METROPOLITAN HEALTH NETWORKS INC
Form 10-K/A
July 28, 2004

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549
FORM 10-K/A
(Mark One)

[x] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the Twelve Month Period Ended December 31, 2003

[ ] TRANSITION REPORT UNDER SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934

Commission File Number 0-28456

Metropolitan Health Networks, Inc.

(Name of registrant as specified in its charter)

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

Registrant s telephone number: (561) 805-8500

Securities registered under Section 12(b) of the Exchange Act:

None

Securities registered under Section 12(g) of the Exchange Act:

Common Stock, $.001 par value

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

Check if there is no disclosure of delinquent filers in response to Item 405 of Regulation S-K contained in this form, and no disclosure will be contained, to the best of registrant s knowledge, in the definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. [X]

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). Yes [ ] No [X]

The aggregate market value of the Registrant s voting Common Stock held by non-affiliates of the registrant was approximately $29,281,051 (computed using the closing price of $0.76 per share of Common Stock on December 31, 2003 as reported by OTCBB, based on the assumption that directors and officers and more than 5% stockholders are affiliates).

There were 44,912,951 shares of the registrant s Common Stock, par value $.001 per share, outstanding on February 27, 2004.

DOCUMENTS INCORPORATED BY REFERENCE

None.

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GENERAL

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

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Sections of this Annual Report contain statements that are forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 (the Securities Act) and Section 21E of the Securities Exchange Act of 1934 (the Exchange Act), and we intend that such forward-looking statements be subject to the safe harbors created thereby. Statements in this Report containing the words estimate, project, anticipate, expect, intend, believe, could, should, may, and similar expressions may be deemed to create forward-looking statements. Accordingly, such statements, including without limitation, those relating to our future business, prospects, revenues, working capital, liquidity, capital needs, interest costs and income, wherever they may appear in this document or in other statements attributable to us, involve estimates, assumptions and uncertainties which could cause actual results to differ materially from those expressed in the forward-looking statements. Specifically, this Annual Report contains forward-looking statements, including the following:

- our ability to service our indebtedness, make capital expenditures and respond to capital needs;
- our ability to restructure any of our debt or current liabilities;
- our ability to enhance the services we provide to our members;
- our ability to strengthen our medical management capabilities;
- our ability to improve our physician network;
- our ability to renew our managed care agreements and negotiate terms which are favorable to us and affiliated physicians;
- our ability to respond to future changes in Medicare reimbursement levels and reimbursement rates from other third parties; and
- our ability to establish relationships and expand into new geographic markets.

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

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pricing pressures exerted on us by managed care organizations and the level of payments we receive under governmental programs or from other payors;

future legislation and changes in governmental regulations;

the impact of Medicare Risk Adjustments on payments we receive for our managed care operations;

loss of significant contracts;

general economic and business conditions;

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

federal and state investigations;

the enactment of unfavorable legislation by the Congress of the United States;

our ability to successfully recruit and retain medical professionals; and

impairment charges that could be required in future periods.

RISK FACTORS

Failure to manage our growth effectively could harm our business and results of operation.

We have experienced growth in our business during the last three years. Continued growth may impair our ability to provide our services efficiently and to manage our employees adequately. Our strategy is to focus on growth within geographic parameters, identifying regions throughout Florida. Future results of operations could be materially adversely affected if we are unable to manage our growth effectively.

Our quarterly results will likely fluctuate, which could cause the value of our common stock to decline.

We are subject to quarterly variations in our medical expenses due to fluctuations in patient utilization. We have significant fixed operating costs and, as a result, are highly dependent on patient utilization to sustain profitability. Our results of operations for any quarter are not necessarily indicative of results of operations for any future period or full year. We experience increased patient population and greater use of medical services in the winter months. As a result, our results of operations may fluctuate significantly from period to period. In addition, there recently has been significant volatility in the market price of securities of health care companies that in many cases we believe has been unrelated to the operating performance of these companies. We believe that certain factors, such as legislative and regulatory developments, quarterly fluctuations in our actual or anticipated results of operations, lower revenues or earnings than those anticipated by securities analysts, and general economic and financial market conditions, could cause the price of our common stock to fluctuate substantially.

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The loss of certain agreements and the capitated nature of our revenues could materially affect our operations.

The majority of our revenues come from agreements with one managed care organization that provides for the receipt of capitated fees. The principal organization that we contract with is Humana. We have one-year renewable agreements with Humana to provide healthcare services to members in certain healthcare networks established or managed by Humana. For the twelve months ended December 31, 2003, approximately 99% of our revenue was obtained from these agreements. The Humana agreements may be terminated in the event we participate in activities Humana reasonably believes may adversely affect the health or welfare of any member or other material breach, or upon 180-day notice of non-renewal by either party. Failure to maintain these agreements, or successfully develop additional sources of revenue could adversely affect our financial condition. A continuing decline in enrollees in Medicare Advantage could also have a material adverse effect on our profitability.

Under Humana agreements we, through our affiliated providers, generally are responsible for the provision of all covered hospital benefits, as well as outpatient benefits, regardless of whether the affiliated providers directly provide the healthcare services associated with the covered benefits. To the extent that enrollees require more care than is anticipated, aggregate capitation rates may be insufficient to cover the costs associated with the treatment of enrollees. If revenue is insufficient to cover costs, our operating results could be adversely affected. As a result, our success will depend in large part on the effective management of health care costs. Pricing pressures may have a material adverse effect on our operating results. Changes in health care practices, inflation, new technologies, and other factors affecting the delivery and cost of health care are beyond our control and may adversely affect our operating results.

Reimbursement for Our Managed Care Operations will be affected by the Medicare Risk Adjustment

The Balanced Budget Act of 1997 directed the Health Care Financing Administration (now CMS) to replace the existing system of risk adjustment, which previously relied solely on demographic factors, with one that took enrollees health status into account (the Medicare Risk Adjustment or MRA). The demographic-only portion of the payment was adjusted for age, gender, Medicaid eligibility, institutional status and working aged status. The revised MRA portion of the payment, however, includes these same categories but adds health status as a new criteria. Such health status is measured by the previous medical costs for inpatient hospital stays incurred by the individual. These are then used to determine each individual s expected future medical risk and, therefore, how much the health plan in which they are enrolled should be paid. To ensure that health plans had time to adjust to the new payment method, CMS built a five-year transition period into the MRA methodology it adopted. The initial data used to facilitate the transition to MRA was based solely upon inpatient hospital encounter data. For 2000 and 2001, under the Balanced Budget Refinement Act of 1999 (BBRA) the transition to risk adjustment was based upon a blend percentage consisting of 10% risk adjustment payment and 90% on the adjustment for demographic factors. For 2002, the blend percentage was adjusted to 20% risk adjustment payment and 80% on the adjustment for demographic factors. The law requires that the ambulatory data be incorporated beginning January 1, 2004, at which time the blend percentage will consist of 30% risk adjustment payment and 70% on the adjustment for

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demographic factors. In 2005, the blend percentage will consist of 50% risk adjustment payment and 50% on the adjustment for demographic factors. In 2006, the blend percentage will consist of 75% risk adjustment payment and 25% on the adjustment for demographic factors. In 2007, the blend percentage will consist of 100% risk adjustment payment and 0% on the adjustment for demographic factors. Through Fiscal 2003, our payments from the HMOs have substantially been based on the demographic model. However, in Fiscal 2004, we anticipate that the payments we receive from the HMOs will begin reflecting the MRA methodology. At this time, it cannot be determined if this impact will be favorable or unfavorable in future years.

