PEDIATRIX MEDICAL GROUP INC
Form 10-K
August 07, 2007

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

Form 10-K

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2006

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number 001-12111

PEDIATRIX MEDICAL GROUP, INC.
(Exact name of registrant as specified in its charter)

FLORIDA	**65-0271219**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
1301 Concord Terrace, Sunrise, Florida	**33323**
(Address of principal executive offices)	*(Zip Code)*

(954) 384-0175

Registrant s telephone number, including area code:

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

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, par value $.01 per share	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: Preferred Share Purchase Rights

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

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

Large accelerated filer þ Accelerated filer o Non-accelerated filer o

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

The aggregate market value of shares of Common Stock of the registrant held by non-affiliates of the registrant on June 30, 2006, the last business day of the registrant s most recently completed second fiscal quarter, was approximately $2,195,780,286 based on a $45.30 closing price per share as reported on the New York Stock Exchange composite transactions list on such date.

The number of shares of Common Stock of the registrant outstanding on July 20, 2007, was 49,020,190.

PEDIATRIX MEDICAL GROUP, INC.

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

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FORWARD-LOOKING STATEMENTS

Certain information included or incorporated by reference in this Form 10-K may be deemed to be forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995, Section 27A of the Securities Act of 1933, and Section 21E of the Securities Exchange Act of 1934. Forward-looking statements may include, but are not limited to, statements relating to our objectives, plans and strategies, and all statements (other than statements of historical facts) that address activities, events or developments that we intend, expect, project, believe or anticipate will or may occur in the future are forward looking statements. These statements are often characterized by terminology such as believe, hope, may, anticipate, should, intend, plan, will, expect, estimate, strategy and similar expressions, and are based on assumptions and assessments made by our management in light of their experience and their perception of historical trends, current conditions, expected future developments and other factors they believe to be appropriate. Any forward-looking statements in this Form 10-K are made as of the date hereof, and we undertake no duty to update or revise any such

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statements, whether as a result of new information, future events or otherwise. Forward-looking statements are not guarantees of future performance and are subject to risks and uncertainties. Important factors that could cause actual results, developments and business decisions to differ materially from forward-looking statements are described in this Form 10-K, including the risks set forth under Risk Factors in Item 1A.

As used in this Form 10-K, unless the context otherwise requires, the terms Pediatrix, the Company, we, us and ou refer to Pediatrix Medical Group, Inc., a Florida corporation, and its consolidated subsidiaries (collectively, PMG), together with PMG s affiliated professional associations, corporations and partnerships (affiliated professional contractors). PMG has contracts with its affiliated professional contractors, which are separate legal entities that provide physician services in certain states and Puerto Rico.

EXPLANATORY NOTE

In this Form 10-K, the Company is restating its Consolidated Balance Sheet as of December 31, 2005 and the related Consolidated Statements of Income and Cash Flows for each of the years ended December 31, 2005 and December 31, 2004. This Form 10-K also reflects (1) the restatement of Selected Financial Data in Item 6 for the years ended December 31, 2005, 2004, 2003 and 2002, (2) the amendment in Item 7 of Management s Discussion and Analysis of Financial Condition and Results of Operations presented in the Company s Form 10-K for the year ended December 31, 2005 as it relates to the years ended December 31, 2005 and 2004, and (3) the restatement of quarterly financial information in Item 8 for the quarter ended March 31, 2006 and for all quarters in the year ended December 31, 2005.

Immediately prior to the filing of this Form 10-K, the Company filed quarterly reports on Form 10-Q for the quarters ended June 30, 2006 and September 30, 2006. The Form 10-Q for the quarter ended June 30, 2006 contains restated financial information for the three and six months ended June 30, 2005 and the Form 10-Q for the quarter ended September 30, 2006 contains restated financial information for the three and nine months ended September 30, 2005.

Previously filed annual reports on Form 10-K and quarterly reports on Form 10-Q (other than for the quarters ended June 30, 2006 and September 30, 2006) have not been amended and should not be relied upon.

Background of Restatement

In June 2006, management of the Company began an informal limited review of its past stock option grant practices in response to a shareholder inquiry following various media reports regarding option granting practices at other companies. Management apprised the Audit Committee of the Company s Board of Directors of this informal limited review and the Audit Committee provided guidance with respect to the scope of the review. In August 2006, findings from this limited review were presented to the Audit Committee and the Company s independent certified registered public accounting firm. Based on these findings, the Audit Committee decided to initiate a comprehensive review to be undertaken by the Audit Committee with the assistance of independent legal counsel and forensic accounting experts. The review covered all stock options granted by the Company from the date of its initial public offering in September 1995 through the Company s option issuances in June 2006 (the Relevant Period).

In July 2007, the Audit Committee completed its review. The key findings, based on the evidence reviewed, are as follows:

> The Audit Committee identified 56 grants made on seven dates between April 1997 and August 2000 which the Audit Committee found were backdated. No instances of backdating were identified after August 2000. The Audit Committee used the term backdating to connote deliberate selection of grant measurement dates to obtain an option exercise price that was lower than would otherwise be the case. The Audit Committee used

this term to describe grants which apparently involved deliberate, opportunistic use of market prices.

The Audit Committee did not find evidence establishing intentional misconduct by any of the Company s current executive officers.

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The Audit Committee believes that it received full cooperation from all of the Company s current executive officers.

The Audit Committee did not find evidence establishing that the Board, any committee of the Board, or any non-executive director participated in backdating or was aware of backdating during the time that it occurred.

During the time period from April 1997 to August 2000 when backdating occurred, the administration and processing of option grants was directed by a former officer who later became a director of the Company. This individual continued to direct the Company s options program after resigning as an officer in May 2000, while remaining with the Company to work on special projects. During this time period, this individual appears to have been responsible for selecting favorable dates for option grants in all but one instance where a record was located regarding favorable date selection. The Audit Committee concluded that this individual knew or should have known the accounting implications of his actions. Further, the Audit Committee identified three occasions on which this individual was able to benefit by affecting the measurement date of options that were granted to him. The Audit Committee found that this individual realized approximately $12,000 from the backdating of these options based on the revised measurement dates assigned to them.

The Audit Committee identified numerous instances in which applicable accounting principles were misapplied and/or process deficiencies or administrative errors occurred resulting in the application of inappropriate measurement dates to option grants. The Audit Committee also identified inadequate record keeping, documentation, disclosure and systems with respect to the stock option grant process, including records of meetings, which in some cases, could not be corroborated in support of option grants on measurement dates that corresponded to periodic low points in the Company s stock price.

The Audit Committee determined that, although these matters did not establish that senior management engaged in intentional misconduct, current senior management did not adequately ensure that these processes and systems were proper, including the Company s current President and Chief Operating Officer and Chief Financial Officer, who were also found to have played a role in the granting of stock options to others that involved errors and process deficiencies.

With respect to the Company s current executive officers, the Audit Committee found that senior management should not have permitted the individual described above to continue to manage the options program after his resignation as a Company officer in May 2000. The Audit Committee found that, during the period in which backdating occurred, Roger J. Medel, M.D., the Company s CEO, was actively involved in determining grant recipients and amounts and was also party to e-mail correspondence concerning the selection of favorable dates for option grants; however, Dr. Medel was not the recipient of any of the grants found to be backdated. In addition, the Audit Committee found that on one occasion in 1997, Dr. Medel directed the selection of a favorable grant date for a group of regional medical officers, one of whom was his spouse, a founding physician of the Company and a full-time employee at the time of the grant. Based on its review, however, the Audit Committee believes that Dr. Medel was not aware of the accounting implications of such grants. Further, based on its review, the Audit Committee believes that Dr. Medel reasonably relied upon senior Company executives as to the administration of the Company s equity compensation plans and the accounting for awards. The Audit Committee found, however, that Dr. Medel bore overall responsibility for assuring that management s implementation of its compensation programs was appropriate but that he did not adequately assure such appropriate implementation.

In light of the evidence reviewed, the Audit Committee found that 640 grants in total required revised measurement dates, variable accounting or the recognition of compensation expense.

Audit Committee Conclusions

In connection with its investigation, the Audit Committee reviewed evidence to determine whether correct measurement dates had been used under generally accepted accounting principles (GAAP) for the Company s stock option grants during the Relevant Period. The measurement date means the date, under APB Opinion No. 25, Accounting for Stock Issued to Employees and its related interpretations (APB 25), on which all of the

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following are first known: (i) the individual employee who is entitled to receive the option grant, (ii) the number of options that an individual employee is entitled to receive, and (iii) the option s exercise price.

Based on the evidence reviewed, the Audit Committee concluded that: (i) in certain instances, available documentation was insufficient to support or inconsistent with the measurement date or exercise price which was originally assigned to the relevant stock option grant, (ii) certain stock option grants which required variable accounting were inappropriately accounted for as fixed awards, and (iii) modifications to certain stock option grants were not accounted for properly. In many cases, more than one of the foregoing conclusions was reached with respect to a single stock option grant.

Consistent with APB 25 and the January 2007 illustrative letter from the Chief Accountant of the SEC (the SEC Letter), grants made with incorrect measurement dates during the Relevant Period were organized into categories based on types of errors. The Audit Committee and its advisors reviewed evidence related to each grant in these categories, including electronic and physical documents, such as meeting minutes of the Compensation Committee or Board of Directors, unanimous written consents of the Compensation Committee, contemporaneous e-mails, personnel files, payroll records and various other records maintained by the Company, and the results of interviews. Based on the relevant facts and circumstances and the evidence reviewed, the Audit Committee applied relevant GAAP and its judgment to determine, for each grant within each category, the measurement date which was most appropriate. If the Audit Committee concluded that (i) the available documentation was insufficient to support or inconsistent with the measurement date or exercise price which was originally assigned to the relevant stock option grant, (ii) the stock option grant was inappropriately accounted for as a fixed award, and/or (iii) a modification to the stock option grant was not accounted for properly, then accounting adjustments were made as required, resulting in non-cash stock-based compensation expense and related tax effects. The Audit Committee and its advisors were unable to locate the supporting documentation for option grants in many instances. In these situations, the measurement date was determined using judgment as to the most likely granting action taken by the Company and the related date based upon the available information, consistent with the SEC Letter.

In addition, in some instances, grants were made through May 2001 by officers in exercise of authority apparently delegated to the Chief Executive Officer, but no documentation of such delegated authority has been located.

The Audit Committee concluded, based on the evidence reviewed, that options to purchase approximately 2.3 million shares of common stock 56 grants on seven dates were backdated as that term was used by the Audit Committee as described more fully above. The Audit Committee further concluded that options to purchase an additional 12.1 million shares of common stock 584 grants on 78 dates prior to 2006 had erroneous measurement dates or required variable accounting or recognition of additional expense.

For more information regarding the Audit Committee s review and the Company s restatement, refer to Note 3, Restatement of Consolidated Financial Statements in Notes to Consolidated Financial Statements in this Form 10-K.

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PART I

ITEM 1. *BUSINESS*

OVERVIEW

Pediatrix is the nation s leading health care services company focused on physician services for newborn, maternal fetal and other pediatric subspecialty care. At December 31, 2006, our national network was comprised of approximately 914 affiliated physicians, including 724 neonatal physician subspecialists who provide clinical care in 32 states and Puerto Rico, primarily within hospital-based neonatal intensive care units (NICUs), to babies born prematurely or with medical complications. Our affiliated neonatal physician subspecialists staff and manage clinical activities at more than 289 hospitals, and our 80 affiliated maternal fetal medicine subspecialists provide care to expectant mothers experiencing complicated pregnancies in many areas where our affiliated neonatal physicians practice. Our network includes other pediatric subspecialists, including 58 pediatric cardiologists, 36 pediatric intensivists and 16 pediatric hospitalists. In addition, we believe that we are the nation s largest provider of hearing screens to newborns and the nation s largest private provider of metabolic screening services to newborns.

Pediatrix Medical Group, Inc. was incorporated in Florida in 1979. Our principal executive offices are located at 1301 Concord Terrace, Sunrise, Florida 33323, and our telephone number is (954) 384-0175.

Our Operations

The following discussion describes the components of our services.

Physician Services. Our principal mission is the provision of comprehensive clinical care to babies born prematurely or with medical complications and to expectant mothers experiencing complicated pregnancies.

Neonatal Care. We provide clinical care to babies born prematurely or with complications within specific units at hospitals, primarily NICUs, through a team of experienced neonatal physician subspecialists (called neonatologists), neonatal nurse practitioners and other pediatric clinicians. Neonatologists are board-certified or eligible-to-apply-for-certification as a neonatologist who have extensive education and training for the care of babies born prematurely or with complications that require complex medical treatment. Neonatal nurse practitioners are registered nurses who have advanced training and education in managing health care needs of newborns, infants and their families.

Maternal Fetal Care. Our operations also include outpatient and inpatient clinical care to expectant mothers experiencing complicated pregnancies and their unborn babies through our affiliated maternal fetal medicine subspecialists and other clinicians, such as maternal fetal nurses, certified nurse mid-wives, ultrasonographers and genetic counselors. Maternal fetal medicine subspecialists are board-certified or eligible-to-apply-for-certification obstetricians who have extensive education and training for the treatment of high-risk expectant mothers and their fetuses. Our affiliated maternal fetal medicine subspecialists practice in certain metropolitan areas where we have affiliated neonatologists to provide coordinated care for women with complicated pregnancies and whose babies are often admitted to a NICU upon delivery.

Pediatric Cardiology Care. Our operations also include outpatient and inpatient pediatric cardiology care of the fetus, infant, child, and adolescent patients with congenital heart defects and acquired heart disease as well as adults with congenital heart defects through our affiliated pediatric cardiologist subspecialists and other

clinicians such as pediatric nurse practitioners, echocardiographers and other diagnostic technicians, and exercise physiologists. Pediatric cardiologists are board-certified pediatricians who have additional education and training in congenital heart defects and pediatric acquired heart disorders.

Other Pediatric Subspecialty Care. Our network also includes pediatric intensivists, who are hospital-based pediatricians with additional education and training in caring for critically ill or injured children and adolescents, pediatric hospitalists, who are hospital-based pediatricians specializing in inpatient care and management of acutely ill children, and other pediatric subspecialists. Our affiliated physicians also provide clinical services in other areas of hospitals, particularly in the labor and delivery area, nursery and pediatric department, where immediate accessibility to specialized care may be critical.

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Newborn Screening Services. We also operate the nation s largest private laboratory providing newborn and other metabolic screenings to approximately 370,000 patients each year. In addition, we are the nation s largest provider of hearing screens to newborns providing approximately 308,000 hearing screens each year. Our newborn screening program identifies more than 54 metabolic disorders and various genetic and biochemical conditions, and potential hearing loss for early treatment or management. All states require screening for a select number of metabolic conditions before newborns are discharged from the hospital. In addition, over 40 states either require newborns to be screened for potential hearing loss before being discharged from the hospital or require that parents be offered the opportunity to submit their newborns to hearing screens.

Clinical Research and Education. As part of our ongoing commitment to improving patient care through evidence-based medicine, we conduct clinical research, monitor clinical outcomes and implement clinical quality initiatives with a view to improving patient outcomes, shortening the length of hospital stays and reducing long-term health system costs. We have managed four neonatal clinical trials to completion and have three other trials in process. We also make extensive continuing medical education resources available to our physicians and neonatal nurse practitioners to give them access to the most current treatment methodologies and clinical quality improvement techniques. We believe that referring physicians, hospitals, third-party payors and patients all benefit from our clinical research, education and quality initiatives.

Demand for our Physician Services

Hospital-Based Care. Hospitals generally must provide cost-effective, quality care in order to enhance their reputations within their communities and desirability to patients, referring physicians and third-party payors. In an effort to improve outcomes and manage costs, hospitals typically employ or contract with physician subspecialists to provide specialized care in many hospital-based units, including NICUs. Hospitals traditionally staffed these units through affiliations with small, local physician groups or independent practitioners. However, management of these units presents significant operational challenges, including variable admissions rates, increased operating costs, complex reimbursement systems and other administrative burdens. As a result, hospitals contract with physician organizations that have the clinical quality initiatives, information and reimbursement systems and management expertise required to effectively and efficiently operate these units in the current health care environment. Demand for hospital-based physician services, including neonatology, is determined by a national market in which qualified physicians with advanced training compete for hospital contracts.

Neonatal Medicine. Of the approximately 4.1 million births in the United States annually, we estimate that approximately 10 to 12 percent require NICU admissions. Research continues to be conducted by numerous institutions to identify potential causes of premature birth and medical complications that often require NICU admissions. Some common contributing factors include the presence of hypertension or diabetes in the mother, lack of prenatal care, complications during pregnancy, drug and alcohol abuse and smoking or poor nutritional habits during pregnancy. Babies admitted to NICUs typically have an illness or condition that requires the care of a neonatalogist. Babies that are born prematurely and have a low birthweight often require neonatal intensive care services because of increased risk for medical complications. We believe obstetricians generally prefer to perform deliveries at hospitals that provide a full complement of labor and delivery services, including a NICU staffed by board-certified or eligible-to-apply-for-certification neonatologists. Because obstetrics is a significant source of hospital admissions, hospital administrators have responded to these demands by establishing NICUs and contracting with independent neonatology group practices to staff and manage these units. As a result, NICUs within the United States tend to be concentrated in hospitals with a higher volume of births. There are approximately 4,000 board-certified neonatologists in the United States who practice at approximately 1,540 hospital-based NICUs.

