Expected to be March 25, 2014
Pricing Date:	Expected to be March 25, 2014
Original Issue Date:	Expected to be March 28, 2014 (to be determined on the Trade Date and expected to be the 3rd Business Day after the Trade Date).
Maturity Date:	March 28, 2019
Business Day:	Any day which is neither a legal holiday nor a day on which banking institutions are authorized or obligated by law, regulation or executive order to close in New York and Toronto.
Interest Payment Dates:	Quarterly payments made on the 28th calendar day of each March, June, September and December commencing June 28, 2014 and ending on the Maturity Date. If these days are not Business Days, interest will actually be paid on the dates determined as described below.
Interest Period:	For each Interest Payment Date, the quarterly period from, and including, the previous Interest Payment Date (or the Original Issue Date in the case of the first Interest Payment Date) to, but excluding, the applicable Interest Payment Date.
Interest Rate:	The Notes will bear interest at the Fixed Interest Rate for the first eight quarterly Interest Periods (such period, "Fixed Interest Period") and at the Floating Interest Rate thereafter (such period, "Floating Interest Period"), subject to a Maximum Rate/Cap.
Fixed Interest Rate:	1.25% per annum
Floating Interest Rate:	During the Floating Interest Period, the Notes are capped. The per annum floating interest rate payable on the Notes during any such Interest Period will equal the lesser of (a) LIBOR + the Spread and (b) the Maximum Rate/Cap. The Floating Interest Rate will also be subject to a minimum rate of 0.00% (the "**Minimum Rate**").

Spread:	30 basis points (0.30%)
Maximum Rate/Cap:	5.00% per annum
LIBOR:	The offered rate appearing on the Reference Page as of 11:00 a.m., London time, on the LIBOR Interest Determination Date, for deposits of U.S. Dollars having the Index Maturity.
Index Maturity:	Three months
Reference Page	Reuters page LIBOR01
LIBOR Interest Determination Dates:	The second London Business Day preceding the relevant Interest Reset Date (regardless of whether such Interest Reset Date is a Business Day).
London Business Day:	A Monday, Tuesday, Wednesday, Thursday or Friday that is neither a legal holiday nor a day on which banking institutions are authorized or required by law, regulation or executive order to close, in London.
Interest Reset Dates:	Each Interest Payment Date (regardless of whether such day is a Business Day or London Business Day)
Day Count Fraction:	30/360, unadjusted, following business day convention (all as more fully described below).
Form of Notes:	Book-entry
Calculation Agent:	Scotia Capital Inc., an affiliate of the Bank
Status:	The Notes will constitute direct, unsubordinated and unsecured obligations of the Bank ranking *pari passu* with all other direct, unsecured and unsubordinated indebtedness of the Bank from time to time outstanding (except as otherwise prescribed by law). Holders will not have the benefit of any insurance under the provisions of the Canada Deposit Insurance Corporation Act, the U.S. Federal Deposit Insurance Act or under any other deposit insurance regime
Tax Redemption:	The Bank (or its successor) may redeem the Notes, in whole but not in part, at a redemption price equal to the Principal Amount thereof together with accrued and unpaid interest to the date fixed for redemption, if it is determined that changes in tax laws or their interpretation will result in the Bank (or its successor) becoming obligated to pay, on the next Interest Payment Date, additional amounts with respect to the Notes. See “Tax Redemption” in this pricing supplement.
Listing:	The Notes will not be listed on any securities exchange or quotation system
Use of Proceeds:	General corporate purposes
Clearance and Settlement:	Depository Trust Company
Terms Incorporated:	All of the terms appearing under the caption “General Terms of the Notes” beginning on page PS-10 in the accompanying product prospectus supplement, as modified by this pricing supplement

ADDITIONAL TERMS OF YOUR NOTES

You should read this pricing supplement together with the prospectus dated August 1, 2013, as supplemented by the prospectus supplement dated August 8, 2013 and the product prospectus supplement (Rate Linked Notes, Series A) dated August 8, 2013, relating to our Senior Note Program, Series A, of which these Notes are a part. Capitalized terms used but not defined in this pricing supplement will have the meanings given to them in the product prospectus supplement. In the event of any conflict, this pricing supplement will control. ***The Notes may vary from the terms described in the accompanying product prospectus supplement in several important ways. You should read this pricing supplement carefully.***

This pricing supplement, together with the documents listed below, contains the terms of the Notes and supersedes all prior or contemporaneous oral statements as well as any other written materials including preliminary or indicative pricing terms, correspondence, trade ideas, structures for implementation, sample structures, brochures or other educational materials of ours. You should carefully consider, among other things, the matters set forth in "Additional Risk Factors Specific to the Notes" in the accompanying product prospectus supplement, as the Notes involve risks not associated with conventional debt securities. We urge you to consult your investment, legal, tax, accounting and other advisors before you invest in the Notes. You may access these documents on the SEC website at www.sec.gov as follows (or if that address has changed, by reviewing our filings for the relevant date on the SEC website at

http://www.sec.gov/cgi-bin/browse-edgar?action=getcompany&CIK=0000009631):

Prospectus dated August 1, 2013:

http://www.sec.gov/Archives/edgar/data/9631/000089109213006699/e54840_424b3.htm

Prospectus Supplement dated August 8, 2013:

http://www.sec.gov/Archives/edgar/data/9631/000089109213006938/e54968_424b3.htm

Product Prospectus Supplement (Rate Linked Notes, Series A), dated August 8, 2013

http://www.sec.gov/Archives/edgar/data/9631/000089109213006942/e54970_424b5.htm

The Bank of Nova Scotia has filed a registration statement (including a prospectus, a prospectus supplement, and a product prospectus supplement) with the SEC for the offering to which this pricing supplement relates. Before you invest, you should read those documents and the other documents relating to this offering that we have filed with the SEC for more complete information about us and this offering. You may obtain these documents without cost by visiting EDGAR on the SEC Website at www.sec.gov. Alternatively, The Bank of Nova Scotia, any agent or any dealer participating in this offering will arrange to send you the prospectus, the prospectus supplement and the product prospectus supplement if you so request by calling 1-416-866-3672.

PAYMENT AT MATURITY

We will pay you the Principal Amount of your Notes on the Maturity Date, plus the final interest payment.

In the event that the stated Maturity Date is not a Business Day, then relevant repayment of principal will be made on the next Business Day, regardless of whether such Business Day falls in the month following that in which the stated Maturity Date would otherwise have fallen ("following business day convention").

Interest

The Notes are Capped Fixed-to-Floating Rate Notes. The Fixed Interest Rate will apply for the first eight quarterly Interest Periods and will be 1.25% per annum. The Floating Interest Rate will apply thereafter and will equal the per annum interest

rate of LIBOR plus the Spread of 30 basis points (0.30%), subject to a Minimum Rate of 0.00% and a Maximum Rate/Cap of 5.00% per annum.

We describe payments as being based on a “day count fraction” of 30/360, unadjusted, “following business day convention”.

This means that the number of days in the Interest Period will be based on a 360-day year of twelve 30-day months (“30/360”) and that the number of days in each Interest Period will not be adjusted if an Interest Payment Date falls on a day that is not a Business Day (“unadjusted”).

If any Interest Payment Date falls on a day that is not a Business Day (including any Interest Payment Date that is also the Maturity Date), the relevant payment of interest will be made in accordance with the following business day convention.

Notwithstanding anything in the Prospectus, Prospectus Supplement, or Product Prospectus Supplement:

- the “Interest Reset Date” will be the stated Interest Payment Date, not the third Wednesday of the month, and the Interest Reset Date will occur on that date even if it is not a Business Day. See “Description of the Notes—Interest Rates—Interest Reset Dates” in the Prospectus Supplement. Thus, the deposits on which LIBOR is based may not, in fact, commence on the relevant Interest Reset Date. See “Description of the Notes—Interest Rates—LIBOR Notes” in the Supplement.

- the “Interest Payment Dates” will be the Interest Payment Dates specified above. See “Description of the Notes—Interest Rates—Interest Payment Dates” in the Prospectus Supplement.

- regardless of whether the Notes are paying a fixed or floating rate of interest, if the Interest Payment Date would otherwise fall on a day that is not a Business Day and the next Business Day falls in the next calendar month, then the Interest Payment Date will still be advanced to the next day that is a Business Day. See “Description of the Notes—Interest Rates—Interest Payment Dates” in the Prospectus Supplement.

EVENTS OF DEFAULT AND ACCELERATION

If the Notes have become immediately due and payable following an Event of Default (as defined in the accompanying prospectus) with respect to the Notes, the Calculation Agent will determine (i) your Principal Amount and (ii) any accrued but unpaid interest payable based upon the then-applicable interest rate calculated on the basis of a 360-day year consisting of twelve 30-day months.

If the Notes have become immediately due and payable following an Event of Default, you will not be entitled to any additional payments with respect to the Notes. For more information, see "Description of the Debt Securities We May Offer — Events of Default" beginning on page 21 of the accompanying prospectus.

TAX REDEMPTION

The Bank (or its successor) may redeem the Notes, in whole but not in part, at a redemption price equal to the Principal Amount thereof together with accrued and unpaid interest to the date fixed for redemption, upon the giving of a notice as described below, if:

- as a result of any change (including any announced prospective change) in or amendment to the laws (or any regulations or rulings promulgated thereunder) of Canada (or the jurisdiction of organization of the successor to the Bank) or of any political subdivision or taxing authority thereof or therein affecting taxation, or any change in official position regarding the application or interpretation of such laws, regulations or rulings (including a holding by a court of competent jurisdiction), which change or amendment is announced or becomes effective on or after the Pricing Date (or, in the case of a successor to the Bank, after the date of succession), and which in the written opinion to the Bank (or its successor) of legal counsel of recognized standing has resulted or will result (assuming, in the case of any announced prospective change, that such announced change will become effective as of the date specified in

such announcement and in the form announced) in the Bank (or its successor) becoming obligated to pay, on the next succeeding date on which interest is due, additional amounts with respect to the Notes; or

- on or after the Pricing Date (or, in the case of a successor to the Bank, after the date of succession), any action has been taken by any taxing authority of, or any decision has been rendered by a court of competent jurisdiction in, Canada (or the jurisdiction of organization of the successor to the Bank) or any political subdivision or taxing authority thereof or therein, including any of those actions specified in the paragraph immediately above, whether or not such action was taken or decision was rendered with respect to the Bank (or its successor), or any change, amendment, application or interpretation shall be officially proposed, which, in any such case, in the written opinion to the Bank (or its successor) of legal counsel of recognized standing, will result (assuming, in the case of any announced prospective change, that such change, amendment, application, interpretation or action is applied to the Notes by the taxing authority and that such announced change will become effective as of the date specified in such announcement and in the form announced) in the Bank (or its successor) becoming obligated to pay, on the next succeeding date on which interest is due, additional amounts with respect to the Notes;

and, in any such case, the Bank (or its successor), in its business judgment, determines that such obligation cannot be avoided by the use of reasonable measures available to it (or its successor).

In the event the Bank elects to redeem the Notes pursuant to the provisions set forth in the preceding paragraph, it shall deliver to the Trustees a certificate, signed by an authorized officer, stating (i) that the Bank is entitled to redeem such Notes pursuant to their terms and (ii) the Principal Amount of the Notes to be redeemed.

Notice of intention to redeem such Notes will be given to holders of the Notes not more than 45 nor less than 30 days prior to the date fixed for redemption and such notice will specify, among other things, the date fixed for redemption and the redemption price.

ADDITIONAL RISK FACTORS

An investment in the Notes involves significant risks. In addition to the following risks included in this pricing supplement, we urge you to read “Additional Risk Factors Specific to the Notes” beginning on page PS-5 of the accompanying product prospectus supplement and “Risk Factors” beginning on page S-2 of the accompanying prospectus supplement and on page 6 of the accompanying prospectus.

You should understand the risks of investing in the Notes and should reach an investment decision only after careful consideration, with your advisers, of the suitability of the Notes in light of your particular financial circumstances and the information set forth in this pricing supplement and the accompanying prospectus, prospectus supplement and product prospectus supplement.

After the First Eight Quarterly Interest Periods, the Amount of Each Interest Payment on an Interest Payment Date is Variable and may be 0.00% Per Annum.

Following the first eight quarterly Interest Periods, you will receive interest on the applicable Interest Payment Date based on a rate per annum equal to the LIBOR fixed on the corresponding Interest Determination Date plus Spread of 30 basis points (0.30%), subject to the Maximum Rate/Cap of 5.00% per annum. While the interest rate applicable to each Interest Payment Date after the first eight quarterly Interest Periods will fluctuate because it is based on the floating rate of LIBOR, the interest rate for any Interest Payment Date will not be greater than the Maximum Rate/Cap. The Floating Interest Rate is subject to a Minimum Rate of 0.00% per annum.

Interest Rate Risk

Generally, when market interest rates rise, the prices of debt obligations fall, and vice versa. This risk may be particularly acute because market interest rates are currently at historically low levels. The prices of long-term debt obligations generally fluctuate more than prices of short-term debt obligations as interest rates change. The Notes are a long-term investment in a

fixed interest rate for the first eight quarterly Interest Periods and an investment in a floating interest rate for the remaining Interest Periods. However, the Floating Interest Rate will become fixed if it rises above the Maximum Rate/Cap. Fixed interest rate instruments are generally more sensitive to market interest rate changes; however floating rate instruments may nevertheless decline in value in response to market interest rate changes. Therefore, an increase in market interest rates will adversely affect the value of your Notes. Furthermore, there can be no assurance that the Floating Interest Rate shall exceed the Fixed Interest Rate.

The Interest Rate for Each Interest Payment Date is limited by the Maximum Rate/Cap.

For each Interest Payment Date during the period when the Note bears a Floating Interest Rate, the Floating Interest Rate will be capped at the Maximum Rate/Cap. THE INTEREST RATE FOR EACH SUCH INTEREST PAYMENT DATE WILL NOT BE GREATER THAN THE MAXIMUM RATE/CAP.

The interest rate on the Notes for the Floating Interest Period is limited to the Maximum Rate/Cap of 5.00% per annum. Even if the Floating Interest Rate is greater than the Maximum Rate/Cap, the Notes will bear interest for such Floating Interest Period only at 5.00% per annum. The Maximum Rate/Cap may be lower than the interest rates for similar debt securities then-prevailing in the market.

As a result of the fact that the quarterly interest rate may not be greater than the Maximum Rate/Cap, you will not be fully compensated for any loss in value due to inflation and other factors relating to the value of money over time. You should consider, among other things, the overall potential annual interest rate of the Notes (taking the Maximum Rate/Cap into account) as compared to other investment alternatives.

Repayment of Principal Only at Maturity.

The Notes offer repayment of principal only if you hold your Notes until the Maturity Date.

Because the Notes Accrue Interest at a Floating Rate During the Floating Rate Period, You May Receive a Lesser Amount of Interest After Such Period.

The interest payable on the Notes during the Floating Interest Period will accrue at a per annum rate equal to the Floating Interest Rate, as determined on the LIBOR Interest Determination Date, subject to the Maximum Rate/Cap. LIBOR may vary from time to time and there will be significant risks not associated with a conventional fixed–rate

debt security. These risks include fluctuation of LIBOR and the possibility that, in the future, the interest rate on the Notes will decrease for any Floating Interest Period.

Because the Notes Accrue Interest at a Fixed Rate During the Fixed Interest Period, the Amount of Interest Payable on Your Notes on Each Interest Payment Date for any Fixed Interest Period May be Below Market Interest Rates.

Because interest payable on your Notes during the Fixed Interest Period accrues at a fixed rate, there can be no guarantee that the interest you will receive on one or more of the Interest Payment Dates for the Fixed Interest Period will be equal to or greater than the market interest rate on such dates. We have no control over a number of factors that may affect market interest rates, including economic, financial and political events that are important in determining the existence, magnitude and longevity of these risks and their results. You should have a view as to the Fixed Interest Rate on the Notes (as specified on the cover and in the "Summary" section of this pricing supplement) and its level relative to market interest rates before investing, and you must be willing to forgo guaranteed market interest rates during the Fixed Interest Period.

LIBOR, and Therefore the Value of the Notes, May be Volatile and Will Be Affected by a Number of Factors.

LIBOR, and therefore the value of the Notes is subject to volatility due to a variety of factors, including but not limited to:

- interest and yield rates in the market,
- changes in, or perceptions about future LIBOR rates,

- general economic conditions,
- policies of the U.S. Federal Reserve Board regarding interest rates,
- supply and demand among banks in London for U.S. dollar-denominated deposits with the relevant term,
- sentiment regarding underlying strength in the U.S. and global economies,
- expectations regarding the level of price inflation,
- sentiment regarding credit quality in the U.S. and global credit markets,
- inflation and expectations concerning inflation,
- performance of capital markets,
- geopolitical conditions and economic, financial, political, regulatory or judicial events that affect markets generally and that may affect LIBOR.

The impact of any of the factors set forth above may enhance or offset some or all of the changes resulting from another factor or factors. A lower LIBOR will result in the corresponding interest rate decreasing, but in no case will the interest rate be greater than the Maximum Rate/Cap.

Changes in Banks' Inter-Bank Lending Rate Reporting Practices or Methods Pursuant to which the LIBOR Rates are determined may adversely affect the Value of Your Notes.

Regulators and law enforcement agencies from a number of governments have been conducting investigations relating to the calculation of the London Interbank Offered Rate, or LIBOR, across a range of maturities and currencies, and certain financial institutions that were member banks surveyed by the British Bankers' Association (the "BBA") in setting daily LIBOR have entered into agreements with the U.S. Department of Justice, the U.S. Commodity Futures Trading Commission and/or the U.K. Financial Services Authority in order to resolve the investigations. In addition, in September 2012, the U.K. government published the results of its review of LIBOR, commonly referred to as the "Wheatley Review." The Wheatley Review made a number of recommendations for changes with respect to LIBOR, including the introduction of statutory regulation of LIBOR, the transfer of responsibility for LIBOR from the BBA to an independent administrator, changes to the method of compilation of lending rates, new regulatory oversight and enforcement mechanisms for rate-setting and the corroboration of LIBOR, as far as possible, by transactional data. Based on the Wheatley Review, on March 25, 2013, final rules for the regulation and supervision of LIBOR by the U.K. Financial Conduct Authority (the "FCA") were published and came into effect on April 2, 2013 (the "FCA Rules"). In particular, the FCA Rules include requirements that (1) an independent LIBOR administrator monitor and survey LIBOR submissions to identify breaches of practice standards and/or potentially manipulative behavior, and (2) firms submitting data to LIBOR establish and maintain a clear conflicts of interest policy and appropriate systems and controls. In addition, in response to the Wheatley Review recommendations, ICE Benchmark Administration Limited has been appointed as the independent LIBOR administrator, effective February 1, 2014. It is not possible to predict the further effect of the FCA Rules, any changes in the methods pursuant to which LIBOR rates are determined or any other reforms to LIBOR that may be enacted in the U.K., the European Union (the "EU") and elsewhere, each of which may adversely affect the trading market for LIBOR-based securities. In addition, any changes announced by the FCA, ICE Benchmark Administration Limited, the European Commission or any other successor governance or oversight body, or future changes adopted by such body, in the method pursuant to which LIBOR rates are determined may result in a sudden or prolonged increase or decrease in the reported LIBOR rates. If such changes and reforms were to be implemented, the level of interest payments and the value of the Notes may be affected. Further, uncertainty as to the extent and manner in which the Wheatley Review recommendations and other proposed reforms will continue to be adopted and the timing of such changes may adversely affect the current trading market for the Notes and their

value.

The Notes are Not Ordinary Debt Securities.

The Notes have certain investment characteristics that differ from traditional fixed income securities. Specifically, the performance of the Notes will not track the same price movements as traditional interest rate products. A person should reach a decision to invest in the Notes after carefully considering, with his or her advisors, the suitability of the Notes in light of his or her investment objectives and the information set out in the above terms of the offering. The Bank does not make any recommendation as to whether the Notes are a suitable investment for any person.

Historical Levels of the 3-Month USD LIBOR do not guarantee Future Levels.

The 3-Month USD LIBOR historical levels do not guarantee future levels of the 3-Month USD LIBOR. It is not possible to predict whether the levels of the 3-Month USD LIBOR will rise or fall during the term of the Notes.

3-Month USD LIBOR as of any LIBOR Interest Determination Date may be less than 3-Month USD LIBOR as of any Other Day during the Term of the Notes.

Because 3-Month USD LIBOR for any relevant Interest Period will be determined solely as of two London Business Days prior to the previous Interest Reset Date, 3-Month USD LIBOR will not be considered on any other dates during the term of the Notes. Therefore, even if 3-Month USD LIBOR as of any day that is not the LIBOR Interest Determination Date for the applicable Interest Period is higher than 3-Month USD LIBOR as of such LIBOR Interest Determination Date, the amount of interest on the corresponding Interest Payment Date will not take into account that higher level.

Your Yield may be lower than the Yield on Other Debt Securities of Comparable Maturity.

The yield that you will receive on your Notes may be less than the return you could earn on other investments. The interest payable for (i) any of the first 8 (eight) Interest Periods is based on a rate of 1.25% per annum, and (ii) any of the remaining Interest Periods is linked to the 3-Month USD LIBOR as of the applicable Interest Reset Date plus 0.30% (subject to the Maximum Rate/Cap). If there is a decline in the 3-Month USD LIBOR over the term of your Notes, the effective yield on your Notes for such Interest Period may be less than that which would be payable on a conventional fixed-rate debt security with the same stated Maturity Date, including those of the Bank. Your investment may not reflect the full opportunity cost to you when you take into account factors that affect the time value of money.

Your Investment is Subject to the Credit Risk of The Bank of Nova Scotia.

The Notes are senior unsecured debt obligations of The Bank of Nova Scotia, and are not, either directly or indirectly, an obligation of any third party. As further described in the accompanying prospectus, prospectus supplement and product prospectus supplement, the Notes will rank on par with all of the other unsecured and unsubordinated debt obligations of The Bank of Nova Scotia, except such obligations as may be preferred by operation of law. Any payment to be made on the Notes, including the return of the Principal Amount at maturity, depends on the ability of The Bank of Nova Scotia to satisfy its obligations as they come due. As a result, the actual and perceived creditworthiness of The Bank of Nova Scotia may affect the market value of the Notes and, in the event The Bank of

Nova Scotia were to default on its obligations, you may not receive the amounts owed to you under the terms of the Notes.

The Price at Which the Notes may be sold prior to Maturity will depend on a Number of Factors and May Be Substantially Less Than the Amount for Which They Were Originally Purchased.

The price at which the Notes may be sold prior to maturity will depend on a number of factors. Some of these factors include, but are not limited to: (i) volatility of the level of interest rates and the market's perception of future volatility of the level of interest rates, (ii) changes in interest rates generally, (iii) any actual or anticipated changes in our credit ratings or credit spreads, and (iv) time remaining to maturity.

Depending on the actual or anticipated level of interest rates, the market value of the Notes may decrease and you may receive substantially less than 100% of the issue price if you sell your Notes prior to maturity.

The Inclusion of Dealer Spread and Projected Profit from Hedging in the Original Issue Price is Likely to Adversely Affect Secondary Market Prices.

Assuming no change in market conditions or any other relevant factors, the price, if any, at which Scotia Capital (USA) Inc. or any other party is willing to purchase the Notes at any time in secondary market transactions will likely be significantly lower than the original issue price, since secondary market prices are likely to exclude underwriting commissions paid with respect

to the Notes and the cost of hedging our obligations under the Notes that are included in the original issue price. The cost of hedging includes the projected profit that we and/or our subsidiaries may realize in consideration for assuming the risks inherent in managing the hedging transactions. These secondary market prices are also likely to be reduced by the costs of unwinding the related hedging transactions. In addition, any secondary market prices may differ from values determined by pricing models used by Scotia Capital (USA) Inc. as a result of dealer discounts, mark-ups or other transaction costs.

The Notes Lack Liquidity.

The Notes will not be listed on any securities exchange or automated quotation system. Therefore, there may be little or no secondary market for the Notes. Scotia Capital (USA) Inc. or any other dealer may, but is not obligated to, make a market in the Notes. Even if there is a secondary market, it may not provide enough liquidity to allow you to trade or sell the Notes easily. Because we do not expect that other broker-dealers will participate significantly in the secondary market for the Notes, the price at which you may be able to trade your Notes is likely to depend on the price, if any, at which Scotia Capital (USA) Inc. is willing to purchase the Notes from you. If at any time Scotia Capital (USA) Inc. or any other dealer were not to make a market in the Notes, it is likely that there would be no secondary market for the Notes. Accordingly, you should be willing to hold your Notes to maturity.

We, our Subsidiaries, or Affiliates may Publish Research that Could Affect the Market Value of the Notes. We also expect to Hedge Our Obligations under the Notes.

We or one or more of our affiliates may, at present or in the future, publish research reports with respect to movements in interest rates generally. This research is modified from time to time without notice and may express opinions or provide recommendations that are inconsistent with purchasing or holding the Notes. Any of these activities may affect the market value of the Notes. In addition, our subsidiaries expect to hedge our obligations under the Notes and they may realize a profit from that expected hedging activity even if investors do not receive a favorable investment return under the terms of the Notes or in any secondary market transaction.

HISTORICAL PERFORMANCE OF LIBOR

Historically, LIBOR has experienced significant fluctuations. Any historical upward or downward trend in the level of LIBOR during any period shown below is not an indication that the interest payable on the Notes is more or less likely to increase or decrease at any time during the floating rate period.

The Floating Interest Rate was 0.2351% on March 6, 2014. The graph below sets forth the historical performance of the Floating Interest Rate from January 1, 2004 through March 6, 2014. ***Past performance of the 3-Month USD LIBOR is not indicative of future performance of the 3-Month USD LIBOR.***

We obtained the information regarding the historical performance of the *3-Month USD LIBOR* in the graph above from Bloomberg Financial Markets. We make no representation or warranty as to the accuracy or completeness of the information obtained from Bloomberg Financial Markets and have not undertaken an independent review or due diligence of the information. The historical performance of the *3-Month USD LIBOR* should not be taken as an indication of its future performance, and no assurance can be given as to the Final Price of the *3-Month USD LIBOR*. We cannot give you assurance that the performance of the *3-Month USD LIBOR* will result in any positive return on your initial investment.