The development of management information systems may involve significant time and expense.

Our management information systems are important components of the business and are becoming a more significant factor in our ability to remain competitive. We already possess a physician billing and collection system. We are participating in the development of an integrated management information system. The development and implementation of such systems involve the risk of unanticipated delay and expense, which could have an adverse impact on our operations.

The high cost of insurance could adversely effect our financial operation.

As a result of the national malpractice award trends and the significant loss of professional insurance underwriting capacity, the cost of our medical malpractice insurance has increased while the coverage afforded under the policies available has decreased. Additionally, as a result of the events of September 11, 2001, as well as recent high profile director and officer related litigation, the cost of our director and officer insurance policy has increased. We anticipate that the cost for both our medical malpractice insurance as well as our director and officer insurance will increase in 2004. We also maintain stop-loss insurance for which the premium is based on a cost per member. We may experience future increases in stop-loss insurance, which could have a material adverse effect on our business, financial condition and results of operations.

Our industry is already very competitive; increased competition could adversely affect our revenues.

The health care industry is highly competitive and subject to continual changes in the method in which services are provided and the manner in which health care providers are selected and compensated. Companies in other health care industry segments, some of which have financial and other resources greater than we do, may become competitors in providing similar services. We may not be able to continue to compete effectively in this industry. Additional competitors may enter our markets and this increased competition may have an adverse effect on our revenues.

We are dependent upon our key management personnel for our future success.

Our success depends to a significant extent on the continued contributions of our key management. We have no insurance policies for our executive officers. The loss of these key personnel could have a material adverse effect on our financial condition, results of operations and plans for future development. While we have employment contracts with certain key

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members of management, we compete with other companies for executive talent and there can be no assurance that highly qualified executives would be readily available.

The health care industry is highly regulated and our failure to comply with laws or regulations, or a determination that in the past we have failed to comply with laws or regulations, could have an adverse effect on our financial condition and results of operations.

The health care services that we and our affiliated professionals provide are subject to extensive federal, state and local laws and regulations governing various matters such as the licensing and certification of our facilities and personnel, the conduct of our operations, our billing and coding policies and practices, our policies and practices with regard to patient privacy and confidentiality, and prohibitions on payments for the referral of business and self-referrals. If we fail to comply with these laws, or a determination is made that in the past we have failed to comply with these laws, our financial condition and results of operations could be adversely affected. Changes to health care laws or regulations may restrict our existing operations, limit the expansion of our business or impose additional compliance requirements. These changes, if effected, could have the effect of reducing our opportunities or continued growth and imposing additional compliance costs on us that may not be recoverable through price increases.

Federal anti-kickback laws and regulations prohibit certain offers, payments or receipts of remuneration in return for referring Medicaid or other government-sponsored health care program patients or patient care opportunities or purchasing, leasing, ordering, arranging for or recommending any service or item for which payment may be made by a government-sponsored health care program. In addition, federal physician self-referral legislation, known as the Stark law, prohibits Medicare or Medicaid payments for certain services furnished by a physician who has a financial relationship with various physician-owned or physician-interested entities. These laws are broadly worded and, in the case of the anti-kickback law, have been broadly interpreted by federal courts, and potentially subject many business arrangements to government investigation and prosecution, which can be costly and time consuming. Violations of these laws are punishable by monetary fines, civil and criminal penalties, exclusion from participation in government-sponsored health care programs and forfeiture of amounts collected in violation of such laws, which could have an adverse effect on our business and results of operations. Florida also has anti-kickback and self-referral laws, imposing substantial penalties for violations.

Limitations of or reduction in reimbursement amounts or rates by government-sponsored healthcare programs could adversely affect our financial condition and results of operations.

As of December 31, 2003 approximately 99% of our revenues were derived from reimbursements by various government-sponsored health care programs. These government programs, as well as private insurers, have taken and may continue to take steps to control the cost, use and delivery of health care services. The following events could result in an adverse effect on our financial condition and results of operations:

reductions in or limitations of reimbursement amounts or rates under programs,

reductions in funding of programs,

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elimination of coverage for certain individuals or treatments under programs, which may be implemented as a result of increasing budgetary and cost containment pressures on the health care industry, or

new federal or state legislation reducing funding and reimbursements.

We have anti-takeover provisions which may make it difficult to replace or remove our current management.

Our Articles of Incorporation authorize the issuance of 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. Our Board of Directors may, without shareholder approval, issue preferred stock with dividends, liquidation, conversion, voting or other rights, which could adversely affect the voting power, or other rights of the holders of our common stock. The ability of our board to issue preferred stock may prevent or frustrate shareholder attempts to replace or remove current management.

Due to the substantial number of our shares that will be eligible for sale in the near future, the market price of our common stock could fall as a result of sales of a large number of shares of common stock in the market, or the price could remain lower because of the perception that such sales may occur.

These factors could also make it more difficult for us to raise funds through future offerings of our common stock. As of December 31, 2003, there were 38,527,699 shares of our common stock outstanding, all of which are freely tradable without restriction with the exception that approximately 7,000,000 shares, which are owned by certain of our officers, directors, affiliates and third parties, and may be sold publicly at any time subject to the volume and other restrictions under Rule 144 of the Securities Act of 1933.

In addition, as of December 31, 2003, approximately 10,400,000 shares of our common stock were reserved for issuance upon the exercise of warrants and options which have been previously granted.

Our common stock has experienced in the past, and is expected to experience in the future, significant price and volume volatility, which substantially increase the risk of loss to persons owning common stock.

Because of the limited trading market for our common stock, and because of the possible price volatility, you may not be able to sell your shares of common stock when you desire to do so. The inability to sell your shares in a rapidly declining market may substantially increase your risk of loss because of such illiquidity and because the price for our common stock may suffer greater declines because of its price volatility.

Dependency on Reimbursement by Third Parties

The Medicare and Medicaid programs are subject to statutory and regulatory changes, retroactive and prospective rate adjustments, administrative rulings and funding restrictions, any of which could have the effect of limiting or reducing reimbursement levels. A substantial portion of our

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managed care revenues is based upon Medicare reimbursable rates. Any changes that limit or reduce Medicare reimbursement levels could have a material adverse effect on our business. Further, significant changes have or may be made in the Medicare program, which could have a material adverse effect on our business, results of operations, prospects, financial results, financial condition or cash flows. In addition, the Congress of the United States may enact unfavorable legislation, which could adversely affect operations by, among other things, decreasing Medicare reimbursement rates.

