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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