SUPPLEMENTAL PLAN OF DISTRIBUTION (CONFLICTS OF INTEREST)

Pursuant to the terms of a distribution agreement, Scotia Capital (USA) Inc., an affiliate of The Bank of Nova Scotia, will purchase the Notes from The Bank of Nova Scotia for distribution to other registered broker-dealers or will offer the Notes directly to investors.

Scotia Capital (USA) Inc. or one of our affiliates will purchase the Notes at the Principal Amount and as part of the distribution, if the Notes priced today, would pay varying discounts and underwriting commissions of $6.50 (0.65%) per $1,000 Principal Amount of the Notes in connection with the distribution of the Notes. The actual discounts and underwriting commissions that Scotia Capital (USA) Inc. or one of our affiliates will pay may be more or less than 0.65% and will depend on market conditions. Certain accounts may pay a purchase price of at least $985.00 (98.50%) per $1,000 Principal Amount of the Notes and third party distributors involved in such transactions may charge a discretionary fee with respect to such sales. In no event will Scotia Capital (USA) Inc. or one of our affiliates pay varying discounts and underwriting commissions in excess of $15.00 (1.50%) per $1,000 Principal Amount of the Notes in connection with the distribution of the Notes. Scotia Capital (USA) Inc. may also receive a structuring and development fee of up to $0.50 (0.05%) per $1,000 Principal Amount of the Notes.

In addition, Scotia Capital (USA) Inc. or another of its affiliates or agents may use the product prospectus supplement to which this pricing supplement relates in market-making transactions after the initial sale of the Notes. While Scotia Capital (USA) Inc. may make markets in the Notes, it is under no obligation to do so and may discontinue any market-making activities at any time without notice. See the sections titled “Supplemental Plan of Distribution” in the accompanying prospectus supplement and product prospectus supplement.

The price at which you purchase the Notes includes costs that the Bank or its affiliates expect to incur and profits that the Bank or its affiliates expect to realize in connection with hedging activities related to the Notes, as set forth above. These costs and profits will likely reduce the secondary market price, if any secondary market develops, for the Notes. As a result, you may experience an immediate and substantial decline in the market value of your Notes on the Issue Date.

Conflicts of Interest

Each of Scotia Capital (USA) Inc. and Scotia Capital Inc. is an affiliate of the Bank and, as such, has a ‘‘conflict of interest’’ in this offering within the meaning of FINRA Rule 5121. In addition, the Bank will receive the gross proceeds from the initial public offering of the Notes, thus creating an additional conflict of interest within the meaning of Rule 5121. Consequently, the offering is being conducted in compliance with the provisions of Rule 5121. Neither Scotia Capital (USA) Inc. nor Scotia Capital Inc. is permitted to sell the Notes in this offering to an account over which it exercises discretionary authority without the prior specific written approval of the account holder.

Scotia Capital (USA) Inc. and its affiliates are full service financial institutions engaged in various activities, which may include securities trading, commercial and investment banking, financial advisory, investment management, investment research, principal investment, hedging, financing and brokerage activities. Scotia Capital (USA) Inc. and

its affiliates have, from time to time, performed, and may in the future perform, various financial advisory and investment banking services for the Bank, for which they received or will receive customary fees and expenses.

In the ordinary course of their various business activities, Scotia Capital (USA) Inc. and its affiliates may make or hold a broad array of investments and actively trade debt and equity securities (or related derivative securities) and financial instruments (including bank loans) for their own account and for the accounts of their customers, and such investment and securities activities may involve securities and/or instruments of the Bank. Scotia Capital (USA) Inc. and its affiliates may also make investment recommendations and/or publish or express independent research views in respect of such securities or instruments and may at any time hold, or recommend to clients that they acquire, long and/or short positions in such securities and instruments.

CERTAIN CANADIAN INCOME TAX CONSEQUENCES

See “Certain Income Tax Consequences—Certain Canadian Income Tax Considerations” at page S-24 of the Prospectus Supplement dated August 8, 2013.

CERTAIN U.S. FEDERAL INCOME TAX CONSIDERATIONS

Based on forward rates for the Floating Interest Rate as of the date of this Pricing Supplement, we intend to treat the Notes as “variable rate debt instruments” that provide for a single fixed rate followed by a qualified floating rate (“QFR”) for U.S. federal income tax purposes. Under applicable Treasury Regulations, solely for the purpose of determining any original issue discount (“OID”) on the Notes, the initial fixed rate is converted to a QFR (the “substitute QFR”). The substitute QFR must be such that the fair market value of the Notes on the issue date is approximately the same as the fair market value of otherwise identical notes that provide for the substitute QFR (rather than the fixed rate) for the initial period. In determining any OID on the Notes, the Notes must then be converted into “equivalent” fixed rate debt instruments by replacing each QFR provided under the terms of the Notes (including the substituted QFR) with a fixed rate equal to the value of the QFR on the issue date of the Notes. Accordingly, depending on the result of this calculation as of the issue date of the Notes, the Notes may be issued with OID.

Qualified stated interest on the Notes will be taxable to a U.S. holder as ordinary interest income at the time it accrues or is received (in accordance with the holder’s method of tax accounting). If the Notes are issued with OID, a U.S. holder will be required to include the OID in income for federal income tax purposes as it accrues, in accordance with a constant-yield method based on a compounding of interest. Upon the sale or other taxable disposition of a Note, a U.S. holder generally will recognize capital gain or loss equal to the difference between the amount realized on such disposition and such holder’s adjusted tax basis in such Note. A U.S. holder’s adjusted tax basis in the Notes will equal the cost of the Notes to the holder, increased by the amounts of any original issue discount previously included in income by the holder with respect to the Notes and reduced by any payments other than qualified stated interest received by the holder. Such gain or loss generally will be long-term capital gain or loss if the U.S. holder has held the Notes for more than one year at the time of disposition.

You should carefully consider the discussion set forth in “Supplemental Discussion of U.S. Federal Income Tax Consequences” in the accompanying product prospectus supplement. In particular, U.S. holders should review the discussion under “—Fixed-to-Floating Rate Notes and Floating-to-Fixed Rate Notes” and “—Sale, Redemption or Maturity of Notes that Are Not Treated as Contingent Payment Debt Instruments” under “Supplemental Discussion of U.S. Federal Income Tax Consequences—Supplemental U.S. Tax Considerations—U.S. Holders—Where the term of your notes exceeds one year” in the product prospectus supplement and “—Variable Rate Debt Securities” in the prospectus, and non-U.S. holders should review the discussion set forth in “Supplemental Discussion of U.S. Federal Income Tax Consequences—Supplemental U.S. Tax Considerations—Non-U.S. Holders” in the product prospectus supplement. U.S. holders should also review the discussion under “—Treasury Regulations Requiring Disclosure of Reportable Transactions”, “—Information With Respect to Foreign Financial Assets” and “Backup Withholding and Information Reporting” under “United States Taxation” in the prospectus.

Foreign Account Tax Compliance Act. Sections 1471 through 1474 of the Internal Revenue Code (which are commonly referred to as “FATCA”) generally impose a 30% withholding tax on certain payments, including “pass-thru” payments to certain persons if the payments are attributable to assets that give rise to U.S.-source income or gain. Pursuant to recently issued final Treasury regulations and administrative guidance, this withholding tax would not be imposed on payments pursuant to obligations that are outstanding on July 1, 2014 (and are not materially modified after June 30, 2014). Accordingly, FATCA withholding generally is not expected to be required on the Notes. If, however, withholding is required as a result of future guidance, we (and any paying agent) will not be required to pay additional amounts with respect to the amounts so withheld.

Significant aspects of the application of FATCA are not currently clear and Investors should consult their own advisors about the application of FATCA, in particular if they may be classified as financial institutions under the FATCA rules.

Prospective purchasers of the Notes should consult their tax advisors as to the federal, state, local and other tax consequences to them of acquiring, holding and disposing of the Notes and receiving payments under the Notes.

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.

Appropriate Risk Coding

We strive to assure 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 assure 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.

Claims Processing

Pursuant to the HMO Agreements, each HMO, among other things, processes claims received from providers, including from our PSN, makes a determination as to whether and to what extent to allow such claims and makes payments for covered services rendered to Participating Customers using the subject HMO's claims processing systems, policies, procedures and guidelines. Each HMO provides notice to the PSN upon qualification of a claim and we have the opportunity to review such claim and approve, deny or modify the claim, as appropriate. Each HMO provides the PSN with electronic data and reports on a monthly basis, which are maintained at our executive offices. We statistically evaluate the data provided by each HMO for a variety of factors including the number of Participating Customers assigned to the PSN, the reasonableness of revenue paid to us and the claims paid on our behalf.

The PSN's staff reviews claims to identify errors and seeks recoveries.

Utilization Management

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

Staff Training

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

PSN Growth Strategy

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

- increasing the number of Participating Customers treated by the PSN physicians through enhanced marketing efforts;
- expanding the PSN's network of providers to include additional physician practices;
- expanding the PSN's geographic scope by contracting to provide and arrange for the provision of medical services to customers of HMO plans in states other than Florida;
- acquiring existing physician practices;
- opening new practices; and
- acquiring other PSNs.

Increasing Customer Base

We believe the PSN's existing network of providers has the capacity to care for additional Participating Customers and could realize certain additional economies of scale if the number of Participating Customers utilizing the network increased. We seek to increase the number of Participating Customers using the PSN network through the general marketing efforts of each HMO and through our own targeted marketing efforts towards Medicare eligible customers, including the use of our telemarketing capabilities.

Selectively Expanding Our Network of Physician Practices Including Acquisition of Existing Physician Practices or Other Provider Services Networks

We are seeking to add additional physician practices to the PSN's existing network either through acquisition of an unaffiliated primary care practice, acquisition of an IPA practice, acquisition of another PSN or opening new primary care offices. We identify and select opportunities based in large part on the following broad criteria:

a history of profitable operations or a perceived synergy such as opportunities for economies of scale through a consolidation of management or service provision functions;

a high concentration of Medicare patients;

a geographic proximity to underserved areas within our current service areas; and

the overall opportunity for new service areas.

As previously discussed, on October 4, 2011 we acquired Continucare which added approximately 36,400 Participating Customers. Also in 2011, we acquired three physician practices and opened a new primary care center.

Expanding the PSN's Geographic Scope

We are also seeking to expand the PSN by contracting with one or more HMO plans to provide and arrange for the provision of medical services to customers located outside the state of Florida. We expect to identify and select opportunities for geographic expansion based in part on the following broad criteria:

- the perceived market opportunity, including the number of Medicare and/or Medicaid beneficiaries residing in the area; and

- the competitive landscape, including the number of competing PSNs serving the area.

PSN Competition

The healthcare industry is highly competitive. We compete for customers with many other healthcare providers, including local physicians and practice groups as well as local, regional and national networks of physicians and healthcare companies. We believe that competition for customers is generally based upon the reputation of the physician treating the customer, the physician's expertise, the physician's demeanor and manner of engagement with the customer, the benefits offered, and the insurance companies and HMOs that the physician is affiliated with. We also compete with other local, regional and national networks of physicians and healthcare companies for the services of physicians and for HMO affiliations.

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

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 December 31, 2011, for 60.0% of our Participating Customers 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 $225,000 in 2011 and $200,000 in 2010 and 2009. Reinsurance recoveries under these policies are remitted to us and are recorded as a reduction to medical claims expense.

Government Regulation

Our operations are affected on a day-to-day basis by numerous federal and state legislative, regulatory and industry-imposed operational and financial requirements, which are administered by a variety of federal and state governmental agencies as well as by self-regulating associations and commercial medical insurance reimbursement programs. The laws and regulations governing our operations are generally intended for the benefit of health plan customers and providers and are intended to limit healthcare program expenditures. These laws and regulations, along with the terms of our contracts, regulate how we do business, what services we offer, and how we interact with Participating Customers, affiliated providers and the public. The government agencies administering these laws and

regulations have broad latitude to interpret and enforce them. We are subject to various governmental reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations.

We believe that we are in material compliance with all government regulations applicable to our business. We further believe that we have implemented reasonable systems and procedures to assist us in maintaining compliance with such regulations. Nonetheless, we face a variety of regulatory related risks. See "Description of Business – Government Regulation – Healthcare Reform Legislation in 2010 and 2011", "Risk Factors - Reductions in Funding for Medicare Programs…", "Risk Factors – CMS Risk Adjustment Payment System…", "Risk Factors - Our Business Activities Are Highly Regulated…", "Risk Factors - The Healthcare Industry is Highly Regulated…", and "Risk Factors - We Are Required to Comply with Laws…"

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

Healthcare Reform Legislation of 2010 and 2011

The Reform Acts 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 HHS 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. See "Item 1. Description of Business – Government Regulation –Healthcare Reform Legislation in 2010 and 2011."

Federal "Fraud and Abuse" Laws and Regulations

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

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

Federal Anti-Kickback Law

The federal Anti-Kickback Law prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce or reward, arrange for, or in return for (i) referrals of an individual for goods, facilities, items or services reimbursable (in whole or in part) by a federal healthcare program (including, without limitation, Medicare and/or Medicaid), or (ii) the purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing or ordering of such goods, facilities, items or services. Violations of the Anti-Kickback Law are punishable by imprisonment, criminal fines, civil monetary penalties, exclusion from federal and state healthcare programs and forfeiture of amounts collected in violation of such laws. "Remuneration" is defined broadly and includes virtually all economic arrangements involving hospitals, physicians and other healthcare providers, and any third party including joint ventures, space and equipment rentals, purchases of physician practices and management and personal services contracts. The Reform Acts relaxed the government's standard of proof to provide that, with regard to knowingly and willfully, a person does not need to have

knowledge of the Anti-Kickback Law or have the specific intent to violate it.

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

Physician Incentive Plan Regulations

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

Federal False Claims Act

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

Florida Fraud and Abuse Regulations

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

Restrictions on Physician Referrals

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

Privacy Laws

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

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

In 2009, as part of the American Recovery and Reinvestment Act of 2009 ("ARRA"), the federal government passed the Health Information Technology for Economic and Clinical Health Act ("HITECH"), which along with its implementing regulations has amended and supplemented HIPAA. HITECH, in part, provides for enhanced enforcement of HIPAA, imposes data breach notification requirements for unauthorized uses and disclosures of unsecured protected health information ("PHI"), and applies certain HIPAA provisions directly to business associates (i.e., business associates may now be held directly liable for violations of HIPAA rather than simply being held in breach of a contractual arrangement with a covered entity). HITECH also limits the use of PHI for marketing and limits the sale of PHI. HITECH mandates that HHS promulgate regulations to implement HITECH and HHS has not yet promulgated some regulations mandated by HITECH.

Clinic Licensure

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

Occupational Safety and Health Administration ("OSHA")

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

The Medicare Improvements for Patients and Providers Act of 2008

MIPPA addressed several aspects of the Medicare program. With respect to Medicare Advantage and Medicare Part D plans, MIPPA increased restrictions on marketing and sales activities, including limitations on compensation systems for agents and brokers, limitations on solicitation of beneficiaries, and prohibitions regarding many sales activities.

Employees

As of December 31, 2011, we had 1,140 full-time employees, 865 of which are employed by the PSN, 160 of which are employed by our sleep diagnostic business and 115 of which are on our corporate staff. None of our employees are covered by a collective bargaining agreement or are represented by a labor union. We consider our employee relations to be good.

Our Executive Officers

Set forth below are: (1) the names and ages of our executive officers as of the date of this Current Report on Form 10-K, (2) all positions with the Company presently held by each such person, and (3) the positions held by, and principal areas of responsibility of, each such person during the last five years.

Name	Age	Position
Michael M. Earley	56	Chairman of the Board and Chief Executive Officer

Jose A. Guethon, M.D.	49	Chief Operating Officer and President

Name	Age	Position
Robert J. Sabo, CPA.	61	Chief Financial Officer
Roberto L. Palenzuela, Esq.	48	General Counsel and Secretary
Luis H. Izquierdo	57	Chief Marketing Officer
Gemma Rosello	56	President – Continucare Corporation

MICHAEL M. EARLEY has served as our Chief Executive Officer since March 2003. He has also served as our Chairman of the Board since September 2004, with the exception of the period between December 7, 2009 and April 23, 2010. He previously served as a member of our Board of Directors from June 2000 to December 2002. From January 2002 until February 2003, Mr. Earley was self-employed as a corporate consultant. Previously, from January 2000 to December 2001, he served as Chief Executive Officer of Collins Associates, an institutional money management firm. From 1997 to December 1999, Mr. Earley served as Chief Executive Officer of Triton Group Management, a corporate consulting firm. From 1986 to 1997, he served in a number of senior management roles, including CEO and CFO of Intermark, Inc. and Triton Group Ltd., both publicly traded diversified holding companies and from 1978 to 1983, he was an audit and tax staff member of Ernst & Whinney. From 2002 until its sale in 2006, Mr. Earley served as a director and member of the audit committee of MPower Communications, a publicly traded telecommunications company. Mr. Earley received undergraduate degrees in accounting and business administration from the University of San Diego.

JOSE A. GUETHON, M.D. has served as our Chief Operating Officer and President since September 2009. Prior to his appointment, he served as President of the PSN since January 2006. Dr. Guethon initially joined us in October 2001 and has served in a variety of positions, including as Medical Director and Staff Physician from October 2001 through June 2004, as Senior Vice President of Utilization and Quality Improvement from June 2004 through January 2005 and as Chief Medical Officer of our HMO from January 2005 to December 2005. Dr. Guethon has approximately 15 years of healthcare experience both in clinical and administrative medicine, and is board-certified in family practice. Prior to joining us, Dr. Guethon served as the Regional Medical Director for JSA Healthcare Corporation, a provider services network located in Tampa, Florida from April 2001 to October 2001 and as the Medical Director of Humana's Orlando market operations from April 1998 to April 2001. Dr. Guethon earned an undergraduate degree from the University of Miami, a doctorate in medicine degree from the University of South Florida College of Medicine, and a M.B.A. from Tampa College.

ROBERT J. SABO, C.P.A. has served as our Chief Financial Officer since November 15, 2006. Mr. Sabo has over 39 years of financial expertise focused substantially in the Florida healthcare industry. From November 2003 to October 2006, he was the Chief Financial Officer of Hospital Partners of America, LLC, a privately held North Carolina healthcare services and hospital partnership company, where his duties included the day to day financial operations of the organization as well as the company's significant business development and merger and acquisition work. He began his career as a CPA in South Florida with Ernst & Young in 1972, and was admitted to the partnership in 1984. He was the Market Leader of the Health Science Practice of the Carolinas from January 1999 to June 2003. Mr. Sabo graduated with a B.B.A. in accounting from the University of Miami. He is a Certified Public Accountant and a member of the American Institute of Certified Public Accountants.

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

1985 and a law degree from the University of Miami School of Law in 1988.

LUIS H. IZQUIERDO has served as our Chief Marketing Officer since the closing of our acquisition of Continucare on October 4, 2011. With over twenty years of health plan and provider marketing and sales senior leadership experience, Mr. Izquierdo most recently was Senior Vice President of Marketing and Business Development for Continucare from January 2004 until October 2011. From 2002 to 2004, Mr. Izquierdo served as Senior Vice President and as a member of the Board of Directors of Neighborhood Health Partnership, a for-profit Florida HMO. From 1999 to 2001, Mr. Izquierdo was Senior Vice President of Marketing, sales and Customer Service for Foundation Health, Florida. From 1997 to 1999, he served as Senior Vice President and Chief Marketing Officer for Oral Health Services, a regional dental and vision health plan. As Corporate Vice President of Marketing and Sales for Physician Corporation of America from 1995 to 1997, Mr. Izquierdo was responsible for all lines of business throughout seven states and Puerto Rico, and, from 1992 to 1995; he served as Senior Vice President, Marketing and Sales for CAC-Ramsay Health Plans. Mr. Izquierdo is a graduate of the University of Miami with a B.B.A. and M.B.A. each in marketing and finance. Additionally, he has attended the Executive Marketing Program at the University of Colorado.

GEMMA ROSELLO has served as President - Continucare Corporation since the closing of our acquisition of Continucare on October 4, 2011. Prior to that, Ms. Rosello served in various positions with Continucare, including as Executive Vice President — Operations from October 2006 to October 2011 and as Senior Vice President — Operations from May 2005 until October 2006. Prior to joining Continucare, Ms. Rosello served as the Medicare Business Development Director for AvMed Health Plan, a non-profit HMO. She served as Vice President of Health Services for Neighborhood Health Plan, a for-profit HMO serving the tri-county area of South Florida from 2003 to 2004. From 1993 to 2002, she served as the Chief Executive Officer of Medical Utilization Review Associates, a management service organization, and Apex Health Services, which managed Medicare, Medicaid and commercial full risk contracts with national and regional payers. Prior to her work in the managed care arena, Ms. Rosello served as Chief Operating Officer for an acute medical/surgical non-profit hospital in Miami, Florida. Ms. Rosello received an undergraduate degree in Nursing from the University of Florida and a M.B.A. from the University of Miami.

ITEM 1A. RISK FACTORS

We Incurred Substantial Indebtedness to Finance the Merger and May Not Be Able to Meet Our Substantial Debt Service Requirements.

We incurred substantial indebtedness in connection with the Merger. As of December 31, 2011, our total indebtedness under the Credit Facilities was approximately $320.0 million. In addition, we have the ability to borrow an additional $30.4 million under the Revolving Loan Facility. Our ability to satisfy our obligations and to reduce our total debt depends on future operating performance and on economic, financial, competitive and other factors, many of which are beyond our control.

If we are unable to generate sufficient funds to meet our obligations under our new Credit Facilities, we may be required to refinance, restructure or otherwise amend some or all of such obligations, sell assets or raise additional cash through the sale of equity. We cannot make any assurances that we would be able to obtain such refinancing on terms as favorable as those set forth in the Credit Facilities or that such restructuring activities, sales of assets or issuances of equity can be accomplished or, if accomplished, would raise sufficient funds to meet these obligations.

These provisions could have a material adverse effect on our ability to withstand competitive pressures or adverse economic conditions (including adverse regulatory changes); could adversely affect our ability to make material acquisitions, obtain future financing or take advantage of business opportunities that may arise; and could increase our vulnerability to a downturn in economic conditions or in our business.

Our Credit Facilities Contain Restrictions That Will Limit Our Flexibility in Operating our Business.

Our Credit Facilities contain restrictive covenants, subject to certain basket amounts and exceptions. These covenants impose significant operating restrictions on us and our subsidiaries, including our and their ability to:

- incur or amend certain types of indebtedness and liens;
- merge with, make an investment in or acquire any property or assets of another company;
- make capital expenditures;
- pay cash dividends;
- repurchase shares of our outstanding stock;

make loans;

dispose of assets (including the equity securities of our subsidiaries); or

prepay the principal on any subordinate indebtedness (including prepayments of indebtedness under the Second Lien Credit Agreement while any indebtedness is outstanding under the First Lien Credit Agreement).

Unless we receive a consent or a waiver from our lenders, these restrictions may limit our ability to pursue our business strategies and/or undertake actions that may be in our best interests. There can be no assurance that we will be able to receive a consent or waiver on acceptable terms, if at all.

Our Credit Facilities Require Us to Dedicate Substantially All of Cash Flow From Operations to the Payment of Principal and Interest, Which Will Reduce Our Ability to Use Our Cash Flow to Fund Our Operations, Capital Expenditures and Future Business Opportunities.

The First Lien Credit Agreement requires us to make quarterly principal amortization payments of between 5.0% and 12.5% of the $240.0 million total loan per year through maturity. In addition, we are required to make Mandatory Prepayments under the First Lien and Second Lien Credit Agreements (subject to certain basket amounts and exceptions) equal to:

75% of our excess free cash flow on an annual basis, beginning for the year ended December 31, 2012. (50% if our total leverage ratio is 2.00x or lower on the last day of any applicable year);

50% of the net proceeds from publicly-offered equity issuances (25% if our senior leverage ratio is 1.25x or lower on the last day of the last fiscal quarter prior to such equity issuance for which financial statements were required to be delivered to the lenders); and

100% of the net proceeds from asset sales, permitted debt issuances and extraordinary receipts.

Any amounts required to be applied to Mandatory Prepayments under our Credit Facilities as described above would not be available to us for any other purpose, including to fund our future operations, capital expenditures and future business opportunities, which may severely limit our liquidity and adversely affect our ability to grow our business and/or take advantage of unanticipated business opportunities.

The Credit Facilities Substantially Limit Our Ability to Prepay or Refinance the Second Lien Term Facility.

Borrowings under the Second Lien Credit Agreement accrue interest at a significantly higher rate of interest than borrowings under the First Lien Credit Agreement. Prior to the repayment of all borrowings under the First Lien Credit Agreement, we are not permitted to prepay any borrowings under the Second Lien Credit Agreement without the prior consent of the First Lien Lenders and/or retirement of the First Lien Credit Agreement. As a result, our ability to prepay or refinance the more expensive Second Lien Term Facility prior to the repayment of all borrowings under the First Lien Credit Agreement will be severely limited.

Furthermore, to the extent a prepayment of borrowings under the Second Lien Credit Agreement is permitted, such prepayment will be subject to a make-whole payment (including a prepayment penalty of 5.0%) if the prepayment is made prior to May 4, 2013, or a prepayment penalty (without the requirement of a make-whole payment) of between 5.0% and 2.0% if the prepayment is made between May 4, 2013 and October 3, 2015, respectively, which has the effect of substantially increasing the cost to us of any refinancing of the Second Lien Term Facility if replacement debt is available on more favorable terms than the Second Lien Term Facility.

Fluctuations in Interest Rates Could Adversely Affect Our Liquidity, Interest Expense and Financial Results.

The Credit Facilities have variable interest rates. To the extent these interest rates increase, our interest expense may increase, in which event, we may have difficulty making interest payments and funding our other costs and our ability to comply with the financial covenants in the Credit Facilities may be adversely affected. We entered into an interest rate cap effective December 4, 2011, which provides interest rate protection in the event LIBOR exceeds 1.5%. This interest rate cap has a notional amount of $157.5 million, 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.