PART I

ITEM 1 DESCRIPTION OF BUSINESS

Introduction

Metropolitan Health Networks, Inc. provides healthcare benefits to over 25,000 Medicare Advantage members (formerly Medicare+Choice) in Central and South Florida under full-risk contracts with Humana, Inc., the second largest participant in this Medicare program. Metcare entered into this business in 1999, operating a Provider Service Network (PSN), also known as a Managed Service Organization (MSO).

The PSN includes thirty-three (33) primary care physician practices. Metcare owns six of these practices; the balance are independently owned and operated under capitation contracts with the Company. In addition to the primary care practices, the PSN contracts with specialists, ancillary service providers, and hospitals. The Company also owns and operates an oncology practice, which is part of the network.

Under its risk agreements, Metropolitan receives credit for a significant percentage of the monthly Medicare premiums received by Humana from the Centers for Medicare and Medicaid Services (CMS) and is obligated to provide all of the covered healthcare benefits for the member lives. To the extent the costs of providing such benefits is less than the related premiums received, Metropolitan profits. Conversely, if the costs exceed related premiums, the Company loses money. The Company re-insures against catastrophic losses and certain diseases annually on a per member basis. The annual stop-loss limits are $100,000 and $40,000 per member in the Daytona and South Florida markets, respectively.

The Medicare Advantage business accounts for the majority of the Company s revenues. In addition, Metcare cares for commercial insurance members and charges a fee for servicing patients in its wholly owned practices.

Background

The Company was incorporated in the State of Florida in January 1996, and began operations as a physician practice group. During the late 1990 s Metcare acquired a number of physician practices and ancillary service providers. In late 1999, the group practice strategy was abandoned in connection with a change in the senior management team.

The first managed care risk contract was secured with Humana in 1999. In 2000 an additional contract was subsequently secured to manage all of Humana s Medicare Advantage lives in the

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Daytona, Florida area (Flagler and Volusia Counties). The Daytona contract currently accounts for over 19,000 lives or 77% of the Company s total Medicare Advantage lives. The balance of the Company s Humana lives resides in South Florida (Palm Beach, Broward and Miami-Dade Counties).

Metropolitan renegotiated its most significant contract with Humana, in Daytona, effective January 1, 2003. This renegotiation increased the percentage of Medicare premium received by Metcare and resolved a number of contractual disputes.

Metcare acquired a diagnostic laboratory business, renamed Metlabs, Inc., in 2000. This operation was subsequently shut down in 2002. The Company formed Metcare Rx, a pharmacy business, in 2001. This business was sold in November 2003.

Metropolitan s Board of Directors replaced the Company s President and CEO in March 2003, and subsequently adopted a strategy to focus its resources and energies on its core managed care business. In December 2003, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (the Medicare Modernization Act or MMA) was signed into law, which, among other changes, is significantly increasing funding for the Medicare Advantage program beginning in 2004. Included in the MMA was the establishment of a significant federal marketing budget to promote the Medicare Advantage program. The stated goal is to triple enrollment in this program over the next several years.

Industry

A report issued in early 2004 by CMS estimated that national healthcare spending in the United States was nearly $1.7 trillion, or $5,800 for every American, in 2003. The CMS report projected that healthcare spending, which today accounts for more than 15% of the national economy, would grow to $3.4 trillion by 2013, more than 18% of projected Gross Domestic Product. The principal drivers for this growth include continued cost-increasing medical innovation, rising price inflation, continued strong demand for prescription drugs and the aging baby-boomer demographic s . The CMS projections did not give effect to the December 2003 Medicare Modernization Act, other than to note that new legislation is not anticipated to have a large impact on overall spending but is expected to cause sizable shifts in payment sources.

Medicare currently provides healthcare benefits to 41 million elderly and disabled Americans, and was established in 1965. This number is expected to more than double by 2030. The newly renamed Medicare Advantage program (formerly Medicare+Choice) represents private health plans participation in the Medicare program. Under Medicare Advantage plans, private insurers provide care under contracts with Medicare. These plans represent an alternative to traditional fee-for-service Medicare and by definition must provide enhanced benefits in exceeding traditional Medicare by at least 30%. Some of these enhancements include prescription drugs, eye exams, hearing aids and routine physical exams. Out-of-pocket cost for the beneficiary may be lower and choice of physicians is typically restricted to the plan s network.

This participation of private health plans under risk contracts began in the 1980 s and grew to a peak membership in 2000 when Medicare HMOs covered 6.3 million lives. Today, private plans account for slightly more than 10% of Medicare members, down from a peak penetration of

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18%. The Balanced Budget Act of 1997 resulted in significant funding decreases causing the number of participating plans to drop from 346 in 1998 to 151 in 2003. The exodus of managed care companies from Medicare left many of its beneficiaries without a private plan option.

The Medicare Modernization Act, or MMA, was signed into law in December 2003, and provides sweeping changes to the Medicare program. At an estimated cost of over $400 billion for the next ten years, the new law provides for a Medicare prescription drug offering beginning in 2006, establishes new tax-advantaged Health Savings Account regulation and makes significant changes to the old Medicare+Choice (now Medicare Advantage) program. The changes to the Medicare Advantage program were a response to the decreased managed care participation in Medicare and the resulting lack of choice for Medicare beneficiaries. The MMA made favorable changes to the premium rate calculation methodology and generally provides for program rates that will better reflect the increased cost of medical services provided to Medicare beneficiaries. The new rates for 2004 were announced in January 2004 reflecting an average increase of 10.6%, which will be reflected in funding beginning in March 2004.

The funding increases are intended to both offset medical cost inflation and to allow enhanced plan benefit design to encourage increased participation in Medicare Advantage plans.

Markets

Metcare currently provides healthcare services to nearly 6,000 Medicare Advantage beneficiaries in South Florida (Palm Beach, Broward and Miami-Dade Counties) and to over 19,000 members in the Daytona area (Flagler and Volusia Counties). Behind only California, which has nearly 4 million Medicare eligibles, Florida has the second largest Medicare population in the U.S. with almost 3 million lives. However, California s Medicare Advantage penetration is approximately 30% while Florida s is only 20%. The most significant counties in terms of Medicare Advantage membership currently include Palm Beach, Broward, Miami-Dade and Volusia. Florida s Medicare population is expected to grow to 4 million by 2015.

Business Model

Metcare provides turnkey healthcare services to Medicare Advantage beneficiaries who participate in the Medicare Advantage program through Humana, Inc. Our current agreements with Humana have one-year terms and renew automatically for additional one-year terms unless terminated for cause or on 180-days prior notice. Humana is paid a certain premium per member, per month, for its Medicare Advantage members by Medicare under its contract with CMS. The monthly amount varies by patient, county and severity of health status. Humana, in turn, allocates a majority of this amount to Metcare for all patients cared for by Metcare.