Maternal Fetal Medicine. Expectant mothers with pregnancy complications often seek or are referred by their obstetricians to maternal fetal medicine subspecialists. These subspecialists provide care to women with conditions such as diabetes, hypertension, sickle cell disease, multiple gestation, recurrent miscarriage, family history of genetic diseases, suspected fetal birth defects, and other complications during their pregnancies. We believe that improved maternal fetal care has a positive impact on neonatal outcomes. Data on neonatal outcomes demonstrate that, in general, the likelihood of mortality or an adverse condition or outcome (referred to as morbidity) is reduced the longer a baby remains in the womb. As a result, our maternal fetal medicine subspecialists focus on extending the pregnancy to improve the viability of the fetus.

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Pediatric Cardiology Medicine. Our operations also include outpatient and inpatient pediatric cardiology care of the fetus, infant, child, and adolescent with congenital heart defects and acquired heart disease as well as adults with congenital heart defects through our affiliated pediatric cardiologist subspecialists and other clinicians such as pediatric nurse practitioners, echocardiographers and other diagnostic technicians, and exercise physiologists. Pediatric cardiologists are board-certified pediatricians who have additional education and training in congenital heart defects and pediatric acquired heart disorders.

Other Pediatric Subspecialty Medicine. Other areas of pediatric subspecialty medicine are closely associated with our operations in maternal fetal-newborn medicine. Pediatric intensivists, another important subspecialist group, care for critically ill or injured children and adolescents in pediatric intensive care units (called PICUs). There are approximately 1,100 board-certified pediatric intensivists in the United States who practice at approximately 300 hospital-based PICUs.

Practice Administration. Administrative demands and cost containment pressures from a number of sources, principally commercial and government payors, make it increasingly difficult for doctors and hospitals to effectively manage patient care, remain current on the latest procedures and efficiently administer non-clinical activities. As a result, we believe that physicians and hospitals remain receptive to being affiliated with larger organizations that reduce administrative burdens, achieve economies of scale and provide value-added clinical research, education and quality initiatives. By relieving many of the burdens associated with the management of a subspecialty group practice, we believe that our practice administration services permit our affiliated physicians to focus on providing quality patient care and thereby contribute to improving patient outcomes, ensuring appropriate length of hospital stays and reducing long-term health system costs. In addition, our national network of affiliated physician practices, although modeled around a traditional group practice structure, is managed by a non-clinical professional management team with proven abilities to achieve significant operating efficiencies in providing administrative support systems, interacting with physicians, hospitals and third-party payors, managing information systems and technologies, and complying with laws and regulations.

Our Business Strategy

Our business objective is to enhance our position as a premier health care services organization that is built primarily around physician services. The key elements of our strategy to achieve our objectives are:

Focus on neonatal, maternal fetal, pediatric cardiology and other pediatric subspecialty care. Through our focus on neonatology, we have developed significant administrative expertise relating to neonatal physician services. We have also facilitated the development of a clinical approach to the practice of medicine among our affiliated physicians that includes research, education and quality initiatives intended to advance the practice of neonatology, improve the quality of care provided to acutely ill newborns and contribute to shortening the length of their hospital stays and reducing long-term health system costs. We are in the process of developing similar expertise in maternal fetal medicine and pediatric cardiology and are committed to doing the same with respect to other pediatric subspecialties in which our physicians are engaged.

Promote same-unit growth. We seek opportunities for increasing revenues in our hospital and office-based operations. For example, our affiliated hospital-based physicians are well situated to, and, in some cases, provide physician services in other departments, such as newborn nurseries, or in situations where immediate accessibility to specialized obstetric and pediatric care may be critical. In addition, we market our capabilities to obstetricians and family physicians to attract referrals to our hospital-based units. We also market the services of our affiliated physicians to other hospitals to attract neonatology transport admissions.

Acquire physician practice groups and expand into additional healthcare services. We continue to seek to expand our operations by acquiring established neonatal, maternal fetal medicine and pediatric cardiology groups and other complementary pediatric subspecialty physician groups, such as pediatric intensivists and pediatric hospitalists. During 2006, we added eight physician groups to our national network through acquisitions consisting of four neonatal groups and four pediatric cardiology practices. We also intend to explore other strategic opportunities that are related to our services and in other health care areas that would allow us to benefit from our business and practice management expertise. For example, we have been

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exploring opportunities within other hospital-based specialties that have operational characteristics that are similar to neonatology, such as anesthesiology. While as of the filing date of this Form 10-K, we have not yet made any definitive plans to acquire any anesthesiology practices, we believe that there are opportunities to apply our administrative expertise to this practice area. We expect to continue our evaluation of this practice area as a business opportunity during 2007.

Expand our newborn screening services. We will continue to seek contracts in the United States with hospitals, third-party payors and, in some cases, state agencies, and internationally with licensees and distributors, to provide screening services to newborns to detect the presence of hearing disorders and metabolic conditions for early treatment or management. We intend to focus on providing quality services and may seek other opportunities to expand our screening capabilities.

Strengthen relationships with our partners. By managing many of the operational challenges associated with a subspecialty practice, encouraging clinical research, education and quality initiatives, and promoting timely intervention by qualified pediatric and maternal fetal medicine subspecialists in emergency situations, we believe that our business model is focused on improving the quality of care delivered to acutely ill newborns, ensuring the appropriate length of their hospital stays and reducing long-term health system costs. We believe that referring physicians, hospitals, third-party payors and patients all benefit to the extent that we are successful in implementing our business model. We will continue to seek opportunities to strengthen relationships with our partners.

OUR PHYSICIAN SERVICES

Neonatal Care

We provide neonatal care to babies born prematurely or with complications within specific hospital units, primarily NICUs, through our network of 724 affiliated neonatologists and other related clinical professionals who staff and manage clinical activities at more than 240 NICUs in 32 states and Puerto Rico. We partner with our hospital clients in an effort to enhance the quality of care delivered to premature and sick babies. Some of the nation s largest and most prestigious hospitals, both not-for-profit and for-profit institutions, retain us to staff and manage their NICUs. Our affiliated neonatologists generally provide 24-hours-a-day, seven-days-a-week coverage, supporting the local referring physician community and being available for consultation in other hospital departments. Our hospital partners benefit from our experience in managing complex critical care units and reducing the costs associated with directly employing physician subspecialists. Our neonatal physicians interact with colleagues across the country through an internal communications system to draw upon their collective expertise in managing challenging patient care issues. Our neonatal physicians also work collaboratively with maternal fetal medicine subspecialists to coordinate care of mothers experiencing complicated pregnancies and their fetuses. We also employ or contract with neonatal nurse practitioners, who work with our affiliated physicians in providing medical care.

Maternal Fetal Care

We provide outpatient and inpatient maternal fetal care to expectant mothers with complicated pregnancies and their fetuses through our network of 80 affiliated maternal fetal medicine subspecialists and other related clinical professionals. Our affiliated neonatologists practice with maternal fetal medicine subspecialists to provide coordinated care for women with complicated pregnancies whose babies are often admitted to the NICU upon delivery. We believe continuity of treatment from mother and developing fetus during the pregnancy to the newborn upon delivery has improved the clinical outcomes of our patients.

Pediatric Cardiology Care

Our pediatric cardiology practice consists of 58 affiliated pediatric cardiologists and other related clinical professionals who provide specialized cardiac care to the fetus, pediatric patients with congenital and acquired heart disorders, as well as adults with congenital heart defects, through scheduled office visits, hospital rounds and immediate consultation in emergency situations.

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Other Pediatric Subspecialty Care

Our network includes other pediatric subspecialists such as pediatric intensivists and pediatric hospitalists. In addition, our affiliated physicians also seek to provide support services in other areas of hospitals, particularly in the labor and delivery area, nursery and pediatric department, where immediate accessibility to specialized care may be critical. Our experience and expertise in maternal fetal-neonatal medicine has led to our involvement in these other areas.

Pediatric Intensive Care. Our 36 affiliated pediatric intensivists provide clinical care for critically ill or injured children and adolescents. They staff and manage PICUs at 17 hospitals.

Pediatric Hospitalists. Our 16 affiliated pediatric hospitalists provide clinical care to acutely ill children at 13 hospitals.

Other Newborn and Pediatric Care. Because our affiliated physicians and advanced nurse practitioners generally provide hospital-based coverage, they are situated to provide highly specialized care to address medical needs that may arise during a baby s hospitalization. For example, as part of our ongoing efforts to support and partner with hospitals and the local referring physician community, our affiliated neonatologists, pediatric hospitalists and advanced nurse practitioners provide in-hospital nursery care to newborns through our newborn nursery program. This program is made available for babies during their hospital stay, which in the case of healthy babies typically comprises two days of evaluation and observation, following which they are referred, and their hospital records are provided, to their pediatricians or family practitioners for follow-up care.

OUR NEWBORN SCREENING SERVICES

We provide screening services to detect the presence of newborn hearing disorders and metabolic conditions for early treatment or management. Since we launched our newborn hearing screening program in 1994, we believe that we have become the largest provider of newborn hearing screening services in the United States. We screened approximately 308,000 babies for potential hearing loss at more than 144 hospitals across the nation in 2006. We also operate a technologically advanced metabolic screening laboratory. This laboratory provides a screening program for newborns that we believe is among the most comprehensive in the world. By analyzing blood samples drawn from newborns during the first few days after birth, we can identify the presence of more than 54 metabolic disorders and other genetic and biochemical conditions. In 2006, we screened approximately 370,000 blood samples for metabolic disorders.

We have advocated expanded newborn screening for several years and newborn screening is becoming an area of increasing interest to health care providers, as well as state and federal agencies. Many metabolic disorders can result in death if not diagnosed and treated in a timely manner. Early detection and successful intervention of many conditions can often improve the long-term quality of life for patients and reduce the long-term health care costs associated with the treatment of identified conditions.

We contract or coordinate with hospitals and, in some cases, state agencies to provide newborn screening services. All states mandate the screening of a limited number of metabolic disorders before newborns are discharged from the hospital so that a course of treatment can begin as soon as possible. In addition, hospitals, health care providers and parents may choose to have expanded screening for more than 54 metabolic disorders and other genetic and biochemical conditions. With respect to hearing screens, over 40 states either require newborns to be screened for potential hearing loss before being discharged from the hospital or require that parents be offered the opportunity to submit their newborns to hearing screens.

OUR CLINICAL RESEARCH AND EDUCATION

As part of our patient focus and ongoing commitment to improving patient care through evidenced-based medicine, we have engaged in a number of clinical research, quality and education initiatives intended to enhance the care provided to patients by our affiliated physicians, thereby contributing to improved patient outcomes and reduced long-term health system costs.

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Clinical Quality Initiatives. We monitor clinical outcomes in an effort to identify specific factors in treating babies born prematurely or with complications and to discover new methods of patient care that result in better outcomes at a reduced cost over the life of the patient. These efforts have resulted in the publication during 2006 of two research papers in the *Journal of Pediatrics*: *The Use of Ampicillin and Cefotaxime Compared to Ampicillin and Gentamicin is Associated with an Increased Mortality Rate During the First Three Days of Life* and *Medication Use in the NICU: Data from a Large National Data Set.* Our efforts have also resulted in our implementation of four best demonstrated process initiatives since 2000: *Improving Weight Gain for Very Low Birth Weight Infants in the First 28 Days*; *Improving Feeding of Breast Milk at NICU Discharge*; *Reducing Red Blood Cell Transfusions for 23-29 Week Infants*; and *Improving Compliance with AAP Recommendation on Use of Hepatitis B Vaccine in Premature Neonates*.

More recently, our physicians have been advancing a collaborative approach toward impacting specific conditions around neonatal care. One collaborative, the Comprehensive Oxygen Management for the Prevention of Retinopathy of Prematurity, involves all members of the clinical team, including hospital-employed nursing staff, in a focused effort to reduce the incidence of vision loss among babies. A second collaborative focuses on optimizing antibiotic usage, and reducing levels of risk associated with antibiotic therapies.

Clinical Trials. We have managed four neonatal clinical trials to completion. Our clinical study entitled *Glutamine Supplementation In Safely Reducing Hospital-Acquired Sepsis in Very Low Birth Weight Infants* commenced in April 2000, resulted in a paper published in the *Journal of Pediatrics* in June 2003. Our clinical study entitled *Epidemiology of Respiratory Failure in Near-Term Neonates*, which commenced in February 2001, resulted in a paper published in the *Journal of Perinatology* in April 2005. A study that we commenced in March 2001 with a grant from Forest Laboratories, *Comparison of Infasurf (Calfactant) and Survanta (Beractant) in the Prevention and Treatment of Respiratory Distress Syndrome* also resulted in a paper published in *Pediatrics* in August 2005. During 2006, a major multi-center trial that evaluated the use of protein administration and growth in the preterm infant was completed and has been submitted for publication. The trial included: *17 A-Hydroxyprogesterone Caproate for Reduction of Neonatal Mortality Due to Preterm Birth in Twin or Triplet Pregnancies; A Randomized Double-Blinded Study Comparing the Impact of One Versus Two Doses of Antenatal Steroids on Neonatal Outcomes; and A Randomized Controlled Trial Evaluating the Effect of Two Different Doses of Amino Acids on Growth and Serum Amino Acids in Premature Neonates.* Several other multi-institutional trials are in the development stages.

In addition, we are currently enrolling neonatal patients in two trials, Demographic, Metabolic, and Genomic Description of Neonates with Severe Hyperbilirubinemia, and Utility of Genetic Testing in Detection of Late-Onset Hearing Loss.

Continuing Medical Education. We also make extensive physician continuing medical education (CME) and continuing nursing education resources available to our affiliated clinicians in an effort to ensure that they have knowledge of current treatment methodologies. We are accredited as a provider of CME Category I credits for physicians and as a provider of continuing education for nurses. We also maintain Pediatrix University A University Without Walls™, which is an interactive educational website. In addition, we have a Professional Development Award program that offers stipend and research support for neonatal and maternal fetal fellows-in-training.

We believe that these initiatives have been enhanced by our integrated national presence together with our management information systems, which are an integral component of our clinical research and education activities. See Our Management Information Systems.

OUR PRACTICE ADMINISTRATION

We provide multiple administrative services to support the practice of medicine by our affiliated physicians and improve operating efficiencies of our affiliated practice groups.

Unit Management. We appoint a senior physician practicing medicine in each NICU, PICU, maternal fetal and pediatric cardiology practice and other subspecialty unit that we manage to act as our medical director

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for that unit. Each medical director is responsible for the overall management of his or her unit, including staffing and scheduling, quality of care, professional discipline, utilization review, coordinating physician recruitment, and monitoring our financial success within the unit or practice. Medical directors also serve as a liaison with hospital administration and the community. Each medical director reports to one of our regional presidents. All medical directors and regional presidents are board-certified or eligible-to-apply-for-certification physicians in their respective specialties.

Staffing and Scheduling. We assist with staffing and scheduling physicians and advanced nurse practitioners within the units that we manage. For example, each unit or practice is staffed by at least one specialist on site or available on call. All of our affiliated physicians are board-certified or eligible-to-apply-for-certification in neonatology, maternal fetal medicine, pediatric cardiology, pediatric critical care or pediatrics, as appropriate. We are responsible for the salaries and benefits paid and provided to our affiliated physicians. In addition, we employ, compensate and manage all non-medical personnel for our affiliated physician groups.

Recruiting and Credentialing. We have significant experience in locating, qualifying, recruiting and retaining experienced neonatologists, maternal fetal medicine subspecialists, pediatric cardiologists, pediatricians and pediatric subspecialists. We maintain an extensive nationwide database of maternal fetal, neonatal and other pediatric subspecialty physicians. Our medical directors and regional presidents play a central role in the recruiting and interviewing process before candidates are introduced to hospital administrators and other practice group physicians. We check the credentials, licenses and references of all prospective affiliated physician candidates. In addition to our database of physicians, we recruit nationally through trade advertising, referrals from our affiliated physicians and attendance at conferences.

Billing, Collection and Reimbursement. We assume responsibility for contracting, billing, collection and reimbursement for services rendered by our affiliated physicians, but not charges for services provided by hospitals to the same payors. Such charges are separately billed and collected by the hospitals. We provide our affiliated physicians with a training curriculum that emphasizes detailed documentation of and proper coding protocol for all procedures performed and services provided, and we provide comprehensive internal auditing processes, all of which are designed to achieve appropriate coding, billing and collection of revenues for physician services. Our billing and collection operations are conducted from our corporate offices, as well as our regional business offices located across the United States and in Puerto Rico.

Risk Management. We maintain a risk management program focused on reducing risk and improving outcomes through evidence-based medicine, including diligent patient evaluation, documentation and access to research, education and best demonstrated processes. We maintain professional liability coverage for our national group of affiliated health care professionals. Through our risk management and medical affairs staff, we conduct risk management programs for loss prevention and early intervention in order to prevent or minimize professional liability claims. In addition, we provide regulatory expertise to assist our affiliated practice groups in complying with increasingly complex laws and regulations.

We also provide management information systems, facilities management, marketing support and other services to our affiliated physicians and affiliated practice groups.

OUR MANAGEMENT INFORMATION SYSTEMS

We maintain several information systems to support our day-to-day operations and ongoing clinical research and business analysis. Since inception, our clinical information systems have accumulated clinical information from approximately 7.6 million daily progress records relating to more than 400,000 discharged patients. These systems are used to report and analyze clinical outcomes and identify prospective clinical trials and quality initiatives. Studies

from these databases have resulted in over 30 articles published in peer-reviewed medical journals.

BabySteps®. BabySteps is a clinical information management system used by our affiliated neonatal physicians to record clinical progress notes electronically and provides a decision tree to assist them in certain situations with the selection of appropriate billing codes. We developed this software system to

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replace our existing Research Data System (RDS). BabySteps is in the process of being implemented throughout Pediatrix neonatal practices.