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

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

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

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

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

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

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

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

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

Due to the Reform Acts' recent passage, scope and complexity, the unsettled nature of the reforms and the numerous steps required to implement them, and our inability to predict or dictate how the Contracting HMO's Participating Customers and/or our various direct and indirect competitors will react to the Reform Acts, we believe that we have limited ability to predict the direct and indirect effects of the Reform Acts upon the Medicare Advantage industry and us. For instance, although we anticipate that we will experience a decline in per beneficiary payment rates under the Reform Acts, we also anticipate the impact of such reduction on us will be mitigated, by some indeterminate amount by some of the following factors: enhanced medical management that will reduce the cost of care, reduced plan benefit offerings, increased customer co-pays and deductibles, the potential for plan quality bonuses, improved plan risk score compliance and/or other factors. We note that, although we are seeking to implement various operational and strategic initiatives with respect to the Reform Acts, our ability to anticipate and effectuate certain initiatives is significantly restricted since we have limited ability to influence, among other things, the Contracting HMOs' marketing efforts to increase enrollment in the plans that we serve, the plan benefits offered by the Contracting HMOs, the plan co-pays and deductibles set by the Contracting HMOs and/or the quality ratings received by the Contracting HMO plans that we serve. If we fail to realize our operational and strategic objectives with respect to the

Reform Acts for any reason, it is reasonably possible that our business may be materially adversely affected by the Reform Acts and related regulations.

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

There are numerous steps required to implement the Reform Acts, and Congress may seek to alter or eliminate some of the provisions described above. Numerous legal challenges have also been raised to the Reform Acts that could alter or eliminate certain provisions. The United States Supreme Court is expected to review challenges to the Reform Acts in March 2012, including whether, if the health insurance mandate is not constitutional, all or some other portions of the Reform Acts are not severable and cannot be implemented. A decision is expected by the end of June 2012. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance reforms may be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business. However, the enacted reforms as well as future legislative changes may have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

Our Operations are Dependent on Competing HMOs and, at Times, Their and Our Economic Interests May Diverge.

For the year ended December 31, 2011, 94.2%, of our revenue was earned through our contracts with Humana. We also have contracts with United, Coventry and Wellcare, among others. These contracts were assumed pursuant to our acquisition of Continucare and Continucare's results are reflected in our financial results from the date of the completion of the acquisition, October 4, 2011. We expect the percentage of revenue from these agreements to increase in 2012, the first full year in which Continucare's business and results will be reflected in our financial results. We expect that, going forward, substantially all of our revenue will continue to be derived from these Contracting HMOs. Each Contracting HMO may immediately terminate any of our contracts and/or any individual physician credentialed upon the occurrence of certain events. They may also amend the material terms of our contracts under certain circumstances. See "Item 1. Business" for a detailed discussion of our agreements with the Contracting HMOs. Failure to maintain the contracts on favorable terms, for any reason, would materially adversely affect our results of operations and financial condition. A material decline in enrollees in any of the Contracting HMOs Medicare Advantage plan could also have a material adverse effect on our results of operations.

Notwithstanding each Contracting HMOs' and our current shared interest in providing service to our Participating Customers enrolled in the subject Contracting HMOs, we and the Contracting HMOs may have different and, at times, opposing economic interests. The Contracting HMOs provide a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, they and we may have different views regarding the proper pricing of our services and/or the proper pricing of the various service providers in their provider networks, the cost of which we bear to the extent we utilize such service providers. These HMOs may also have views different than we do regarding the efforts and expenditures that they, we and/or other service providers should make to achieve and/or maintain various quality ratings. Similarly, as a result of changes in laws, regulations, consumer preferences or other factors, the Contracting HMOs may find it in their best interest to provide health insurance services in Florida pursuant to another payment or reimbursement structure. In the event our interests diverge, we may have limited recourse or alternative options in light of our dependence on these Contracting HMOs. There can be no assurances that we will continue to find it mutually beneficial to work together. As a result of various restrictive provisions that appear in some of our managed care agreements with Contracting HMOs, we or our PSN may, at times, have limitations on our ability to cancel an agreement with one Contracting HMO and immediately thereafter contract with a competing HMO with respect to the same service area.

Furthermore, under the Credit Facilities, the termination of any agreement that generates greater than 20% of our consolidated annual gross profit (unless replaced by a substantially similar agreement within thirty days), or the termination of any healthcare permits or any payment programs or reimbursement authorizations sponsored or maintained by any government payer, private insurer, or managed care plan, will constitute an event of default, in which case the lenders under the Credit Facilities may, among other things, accelerate all or any portion of the unpaid principal amount of the outstanding loans thereunder and/or exercise any other rights and remedies available to them

under our loan documents and applicable law.

We May be Required to Continue Providing Services Following Termination of Certain of Our Agreements with Contracting HMOs.

Under our agreements with the Contracting HMOs, there are circumstances under which we could be obligated to continue to provide medical services to Participating Customers in our care following a termination of the applicable agreement. In certain cases, this obligation could require us to provide care to Participating Customers following the bankruptcy or insolvency of a Contracting HMO. Accordingly, our obligations to provide medical services to our Participating Customers (and the associated costs we incur) may not terminate at the time that our agreement with the Contracting HMO terminates, and we may not be able to recover our cost of providing those services from the Contracting HMO, which could have a material adverse effect on our financial condition, results of operations and/or cash flows.

All of Our PSN Operations are Concentrated in the State of Florida, and We May Not be Able to Successfully Establish a Presence in New Geographic Markets.

We derive substantially all of our revenue from our PSN, which operates exclusively in the State of Florida. As a result, our exposure to many of the risks described herein are not mitigated by a diversification of geographic focus. Furthermore, due to the concentration of our PSN operations in the State of Florida, our business may be adversely affected by economic conditions, natural disasters (such as hurricanes), or acts of war or terrorism that disproportionately affect Florida as compared to other states. To expand our PSN operations outside of Florida, we will have to devote resources to identifying and exploring such perceived opportunities. Thereafter, we will have to, among other things, recruit and retain qualified personnel, develop new offices, establish potentially new relationships with an HMO and establish new relationships with physicians and other healthcare providers. In addition, if we were to seek expansion outside of Florida, we would be required to comply with laws and regulations of states that may differ from the ones in which we currently operate, and could face competitors with greater knowledge of such local markets. We anticipate that any geographic expansion may require us to make a substantial investment of management time, capital and/or other resources. There can be no assurance that we will be able to establish a profitable PSN operation in any new geographic markets.

Reductions in the Quality Ratings of the HMO Plans We Serve Could Have an Adverse Effect on Our Results of Operations, Financial Condition and/or Cash Flow.

As a result of the Reform Acts, we anticipate the level of reimbursement each Contracting HMO receives from CMS will be dependent in part upon the quality rating of their Medicare plans that we serve. Such ratings are expected to impact the percentage of any Cost Savings Rebate and any Bonuses earned by the Contracting HMO. Since substantially all of our revenue for 2012 is expected to be calculated as a percentage of CMS reimbursements received by these Contracting HMOs with respect to Participating Customers, reductions in the quality ratings of an HMO plan that we serve could have an adverse effect on our results of operations, financial condition and/or cash flows. Given each Contracting HMO's control of its plans and the many other providers that serve such plans, we believe we will have limited ability to influence the overall quality rating of any such plan.

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

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

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

For instance, the Reform Acts froze the 2011 Medicare Advantage payment benchmarks at 2010 levels and thereafter reduce future year benchmark payments pursuant to a statutorily prescribed schedule. The Reform Acts also established a new Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the increase in Medicare costs per capita exceeds certain targets, which will be implemented unless Congress passes alternative legislation that achieves the same savings, and the BCA mandates a 2% decrease in Medicare Advantage spending. Additional steps could be taken by government agencies and plan providers to further restrict, directly or indirectly, the reimbursements available to plan service providers.

We May Not be Able to Successfully Integrate Continucare's Operations with Our Own or Realize the Anticipated Benefits of the Merger, which Could Materially and Adversely Affect Our Financial Condition, Results of Operations and Business Prospects.

We may not be able to successfully integrate Continucare's operations with our own, and we may not realize all or any of the expected benefits of the Merger as and when planned. The integration of Continucare's operations with our own will be complex, costly and time-consuming. We expect that the integration of Continucare's operations will require significant attention from our senior management and will impose substantial demands on our operations and personnel, potentially diverting attention from other important pending projects. The difficulties and risks associated with the integration of Continucare's operations include, but are not limited to:

- the possibility that we will fail to implement our business plans for the combined company, including as a result of new legislation or regulation in the healthcare industry that affects the timing or costs associated with the operations of the combined company or our integration plan;
- possible inconsistencies between our standards, controls, procedures, policies and compensation structures and those of Continucare;
- the increased scope and complexity of our operations following the Merger;
- the potential loss of key employees and the costs associated with our efforts to retain key employees;
- provisions in our and Continucare's contracts with third parties that may limit our flexibility to take certain actions;
- risks and limitations on our ability to consolidate the corporate and administrative infrastructures of the two companies;
- the possibility that we may have failed to discover liabilities of Continucare during our due diligence investigation as part of the Merger for which we, as a successor owner, may be responsible;
- obligations that we will have to joint venture partners and other counterparties of Continucare that arise as result of the change in control of Continucare; and
- the possibility of unanticipated delays, costs or inefficiencies associated with the integration of Continucare's operations with ours.

As a result of these difficulties and risks, we may not accomplish the integration of Continucare's business smoothly, successfully or within our budgetary expectations and anticipated timetable. Accordingly, we may fail to realize some or all of the anticipated benefits of the Merger, such as increases in our scale, diversification, cash flows and operational efficiency and meaningful accretion to our diluted earnings per share.

We May be Unable to Realize Projected Cost Synergies or May Incur Additional and Unexpected Costs in Order to Realize Them.

We project that we will realize approximately $5.0 million of operating synergies per year following the completion of the Merger, beginning in 2012. We may be unable to realize all of these cost synergies within the timeframe expected, or at all, and we may incur additional and unexpected costs in order to realize them.

Our Records and Submissions to an HMO May Contain Inaccurate or Unsupportable Information Regarding Risk Adjustment Scores of Participating Customers, which Could Cause Us to Overstate or Understate Our Revenue and Subject Us to Various Penalties.

We submit to Contracting HMOs claims and encounter data that support the risk adjustment scores of our Participating Customers, which determine, in part, the revenue to which the plan provider and we are entitled for such Participating Customers. This data is submitted to CMS by each HMO based on medical charts and diagnosis codes prepared and submitted by us. Each HMO generally relies on us to appropriately document and support such risk-adjustment data in their medical records and appropriately code customer claims. Inaccurate or unsupportable coding, inaccurate records for new Participating Customers, and erroneous claims and encounter recording and submissions could result in inaccurate capitation fee revenue and risk adjustment payments, which are subject to correction or retroactive adjustment in later periods. Payments that we receive in connection with this corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. We, Contracting HMOs or CMS through a medical records review and risk adjustment validation, may also find that data regarding our Participating Customers' risk scores, when reconciled, requires that we refund a portion of the revenue that we received, which refund, depending on its magnitude, could damage our relationship with the subject Contracting HMO and have a material adverse effect on our results of operations or cash flows.

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.

Under Most of Our Agreements With Contracting HMOs, We Assume Some or All of The Risk That the Cost of Providing Services Will Exceed Our Compensation.

A significant portion of our revenue is earned under risk agreements under which we receive a monthly capitation fee for each Participating Customer. In accordance with the agreements, the total monthly payment is a function of the number of Participating Customers, regardless of the actual utilization rate of covered services. In return, the PSN assumes financial responsibility for the provision of all necessary medical care to the Participating Customers, regardless of whether or not its affiliated providers directly provide the covered medical services.

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

Since we do not negotiate with CMS or any HMO regarding the benefits to be provided under their Medicare Advantage plans, we often have just a few months to familiarize ourselves with each new, annual package of benefits we are expected to offer. In addition, under most of our agreements with Contracting HMOs, the Contracting HMO is generally permitted to modify the benefit and risk obligations and compensation rights from time to time. If a Contracting HMO exercises its right to amend the benefit and risk obligations and compensation rights under one of our agreements, we generally are allowed a period of time to object to such amendment. If we object to such amendment, under some of our managed care agreements the relevant Contracting HMO may terminate the applicable agreement upon 60 to 90 days written notice. Aside from the foregoing, we have potentially limited opportunities to negotiate with an HMO regarding the scope of benefits we will be directly or indirectly responsible for providing and/or our compensation rights. If we enter into contracts with unfavorable economic terms, or a contract is amended to include unfavorable terms, we could suffer losses with respect to such contract through its termination date.

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

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

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the health status of our Participating Customers;

higher than expected utilization of new or existing healthcare services or technologies;

an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;

changes to mandated benefits or other changes in healthcare laws, regulations, and practices;

periodic renegotiation of provider contracts with specialist physicians, hospitals and ancillary providers;

periodic renegotiation of contracts with our affiliated primary care physicians;

changes in the demographics of our Participating Customers and medical trends;

contractual or claims disputes with providers, hospitals, or other service providers within a Contracting HMO's network; and

the occurrence of catastrophes, major epidemics, or acts of terrorism.

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

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

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

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

As a result of the direct and indirect impacts of the Reform Acts, many Participating Customers may decide that an original fee-for-service Medicare program is more attractive than a Medicare Advantage plan. As a result, enrollment in the plans we serve may decrease.

Managed care companies offer alternative products such as regional PPOs and private fee-for-service plans. Medicare PPOs and private fee-for-service plans allow their customers more flexibility in selecting physicians than Medicare Advantage HMOs, which typically require customers to coordinate care with a primary care physician. The Medicare Modernization Act has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost-reimbursement provisions, a

stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan that treat regional plan enrollees. The formation of regional Medicare PPOs and private fee-for-service plans can affect our PSN's relative attractiveness to existing and potential Medicare customers in their service areas.

The payments for the local and regional Medicare Advantage plans are based on a competitive bidding process that may indirectly cause a decrease in the amount of the capitation fee paid to the PSN or result in an increase in the benefits offered by the Contracting HMO.

The annual enrollment process and subsequent "lock-in" provisions of the Reform Act may adversely affect our level of revenue growth as it will limit the ability of a Contracting HMO to market to and enroll new Participating Customers in its established service areas outside of the annual enrollment period.

Commencing in 2012, CMS will allow Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating of 4.5 stars or less to enroll in a 5 star rated Medicare Advantage plan at any time during the benefit year. None of the plans we serve are 5 star rated. Therefore, we and the Contracting HMOs may face a competitive disadvantage in recruiting and retaining customers.

CMS' Risk Adjustment Payment System Could Result in Material Retroactive Adjustments to Our Results of Operations.

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

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

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

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

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

We Depend on Each Contracting HMO to Provide Us with Crucial Information and Data.

Each Contracting HMO provides a significant amount of information and services to the PSN, including revenue, claims and Participating Customer data and other information, including reports and calculations of costs of services

provided and payments to be received by the PSN. The PSN does not own or control such systems and, accordingly, has limited ability to ensure that these systems are properly maintained, serviced and updated. In addition, information systems such as these may be vulnerable to failure, acts of sabotage and obsolescence. The PSN's business and results of operations could be materially and adversely affected by its inability, for any reason, to receive timely and accurate information from a Contracting HMO.

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

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

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

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

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

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

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

We compete in the highly competitive and regulated healthcare industry, which is subject to continuing changes with respect to the provision of services and the selection and compensation of providers. Approximately 96.9% of our revenue was directly or indirectly derived from premiums generated by Medicare Advantage health plans. In 2011, substantially all of our revenue was earned through contracts with the Contracting HMOs. These organizations compete with other health plans, as well as with each other, in securing and serving customers in the Medicare Advantage Program. Companies in other healthcare industry segments, some of which have financial and other resources comparable to or greater than these HMOs, can be their competitors. The market in Florida has become increasingly attractive to health plans that may compete with these organizations and they may not be able to continue

to compete profitably in the healthcare industry if additional competitors enter the same market.

The PSN competes with other service providers for the business of each of the Contracting HMOs. Failure to maintain favorable contract terms with the Contracting HMOs would adversely affect our results of operations and financial condition.

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

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

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

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

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

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

- reducing the capitation payments we receive;
- imposing additional license, registration, or capital reserve requirements;
- increasing our administrative and other costs;
- forcing us to undergo a corporate restructuring;
- increasing mandated benefits without corresponding capitation fee increases;
- increasing the number and type of healthcare providers and organizations with which we compete for business;
- limiting our ability to engage in inter-company transactions with our affiliates and subsidiaries;
- forcing us to restructure our relationships with providers; or
- requiring us to implement additional or different programs and systems.

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

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

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

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

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

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

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

Regulations under HIPAA require us to comply with standards regarding the exchange of health information within our company and with third parties, including healthcare providers, designated "business associates" and customers. These regulations include standards for common healthcare transactions, including claims information, plan eligibility, and payment information; unique identifiers for providers and employers; security; privacy; and enforcement. HIPAA also provides that to the extent state laws impose stricter privacy standards than HIPAA privacy regulations, the stricter state law requirements are not preempted by HIPAA. However, HIPAA generally does preempt more lenient state law requirements.

In 2009, as part of the ARRA, the federal government passed HITECH, which along with its implementing regulations has amended and supplemented HIPAA. HITECH, in part, provides for enhanced enforcement of HIPAA, imposes data breach notification requirements for unauthorized uses and disclosures of unsecured Protected Health Information, limits the use of PHI for marketing, limits the sale of PHI and applies certain HIPAA provisions directly to business associates (i.e., business associates may now be held directly liable for violations of HIPAA rather than simply being held in breach of a contractual arrangement with a covered entity).

We conduct our operations in an attempt to comply with all applicable HIPAA requirements. Given the complexity of the HIPAA regulations, the possibility that the regulations may change and that HHS has not yet promulgated some regulations mandated by HITECH, and the fact that the regulations are subject to changing and, at times, conflicting

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

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

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

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

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

- any shareholder wishing to properly bring a matter before a meeting of shareholders must comply with specified procedural and advance notice requirements;
- the authorized number of directors may be changed only by resolution of the Board of Directors; and
- the Board of Directors has the ability to issue up to 10,000,000 shares of preferred stock, with such rights and preferences as may be determined from time to time by the Board of Directors, without shareholder approval.

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

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

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

We cannot predict the effect, if any, that future sales or the possibility of future sales may have on the market price of our Common Stock. As of December 31, 2011, there were approximately 43.8 million shares of our Common Stock outstanding, all of which are freely tradable without restriction or tradable in accordance with Rule 144 of the Securities Act, with the exception of approximately 1.3 million shares owned by certain of our officers, directors and affiliates which may be sold publicly at any time subject to the volume and other restrictions promulgated pursuant to Rule 144 of the Securities Act and subject to legal restrictions such as insider trading laws. There are approximately 1.1 million restricted shares of our Common Stock owned by certain of our employees and directors at December 31, 2011 that are subject to forfeiture until vested in accordance with their terms. In addition, as of December 31, 2011, approximately 4.1 million shares of our Common Stock were reserved for issuance upon the exercise of options which were previously granted and 301,000 shares of our Common Stock were reserved for future issuance upon conversion of the Series A Preferred Stock.

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

Delisting of Our Common Stock from New York Stock Exchange Would Adversely Affect Us and Our Shareholders.

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

We May Be Required to Record Additional Impairment Related to Goodwill and Other Intangible Assets

Our balance sheet includes intangible assets, including goodwill and other separately identifiable intangible assets, of approximately $364.9 million, which represented 77.7% of our total assets at December 31, 2011. The most significant component of the intangible assets consists of the intangible assets recorded in connection with the acquisition of Continucare. The purchase price for Continucare, excluding acquisition costs, of approximately $415.9 million was allocated to the estimated fair value of acquired tangible assets of $102.6 million, identifiable intangible assets of $105.0 million and assumed liabilities of $52.1 million, resulting in goodwill totaling $260.4 million.

We do not amortize goodwill and intangible assets with indefinite useful lives. We review such assets for impairment on an annual basis or more frequently if certain indicators of impairment arise. We amortize intangible assets with definite useful lives over their respective useful lives to their estimated residual values and also review for impairment annually or more frequently if certain indicators of impairment arise. Indicators of impairment include, among other things, a significant adverse change in legal factors or the business climate, the loss of a key HMO contract, an adverse action by a regulator, unanticipated competition, and the loss of key personnel or allocation of goodwill to a portion of business that is to be sold. The goodwill impairment test requires the allocation of goodwill and all other assets and liabilities to reporting units.

We have two reporting units: the PSN and the sleep diagnostic business. Our goodwill impairment reviews are determined using a two-step process. The first step of the process is to compare the fair value of a reporting unit with its carrying amount, or book value, including goodwill. If the fair value of a reporting unit exceeds its carrying amount, the goodwill of the reporting unit is not impaired and the second step of the impairment review is not necessary. If the carrying amount of a reporting unit exceeds its fair value, the second step of the goodwill impairment review is required to be performed to estimate the implied fair value of the reporting unit's goodwill. The implied fair value of the reporting unit's goodwill is compared with the carrying amount of that goodwill. If the carrying amount of the reporting unit's goodwill exceeds the implied fair value of that goodwill, an impairment loss is recognized in an amount equal to that excess. The annual impairment review performed as of December 31, 2011, resulted in goodwill impairment in the sleep diagnostic business of $3.5 million. Future evaluations may require further impairment allowances to our goodwill and other long-lived assets, which could materially adversely affect our financial condition and results of operations.

We May Not Be Able to Locate a Suitable Purchaser for the Sleep Diagnostic Business and Any Sale of Such Business is Subject to Significant Risks.

Since the acquisition of Continucare, we've operated a sleep diagnostic business which operates and manages over 70 sleep diagnostic centers in 15 states. On February 27, 2012, the Board of Directors approved a plan to sell the sleep diagnostic business. While we have retained an investment banking firm to assist us with the sale of the sleep diagnostic business, we cannot provide any assurance that we will be successful in finding suitable purchasers. Even if we are able to find suitable purchasers, we may not be able to obtain attractive terms and conditions for such sale, including attractive pricing. Furthermore, at December 31, 2011, included in income before income taxes is a $3.5 million impairment charge, representing the difference between the carrying values of the assets being sold, including goodwill, the liabilities to be assumed and the estimated sales price of the business. We may not be able to sell the sleep business at the carrying value of the assets being sold, which could result in our recognition of further impairment losses.

Divestitures of businesses involve a number of risks, including among other things the diversion of management and employee attention and significant costs and expenses. In addition, divestitures potentially involve significant post-closing separation activities, which could involve the expenditure of significant financial and employee resources. Inability to consummate a sale of the sleep diagnostic business or to manage the post-separation transition arrangements could materially adversely affect our financial condition, results of operations and cash flows.

ITEM 1B. UNRESOLVED STAFF COMMENTS

NONE

ITEM 2. PROPERTIES

Our principal executive office is located at 777 Yamato Road, Suite 510, Boca Raton, Florida, where we occupy 19,600 square feet at a current monthly base rent of approximately $18,000 pursuant to a lease that expires in September 2021 (subject to extension for up to two additional five-year terms, at our option). We maintain an additional executive office in Miami, Florida, where we occupy 11,488 square feet at a current monthly base rent of approximately $10,000 pursuant to a lease that expires in February 2015 (subject to extension for one additional five-year term, at our option).

The PSN serves our customers out of 34 offices in central and south Florida. The PSN has leases for 28 of these offices, totaling 177,600 square feet, with current monthly aggregate base rental payments of approximately $250,000 pursuant to lease agreements with remaining noncancellable terms ranging from one to seven years. The PSN owns two office buildings in Dade County, Florida totaling 51,000 square feet.

Substantially all of our and our Guarantors' existing and future assets are encumbered by the First Lien Facilities and the Second Lien Facility entered into in connection with the Merger. For further information regarding the First Lien Facilities, Second Lien Facility and the Merger, see "Item 1 – Description of Business".

ITEM 3 LEGAL PROCEEDINGS

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

On July 1, 2011, a putative class action was filed in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida by Kathryn Karnell, Trustee and the Aaron and Kathryn Karnell Revocable Trust U/A Dtd 4/9/09 against Continucare, the members of the Continucare Board, individually, Metropolitan, and Merger Sub (styled Kathryn Karnell Trustee, etc. v. Continucare Corporation et al., No. 11-20538 CA40). Also on July 1, 2011, a second putative class action was filed in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida by Steven L. Fuller against Continucare, the members of the Continucare Board, individually, Metropolitan, and Merger Sub (styled Steven L. Fuller v. Richard C. Pfenniger et al., No. 11-20537 GA04). On July 6, 2011, a third putative class action was filed in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida by Hilary Kramer against Continucare, the members of the Continucare Board, individually, Metropolitan, and Merger Sub (styled Hilary Kramer v. Richard C. Pfenniger Jr. et al., No. 11-20925 CA20). On July 12, 2011, a fourth putative class action was filed in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida by Jamie Suprina against Continucare, the members of the Continucare board of directors, individually, Metropolitan, and Merger Sub (styled Jamie Suprina v. Continucare Corporation et al., No. 11-21522 CA15). On July 22, 2011, a fifth putative class action was filed in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida by Kojo Acquaah against Continucare, the members of the Continucare board of directors, individually, Metropolitan, and Merger Sub (styled Kojo Acquaah v. Continucare Corporation et al., No. 11-22833 CA40). Also on July 22, 2011, a sixth putative class action was filed in the Circuit Court of the Eleventh Judicial Circuit in and for Miami-Dade County, Florida by David DeYoung against Continucare, the members of the Continucare board of directors, individually, Metropolitan, and Merger Sub (styled David DeYoung v. Continucare Corporation et al., No. 11-22837 CA40). The plaintiffs in the Fuller, Karnell, and Acquaah and DeYoung actions filed motions seeking appointment of lead counsel and to expedite discovery and the proceedings.

The complaints in each of these suits alleges a claim against the members of the Continucare Board for breach of fiduciary duty and a claim against Continucare, Metropolitan, and Merger Sub for aiding and abetting the individual defendants' alleged breach of fiduciary duty. The amended complaints in Karnell, Suprina and Fuller and the

complaints in Acquaah and DeYoung also alleged that the disclosure contained in the Proxy Statement or Registration Statement on Form S-4 originally filed by us on July 11, 2011 regarding the pending Merger was inadequate. All of the above-mentioned complaints sought to enjoin the now completed transaction between Continucare and Metropolitan, as well as attorneys' fees. The Acquaah and DeYoung complaints also sought rescission. The Fuller, Kramer, and Suprina suits also sought rescission and money damages.

On July 28, 2011 the Court entered an order consolidating all six actions arising from the Metropolitan Health/Continucare proposed transaction (the "Consolidated Action") appointed Fuller as Lead Plaintiff and the law firm of Levi & Korinsky LLP as Plaintiffs Lead Counsel and Julie Vinale, Esq. as Liaison Counsel. Following the consolidation and Lead Plaintiff/Lead Counsel orders the parties engaged in limited expedited discovery, including the production of certain documents from Continucare and the depositions of Plaintiff Fuller and Defendants Richard C. Pfenniger and Phillip Frost.