Metcare serves over 25,000 patients enrolled by Humana, Inc. in South and Central Florida. Metcare s Provider Service Network (PSN) operates predominantly as an affiliated model as contrasted with a staff model in which the physician practices are owned and operated by the risk provider. Under the Company s model, the physicians maintain their independence but are aligned with a professional staff that assists in providing high quality, cost effective health care. Metcare s PSN is comprised of 33 primary care physician practices, six of which the Company owns. The others are independent practices that are contracted with on a capitated-basis. Under

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these agreements, Metcare pays the physician a set amount per member, per month, to provide the necessary primary care services on a risk basis. The monthly amount is negotiated and is subject to change based on certain quality metrics under the Company s Partners In Quality (PIQ) program. In addition to primary care physicians, the Company s PSN contracts with specialists, ancillary service providers and hospitals. These providers deliver services to the Company s patients based on certain fee schedules and care requirements. Metcare has capitated (fixed cost) certain high volume specialties, averaging the cost on a per member, per month basis; the others are paid on a contractual fee-for-service basis.

Metropolitan does not pay or process any of the payments to its PSN physicians or other providers. All claims processing is handled directly by Humana. The Company does review and approve claims in advance of payment (prospective payment review). Incorrect claims are identified and corrected prior to payment by the Company s claims suspense staff . Paid claims are reviewed again and errors are handled and recovered by Metcare s contestation staff. The Company regularly monitors and measures Humana s claims escrow pools, or allocations for claims incurred but not yet reported (IBNR), for accuracy and underfunding.

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

The Company has developed a proprietary care management model, Partners In Quality (PIQ), which was implemented in 2002. PIQ is based on the principle that optimal clinical outcomes depend on multiple factors including perceptions of care, efficient utilization of healthcare resources, evidence-based medical treatment and appropriate follow-up. This model is used to manage and compensate the Company s primary care physicians in caring for Metcare s patients. The PIQ program measures performance based on quality metrics including patient satisfaction, disease state management of high-risk, chronically ill patients, increased frequency of physician-patient encounters, and enhanced medical record documentation. Metropolitan believes this focus provides a competitive advantage as a provider service network.

Competition

The healthcare industry is highly competitive and is subject to continuing changes in the provisioning of services and the selection and compensation of providers. The Company competes with national, regional and local companies in providing its services. Metcare competes with other risk providers for Humana s business, and Humana competes with other HMO s in securing and serving patients in the Medicare Advantage program.

Growth Initiatives

Membership in Medicare Advantage programs (previously Medicare +Choice) has declined as a percentage of Medicare eligible lives over the last several years, principally the result of decreased funding which has negatively impacted plan benefits. Although the Company has

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seen growth in its membership through its expansion of its relationship with Humana, Metcare has experienced gradual attrition in membership commensurate with the industry. Net membership decreases from attrition were approximately 1,200 or 4.4% in 2003. The Company expects this trend to reverse with the passage of the Medicare Modernization Act in late 2003. With operations focused in Florida, the nation s second largest Medicare market, the Company expects incremental membership growth in its current markets. Among a number of sweeping changes to Medicare, the legislation is intended to substantially increase participation in Medicare Advantage through increased funding commitments. Beginning with an average increase of 10.6% in 2004, this stimulus allows plans to improve benefits and attract new enrollees. The Company s 2004 premium increases are approximately 9.8% in Daytona and 17.8% in South Florida, a significant portion of which will be utilized to enhance plan benefits. As well, Metcare expects that opportunities to expand into other Florida markets will develop as Humana and other Medicare HMO s grow their respective businesses.

The underlying economics of the Medicare Modernization Act may also provide sufficient incentive for companies such as Metcare to directly enter the Medicare Advantage business. The Company is currently evaluating its opportunities in the Florida, particularly in underserved markets, and may file for its own Medicare HMO license in 2004. The decision to enter this business would necessarily be based on a number of factors including analysis of the opportunity, consideration of alternative strategies and availability of necessary capital.

Employees

As of December 31, 2003, the Company had approximately 100 full-time employees, of which 31 were employed at the Company s executive offices. No employees of the Company are covered by a collective bargaining agreement or are represented by a labor union. The Company considers its employee relations to be good.

ITEM 2 DESCRIPTION OF PROPERTY

Our offices are located at 250 Australian Avenue South, Suite 400, West Palm Beach, Florida where we occupy 13,211 square feet at a current monthly rent of $15,700 pursuant to a lease expiring March 31, 2008.

The Company has a satellite office in Daytona Beach with 5,700 square feet and monthly rent of $8,600. The lease expires September 30, 2006.

The managed care division leases 6 offices in Florida with an aggregate monthly rental of $28,800 with expiration dates ranging from one to five years.

None of the Company s properties are leased from affiliates.

ITEM 3 LEGAL PROCEEDINGS

The Company is a party to various claims arising in the ordinary course of business. There are no material pending legal proceedings, other than routine litigation incidental to the business of the Company and its subsidiaries, to which the Company or any of its subsidiaries is a party or of which any property of the Company or its subsidiaries is the subject.

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On May 28, 2003, the Company was informed that the U.S. Attorneys Office in Wilmington, Delaware was conducting an investigation of the Company. The Inquiry was not related to Metropolitan s underlying healthcare or pharmacy business practices. The Company fully cooperated with the U.S. Attorneys Office and on February 9, 2004 the investigation was terminated.

ITEM 4 SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

No matter was submitted to a vote of the security holders, through the solicitation of proxies or otherwise, during the twelve months ended December 31, 2003.

PART II

ITEM 5 MARKET FOR COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

The Company s Common Stock is currently traded on the OTCBB under the symbol MDPA . The Company s Warrants traded under the symbol MDPAW until March 15, 2001 when they expired. The following table sets forth the high and low closing bid prices for the common stock, as reported by OTCBB:

	High ($)	Low ($)
COMMON STOCK		
Quarter ended March 31, 2002	1.40	0.67
Quarter ended June 30, 2002	0.83	0.45
Quarter ended September 30, 2002	0.46	0.18
Quarter ended December 31, 2002	0.47	0.17
Quarter ended March 31, 2003	0.27	0.14
Quarter ended June 30, 2003	0.20	0.07
Quarter ended September 30, 2003	0.34	0.13
Quarter ended December 31, 2003	0.79	0.26

The foregoing bid prices reflect inter-dealer prices, without retail mark-up, mark-down or commission, and may not necessarily represent actual transactions.

As of the date of this filing there were approximately 1,200 holders of our common stock.

The Company has never declared nor paid any dividends on its common stock. The Company presently intends to invest its earnings, if any, in the development and growth of its operations and the reduction of debt.

Equity Compensation Plan

A table detailing the Company s existing equity compensation plans as of December 31, 2003 is included in Item 12.

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ITEM 6 SELECTED FINANCIAL DATA

Set forth below is our selected historical consolidated financial data for the five fiscal years ended December 31, 2003. The selected historical consolidated financial data should be read in conjunction with our consolidated financial statements and accompanying notes and Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this report. The consolidated statement of operations data and balance sheet data for the years ended December 31, 1999, 2000, 2001, 2002 and 2003 are derived from our audited consolidated financial statements which have been audited by Kaufman, Rossin & Co., P.A., our independent auditors.