RDS. First installed in March 1996, RDS is a centralized clinical database which is still being used at various locations within Pediatrix pending the full implementation of BabySteps.

*Nextgen*tm. We have licensed the Nextgen Electronic Medical Record (EMR) for our office-based maternal fetal and pediatric cardiology physicians to record clinical documentation related to their patients. This system provides benefits to our office-based practices that are similar to what BabySteps and RDS provide to our neonatology practices, including decision trees to assist physicians with the selection of appropriate billing codes, promotion of consistent documentation, and data for research and education. We are currently in the process of implementing EMR in all of our office-based maternal fetal and pediatric cardiology practices.

*Pediatrix University*tm. Pediatrix University is an educational website that disseminates clinical research, continuing quality improvement and education materials for which physicians may obtain CME credit. Pediatrix University also functions as a virtual doctors lounge, enabling physicians around the country to discuss difficult or unusual cases with one another.

Our management information systems are also an integral component of the billing and reimbursement process. We maintain systems that provide for electronic data interchange with payors accepting electronic submission, including electronic claims submission, insurance benefits verification and claims processing and remittance advice, which enable us to track numerous and diverse third-party payor relationships and payment methods. Our information systems have been designed to meet our requirements by providing for scalability and flexibility as payor groups upgrade their payment and reimbursement systems. We continually seek improvements in our systems to provide even greater streamlining of information from the clinical systems through the reimbursement process, thereby expediting the overall process.

We maintain additional information systems designed to improve operating efficiencies of our affiliated practice groups, reduce physicians paperwork requirements and facilitate interaction among our affiliated physicians and their colleagues regarding patient care issues. Following the acquisition of a physician practice group, we implement systematic procedures to improve the acquired group s operating and financial performance. One of our first steps is to convert the newly acquired group to our broad-based management information system. We also maintain a database management system to assist our business development and recruiting departments to identify potential practice group acquisitions and physician candidates.

RELATIONSHIPS WITH OUR PARTNERS

Our business model, which has been influenced by the direct contact and daily interaction that our affiliated physicians have with their patients, emphasizes a patient-focused clinical approach that addresses the needs of our various partners, including hospitals, third-party payors, referring physicians, affiliated physicians and, most importantly, our patients. Our relationships with all our partners are important to our continued success.

Hospitals

Our relationships with our hospital partners are critical to our operations. We have been retained by over 289 hospitals to staff and manage clinical activities within specific hospital-based units, primarily NICUs. Our hospital-based focus enhances our relationships with hospitals and creates opportunities for our affiliated physicians to provide patient care in other areas of the hospital, including emergency rooms, nurseries and other departments where access to specialized obstetric and pediatric care may be critical. Because hospitals control access to their NICUs through the awarding of

contracts and hospital privileges, we must maintain good relationships with our hospital partners. Our affiliated physicians are important components of obstetric and pediatric services provided by hospitals. Our hospital partners benefit from our expertise in managing critical care units staffed with physician specialists, including managing variable admission rates, operating costs, complex reimbursement systems and other administrative burdens. We also work with our hospital partners to enhance their reputation and market our

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services to referring physicians, an important source of hospital admissions, within the communities served by those hospitals.

Under our contracts with hospitals, we have the responsibility to manage, in many cases exclusively, the provision of physician services to the NICUs and other hospital-based units. We typically are responsible for billing patients and third-party payors for services rendered by our affiliated physicians separately from other related charges billed by the hospital to the same payors. Some of our hospital contracts require a hospital to pay us administrative fees if the hospital does not generate sufficient patient volume in order to guarantee that we receive a specified minimum revenue level. We also receive fees from hospitals for administrative services performed by our affiliated physicians providing medical director services at the hospital. Administrative fees accounted for approximately 6% of our net patient service revenue during 2006. Our contracts with hospitals also generally require us to indemnify them and their affiliates for losses resulting from the negligence of our affiliated physicians. Our hospital contracts typically have terms of one to three years which can be terminated without cause by either party upon prior written notice, and renew automatically for additional terms of one to three years unless earlier terminated by any party. While we have in most cases been able to renew these arrangements, hospitals may cancel or not renew our arrangements, or reduce or eliminate our administrative fees in the future.

Third-Party Payors

Our relationships with government-sponsored plans (principally Medicaid), managed care organizations and commercial health insurance payors are vital to our business. We seek to maintain professional working relationships with our third-party payors and streamline the administrative process of billing and collection, and assist our patients and their families in understanding their health insurance coverage and any balance due for co-payment, co-insurance deductible or out-of-network benefit limitations. In addition, through our quality initiatives and continuing research and education efforts, we have sought to enhance clinical care provided to patients, which we believe benefits third-party payors by contributing to improved patient outcomes and reduced long-term health system costs.

We receive compensation for professional services provided by our affiliated physicians to patients based upon rates for specific services provided, principally from third-party payors. Our billed charges are substantially the same for all parties in a particular geographic area, regardless of the party responsible for paying the bill for our services. A significant portion of our net patient service revenue is received from government-sponsored plans, principally state Medicaid programs. Medicaid programs can be either standard fee-for-service payment programs or managed care programs in which states have contracted with health insurance companies to run local or state-wide health plans with features similar to Health Maintenance Organizations. Our compensation rates under standard Medicaid programs are established by state governments and are not negotiated. Rates under Medicaid managed care programs are negotiated but are similar to rates established under standard Medicaid programs. Although Medicaid rates vary across the states, these rates are generally much lower in comparison to private sector health plan rates. In order to participate in the Medicaid programs, we and our affiliated practices must comply with stringent and often complex enrollment and reimbursement requirements. Different states also impose differing standards for their Medicaid programs. See Government Regulation Government Reimbursement Requirements.

We also receive compensation pursuant to contracts with commercial payors that offer a wide variety of health insurance products, such as Health Maintenance Organizations, Preferred Provider Organizations and Exclusive Provider Organizations that are subject to various state laws and regulations, as well as self-insured organizations subject to federal ERISA requirements. We seek to secure mutually agreeable contracts with payors that enable our affiliated physicians to be listed as in-network participants within the payors provider networks. We generally contract with commercial payors through our affiliated professional contractors, principally on a local basis. Subject to applicable laws and regulations, the terms, conditions and compensation rates of our contracts with commercial third-party payors are negotiated and often vary widely across markets and among payors. In some cases, we contract

with organizations that establish and maintain provider networks and then rent or lease such networks to the actual payor. Our contracts with commercial payors typically provide for discounted fee-for-service arrangements and grant each party the right to terminate the contracts without cause upon prior written notice. In

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addition, these contracts generally give commercial payors the right to audit our billings and related reimbursements to us for professional services provided by our affiliated physicians.

If we do not have a contractual relationship with a health insurance payor, we generally bill the payor our full billed charges. If payment is less than billed charges, we bill the balance to the patient, subject to state and federal billing practice regulations. Although we maintain standard billing and collections procedures with appropriate discounts for prompt payment, we also provide discounts in certain hardship situations where patients and their families do not have financial resources necessary to pay the amount due for services rendered. Any amounts written-off related to private-pay patients are based on the specific facts and circumstances related to each individual patient account.

Referring Physicians

We consider referring physicians to be our partners, and our affiliated physicians seek to establish and maintain professional relationships with referring physicians in the communities where they practice. Because patient volumes at our NICUs are based in part on referrals from other physicians, particularly obstetricians, it is important that we are responsive to the needs of referring physicians in the communities in which we operate. We believe that our community presence, through our hospital coverage and outpatient clinics, assists referring obstetricians, office-based pediatricians and family physicians with their practices. Our affiliated physicians are able to provide comprehensive maternal fetal newborn and pediatric subspecialty care to patients using the latest advances in methodologies, supporting the local referring physician community with 24-hours-a-day, seven-days-a-week on-site or on-call coverage.

Affiliated Physicians and Practice Groups

One of our most important assets is our relationship with our affiliated physicians. Our affiliated physicians are organized in traditional practice group structures. In accordance with applicable state laws, our affiliated practice groups are responsible for the provision of medical care to patients. Our affiliated practice groups are separate legal entities organized under state law as professional associations, corporations and partnerships, which we sometimes refer to as our affiliated professional contractors. Each of our affiliated professional contractors is owned by a licensed physician affiliated with PMG through employment or another contractual relationship. Our national infrastructure enables more effective and efficient sharing of new discoveries and clinical outcomes data, including implementation of best demonstrated processes, and affords access to our sophisticated information systems, and clinical research and education.

Our affiliated professional contractors employ or contract with physicians to provide clinical services in certain states and Puerto Rico. In most of our affiliated practice groups, each physician has entered into an employment agreement with us or one of our affiliated professional contractors providing for a base salary and incentive bonus eligibility and having typically a term of three to five years which usually can be terminated without cause by any party upon prior written notice. We typically are responsible for billing patients and third-party payors for services rendered by our affiliated physicians and, with respect to our hospital based practices, separately from other charges billed by hospitals to the same payors. Each physician must hold a valid license to practice medicine in the state in which he or she provides patient care and must become a member of the medical staff, with appropriate privileges, at each hospital at which he or she practices. Substantially all the physicians employed by us or our affiliated professional contractors have agreed not to compete within a specified geographic area for a certain period after termination of employment. Although we believe that the non-competition covenants of our affiliated physicians are reasonable in scope and duration and therefore enforceable under applicable state laws, we cannot predict whether a court or arbitration panel would enforce these covenants. Our hospital contracts also typically require that we and the physicians performing services maintain minimum levels of professional and general liability insurance. We negotiate those policies and contract and pay the premiums for such insurance on behalf of the physicians.

Each of our affiliated professional contractors has entered into a comprehensive management agreement with PMG that is long-term in nature, and in most cases permanent, subject only to a right of termination by PMG (except in the case of gross negligence, fraud or illegal acts of PMG). Under the terms of these management agreements,

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PMG is paid for its services based on the performance of the applicable practice group, and PMG is responsible for the provision of non-medical services and the compensation and benefits of the practices non-physician medical personnel. Government Regulation Fee Splitting; Corporate Practice of Medicine.

COMPETITION

Competition in our business is generally based upon a number of factors, including reputation, experience and level of care and our affiliated physicians ability to provide cost-effective, quality clinical care. The nature of competition for our hospital-based practices, such as neonatology and pediatric intensive care, differs significantly from competition for our office-based practices. Our hospital-based practices compete nationally with other pediatric health services companies and physician groups for hospital contracts and qualified physicians. In some instances, they also compete on a more local basis for referrals from physicians and transports from surrounding hospitals. Our office-based practices, such as maternal fetal medicine and pediatric cardiology, compete for patients with office-based practices in those subspecialties.

Because our operations consist primarily of physician services provided within hospital-based units, primarily NICUs, we compete with others for contracts with hospitals to provide neonatal services. We also compete with hospitals themselves to provide such services. Hospitals may employ neonatologists directly or contract with other physician groups to provide services either on an exclusive or non-exclusive basis. A hospital not otherwise competing with us may facilitate competition by creating a new NICU, expanding the capacity of an existing NICU or upgrading the level of its existing NICU and then awarding the contract to operate the neonatal service to a competing group or company. Because hospitals control access to their NICUs by awarding contracts and hospital privileges, we must maintain good relationships with our hospital partners. Our contracts with hospitals generally provide that they may be terminated without cause upon prior written notice.

The health care industry is highly competitive. Companies in other segments of the industry, some of which have financial and other resources greater than ours, may become competitors in providing neonatal, maternal fetal and other pediatric subspecialty care or newborn screening services.

GOVERNMENT REGULATION

The health care industry is governed by a framework of federal and state laws, rules and regulations that are extensive and complex and for which, in many cases, the industry has the benefit of only limited judicial and regulatory interpretation. If we or one of our affiliated practice groups is found to have violated these laws, rules or regulations, our business, financial condition and results of operations could be materially adversely affected. Moreover, health care continues to attract legislative interest and public attention. Changes in health care legislation or government regulation may restrict our existing operations, limit the expansion of our business or impose additional compliance, requirements and costs, any of which could have a material adverse effect on our business, financial condition, results of operations and the trading price of our common stock.

Licensing and Certification

Each state imposes licensing requirements on individual physicians and clinical professionals, and on facilities operated or utilized by health care companies like us. Many states require regulatory approval, including certificates of need, before establishing certain types of health care facilities, offering certain services or expending amounts in excess of statutory thresholds for health care equipment, facilities or programs. We and our affiliated physicians also are required to meet applicable Medicaid provider requirements under state laws and regulations. In addition, our metabolic screening laboratory is required to be certified pursuant to the federal Clinical Laboratory Improvement Amendments.

Fee Splitting; Corporate Practice of Medicine

Many states have laws that prohibit business corporations, such as PMG, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians, or engaging in certain arrangements, such as fee splitting, with physicians. In light of these restrictions, we operate by maintaining long-term management contracts with affiliated professional contractors, which employ or contract with physicians to

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provide physician services. Under these arrangements, we perform only non-medical administrative services, do not represent that we offer medical services and do not exercise influence or control over the practice of medicine by the physicians employed by our affiliated professional contractors. In states where fee splitting is prohibited, the fees that we receive from our affiliated professional contractors have been established on a basis that we believe complies with the applicable states laws. Although the relevant laws in these states have been subjected to limited judicial and regulatory interpretation, we believe that we are in compliance with applicable state laws in relation to the corporate practice of medicine and fee splitting. However, regulatory authorities or other parties, including our affiliated physicians, may assert that, despite these arrangements, we are engaged in the corporate practice of medicine or that our contractual arrangements with our affiliated professional contractors constitute unlawful fee splitting, in which case we could be subject to civil or criminal penalties, our contracts could be found legally invalid and unenforceable (in whole or in part) or we could be required to restructure our contractual arrangements with our affiliated professional contractors.

Fraud and Abuse Provisions

Existing federal laws governing Medicaid and other federal health care programs (the FHC Programs), as well as similar state laws, impose a variety of fraud and abuse prohibitions on health care companies like PMG. These laws are interpreted broadly and enforced aggressively by multiple government agencies, including the Office of Inspector General of the Department of Health and Human Services (the OIG), the Department of Justice (the DOJ) and various state authorities. In addition, in the Deficit Reduction Act of 2005, Congress created a new Medicaid Integrity Program to enhance federal and state efforts to detect Medicaid fraud, waste and abuse and provide financial incentives for states to enact their own false claims acts as an additional enforcement tool against Medicaid fraud and abuse.

The fraud and abuse laws include extensive federal and state regulations applicable to our financial relationships with hospitals, referring physicians and other health care entities. In particular, the federal anti-kickback law prohibits the offer, payment or receipt of any remuneration in return for either referring Medicaid or other government-sponsored health care program business, or purchasing, leasing, ordering, or 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, commonly known as the Stark Law, prohibits a physician from ordering certain designated health services reimbursable by Medicaid from an entity with which the physician has a prohibited financial relationship. 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 substantial penalties, including monetary fines, civil penalties, criminal sanctions (in the case of the anti-kickback law), exclusion from participation in government-sponsored health care programs and forfeiture of amounts collected in violation of such laws, any of which could have an adverse effect on our business and results of operations. Many of the states in which we operate also have similar anti-kickback and self-referral laws which are applicable to our government and non-government business and which also authorize substantial penalties for violations.

There are a variety of other types of federal and state fraud and abuse laws, including laws authorizing the imposition of criminal, civil and administrative penalties for filing false or fraudulent claims for reimbursement with government health care programs. These laws include the civil False Claims Act (FCA), which prohibits the filing of false claims in FHC Programs, including Medicaid, the TRICARE program for military dependents and retirees, and the Federal Employees Health Benefits Program. Substantial civil fines can be imposed for violating the FCA. Furthermore, proving a violation of the FCA requires only that the government show that the individual or company that filed the false claim acted in reckless disregard of the truth or falsity of the claim, notwithstanding that there was no intent to

defraud the government program and no actual knowledge that the claim was false (which are required to be shown to uphold a typical criminal conviction). The FCA also includes whistleblower provisions that permit private citizens to sue a claimant on behalf of the government and thereby share in any fines imposed under the law. In recent years, many cases have been brought against health care companies by such whistleblowers, which have resulted in the imposition of substantial fines on the companies involved. In addition, federal and state agencies that administer health care programs have at their disposal statutes, commonly known as

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the civil money penalty laws, that authorize substantial administrative fines and exclusion from government programs in any case where the individual or company that filed a false claim, or caused a false claim to be filed, knew or should have known that the claim was false or fraudulent. As under the FCA, it often is not necessary for the agency to show that the claimant had actual knowledge that the claim was false or fraudulent in order to impose these penalties. The civil and administrative penalty statutes are being applied in an increasingly broader range of circumstances. For example, government authorities often argue that claiming reimbursement for services that fail to meet applicable quality standards may, under certain circumstances, violate these statutes. Government authorities also often take the position that claims for services that were induced by kickbacks, Stark Law violations or other illicit marketing schemes are fraudulent and, therefore, violate the false claims statutes. If we or our affiliated professional contractors were excluded from any government-sponsored healthcare programs, not only would we be prohibited from submitting claims for reimbursement under such programs, but we also would be unable to contract with other healthcare providers, such as hospitals, to provide services to them.

Although we intend to conduct our business in compliance with all applicable federal and state fraud and abuse laws, many of the laws and regulations applicable to us, including those relating to billing and those relating to financial relationships with physicians and hospitals, are broadly worded and may be interpreted or applied by prosecutorial, regulatory or judicial authorities in ways that we cannot predict. Accordingly, we cannot assure you that our arrangements or business practices will not be subject to government scrutiny or be found to violate applicable fraud and abuse laws. Moreover, the standards of business conduct expected of health care companies under these laws and regulations have become more stringent in recent years, even in instances where there has been no change in statutory language. If there is a determination by government authorities that we have not complied with any of these laws and regulations, our business, financial condition and results of operations could be materially adversely affected. In addition, as part of the settlement of our Medicaid and TRICARE investigation, we have entered into a corporate integrity agreement with the OIG (the Corporate Integrity Agreement). See Government Investigations.