The parties executed a Memorandum of Understanding (the "MOU") on August 12, 2011 with Plaintiff's Lead Counsel regarding the settlement of the Consolidated Action. In connection with the settlement, Continucare agreed to make certain additional disclosures to its shareholders, which were contained in a Form 8-K filed with the SEC on August 12, 2011. Subject to the completion of certain confirmatory discovery by Plaintiff's Lead Counsel, the MOU contemplated that the parties would enter into a stipulation of settlement. The confirmatory discovery has been completed and the parties entered a stipulation of settlement on November 21, 2011.

On November 29, 2011, the court entered an order preliminarily approving the settlement, conditionally certifying a settlement class and ordering that notice be provided to Continucare shareholders. On February 24, 2012, the court conducted a final settlement hearing to consider the fairness, reasonableness and adequacy of the settlement and finally approved the settlement. The court entered a Final Judgment and Order that resolved and dismissed with prejudice all of the claims that were or could have been brought in the Consolidated Action, including all claims relating to the merger transaction, the merger agreement, and any disclosure made in connection therewith. In addition, the court entered an award of attorneys' fees and expenses of $350,000 to Plaintiff's Lead Counsel to be paid by Continucare or its successor. We estimate that we will pay $100,000 of this amount.

Continucare, the director defendants, and Metropolitan vigorously deny all liability with respect to the facts and claims alleged in the lawsuits, and specifically deny that supplemental disclosure was required under any applicable rule, statute, regulation or law. However, solely to avoid the risk of delaying or adversely affecting the Merger and the related transactions and to minimize the expense of defending the lawsuits, Continucare, its directors, and Metropolitan agreed to the settlement described above.

ITEM 4 – Mine Safety Disclosures

NONE

PART II

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

Market Information

Our common stock is currently traded on the New York Stock Exchange under the symbol "MDF." Prior to November 21, 2011, our Common Stock was traded on the NYSE Amex. The following table sets forth the high and low sales prices for our Common Stock, as reported by the NYSE Amex (for all periods prior to November 21, 2011) and the New York Stock Exchange (for all periods on or after November 21, 2011), for each full quarterly period within the two most recent years:

	High ($)	Low ($)
Quarter ended March 31, 2010	$ 3.23	$ 2.00
Quarter ended June 30, 2010	$ 4.31	$ 3.01
Quarter ended September 30, 2010	$ 3.95	$ 3.44
Quarter ended December 31, 2010	$ 4.80	$ 3.70
Quarter ended March 31, 2011	$ 5.26	$ 4.23
Quarter ended June 30, 2011	$ 4.99	$ 3.83
Quarter ended September 30, 2011	$ 5.78	$ 4.48
Quarter ended December 31, 2011	$ 7.92	$ 4.23

Holders

At February 17, 2012, we believe we had approximately 10,200 beneficial shareholders, based on responses from brokers to a search conducted by Broadridge Financial Solutions, Inc. on our behalf.

Issuer Purchases of Equity Securities

In October 2008, the Board of Directors established a stock repurchase program that currently, due to various amendments, authorizes the repurchase of up to a total of 25.0 million shares of common stock. No shares of common stock were repurchased during the fourth quarter of 2011. In 2011, we repurchased approximately 71,000 shares of stock at an aggregate price of $0.3 million. There are 10.3 million common shares yet be repurchased under the plan at December 31, 2011. The plan does not have a scheduled expiration date.

Under the First and Second Lien credit Facilities we have the right to make up to $15.0 million of stock repurchases during the term of the Credit Facilities, generally not to exceed $5.0 million in any year.

Dividends

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

In addition, the First Lien Facilities and the Second Lien Facility impose customary restrictive covenants, subject to certain basket amounts and exceptions, that currently, and in the future are reasonably likely to, materially limit our ability to pay dividends on our Common Stock. For more information on the restrictions imposed by the First Lien Facilities and the Second Lien Facility, please see "Item 1 - Description of Business - Overview - Acquisition of Continucare," "Management's Discussion and Analysis - Liquidity and Capital Resources" and Note 6 to the Consolidated Financial Statements.

Securities Authorized for Issuance Under Equity Compensation Plans

The following table provides certain information regarding our existing equity compensation plans as of December 31, 2011:

EQUITY COMPENSATION PLAN INFORMATION

	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for issuance under equity compensa–tion plans excluding securities in first column–see (1)
Equity compensation plans approved by security holders	4,131,000	$ 2.61	4,042,000

(1) The number of securities remaining available for issuance under equity compensa–tion plans in the table above has been reduced by 1,119,000 shares of unvested restricted common stock. For information concerning these awards see the Notes to the Consolidated Financial Statements.

Performance Graph

The following graph depicts our cumulative total return for the last five fiscal years relative to the cumulative total returns of the New York Stock Exchange and NASDAQ Stock Market Indexes and a group of peer companies (the "Peer Group"). All indices shown in the graph have been reset to a base of $100 as of December 31, 2006 and assume an investment of $100 on that date and the reinvestment of dividends paid since that date.

	December 31, 2007	December 31, 2008	December 31, 2009	December 31, 2010	December 31, 2011
Metropolitan Health Networks, Inc.	$78	$52	$65	$146	$244
NYSE Composite Index	109	66	85	97	93
NASDAQ Composite	111	66	97	114	113
NASDAQ Health Services	131	95	126	152	144
NYSE Health Services Index	106	63	87	93	87
SIC Code 8000-8099 Health Services	98	70	92	101	97

ITEM 6 SELECTED FINANCIAL DATA

Set forth below is our selected historical consolidated financial data as of and for each of the five years ended December 31, 2011. The selected historical consolidated financial data should be read in conjunction with the consolidated financial statements and accompanying notes and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Item 7 of this Annual Report. The consolidated statement of operations data and balance sheet data as of and for each of the five years ended December 31, 2011 are derived from our audited consolidated financial statements which have been audited by Grant Thornton LLP, our independent registered public accounting firm. The 2011 results of operations include the accounts of Continucare Corporation from its acquisition date of October 4, 2011.

	For the years ended December 31,				
	2011	2010	2009	2008	2007
	(in thousands, except per share amounts)				
Statement of Operations Data					
Revenue	$ 459,792	$ 368,186	$ 354,407	$ 317,212	$ 277,577
Operating income	$ 55,109 (3)	$ 41,284 (2)	$ 22,981 (2)	$ 16,541 (1)	$ 8,072
Income before income taxes	$ 39,634 (4)	$ 41,584	$ 23,349	$ 16,619	$ 9,441
Net income	$ 22,714	$ 25,700	$ 14,449	$ 10,204	$ 5,914
Basic earnings per share	$ 0.56	$ 0.65	$ 0.32	$ 0.21	$ 0.12
Diluted earnings per share	$ 0.53	$ 0.62	$ 0.31	$ 0.21	$ 0.12
Weighted average common shares outstanding-basic	40,579	39,195	44,496	49,093	50,573
Weighted average common shares outstanding-diluted	42,811	41,509	45,941	50,354	51,796
Cash dividend declared	$ -	$ -	$ -	$ -	$ -
Balance Sheet Data					
Cash and equivalents	$ 17,964	$ 10,596	$ 6,795	$ 2,701	$ 38,682
Short-term investments	$ 1,003	$ 38,949	$ 27,036	$ 33,641	$ -
Total current assets	$ 72,140	$ 60,974	$ 35,715	$ 40,867	$ 44,764
Total assets	$ 469,746	$ 74,723	$ 51,332	$ 49,144	$ 53,811
Total current liabilities	$ 28,898	$ 6,814	$ 8,009	$ 6,340	$ 15,545
Total liabilities	$ 365,102	$ 6,973	$ 8,406	$ 6,340	$ 15,545
Total working capital	$ 43,242	$ 54,160	$ 27,706	$ 34,528	$ 29,219
Long - term obligations, including current portion	$ 320,689	$ 477	$ 716	$ -	$ -
Total stockholders' equity	$ 104,644	$ 67,750	$ 42,926	$ 42,805	$ 38,266

(1) Includes a gain on the sale of our HMO of $5.9 million and related stay bonuses and termination costs of $1.6 million.
(2) Includes an incremental gain on the sale of our HMO of $62,000 in 2010 and $1.3 million in 2009.
(3) Includes goodwill impairment charge of $3.5 million.
(4) Includes transaction costs of $7.9 million incurred in connection with our acquisition of Continucare Corporation on October 4, 2011.

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

The following discussion and analysis of our financial condition and results of operations should be read together with our consolidated financial statements and related notes appearing elsewhere in this Annual Report on Form 10-K. This discussion and analysis contains forward-looking statements that involve risks, uncertainties, judgment and assumptions. You should review the "Risk Factors" section of this Annual Report on Form 10-K for a discussion of important factors that could cause actual results to differ materially from the results described in or implied by the forward-looking statements contained in the following discussion and analysis.

Overview

We are a for profit corporation incorporated under the laws of Florida. We primarily operate a PSN through our wholly-owned subsidiaries, Metcare of Florida, Inc. and Continucare, the latter of which we acquired on October 4, 2011. The results of Continucare are included in our operating results from the date of acquisition.

The PSN provides and arranges for medical care to Medicare Advantage and Medicaid beneficiaries in the State of Florida. We operate the PSN through our 33 wholly-owned primary care practices, a wholly-owned oncology practice and contracts with almost 450 independent primary care practices (each, an "IPA"). As of December 31, 2011, the PSN operated in 18 Florida counties, including the Miami, Ft. Lauderdale, West Palm Beach, Tampa and Daytona metropolitan areas. On January 1, 2012, we began operations in Escambia and Santa Rosa counties in Florida's panhandle under a mutually exclusive contract with Medicare Advantage Participating Customers with Humana for these years.

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 with several other HMOs. Our most significant managed care agreements are Medicare Advantage risk agreements with Humana. As a result of the Continucare acquisition, we also have agreements with United, Coventry and Wellcare. In addition, we now also provide or manage the care for Medicaid eligible and commercial Participating Customers. Our managed care agreements with these HMOs are primarily risk agreements under which we receive a monthly capitated fee with respect to the Participating Customers. The capitated fee is a significant percentage of the premium that the HMOs receive with respect to Participating Customers. In return, we assume full financial responsibility for the provision of all necessary medical care to Participating Customers even for services we do not provide directly. We also have non-risk agreements with these HMOs, under which we receive a monthly 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 the surplus generated as determined by the respective contract. The fees and our portion of the surplus generated under these arrangements are recorded as revenue in the period in which services are provided as determined by the respective contract.

The sleep diagnostic business is 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 have the sale completed before the end of 2012. Our sleep diagnostic operations have been included in operations in 2011. We did not operate the sleep diagnostic business prior to October 4, 2011, the date of the Continucare acquisition.

We recognized goodwill of $260.4 million related to the acquisition of Continucare, a portion of which was allocated to the sleep diagnostic business. The annual impairment review performed as of December 31, 2011, resulted in goodwill impairment for the sleep diagnostic business of $3.5 million. The impairment related primarily to our evaluation that it was more likely than not that we would sell the sleep diagnostic business in 2012 and that the anticipated sales price would be less than the carrying value of the net assets.

Critical Accounting Policies

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

We believe that our most critical accounting policies include "Use of Estimates, Revenue, Expense and Receivables" and "Consideration of Impairment Related to Goodwill and Other Intangible Assets."

Use of Estimates, Revenue, Expense and Receivables

Substantially all of our revenue is derived from risk-based managed care agreements with HMOs under which we receive for our services a monthly capitated fee, which fee varies depending on the demographics and health status of the Participating Customer. We assume the economic risk of funding our Participating Customers' healthcare services and related administrative costs. Capitation fee revenue is recognized in the period in which the Participating Customers are entitled to receive healthcare services. Because we have the obligation to fund medical expenses, we recognize gross revenue and medical expenses associated with these risk agreements in our consolidated financial statements.

Under our non-risk agreements with HMOs, we receive a fee based on the number of Participating Customers for which we are providing services on a monthly basis. Under certain agreements, we also receive a percentage of the 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.

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

Medical expenses are recognized in the period in which services are provided and include an estimate of our obligations for medical services that have been provided to our Participating Customers but for which we have neither received nor processed claims, and for liabilities for physician, hospital and other medical expense disputes. We develop our estimated medical claims payable by using an actuarial process that is consistently applied. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, care provider contract rate changes, medical care consumption and other medical expense trends. The actuarial process and models develop a range of projected medical claims payable and we record to the amount within the range that is our best estimate of the ultimate liability. The actual liability incurred could differ materially from the amount recorded.

Each period we re-examine previously established medical claims payable estimates based on actual claim submissions and other changes in facts and circumstances. As the estimate of medical claims payable recorded in prior

periods becomes more exact, we adjust the amount of our liability estimates, and include the changes in such estimates in medical expense in the period in which the change is identified. In each reporting period, our operating results include the effects of more completely developed medical expense payable estimates associated with previously reported periods. While we believe our medical expenses payable is adequate to cover future claims payments required, such estimates are based on claims experience to date and various assumptions. Therefore, the actual liability could differ materially from the amounts recorded. See Notes 2 and 11 to the Consolidated Financial Statements and “Item 1A Risk Factors - A Failure To Estimate Incurred But Not Reported…”

Acquisition Accounting

We completed the acquisition of Continucare in 2011. The acquisition method of accounting requires companies to assign values to assets and liabilities acquired based upon their fair values. In most instances, there is not a readily defined or listed market price for individual assets and liabilities acquired in connection with a business, including intangible assets. The determination of fair value for assets and liabilities in many instances requires a high degree of estimation. The valuation of intangibles assets, in particular, is very subjective. The use of different valuation techniques and assumptions can change the amounts and useful lives assigned to the assets and liabilities acquired, including goodwill and other intangible assets and related amortization expense. We account for the acquisition under the provisions of ASC 805, Business Combinations, which was effective January 1, 2009.

Consideration of Impairment Related to Goodwill and Other Intangible Assets

Our balance sheet includes intangible assets, including goodwill and other separately identifiable intangible assets, of approximately $364.9 million, which represented 77.7% of our total assets at December 31, 2011. Substantially all of the intangible assets consist of the intangible assets recorded in connection with the acquisition of Continucare. The purchase price, including acquisition costs, of approximately $415.9 million was allocated to the estimated fair value of acquired tangible assets of $102.6 million, identifiable intangible assets of $105.0 million and assumed liabilities of $52.1 million, resulting in goodwill totaling $260.4 million.

We do not amortize goodwill and intangible assets with indefinite useful lives. We review such assets for impairment on an annual basis or more frequently if certain indicators of impairment arise. We amortize intangible assets with definite useful lives over their respective useful lives to their estimated residual values and also review for impairment annually or more frequently if certain indicators of impairment arise. Indicators of impairment include, among other things, a significant adverse change in legal factors or the business climate, the loss of a key HMO contract, an adverse action by a regulator, unanticipated competition, and the loss of key personnel or allocation of goodwill to a portion of business that is to be sold.

The goodwill impairment test requires the allocation of goodwill and all other assets and liabilities to reporting units. We have determined that we have two reporting units: the PSN and the sleep diagnostic business. Our goodwill impairment reviews are determined using a two-step process. The first step of the process is to compare the fair value of a reporting unit with its carrying amount, or book value, including goodwill. If the fair value of a reporting unit exceeds its carrying amount, the goodwill of the reporting unit is not impaired and the second step of the impairment review is not necessary. If the carrying amount of a reporting unit exceeds its fair value, the second step of the goodwill impairment review is required to be performed to estimate the implied fair value of the reporting unit’s goodwill. The implied fair value of the reporting unit’s goodwill is compared with the carrying amount of that goodwill. If the carrying amount of the reporting unit’s goodwill exceeds the implied fair value of that goodwill, an impairment loss is recognized in an amount equal to that excess. The impairment review performed as of December 31, 2011 resulted in goodwill impairment in the sleep diagnostic business of $3.5 million. The impairment related primarily to our evaluation that it was more likely than not that we would sell the sleep diagnostic business in 2012 and that the anticipated sales price would be less than the carrying value of the net assets.

Off-Balance Sheet Arrangements

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

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Contractual Obligations and Other Contractual Commitments

The following table summarizes our significant contractual obligations and commercial commitments as of December 31, 2011 (in thousands).

Contractual Obligations	Total	Less Than 1 Year	1 - 3 Years	3 - 5 Years	More Than 5 years
Operating lease obligations	$18,829	$4,381	$8,178	$4,467	$1,803
Long-term debt	320,689	12,538	42,151	191,000	75,000
Service agreements and equipment leases	5,050	3,218	1,512	307	13
Employment obligations	4,777	4,777	-	-	-
Less sublease amount	(3,065)	(919)	(1,636)	(510)	-
	$346,280	$23,995	$50,205	$195,264	$76,816

As of December 31, 2011, our long-term debt totaled $320.7 million (including current portion).

Impact of Inflation

In 2011, CMS projected that Medicare would grow 5.9% in 2011, but only 1.7% in 2012; the slow growth in 2012 is being driven by a 29.4% reduction in physician payment rates required under the Medicare Sustainable Growth Rate (SGR) formula.

Comparison of 2011 and 2010

Summary

Net income in 2011 was $22.7 million compared to $25.7 million in 2010, a decrease of $3.0 million or 11.7%. The decrease in net income was primarily a result of the after tax impact of the impairment loss related to sleep diagnostic business, transaction costs related to the acquisition of Continucare, interest expense associated with the acquisition debt and an increase in our effective tax rate offset, in part, by an increase in the net income from our PSN business, primarily as a result of the net income of Continucare. From the date of acquisition to year-end, Continucare contributed $7.5 million to net income. Our effective tax rate in 2011 was 42.7% compared to 38.2% in 2010, the increase being a result of certain transaction costs in 2011 not being deductible for tax purposes.

Basic earnings per share in 2011 were $0.56 compared to $0.65 in 2010. Diluted earnings per share were $0.53 in 2011 compared to $0.62 in 2010. The impairment charge reduced both basic and diluted earnings per share by $0.05. Transaction costs reduced both basic and diluted earnings per share by $0.16.

Revenue increased to $459.8 million in 2011 from $368.2 million in 2010, an increase of $91.6 million or 24.9%. The increase in revenue is primarily attributable to Continucare, which contributed $78.6 million. We also realized an increase in revenue as a result of an increase in the average risk scores of the Participating Customers we serve.

Total medical expense for 2011 was $363.4 million compared to $302.4 million for 2010, an increase of approximately $61.0 million or 20.2%. Continucare's medical expenses contributed $58.8 million of the increase. Medical cost inflation and utilization also contributed to this increase.

Our gross profit was $96.4 million in 2011 as compared to $65.8 million in 2010, an increase of $30.6 million or 46.5%. Continucare contributed $19.8 million to this increase in gross profit.

We rely on a key statistical performance measure, the medical expense ratio ("MER"), which is computed by dividing total medical expense by revenue. This measure represents a statistic used to measure gross profit. The MER was 79.0% in 2011 compared to 82.1% in 2010.

Operating expenses increased to $41.3 million in 2011 as compared to $24.5 million in 2010, an increase of $16.8 million or 68.6%. The increase in operating expenses is primarily due to the impairment charge of $3.5 million, an increase in payroll, payroll taxes and benefits of $5.5 million, an increase in general and administrative expense of $2.6 million, an increase in amortization of intangible assets of $3.5 million and termination costs associated with the Continucare acquisition of $0.8 million. Continucare's operating expenses of $7.7 million are included in the above increases.

Operating income was $55.1 million in 2011 compared to $41.3 million in 2010. Net of the impairment charge of $3.5 million, operating income increased $17.3 million or 41.9%. Continucare contributed $12.1 million of this increase.

Income before income taxes in 2011 was $39.6 million compared to of $41.6 million in 2010. The decrease of $2.0 million is primarily a result of the decreased operating income discussed above reduced primarily by transaction costs of $7.9 million and interest expense of $8.2 million.

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

Customer Information

The table set forth below provides (i) the total number of Participating Customers to whom we were providing healthcare services as of December 31, 2011 and 2010 and (ii) the aggregate customer months for 2011 and 2010. Customer months are the aggregate number of months of healthcare services we have provided to Participating Customers during a period of time.

	Participating Customers at December 31		Participating Customer Months In		Percentage Increase in Participating Customer Months Between Years	
	2011	2010	2011	2010		
Risk arrangements	63,400	34,800	495,000	421,900	17.3	%
Non-risk arrangements	8,300	-	23,700	-	N/A	
	71,700	34,800	518,700	421,900	22.9	%

The following table sets forth the number of Participating Customer by program at December 31, 2011 and 2010.

	Participating Customers at December 31	Percentage Increase in

	2011	2010	Participating Customer Months Between Years	
Medicare	54,800	34,800	57.5	%
Medicaid	12,800	-	N/A	
Commercial	4,100	-	N/A	
	71,700	34,800	106.0	%

The increase in total customer months for 2011 as compared to 2010 is primarily a result of the 36,400 Participating Customers and 106,000 Participating Customer months added with the Continucare acquisition. We also realized new enrollments and transfers from other physician's practices 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.

At January 1, 2012, including the aforementioned Participating Customers, the PSN was providing services to approximately 77,800 Participating Customers, of which 60,000 are Participating Customers covered under Medicare risk agreements.

Revenue

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

	Year Ended December 31		$	%
	2011	2010	Increase	Change
	(Dollar amounts in thousands)			
Risk arrangements	$ 452,108	$ 366,520	$ 85,588	23.4 %
Non-risk agreements	1,067	-	1,067	-
Fee-for-service	6,617	1,666	4,951	297.2 %
Total revenue	$ 459,792	$ 368,186	$ 91,606	24.9 %

The most significant component of our revenue is the revenue we generate from Medicare Advantage under risk arrangements which increased by $75.5 million, or 20.6%, during 2011. Continucare contributed $65.7 million of this revenue increase.

Our PCPM Medicare risk revenue increased by $73 or 8.4%. The increase in our PCPM revenue was generated by the acquisition of Continucare, which realizes higher rates in Miami-Dade County than we realize in our other service areas, and increases in our capitation payments as a result of changes in the Medicare risk adjustment scores of our Participating Customers. The benchmark payments we receive under our percentage of premium arrangements with HMOs for our Medicare Advantage Participating Customers were frozen by CMS in 2011 at the 2010 level.

Periodically, we receive retroactive adjustments to the capitation fees paid to us based on the updated MRA scores of our Participating Customers. The factors considered in this update include changes in demographic factors, risk adjustment scores and customer information. 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.

At December 31, 2011, we recorded a $1.5 million receivable representing our estimate of the retroactive MRA capitation fee for services provided in 2011 that we expect to receive in the third quarter of 2012. In the third quarter of 2011, we were notified of the final retroactive MRA premium increase for services provided in 2010. We received $1.0 million as compared to the $2.2 million estimate we had recorded at December 31, 2010. The $1.2 million difference reduced revenue and income before income taxes for 2011.

In February 2012, Humana notified us that the actuarially estimated claims in excess of policy limits were lower than what had been projected for 2010 and 2011. Accordingly, Humana informed us that they would refund a portion of the premiums paid for these periods. The amount of the rebate recorded in the fourth quarter of 2011 was $2.1 million. This amount increased gross profit and operating income in 2011.

Under our non-risk agreements, we receive a monthly 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 the surplus generated as determined by the respective agreement. Under non-risk agreements, we are not responsible for cost of the medical care provided to the Participating Customer. The fees and our portion of the surplus are recorded as revenue in the period in which services are provided.

In 2011, the fee-for-service revenue included medical services provided to non-Participating Customers in our owned physician practices and $4.2 million of revenue from the sleep diagnostic business. The fee-for-service revenue in

2010 represents amounts earned from medical services provided to non-Participating Customers in our owned physician practices.

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 center costs. Medical claims expense is recognized in the period in which services are provided and includes an estimate of our obligations for medical services that have been provided to our Participating Customers but for which we have neither received nor processed claims, and for liabilities for physician, hospital and other medical expense disputes. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by providers other than the physician practices owned by the PSN (collectively "Non-Affiliated Providers"). Medical center costs represent the operating costs of the physician practices owned by the PSN.

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

Total medical expense and MER are as follows:

	Year Ended December 31,					
	2011		2010		% Change	
	(Dollar amounts in thousands)					
Estimated medical expense for the year, excluding prior period claims development	$	366,955	$	303,328	21.0	%
(Favorable) prior period medical claims development in current year based on actual claims submitted		(3,575)		(900)	297.2	%
Total reported medical expense for the year	$	363,380	$	302,428	20.2	%
Medical Expense Ratio for the year		79.0 %		82.1 %		

Favorable adjustments reduce total medical expense for the respective applicable 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 MRA capitation fee adjustments and settlement of Part D program capitation fees. In addition, actual medical claims expense usually develops differently than estimated during the period. Favorable claims development is a result of actual medical claim cost for prior periods developing lower than the original estimated cost which reduces the reported medical expense and the MER for the current period. Unfavorable claims development is a result of actual medical claim cost for prior periods exceeding the original estimated cost which increases total reported medical expense and the MER for the current period.

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 in 2011 increased by $61.0 million, or 20.2%, to $363.4 million from $302.4 million in 2010. Medical claims expense, which is the largest component of medical services expense, increased by $46.3 million, or 16.2%, to $332.9 million in 2011 from $286.6 million in 2010, primarily due to the acquisition of Continucare, which increased medical claims expense by $47.4 million. Including the costs associated with Continucare, our PCPM for Medicare risk arrangements increased from $679 in 2010 to $697 in 2011, an increase of $18 or 2.7%. The increase in total medical expense was primarily a result of medical cost inflation and an increase in utilization during 2011.

The MER in 2011 decreased to 79.0% in 2011 as compared to 82.1% in 2010. This decrease was primarily due to our revenue increasing at a greater rate than the increase in medical expense on a PCPM basis.

Medical center costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services, the costs associated with the operations of our wholly owned medical centers and the costs of our sleep diagnostic business. Medical center costs increased by $14.6 million, or 92.4%, to $30.5 million in 2011 from $15.8 million in 2010. The increase in medical center costs was primarily a result of our acquisition of Continucare with its 19 wholly-owned centers and sleep diagnostic business, which increased our medical center costs by $11.5 million. We also acquired three physician practices in the first half of 2011 that also increased our costs.

At December 31, 2011, we determined that the range for estimated medical claims payable was between $36.7 million and $40.5 million and we recorded a liability of $38.4 million that approximates the actuarial mid-point of the range. Based on historical results, we believe that the actuarial mid-point of the range continues to be the best estimate within the range of the PSN's ultimate liability.