	For the fiscal year ended December 31, (1)(2)				
	2003	**2002**	**2001**	**2000**	**1999**
Income:					
Net revenues	$143,874,488	$140,063,566	$128,186,307	$119,047,520	$18,501,497
Income (Loss) from continuing operations	$ 5,861,303	$ (13,865,800)	$ 997,990	$ 4,417,862	$ (7,841,805)
Income (Loss) from continuing operations per share basic	$ 0.17	$ (0.46)	$ 0.04	$ 0.26	$ (1.09)
Cash dividend declared					
Financial Position:					
Total assets	$ 9,223,729	$ 10,158,911	$ 17,379,262	$ 11,159,834	$11,944,747
Long - term obligations, including current portion	$ 2,983,576	$ 5,603,370	$ 1,821,705	$ 1,664,961	$ 9,370,948

(1) The financial data for 2000 includes the operations of Metlabs, Inc. which was discontinued in 2002.

(2) The financial data for the years ended 2003, 2002, 2001 and 2000 are presented on a calendar year with the Company s year-end being December 31. The financial data for the year ended 1999 is presented on a fiscal year with the Company s year-end being June 30.

ITEM 7 MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITIONS AND RESULTS OF OPERATIONS

Critical Accounting Policies

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Company s management to make a variety of estimates and assumptions. These

estimates and assumptions affect, among other things, the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenues and expenses. Actual results can differ from the amounts previously estimated, which were based on the information available at the time the estimates were made.

The critical accounting policies described below are those that the Company believes are important to the portrayal of the Company s financial condition and results, and which require management to make difficult, subjective and/or complex judgments. Critical accounting

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policies cover accounting matters that are inherently uncertain because the future resolution of such matters is unknown. The Company believes that critical accounting policies include accounts receivable and revenue recognition, use of estimates and goodwill.

Accounts Receivable and Revenue Recognition

The Company is a party to certain managed care contracts and provides medical care to its patients through owned and non-owned medical practices. In connection with its Provider Service Network (PSN) operations, the Company is exposed to losses to the extent of its share of deficits. Accordingly, revenues under these contracts are reported as PSN revenue, and the cost of provider services under these contracts are reported as an operating expense.

The Company recognizes non-Humana revenues, net of contractual allowances, as medical services are provided. These services are typically billed to patients, Medicare, Medicaid, health maintenance organizations, insurance companies and other third parties. The Company provides an allowance for uncollectible amounts and for contractual adjustments relating to the difference between standard charges and agreed upon rates paid by certain third party payers.

Use of Estimates-PSN

In HMO-PSN arrangements, accounts receivable estimates often change as a result of one or more future confirming events. With regard to revenues, expenses and resulting accounts receivable arising from agreements with Humana, the Company estimates amounts it believes will ultimately be realizable through the use of judgments and assumptions. Contractual terms with an HMO are sometimes complex and at times subject to different interpretation by the Company and Humana. As a result, certain revenue, expense and accounts receivable estimates may change from amounts previously recorded in the financial statements and may require subsequent adjustments. To assist in estimating and collecting amounts due from Humana, the Company has contracted with several outside consultants that have worked closely with Humana or other HMOs for extended periods of time. These consultants provide numerous services including, but not limited to, revenue, expense and accounts receivable analysis, and monthly claims and contestation analysis. However, it is possible that actual results may differ from the estimates.

Direct medical expenses include costs incurred directly by the Company and costs paid by the HMO on the Company s behalf. These costs also include estimates of claims incurred but not reported (IBNR), estimates of retroactive adjustments to be applied by Humana and adjustments for charges which the Company believes it is not liable (contestations). The IBNR estimates are made by Humana utilizing actuarial methods and are continually evaluated and adjusted by management of the Company, based upon its specific claims experience and input from outside consultants. The Company bases its estimates of retroactive adjustments on agreements with the HMO to modify previous charges. Some of these adjustments have been quantified while others involve situations where Humana has agreed the charges were processed at incorrect rates, but the amount of the correction has not yet been quantified. Contestations involve charges where the Company, with the assistance of its consultants, contest certain expenses charged by the HMO. The estimate of direct medical expense includes an estimated recovery of 20% of

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outstanding contestations with Humana. It is possible that estimates of such recoveries could change and the effect of the change could be material.

Accounts receivable from Humana represents the combined effect of the Company s interpretation of the contract with the HMO and its payment patterns. Collection times on these accounts typically exceed normal collection periods reflecting the need to reconcile the different interpretations and the HMO s cash management practices.

Goodwill

The Company has made several acquisitions in the past that included a significant amount of goodwill. Under accounting principles generally accepted in the United States of America in effect through December 31, 2001, these assets were amortized over their useful lives and tested periodically to determine if they were recoverable from operating earnings on a discounted basis over their useful lives.

Effective January 1, 2002, goodwill is accounted for under SFAS No. 142, Goodwill and Other Intangible Assets . The new rules eliminate amortization of goodwill but subject these assets to impairment tests. Management is required to make assumptions and estimates, such as the discount factor, in determining fair value. Such estimated fair values might produce significantly different results if other reasonable assumptions and estimates were to be used.

Balance Sheet

The Company does not have any Off-Balance Sheet Arrangements.

Tabular Disclosure of Contractual Obligations

		Payment Due by Period			
Contractual Obligations	**Total**	**Less than 1 Year**	**1-3 Years**	**3-5 Years**	**More than 5 Years**
Long Term Debt	$2,876,169	$1,990,169	$ 886,000	$	$
Capital Lease Obligations	107,408	104,316	3,092		
Operating Lease Obligations	2,224,602	629,176	1,117,376	419,957	58,093
Employment Obligations	2,297,485	1,447,485	850,000		
	$7,505,664	$4,171,146	$2,856,468	$419,957	$58,093

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Comparison of Fiscal 2003 and 2002

Introduction

Revenues for the year ended December 31, 2003 totaled $143.9 million compared to $140.1 million in the prior year. Net income was $4.4 million for the year ended December 31, 2003 compared to a net loss of $17.1 million in 2002. On a per share basis, the Company earned $0.13 for the year ended December 31, 2003, compared to a loss of $0.56 in the prior year. Income from continuing operations amounted to $5.9 million in 2003, compared to a net loss of $13.9 million in 2002. Results for 2002 included significant adjustments to direct medical costs of approximately $6.6 million, imputed interest expense of $1.2 million and $520,000 in write-downs of accounts receivable from medical practices closed in prior years.

Included in the 2003 and 2002 years were $1.5 million and $3.2 million, respectively, of losses related to the discontinued operations. The Company operated two business segments in 2003, managed care and direct medical services (PSN) and pharmacy. It operated a third segment in 2002, the clinical laboratory business, which was disposed of in July 2002. The pharmacy business was established in 2001 and sold in November 2003.

As discussed in the audited financial statements, the PSN segment reported a gain of $11.5 million before allocated overhead of $3.7 million for 2003, compared to a loss of $5.0 million in 2002 and a gain of $6.1 million in 2001. Segment revenues for the same time periods were $143.9 million, $140 million and $128.2 million, respectively. Expenses, which include direct medical costs and supplies, physician salaries and other costs relating to the operations of medical practices, were $132.2 million, $147.2 million, and $122.7 million for the years ended December 31, 2002, 2001 and 2000, respectively.