Government Reimbursement Requirements

In order to participate in various state Medicaid programs, we and our affiliated practices must comply with stringent and often complex enrollment and reimbursement requirements. Moreover, different states impose differing standards for their Medicaid programs. While our compliance program requires that we and our affiliated practices adhere to the laws and regulations applicable to the government programs in which we participate, our failure to comply with these laws and regulations could negatively affect our business, financial condition and results of operations. See Government Regulation Fraud and Abuse Provisions, Government Regulation Compliance Plan, Government Investigations and Other Legal Proceedings.

In addition, Medicaid and other government health care programs (such as the TRICARE program) are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review and new governmental funding restrictions, all of which may materially increase or decrease program payments as well as affect the cost of providing services and the timing of payments to providers. Moreover, because these programs generally provide for reimbursements on a fee-schedule basis rather than on a charge-related basis, we generally cannot increase our revenues by increasing the amount we charge for our services. To the extent our costs increase, we may not be able to recover our increased costs from these programs, and cost containment measures and market changes in non-governmental insurance plans have generally restricted our ability to recover, or shift to non-governmental payors, these increased costs. In attempts to limit federal and state spending, there have been, and we expect that there will continue to be, a number of proposals to limit or reduce Medicaid reimbursement for various services. Our business may be significantly and adversely affected by any such changes in reimbursement policies and other legislative initiatives aimed at reducing health care costs associated with Medicaid and other government healthcare programs.

Our business also could be adversely affected by reductions in or limitations of reimbursement amounts or rates under these government programs, reductions in funding of these programs or elimination of coverage for certain individuals or treatments under these programs, which may be implemented as a result of:

- increasing budgetary and cost containment pressures on the health care industry generally;

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new federal or state legislation reducing state Medicaid funding and reimbursements or increasing the proportion of state discretionary funding;

new state legislation mandating state Medicaid managed care or encouraging managed care organizations to provide benefits to Medicaid enrollees, thereby reducing Medicaid reimbursement payments to us;

state Medicaid waiver requests granted by the federal government, increasing discretion with respect to, or reducing coverage or funding for, certain individuals or treatments under Medicaid, even in the absence of new federal legislation;

increasing state discretion in Medicaid expenditures, which may result in decreased reimbursement for, or other limitations on, the services that we provide; or

other changes in reimbursement regulations, policies or interpretations that place material limitations on reimbursement amounts or coverage for services that we provide.

Antitrust

The health care industry is highly regulated for antitrust purposes and we believe that it will continue to be subject to close regulatory scrutiny. In recent years, the Federal Trade Commission (the FTC), the DOJ, and state Attorney Generals have increasingly taken steps to review and, in some cases, take enforcement action against, business conduct and acquisitions in the health care industry. Violations of antitrust laws are punishable by substantial penalties, including significant monetary fines, civil penalties, criminal sanctions, consent decrees and injunctions prohibiting certain activities or requiring divestiture or discontinuance of business operations. Any of these penalties could have a material adverse effect on our business, financial condition and results of operations. We were the subject of an investigation by the FTC relating to issues of competition in connection with our 2001 acquisition of Magella Healthcare Corporation (Magella) and our business practices generally. We were notified in November 2006, however, that the FTC has closed its investigation with a finding that no further action was warranted. See Government Investigations.

Medical Records Privacy Legislation

Numerous federal and state laws and regulations govern the collection, dissemination, use and confidentiality of patient health information, including the federal Health Insurance Portability and Accountability Act of 1996 and related rules (HIPAA), violations of which are punishable by monetary fines, civil penalties and, in some cases, criminal sanctions. As part of our medical record keeping, third-party billing, research and other services, we and our affiliated practices collect and maintain patient health information.

Pursuant to HIPAA, the Department of Health and Human Services (DHHS) has adopted standards to protect the privacy and security of health-related information. DHHS s privacy standards became effective in April 2003 and apply to medical records and other individually identifiable health information used or disclosed by healthcare providers, hospitals, health plans and healthcare clearinghouses in any form, whether electronically, on paper, or orally. We have implemented privacy policies and procedures, including training programs, designed to ensure compliance with the HIPAA privacy regulations.

DHHS s security standards became effective in April 2005 and require healthcare providers to implement administrative, physical and technical safeguards to protect the integrity, confidentiality and availability of electronically received, maintained or transmitted (including between us and our affiliated practices) individually

identifiable health-related information. We have implemented security policies, procedures and systems designed to facilitate compliance with the HIPAA security regulations.

Environmental Regulations

Our health care operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our outpatient and laboratory operations are subject to compliance with various other environmental laws, rules and regulations. Such compliance does not, and we

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anticipate that such compliance will not, materially affect our capital expenditures, financial position or results of operations.

Compliance Plan

We have adopted a compliance plan that reflects our commitment to complying with laws and regulations applicable to our business and meeting our ethical obligations in conducting our business (the Compliance Plan). We believe our Compliance Plan provides a solid framework to meet this commitment and our obligations under the Corporate Integrity Agreement entered into in connection with the settlement of the Medicaid, Tricare and state billing investigation including:

a Chief Compliance Officer who reports to the Board of Directors on a regular basis;

a Compliance Committee consisting of our senior executives;

a formal internal audit function, including a Director of Internal Audit who reports to the Audit Committee on a regular basis;

our *Code of Conduct*, which is applicable to our employees, independent contractors, officers and directors;

our *Code of Professional Conduct Finance*, which is applicable to our finance personnel, including our chief executive officer, chief financial officer, chief accounting officer and controller;

a disclosure program that includes a mechanism to enable individuals to disclose, to the Compliance Officer or any person who is not in the disclosing individual s chain of command, issues or questions believed by the individual to be a potential violation of criminal, civil, or administrative laws;

an organizational structure designed to integrate our compliance objectives into our corporate, regional and practice levels; and

education, monitoring and corrective action programs designed to establish methods to promote the understanding of our Compliance Plan and adherence to its requirements.

The foundation of our Compliance Plan is our *Code of Conduct*, which is intended to be a comprehensive statement of the ethical and legal standards governing the daily activities of our employees, affiliated professionals, independent contractors, officers and directors. All our personnel are required to abide by, and are given a thorough introduction to, our *Code of Conduct*. In addition, all employees and affiliated professionals are expected to report incidents that they believe in good faith may be in violation of our *Code of Conduct*. We maintain a toll-free hotline to permit individuals to report compliance concerns on an anonymous basis and obtain answers to questions about our *Code of Conduct*. Our Compliance Plan, including our *Code of Conduct*, is administered by our Chief Compliance Officer with oversight by our Chief Executive Officer and Board of Directors. We also have a *Code of Professional Conduct Finance*, which is applicable to our finance personnel, including our Chief Executive Officer, Chief Financial Officer (who is also our Chief Accounting Officer), Vice President of Accounting and Finance and Controller. A copy of our *Code of Conduct* and our *Code of Professional Conduct Finance* is available on our website, www.pediatrix.com. Any amendments or waivers to our *Code of Professional Conduct Finance* will be promptly disclosed on our website following the date of any such amendment or waiver. See Government Investigations.

GOVERNMENT INVESTIGATIONS

As described in the Explanatory Note immediately preceding Part I, Item 1, and in Note 3, Restatement of Consolidated Financial Statements in Notes to Consolidated Financial Statements in this Form 10-K, the Audit Committee of our Board of Directors conducted a comprehensive review of the Company s historical practices related to the granting of stock options with the assistance of independent legal counsel and forensic accounting experts. We voluntarily contacted the staff of the Securities and Exchange Commission (SEC) regarding the Audit Committee s review and subsequently the SEC notified us that it had commenced a formal investigation into our stock option practices. We have also had discussions with the U.S. Attorney s office for the Southern District of Florida regarding the Audit Committee s review. Based on these discussions, we believe that the U.S. Attorney s

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office may make a request for various documents and information related to the review and our stock option granting practices. We intend to continue full cooperation with the U.S. Attorney s office and the SEC. We cannot predict the outcome of these matters.

In November 2006, we were notified that the FTC closed its investigation of our acquisition of Magella and our business practices generally with a finding that no further action is warranted. See Government Regulation Antitrust.

Beginning in April 1999, we received requests from various federal and state investigators for information relating to our billing practices for services reimbursed by Medicaid, and the United States Department of Defense s TRICARE program for military dependents and retirees. From 1999 through 2002, a number of the individual state investigations were resolved through agreements to refund certain overpayments and reimburse certain costs to the states. In June 2003, we were advised by a United States Attorney s Office that it was conducting a civil investigation with respect to our Medicaid billing practices nationwide. The federal Medicaid investigation was initiated as a result of a complaint filed under seal by a third party, known as qui tam or whistleblower complaint, under the FCA which permits private individuals to bring confidential actions on behalf of the government. Beginning in late 2003, the federal Medicaid investigation, the TRICARE investigation, and related state inquiries were coordinated together.

In February 2006, we announced that we had reached an agreement in principle on the amount of a financial settlement with federal and state authorities that would resolve the Medicaid, TRICARE and state billing investigations, subject to, among other things, completion and approval of final settlement agreements, including a corporate integrity agreement with the OIG. In September 2006, we announced that we had completed a final settlement agreement with the DOJ and the relator who initiated the qui tam complaint (Federal Settlement Agreement). In February 2007, we announced that we had completed separate state settlement agreements with each state Medicaid program involved in the settlement (the State Settlement Agreements). Under the terms of the Federal Settlement Agreement and State Settlement Agreements, the Company paid the federal government $25.1 million related to neonatal services provided from January 1996 through December 1999, of which $9.5 million was transferred to an escrow agent for distribution to each Medicaid-participating state that entered into a State Settlement Agreement with us.

As part of the Federal Settlement Agreement, we entered into a five-year Corporate Integrity Agreement with the OIG. The Corporate Integrity Agreement acknowledges the existence of our comprehensive Compliance Plan, which provides for policies and procedures aimed at promoting our adherence with FHC Program requirements and requires us to maintain the Compliance Plan in full operation for the term of the Corporate Integrity Agreement. See Government Regulation Compliance Plan. In addition, the Corporate Integrity Agreement requires, among other things, that we must comply with the following integrity obligations during the term of the Corporate Integrity Agreement:

- maintaining a Compliance Officer and Compliance Committee to administer our compliance with FHC Program requirements, our Compliance Plan and the Corporate Integrity Agreement;

- maintaining the Code of Conduct we previously developed, implemented, and distributed to our officers, directors, employees, contractors, subcontractors, agents, or other persons who provide patient care items or services (the Covered Persons);

- maintaining the written policies and procedures we previously developed and implemented regarding the operation of the Compliance Plan and our compliance with FHC Program requirements;

- providing general compliance training to the Covered Persons as well as specific training to the Covered Persons who perform coding functions relating to claims for reimbursement from any FHC Program;

engaging an independent review organization to perform annual reviews of samples of claims from multiple hospital units to assist us in assessing and evaluating our coding, billing, and claims-submission practices;

maintaining the Disclosure Program we previously developed and implemented that includes a mechanism to enable individuals to disclose, to the Chief Compliance Officer or any person who is not in the disclosing

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individual s chain of command, issues or questions believed by the individual to be a potential violation of criminal, civil, or administrative laws;

not hiring or, if employed, removing from Pediatrix s business operations which are related to or compensated, in whole or part, by FHC Programs, persons (i) convicted of a criminal offense related to the provision of health care items or services or (ii) ineligible to participate in FHC Programs or Federal procurement or nonprocurement programs;

notifying the OIG of (i) new investigations or legal proceedings by a governmental entity or its agents involving an allegation that Pediatrix has committed a crime or has engaged in fraudulent activities, (ii) matters that a reasonable person would consider a probable violation of criminal, civil or administrative laws applicable to any FHC Program for which penalties or exclusion may be imposed, and (iii) the purchase, sale, closure, establishment, or relocation of any facility furnishing items or services that are reimbursed under FHC Programs;

reporting and returning overpayments received from FHC Programs;

submitting reports to the OIG regarding our compliance with the Corporate Integrity Agreement; and

maintaining for inspection, for a period of six years from the effective date, all documents and records relating to reimbursement from the FHC Programs and compliance with the Corporate Integrity Agreement.

Failure to comply with our duties under the Corporate Integrity Agreement could result in substantial monetary penalties and in the case of a material breach, could even exclude us from participating in FHC Programs. Management believes we were in compliance with the Corporate Integrity Agreement as of December 31, 2006.

We expect that additional audits, inquiries and investigations from government authorities and agencies will continue to occur in the ordinary course of business. Such audits, inquiries and investigations and their ultimate resolutions, individually or in the aggregate, could have a material adverse effect on our business, financial condition, results of operations or the trading price of our common stock.

OTHER LEGAL PROCEEDINGS

In the ordinary course of our business, we become involved in pending and threatened legal actions and proceedings, most of which involve claims of medical malpractice related to medical services provided by our affiliated physicians. Our contracts with hospitals generally require us to indemnify them and their affiliates for losses resulting from the negligence of our affiliated physicians. We may also become subject to other lawsuits which could involve large claims and significant defense costs. We believe, based upon our review of pending actions and proceedings, that the outcome of such legal actions and proceedings will not have a material adverse effect on our business, financial condition or results of operations. The outcome of such actions and proceedings, however, cannot be predicted with certainty and an unfavorable resolution of one or more of them could have a material adverse effect on our business, financial condition, results of operations and the trading price of our common stock.

We have received three letters from shareholders demanding that our Board of Directors initiate legal proceedings against certain current and former officers and directors for, among other things, breaches of fiduciary duty in connection with our historical stock option granting practices. These demands have been reviewed by a special committee (Special Committee) of our Board of Directors in connection with the review of our stock option practices. The Special Committee has considered the matter and has determined that it is not in the best interest of the Company to take further action with respect to the Company s current management or directors. The Special Committee is still

considering whether any future action should be taken regarding any former management or directors. We cannot predict whether any derivative actions will result from the shareholder demands and, if so, their outcomes.

Although we currently maintain liability insurance coverage intended to cover professional liability and certain other claims, we cannot assure that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us in the future where the outcomes of such claims are unfavorable to us. With respect to professional liability insurance, we self-insure our liabilities to pay deductibles through our wholly owned captive

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insurance subsidiary. Liabilities in excess of our insurance coverage, including coverage for professional liability and certain other claims, could have a material adverse effect on our business, financial condition and results of operations. See Professional and General Liability Coverage.

PROFESSIONAL AND GENERAL LIABILITY COVERAGE

We maintain professional and general liability insurance policies with third-party insurers on a claims-made basis, subject to self-insured retention limits, policy aggregates, exclusions, and other restrictions, in accordance with standard industry practice. We believe that our insurance coverage is appropriate based upon our claims experience and the nature and risks of our business. However, we cannot assure that any pending or future claim will not be successful or if successful will not exceed the limits of available insurance coverage.

Our business entails an inherent risk of claims of medical malpractice against our affiliated physicians and us. We contract and pay premiums for third-party professional liability insurance that indemnifies us and our affiliated health care professionals on a claims-made basis for losses incurred related to medical malpractice litigation. Professional liability coverage is required in order for our affiliated physicians to maintain hospital privileges. Our self-insured retention under our professional liability insurance program is maintained through a wholly owned captive insurance subsidiary. We record estimates in our Consolidated Financial Statements for our liabilities for self-insured retention amounts and claims incurred but not reported based on an actuarial valuation using historical loss patterns. Liabilities for claims incurred but not reported are not discounted. Because many factors can affect historical and future loss patterns, the determination of an appropriate reserve involves complex, subjective judgment, and actual results may vary significantly from estimates. If the self-insured retention amounts and other amounts that we are actually required to pay materially exceed the estimates that have been reserved, our financial condition and results of operations could be materially adversely affected.

EMPLOYEES AND PROFESSIONALS UNDER CONTRACT

In addition to the approximately 914 practicing physicians affiliated with us as of December 31, 2006, Pediatrix employed or contracted with approximately 1,119 other clinical professionals and 1,345 other full-time and part-time employees. None of our employees is a member of a labor union or subject to a collective bargaining agreement.

GEOGRAPHIC COVERAGE

We provide services in 32 states, including Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Indiana, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington and West Virginia, and Puerto Rico. During 2006, approximately 55% of our net patient service revenue was generated by operations in our five largest states. Our operations in Texas accounted for approximately 27% of our net patient service revenue for the same period. Although we continue to seek to diversify the geographic scope of our operations, primarily through acquisitions of physician group practices, we may not be able to implement successfully or realize the expected benefits of any of these initiatives. Adverse changes or conditions affecting states in which our operations are concentrated, such as health care reforms, changes in laws and regulations, reduced Medicaid reimbursements or government investigations, may have a material adverse effect on our business, financial condition and results of operations.

SERVICE MARKS

We have registered the service marks Pediatrix Medical Group, Obstetrix Medical Group, Pediatrix University and the baby design logo, among others, with the United States Patent and Trademark Office. In addition, we have pending

applications to register the trademarks and service marks for Pediatrix Screening and Pediatrix University A University Without Walls.