Other Operating Expenses

The following table provides information regarding the various items which comprise other operating expenses.

	Year Ended December 31					
	2011		2010		Increase	% Change
	(Dollar amounts in thousands)					
Payroll, payroll taxes and benefits	$20,911		$15,420		$5,491	35.6 %
Percentage of total revenue	4.6	%	4.2	%		
General and administrative	11,292		8,656		2,636	30.5 %
Percentage of total revenue	2.5	%	2.4	%		
Marketing and advertising	1,271		385		886	230.1 %
Percentage of total revenue	0.3	%	0.1	%		
Amortization of intangible assets	3,545		75		3,470	4626.7 %
Percentage of total revenue	0.8	%	0.0	%		
Impairment of goodwill	3,500		-		3,500	-
Percentage of total revenue	0.8	%	0.0	%		
Termination costs	784		-		784	-
Percentage of total revenue	0.2	%	0.0	%		
Total other operating expenses	$41,303		$24,536		$16,767	68.3 %

Payroll, Payroll Taxes and Benefits

Payroll, payroll taxes and benefits include salary and related costs associated with our corporate level executive, administrative costs, and transportation and call center personnel. The increase in 2011 is primarily a result of Continucare's executive, administrative, transportation and call center payroll, payroll taxes and benefits of $4.9 million from the date of acquisition.

General and Administrative

The increase in general and administrative expense is primarily attributable to Continucare's general and administrative costs from the date of acquisition which were $2.3 million.

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Marketing and Advertising

Marketing and advertising costs increased $0.9 million, $0.4 million of which is attributable to Continucare. The balance of the increase was due to sales and marketing programs we undertook in the last quarter of 2011 in connection with Medicare's annual enrollment period.

Amortization of Intangibles

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

Impairment of Goodwill

At December 31, 2011 we determined that it was more likely than not that we would sell the sleep diagnostic business in 2012. Based on recent sales of similar businesses, we determined that the carrying amount of the sleep diagnostic business' goodwill exceeded its implied fair value resulting in an impairment charge of $3.5 million. We may not be able to sell the sleep business at the carrying value of the assets being sold, which could result in our recognition of further impairment losses.

Termination Costs

In connection with the acquisition of Continucare, we incurred severance benefits for the former CEO and CFO of that company.

Other (Expense) Income

We recognized other expense of $15.5 million compared to other income of $0.3 million in 2011. The increase in other expense is primarily due to $7.9 million of transaction costs incurred in connection with the acquisition of Continucare and $8.2 million of interest on the acquisition related debt.

Investment income was $0.6 million in 2011 compared to $0.3 million in 2010. Realized and unrealized gains and losses were not material in either year.

Income taxes

Our effective income tax rate was 42.7% in 2011 and 38.2% in 2010. The increase in the effective rate is primarily a result of transaction related expenses that were expenses in the financial statements but which are not deductible for tax purposes. We expect our effective income tax rate to return to more normal levels in 2012.

Comparison of 2010 and 2009

Summary

Net income in 2010 was $25.7 million compared to $14.4 million in 2009, an increase of $11.3 million or 78.5%. The increase in net income was primarily a result of a $39 increase in our PCPM revenue, and a decrease in our PCPM medical expense of $21, which was partially offset by an increase in operating expenses.

Basic earnings per share were $0.65 in 2010 compared to $0.32 in 2009. Diluted earnings per share were $0.62 in 2010 compared to $0.31 in 2009. The increase in earnings per share in 2010 was primarily a result of our increased net income and a reduction of 5.3 million basic weighted average shares outstanding and 4.4 million diluted weighted

average shares outstanding in 2010 as compared to 2009.

Revenue increased to $368.2 million in 2010 from $354.4 million in 2009, an increase of $13.8 million or 3.9%. The increase in revenue is primarily attributable to an increase in the average risk scores of the Participating Customers we serve. We believe this increase primarily reflects our continuing efforts to assure that our Participating Customers are properly diagnosed and assigned the appropriate Medicare risk score. This increase was partially offset by a 5.0% reduction in the premium rate paid by CMS to Medicare Advantage plans effective January 1, 2010 and a 0.8% reduction in the number of customer months for the year.

Total medical expense for 2010 was $302.4 million compared to $313.6 million for 2009, a decrease of approximately $11.2 million or 3.6%. PCPM medical costs decreased $21. The decrease in PCPM medical costs is attributable to a number of factors, including certain plan design changes made by Humana in selected markets to increase customer co-pays and deductibles and modify certain benefits. Such changes were primarily a response to the CMS premium reduction and expected utilization and cost increases. In addition, certain high cost special needs plans were eliminated in January 2010 which reduced both our medical costs and our revenue. We also believe that these decreases resulted in part from the adoption of the patient centered medical home (“PCMH”) model of customer care in our owned offices as well as our continued efforts to improve medical care to our Participating Customers so they receive the appropriate level of medical care at the appropriate time.

Our gross profit was $65.8 million in 2010 as compared to $40.9 million in 2009, an increase of $24.9 million or 60.9%.

Our MER was 82.1% in 2010 compared to 88.5% in 2009. The decrease in MER is a result of our increased revenue and lower medical costs.

Operating expenses increased to $24.5 million in 2010 as compared to $19.2 million in 2009, an increase of $5.3 million or 27.6%. The increase in operating expenses is primarily due to an increase in payroll, payroll taxes and benefits of $4.1 million and an increase in general and administrative expense of $1.2 million.

Income before income taxes in 2010 was $41.6 million compared to of $23.3 million in 2009. The increase in the income before income taxes between the periods is primarily a result of the increased gross profit discussed above reduced primarily by the increase in our operating expenses.

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

Customer Information

The table set forth below provides (i) the total number of Participating Customers to whom we were providing healthcare services as of December 31, 2010 and 2009 and (ii) the aggregate customer months for 2010 and 2009. Customer months are the aggregate number of months of healthcare services we have provided to Participating Customers during a period of time.

Customers at December 31		Customer Months In		Percentage Decrease in Customer Months Between Years	
2010	2009	2010	2009		
34,800	35,500	421,900	425,100	-0.8	%

The decrease in total customer months for 2010 as compared to 2009 is primarily a result of the net effect of the elimination of certain high cost special needs plans, new enrollments and disenrollments, deaths, Participating Customers moving from the covered areas, Participating Customers transferring to another physician practice or Participating Customers making other insurance selections.

Revenue

The following table provides a breakdown of our sources of revenue, in thousands.

	Year Ended December 31		$	%
	2010	2009	Increase	Change
	(Dollar amounts in thousands, except PCPM amounts)			
Risk arrangements	$ 366,520	$ 352,993	$ 13,527	3.8 %
Fee-for-service	1,666	1,414	252	17.8 %
Total PSN revenue	$ 368,186	$ 354,407	$ 13,779	3.9 %

In 2010, the increase in our PCPM revenue resulted primarily from an increase in the Medicare risk score of our Participating Customers and was partially offset by a 5% CMS premium rate reduction in 2010.

The PSN's most significant source of revenue during both 2010 and 2009 was the capitation fee revenue generated pursuant to the Humana Agreements (the "Humana Related Revenue"). The Humana Related Revenue increased from $353.0 million in 2009 to $366.5 million in 2010, an increase of approximately $13.5 million or 3.8%.

At December 31, 2010, we recorded a $2.2 million receivable representing our estimate of the retroactive MRA capitation fee for services provided in 2010 that we expect to receive in the summer of 2011. In 2012, we received the final 2010 retroactive MRA premium adjustment of $1.0 million. The difference of $1.2 million reduced revenue and income before income taxes in 2011. In 2010, we received the final retroactive MRA capitation fee payment for services provided in 2009. The amount received was not materially different than the $1.4 million receivable that was included in the due to HMOs at December 31, 2009. At December 31, 2008, we had recorded a $3.8 million estimated retroactive MRA capitation fee receivable for services provided in 2008 and received $3.0 million in 2009. The difference of $0.8 million reduced revenue in 2009.

At December 31, 2010, we recorded a receivable of $0.4 million, for the amount we estimate the Part D Actual Costs will exceed 2010 Part D revenue. At December 31, 2009, we recorded a receivable of $0.6 million, the amount we estimated 2009 Part D Actual Costs would exceed the Part D revenue received. The 2009 amount settled in 2010 at the approximate amount that was estimated.

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

Total Medical Expense

Total medical expense and MER are as follows, in thousands:

	Year Ended December 31,	
	2010	2009
	(Dollar amounts in thousands, except PCPM amounts)	
Estimated medical expense for the year, excluding prior period claims development	$ 303,328	$ 313,532
(Favorable) unfavorable prior period medical claims development in current year based on actual claims submitted	(900)	20
Total reported medical expense for the year	$ 302,428	$ 313,552
Medical Expense Ratio for year	82.1%	88.5%

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

The decrease in total medical expense in 2010 was primarily due to a decrease in utilization of medical services and, to a lesser extent, the decrease in the number of customer months. Approximately $286.6 million or 94.8% of our total medical expense in 2010 is attributable to medical claims expense. In 2009, approximately $299.0 million or 95.3% of our total medical expenses were attributable to medical claims expense. The balance was the expenses associated with operating our medical centers.

Medical center costs include the salaries, taxes and benefits of the PSN's employed health professionals and staff providing primary care services, as well as the costs associated with the operations of those practices. Approximately $15.8 million of our total medical expenses in 2010 related to physician practices we own as compared to $14.5 million in 2009. The increase is due primarily to an office acquired in July 2009 and an increase in our offices' staff

and additional technology costs as we transition to a PCMH model of care and implement an electronic medical record system.

Our PCPM medical expense decreased from $738 in 2009 to $717 in 2010. Despite medical cost inflation, we believe that PCPM medical costs decreased in 2010, as compared to 2009, due to, among other things, certain plan design changes made by Humana in selected markets to increase customer co-pays and deductibles and modify certain benefits, the elimination of certain high cost special needs plans in certain of our counties, and the continued efforts of our medical management team to assure that proper medical care is provided to our Participating Customers.

The increase in revenue and reduction in medical costs resulted in a decrease in our MER, from 88.5% in 2009 to 82.1% in 2010. A number of factors impacting both revenue and medical expense that are discussed in this management's discussion and analysis have positively impacted our MER in 2010.

At December 31, 2010, we determined that the range for estimated medical claims payable was between $24.7 million and $27.3 million and we recorded a liability of $25.7 million, the actuarial mid-point of the range. Based on historical results, we believe that the actuarial mid-point of the range continues to be the best estimate within the range of the PSN's ultimate liability.

Other Operating Expenses

The following table provides information regarding the various items which comprise other operating expenses.

	2010		2009		Increase	Change	
	(Dollar amounts in thousands)						
Payroll, payroll taxes and benefits	$15,420		$11,287		$4,133	36.6	%
Percentage of total revenue	4.2	%	3.2	%			
General and administrative	8,656		7,546		1,110	14.7	%
Percentage of total revenue	2.4	%	2.1	%			
Marketing and advertising	385		359		26	7.2	%
Percentage of total revenue	0.1	%	0.1	%			
Amortization of intangible assets	75		19		56	294.7	%
Percentage of total revenue	0.1	%	0.1	%			
Total other operating expenses	$24,536		$19,211		$5,325	27.7	%

Payroll, Payroll Taxes and Benefits

Payroll, payroll taxes and benefits include salary and related costs associated with our corporate level executive and administrative costs. The increase in 2010 is primarily a result of an increase in the amount accrued for employee bonuses for 2010 resulting from improved earnings, an increase in stock-based compensation expense and an increase in salary costs associated with the implementation of our PCMH model of care and the installation of electronic medical records in our practices.

General and Administrative

This increase in general and administrative expense was primarily a result of an increase in the fees of an outside entity to review our risk score coding compliance and an increase in director fees related to the early vesting of stock-based compensation of the directors that resigned in April 2010.

Marketing and Advertising

Marketing and advertising costs did not increase significantly in 2010 from 2009. We believe that our marketing and advertising expense will increase in the future.

Gain on Sale of HMO Subsidiary

During 2010, we finalized the net statutory equity settlement related to the sale of the HMO and recognized an additional gain of $0.1 million. The final settlement was paid to us in April 2010.

The gain on sale in 2009 of $1.3 million includes additional gain from the closing net equity settlement for the HMO and the settlement of certain liabilities of the HMO that we settled in 2009 at amounts lower than the liability recorded at August 29, 2008.

Other Income

We realized other income of $0.3 million in 2010 compared to $0.4 million in 2009. Investment income, which includes realized and unrealized gains and losses was $0.3 million in 2010 as compared to $0.4 million in 2009. Investment income is included in other income. Realized and unrealized losses in our investment portfolio were $0.1 million in 2010 compared to realized and unrealized gains of $0.1 million in 2009.

Income Taxes

Our effective income tax rate was 38.2% in 2010 and 38.1% in 2009.

Liquidity and Capital Resources

Cash, cash equivalents and short-term investments at December 31, 2011 and December 31, 2010 totaled $19.0 million and $49.5 million, respectively. As of December 31, 2011, we had working capital of $43.2 million as compared to working capital of $54.2 million at December 31, 2010, a decrease of $11.0 million or 20.3%. Our total stockholders' equity was $104.6 million at December 31, 2011 and $67.8 million at December 31, 2010.

During 2011, our cash and equivalents increased $7.4 million. Net cash provided by operating activities during this year was $24.2 million. The most significant source of cash from operating activities was net income of $22.7 million. The following non-cash expenses also contributed to the cash provided by operating activities: an impairment loss of $3.5 million, depreciation and amortization of $5.2 million, amortization of debt issuance costs of $1.3 million and amortization of stock based compensation of $2.6 million. Our primary operating sources of cash were partially offset by an increase in due from HMOs of $8.8 million, a decrease in the deferred tax liability of $1.7 million and a decrease of accrued payroll and payroll taxes of $1.4 million.

The due from HMOs account is used to record the net amount due to us as a result of normal activity between the Contracting HMOs and us. These transactions include, among other things, capitation fees due to us, retroactive capitation fee payments due to us, claim payments made by an HMO on our behalf, and estimated medical claims expense payable. The increase in the due from HMOs in 2011 from $9.1 million in 2010 to $40.2 million substantially relates to the acquisition of Continucare which increased the due from HMO by $22.5 million and an increase in the amounts due to us from the Contracting HMOs. The amount due from HMOs generally increases during the first half of the year and is generally collected by us over the next three to nine months and is paid in the normal course of business. We are not aware of any material amounts in dispute with any of the Contracting HMOs. We collected a total of $19.9 million of this receivable in January 2012.

Net cash used in investing activities during 2011 was $312.7 million. The most significant use of cash from investing activities was the cash used in the acquisition of Continucare of $348.9 million which was partially offset by cash generated from the sale of short-term investments of $38.0 million. We sold substantially all of our short-term investments to generate a portion of the cash required for the Continucare acquisition.

Net cash provided by financing activities during 2011 was $295.8 million. The most significant source of cash was $315.0 million from the issuance of long-term debt obligations and $5.0 million borrowed under the revolving loan facility which was partially offset by $23.5 million of debt issuance and acquisition costs.

The following table presents our Adjusted EBITDA (Non-GAAP measure) for the years and three months ended December 31, 2011 and 2010, as well as a reconciliation of Adjusted EBITDA to the reported net income for such periods (in thousands):

	Year Ended December 31,		Three Months Ended December 31,	
	2011	2010	2011	2010
Net income	$22,714	$25,700	$2,827	$6,020
Income tax expense	16,920	15,884	4,457	3,885
Interest expense (income), net of investment income	7,602	(328)	8,138	72
Depreciation and amortization	5,230	1,056	4,200	358
Goodwill impairment charge	3,500	-	3,500	-
Stock-based compensation	2,618	2,377	677	788
Adjusted EBITDA	$58,584	$44,689	$23,799	$11,123

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

On October 4, 2011, we completed the acquisition of Continucare. The total value of the transaction was $415.9 million, excluding transaction expenses and financing fees. Concurrent with the completion of the Merger, we entered into a First Lien Credit Agreement and a Second Lien Credit Agreement, described in greater detail in ““Item 1. Description of Business - Overview – Acquisition of Continucare.” To fund the cash component of the purchase price, transaction expenses and financing costs we and Continucare used a total of $143.2 million of cash and borrowed a total of $315.0 million under the First Lien Credit Agreement and the Second Lien Credit Agreement. Certain transaction costs are not deductible for tax purposes which increased our effective tax rate in 2011.

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

Commencing for the year ended December 31, 2012 and each year thereafter, we will be required to pay our First Lien Lenders 75.0% of our excess cash flow (defined as cash flow less scheduled principal and interest payments, cash taxes, and any increase in working capital, plus any decrease in working capital) less any voluntary prepayments made during the applicable year, with a reduction to 50.0% based on achievement of a total leverage ratio (defined as the ratio of Metropolitan’s aggregate outstanding indebtedness to its adjusted earnings before stock-based compensation, interest, taxes, depreciation and amortization) not exceeding 2.00x as of the last day of each year. We expect to begin making excess cash flow payments in March 2013 related to calendar year 2012.

The following unaudited pro forma condensed consolidated financial information assumes that the acquisition of Continucare was accounted for using the acquisition method of accounting for business combinations in accordance with ASC 805 and represents a pro forma presentation based upon available information of the combining companies giving effect to the acquisition of Continucare as if it had occurred on January 1, 2010, with adjustments for amortization expense of intangible assets, termination or changes in certain compensation arrangements and on-going operating expenses, non-operating expenses not acquired in the acquisition, interest expense and income tax expense:

	Year ended December 31	
	2011	2010
	(in thousands, except per share data)	
Revenue	$ 701,285	$ 651,610
Net income	$ 31,719	$ 23,814

Earnings per share:		
Basic	$ 0.78	$ 0.61
Diluted	$ 0.74	$ 0.57
Adjusted EBITDA	$ 107,780	$ 90,746

The unaudited pro forma condensed financial information is based on the assumptions and adjustments which give effect to events that are: (i) directly attributable to the acquisition; (ii) expected to have a continuing impact; and (iii) factually supportable. The unaudited pro forma condensed financial information is presented for informational purposes only and is not necessarily indicative of the operating results that would have been achieved had the acquisition of Continucare been consummated as of the dates indicated or of the results that may be obtained in the future.

Effective December 4, 2011, we entered into an interest rate cap agreement pursuant to which we will be entitled to receive certain payments in the event the LIBOR rate exceeds 1.5%. The notional amount of the interest rate cap, which expires on September 30, 2014, is $157.5 million and will decrease to $134.1 million over the life of the agreement. The effect of this interest rate cap is to hedge our risk of a rise in the LIBOR rate above 1.5% with respect to a portion of the outstanding indebtedness under the First Lien Credit Agreement and the Second Lien Credit Agreement equal to the notional amount of the cap.

On October 4, 2011, we terminated our $3.0 million secured one year commercial line of credit agreement and replaced it with a letter of credit under the Revolving Loan Facility. Upon the termination of the secured line of credit, the restricted cash and investments securing the letter of credit were released.

On October 11, 2011, we borrowed $5.0 million under the Revolving Credit Facility. We repaid this amount in January 2012.

In October 2008, our Board of Directors established a stock repurchase program that now, due to various amendments, authorizes the repurchase of up to a total of 25.0 million shares of common stock. In 2011, we repurchased approximately 71,000 shares of common stock for an aggregate of $0.3 million. From October 6, 2008 (the date of our first repurchases under the plan) through December 31, 2011, we have repurchased 14.0 million shares and options to purchase 684,200 shares of our common stock for $28.3 million. The number of shares to be repurchased and the timing of the purchases are influenced by a number of factors, including the then prevailing market price of our common stock, other perceived opportunities that may become available to us and regulatory requirements. 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 in any year.

ITEM 7A QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

Interest Rate Risk

We monitor the third-party depository institutions that hold our cash, cash equivalents and investments. We diversify our cash, cash equivalents and investments among counterparties and investment positions to reduce our exposure to any one of these entities or investments. Our emphasis is primarily on safety of principal while maximizing yield on those funds. To achieve this objective, we maintain our portfolio of cash equivalents and investments in municipal bonds. Our investments are classified as trading securities. Investments in both fixed rate and floating rate interest earning securities carry a degree of interest rate risk. Fixed rate securities may have their fair market value adversely impacted due to a rise in interest rates, while floating rate securities may produce less income than predicted if interest rates fall. Due in part to these factors, the value of our investments and/or our income from investments may decrease in the future. Our interest rate risk relative to our investments has decreased significantly with the sale of substantially

all our investments in the third quarter of 2011.

The interest rate on our borrowings under the Credit Agreements can fluctuate based on both the interest rate option (i.e., base rate or LIBOR rate plus applicable margins) and the interest period. As of December 31, 2011, the total amount of outstanding debt subject to interest rate fluctuations was $320.0 million. A hypothetical 100 basis point change in LIBOR as of the date of the Agreement would have no impact on interest expense due to the LIBOR floor contained in the Credit Agreement. Effective December 4, 2011, we entered into an interest rate cap which provides protection against increases in the LIBOR rate above 1.5%. The notional amount of the cap is $157.5 million decreasing to $134.1 million over the life of the agreement. The interest rate cap expires on September 30, 2014.

Intangible Asset Risk

We have intangible assets and perform goodwill impairment tests annually and whenever events or changes in circumstances indicate that the carrying value may not be recoverable from estimated future cash flows. As a result of our periodic evaluations, we may determine that the intangible asset values need to be written down to their fair values, which could result in material charges that could be adverse to our operating results and financial position. We evaluate the continuing value of goodwill by using valuation techniques based on multiples of earnings, revenue and EBITDA (i.e., earnings before interest, taxes, depreciation and amortization) particularly with regard to entities similar to us that have recently been acquired. We also consider the market value of our own stock and those of companies similar to ours. At December 31, 2011, we believe that goodwill related to the sleep diagnostic business is impaired in the amount of $3.5 million. The impairment related primarily to our evaluation that it was more likely than not that we would sell the sleep diagnostic business in 2012 and that the anticipated sales price would be less than the carrying value of the net assets. We continue to monitor those assumptions and their effect on the estimated recoverability of our intangible assets.

Equity Price Risk

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

Commodity Price Risk

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

ITEM 8 FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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

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

None

ITEM 9A. CONTROLS AND PROCEDURES

(a) Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures, as defined in Rule 13a-15(e) and 15d-15(e) of the Exchange Act, as of December 31, 2011. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures are effective to ensure that information required to be disclosed in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC’s rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosure.

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

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

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

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

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

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

Management assessed the effectiveness of our internal control over financial reporting as of December 31, 2011. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in Internal Control-Integrated Framework.

Based on our assessment, management believes that, as of December 31, 2011, our internal control over financial reporting is effective.

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

(c) Attestation Report of Independent Registered Public Accounting Firm

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders
Metropolitan Health Networks, Inc.

We have audited Metropolitan Health Networks, Inc. and subsidiaries, (the Company) internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control—Integrated Framework issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of the Company as of December 31, 2011 and 2010, and the related consolidated statements of income and comprehensive income, changes in stockholders' equity and cash flows for each of the three years in the period ended December 31, 2011 and our report dated March 6, 2012 expressed an

unqualified opinion on those financial statements.

/s/ GRANT THORNTON LLP

Miami, Florida
March 6, 2012

(d) Changes in Internal Control over Financial Reporting

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

PART III

ITEM 10 DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Code of Ethics

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

Metropolitan Health Networks, Inc.
Attn: Roberto L. Palenzuela, General Counsel and Secretary
777 Yamato Road, Suite 510
Boca Raton, Fl. 33431
(561) 805-8500

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

Corporate Governance Guidelines — Certain Committee Charters

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

The information required by this item about our Executive Officers is included in Part I, "Item 1. Business" of this Annual Report on Form 10-K under the caption "Our Executive Officers." All other information required by this item is incorporated herein by reference from our definitive Proxy Statement for the 2012 Annual Meeting of Shareholders to be filed with the SEC pursuant to Regulation14A no later than April 30, 2012 (the "2012 Proxy Statement").

ITEM 11 EXECUTIVE COMPENSATION

The information required by this item is included in our 2012 Proxy Statement and is incorporated herein by reference.

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

The information required by this item is included in our 2012 Proxy Statement and is incorporated herein by reference.

ITEM 13 CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

The information required by this item is included in our 2012 Proxy Statement and is incorporated herein by reference.

ITEM 14 PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by this item is included in our 2012 Proxy Statement and is incorporated herein by reference.

PART IV

ITEM 15 EXHIBITS, FINANCIAL STATEMENT SCHEDULES

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

(1) Consolidated Financial Statements.

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

METROPOLITAN HEALTH
NETWORKS, INC. AND SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS

DECEMBER 31, 2011

C O N T E N T S

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Stockholders
Metropolitan Health Networks, Inc.

We have audited the accompanying consolidated balance sheets of Metropolitan Health Networks, Inc. and subsidiaries (the Company) as of December 31, 2011 and 2010, and the related consolidated statements of income and comprehensive income, changes in stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2011. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Metropolitan Health Networks, Inc. and subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Metropolitan Health Networks, Inc. and subsidiaries' internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) and our report dated March 6, 2012 expressed an unqualified opinion thereon.