Revenues

Revenues for the year ended December 31, 2003 increased $3.8 million or 2.7% over the prior year, from $140.1 million to $143.9 million. PSN revenues from Humana increased 2.8%, from $138.5 million to $142.3 million. Approximately $12.1 million in incremental revenues were generated by funding increases resulting from the renegotiation of the Company s contract with Humana in the Daytona market, combined with governmental funding increases of approximately 1.8%. These increases were partially offset by a decline in the number of patients in our Daytona network, resulting in approximately $6.7 million in reduced funding. In connection with the renegotiation of its Daytona HMO contract, the Company was no longer at risk for the HMO s commercial membership effective January 1, 2003, resulting in lost revenue of approximately $3.1 million for the year, but increased profitability as this line of business had been unprofitable.

The Company s South Florida centers reported a net increase in PSN revenues from Humana of $1.6 million over the prior year period, with $1.4 million in increases from a new center in Broward County, which the Company assumed management of in October 2002, and $1.9 million due to increased membership at its Boca Raton medical office. Effective August 1, 2003 the Company cancelled its risk arrangement with the Broward County center due to noncompliance with the Company s policies and procedures. These revenue increases were

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partially offset by $1.7 million in decreases due to net decreased membership in the Company s other South Florida medical centers.

Total Medicare Advantage lives declined approximately 1,700 members from year-end 2002 to a membership of approximately 25,500 at December 31, 2003. Approximately 500 of these belong to the terminated Broward County center, with the other 1,200 attributable to attrition.

Non-Humana revenue for Metcare s wholly owned physician practices in 2003 remained the same as the prior year, $1.6 million. The Company operated six physician practices and an oncology center in each of the years.

Expenses

Operating expenses for the year ended December 31, 2003 decreased $14.3 million (9.5%) over the prior year, from $151.0 million to $136.7 million. Operating expenses other than direct medical costs and medical supplies, which correlate to revenue, decreased 12.5% over the prior year due in part to several cost cutting measures undertaken by the Company in late 2002 and 2003.

Direct medical costs, the largest component of expense, represents costs associated with providing services of the PSN operation including direct medical payments to physician providers, hospitals and ancillaries on a capitated or fee for service basis. Direct medical costs for 2003 were $121.0 million compared to $133.6 million for 2002, a decrease of $12.6 million, or 9.4%, despite a $3.8 million increase in HMO revenues. A savings of $3.5 million in expenses was realized in 2003 due to no longer being at risk for commercial membership in conjunction with the Company s renegotiated Daytona HMO contract. Included in 2002 were significant adjustments to direct medical costs of approximately $6.6 million relating to prior years. The Company was able to obtain its own stop-loss insurance in the Daytona market in 2003, accounting for additional savings estimated at approximately $2.4 million.

Salaries and benefits for 2003 increased 1.9% over 2002, from $7.7 million to $7.8 million. Increases were comprised of approximately $400,000 in management and staff bonuses, increases of $378,000 in the Company s growing Boca Raton medical and Daytona oncology offices and $67,000 related to the Company s Daytona operations. Offsetting the increases were approximately $139,000 in savings resulting from the closure of two unprofitable medical practices in 2002 and $676,000 related to the termination of the Company s hospitalist program in the first quarter.

Medical supplies were $2.1 million for 2003, compared to $1.9 million in 2002, as the 2002 expense only represented ten months of operations for the Company s Daytona oncology offices. Medical supply costs are incurred in all the Company s medical offices, but most prominently in the Company s Daytona oncology offices, accounting for 94.0% of the 2003 expense.

Depreciation and amortization for the year ended December 31, 2003 totaled $655,000, a 30.8% decrease over the prior year total of $946,000. The prior year included $429,000 in amortization and write-offs of financing costs, compared to $164,000 in the current year.

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Rent and leases for the year ended December 31, 2003 totaled $1.0 million, a $162,000 increase over 2002. Approximately $100,000 of the increase resulted from increased rent at the Company s new corporate offices, with another $119,000 arising from the expansion of the aforementioned Boca Raton and oncology medical offices. These increases were offset in part by $56,000 in savings resulting for the closure of the medical practices previously mentioned.

Consulting expense for the year decreased approximately $1.3 million, or 49.3%, from $2.7 million in 2002 to $1.4 million in 2003. These savings resulted in part from $273,000 in reductions of consulting services connected with the Company s pharmacy and HMO development efforts. Further savings were achieved through the discontinued use of medical consultants in the Company s hospitalist program in the first quarter of 2003 amounting to $973,000, a $314,000 reduction in marketing consultants and $81,000 in savings due to a closed medical practice in July 2002. These reductions were partially offset by $303,000 in increases related to the development of the Company s oncology practice.

General and administrative expenses for the year decreased $492,000, or 16.1%, from the $3.0 million reported in the year ended December 31, 2002. The result of cost cutting measures undertaken by the Company in the second half of 2002 and 2003, decreases were recognized in a wide number of expense categories, most significantly in legal and accounting. These reductions were partly offset by an increase in insurance costs amounting to $158,000.

Other income and expenses for 2003 included a decrease in interest expense of $1.1 million from the prior year, as 2002 included $1.2 million of imputed interest due to beneficial conversion features on convertible notes. The difference of $100,000 is due to the increased average amount of debt carried by the Company in 2003 as compared to the prior year.

Loss from discontinued operations for the year, which includes the Company s pharmacy division in 2003 and both the pharmacy and clinical laboratory in 2002, was $1.7 million in 2003 compared to $2.4 million in 2002. The 2003 year also included a $290,000 gain on the disposal of the pharmacy division, while 2002 reported a $834,000 loss on the disposal of the clinical laboratory.

Comparison of Fiscal 2002 and 2001

Introduction

The Company generated revenues of $140.1 million for the year ended December 31, 2002 compared to $128.2 million in the prior year, and incurred a net loss of $17.1 million for the year ended December 31, 2002 compared to a net loss of $369,000 for the year ended December 31, 2001. On a per share basis, losses were $0.56 and $0.02 for the years ended December 31, 2002 and December 31, 2001, respectively. Included in 2002 are significant adjustments to direct medical costs of approximately $6.6 million, imputed interest expense of $1.2 million, $520,000 in write-downs of accounts receivable remaining on medical practices closed in prior years and $3.2 million in losses related to the discontinued operations of the Company s clinical laboratory and pharmacy businesses.

Generally accepted accounting principles (GAAP) require the Company to make certain revenue and cost estimates with regards to its contracts with the HMO. Programs with the HMO are

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complex and at times subject to various interpretations. These revenue and cost estimates may be settled for amounts different than previously estimated or the Company s estimate could change by amounts that could be material to the financial statements. The nature of the relationship with the HMO is, and has been such, that certain estimates made by the Company are based upon verbal agreements with, or representations from the HMO regarding retroactive adjustments to amounts previously credited or charged to Metcare s fund balance. These estimates are particularly likely to change as policy, and/or personnel, at Humana changes. In connection with a change in Humana s management during 2002, deterioration in the relationship with Humana in the fourth quarter of 2002, and other factors, during 2002 Metcare recorded additional medical costs of approximately $6.6 million related to amounts that were included in accounts receivable at December 31, 2001. Conversely in 2001, upon favorable resolution of unsettled medical costs, Metcare recorded a reduction to medical costs of approximately $1.9 million.