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AVAILABLE INFORMATION

Our annual proxy statements, reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those statements and reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are available free of charge and may be printed out through our Internet website, www.pediatrix.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Our proxy statements and reports may also be obtained directly from the SEC s Internet website at www.sec.gov or from the SEC s Public Reference Room at 100 F Street, N.E., Washington, D.C. 20549. Information on the operation of the Public Reference Room can be obtained by calling 1-800-SEC-0330. Our Internet website and the information contained therein or connected thereto are not incorporated into or deemed a part of this Form 10-K.

As described in the Explanatory Note immediately preceding Part I, Item 1, and in Note 3, Restatement of Consolidated Financial Statements in Notes to Consolidated Financial Statements in this Form 10-K, we are restating certain previously filed financial statements and financial information and, accordingly, previously filed annual reports on Form 10-K and quarterly reports on Form 10-Q (other than for the quarters ended June 30, 2006 and September 30, 2006) should not be relied upon.

ITEM 1A. *RISK FACTORS*

Any of the following risks could have a material adverse effect on our business, financial condition or results of operations and the trading price of our common stock.

The matters relating to the investigation by the Audit Committee of the Board of Directors and the restatement of the Company s consolidated financial statements have required us to incur substantial expenses and may result in litigation and governmental enforcement actions.

As described in the Explanatory Note immediately preceding Part I, Item 1, and in Note 3, Restatement of Consolidated Financial Statements in Notes to Consolidated Financial Statements in this Form 10-K, the Audit Committee of our Board of Directors conducted a comprehensive review of the Company s historical practices related to the granting of stock options with the assistance of independent legal counsel and forensic accounting experts. Based on the evidence reviewed, the Audit Committee concluded that (i) in certain instances, available documentation was insufficient to support or inconsistent with the measurement date or exercise price which was originally assigned to the relevant stock option grant, (ii) certain stock option grants which required variable accounting were inappropriately accounted for as fixed awards, and (iii) modifications to certain stock option grants were not accounted for properly. Accordingly, we have recorded additional non-cash stock-based compensation expense and related tax effects with regard to certain past stock option grants, and have restated certain previously filed financial statements included in this Form 10-K.

The review and related activities have required us to incur substantial expenses for legal, accounting, tax and other professional services, have diverted management s attention from our business, and could in the future harm our business, financial condition, results of operations and cash flows.

While we believe that we have made appropriate judgments in determining the correct measurement dates for our stock option grants in light of the Audit Committee s findings, the SEC may disagree with the manner in which we have accounted for and reported, or not reported, the financial impact of past stock option grants. Accordingly, there is a risk that we may have to further restate our prior financial statements, amend prior filings with the SEC, or take other actions not currently contemplated.

Our past stock option granting practices and the restatement of prior financial statements have exposed us to greater risks associated with litigation, regulatory proceedings and government enforcement actions. We voluntarily contacted the SEC regarding the Audit Committee s review and subsequently the SEC notified us that it had commenced a formal investigation into our stock option practices. We have also had discussions with the U.S. Attorney s office for the Southern District of Florida regarding the Audit Committee s review. Based on these discussions, we believe that the U.S. Attorney s office may make a request for various documents and information related to the review and our stock option granting practices. We intend to continue full cooperation

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with the U.S. Attorney s office and the SEC. See Business Government Investigations. In addition, we have received three letters from shareholders demanding that our Board of Directors initiate legal proceedings against certain current and former officers and directors for, among other things, breaches of fiduciary duty in connection with our historical stock option granting practices. Accordingly, there is risk that derivative actions could be filed against certain current or former officers and directors based on allegations relating to our historical stock option granting practices.

Subject to certain limitations, we are obligated to indemnify our current and former directors, officers and employees in connection with any regulatory or litigation matter relating to our historical stock option granting practices. These obligations arise under the terms of the Company s articles of incorporation, as amended, its amended and restated bylaws, applicable agreements and Florida law. The obligation to indemnify generally means that we are required to pay or reimburse the individual s reasonable legal expenses and possibly damages and other liabilities that may be incurred.

No assurance can be given regarding the outcomes from any litigation, regulatory proceedings or government enforcement actions relating to our historical stock option granting practices. The resolution of these matters may be time consuming, expensive, and may distract management from the conduct of our business. Furthermore, if we are subject to adverse findings in litigation, regulatory proceedings or government enforcement actions, we could be required to pay damages or penalties or have other remedies imposed, which could harm our business, financial condition, results of operations and cash flows.

As a result of our delayed filing of our Quarterly Report on Form 10-Q for the quarters ended June 30, 2006, September 30, 2006 and March 31, 2007 and this Form 10-K, we will be ineligible to register our securities on Form S-3 for sale by us or resale by others until we have timely filed all periodic reports under the Securities Exchange Act of 1934, as amended, for a period of twelve months and any portion of a month from the due date of the last untimely report. We may use Form S-1 to raise capital or complete acquisitions using our securities, but doing so could increase transaction costs and adversely affect our ability to raise capital or complete such acquisitions in a timely manner.

In March 2007, we received a New York Stock Exchange (NYSE) letter stating that, as a result of the delayed filing of the Company s Form 10-K for the year ended December 31, 2006, we were not in compliance with the filing requirements for continued listing as set forth in the New York Stock Exchange listed company manual and was therefore subject to delisting from the NYSE. With the filing of this Form 10-K, we believe that we have remedied our non-compliance with the NYSE continued listing requirements. If, however, the SEC disagrees with the manner in which we have accounted for and reported, or not reported, the financial impact of past stock option grants, there could be further delays in filing subsequent SEC reports that might result in delisting of our common stock from the NYSE.

Government authorities or other parties may assert that our business practices violate antitrust laws.

The health care industry is highly regulated for antitrust purposes and we believe that it will continue to be subject to close regulatory scrutiny. In recent years, the FTC, the DOJ and state Attorney Generals have taken increasing steps to review and, in some cases, take enforcement action against business conduct and acquisitions in the health care industry. Violations of antitrust laws are punishable by substantial penalties, including significant monetary fines, civil penalties, criminal sanctions, and consent decrees and injunctions prohibiting certain activities or requiring divestiture or discontinuance of business operations. Any of these penalties could have a material adverse effect on our business, financial condition and results of operations. We were the subject of an investigation by the FTC relating to issues of competition in connection with our 2001 acquisition of Magella and our business practices generally. We were notified in November 2006, however, that the FTC has closed its investigation with a finding that no further action was warranted. See Item 1. Business Government Investigations.

We may become subject to billing investigations by federal and state government authorities.

State and federal statutes impose substantial penalties, including civil and criminal fines, exclusion from participation in government health care programs and imprisonment, on entities or individuals (including any individual corporate officers or physicians deemed responsible) that fraudulently or wrongfully bill governmental

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or other third-party payors for health care services. In addition, federal laws allow a private person to bring a civil action in the name of the United States government for false billing violations. See Item 1. Business Government Regulation Fraud and Abuse Provisions. In September 2006, we entered into a settlement agreement with the DOJ that sets forth the terms of a financial settlement related to an investigation by federal and state authorities into our coding and billing practices for the period of time from 1996 through 1999 for neonatal critical care and intensive care services reimbursed by the Medicaid program nationwide, the Federal Employees Health Benefit program and the TRICARE program. As part of the financial settlement with the Department of Justice, we entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services for a term of five years. The Corporate Integrity Agreement imposes yearly compliance and audit obligations upon us. We believe that additional audits, inquiries and investigations from government agencies will continue to occur from time to time in the ordinary course of our business, which could result in substantial defense costs to us and a diversion of management s time and attention. We cannot predict whether any future audits, inquiries or investigations, or the public disclosure of such matters, would have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our common stock. See Item 1. Business Government Investigations.

The health care industry is highly regulated and government authorities may determine that we have failed to comply with applicable laws or regulations.

The health care industry and physicians medical practices, including the health care and other services that we and our affiliated physicians provide, are subject to extensive and complex federal, state and local laws and regulations, compliance with which imposes substantial costs on us. Of particular importance are:

- federal laws (including the federal False Claims Act) that prohibit entities and individuals from knowingly or recklessly making claims to Medicaid, Medicare and other government programs, as well as third-party payors, that contain false or fraudulent information;

- a provision of the Social Security Act, commonly referred to as the anti-kickback law, that prohibits the knowing and willful offer, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration, in cash or in kind, in return for the referral or recommendation of patients for items and services covered, in whole or in part, by federal healthcare programs, such as Medicaid and Medicare;

- a provision of the Social Security Act, commonly referred to as the Stark Law, that, subject to limited exceptions, prohibits physicians from referring Medicaid or Medicare patients to an entity for the provision of certain designated health services if the physician or a member of such physician s immediate family has a direct or indirect financial relationship (including a compensation arrangement) with the entity;

- a provision of the Social Security Act that imposes criminal penalties on healthcare providers who fail to disclose or refund known overpayments;

- similar state law provisions pertaining to anti-kickback, fee splitting, self-referral and false claims issues, which typically are not limited to relationships involving federal payors;

- provisions of, and regulations relating to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prohibit knowingly and willfully executing a scheme or artifice to defraud a healthcare benefit program or falsifying, concealing or covering up a material fact or making any material false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services;

- provisions of HIPAA limiting how healthcare providers may use and disclose individually identifiable health information and imposing certain security requirements in connection with that information and related

systems, as well as similar state laws;

state laws that prohibit general business corporations from practicing medicine, controlling physicians medical decisions or engaging in certain practices, such as splitting fees with physicians;

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federal and state laws that prohibit providers from billing and receiving payment from Medicaid or Medicare for services unless the services are medically necessary, adequately and accurately documented and billed using codes that accurately reflect the type and level of services rendered;

federal and state laws pertaining to the provision of services by non-physician practitioners, such as advanced nurse practitioners, physician assistants and other clinical professionals, physician supervision of such services and reimbursement requirements that may be dependent on the manner in which the services are provided and documented; and

federal laws that impose civil administrative sanctions for, among other violations, inappropriate billing of services to federally funded healthcare programs, inappropriately reducing hospital care lengths of stay for such patients, or employing individuals who are excluded from participation in federally funded healthcare programs.

In addition, we believe that our business will continue to be subject to increasing regulation, the scope and effect of which we cannot predict. See Item 1. Business Government Regulation.

We are currently and may in the future become the subject of regulatory or other investigations or proceedings, and our interpretations of applicable laws, rules and regulations may be challenged. For example, regulatory authorities or other parties may assert that our arrangements with our affiliated professional contractors constitute fee splitting or the corporate practice of medicine and seek to invalidate these arrangements, which could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our common stock. See Item 1. Business Government Regulation Fee Splitting; Corporate Practice of Medicine. Regulatory authorities or other parties also could assert that our relationships, including fee arrangements, among our affiliated professional contractors, hospital clients or referring physicians violate the anti-kickback, fee splitting or self-referral laws and regulations. See Item 1. Business Government Regulation Fraud and Abuse Provisions and Government Reimbursement Requirements. Such investigations, proceedings and challenges could result in substantial defense costs to us and a diversion of management s time and attention. In addition, 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 and regulations, any of which could have a material adverse effect on our business, financial condition, cash flows, results of operations and the trading price of our common stock.

We are subject to changes in private employer healthcare insurance and government-sponsored programs.

We believe that, over the past several years, there has been a general decline in the number of private employers that offer healthcare insurance coverage to their employees, and for those employers that do offer healthcare insurance coverage, there has been an increase in the required contributions from employees to pay for coverage for them and their families. These trends could continue or accelerate and, as a consequence, the number of patients who are uninsured or participate in government-sponsored programs may increase. Payments received from government-sponsored programs are substantially less than payments received from managed care and other third-party payors. A payor mix shift from managed care and other third-party payors to government payors may result in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net patient service revenue. Further increases in the government component of our payor mix at the expense of other third-party payors could result in a significant reduction in our average reimbursement rates. Moreover, changes in eligibility requirements for government-sponsored programs could increase the number of patients who participate in such programs or the number of uninsured patients. In addition, private employers who offer healthcare insurance could change employee coverage by increasing patient responsibility amounts. These

factors and events could have a material adverse effect on our business, results of operations, financial condition, cash flows and the trading price of our common stock.

Government programs or private insurers may limit, reduce or make retroactive adjustments to reimbursement amounts or rates.

A significant portion of our net patient revenue is derived from payments made by government-sponsored health care programs, principally Medicaid. These government programs, as well as private insurers, have taken and

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may continue to take steps, including a movement toward managed care, to control the cost, eligibility for, use and delivery of health care services as a result of budgetary constraints, cost containment pressures and other reasons, including those described above under Item 1. Business Government Regulation Government Reimbursement Requirements. These government programs and private insurers may attempt other measures to control costs including bundling of services and denial of or reduction in reimbursement for certain services and treatments. As a result, payments from government programs or private payors may decrease significantly. Also, any adjustment in Medicare reimbursement rates may have a detrimental impact on our reimbursement rates as Medicaid and many third-party payors base their reimbursement rates on a percentage of Medicare reimbursement rates. Our business may be materially affected by limitations of or reductions in reimbursement amounts or rates or elimination of coverage for certain individuals or treatments. Moreover, because government programs generally provide for reimbursements on a fee-schedule basis rather than on a charge-related basis, we generally cannot increase our revenues from these programs by increasing the amount we charge for our services. To the extent our costs increase, we may not be able to recover our increased costs from these programs, and cost containment measures and market changes in non-governmental insurance plans have generally restricted our ability to recover, or shift to non-governmental payors, these increased costs. In addition, funds we receive from third-party payors are subject to audit with respect to the proper billing for physician and ancillary services and, accordingly, our revenue from these programs may be adjusted retroactively. Any retroactive adjustments to our reimbursement amounts could have a material effect on our financial condition, results of operations, cash flows and the trading price of our common stock.

Our affiliated physicians may not appropriately record or document services they provide.

Our affiliated physicians are responsible for assigning reimbursement codes and maintaining sufficient supporting documentation for the services they provide. We use this information to seek reimbursement for their services from third-party payors. If these physicians do not appropriately code or document their services, our business, financial condition, results of operations and cash flows could be adversely affected.

We may not find suitable acquisition candidates or successfully integrate our acquisitions. Our acquisitions may affect our payor mix.

We have expanded and intend to continue to seek to expand our presence in new and existing metropolitan areas for us by acquiring established neonatal, maternal fetal and pediatric cardiology physician practice groups and other complementary pediatric subspecialty physician groups. We intend to explore other strategic opportunities in areas that are related to our services and in other health care areas that would allow us to benefit from our business and practice management expertise. For example, we have been exploring opportunities within other hospital-based specialties that have operational characteristics that are similar to neonatology, such as anesthesiology. Our acquisition strategy involves numerous risks and uncertainties, including:

- We may not be able to identify suitable acquisition candidates or strategic opportunities or implement successfully or realize the expected benefits of any suitable opportunities. In addition, we compete for acquisitions with other potential acquirers, some of which may have greater financial or operational resources than we do. This competition may intensify due to the ongoing consolidation in the health care industry, which may increase our acquisition costs.

- We may not be able to successfully integrate completed acquisitions, including our recent acquisitions. Integrating completed acquisitions into our existing operations involves numerous short-term and long-term risks, including diversion of our management s attention, failure to retain key personnel, long-term value of acquired intangible assets and acquisition expenses. In addition, we may be required to comply with laws and regulations that may differ from those of the states in which our operations are currently conducted.

We cannot be certain that any acquired business will continue to maintain its pre-acquisition revenues and growth rates or be financially successful. In addition, we cannot be certain of the extent of any unknown or contingent liabilities of any acquired business, including liabilities for failure to comply with applicable laws, including laws relating to medical malpractice. We may incur material liabilities for past activities of acquired businesses.

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We could incur or assume indebtedness and issue equity in connection with acquisitions. The issuance of shares of our common stock for an acquisition may result in dilution to our existing shareholders and, depending on the number of shares that we issue, the resale of such shares could affect the trading price of our common stock.

We may acquire businesses that derive a greater portion of their revenue from government-sponsored programs than what we recognize on a consolidated basis. These acquisitions could affect our overall payor mix in future periods.

Acquisitions of practices outside of our current areas could entail financial and operating risks not fully anticipated. Such acquisitions could divert management s attention and our resources.

Federal and state laws that protect the privacy and security of patient health information may increase our costs and limit our ability to collect and use that information.

Numerous federal and state laws and regulations govern the collection, dissemination, use, security and confidentiality of patient-identifiable health information, including HIPAA. As part of our medical record keeping, third-party billing, research and other services, we collect and maintain patient health information in paper and electronic format. New patient health information standards, whether implemented pursuant to HIPAA, congressional action or otherwise, could have a significant effect on the manner in which we handle health care-related data and communicate with payors, and compliance with these standards could impose significant costs on us or limit our ability to offer services, thereby negatively impacting the business opportunities available to us. If we do not comply with existing or new laws and regulations related to patient health information we could be subject to monetary fines, civil penalties or criminal sanctions.

Our employees may not appropriately secure and protect confidential information in their possession.

Each Pediatrix employee is responsible for the security of the information in our systems and to ensure that private and financial information is kept confidential. Should an employee not follow appropriate security measures it may result in the release of private or confidential financial information. The release of such information could have a material adverse effect on our business, financial condition, results of operations and cash flows.

There may be federal and state health care reform, or changes in the interpretation of government-sponsored health care programs.

Federal and state governments continue to focus significant attention on health care reform. In recent years, many legislative proposals have been introduced or proposed in Congress and some state legislatures that would effect major changes in the health care system. Among the proposals which are being or have been considered are cost controls on hospital physicians and other providers, healthcare insurance reforms, Medicaid reforms, mandated coverage for children, taxes on physician revenue, and the creation of a single government health plan that would cover all citizens. We cannot predict which, if any, proposal that has been or will be considered will be adopted or what effect any future legislation will have on us. Changes in healthcare laws or regulations could reduce our revenue, impose additional costs on us or affect our opportunities for continued growth.