/s/ GRANT THORNTON LLP
Miami, Florida
March 6, 2012

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2011	2010
	(in thousands, except share data)	
ASSETS		
CURRENT ASSETS		
Cash and equivalents	$17,964	$10,596
Investments, at fair value	1,003	38,949
Accounts receivable from customers, net of allowance of $1,615 and $817 in 2011 and 2010, respectively	3,023	904
Due from HMOs, net	40,241	9,067
Deferred income taxes	949	517
Prepaid income taxes	3,717	-
Prepaid expense and other current assets	5,243	941
TOTAL CURRENT ASSETS	72,140	60,974
PROPERTY AND EQUIPMENT, net of accumulated depreciation and amortization of $4,743 and $3,443 in 2011 and 2010, respectively	21,683	1,973
RESTRICTED CASH AND INVESTMENTS	295	4,385
DEFERRED INCOME TAXES, net of current portion	-	1,571
OTHER INTANGIBLE ASSETS, net of accumulated amortization of $4,371 and $1,238 in 2011 and 2010, respectively	102,053	570
GOODWILL	262,805	4,362
DEFERRED FINANCING COSTS	9,882	-
OTHER ASSETS	888	888
TOTAL ASSETS	$469,746	$74,723
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts payable	$1,295	$436
Accrued payroll and payroll taxes	5,941	5,158
Accrued expenses	6,690	902
Accrued interest payable	2,434	-
Current portion of long-term debt	12,538	318
TOTAL CURRENT LIABILITIES	28,898	6,814
LONG-TERM DEBT, net of current portion and original issue discount	296,029	159
DEFERRED INCOME TAXES	40,175	-
TOTAL LIABILITIES	365,102	6,973
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 shares issued and outstanding at December 31, 2011 and 2010, respectively	500	500

Common stock, par value $.001 per share; 80,000,000 shares authorized; 43,751,000 and 40,750,000 issued and outstanding at December 31, 2011 and 2010, respectively	44	41
Additional paid-in capital	36,740	22,453
Accumulated other comprehensive (loss)	(110)	-
Retained earnings	67,470	44,756
TOTAL STOCKHOLDERS' EQUITY	104,644	67,750
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$469,746	$74,723

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

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

	Years Ended December 31,		
	2011	2010	2009
	(in thousands, except per share amounts)		
REVENUE	$ 459,792	$ 368,186	$ 354,407
MEDICAL EXPENSE			
Medical claims expense	332,929	286,602	299,040
Medical center costs	30,451	15,826	14,512
Total medical expense	363,380	302,428	313,552
GROSS PROFIT	96,412	65,758	40,855
OTHER OPERATING EXPENSES			
Administrative payroll, payroll taxes and benefits	20,911	15,420	11,287
General and administrative	11,292	8,656	7,545
Marketing and advertising	1,271	385	359
Amortization of intangible assets	3,545	75	19
Impairment of goodwill	3,500	-	-
Termination costs related to the Continucare acquisition	784	-	-
Total other operating expenses	41,303	24,536	19,210
OPERATING INCOME BEFORE GAIN ON SALE OF HMO	55,109	41,222	21,645
Gain on sale of HMO subsidiary	-	62	1,336
OPERATING INCOME	55,109	41,284	22,981
OTHER INCOME (EXPENSE)			
Transaction costs	(7,876)	-	-
Interest expense	(8,174)	-	-
Investment income, net	572	328	390
Other income (expense), net	3	(29)	(23)
Total other (expense) income	(15,475)	299	368
INCOME BEFORE INCOME TAXES	39,634	41,584	23,349
PROVISION FOR INCOME TAXES	16,920	15,884	8,900
NET INCOME	22,714	25,700	14,449
OTHER COMPREHENSIVE (LOSS), NET OF TAX BENEFIT OF $69	(110)	-	-
COMPREHENSIVE INCOME	$ 22,604	$ 25,700	$ 14,449
EARNINGS PER SHARE:			
Basic	$ 0.56	$ 0.65	$ 0.32
Diluted	$ 0.53	$ 0.62	$ 0.31

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

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY
YEARS ENDED DECEMBER 31, 2011, 2010 AND 2009

	$0.001 Par Value Preferred Shares	$0.001 Par Value Preferred Stock	Common Stock Shares	$0.001 Par Value Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Total
	(in thousands, except share amounts)							
BALANCES - JANUARY 1, 2009	5,000	$ 500	48,251,395	$ 48	$ 37,649	$ -	$ 4,607	$ 42,804
Stock option compensation expense	-	-	-	-	688	-	-	688
Shares issued for directors' fees	-	-	100,974	-	165	-	-	165
Shares issued to employees	-	-	366,700	1	502	-	-	503
Stock repurchases	-	-	(7,816,678)	(8)	(15,873)	-	-	(15,881)
Tax benefit from options repurchased	-	-	-	-	198	-	-	198
Net income	-	-	-	-	-	-	14,449	14,449
BALANCES - DECEMBER 31, 2009	5,000	500	40,902,391	41	23,329	-	19,056	42,926
Exercise of options, net	-	-	981,339	1	443	-	-	444
Stock option compensation expense	-	-	-	-	1,015	-	-	1,015
Shares issued for directors' fees	-	-	102,012	-	292	-	-	292
Shares issued to employees	-	-	651,826	1	1,069	-	-	1,070
Tax benefit from options exercised and stock vested	-	-	-	-	791	-	-	791
Stock repurchases	-	-	(1,887,390)	(2)	(4,486)	-	-	(4,488)
Net income	-	-	-	-	-	-	25,700	25,700
BALANCES - DECEMBER 31, 2010	5,000	500	40,750,178	41	22,453	-	44,756	67,750
Shares issued in connection with acquisition of Continucare, net of issuance costs of $127	-	-	2,542,011	3	11,411	-	-	11,414
Exercise of options, net	-	-	142,112	-	(44)	-	-	(44)
Tax benefit from options exercised and stock vested	-	-	-	-	623	-	-	623
Stock option compensation expense	-	-	-	-	1,164	-	-	1,164
	-	-	66,966	-	320	-	-	320

Shares issued for directors' fees								
Shares issued to employees	-	-	320,725	-	1,134	-	-	1,134
Stock repurchases	-	-	(71,054)	-	(321)	-	-	(321)
Change in fair value of derivative instrument, net of tax benefit of $69	-	-	-	-	-	(110)	-	(110)
Net income	-	-	-	-	-	-	22,714	22,714
BALANCES - DECEMBER 31, 2011	5,000	$ 500	43,750,938	$ 44	$ 36,740	$ (110)	$ 67,470	$ 104,644

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

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

	Years Ended December 31,		
	2011	2010	2009
	(in thousands)		
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income	$22,714	$25,700	$14,449
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of HMO subsidiary	-	(62)	(1,336)
Impairment of goodwill	3,500	-	-
Unrealized (gains) losses on short-term investments	(10)	151	(44)
Depreciation and amortization	5,230	1,056	884
Amortization of debt issuance costs and original issue discount	1,338	-	-
Bad debt expense	798	234	93
Loss from disposal of property and equipment	24	-	1
Stock-based compensation expense	2,618	2,377	1,355
Deferred income taxes	(1,740)	(404)	(237)
Excess tax benefits from exercised options and stock vested	(623)	(792)	(198)
Changes in operating assets and liabilities, net of effect of acquisitions:			
Accounts receivable from customers	(663)	(621)	(324)
Due from HMOs	(8,832)	(10,390)	5,100
Prepaid income taxes	486	-	406
Prepaid expenses and other current assets	(846)	(85)	297
Other assets	141	(111)	(43)
Accounts payable	617	(19)	297
Accrued payroll and payroll taxes	(1,370)	2,198	671
Income taxes payable	-	(1,543)	-
Accrued interest payable	2,434	-	-
Accrued expenses	(1,605)	341	(963)
Total adjustments	1,497	(7,670)	5,959
Net cash provided by operating activities	24,211	18,030	20,408
CASH FLOWS USED IN INVESTING ACTIVITIES:			
Capital expenditures	(5,085)	(733)	(1,084)
Restricted cash released as security for letter of credit	4,385	646	-
Restricted cash from sale of HMO subsidiary	-	1,414	-
Acquisition of Continucare, net of cash acquired	(348,933)	-	-
Cash paid for physician practice acqusitions	(975)	-	(1,000)
Sale (purchase) of short-term investments	37,957	(12,064)	1,612
Net cash used in investing activities	(312,651)	(10,737)	(472)
CASH FLOWS PROVIDED BY (USED IN) FINANCING ACTIVITIES:			
Repayments on notes payable and capital lease obligations	(803)	(239)	(159)
Proceeds from revolving loan facility	5,000	-	-
Issuance of long-term debt obligations	315,000		

Proceeds from exercise of stock options and warrants, net	(44)	443	-
Stock issuance costs	(127)	-	-
Deferred financing costs	(10,662)	-	-
Original issue discount	(12,858)	-	-
Stock repurchases	(321)	(4,488)	(15,881)
Excess tax benefits from exercised options and stock vested	623	792	198
Net cash provided by (used in) financing activities	295,808	(3,492)	(15,842)
NET INCREASE IN CASH AND EQUIVALENTS	7,368	3,801	4,094
CASH AND EQUIVALENTS - beginning of year	10,596	6,795	2,701
CASH AND EQUIVALENTS - end of year	$17,964	$10,596	$6,795

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

METROPOLITAN HEALTH NETWORKS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)

	Years ended December 31,		
	2011	2010	2009
		(in thousands)	
Supplemental Disclosures:			
Interest paid	$4,448	$29	$26
Cash paid for income taxes	$17,841	$17,832	$8,731
Supplemental Disclosure of Non-cash Investing and Financing Activities:			
Issuance of notes payable for physician practice acquisitions	$670	$-	$875
Stock issued for Continucare acquisition	$11,541	$-	$-

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

Metropolitan Health Networks, Inc. and Subsidiaries

Year Ended December 31, 2011

Notes to Consolidated Financial Statements

NOTE 1 - ORGANIZATION AND BUSINESS ACTIVITY

Our primary business is the operation of our provider services network ("PSN") through our wholly owned subsidiaries, Metcare of Florida, Inc. and Continucare Corporation ("Continucare"), which we acquired on October 4, 2011. The PSN provides and arranges for the provision of healthcare services to Medicare Advantage and Medicaid beneficiaries in the State of Florida. At December 31, 2011, we operate the PSN through 33 wholly-owned primary care practices, a wholly-owned oncology practice and have contracts with almost 450 independent primary care practices (each an "IPA"). As of December 31, 2011, the PSN operated in 18 Florida counties, including the Miami, Ft. Lauderdale, West Palm Beach, Tampa and Daytona metropolitan areas. On January 1, 2012, we began operations in Escambia and Santa Rosa counties in Florida's panhandle region under a mutually exclusive contract with Humana's (defined below) Medicare Advantage plan.

Prior to the acquisition of Continucare, substantially all of our revenue was derived from Medicare Advantage health plans operated by Humana, Inc. or its subsidiaries ("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 and commercially insured customers with several other health maintenance organizations ("HMOs"). Our most significant managed care agreements continue to be Medicare Advantage 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. Our agreements with these HMOs are primarily risk agreements under which we receive for our services a monthly capitated fee with respect to the customers assigned to us by the Contracting HMOs (each a "Participating Customer"). The capitated fee is a significant percentage of the premium that the HMOs receive with respect to those Participating Customers. In return, we assume full financial responsibility for the provision of all necessary medical care to our Participating Customers even for services we do not provide directly.

We also have non-risk agreements with these HMOs. Under our non-risk agreements, we receive a monthly 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 the 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 the medical care provided to the Participating Customer.

As of December 31, 2011, we provided services to or for approximately 63,400 Participating Customers on a risk basis and approximately 8,300 Participating Customers on a non-risk basis. We also provide services to non-participating customers on a fee-for-service basis.

Since the acquisition of Continucare, we have operated a sleep diagnostic business which operates and manages over 70 sleep diagnostic centers in 15 states. On February 27, 2012, the Board of Directors approved a plan to sell the sleep diagnostic business. As a result, we will reflect the sleep diagnostic business as a discontinued operation in the March 31, 2012 financial statements and all prior comparative periods in which we owned the sleep diagnostic business.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Consolidation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP"). The consolidated financial statements include the accounts of Metropolitan Health Networks, Inc., and subsidiaries that we control, including Continucare from the date of acquisition. All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in accordance with U.S. GAAP requires us to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. The areas involving the most significant use of estimates are medical expenses payable, retroactive capitation fee adjustment estimates, the impact of risk sharing provisions related to our contracts with the Contracting HMOs, the future benefit of our deferred tax asset and the valuation and related impairment recognition of long-lived assets, including goodwill and accounting for acquisitions. 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.

Revenue

Substantially all of our revenue is derived from risk agreements with HMOs in which a monthly capitation fee is paid by the Contracting HMO to us 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 expenses, we recognize revenue and medical expenses for these contracts in our consolidated financial statements.

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

Under our non-risk agreements with HMOs, we receive a monthly fee based on the number of Participating Customers to which we provide services on a monthly basis and, under certain agreements; we also receive a percentage of the surplus generated as determined by the respective contract. The fees and our portion of the surplus generated under these arrangements are recorded as revenue in the period in which services are provided.

Our PSN's owned medical practices and sleep centers also provide services on a fee-for-service basis. These services are typically billed to non-Participating Customers, Medicare, Medicaid, health maintenance organizations and insurance companies. Fee-for-service revenue, which was 1.4% of revenue in 2011 and approximately 0.5% in 2010

and 2009, is recorded at the net amount expected to be collected from the customer or from the insurance company paying the bill. Often this amount is less than the charge that is billed and such discounts reduce the revenue recorded.

Investment income includes realized and unrealized gains and losses on trading securities, and interest and dividends earned and is recorded in other income.

Medicare Part D

We provide prescription drug benefits to our Medicare Advantage Participating Customers in accordance with the requirements of Medicare Part D (“Part D”). The benefits covered under Part D are in addition to the benefits covered by the PSN under Medicare Parts A and B. Capitation fee revenue for the provision of Part D insurance coverage is included in our monthly payment from Contracting HMOs.

The Part D Payment we receive is subject to adjustment, positive or negative, based upon the application of risk corridors that compare the estimated prescription drug benefit costs (“Estimated Costs”) to actual prescription drug benefit incurred costs (the "Actual Costs"). To the extent the Actual Costs exceed the Estimated Costs by more than the risk corridor, we may receive additional payments. Conversely, to the extent the Estimated Costs exceed the Actual Costs by more than the risk corridor; we may be required to refund a portion of the Part D Payment. We estimate and recognize an adjustment to revenue based upon pharmacy claims experience to date as if the contract to provide Part D coverage were to end at the end of each reporting period. Accordingly, this estimate does not take into consideration projected future pharmacy claims experience. It is reasonably possible that this estimate could change in the near term by an amount that could be material. Since these amounts represent additional revenue or revenue that is to be returned, any adjustment is recorded as an increase or decrease to revenue. The final settlement for the Part D program occurs in the subsequent year.

Medical Expense and Medical Claims Expense Payable

Total medical expense represents the estimated total cost of providing customer care under risk agreements and is comprised of two components, medical claims expense and medical center costs. Medical claims expense is recognized in the period in which services are provided and includes an estimate of our obligations for medical services that have been provided to our Participating Customers but for which we have neither received nor processed claims, and for liabilities for physician, hospital and other medical expense disputes. Medical claims expense includes such costs as inpatient and outpatient services, pharmacy benefits and physician services by providers other than the physician practices owned by the PSN. Medical center 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 to the amount in the range that is our best estimate of the ultimate liability. Each period, we re-examine previously recorded medical claims payable estimates based on actual claim submissions and other changes in facts and circumstances. As medical claims expense 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, total medical expense includes a change 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. Medical claims expense payable is included in the due from HMOs in the accompanying consolidated balance sheets.

Under our risk agreements, we are responsible for substantially all of the cost of all medical services provided to each Participating Customer. To the extent that Participating Customers require more frequent or expensive care than was anticipated, the capitation fee we receive may be insufficient to cover the costs of care provided. When it is probable that expected future healthcare and maintenance costs will exceed the anticipated revenue under the 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 is no premium deficiency liability recorded at December 31, 2011 or 2010, and we do not anticipate recording a premium deficiency liability, except when, or if, unanticipated adverse events or changes in circumstances indicate otherwise.

Cash and Cash Equivalents

All highly liquid investments with original maturities of three months or less are considered to be cash equivalents. From time to time, we maintain cash balances with financial institutions in excess of federally insured limits.

Investments

At December 31, 2011, investment securities consist primarily of cash and state and municipal bonds. We classify our debt securities as trading and do not classify any securities as available-for-sale or held to maturity. Trading securities are bought and held principally for the purpose of selling them in the near term. Available-for-sale securities are all securities not classified as trading or held to maturity. Cash and cash equivalents that have been set aside to invest in trading securities are classified as investments.

Trading securities are recorded at fair value. Unrealized holdings gains and losses on trading securities are included in operations. Dividend and interest income is recognized when earned.

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 our long-term debt is the estimated amount we would have to pay to repurchase our 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.

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. United States government and agency securities and state, municipal and corporate bonds are Level 2 and are valued at the recent trading value of bonds with similar credit characteristics and rates. Restricted investments are comprised of municipal bonds.

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

Accounts Receivable from Customers

Accounts receivable from customers represent amounts due for medical services provided directly by physicians in our owned centers and for sleep diagnostic services to individuals who are non-Participating Customers. We do not obtain collateral for these amounts. Accounts receivable from customers are shown net of allowances for estimated uncollectible accounts.

The allowance for uncollectible accounts is our best estimate of the amount of probable losses in our existing accounts receivable and is based on a number of factors, including responsible payer, collection history and a review of past due balances, with a particular emphasis on past due balances greater than 90 days old. Account balances are charged off against the allowance after all means of collection have been exhausted and the potential for recovery is considered remote.

Property and Equipment

Property and equipment, acquired in the ordinary course of business, is recorded at cost. Property and equipment acquired in a business combination is recorded at fair value at the date of acquisition. Expenditures for major improvements and additions are charged to the asset accounts, while replacements, maintenance and repairs, which do not extend the lives of the respective assets, are charged to expense.

Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. If the sum of the expected future undiscounted cash flows is less than the carrying amount of the asset, a loss is recognized for the difference between the fair value and carrying value of the asset. At December 31, 2011, we are not aware of any indicators of impairment.

We calculate depreciation using the straight-line method over the estimated useful lives of the assets. Amortization of leasehold improvements is computed on a straight-line basis over the shorter of the estimated useful lives of the assets or the remaining term of the lease. The range of useful lives is as follows:

Medical equipment	3 - 7 years
Computers and office equipment	3 - 5 years
Furniture and equipment	3 - 7 years
Vehicles	5 years
Buildings and building improvements	40 years or the remaining life of the building
Leasehold improvements	Shorter of estimated useful life of 3-10 years or term of lease

Deferred Taxes

Realization of our deferred tax asset is dependent on generating sufficient taxable income prior to the expiration of our various deferred tax items. The amount of the deferred tax asset considered realizable could change in the near term if estimates of future taxable income are modified and such changes could be material.

U.S. GAAP requires the establishment of a valuation allowance to reduce the deferred tax assets reported if, based on the weight of the evidence, it is more likely than not that some portion or all of the deferred tax assets will not be realized. After consideration of all the evidence, both positive and negative (including, among others, projections of future taxable income and our profitability in recent years), we determined that future realization of our deferred tax assets was more likely than not and, accordingly, we have not recorded a valuation allowance. In the event we determine that we would not be able to realize all or part of our net deferred tax assets in the future, an adjustment to establish a deferred tax asset valuation allowance would be charged to income in the period such determination is made.

Goodwill and Other Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired related to the acquisition of Continucare and certain physician practices by the PSN. U.S. GAAP requires that we not amortize goodwill to earnings, but instead requires that we test at least annually for impairment at a level of reporting referred to as the reporting unit. We have determined that we have two reporting units: the PSN and the sleep diagnostic business. Our goodwill impairment reviews are determined using a two-step process. We test more frequently if adverse events or changes in circumstances indicate that an asset may be impaired. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

At December 31, 2011, we conducted impairment testing on our PSN reporting unit. The testing is performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan, annual planning process, and the market value of our shares and metrics of comparable companies. At December 31, 2011, we determined that there was no goodwill impairment associated with the PSN reporting unit. Goodwill impairment tests completed for 2010 and 2009 did not result in an impairment loss.

We evaluated the sleep diagnostic business reporting unit's long-lived assets for impairment and determined, as of December 31, 2011, that events indicated the carrying amounts may not be recoverable because there was a more likely than not expectation the sleep diagnostic business reporting unit will be sold significantly before the end of these assets' useful lives. We completed our analysis related to this reporting unit's long-lived tangible and finite and indefinite lived intangible assets and concluded that these assets were not impaired as of December 31, 2011. We then evaluated this reporting unit's goodwill for impairment as of December 31, 2011, and recorded an impairment charge of $3.5 million in the fourth quarter of 2011.

We amortize intangible assets with determinable lives over 1 to 25 years, generally using the straight line method. We amortize customer relationships on an accelerated basis based on the estimated net income impact of customer turnover. If we were to renew or extend an arrangement where there is likely to be substantial cost, we would use our own assumptions, adjusted for our specific factors, commonly using the income approach to measure the fair value of the recognized intangible asset.

Earnings Per Share

Earnings per share, basic is computed by dividing net income by the weighted average number of common shares outstanding during the period. Earnings per share, diluted reflects the potential dilution that could occur if securities or other contracts to issue common stock were exercised or converted into common stock or resulted in the issuance of common stock that then shared in our earnings.

Stock-Based Compensation

We measure and recognize compensation expense for all share-based payment awards made to employees and directors, including employee stock options, based on estimated fair values. We estimate the fair value of stock option awards on the date of grant using an option-pricing model. The value of awards that are ultimately expected to vest is recognized as expense over the requisite service periods in the consolidated statements of income and comprehensive income. Stock-based compensation expense recognized in the consolidated statements of income and comprehensive income for fiscal 2011, 2010 and 2009 is based on awards ultimately expected to vest and has been adjusted for estimated forfeitures.

Advertising Costs

Advertising expense was approximately $1.3 million, $0.4 million, and $0.4 million for the years ended December 31, 2011, 2010 and 2009, respectively, and are expensed as incurred.

Income Taxes

Income taxes are accounted for under the asset and liability method. Under this method, deferred income tax assets and liabilities are determined based upon differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases using enacted tax rates in effect for the year in which the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in earnings in the period that includes the enactment date.

We recognize the financial statement benefit of a tax position only after determining that the relevant tax authority would more-likely-than-not sustain the position following an audit. For tax positions meeting the more-likely-than-not threshold, the amount recognized in the financial statements is the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement with the relevant tax authority.

We recognize interest related to unrecognized tax benefits in interest expense and penalties in operating expenses for all periods presented.

Stop Loss Reinsurance

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. For approximately 60.0% of our Participating Customers we purchase reinsurance through the Contracting HMOs. The Contracting HMOs charge us a

per Participating Customer per month fee that limits our healthcare costs for any individual Participating Customer. Healthcare costs in excess of the 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 deductible of $225,000 in 2011 and $200,000 in 2010 and 2009. Reinsurance recoveries under these policies are remitted to us and are recorded as a reduction to medical claims expense. Our policies have a maximum annual benefit of $1.0 million.

Comprehensive Income

In 2011, we included in comprehensive income the change in fair value of our interest rate cap. In 2010 and 2009, other than net income we had no other items of comprehensive income or loss.

NOTE 3 – ACQUISITIONS

During 2011, we acquired Continucare and three physician practices. We did not consummate any material acquisitions during 2010. In 2009, we acquired one physician practice. 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 the acquisition date. The purchase price allocations presented for our 2011 acquisitions have been finalized. Other than for the Continucare acquisition, we do not present pro forma information given the immateriality of the preacquisition results of the acquired physician practices to our consolidated financial statements.

Our consolidated financial statements include the operating results for each acquired entity from its respective date of acquisition.

Acquisition of Continucare Corporation

On October 4, 2011, we completed the acquisition of Continucare. The acquisition was structured as a merger of our wholly-owned subsidiary, CAB Merger Sub, Inc. (“Merger Sub”), with and into Continucare (the “Merger”) in accordance with the terms of the Agreement and Plan of Merger, dated June 26, 2011. As a result of the Merger, Continucare became a wholly-owned subsidiary of Metropolitan. The business and results of Continucare are reflected in our financial results from the date of acquisition.

Upon consummation of the Merger, each outstanding share of Continucare common stock, other than any shares owned by Continucare or us or any of our or their respective wholly owned subsidiaries, was converted into the right to receive $6.25 per share in cash and 0.0414 of a share of our common stock. In addition, each issued and outstanding option to purchase Continucare common stock became fully vested and was cancelled in exchange for the right to receive an amount of cash equal to $6.45 less the per share exercise price of the option, subject to withholding taxes. 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. The total value of the transaction was $415.9 million, excluding expenses and financing fees. Immediately after the effective time of the Merger, the former stockholders of Continucare owned 5.8% of our outstanding common stock.

Concurrently with the completion of the Merger, we entered into the First Lien Credit Agreement and the Second Lien Credit Agreement, each of which is described in greater detail below. To fund the cash component of the purchase price, transaction expenses and financing costs, we and Continucare used a total of $143.2 million of cash and borrowed a total of $315.0 million under the First Lien Credit Agreement and the Second Lien Credit Agreement.

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 its revenues were derived from managed care agreements with Humana, United,

Coventry and Wellcare. As of October 4, 2011, Continucare provided services to or for approximately 28,000 Participating Customers on a risk basis and approximately 8,400 Participating Customers on a non-risk basis. Prior to the acquisition, substantially all of Continucare's 2011 revenue was generated by providing services to Medicare-eligible and Medicaid-eligible Participating Customers, respectively, under such risk arrangements.

The following summarizes the purchase price allocation for Continucare (in thousands):

	Continucare Historical Balances as of October 4, 2011	Fair Value and Other Adjustments	Allocation of Merger Consideration
Current assets	$ 84,800		$ 84,800
Property and equipment, net	16,327		16,327
Indentifiable intangible assets	5,789	$ 99,207	104,996
Noncurrent assets	1,449		1,449
Current liabilities	(8,261)	361	(7,900)
Deferred tax liabilities	(9,168)	(34,704)	(43,872)
Non current liabilities	(345)		(345)
Total identifiable net assets	90,591	64,864	155,455
Goodwill	82,798	177,622	260,420
Net assets	$ 173,389	$ 242,486	$ 415,875

Transaction costs associated with these acquisitions were expensed as incurred through transaction costs in the statements of income and comprehensive income in 2011 and totaled $7.9 million.

We allocated the purchase price to specific intangible asset categories as follows:

	Amount Assigned (in thousands)	Estimated Weighted Average Life	Range of Risk-Adjusted Discount Rates used in Purchase Price Allocation
Customer relationships	$ 74,822	10.5	13 %
Trade name	29,800	25	13 %
Unfavorable leases	(30)	5	13 %
Medicare license (1)	320	-	7% - 9%
Other	84	3 -5	13 %
	$ 104,996		

(1) Indefinite life

The amortizable intangible assets, other than customer relationships which are being amortized on an accelerated basis, are being amortized on a straight-line basis over their assigned useful lives. The indefinite-lived intangible asset will be tested for impairment on an annual basis, or more frequently if impairment indicators are present, in accordance with our accounting policies. We believe that the estimated intangible asset values so determined represent the fair value at the date of the acquisition and do not exceed the amount a third party would pay for the assets. For customer relationships, we used the excess earnings method of the income approach. For trademarks, we used the relief from royalty method, a combination of both income and market approach. For the Medicare license, we used the cost approach to derive fair value of the intangible asset. These fair value measurements are based on significant unobservable inputs, including management estimates and assumptions and, accordingly, are classified as Level 3 within the fair value hierarchy prescribed by US GAAP.