In the fourth quarter of 2002 the Company incurred significant increases in Part A (hospital) and related costs due to the loss of a hospital contract by Humana in the Company s Daytona network. In response to the increased costs, management approached Humana in the fourth quarter of 2002 seeking to renegotiate its contract. The Company successfully completed an amendment to offset the cost increases, allowing the Daytona market to be financially viable. The amendment was effective January 1, 2003 and provides for increased funding in addition to other financial concessions. In return, the Company made certain concessions, a portion of which related to the charge to direct medical expenses discussed above.

In conjunction with a convertible debenture financing completed in May 2002, the Company incurred charges to interest of approximately $1.2 million. These charges were necessary as the holder may convert the debt at any time into company stock at a price lower than it was at the issuance of the debt.

As discussed in the audited financial statements, the Company operated in three segments for fiscal years 2002 and 2001; managed care and direct medical services (PSN), pharmacy and clinical laboratory. The largest of these, the PSN division, reported a loss before allocated overhead of $5.0 million for 2002, compared to profits of $6.1 million in 2001 and $4.5 million in 2000. Revenues for the same time periods were $140.1 million, $128.2 million and $119.0 million, respectively. Expenses, which include direct medical costs and supplies, physician salaries and other costs relating to the operations of medical practices, were $147.0 million, $122.7 million and $114.5 million for the years ended December 31, 2002, 2001 and 2000, respectively.

During 2001 the Company formed its pharmacy division. For the years ended December 31, 2002 and 2001, the pharmacy division reported losses, before allocation of corporate overhead, of $1.8 million and $744,000, respectively. For those same periods, revenues were $12.9 million compared to $2.8 million, while expenses, which include the costs of pharmaceuticals and other related expenses, were $15.8 million and $3.8 million for 2002 and 2001, respectively. The pharmacy was disposed of in November 2003 and, accordingly, the operations of this division are included in the loss from operations of discontinued business segments.

In the third quarter of 2002, the Company decided to dispose of its third segment, its clinical laboratory. Accordingly, in the year ended December 31, 2002, the Company recognized $1.4

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million in losses on discontinued operations, compared to losses of $559,000 in 2001 and $95,000 in 2000.

Revenues

Revenues for the year ended December 31, 2002 increased $11.9 million, or 9.3%, over the prior year, from $128.2 million to $140.1 million. PSN revenues, the core of the Company s business, increased 9.1%, from $126.9 million to $138.5 million, due primarily to funding increases from revisions to the Balanced Budget Act of approximately $7.5 million and approximately $4.0 million resulting from increased membership. In addition, revenues for 2002 included $635,000 of fee-for-service billings relating to the Company s newly formed Daytona oncology practice. Offsetting these increases were decreases in revenue from the closure of certain medical practices in 2002 and the second half of 2001 of $388,000.

Expenses

Operating expenses for the year ended December 31, 2002 increased approximately 20.0%. Direct medical costs, the largest component of expense, represent certain costs associated with providing services of the PSN operation including direct medical payments to physician providers, hospitals and ancillaries on a capitated or fee-for-service basis. Direct medical costs for 2002 were $133.6 million compared to $114.6 million for 2001. During the year the Company implemented several utilization initiatives, including its hospitalist, partners in quality (PIQ), and oncology programs, in an effort to improve patient care and reduce its medical costs. In the fourth quarter, the Company incurred significant increases in Part A (hospital) and related costs due to the loss of a hospital contract by Humana in the Company s Daytona network. In response to the increased costs, management renegotiated the Company s contract with the Humana. The Company successfully completed an amendment, which offset the cost increases, allowing the Daytona market to be financially viable. The amendment was effective January 1, 2003 and provided for increased funding in addition to other financial concessions.

Salaries and benefits for the year increased 26.7% over 2001, from $6.1 million to $7.7 million. PSN expansion in South Florida accounted for approximately $415,000 in increases while expansion of the services the Company provides in its Daytona market in an effort to improve patient care and control medical costs accounted for another $1.2 million of increases. Salary increases, increases in medical insurance premiums and a bolstering of staffing throughout the Company accounted for the balance of the increase, which was partially offset by $269,000 in savings achieved by the closure of two unprofitable medical practices

Medical supplies were $1.9 million for 2002, compared to $63,000 in 2001, due to the implementation of the Company s oncology practice in early 2002. Medical supply costs are incurred in all the Company s medical offices, but most prominently in the Company s two Daytona oncology offices, accounting for 96.8% of the 2002 supplies expense.

Depreciation and amortization for the year ended December 31, 2002 totaled $946,000, an increase of $101,000 over the prior year. The increase is due primarily to depreciation on fixed assets acquired in 2002 as well as the amortization recorded on certain financing costs incurred during the year.

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Rent and leases for the year ended December 31, 2002 totaled $854,000, a $97,000 increase over 2001. The aforementioned new operations accounted for a majority of the increase, with the balance resulting from annual increases in rent in our corporate and medical offices. This was offset in part by $84,000 in savings resulting for the closure of the medical practices previously mentioned.

Consulting expense increased approximately $1.6 million, from $1.1 million in 2001 to nearly $2.7 million in 2002. Of the increase, $1.3 million was incurred in the Company s Hospitalist, Oncology and Utilization/Quality Assurance/Management programs, which are designed to lower direct medical costs while improving patient care. In addition, approximately $386,000 of incremental expense was incurred in connection with investment banking and advisory services.

General and administrative expenses increased from $2.3 million in 2001 to $3.0 million in 2002, an increase of $770,000. Costs associated with the Company s oncology and hospitalist programs and other PSN expansion accounted for $411,000 in incremental expense. Increases also were incurred in accounting and legal fees ($245,000) and insurance ($158,000). The prior year also included approximately $313,000 in accounts payable write-offs and settlements relating to discontinued operations. These increases were partially offset by the savings of $115,000 resulting from the closure of a medical practice in the second half of 2001 and a $196,000 decrease in billing and collection fees from 2001 to 2002 resulting from the renegotiation and eventual cancellation of the Company s contract with an outside billing company in the second half of 2001.

Other income and expenses for the year ended December 31, 2002 included write downs of accounts receivable from medical practices closed in prior years of $520,000 and $3.2 million in losses on discontinued operations relating to the Company s clinical laboratory and pharmacy divisions. Interest expense increased $1.8 million for the year, due in large part to the previously mentioned charge of $1.2 million incurred in conjunction with a Convertible Debenture financing completed in May 2002. The balance of the increase is due to the increased amount of debt carried by the Company at December 31, 2002 as compared to the prior year.