We may not be able to successfully recruit and retain qualified physicians to serve as affiliated physicians or independent contractors.

We are dependent upon our ability to recruit and retain a sufficient number of qualified physicians to service existing units at hospitals and our affiliated practices and expand our business. We compete with many types of health care providers, including teaching, research and government institutions and other practice groups, for the services of qualified physicians. We may not be able to continue to recruit new physicians or renew contracts with existing physicians on acceptable terms. If we do not do so, our ability to service existing or new hospital units and staff existing or new office-based practices could be adversely affected.

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A significant number of our affiliated physicians could leave our affiliated practices or our affiliated professional contractors may be unable to enforce the non-competition covenants of departed physicians.

Our affiliated professional contractors usually enter into employment agreements with our affiliated physicians which typically can be terminated without cause by any party upon prior written notice. In addition, substantially all of our affiliated physicians have agreed not to compete within a specified geographic area for a certain period after termination of employment. The law governing non-compete agreements and other forms of restrictive covenants varies from state to state. Although we believe that the non-competition and other restrictive covenants applicable to our affiliated physicians are reasonable in scope and duration and therefore enforceable under applicable state law, courts and arbitrators in some states are reluctant to strictly enforce non-compete agreements and restrictive covenants against physicians. If a substantial number of our affiliated physicians leave our affiliated practices or our affiliated professional contractors are unable to enforce the non-competition covenants in the employment agreements, our business, financial condition, results of operations and cash flows could be materially adversely affected. We cannot predict whether a court or arbitration panel would enforce these covenants.

We may be subject to medical malpractice and other lawsuits not covered by insurance.

Our business entails an inherent risk of claims of medical malpractice against our affiliated physicians and us. We may also be subject to other lawsuits which may involve large claims and significant defense costs. Although we currently maintain liability insurance coverage intended to cover professional liability and other claims, there can be no assurance that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us where the outcomes of such claims are unfavorable to us. With respect to professional liability insurance, we self-insure our liabilities to pay retention amounts through a wholly owned captive insurance subsidiary. Liabilities in excess of our insurance coverage, including coverage for professional liability and other claims, could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our common stock. See Item 1. Business Other Legal Proceedings and Professional and General Liability Coverage.

The reserves that we have established in respect of our professional liability losses are subject to inherent uncertainties and if a deficiency is determined this may lead to a reduction in our net earnings.

We have established reserves for losses and related expenses, which represent estimates involving actuarial projections, at a given point in time, of our expectations of the ultimate resolution and administration of costs of losses incurred with respect to professional liability risks for the amount of risk retained by us. Insurance reserves are inherently subject to uncertainty. Our reserves are based on historical claims, demographic factors, industry trends, severity and exposure factors and other actuarial assumptions calculated by an independent actuary firm. The independent actuary firm performs studies on projected ultimate losses at least annually. We use the actuarial estimates to establish reserves. Our reserves could be significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating reserves, the complexity of the claims and wide range of potential outcomes often hampers timely adjustments to the assumptions used in these estimates. Actual losses and related expenses may deviate, perhaps substantially, from the reserve estimates reflected in our financial statements. If our estimated reserves are determined to be inadequate, we will be required to increase reserves at the time the deficiency is determined.

We may write-off intangible assets, such as goodwill.

Our intangible assets, which consist primarily of goodwill related to our acquisitions, are subject to annual impairment testing. Under current accounting standards, goodwill is tested for impairment on an annual basis and we may be subject to impairment losses as circumstances change after an acquisition. If we record an impairment loss related to our goodwill, it could have a material adverse effect on our results of operations for the year in which the impairment

is recorded.

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We may not effectively manage our growth.

We have experienced rapid growth in our business and number of our employees and affiliated physicians in recent years. Continued rapid growth may impair our ability to provide our services efficiently and to manage our employees adequately. While we are taking steps to manage our growth, our future results of operations could be materially adversely affected if we are unable to do so effectively.

We may not be able to maintain effective and efficient information systems.

Our operations are dependent on uninterrupted performance of our information systems. Failure to maintain reliable information systems or disruptions in our information systems could cause disruptions in our business operations, including errors and delays in billings and collections, difficulty satisfying requirements under hospital contracts, disputes with patients and payors, violations of patient privacy and confidentiality requirements and other regulatory requirements, increased administrative expenses and other adverse consequences, any or all of which could have a material adverse effect on our business, financial condition and results of operations.

Our quarterly results will likely fluctuate from period to period.

We have historically experienced and expect to continue to experience quarterly fluctuations in net patient service revenue and net income. For example, we typically experience negative cash flow from operations in the first quarter of each year, principally as a result of bonus payments to affiliated physicians. In addition, a significant number of our employees and associated professional contractors (primarily affiliated physicians) exceed the level of taxable wages for social security during the first and second quarters. As a result, we incur a significantly higher payroll tax burden and our net income is lower during those quarters. Moreover, a lower number of calendar days are present in the first and second quarters of the year as compared to the remainder of the year. Because we provide services in the NICU on a 24- hour-a-day basis, 365 days a year, any reduction in service days will have a corresponding reduction in net patient service revenue. We also have significant fixed operating costs, including costs for our affiliated physicians, and as a result, are highly dependent on patient volume and capacity utilization of our affiliated physicians to sustain profitability. Quarterly results may also be impacted by the timing of acquisitions and any fluctuation in patient volume. As a result, our results of operations for any quarter are not indicative of results of operations for any future period or full fiscal year.

The value of our common stock may fluctuate.

There has been significant volatility in the market price of securities of health care companies generally that we believe in many cases has been unrelated to operating performance. In addition, we believe that certain factors, such as legislative and regulatory developments, including announced regulatory investigations, 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.

We may not be able to collect reimbursements for our services from third-party payors in a timely manner.

A significant portion of our net patient service revenue is derived from reimbursements from various third-party payors, including government-sponsored health care plans, private insurance plans and managed care plans, for services provided by our affiliated professional contractors. We are responsible for submitting reimbursement requests to these payors and collecting the reimbursements, and we assume the financial risks relating to uncollectible and delayed reimbursements. In the current health care environment, payors continue their efforts to control expenditures for health care, including revisions to coverage and reimbursement policies. Due to the nature of our business and our

participation in government and private reimbursement programs, we are involved from time to time in inquiries, reviews, audits and investigations by governmental agencies and private payors of our business practices, including assessments of our compliance with coding, billing and documentation requirements. We may be required to repay these agencies or private payors if a finding is made that we were incorrectly reimbursed, or we may be subjected to pre-payment reviews, which can be time-consuming and result in non-

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payment or delayed payment for the services we provide. We may also experience difficulties in collecting reimbursements because third-party payors may seek to reduce or delay reimbursements to which we are entitled for services that our affiliated physicians have provided. If we are not reimbursed fully and in a timely manner for such services or there is a finding that we were incorrectly reimbursed, our revenues, cash flows and financial condition could be materially adversely affected.

Hospitals may terminate their agreements with us, our physicians may lose the ability to provide services in hospitals or administrative fees paid to us by hospitals may be reduced.

Our net patient service revenue is derived primarily from fee-for-service billings for patient care provided within hospital units by our affiliated physicians and from administrative fees paid to us by hospitals. See Item 1. Business Relationships with Our Partners Hospitals. Our hospital partners may cancel or not renew their contracts with us or they may reduce or eliminate our administrative fees in the future. To the extent that our arrangements with our hospital partners are canceled, or are not renewed or replaced with other arrangements having at least as favorable terms, our business, financial condition and results of operations could be adversely affected. In addition, to the extent our affiliated physicians lose their privileges in hospitals or hospitals enter into arrangements with other physicians, our business, financial condition, results of operations and cash flows could be materially adversely affected.

Hospitals could limit our ability to use our management information systems in our units by requiring us to use their own management information systems.

Our management information systems, including *BabySteps*® and *RDS,* are used to support our day-to-day operations and ongoing clinical research and business analysis. If a hospital prohibits us from using our own management information systems, it may interrupt the efficient operation of our information systems which, in turn, may limit our ability to operate important aspects of our business, including billing and reimbursement as well as research and education initiatives. This inability to use our management information systems at hospital locations may have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our industry is already competitive and could become more competitive.

The health care industry is highly competitive and subject to continual changes in the methods by which services are provided and the manner in which health care providers are selected and compensated. Because our operations consist primarily of physician services provided within hospital-based units, primarily NICUs, we compete with other health care services companies and physician groups for contracts with hospitals to provide our services to patients. We also face competition from hospitals themselves to provide our services. Companies in other health care industry segments, some of which have greater financial and other resources than ours, may become competitors in providing neonatal, maternal fetal and pediatric subspecialty care. We may not be able to continue to compete effectively in this industry, additional competitors may enter metropolitan areas where we operate, and this increased competition may have a material adverse effect on our business, financial condition, results of operations and cash flows.

Unfavorable changes or conditions could occur in the states where our operations are concentrated.

A majority of our net patient service revenue in 2006 was generated by our operations in five states. In particular, Texas accounted for approximately 27% of our net patient service revenue in 2006. See Item 1. Business Geographic Coverage. Adverse changes or conditions affecting these particular states, such as health care reforms, changes in laws and regulations, reduced Medicaid reimbursements and government investigations, may have a material adverse effect on our business, financial condition, results of operations and cash flows.

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 personnel, including our Chief Executive Officer, Roger J. Medel, M.D., for the management of our business and implementation of our business strategy. The loss of Dr. Medel or other key management personnel could have a material

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adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our common stock.

Our currently outstanding preferred stock purchase rights could deter takeover attempts.

We have adopted a preferred share purchase rights plan, under which each outstanding share of our common stock includes a preferred stock purchase right entitling the registered holder, subject to the terms of our rights agreement, to purchase from us a one two-thousandth of a share of our series A junior participating preferred stock at an initial exercise price of $75. If a person or group of persons acquires, or announces a tender offer or exchange offer which if consummated would result in the acquisition or beneficial ownership of 15% or more of the outstanding shares of our common stock, each right will entitle its holder (other than the person or persons acquiring 15% or more of our common stock) to purchase $150 worth of our common stock for $75. Some provisions contained in our rights agreement may have the effect of discouraging a third-party from making an acquisition proposal for Pediatrix and may thereby inhibit a change in control. For example, such provisions may deter tender offers for our shares, which offers may be attractive to shareholders, or deter purchases of large blocks of common stock, thereby limiting the opportunity for shareholders to receive a premium for their shares over the then-prevailing market prices.

Provisions of our articles and bylaws could deter takeover attempts.

Our Amended and Restated Articles of Incorporation authorize our board of directors to issue up to 1,000,000 shares of undesignated preferred stock and to determine the powers, preferences and rights of these shares without shareholder approval. This preferred stock could be issued with voting, liquidation, dividend and other rights superior to those of the holders of common stock. The issuance of preferred stock under some circumstances could have the effect of delaying, deferring or preventing a change in control. In addition, provisions in our amended and restated bylaws, including those relating to calling shareholder meetings, taking action by written consent and other matters, could render it more difficult or discourage an attempt to obtain control of Pediatrix through a proxy contest or consent solicitation. These provisions could limit the price that some investors might be willing to pay in the future for our shares of common stock.

ITEM 1B. *UNRESOLVED STAFF COMMENTS*

None.

ITEM 2. *PROPERTIES*

Our corporate office building, which we own, is located in Sunrise, Florida and contains approximately 80,000 square feet of office space. During 2006, we leased space in other facilities in various states for our business and medical offices, storage space and temporary housing of medical staff having an aggregate annual rent of approximately $10,360,000. See Note 11 in Notes to Consolidated Financial Statements in this Form 10-K, which is incorporated herein by reference. We believe that our facilities and equipment are in good condition in all material respects and sufficient for our present needs.

ITEM 3. *LEGAL PROCEEDINGS*

The information required by this Item is included in and incorporated herein by reference to Item 1. Business of this Form 10-K under Government Investigations and Other Legal Proceedings.

ITEM 4. *SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS*

No matter was submitted to a vote of security holders during the three months ended December 31, 2006.

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PART II

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

Price Range of Common Stock

Our common stock is traded on the New York Stock Exchange (the NYSE) under the symbol PDX. The high and low sales price for a share of our common stock for each quarter during our last two fiscal years is set forth below, as reported in the NYSE consolidated transaction reporting system:

	High	Low
2006		
First Quarter	$ 51.39	$ 41.10
Second Quarter	52.45	42.40
Third Quarter	48.57	37.60
Fourth Quarter	50.59	43.85
2005		
First Quarter	$ 34.77	$ 30.70
Second Quarter	38.19	32.25
Third Quarter	40.08	36.20
Fourth Quarter	45.69	36.17

As of July 20, 2007, we had approximately 190 holders of record of our common stock, and the closing sales price on that date for our common stock was $57.44 per share. We believe that the number of beneficial owners of our common stock is substantially greater than the number of record holders because a significant number of shares of our common stock is held through brokerage firms in street name.

Dividend Policy

We did not declare or pay any cash dividends on our common stock in 2006 or 2005, nor do we currently intend to declare or pay any cash dividends in the future. The payment of any future dividends will be at the discretion of our Board of Directors and will depend upon, among other things, future earnings, results of operations, capital requirements, our general financial condition, general business conditions and contractual restrictions on payment of dividends, if any, as well as such other factors as our Board of Directors may deem relevant. Our revolving line of credit restricts our ability to declare and pay cash dividends. See Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources.

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Performance Graph

The following graph compares the cumulative total shareholder return on $100 invested on December 31, 2001 in Pediatrix s common stock against the cumulative total return of the S&P 500 Index, S&P 600 Health Care Index, and the NYSE Composite Index. The returns are calculated assuming reinvestment of dividends. The graph covers the period from December 31, 2001 through December 31, 2006. The stock price performance included in the graph is not necessarily indicative of future stock price performance.

Company/Index	Base Period 2001	Years Ending 2002	2003	2004	2005	2006
Pediatrix Medical Group	$ 100.00	$ 118.10	$ 162.41	$ 188.83	$ 261.11	$ 288.33
S&P 500 Index	$ 100.00	$ 77.90	$ 100.25	$ 111.15	$ 116.61	$ 135.03
S&P 600 Health Care	$ 100.00	$ 81.56	$ 107.28	$ 131.57	$ 146.25	$ 159.02
NYSE Composite Index	$ 100.00	$ 80.17	$ 103.65	$ 116.25	$ 124.33	$ 146.54

Issuer Purchases of Equity Securities

During the three months ended December 31, 2006, we did not repurchase any shares of our securities.

Equity Compensation Plans

Information regarding equity compensation plans is set forth in Item 12 of this Form 10-K and is incorporated herein by reference.

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ITEM 6. *SELECTED FINANCIAL DATA*

The following table includes selected consolidated financial data set forth as of and for each of the five years in the period ended December 31, 2006. The balance sheet data at December 31, 2006 and the income statement data for the year ended December 31, 2006 have been derived from the audited consolidated financial statements included elsewhere in this Form 10-K. The balance sheet date at December 31, 2005 and the income statement data for the years ended December 31, 2005 and 2004 have been restated to reflect the impact of the stock-based compensation adjustments and have been derived from the restated audited financial statements included in this Form 10-K. The balance sheet data at December 31, 2004, 2003 and 2002 and the income statement data for the years ended December 31, 2003 and 2002 have been restated to reflect the impact of the stock-based compensation adjustments. This selected financial data should be read in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations, and our Consolidated Financial Statements and the related notes included in Items 7 and 8, respectively of this Form 10-K (in thousands, except per share and other operating data).

	Years Ended December 31,				
	2006	2005 As Restated(1)	2004 As Restated(1)	2003 As Restated(1)	2002 As Restated(1)
Consolidated Income Statement Data:					
Net patient service revenue(2)	$ 818,554	$ 693,700	$ 619,629	$ 551,197	$ 465,481
Operating expenses:					
Practice salaries and benefits	468,498	393,719	351,334	311,580	263,898
Practice supplies and other operating expenses(3)	33,055	27,678	24,254	18,588	15,791
General and administrative expenses(3)(4)	109,057	116,375	81,441	77,529	69,268
Depreciation and amortization	9,470	9,915	9,353	8,405	6,135
Total operating expenses	620,080	547,687	466,382	416,102	355,092
Income from operations	198,474	146,013	153,247	135,095	110,389
Investment income	3,836	1,177	893	482	818
Interest expense	(1,032)	(2,262)	(1,295)	(1,372)	(1,156)
Income before income taxes	201,278	144,928	152,845	134,205	110,051
Income tax provision	76,813	57,419	56,650	50,981	42,551
Net income	$ 124,465	$ 87,509	$ 96,195	$ 83,224	$ 67,500
Per Share Data:					
Net income per common share:					
Basic	$ 2.60	$ 1.88	$ 2.02	$ 1.75	$ 1.32

Diluted	$ 2.52	$ 1.82	$ 1.93	$ 1.69	$ 1.26
Weighted average shares used in computing net income per common share:					
Basic	47,924	46,484	47,662	47,484	51,244
Diluted	49,387	48,040	49,735	49,344	53,540

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	Years Ended December 31,				
	2006	2005 As Restated(1)	2004 As Restated(1)	2003 As Restated(1)	2002 As Restated(1)
Other Operating Data:					
Number of physicians at end of year	914	834	776	690	622
Number of births	674,336	629,948	567,794	522,612	501,832
NICU admissions	80,151	72,876	63,115	57,239	55,121
NICU patient days	1,472,428	1,347,064	1,195,936	1,087,753	983,733
Consolidated Balance Sheet Data:					
Cash and cash equivalents	$ 69,595	$ 11,192	$ 7,011	$ 27,896	$ 73,195
Working capital (deficit)	80,284	(13,034)	13,561	20,798	76,307
Total assets	1,135,170	900,403	788,889	717,594	648,679
Total liabilities	269,369	218,269	223,985	147,791	102,666
Borrowings under line of credit			54,000		
Long-term debt and capital lease obligations, including current maturities	860	1,504	1,312	1,864	2,489
Shareholders equity	865,801	682,134	564,904	569,803	546,013

(1) The periods presented include the impact of additional stock-based compensation and related tax effects made to our previously filed Consolidated Financial Statements. See Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations, and Note 3, Restatement of Consolidated Financial Statements in Notes to Consolidated Financial Statements.