We recorded the excess of the purchase price over the estimated fair values of the identifiable assets as goodwill, which is generally non-deductible for income tax purposes. Goodwill was established based primarily on the revenue

and cash flow projections associated with future operations, as well as synergies expected to be gained from the integration of Continucare into our existing operations.

The following represents condensed financial information of Continucare since the date of the acquisition on October 4, 2011 which has been included in our 2011 consolidated results of operations (in thousands):

Revenue	$78,647
Net income (1)	$7,465

(1) Excludes amortization of intangible assets and a $3.5 million goodwill impairment charge.

The following unaudited pro forma condensed consolidated financial information assumes that the acquisition of Continucare was accounted for using the acquisition method of accounting for business combinations in accordance with ASC 805 and represents a pro forma presentation based upon available information of the combining companies giving effect to the acquisition of Continucare as if it had occurred on January 1, 2010, with adjustments for amortization expense of intangible assets, termination or changes in certain compensation arrangements and on-going operating expenses, non-operating expenses not acquired in the acquisition, interest expense and income tax expense:

	Year ended December 31	
	2011	2010
	(in thousands, except per share data)	
Revenue	$701,285	$651,610
Net income	$31,719	$23,814
Earnings per share:		
Basic	$0.78	$0.61
Diluted	$0.74	$0.57

The unaudited pro forma condensed financial information is based on the assumptions and adjustments which give effect to events that are: (i) directly attributable to the acquisition; (ii) expected to have a continuing impact; and (iii) factually supportable. The unaudited pro forma condensed financial information is presented for informational purposes only and is not necessarily indicative of the operating results that would have been achieved had the acquisition of Continucare been consummated as of the dates indicated or of the results that may be obtained in the future.

Physician Practice Acquisitions

During 2011, we closed on the acquisitions of three physician practices with a total of approximately 960 Humana 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. The completed transactions were accounted for under the acquisition method. The purchase price of the practices was allocated as follows (in thousands):

Property and equipment	$40
Identifiable intangible assets	82
Goodwill	1,523
	$1,645

Effective July 31, 2009, we acquired certain assets of one of our contracted independent primary care physician practices for approximately $1.9 million. This transaction was accounted for under the acquisition method. Approximately $1.8 million of the purchase price was allocated to goodwill while approximately $0.1 million was allocated to the non-compete agreement and customer records. The amount allocated to the non-compete was amortized over two years and the cost associated with the customer records was amortized over one year.

NOTE 4 – SALE OF SLEEP DIAGNOSTIC BUSINESS AND IMPAIRMENT CHARGE

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 have the sale completed before the end of 2012. Our sleep diagnostic operations have been included in operations in 2011. We did not operate the sleep diagnostic business prior to October 4, 2011, the date of the Continucare acquisition.

We recognized goodwill of $260.4 million related to the acquisition of Continucare, a portion of which was allocated to the sleep diagnostic business. The annual impairment review performed as of December 31, 2011 resulted in goodwill impairment to the sleep diagnostic business of $3.5 million. The impairment related primarily to our evaluation that it was more likely than not that we would sell the sleep diagnostic business in 2012 and that the anticipated sales price would be less than the carrying value of the net assets.

The fair value of the sleep diagnostic business is valued based on the multiples of recent sales of other sleep diagnostic businesses.

NOTE 5 - SALE OF HMO

On August 29, 2008 ("the Closing Date"), we completed the sale of all of the outstanding capital stock of our HMO to Humana pursuant to the terms of the Stock Purchase Agreement, dated as of June 27, 2008, by and between Humana and us, for a cash purchase price of approximately $14.6 million (the "Purchase Price"). We recognized a gain on the sale of the HMO of approximately $5.9 million in 2008.

The Purchase Price was subject to positive or negative post-closing adjustment based upon the difference between the HMO's estimated closing net equity and the HMO's actual net equity as of the Closing Date. The settlement period for determining the HMO's actual net equity was December 31, 2009. The gain on sale in 2009 of $1.3 million includes additional gain from the closing net equity settlement for the HMO and the settlement of certain liabilities of the HMO in 2009 at amounts lower than the liability recorded at the time of the sale.

In April 2010, the Closing Net Equity was finalized and we received the final payment. This settlement resulted in an additional gain on the sale of the HMO of $0.1 million in 2010.

Concurrent with the sale, the PSN and Humana entered into the IPA Agreement to provide or coordinate the provision of healthcare services to the HMO's Participating Customers pursuant to a capitation arrangement.

NOTE 6 – LONG-TERM DEBT AND REVOLVING LOAN FACILITY

Long-term debt consists of the following (in thousands):

	December 31,	
	2011	2010
	(in thousands)	
First-lien debt	$ 240,000	$ -
Second-lien debt	75,000	-
Revolving loan facility	5,000	-
Other	689	477
	320,689	477
Less amount due in one year	12,538	318
Less original issue discount	12,122	-
Total long-term debt	$ 296,029	$ 159

As of December 31, 2011, our annual fiscal year debt contractual principal maturities are summarized as follows (in thousands):

Year ending December 31,	Amount
2012	$ 12,538

2013	18,094
2014	24,057
2015	30,000
2016	161,000
Thereafter	75,000
Total debt	$ 320,689

On October 4, 2011, we entered into a senior secured credit agreement (the "First Lien Credit Agreement") that provides for a $240.0 million senior secured first lien term loan facility (the "First Lien Term Loan Facility") and a $40.0 million revolving credit facility (the "Revolving Loan Facility" and, together with the First Lien Term Loan Facility, the "First Lien Facilities").

The First Lien Facilities are guaranteed jointly and severally by substantially all of our existing and future subsidiaries (collectively, the "Guarantors"), and are secured by a first-priority security interest in substantially all of our and the Guarantors' existing and future assets (the "Collateral").

Borrowings under the First Lien Term Loan Facility bear interest at a rate per annum equal to, at our option, LIBOR plus 5.5% or the Base Rate plus 4.5% for the term loan. The "LIBOR" rate is determined by reference to the London Interbank Offered Rate, subject to a minimum rate of 1.5%. The "Base Rate" is determined by reference to the highest of (1) the Prime Rate quoted by the Wall Street Journal, (2) the applicable federal funds rate plus 0.50% and (3) LIBOR, subject to a minimum rate of 1.5%. Upon the occurrence of certain events of default under the First Lien Credit Agreement, borrowings under the First Lien Facilities will automatically be subject to an additional 2% per annum interest charge and upon the occurrence of certain other events of default may be subject to an additional 2% per annum interest charge. We have elected the LIBOR rate under the First Lien Facilities and, as of December 31, 2011, the interest rate under the First Lien Term Facility was 7.0%. The effective interest rate on the First Lien Term Loan Facility is 8.1%.

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

We may prepay the term loans at any time without penalty. We will also be required to make prepayments (subject to certain basket amounts and exceptions) equal to:

Annually commencing for the year ended December 31, 2012, and each year thereafter, 75.0% of the annual excess cash flow (defined as cash flow less scheduled principal and interest payments, cash taxes, and any increase in working capital, plus any decrease in working capital) less any voluntary prepayments made during the applicable year, with a reduction to 50.0% based on achievement of a total leverage ratio (defined as the ratio of our aggregate outstanding indebtedness to our adjusted earnings before stock-based compensation, interest, taxes, depreciation and amortization) not exceeding 2.00x as of the last day of each year within 10 days of filing our annual financial statements:

50.0% of the net proceeds from publicly offered equity issuances, with a reduction to 25.0% based on achievement of a senior leverage ratio (defined as the ratio of our aggregate outstanding indebtedness under the First Lien Credit Agreement to our adjusted earnings before stock-based compensation, interest, taxes, depreciation and amortization) not exceeding 1.25x as of the last day of the last fiscal quarter for which financial statements were required to be delivered under the First Lien Credit Agreement; and

100% of the net proceeds from asset sales, debt issuances (other than to the extent permitted under the First Lien Credit Agreement) and extraordinary receipts, as defined (collectively, the "Mandatory Prepayments").

We expect to begin making excess cash flow payments in March 2013 related to calendar year 2012.

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

The First Lien Credit Agreement includes the following items, among a variety of customary items, as events of default: the termination of any agreement that generates greater than 20.0% of our consolidated annual gross profit (unless replaced by a substantially similar agreement within thirty days), or the termination of any healthcare permits or any payment programs or reimbursement authorizations sponsored or maintained by any government payer, private insurer, or managed care plan, which could reasonably be expected to result in a material adverse effect (as defined in the First Lien Credit Agreement.)

The First Lien Credit Agreement also provides for an incremental term loan facility (the "Incremental Facility"), pursuant to which we may request that the lenders under the First Lien Credit Agreement (the "First Lien Lenders"), and potentially other lenders, provide an additional $50.0 million of term loans and/or revolving loans (the "Incremental Term Loans") on terms substantially consistent with those provided under the First Lien Facilities. Among other things, the utilization of the Incremental Facility is conditioned on our ability to meet certain senior leverage ratios and a sufficient number of lenders expressing an interest in participating in the facility. Alternatively, and subject to a variety of more stringent terms and conditions, we may also request that the First Lien Lenders, and potentially other lenders, provide an additional $50.0 million of term loans on terms and conditions that are not substantially consistent with those provided under the First Lien Facilities.

Second Lien Credit Facility

On October 4, 2011, we also entered into a secured credit agreement (the "Second Lien Credit Agreement") that provides for a $75.0 million secured second lien term loan facility guaranteed jointly and severally by the Guarantors and secured by a second-priority interest in the Collateral. As of the closing of the Merger, we had $75.0 million outstanding under the Second Lien Credit Agreement.

Borrowings under the Second Lien Credit Agreement bear interest equal to, at our option, LIBOR plus 11.75%, or the Base Rate plus 10.75%. Under the Second Lien Credit Agreement the minimum LIBOR rate is equal to 1.75%. Upon the occurrence of certain events of default under the Second Lien Credit Agreement, borrowings under the Second Lien Credit Agreement will automatically be subject to an additional 2.0% per annum interest charge and upon the occurrence of certain other events of default may be subject to an additional 2.0% per annum interest charge. We have elected the LIBOR rate under the Second Lien Credit Agreement and, as of December 31, 2011, the interest rate was 13.5%. The effective interest rate on the Second Lien Credit Facility is 14.1%.

Borrowings under the Second Lien Credit Agreement are generally due and payable on the maturity date, October 4, 2017. Prior to the repayment of all borrowings under the First Lien Credit Agreement, we may not make any prepayments without the prior written consent of the First Lien Lenders.

To the extent a prepayment of borrowings under the Second Lien Credit Agreement is permitted, the payment is subject to the following charges: 5.0% if the prepayment is made between May 4, 2013 and October 3, 2013, 3.0% if the prepayment is made between October 4, 2013 and October 3, 2014 and 2.0% if the prepayment is made between October 4, 2014 and October 3, 2015. For prepayments prior to May 4, 2013, we will also be required to pay an amount equal to the estimated, discounted net present value of any interest payments that would have been required to have been made on or before May 4, 2013 and that are avoided by us as a result of the prepayment plus 5.0% of the principal amount prepaid.

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

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

The Second Lien Credit Agreement also contains substantially the same events of default as under the First Lien Credit Agreement, except that the thresholds included in the Second Lien Credit Agreement are generally higher than under the First Lien Credit Agreement and the Second Lien Credit Agreement includes a cross-acceleration provision (tied to any acceleration of the obligations under the First Lien Facilities) as well as a cross-default tied to the failure to make principal payments when due under the First Lien Credit Agreement.

As of December 31, 2011, we were in compliance with the covenants under each of the First Lien Credit Agreement and the Second Lien Credit Agreement.

The fair values of the debt were based upon trading prices at year-end and determined to be Level 2 under the fair value hierarchy. At December 31, 2011, the fair value of our First and Second Lien Credit Agreement lien debt was approximately $237.6 million and $72.0 million, respectively.

Revolving Loan Facility

Under the Revolving Loan Facility, subject to various terms and conditions we may, from time to time, borrow up to $40.0 million, reduced by the $4.6 million reserved under letter of credit agreements, until the maturity date at October 4, 2016. We may prepay or permanently reduce the Revolving Loan Facility commitment at any time without penalty. The revolving Loan Facility includes subfacilities for up to $15.0 million for letters of credit and $5.0 million for same day, "swingline" borrowings. On October 4, 2011, we terminated our $3.0 million secured one year commercial line of credit agreement and replaced it and Continucare's then existing letters of credits with letters of credit under the Revolving Loan Facility. Upon termination of the then existing $3.0 million line of credit, the restricted cash and investments securing the letter of credit were released.

In October 2011, we borrowed $5.0 million under the Revolving Loan Facility. In January 2012, we repaid the entire $5.0 million outstanding. The interest rate of the Revolving Loan Facility is LIBOR plus 5.0% or the Base Rate plus 4.0%. The "LIBOR" rate is determined by reference to the London Interbank Offered Rate, subject to a minimum rate of 1.5%. Subject to various terms and conditions, we may from time to time, borrow and repay funds under the Revolving Loan Facility until the maturity date of October 4, 2016.

The interest rate on the Revolving Loan Facility at December 31, 2011 was 6.5%. The average amount outstanding under the Revolving Credit Facility from the date of borrowing in 2011 was $5.0 million. The weighted average interest rate from the date of borrowing was 6.5%.

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 this objective, we used 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 has a notional amount of $157.5 million, 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. During the next twelve months, we estimate that an additional $70,000 will be reclassified to interest expense.

The table below presents the fair value of our derivative financial instruments as well as their classification on the consolidated balance sheets as of December 31, 2011 (in thousands):

	Consolidated Balance Sheet Location		Carrying Amount
Asset derivatives:			
Derivatives designated as hedging instruments			
Interest rate cap	Noncurrent assets	$	498

The table below presents the effect of our financial derivative on the consolidated statements of income and comprehensive income for the year ended December 31, 2011 (in thousands).

Derivatives in Cash Flow Hedging Relationships	Amount of (Loss) Recognized in OCI on Derivative (Effective Portion) as of December 31, 2011	Location of (Loss) Reclassified from Accumulated OCI into Income (Effective Portion)	Amount of (Loss) Reclassified from Accumulated OCL into Income (Effective Portion) as of December 31, 2011	Location of (Loss) Recognized in Income on Derivative (Ineffective Portion and Amount Excluded from Effectiveness Testing)	Amount of (Loss) Recognized in Income on Derivative (Ineffective Portion and Amount Excluded from Effectiveness Testing) as of December 31, 2011
Interest rate products	$(179)	Interest expense	$-	Interest expense	$-

NOTE 8 - MAJOR CUSTOMER

Revenue from Humana accounted for 94.2%, 99.5% and 99.6% in 2011, 2010 and 2009, respectively, of our total revenue.

Humana may immediately terminate a Humana Agreement and/or any individual physician in our primary care physician network if: (i) the PSN 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 provisions 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.

NOTE 9 - DUE FROM HMOs

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

	December 31, 2011	2010
Due from HMOs	$80,324	$36,268
Due to HMOs	(40,083)	(27,201)
Total Due From HMOs	$40,241	$9,067

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

Included in due from HMOs at December 31, 2011 is a $1.5 million receivable representing our estimate of the retroactive MRA capitation fee for 2011 that we expect to receive in the summer of 2012 At December 31, 2010, we recorded a $2.2 million receivable representing our estimate of the retroactive MRA capitation fee for 2010. The final retroactive MRA capitation fee settlement we received in the summer of 2011 for 2010 was $1.0 million. The difference of $1.2 reduced revenue and income before income taxes in 2011. There was no material difference between the estimated final settlement for 2009 of $1.4 million and the final settlement that we received in 2010.

NOTE 10 – INVESTMENTS

Investments consist solely of trading securities. Trading securities are reported at fair value, with unrealized gains and losses included in earnings. For trading securities held at December 31, 2011 and 2010, the amount of unrealized gain was immaterial. Included in investment income are net realized gains of $0.3 million and $41,000 in 2011 and 2010, respectively.

We use asset managers to invest our excess funds. Investments that no longer meet the criteria of a cash equivalent are classified as investments on the consolidated balance sheets. Investments include securities with varying maturities issued by federal agencies, states or municipalities.

Investments, which are recorded at fair value, are as follows (in thousands):

	December 31,	
	2011	2010
Cash and money market funds	$18	$996
United States government and agency securities (Level 2)	-	2,068
State and municipal bonds (Level 2)	985	29,705
Corporate bonds (Level 2)	-	6,180
Total Investments	$1,003	$38,949

NOTE 11 - ESTIMATED MEDICAL EXPENSES PAYABLE

Activity in estimated medical expenses payable is as follows (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Balance at beginning of year	$25,668	$27,357	$23,144
IBNR assumed in Continucare acquisition	14,494	-	-
Incurred related to:			
Current year	284,477	252,198	264,543
Prior years	(3,575)	(900)	20
Total incurred	280,902	251,298	264,563
Paid related to:			
Current year	(260,539)	(226,427)	(237,155)
Prior years	(22,093)	(26,560)	(23,195)
Total paid	(282,632)	(252,987)	(260,350)
Balance at end of year	$38,432	$25,668	$27,357

At December 31, 2011, we determined that the range for estimated medical expenses payable was between $36.7 million and $40.5 million and we recorded a liability at the approximate actuarial mid-range of $38.4 million. This amount is included within the due from HMOs in the accompanying consolidated balance sheets.

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Amounts paid for 2010 claims were less than the amount of the liability that was recorded at December 31, 2010 by $3.6 million resulting in favorable claims development. Amounts paid subsequent to year end for 2009 were less than the amount of the liability that was recorded at December 31, 2010 by $0.9 million resulting in favorable claims development. Amounts paid subsequent to year end for 2009 were substantially the same as what was accrued at December 31, 2008. Favorable claims development occurs when claims paid are less than the amount accrued at the end of the year and results in lower claims expense the following year.

We maintain stop loss reinsurance with a commercial insurance company. Included in medical expense for 2011, 2010 and 2009 were stop loss premium expense of $0.9 million in each year and stop loss recoveries of $0.5 million, $0.8 million, and $0.3 million, respectively.

NOTE 12 - PROPERTY AND EQUIPMENT

Property and equipment consisted of the following (in thousands):

	2011	2010
Land	$1,920	$-
Buildings and building improvements	6,137	-
Medical equipment	2,185	210
Furniture and equipment	3,091	469
Leasehold improvements	5,353	1,711
Computers and office equipment	5,298	3,001
Construction in progress	1,370	-
Vehicles	1,072	25
	26,426	5,416
Less accumulated depreciation and amortization	(4,743)	(3,443)
	$21,683	$1,973

Depreciation and amortization of property and equipment totaled approximately $1.7 million, $0.7 million, and $0.5 million, in 2011, 2010, and 2009, respectively.

NOTE 13 – INTANGIBLE ASSETS AND GOODWILL

Intangible assets consisted of (in thousands):

	December 31,	
	2011	2010
Customer relationships	$76,187	$1,616
Trade name	29,800	-
Medicare license	320	-
Other	117	192
	106,424	1,808
Less accumulated amortization	(4,371)	(1,238)
	$102,053	$570

Amortization of intangible assets totaled $3.5 million in 2011 and $0.1 million in 2010. Amortization expense is estimated to be approximately $13.8 million in 2012, $12.8 million in 2013, $12.3 million in 2014, $10.1 million in 2015 and $8.4 million in 2016. The weighted average amortization period for intangible assets at December 31, 2011 is 14.3 years. The Medicare license is deemed to have an indefinite life and is not amortized.

Activity impacting goodwill in 2011, for each reporting unit and in total, is as follows (in thousands):

	PSN	Sleep Diagnostic Business	Total
Goodwill at beginning of year	$4,362	$-	$4,362
Additions:			
Acquisitions	258,248	3,695	261,943
Impairment charge	-	(3,500)	(3,500)
Goodwill at end of year	$262,610	$195	$262,805

NOTE 14 - INCOME TAXES

The components of the provision for income taxes are as follows (in thousands):

	December 31,		
	2011	2010	2009
Current			
Federal	$16,221	$13,959	$8,303
State	2,439	2,329	834
	18,660	16,288	9,137
Deferred			
Federal (benefit)	(1,512)	(362)	(217)
State (benefit)	(228)	(42)	(20)
	(1,740)	(404)	(237)
Provision for income taxes	$16,920	$15,884	$8,900

A reconciliation of the amount computed by applying the statutory federal income tax rate to income before income taxes with our provision for income taxes is as follows (in thousands):

	Years ended December 31,		
	2011	2010	2009
Statutory federal tax	$13,872	$14,555	$8,172
State income taxes, net of federal income tax benefit	1,437	1,509	848
Non-deductible transaction costs	1,663	-	-
Permanent differences and other, net	(52)	(180)	(120)
Provision for income taxes	$16,920	$15,884	$8,900

Deferred tax assets and liabilities are as follows (in thousands):

	December 31,	
	2011	2010
Allowances for doubtful accounts	$689	$315
Accrued expenses	260	120
Other	-	82
Total deferred tax assets - current	$949	$517
Stock-based compensation expense	$1,934	$1,521
Impairment charges	1,351	-
Depreciation and amortization	-	113
Other, net	700	(63)
Total deferred tax assets - non-current	3,985	1,571
Depreciation and amortization	(3,992)	-
Basis difference in intangible assets	(40,168)	-
Total deferred tax liabilities - non-current	(44,160)	-
Net deferred tax (liabilities) assets - non-current	$(40,175)	$1,571

There are no unrecognized tax benefits at December 31, 2011 and 2010.

We are primarily 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 carryforwards, including net operating loss carryforwards related to years prior to 2004. These net operating losses are open for examination by the relevant taxing authorities.

The statute of limitations for the Federal 2008 and various state statutes for 2007 tax years will expire in the next twelve months.

Excess tax benefits of $0.6 million, $0.8 million, and $0.2 million, respectively, were recorded directly to equity as a result of the exercise or repurchase of non-qualified stock options in 2011, 2010 and 2009, respectively.

NOTE 15 - STOCKHOLDERS' EQUITY

As of December 31, 2011 and 2010, we had authorized 10,000,000 shares of preferred stock, including 30,000 shares which were designated as Series A Preferred Stock, par value $.001, of which 5,000 were issued and outstanding. Each share of Series A Preferred Stock has a stated value of $100 and pays dividends equal to 10% of the stated value per annum. At December 31, 2011 and 2010, the aggregate and per share amounts of cumulative dividend arrearages

were approximately $716,667 ($143 per share) and $666,667 ($133 per share), respectively. Each share of Series A Preferred Stock is convertible into shares of common stock at the option of the holder at the lesser of 85% of the average closing bid price of the common stock for the ten trading days immediately preceding the conversion or $6.00. We have the right to deny conversion of the Series A Preferred Stock at which time the holder shall be entitled to receive, and we shall pay, additional cumulative dividends at 5% per annum together with the initial dividend rate to equal 15% per annum. In the event of any liquidation, dissolution or winding up of the Company, holders of the Series A Preferred Stock shall be entitled to receive a liquidating distribution before any distribution may be made to holders of our common stock. We have the right to redeem the Series A Preferred Stock at a price equal to 105% of the price paid for the shares. The Series A Preferred Stock has no voting rights. Through December 31, 2011, none of the holders of our Series A Preferred Stock have converted any shares to common stock.

We have also designated 7,000 shares of preferred stock as Series B Preferred Stock, with a stated value of $1,000 per share. No shares of series B preferred stock have been issued.

In 2011, the Board of Directors approved the issuance to employees of 321,000 restricted shares of common stock and options to purchase 815,000 shares of common stock. In 2010, the Board of Directors approved the issuance to employees of 652,000 restricted shares of common stock and options to purchase 1.1 million shares of common stock. In 2009, the Board of Directors approved the issuance to our employees of 367,000 restricted shares of common stock and options to purchase 1.4 million shares of common stock. The restricted shares and stock options awarded to employees 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 is recognized for each separately vesting portion on a straight-line basis over the vesting period.

In 2011, we issued a total of 67,000 restricted shares of common stock to the non-management members of our Board of Directors. In 2010, we issued a total of 102,000 restricted shares of common stock and options to purchase 36,000 shares of common stock to the non-management members of our Board of Directors. During 2009, we issued a total of 101,000 restricted shares of common stock and options to purchase 50,000 shares of common stock to the non-management members of our Board of Directors. The restricted shares and stock options issued to the non-management members of the Board of Directors vest one year from 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 is recognized for each separately vesting portion on a straight-line basis over the vesting period.

Restricted shares of common stock are reflected as issued and outstanding from the date of issuance for purposes of the consolidated statements of changes in stockholders' equity.

Shares reserved for future issuance at December 31, 2011 are as follows:

	Number of Shares
Shares Issuable Upon the Exercise of Outstanding Stock Options	4,131,000
Shares Issuable Upon the Conversion of Preferred Stock	1,119,000
Total	5,250,000

On September 10, 2009 (the "Repurchase Closing Date"), we repurchased 500,000 shares of our common stock from certain of our directors and executive officers for approximately $1.1 million. The shares were repurchased at a per share price of $2.1462, which was 2% below the closing price of our common stock on September 8, 2009, the date we entered into definitive repurchase agreements with such officers and directors. In addition, on the Repurchase Closing Date, we repurchased options exercisable for an aggregate of 567,500 shares of our common stock from certain of our executive officers for approximately $0.3 million, which represents the difference between the exercise price of the options and $2.1462. The shares underlying the options repurchased are also included in the number of shares repurchased during 2009 and deplete the repurchase authority granted by our Board.

On December 8, 2009, we repurchased options exercisable for an aggregate of 116,700 shares of our common stock from certain of our executive officers for approximately $0.2 million, which represents the difference between the exercise price of the options and $1.9012, which was 2% below the closing price of our common stock on December 8, 2011, the date we entered into the definitive repurchase agreement. The shares underlying the options repurchased are included in the number of shares repurchased and deplete the repurchase authority granted by our Board.

NOTE 16 - STOCK-BASED COMPENSATION

As of December 31, 2011, we had one nonqualified stock option plan, the Omnibus Equity Compensation Plan (the "Plan"). The Plan is administered by the Compensation Committee of the Board of Directors. A total of 12,000,000 shares of our common stock are authorized for issuance pursuant to awards granted under the Plan. Total compensation cost that has been charged against income in 2011, 2010 and 2009 for nonqualified stock options was $1.2 million, $1.0 million and $0.7 million, respectively.