Liquidity and Capital Resources

For the year ended December 31, 2003 the Company reported a profit of $4.4 million and over $2.1 million in positive cash flows from operations, significant improvements over the prior year results. These results combined with proceeds from the sale of the Company s pharmacy business and convertible debt conversions have enabled the reduction in liabilities by more than $7.3 million during the year, with additional reductions occurring in the first quarter of 2004 as detailed below. Prior to 2003, however, the Company had historically sustained negative cash flows from operations, in part as a result of the Company s diversification efforts, including the pharmacy and clinical laboratory operations. In 2003 the Company determined to refocus on its core managed care business. Although the Company expects its cash flow from operations to continue to be positive, there can be no assurance that this will occur. In the absence of continuing positive cash flows from operations or obtaining additional debt or equity financing, the Company may have difficulty meeting current and long-term obligations.

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In the fourth quarter of 2002 the Company incurred significant increases in Part A (hospital) and related costs due to the loss of a hospital contract by Humana in the Company s Daytona network. In response to the increased costs, management successfully renegotiated its Daytona contract, allowing it to be financially viable. The amendment was effective January 1, 2003 and provided for increased funding in addition to other financial concessions. The 2003 results reflect the effects of the contract revision.

During the first quarter of 2003, the Company borrowed an additional $500,000 from an existing lender on a short-term note bringing the total balance to $1 million, which note was due August 21, 2003. The note was renegotiated during the year extending the due date and was subsequently paid down to $620,000 at December 31, 2003. The balance of this note was repaid in the first quarter of 2004.

The Company borrowed $1.3 million from Humana during the first half of 2003, which amount was repaid over the course of the year.

The Company sold the operations of its pharmacy division in November 2003 for a cash price of $3.1 million plus the assumption of approximately $1.1 in liabilities. The pharmacy incurred losses of $1.5 million and $1.8 million in 2003 and 2002, respectively. The Company believes that this sale will result in both improved profitability and cash flows.

During 2003, approximately $1.1 million of long-term debt was paid through the issuance of 2.3 million shares, as provided for in the terms of the Convertible Notes with the investors. In January 2004, the remaining balance of $715,000 on a Convertible Note was paid in full through the issuance of 1.3 million shares of common stock. In March 2004, two Notes due August 2004 totaling $300,000 were repaid through the issuance of approximately 611,000 shares of common stock. Additionally, the Company s remaining significant note payable for $1.2 million due May 2004 was extended, with payments due over a twenty-four month period beginning June 2004.

In February 2004 the Company successfully negotiated a settlement with the Internal Revenue Service (IRS) on outstanding payroll tax liabilities for an amount totaling approximately $3.3 to $3.4 million. $3.2 million of this settlement has been paid with the balance to be paid once the IRS has determined the final settlement amount.

In conjunction with its IRS settlement, in February 2004 the Company raised approximately $3 million through the issuance of approximately 5.0 million shares of common stock under a private placement offering. The proceeds went toward the settlement of the IRS obligations.

Membership in Medicare Advantage programs (previously Medicare+Choice) has declined as a percentage of Medicare eligible lives over the last several years, principally the result of decreased funding which has negatively impacted plan benefits. Although the Company has seen growth in its membership through its expansion of its relationship with Humana, Metcare has experienced gradual attrition in membership commensurate with the industry. Net membership decreases from attrition were approximately 1,200 or 4.4% in 2003. The Company expects this trend to reverse with the passage of the Medicare Modernization Act in late 2003. Among a number of sweeping changes to Medicare, the legislation is intended to substantially increase participation in Medicare Advantage through increased funding commitments.

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Beginning with an average increase of 10.6% in 2004, this stimulus allows plans to improve benefits and attract new enrollees. With total 2004 premium increases of approximately 9.8% in Daytona and 17.8% in South Florida, and the resulting benefit enhancements, the Company expects its Medicare membership to grow. As well, Metcare expects that opportunities to expand into other Florida markets will develop as Humana and other Medicare HMO s grow their respective businesses.

The underlying economics of the Medicare Modernization Act may also provide sufficient incentive for companies such as Metcare to directly enter the Medicare Advantage business. The Company is currently evaluating its opportunities in the Florida, particularly in underserved markets, and may file for its own Medicare HMO license in 2004. The decision to enter this business would necessarily be based on a number of factors including analysis of the opportunity, consideration of alternative strategies and availability of necessary capital.

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.

Intangible Asset Risk

We have a substantial amount of intangible assets. We are required to perform goodwill impairment tests at least on an annual basis and whenever events or circumstances indicate that the carrying value may not be recoverable from estimated future cash flows. As a result of our annual and other 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. Although at December 31, 2003 we believe our intangible assets are recoverable, changes in the economy, the business in which we operate and our own relative performance could change the assumptions used to evaluate intangible asset recoverability. We continue to monitor those assumptions and their consequent 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.

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ITEM 8 FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Summary of Consolidated Quarterly Earnings (unaudited)

	For the Quarter Ended,			
	December 31, 2003	**September 30, 2003**	**June 30, 2003**	**March 31, 2003**
Net revenues	$35,452,435	$35,680,129	$35,865,376	$36,876,548
Income (Loss) from continuing Operations	$ 1,555,763	$ 1,691,617	$ 1,649,329	$ 964,594
Net Income (Loss)	$ 1,565,390	$ 1,172,972	$ 947,694	$ 715,697
Net Income - per share - basic	$ 0.04	$ 0.03	$ 0.03	$ 0.02
Net Income - per share - diluted	$ 0.04	$ 0.03	$ 0.02	$ 0.02

	For the Quarter Ended			
	December 31, 2002	**September 30, 2002**	**June 30, 2002**	**March 31, 2002**
Net revenues	$ 34,838,083	$34,613,150	$36,191,511	$34,420,822
Income (Loss) from continuing Operations	$(12,668,802)	$ (311,917)	$ (1,746,023)	$ 860,924
Net Income (Loss)	$(13,449,681)	$ (1,989,225)	$ (2,091,568)	$ 449,587
Net Income (Loss) - per share - basic	$ (0.43)	$ (0.06)	$ (0.07)	$ 0.02
Net Income (Loss) - per share - diluted	$ (0.43)	$ (0.06)	$ (0.07)	$ 0.01

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

None.

ITEM 9A. Controls and Procedures

Our management, which includes our CEO and our CFO, have conducted an evaluation of the effectiveness of our disclosure controls and procedures (as defined in Rule 13a-15(e) and 15d-15(e) promulgated under the Securities and Exchange Act of 1934, as amended) as of the end of the fiscal year covered by this report. Based upon that evaluation, our management has concluded that the design and operation of our disclosure controls and procedures are effective for timely gathering, analyzing and disclosing the information we are required to disclose in our reports filed under the Securities Exchange Act of 1934, as amended.

There have been no significant changes made in our internal controls over financial reporting that occurred during our last fiscal quarter that has materially affected or is reasonably likely to materially affect our internal control over financial reporting.

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PART III

ITEM 10 DIRECTORS, EXECUTIVE OFFICERS, PROMOTERS AND CONTROL PERSONS OF THE REGISTRANT; COMPLIANCE WITH SECTION 16(A) OF THE EXCHANGE ACT.

As of the date of this filing, the directors, control persons and executive officers of the Company are as follows:

Name	Age	Position