(2) The Company adds new physician practices each year as a result of acquisitions. In addition, the Company acquired an independent laboratory specializing in newborn metabolic screening in May 2003. The increase in net patient service revenue related to acquisitions was approximately $45.8 million, $41.1 million, $37.6 million, $30.1 million and $69.8 million for the years ended December 31, 2006, 2005, 2004, 2003 and 2002, respectively.

(3) Effective January 1, 2006, the Company adopted Statement of Financial Accounting Standards No. 123R (FAS 123(R)) Share-Based Payment. In 2005, the Company began a program to issue restricted stock to its key employees as equity compensation. The result of these two events was a significant increase in stock-based compensation. For the years ended December 31, 2006, 2005, 2004, 2003 and 2002, the Company recorded approximately $20.1 million, $11.9 million, $3.0 million, $1.8 million and $1.7 million, respectively, in stock-based compensation.

(4) In 2005, the Company recorded a $20.9 million increase in its estimated liability reserve for the 2006 settlement of the government s national Medicaid and TRICARE investigations.

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The following table presents the financial impact of additional stock-based compensation and related tax effects not covered by the accompanying Consolidated Financial Statements. The adjustments and restated amounts related to our previously filed Consolidated Statements of Income for the years ended December 31, 2003 and 2002 are as follows (in thousands, except per share data):

	Year Ended December 31, 2003			Year Ended December 31, 2002		
	As Reported	Adjustments	As Restated(1)	As Reported	Adjustments	As Restated(1)
Net patient service revenue	$ 551,197	$	$ 551,197	$ 465,481	$	$ 465,481
Operating expenses:						
Practice salaries and benefits	310,778	802	311,580	263,165	733	263,898
Practice supplies and other operating expenses	18,588		18,588	15,791		15,791
General and administrative expenses	76,537	992	77,529	68,315	953	69,268
Depreciation and amortization	8,405		8,405	6,135		6,135
Total operating expenses	414,308	1,794	416,102	353,406	1,686	355,092
Income from operations	136,889	(1,794)	135,095	112,075	(1,686)	110,389
Investment income	482		482	818		818
Interest expense	(1,372)		(1,372)	(1,156)		(1,156)
Income before income taxes	135,999	(1,794)	134,205	111,737	(1,686)	110,051
Income tax provision	51,671	(690)	50,981	42,961	(410)	42,551
Net income	$ 84,328	$ (1,104)	$ 83,224	$ 68,776	$ (1,276)	$ 67,500
Per share data:						
Net income per common and common equivalent share:						
Basic	$ 1.78	$ (0.03)	$ 1.75	$ 1.34	$ (0.02)	$ 1.32
Diluted	$ 1.72	$ (0.03)	$ 1.69	$ 1.29	$ (0.03)	$ 1.26
Weighted average shares used in computing net income per common and common equivalent share:						
Basic	47,484		47,484	51,244		51,244
Diluted	49,154	190	49,344	53,258	282	53,540

(1) Includes adjustments resulting from the stock option review as described in Note 3, Restatement of Consolidated Financial Statements.

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

The following discussion highlights the principal factors that have affected our financial condition and results of operations as well as our liquidity and capital resources for the periods described. This discussion should be read in conjunction with our Consolidated Financial Statements and the related notes included in Item 8 of this Form 10-K. This discussion contains forward-looking statements. Please see Item 1A. Risk Factors, for a discussion of the uncertainties, risks and assumptions associated with these forward-looking statements. The operating results for the periods presented were not significantly affected by inflation.

RESTATEMENT OF CONSOLIDATED FINANCIAL STATEMENTS

In June 2006, management of the Company began an informal limited review of its past stock option grant practices in response to a shareholder inquiry following various media reports regarding option granting practices at other companies. Management apprised the Audit Committee of the Company s Board of Directors of this informal limited review and the Audit Committee provided guidance with respect to the scope of the review. In August 2006, findings from this limited review were presented to the Audit Committee and the Company s independent certified registered public accounting firm. Based on these findings, the Audit Committee decided to initiate a comprehensive review to be undertaken by the Committee with the assistance of independent legal counsel and forensic accounting experts. The review covered all stock options granted by the Company from the date of its initial public offering in September 1995 through the Company s option issuances in June 2006.

In July 2007, the Audit Committee completed its review. Based on the evidence reviewed, the Audit Committee concluded that (i) in certain instances, available documentation was insufficient to support or was inconsistent with the measurement date or exercise price which was originally assigned to the relevant stock option grant, (ii) certain stock option grants which required variable accounting were inappropriately accounted for as fixed awards and (iii) modifications to certain stock option grants were not accounted for properly. Accordingly, the Company has determined, and the Audit Committee has agreed, to restate its consolidated financial statements and therefore has recorded additional non-cash stock-based compensation expense and related tax effects with regard to these option grants.

The financial information presented in this Item 7 and related to the years ended December 31, 2005 and 2004 has been adjusted to reflect the restatement of the Company s financial results, which is more fully described in the Explanatory Note immediately preceding Part I, Item 1 and in Note 3, Restatement of Consolidated Financial Statements of the Notes to Consolidated Financial Statements in this Form 10-K.

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The following table reflects the impact of additional stock-based compensation expense adjustments and the related tax effects on our previously reported net income for the periods presented below (in thousands):

Year	Net Income As Previously Reported	Pre-Tax Stock-Based Compensation Expense Adjustments	Related Income Tax Adjustments(2)	Net Income As Restated(1)
1995	$ 6,713	$ (18)	$ 3	$ 6,698
1996	13,120	(6,546)	445	7,019
1997	20,913	(6,101)	684	15,496
1998	29,099	(5,577)	1,859	25,381
1999	25,038	(3,622)	1,103	22,519
2000	10,986	(1,549)	508	9,945
2001	30,428	(1,423)	366	29,371
2002	68,776	(1,686)	410	67,500
2003	84,328	(1,794)	690	83,224
Cumulative effect at December 31, 2003	289,401	(28,316)	6,068	267,153
2004	98,279	(2,976)	892	96,195
2005	89,037	(1,653)	125	87,509
Total	$ 476,717	$ (32,945)	$ 7,085	$ 450,857

(1) Includes adjustments resulting from the stock option review as described in Note 3, Restatement of Consolidated Financial Statements.

(2) The income tax adjustments include the impact of limitations on the deductibility of certain stock option grants and the recording of interest expense, in certain periods, relating to tax deductions previously taken which no longer qualify as deductible expenses.

OVERVIEW

Pediatrix is the nation s leading health care services company focused on physician services for newborn, maternal fetal and other pediatric subspecialty care. Our national network is comprised of approximately 914 affiliated physicians, including 724 neonatal physician subspecialists who provide clinical care in 32 states and Puerto Rico, primarily within hospital-based NICUs, to babies born prematurely or with medical complications. Our affiliated neonatal physician subspecialists staff and manage clinical activities at more than 289 hospitals, and our 80 affiliated maternal fetal medicine subspecialists provide care to expectant mothers experiencing complicated pregnancies in many areas where our affiliated neonatal physicians practice. Our network includes other pediatric subspecialists, including 58 pediatric cardiologists, 36 pediatric intensivists and 16 pediatric hospitalists. In addition, we believe that we are the nation s largest provider of hearing screens to newborns and the nation s largest private provider of metabolic screening services to newborns.

In September 2006, we finalized the Federal Settlement Agreement to settle the federal government s national Medicaid and TRICARE investigation and claims made by a *qui tam* relator. Under the terms of the Federal Settlement Agreement, we paid the federal government $25.1 million related to neonatal services provided from January 1996 through December 1999 of which $9.5 million was transferred to an escrow agent for distribution to participating Medicaid states. We also received certain releases from the federal government and the *qui tam* relator. In addition, we entered into separate State Settlement Agreements with each state Medicaid program involved in the settlement and received releases from these programs.

On April 4, 2006, we announced that our Board of Directors authorized a two-for-one stock split of the Company s common stock. Shareholders of record at the close of business on April 13, 2006 received one additional share of Pediatrix common stock for each share held of record on that date. The shares were issued on April 27, 2006. All share and per share amounts presented in this Form 10-K reflect the effect of the two-for-one stock split.

Effective January 1, 2006, we adopted Statement of Financial Accounting Standards No. 123(R) (FAS 123(R)) Share-Based Payment. This statement requires us to expense stock-based awards to our

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employees using a fair-value-based measurement method. Our results of operations for the year ended December 31, 2006 include stock-based compensation expense related to stock options and restricted stock awarded under our stock incentive plans (the Stock Incentive Plans) and employee stock purchases under our stock purchase plans (the Stock Purchase Plans) in accordance with FAS 123(R). For the years ended December 31, 2005 and 2004, we recorded stock-based compensation expense using the intrinsic value method prescribed by Accounting Principles Board Opinion No. 25, Accounting for Stock Issued to Employees and its related interpretations (APB 25) for stock options determined to have been issued at grant prices below market value on the measurement date and in 2005 for restricted stock first awarded on July 14, 2005.

During 2006, we acquired eight physician group practices, consisting of four neonatal practices and four pediatric cardiology practices. Also during 2006, we announced plans to explore opportunities within other hospital-based physician specialties with an initial focus on anesthesia services. While we have not yet made any definitive plans to acquire any anesthesiology practices, we believe that there are opportunities to apply our administrative expertise to this practice area. We expect to continue our evaluation of this practice area as a business opportunity during 2007.

Geographic Coverage and Payor Mix

During 2006, 2005 and 2004, approximately 55%, 58% and 59%, respectively, of our net patient service revenue was generated by operations in our five largest states, Arizona, California, Florida, Texas and Washington. Over those same periods, our operations in Texas accounted for approximately 27%, 29% and 28% of our net patient service revenue. Although we continue to seek to diversify the geographic scope of our operations, primarily through acquisitions of physician group practices, we may not be able to implement successfully or realize the expected benefits of any of these initiatives. Adverse changes or conditions affecting states in which our operations are concentrated, such as health care reforms, changes in laws and regulations, reduced Medicaid reimbursements or government investigations, may have a material adverse effect on our business, financial condition, results of operations and cash flows.

We bill payors for professional services provided by our affiliated physicians to our patients based upon rates for specific services provided. Our billed charges are substantially the same for all parties in a particular geographic area regardless of the party responsible for paying the bill for our services. We determine our net patient service revenue based upon the difference between our gross fees for services and our estimated ultimate collections from payors. Net patient service revenue differs from gross fees due to (i) Medicaid reimbursements at government-established rates, (ii) managed care payments at contracted rates, (iii) various reimbursement plans and negotiated reimbursements from other third-parties and (iv) discounted and uncollectible accounts of private-pay patients.

Our payor mix is comprised of government (principally Medicaid), contracted managed care, other third-parties and private-pay patients. We benefit from the fact that most of the medical services provided in the NICU are classified as emergency services, a category typically classified as a covered service by managed care payors. In addition, we benefit when patients are covered by Medicaid, despite Medicaid s lower reimbursement rates as compared with other payors, because typically these patients would not otherwise be able to pay for services due to lack of insurance coverage.

The following is a summary of our payor mix, expressed as a percentage of net patient service revenue, exclusive of administrative fees, for the periods indicated:

	Years Ended December 31,		
	2006	2005	2004

Government	26%	27%	27%
Contracted managed care	61%	59%	60%
Other third-parties	12%	13%	12%
Private-pay patients	1%	1%	1%
	100%	100%	100%

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The payor mix shown above is not necessarily representative of the amount of services provided to patients covered under these plans. For example, services provided to patients covered under government programs for the years ended December 31, 2006, 2005 and 2004 represented 54%, 54% and 52% of our total gross patient service revenue but only 26%, 27% and 27% of our net patient service revenue, respectively.

The increase in the government component of our gross patient service revenue payor mix from 2004 is the result of an increase in the number of patients enrolled in government-sponsored programs. Payments received from government-sponsored programs are substantially less than payments received from managed care and other third-party payors. A payor mix shift from managed care and other third-party payors to government payors results in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net patient service revenue. Further increases in the government component of our payor mix at the expense of other third-party payors could result in a significant reduction in our average reimbursement rates, and in the absence of increased patient volume or improved reimbursement from contracted managed care or other third-parties, could have a material adverse effect on our business, financial condition and results of operations. See Item 1A. Risk Factors Government programs or private insurers may limit, reduce or make retroactive adjustments to reimbursement amounts or rates.

Quarterly Results

We have historically experienced and expect to continue to experience quarterly fluctuations in net patient service revenue and net income. These fluctuations are primarily due to the following factors:

A significant number of our employees and our associated professional contractors, primarily physicians, exceed the level of taxable wages for social security during the first and second quarters of the year. As a result, we incur a significantly higher payroll tax burden and our net income is lower during those quarters.

There is a lower number of calendar days in the first and second quarters of the year as compared to the remainder of the year. Because we provide services in NICUs on a 24-hour basis, 365 days a year, any reduction in service days will have a corresponding reduction in net patient service revenue.

We have significant fixed operating costs, including physician costs, and, as a result, are highly dependent on patient volume and capacity utilization of our affiliated professional contractors to sustain profitability. Additionally, quarterly results may be impacted by the timing of acquisitions and fluctuations in patient volume. As a result, the operating results for any quarter are not necessarily indicative of results for any future period or for the full year. Our quarterly results are presented in further detail in Note 17 to the Consolidated Financial Statements in this Form 10-K.

Application of Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires estimates and assumptions that affect the reporting of assets, liabilities, revenues and expenses, and the disclosure of contingent assets and liabilities. Note 2 to our Consolidated Financial Statements provides a summary of our significant accounting policies, which are all in accordance with generally accepted accounting policies in the United States. Certain of our accounting policies are critical to understanding our Consolidated Financial Statements because their application requires management to make assumptions about future results and depends to a large extent on management s judgment, because past results have fluctuated and are expected to continue to do so in the future.

We believe that the application of the accounting policies described in the following paragraphs are highly dependent on critical estimates and assumptions that are inherently uncertain and highly susceptible to change. For all of these policies, we caution that future events rarely develop exactly as estimated, and the best estimates routinely require

adjustment. On an ongoing basis, we evaluate our estimates and assumptions, including those discussed below.

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Revenue Recognition

We recognize patient service revenue at the time services are provided by our affiliated physicians. Almost all of our patient service revenue is reimbursed by state Medicaid programs and third-party insurance payors. Payments for services rendered to our patients are generally less than billed charges. We monitor our revenue and receivables from these sources and record an estimated contractual allowance to properly account for the anticipated differences between billed and reimbursed amounts. Accordingly, patient service revenue is presented net of an estimated provision for contractual adjustments and uncollectibles. Management estimates allowances for contractual adjustments and uncollectibles on accounts receivable based upon historical experience and other factors, including days sales outstanding (DSO) for accounts receivable, evaluation of expected adjustments and delinquency rates, past adjustments and collection experience in relation to amounts billed, an aging of accounts receivable, current contract and reimbursement terms, changes in payor mix and other relevant information. Contractual adjustments result from the difference between the physician rates for services performed and the reimbursements by government-sponsored health care programs and insurance companies for such services. The evaluation of these historical and other factors involves complex, subjective judgments. We believe that evaluating DSO is a key factor in evaluating the condition of our accounts receivable and the related allowances for contractual adjustments and uncollectibles. We calculate our DSO using a three-month rolling average of net patient service revenue. As of December 31, 2006, our DSO was 54.7 days and we had approximately $391.7 million in gross accounts receivable outstanding. Considering the outstanding balance, a one percentage point change in our estimated collection rate would result in an impact to net patient service revenue of approximately $3.9 million. Our net patient service revenue, net income and operating cash flows, may be materially and adversely affected if actual adjustments and uncollectibles exceed management s estimated provisions as a result of changes in these factors. In addition, we are subject to audits of our billing by Medicaid and other third-party payors (see Government Investigations and Note 11 to our Consolidated Financial Statements in this Form 10-K).

Stock Incentive Plans

We grant stock-based awards consisting of restricted stock and stock options to key employees under our Stock Incentive Plans. As permitted under Statement of Financial Accounting Standard No. 123, Accounting for Stock-Based Compensation, we accounted for stock-based compensation to employees using the intrinsic value method prescribed by APB 25 through December 31, 2005. Effective January 1, 2006, the accounting treatment for our stock-based awards was significantly impacted by the implementation of FAS 123(R). Under FAS 123(R), we recognize the grant-date fair value of stock-based awards made to employees as compensation expense in our Consolidated Financial Statements. As prescribed under FAS 123(R), we estimate the grant-date fair value of our stock option grants using a valuation model known as the Black-Scholes-Merton formula or the Black-Scholes Model and allocate the resulting compensation expense over the corresponding requisite service period associated with each grant. The Black-Scholes Model requires the use of several variables to estimate the grant-date fair value of stock options including expected term, expected volatility, expected dividends and risk-free interest rate. We perform significant analyses to calculate and select the appropriate variable assumptions used in the Black-Scholes Model.