Stock Options

Option awards are generally granted with an exercise price equal to the closing market price of our common stock on the grant date, generally vest ratably over 4 years of continuous service and generally expire 10 years after the date of the grant. The options provide for accelerated vesting if there is a change in control as defined by the Plan.

The fair value of each option award was estimated on the date of grant using the Black-Scholes option pricing model using the weighted average assumptions noted in the table below. Because this option valuation model incorporates ranges of assumptions for inputs, those ranges are disclosed. Expected volatilities are primarily based on implied volatilities from the historical volatility of our stock. We use historical data to estimate option exercise and employee termination within the valuation model. The expected terms of the options granted represent the period of time that option grants are expected to be outstanding based on historical data. The range below results from certain groups of employees exhibiting different behavior. The risk free rate for the periods within the contractual life of the option is based on the U.S. Treasury yield curve in effect at the time of grant.

	Year Ended December 31,		
Weighted Average Assumptions	2011	2010	2009
Risk Free Interest Rate	0.41% - 2.18 %	0.42%-2.56 %	0.90%-1.83 %
Expected Option Life (in years)	2-4.5	2-4.5	2-4.5
Expected Volatility	50 %	50 %	50 %
Dividends to be Paid	None	None	None

A summary of option activity under the Plan and the changes during the year ended December 31, 2011 is presented below:

Options	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding at December 31, 2010	3,696,000	$2.08	7.57	$8,850,000
Granted	815,000	$4.81		
Exercised	(267,000)	$2.03		
Forfeited	(109,000)	$2.56		
Expired	(4,000)	$1.76		
Outstanding at December 31, 2011	4,131,000	$2.61	7.04	$20,090,000
Vested or expected to vest at December 31, 2011	4,082,000	$2.60	7.03	$19,874,000
Non-vested at December 31, 2011	2,425,000	$3.03	8.04	$10,764,000

The weighted average per share grant date fair value of options granted during 2011, 2010 and 2009 was $1.73, $0.92 and $0.59, respectively. The fair value of non-vested options is determined based on the closing trading price of our shares at grant date. The aggregate intrinsic value of options exercised in 2011 and 2010 was $0.7 million and $3.3 million, respectively, and is based on the difference between the exercise price and quoted market value at exercise. The intrinsic value of options repurchased by us in 2009 was $0.5 million.

In 2011, options to acquire 267,000 shares of our common stock were exercised. We issued 142,000 new shares with the balance being used to satisfy the payment of the exercise price and minimum withholding requirements. During 2010, options to acquire 1.6 million shares of our common stock were exercised. We issued 1.0 million new shares

with the balance being used to satisfy the payment of the exercise price and minimum withholding requirements.

A summary of the status of our non-vested options as of December 31, 2011 and changes during the year then ended is presented below:

Non-Vested Options	Shares	Weighted Average Grant Date Fair Value
Non-vested at December 31, 2010	2,653,000	$0.81
Granted	815,000	$1.73
Vested	(934,000)	$0.72
Forfeited	(109,000)	$0.96
Non-vested at December 31, 2011	2,425,000	$1.15

As of December 31, 2011, there was $1.1 million of total unrecognized compensation cost related to non-vested nonqualified stock options granted under the Plan. That cost is expected to be recognized over a weighted average period of 2.01 years. The total fair value at the date of grant of options that vested during 2011, 2010 and 2009 was $0.7 million, $0.5 million, and $0.3 million, respectively.

Excess tax benefits of $0.6 million, $0.8 million and $0.2 million were realized from the exercise or repurchase of options in 2011, 2010 and 2009, respectively, and were recorded directly to equity. In 2011, we paid $44,000 in excess of the proceeds for taxes related to the cashless exercise of options. Net cash received from option exercises under all share-based payment arrangements for 2010 was $0.4 million. No options were exercised in 2009. It is our policy to issue new shares to satisfy share option purchases.

Restricted Stock Awards

Restricted stock awards are valued at the closing market price of our common stock on the date of grant. Compensation expense is recorded straight-line over the vesting period, generally four years from the date of grant. The restricted stock awards provide for accelerated vesting if there is a change of control as defined by the Plan.

The weighted average per share grant date fair value of our restricted stock awards was $4.84, $2.49 and $1.68 for the years ended December 31, 2011, 2010 and 2009, respectively. Activity for our restricted stock awards was as follows for the year ended December 31, 2011:

	Shares	Weighted Average Grant Date Fair Value
Non-vested restricted stock at December 31, 2010	1,184,000	$ 2.24
Granted	388,000	$ 4.84
Vested	(453,000)	$ 2.34
Forfeited	(11,000)	$ 3.01
Non-vested restricted stock at December 31, 2011	1,108,000	$ 3.12

The fair value of restricted shares at the vesting date for shares that vested during the years ended December 31, 2011, 2010, and 2009 was $2.2 million, $0.9 million and $0.4 million, respectively. Total compensation expense not yet recognized related to non-vested restricted stock awards was $1.6 million at December 31, 2011. We expect to recognize this compensation expense over a weighted-average period of approximately 1.85 years. There are no other contractual terms covering restricted stock awards once vested.

NOTE 17 - EARNINGS PER SHARE

The following table sets forth the computations of earnings per common share, basic and earnings per share, diluted (in thousands, except share and per share data):

	Year Ended December 31,		
	2011	2010	2009
BASIC			
Net income	$ 22,714	$ 25,700	$ 14,449
Less: Preferred stock dividend	(50)	(50)	(50)
Income available to common shareholders	$ 22,664	$ 25,650	$ 14,399
Denominator:			
Weighted average common shares outstanding	40,579	39,195	44,496
Basic earnings per share	$ 0.56	$ 0.65	$ 0.32
DILUTED			
Income available to common shareholders	$ 22,664	$ 25,650	$ 14,399
Add: Preferred stock dividend	50	50	50
	$ 22,714	$ 25,700	$ 14,449
Denominator:			
Weighted average common shares outstanding	40,579	39,195	44,496
Common share equivalents of outstanding stock:			
Convertible preferred stock	301	659	881
Nonvested common stock	565	523	270
Options and warrants	1,366	1,132	294
Weighted average common shares outstanding	42,811	41,509	45,941
Diluted earnings per common share	$ 0.53	$ 0.62	$ 0.31

The following securities were not included in the computation of diluted earnings per common share as their effect would be anti-dilutive (in thousands):

	Year Ended December 31,		
Security Excluded From Computation	2011	2010	2009
Stock options	493	290	2,912
Restricted stock	56	121	89

NOTE 18 - EMPLOYEE BENEFIT PLAN

We have a tax qualified employee savings and retirement plan covering our eligible employees, the Metropolitan Health Network 401(k) Plan (the “401(k) Plan”). The 401(k) Plan is intended to qualify under Section 401 of the Internal Revenue Code (the “Code”) and contains a feature described in Code Section 401(k) under which a participant may elect to reduce their taxable compensation by the statutorily prescribed annual limit of $16,500 for 2011. Under the 401(k) Plan, new employees are eligible to participate after three consecutive months of service. At our discretion, we may make a matching contribution and a non-elective contribution to the 401(k) Plan. We expensed approximately

$0.3 million, $0.3 million and $0.2 million for purposes of making matching contributions for the 2011, 2010, and 2009 plan years, respectively. The rights of the participants in the 401(k) Plan to our contributions do not fully vest until such time as the participant has been employed by us for three years.

NOTE 19 - SEPARATION ARRANGEMENT

Effective April 23, 2010, all of the members of our Board of Directors, other than Mr. Michael Earley, our Chief Executive Officer (CEO), resigned from the Board and six new directors were subsequently appointed to fill these vacancies. The new Board entered into an amended employment agreement with Mr. Earley. As a result of this action, in the second quarter of 2010, we recorded a $0.4 million reduction to payroll, payroll taxes and benefits for expenses that had been accrued pursuant to Mr. Earley's resignation in the fourth quarter of 2009. In addition, in April 2010, Mr. Earley was awarded options to purchase 216,800 shares of common stock and 72,300 restricted shares of common stock. The restricted shares and stock options vest in equal annual installments over a four-year period from the date of grant. The stock options have an exercise price equal to the closing price of our common stock on the grant date. Compensation expense related to the restricted stock and options is being recognized ratably over the vesting period.

NOTE 20 - COMMITMENTS AND CONTINGENCIES

Leases

We lease office and medical facilities under various non-cancelable operating leases. Approximate future minimum payments under these leases for the years subsequent to December 31, 2011 are as follows (in thousands):

	Buildings	Equipment	Service Agreements	Less Sublease Amount	Net Minimum Payment
2012	$ 4,381	$ 545	$ 2,672	$ 919	$ 6,679
2013	4,215	430	354	810	4,189
2014	3,963	417	311	826	3,865
2015	2,859	67	234	469	2,691
2016	1,608	7	-	41	1,574
Thereafter	1,803	13	-	-	1,816
Total	$ 18,829	$ 1,479	$ 3,571	$ 3,065	$ 20,814

The renewal options on the leases range from 3 to 5 years and contain escalation clauses of up to 5%. Rental expense for 2011, 2010, and 2009 was $3.0 million, $1.7 million and $1.6 million, respectively.

We utilized vendors during the year to assist us in the ongoing implementation of an electronic medical records system as well as attaining other operational objectives. Payments under these service contracts for the years subsequent to December 31, 2011 are approximately $0.4 million and $0.1 million in the years 2012 and 2013, respectively. Some contracts will renew automatically unless written notice is provided to the vendor within a stated period of time prior to the end of the contract period.

Litigation

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

Six putative class actions suits were filed in connection with the now completed acquisition of Continucare. Each of these suits alleged a claim against the members of the Continucare Board for breach of fiduciary duty and a claim against Continucare, Metropolitan, and Merger Sub for aiding and abetting the individual defendants' alleged breach of fiduciary duty. The complaints in certain of these actions alleged that the disclosure contained in the Proxy Statement or Registration Statement on Form S-4 originally filed by us on July 11, 2011 regarding the pending Merger was inadequate. All of the above-mentioned suits sought to enjoin the pending transaction between Continucare and Metropolitan and seek attorneys' fees. Some suits also seek rescission and money damages.

On July 28, 2011 the Court entered an order consolidating all six actions arising (the "Consolidated Action") from the Metropolitan Health/Continucare proposed transaction, appointed a Lead Plaintiff , a Plaintiff's Lead Counsel and a Liaison Counsel. Following the Consolidated Action and Lead Plaintiff/Lead Counsel orders the parties engaged in limited expedited discovery.

The parties engaged in arms-length negotiations, which resulted in the execution of a Memorandum of Understanding (the "MOU") on August 12, 2011 with Plaintiff's Lead Counsel regarding the settlement of the Consolidated Action. In connection with the settlement, Continucare agreed to make certain additional disclosures to its shareholders, which

were contained in a Form 8-K filed with the SEC on August 12, 2011. Subject to the completion of certain confirmatory discovery by Plaintiff's Lead Counsel, the MOU contemplated that the parties would enter into a stipulation of settlement. The confirmatory discovery has been completed and the Parties entered a stipulation of settlement on November 21, 2011.

On November 29, 2011, the court entered an order preliminarily approving the settlement, conditionally certifying a settlement class and ordering that notice be provided to Continucare shareholders. On February 24, 2012, the court conducted a final settlement hearing to consider the fairness, reasonableness and adequacy of the settlement and finally approved the settlement. The court entered a Final Judgment and Order that resolved and dismissed with prejudice all of the claims that were or could have been brought in the Consolidated Action, including all claims relating to the merger transaction, the merger agreement, and any disclosure made in connection therewith. In addition, the court entered an award of attorneys' fees and expenses of $350,000 to Plaintiff's Lead Counsel to be paid by Continucare or its successor. We estimate that we will pay $100,000 of this amount.

Continucare, the director defendants, and Metropolitan vigorously deny all liability with respect to the facts and claims alleged in the lawsuits, and specifically deny that supplemental disclosure was required under any applicable rule, statute, regulation or law. However, solely to avoid the risk of delaying or adversely affecting the merger and the related transactions and to minimize the expense of defending the lawsuits, Continucare, its directors, and Metropolitan agreed to the settlement described above.

Other Contingencies

We maintain professional liability policies with a captive insurance company of which we are a member, and with commercial insurance companies. At December 31, 2011, we are not aware of any claims that will exceed our coverage.

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.

NOTE 21 – RECENT ACCOUNTING PRONOUNCEMENTS

In November 2011, the Financial Accounting Standards Board ("FASB") issued ASU 2011-08, which introduced an optional qualitative assessment for testing goodwill for impairment (qualitative screen) that may allow companies to skip the annual two-step test. ASC 350 requires companies to test goodwill for impairment annually, and more frequently if indicators of impairment exist. Testing goodwill for impairment requires companies to compare the fair value of a reporting unit with its carrying amount, including goodwill. ASU 2011-08 allows companies to qualitatively assess whether it is more likely than not (i.e., a likelihood of greater than 50%) that the fair value of a reporting unit is less than its carrying amount. If that is the case, we would have to perform the annual two-step impairment test. We utilized the qualitative method to assess whether the fair value of the PSN reporting unit was less than its carrying amount at December 31, 2011.

In the first quarter of 2011, we adopted an amendment to the FASB Financial Accounting Standards Codification that requires the cost of professional liability claims or similar contingent liabilities to no longer be presented net of anticipated insurance recoveries. An entity that is indemnified for these liabilities shall recognize an insurance receivable at the same time that it recognizes the liability, measured on the same basis as the liability, subject to the need for a valuation allowance for uncollectible amounts.

At December 31, 2011, we have recorded this liability in accrued expenses and the estimated insurance recovery in other current assets in the accompanying consolidated balance sheet. The adoption of this amendment had no impact on our results of operations or cash flows in 2011.

NOTE 22 - VALUATION AND QUALIFYING ACCOUNTS

Activity in our Valuation and Qualifying Accounts consists of the following (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Allowance for doubtful trade accounts			
Balance at beginning of period	$ 817	$ 583	$ 490
Charged to costs and expenses	798	234	93
Increase (Deductions - accounts written off)	-	-	-
Balance at end of period	$ 1,615	$ 817	$ 583
Allowance for note receivable:			
Balance at beginning of period	$ -	$ -	$ 177
Charged to costs and expenses	-	-	-
Increase (Deductions - accounts written off)	-	-	(177)
Balance at end of period	$ -	$ -	$ -

NOTE 23 - SELECTED QUARTERLY FINANCIAL DATA (in thousands, except per share data) (unaudited)

	For the Quarter Ended			
	December 31, 2011 (1)	September 30, 2011	June 30, 2011	March 31, 2011
Revenue	$ 175,143	$ 92,664	$ 97,320	$ 94,665
Gross profit	$ 42,342	$ 18,299	$ 16,591	$ 19,180
Net income	$ 2,827	$ 5,996	$ 5,926	$ 7,965
Net income per share - basic	$ 0.07	$ 0.15	$ 0.15	$ 0.20
Net income per share - diluted	$ 0.06	$ 0.14	$ 0.14	$ 0.19

	For the Quarter Ended			
	December 31, 2010	September 30, 2010	June 30, 2010	March 31, 2010
Revenue	$ 91,414	$ 91,163	$ 92,567	$ 93,042
Gross profit	$ 16,758	$ 17,033	$ 14,956	$ 17,011
Net income	$ 6,020	$ 6,789	$ 5,762	$ 7,129
Net income per share - basic	$ 0.15	$ 0.17	$ 0.15	$ 0.18
Net income per share - diluted	$ 0.14	$ 0.16	$ 0.14	$ 0.17

(1) Includes the results of Continucare from October 4, 2011.

Significant Fourth Quarter Adjustments

As a result of new information that became available in the fourth quarter of 2011 and 2010, we recorded adjustments of $1.5 million and $2.2 million, respectively, for the estimated retroactive capitation fee that we expect to receive in the summer of the subsequent year related to the final MRA capitation fee adjustment for the prior year. These amounts increased revenue and gross profit for these quarters. Of this amount, approximately $900,000 and $1.6 million relates to revenue recorded in the first three quarters of 2011 and 2010, respectively.

In February 2012, Humana notified us that the actuarially estimated claims in excess of policy limits were lower than what had been projected for 2010 and 2011. Accordingly, Humana informed us that they would refund a portion of the premiums paid for these periods. The amount of the rebate recorded in the fourth quarter of 2011 was $2.1 million. This amount increased gross profit and operating income in 2011.

In the fourth quarter of 2010 we reduced the Part D receivable by $450,000. Accordingly, we decreased revenue and the due from HMOs by this amount.

Also recorded in the fourth quarter of 2011 is the goodwill impairment related to the sleep diagnostic business of $3.5 million.

The fourth quarter results are also impacted by the acquisition of Continucare.

METROPOLITAN HEALTH NETWORKS, INC.

EXHIBIT INDEX

Year Ended December 31, 2011

(3) Exhibits

3.1	Articles of Incorporation, as amended (1)
3.2	Amended and Restated Bylaws (2)
10.1	Physician Practice Management Participation Agreement, dated as of January 1, 2000, by and between Metcare of Florida, Inc. and Humana Medical Plan, Inc. (3)
10.2.	Letter of Agreement, dated February 2003, by and between Metropolitan of Florida, Inc. and Humana, Inc. (4)
10.3.	Omnibus Equity Compensation Plan, as amended and restated (5)
10.4.	Amended and Restated Employment Agreement, dated as of April 26, 2010, by and between Metropolitan and Michael M. Earley (6)
10.5.	Amended and Restated Employment Agreement, dated as of November 9, 2006, by and between Metropolitan and Robert J. Sabo (7)
10.6.	Amended and Restated Employment Agreement, dated as of January 3, 2005, by and between Metropolitan and Roberto L. Palenzuela (8)
10.7	Employment Agreement, dated as of February 1, 2005, by and between Metcare of Florida, Inc. and Jose A. Guethon, M.D. (9)
10.8.	Form of Non-Qualified Stock Option Agreement for Directors pursuant to the Omnibus Compensation Plan (10)
10.9.	Form of Non-Qualified Stock Option Agreement for Employees pursuant to the Omnibus Compensation Plan (11)
10.10	Summary of 2009 Bonus Plan for Executive Officers and Certain Key Management Employees (12)
10.11	Summary of Director Compensation Plan for 2007 (13)
10.12	Form of Restricted Stock Award Agreement for Independent Directors pursuant to the Omnibus Compensation Plan (14)
10.13	Form of Restricted Stock Award Agreement for Executive Officers pursuant to the Omnibus Compensation Plan (15)

10.14	Amendment to Employment Agreement, dated as of December 22, 2008, by and between Metropolitan and Jose A. Guethon, M.D. (16)
10.15	Amendment to Employment Agreement, dated as of December 22, 2008, by and between Metropolitan and Robert J. Sabo (17)

10.16	Amendment to Employment Agreement, dated as of December 22, 2008, by and between Metropolitan and Roberto L. Palenzuela (18)
10.17	Independent Practice Association Agreement, dated as of August 29, 2008, by and between Metcare of Florida, Inc. and Humana Insurance Company, Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc. and their affiliates who underwrite or administer health plans (19)
10.18	Physician Practice Management Participation Amendment, dated as of September 4, 2008, by and between Metcare of Florida, Inc. and Humana Medical Plan, Inc., Humana Health Insurance Company of Florida, Inc. and Humana Insurance Company, Employers Health Insurance Company and their affiliates who underwrite or administer health plans (20)
10.19	Integrated Delivery System Participation Agreement, dated as of April 1, 1999, by and among Miami Dade Health & Rehabilitation Services, Inc., Humana Medical Plan, Inc., PCA Health Plans of Florida, Inc., PCA Family Health Plan, Inc., Humana Health Insurance Company of Florida, Inc., Humana Insurance Company, Employers Health Insurance Company, PCA Life Insurance Company and their affiliates who underwrite and administer health benefit plans, as amended (21)
10.20	Independent Practice Association Participation Agreement, dated as of October 11, 2007, by and among Continucare Medical Management, Inc. and Humana Insurance Company, Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc. and their affiliates that underwrite or administer health plans (22)
10.21	Independent Practice Association Participation Agreement, dated as of October 11, 2007, by and among Continucare Medical Management, Inc. and Humana Insurance Company, Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc. and their affiliates that underwrite or administer health plans (23)
10.22	Independent Practice Association Participation Agreement, dated as of October 11, 2007, by and among Continucare Medical Management, Inc. and Humana Insurance Company, Humana Health Insurance Company of Florida, Inc., Humana Medical Plan, Inc. and their affiliates that underwrite or administer health plans (24)
21.1	List of Subsidiaries*
23.1	Consent of Independent Registered Public Accounting Firm*
31.1.	Certification of the Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
31.2.	Certification of the Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002*
32.1.	Certification of the Chief Executive Officer and pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**
32.2.	Certification of the Chief Financial Officer and pursuant to Section 906 of the Sarbanes-Oxley Act of 2002**
101.INS	XBRL Instance Document***

101.SCH XBRL Schema Document***

101.CAL XBRL Calculation Linkbase Document***

101.LAB XBRL Label Linkbase Document***

101.PRE XBRL Presentation Linkbase Document***

101.DEF XBRL Definition Linkbase Document***

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

(1) Incorporated by reference to Exhibit 4.1 of our Registration Statement on Form 8-A12B (No. 001-32361), as filed with the SEC on November 19, 2004.

(2) Incorporated by reference to Exhibit 3.1 of our Current Report on Form 8-K (No. 000-2845), as filed with the SEC on September 30, 2004.

(3) Incorporated by reference to Exhibit 10.22 of the Amendment to our Registration Statement on Form SB-2/A (No. 333-61566), as filed with the SEC on August 2, 2001. Portions of this document were omitted and were filed separately with the SEC on or about August 2, 2001 pursuant to a request for confidential treatment.

(4) Incorporated by reference to Exhibit 10.2 to the Amendment to our Annual Report for the year ended December 31, 2003 on Form 10-K/A (No. 000-28456) filed with the SEC on July 28, 2004. Portions of this document have been omitted and were filed separately with the SEC on July 28, 2004 pursuant to a request for confidential treatment.

(5) Incorporated by reference to Exhibit 10.1 of our Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, as filed with the SEC on August 5, 2008.

(6) Incorporated by reference to Exhibit 10.1 of our Current Report on Form 8-K, as filed with the SEC on April 27, 2010.

(7) Incorporated by reference to Exhibit 10.1 of our Current Report on Form 8-K (No. 001-32361), as filed with the SEC on October 20, 2006.

(8) Incorporated by reference to Exhibit 10.7 of our Annual Report on Form 10-K (No. 001-32361) for the year ended December 31, 2004, as filed with the SEC on March 22, 2005.

(9) Incorporated by reference to Exhibit 10.10 of our Annual Report on Form 10-K (No. 001-32361) for the year ended December 31, 2005, as filed with the SEC on March 16, 2006.

(10) Incorporated by reference to Exhibit 10.10 of our Annual Report on Form 10-K for the year ended December 31, 2009, as filed with the SEC on March 2, 2010.

(11) Incorporated by reference to Exhibit 10.11 of our Annual Report on Form 10-K for the year ended December 31, 2009, as filed with the SEC on March 2, 2010.

(12) Incorporated by reference to Exhibit 10.1 of our Current Report on Form 8-K, as filed with the SEC on February 11, 2009.

(13) Incorporated by reference to Exhibit 10.16 of our Annual Report on Form 10-K for the year ended December 31, 2007, as filed with the SEC on March 6, 2008.

(14) Incorporated by reference to Exhibit 10.14 of our Annual Report on Form 10-K for the year ended December 31, 2009, as filed with the SEC on March 2, 2010.

(15) Incorporated by reference to Exhibit 10.15 of our Annual Report on Form 10-K for the year ended December 31, 2009, as filed with the SEC on March 2, 2010.

(16) Incorporated by reference to Exhibit 10.2 of our Current Report on Form 8-K, as filed with the SEC on December 23, 2008.

(17) Incorporated by reference to Exhibit 10.3 of our Current Report on Form 8-K, as filed with the SEC on December 23, 2008.

(18) Incorporated by reference to Exhibit 10.4 of our Current Report on Form 8-K, as filed with the SEC on December 23, 2008.

(19) Incorporated by reference to Exhibit 10.1 of our Current Report on Form 8-K, as filed with the SEC on September 2, 2008. Confidential treatment has been granted with respect to certain portions of this exhibit. Omitted portions were filed separately with the SEC on September 2, 2008.

(20) Incorporated by reference to our Current Report on Form 8-K, as filed with the SEC on September 9, 2008. Confidential treatment has been granted with respect to certain portions of this exhibit. Omitted portions were filed separately with the SEC on September 9, 2008.

(21) Incorporated by reference to Exhibit 10.1 of Continucare's Quarterly Report on Form 10-Q for the quarter ended September 30, 2006 (No. 001-12115), as filed with the SEC on November 13, 2006.

(22) Incorporated by reference to Exhibit 10.1 of Continucare's Current Report on Form 8-K (No. 001-12115), as filed with the SEC on October 15, 2007.

(23) Incorporated by reference to Exhibit 10.2 of Continucare's Current Report on Form 8-K (No. 001-12115), as filed with the SEC on October 15, 2007.

(24) Incorporated by reference to Exhibit 10.3 of Continucare's Current Report on Form 8-K (No. 001-12115), as filed with the SEC on October 15, 2007.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Exchange Act of 1934, as amended, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, this 6th day of March 2012.

METROPOLITAN HEALTH NETWORKS, INC.

By: /s/ MICHAEL M. EARLEY

Michael M. Earley
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons in the capacities and on the dates indicated.

March 6, 2012	/s/ MICHAEL M. EARLEY Michael M. Earley Chief Executive Officer
March 6, 2012	/s/ ROBERT J. SABO Robert J. Sabo Chief Financial Officer (Principal Finance and Accounting Officer)
March 6, 2012	/s/ MICHAEL CAHR Michael Cahr Director
March 6, 2012	/s/ RICHARD FRANCO Richard Franco Director
March 6, 2012	/s/ CASEY GUNNELL Casey Gunnell Director
March 6, 2012	/s/ ARTHUR KOWALOFF Arthur Kowaloff Director
March 6, 2012	/s/ MARK STOLPER Mark Stolper Director
March 6, 2012	/s/ JOHN WATTS, Jr. John Watts, Jr. Director

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