We also perform significant analyses to estimate forfeitures of stock-based awards as required by FAS 123(R). We are required to adjust our forfeiture estimates on at least an annual basis based on the number of share-based awards that ultimately vest. The selection of assumptions and estimated forfeiture rates is subject to significant judgment and future changes to our assumptions and estimates may have a material impact on our Consolidated Financial Statements.

Professional Liability Coverage

We maintain professional liability insurance policies with third-party insurers on a claims-made basis, subject to self-insured retention, exclusions and other restrictions. Our self-insured retention under our professional liability insurance program is maintained through a wholly owned captive insurance subsidiary. We record liabilities for self-insured amounts and claims incurred but not reported based on an actuarial valuation using historical loss patterns. An inherent assumption in such estimates is that historical loss patterns can be used to predict future patterns with reasonable accuracy. Because many factors can affect historical and future loss patterns,

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the determination of an appropriate reserve involves complex, subjective judgment, and actual results may vary significantly from estimates. Insurance liabilities are necessarily based on estimates including claim frequency and severity. Liabilities for claims incurred but not reported are not discounted.

Goodwill

We record acquired assets, including identifiable intangible assets, and liabilities at their respective fair values, recording to goodwill the excess of cost over the fair value of the net assets acquired. In accordance with the provisions of Statement of Financial Accounting Standards, No. 142 (FAS 142), Goodwill and Other Intangible Assets, no goodwill amortization was recorded for the years ended December 31, 2006, 2005 and 2004. See Note 2 to our Consolidated Financial Statements in this Form 10-K.

We test goodwill for impairment at a reporting unit level on an annual basis. We define a reporting unit as a specific region of the United States based on our management structure. The testing for impairment is completed using a two-step test. The first step compares the fair value of a reporting unit with its carrying amount, including goodwill. If the carrying amount of a reporting unit exceeds its fair value, a second step is performed to determine the amount of any impairment loss. We use income and market-based valuation approaches to determine the fair value of our reporting units. These approaches focus on discounted cash flows and market multiples to derive the fair value of a reporting unit. We also consider the economic outlook for the healthcare services industry and various other factors during the testing process, including hospital and physician contract changes, local market developments, changes in third-party payor payments, and other publicly available information.

Other Matters

Other significant accounting policies, not involving the same level of measurement uncertainties as those discussed above, are nevertheless important to an understanding of our Consolidated Financial Statements. For example, our Consolidated Financial Statements are presented on a consolidated basis with our affiliated professional contractors because we or one of our subsidiaries have entered into management agreements with our affiliated professional contractors meeting the criteria set forth in the Emerging Issues Task Force Issue 97-2 for a controlling financial interest. Our management agreements are further described in Note 2 to our Consolidated Financial Statements in this Form 10-K. The policies described in Note 2 often require difficult judgments on complex matters that are often subject to multiple sources of authoritative guidance and are frequently reexamined by accounting standards setters and regulators. See New Accounting Pronouncements for matters that may impact our accounting policies in the future.

Government Investigations

As described in the Explanatory Note immediately preceding Part I, Item 1, and in Note 3, Restatement of Consolidated Financial Statements in Notes to Consolidated Financial Statements in this Form 10-K, the Audit Committee of our Board of Directors conducted a comprehensive review of the Company s historical practices related to the granting of stock options with the assistance of independent legal counsel and forensic accounting experts. We voluntarily contacted the staff of the SEC regarding the Audit Committee s review and subsequently the SEC notified us that it had commenced a formal investigation into our stock option practices. We have also had discussions with the U.S. Attorney s office for the Southern District of Florida regarding the Audit Committee s review. Based on these discussions, we believe that the U.S. Attorney s office may make a request for various documents and information related to the review and our stock option granting practices. We intend to continue full cooperation with the U.S. Attorney s office and the SEC. We cannot predict the outcome of these matters.

In November 2006, we were notified that the FTC closed its investigation of our acquisition of Magella and our business practices generally with a finding that no further action is warranted. See Government Regulation Antitrust.

Beginning in April 1999, we received requests from various federal and state investigators for information relating to our billing practices for services reimbursed by Medicaid, and the United States Department of Defense s TRICARE program for military dependents and retirees. From 1999 through 2002, a number of the individual state investigations were resolved through agreements to refund certain overpayments and reimburse certain costs to the

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states. In June 2003, we were advised by a United States Attorney s Office that it was conducting a civil investigation with respect to our Medicaid billing practices nationwide. The federal Medicaid investigation was initiated as a result of a complaint filed under seal by a third party, known as qui tam or whistleblower complaint, under the FCA which permits private individuals to bring confidential actions on behalf of the government. Beginning in late 2003, the federal Medicaid investigation, the TRICARE investigation, and related state inquiries were coordinated together.

In February 2006, we announced that we had reached an agreement in principle on the amount of a financial settlement with federal and state authorities that would resolve the Medicaid, TRICARE and state billing investigations, subject to, among other things, completion and approval of final settlement agreements, including a corporate integrity agreement with the OIG. In September 2006, we announced that we had completed the Federal Settlement Agreement with the DOJ and the relator who initiated the qui tam complaint. In February 2007, we announced that we had completed separate State Settlement Agreements with each state Medicaid program involved in the settlement. Under the terms of the Federal Settlement Agreement and State Settlement Agreements, the Company paid the federal government $25.1 million related to neonatal services provided from January 1996 through December 1999, of which $9.5 million was transferred to an escrow agent for distribution to each Medicaid-participating state that entered into a State Settlement Agreement with us.

As part of the Federal Settlement Agreement, we entered into a five-year Corporate Integrity Agreement with the OIG. The Corporate Integrity Agreement acknowledges the existence of our comprehensive Compliance Plan, which provides for policies and procedures aimed at ensuring our adherence with FHC Program requirements and requires, among other things, our maintenance of the Compliance Plan for the term of the Corporate Integrity Agreement. See Government Investigations. Failure to comply with our duties under the Corporate Integrity Agreement could result in substantial monetary penalties and in the case of a material breach, could even exclude us from participating in FHC Programs. We believe that we were in compliance with the Corporate Integrity Agreement as of December 31, 2006.

We expect that additional audits, inquiries and investigations from government authorities and agencies will continue to occur in the ordinary course of business. Such audits, inquiries and investigations and their ultimate resolutions, individually or in the aggregate, could have a material adverse effect on our business, financial condition, results of operations, cash flows or the trading price of our common stock.

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RESULTS OF OPERATIONS

The following table sets forth, for the periods indicated, certain information related to our operations expressed as a percentage of our net patient service revenue (patient billings net of contractual adjustments and uncollectibles, and including administrative fees):

	Years Ended December 31,		
	2006	2005 As Restated (1)	2004 As Restated(1)
Net patient service revenue	100.0%	100.0%	100.0%
Operating expenses:			
Practice salaries and benefits	57.2	56.8	56.7
Practice supplies and other operating expenses	4.0	4.0	3.9
General and administrative expenses	13.3	16.8	13.1
Depreciation and amortization	1.2	1.4	1.5
Total operating expenses	75.7	79.0	75.2
Income from operations	24.3	21.0	24.8
Other income (expense), net	.3	(.1)	(.1)
Income before income taxes	24.6	20.9	24.7
Income tax provision	9.4	8.3	9.1
Net income	15.2%	12.6%	15.6%

(1) Includes adjustments resulting from the stock option review as described in Note 3, Restatement of Consolidated Financial Statements.

Year Ended December 31, 2006 as Compared to Year Ended December 31, 2005

Our net patient service revenue increased $124.9 million, or 18.0%, to $818.6 million for the year ended December 31, 2006, as compared to $693.7 million in 2005. Of this $124.9 million increase, $45.8 million, or 36.7%, was primarily attributable to revenue generated from acquisitions completed during 2006 and 2005. Same-unit net patient service revenue increased $79.1 million, or 11.9%, for the year ended December 31, 2006. The change in same-unit net patient service revenue was primarily the result of a net increase in revenue of approximately $46.2 million related to pricing and reimbursement factors and increased revenue of $32.9 million from higher patient service volumes across our subspecialties. The net increase in revenue of $46.2 million related to pricing and reimbursement factors is due to improved reimbursement for our services as result of a new billing code introduced by the American Medical Association early in the first quarter of 2006, improved managed care contracting and the flow through of revenue from modest price increases. Increased revenue of $32.9 million from higher patient service volumes includes $16.8 million from a 3.6% increase in neonatal intensive care unit patient days and $16.1 million from volume growth in maternal fetal, pediatric cardiology, metabolic screening and other services, including hearing

screens and newborn nursery services. Same-units are those units at which we provided services for the entire current period and the entire comparable period.

Practice salaries and benefits increased $74.8 million, or 19.0%, to $468.5 million for the year ended December 31, 2006, as compared to $393.7 million in 2005. The increase was primarily attributable to: (i) costs associated with new physicians and other staff of $42.3 million to support acquisition-related growth and volume growth at existing units; (ii) an increase in incentive compensation of $30.5 million as a result of same-unit growth and operational improvements at the physician practice level; and (iii) an increase in stock-based compensation of $2.0 million related to our equity compensation plans (Stock Incentive Plans) and employee stock purchase plans (Stock Purchase Plans).

Practice supplies and other operating expenses increased $5.4 million, or 19.4%, to $33.1 million for the year ended December 31, 2006, as compared to $27.7 million in 2005. The increase was attributable to: (i) medical and

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office supply costs of approximately $1.7 million related to physician practices acquired during 2006 and 2005 and volume growth at existing office-based practices; (ii) rent and other maintenance costs of approximately $1.5 million primarily related to office-based practices acquired during 2006 and 2005; (iii) professional fees of approximately $1.2 million primarily associated with physician practices acquired during 2006 and 2005; and (iv) travel, meeting and other costs of approximately $1.0 million.

General and administrative expenses include all salaries, benefits, supplies and operating expenses not specifically related to the day-to-day operations of our physician group practices, including billing and collections functions. General and administrative expenses decreased $7.3 million, or 6.3%, to $109.1 million for the year ended December 31, 2006, as compared to $116.4 million in 2005. This $7.3 million net decrease is primarily attributable to: (i) the $20.9 million liability reserve recorded during the comparable 2005 period relating to the settlement of our national Medicaid and TRICARE investigation; (ii) an increase in stock-based compensation of $6.3 million related to our Stock Incentive Plans and Stock Purchase Plans; (iii) a $4.8 million increase in professional fees related to the review of our stock option practices; (iv) a $4.1 million increase in salaries and benefits and other general and administrative expenses due to the continued growth of the Company; and (v) a decrease in general and administrative expenses associated with a $1.6 million gain on sale of the Company s aircraft in June 2006.

Depreciation and amortization expense decreased by $445,000, or 4.5%, to $9.5 million for the year ended December 31, 2006, as compared to $9.9 million in 2005. This decrease was primarily attributable to the completion of amortization of certain intangibles during the year ended December 31, 2006.

Income from operations increased $52.5 million, or 35.9%, to $198.5 million for the year ended December 31, 2006, as compared to $146.0 million in 2005. Our operating margin increased to 24.3% for the year ended December 31, 2006, as compared to 21.0% for the same period in 2005. The net increase in our operating margin was primarily due to: (i) the $20.9 million estimated liability reserve we recorded during the comparable 2005 period; (ii) an improvement in operating margin related to improved management of general and administrative expenses; and (iii) an improvement in operating margin related to the $1.6 million gain on sale of the Company s aircraft in June 2006. These improvements were offset by an increase in stock-based compensation of $8.3 million related to our Stock Incentive Plans and Stock Purchase Plans; and (iv) costs of $4.8 million related to the review of our stock option practices.

We recorded net investment income of $2.8 million for the year ended December 31, 2006, as compared to net interest expense of $1.1 million in 2005. The increase in net investment income is due to an increase in funds available to invest and a higher return on outstanding investment balances combined with a lower average outstanding balance on our Line of Credit for the year ended December 31, 2006 as compared to the prior year. Interest expense for the year ended December 31, 2006 and 2005 consisted of interest charges, commitment fees and amortized debt costs associated with our revolving credit facility (Line of Credit) and interest charges associated with an aircraft operating lease.

Our effective income tax rates were 38.16% and 39.62% for the years ended December 31, 2006 and 2005, respectively. Our effective income tax rate of 39.62% for the year ended December 31, 2005 was higher than our 2006 rate of 38.16% primarily due to the non-deductibility of approximately $7.9 million of our estimated reserve recorded in 2005 related to the settlement of our national Medicaid and TRICARE investigation. We anticipate that our effective tax rate for 2007 will increase as a result of our adoption in 2007 of Interpretation No. 48, Accounting for Uncertainty in Income Taxes an Interpretation of FASB Statement No. 109 (FIN 48) and the establishment of new taxes in the State of Texas. In addition, our effective tax rate may be impacted by the recognition of certain tax benefits as a result of statute of limitations expiring on certain filed tax returns.

Net income increased to $124.5 million for the year ended December 31, 2006, as compared to $87.5 million for the same period in 2005. Net income for the year ended December 31, 2006 reflects the after-tax impact of both an increase in stock-based compensation expense and professional fees related to the review of our stock option practices offset by the after-tax impact of the gain on sale of the Company s aircraft. Net income for the year ended December 31, 2005 reflects the $16.1 million after-tax impact of the estimated liability reserve we recorded relating to the settlement of our national Medicaid and TRICARE investigation.

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Diluted net income per share was $2.52 on weighted average shares of 49.4 million for the year ended December 31, 2006, as compared to $1.82 on weighted average shares of 48.0 million in 2005. Diluted net income per share of $2.52 for the year ended December 31, 2006 includes the after-tax impact of increased stock-based compensation expense, the after-tax impact of increased professional fees related to the review of our stock option practices, and the after-tax impact of the gain on sale of the Company s aircraft. Diluted net income per share of $1.82 for the year ended December 31, 2005 includes the after-tax impact of the adjustment related to the settlement of our national Medicaid and TRICARE investigation. The net increase in weighted average shares outstanding was primarily due to the exercise of employee stock options, the impact of restricted stock awards, and the issuance of shares under our Stock Purchase Plans partially offset by shares repurchased during the fourth quarter of 2005.

Year Ended December 31, 2005 as Compared to Year Ended December 31, 2004

Our net patient service revenue increased $74.1 million, or 12.0%, to $693.7 million for the year ended December 31, 2005, as compared to $619.6 million in 2004. Of this $74.1 million increase, $41.1 million, or 55.5%, was primarily attributable to revenue generated from acquisitions completed during 2004 and 2005. Same-unit net patient service revenue increased $33.0 million, or 5.6%, for the year ended December 31, 2005. The change in same-unit net patient service revenue was primarily the result of: (i) increased revenue of approximately $16.8 million from a 4.0% increase in neonatal intensive care unit patient days; (ii) increased revenue of approximately $15.0 million from volume growth in pediatric cardiology services, maternal fetal services, metabolic screening services and other services, including hearing screens and newborn nursery services provided by existing practices; (iii) increased revenue of approximately $2.8 million related to greater hospital contract administrative fees due to expanded services in existing practices; and (iv) a net decrease in revenue of approximately $1.6 million due to a decline in revenue caused by a greater percentage of our patients being enrolled in government-sponsored programs partially offset by improved managed care contracting and the flow through of revenue from annual price increases. Payments received from government-sponsored programs are substantially less than payments received from commercial insurance payors for equivalent services. This shift in our payor mix resulted in an increase in our estimated provision for contractual adjustments and uncollectibles for the year ended December 31, 2005 as compared to the same period in 2004. Same-units are those units at which we provided services for the entire current period and the entire comparable period.

Practice salaries and benefits increased $42.4 million, or 12.1%, to $393.7 million for the year ended December 31, 2005, as compared to $351.3 million in 2004. The increase was primarily attributable to: (i) costs associated with new physicians and other staff of $36.3 million to support acquisition related growth and volume growth at existing units; (ii) an increase in incentive compensation of $4.3 million as a result of same-unit growth and operational improvements at the physician practice level; and (iii) an increase in stock-based compensation of $1.8 million.

Practice supplies and other operating expenses increased $3.4 million, or 14.1%, to $27.7 million for the year ended December 31, 2005, as compared with $24.3 million in 2004. The increase was attributable to: (i) professional services of approximately $1.3 million primarily related to new physician practices; (ii) rent and other maintenance costs of approximately $1.0 million related to practices acquired during 2005 and 2004; (iii) laboratory and other supply costs of approximately $540,000 related to the growth of our metabolic screening laboratory and our acquisition of office-based cardiology and maternal fetal practices during 2005 and 2004; and (iv) insurance and other costs of approximately $530,000.

General and administrative expenses include all salaries, benefits, supplies and operating expenses not specifically related to the day-to-day operations of our physician group practices, including billing and collections functions. General and administrative expenses increased $35.0 million, or 42.9%, to $116.4 million for the year ended December 31, 2005, as compared to $81.4 million in 2004. This $35.0 million increase is primarily attributable to: (i) a $20.9 million increase in our estimated liability reserve as a result of the financial settlement relating to our

national Medicaid and TRICARE investigation; (ii) an increase in stock-based compensation of $7.1 million related to equity awards made to key corporate administrative employees; and (iii) a $7.0 million increase in salaries and benefits and other general and administrative expenses associated with the continued growth of the Company. As a percentage of revenue, general and administrative expenses were 16.8% for the year ended December 31, 2005, as compared to 13.1% for the same period in 2004. The net increase in our general and

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administrative expenses as a percentage of revenue of 3.6 percentage points is due to the $20.9 million increase in our estimated liability reserve for the national Medicaid and TRICARE i