MEDNAX, INC.
Form 10-K
February 09, 2015
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2014

¨ **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

MEDNAX, INC.

(Exact name of registrant as specified in its charter)

FLORIDA	**26-3667538**
(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)**

Registrant s telephone number, including area code (954) 384-0175

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: None

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

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 ¨ No x

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

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

Indicate by check mark 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. x

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

Large accelerated filer x Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨

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

The aggregate market value of shares of Common Stock of the registrant held by non-affiliates of the registrant on June 30, 2014, the last business day of the registrant s most recently completed second fiscal quarter, was approximately $5,710,786,536 based on a $58.15 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 January 30, 2015 was 96,083,342.

DOCUMENTS INCORPORATED BY REFERENCE:

The registrant s definitive proxy statement to be filed with the Securities and Exchange Commission pursuant to Regulation 14A, with respect to the 2015 Annual Meeting of Shareholders is incorporated by reference in Part III of this Form 10-K to the extent stated herein. Except with respect to information specifically incorporated by reference in the Form 10-K, each document incorporated by reference herein is deemed not to be filed as part hereof.

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MEDNAX, INC.

ANNUAL REPORT ON FORM 10-K

For the Year Ended December 31, 2014

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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 which 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. These statements are often characterized by terminology such as believe, hope, may, anticipate, should, intend, plan, will, expect, esti positioned, 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 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.

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As used in this Form 10-K, unless the context otherwise requires, the terms MEDNAX, the Company, we, us and our refer to the parent company, MEDNAX, Inc., a Florida corporation, and the consolidated subsidiaries through which its businesses are actually conducted (collectively, MDX), together with MDX s affiliated business corporations or professional associations, professional corporations, limited liability companies and partnerships (affiliated professional contractors). Certain subsidiaries of MDX have contracts with our affiliated professional contractors, which are separate legal entities that provide physician services in certain states and Puerto Rico. All share and per share data set forth herein give effect to the two-for-one split of our common stock that became effective on December 19, 2013.

PART I

ITEM 1. BUSINESS

OVERVIEW

MEDNAX is a leading provider of physician services including newborn, anesthesia, maternal-fetal and other pediatric subspecialty care. At December 31, 2014, our national network comprised over 2,625 affiliated physicians, including approximately 1,080 physicians who provide neonatal clinical care, in 34 states and Puerto Rico, primarily within hospital-based neonatal intensive care units (NICUs), to babies born prematurely or with medical complications. We have over 950 affiliated physicians who provide anesthesia care to patients in connection with surgical and other procedures, as well as pain management. We have over 245 affiliated physicians who provide maternal-fetal care to expectant mothers experiencing complicated pregnancies and obstetrical hospitalist services in many areas where our affiliated neonatal physicians practice. Our network also includes other pediatric subspecialists, including approximately 125 physicians providing pediatric intensive care, 115 physicians providing pediatric cardiology care, 90 physicians providing hospital-based pediatric care and 20 physicians providing pediatric surgical care.

In addition to our national physician network, during 2014 we added two complementary businesses that offer services to medical providers, including ours, consisting of a revenue cycle management company and a consulting services company. We expect that the development of our service offerings will function as support for our own physician practices as well as a revenue generating outsourced services capability.

MEDNAX, Inc. was incorporated in Florida in 2007 and is the successor to Pediatrix Medical Group, Inc., which 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 PHYSICIAN SPECIALTIES AND SERVICES

The following discussion describes our physician specialties and the care that we provide:

Neonatal Care

We provide clinical care to babies born prematurely or with complications within specific units at hospitals, primarily NICUs, through our network of approximately 1,080 affiliated neonatal physician subspecialists (neonatologists), neonatal nurse practitioners and other pediatric clinicians who staff and manage clinical activities at more than 370 NICUs in 34 states and Puerto Rico. Neonatologists are board-certified, or eligible-to-apply-for-certification, physicians 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 assessing and treating the healthcare needs of newborns and infants as well as managing the needs of their families.

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, including both not-for-profit and

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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 in NICUs, support the local referring physician community and are available for consultation in other hospital departments. Our hospital partners benefit from our experience in managing complex intensive care units. 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 the care of mothers experiencing complicated pregnancies and their fetuses.

Anesthesia and Anesthesia Subspecialty Care

We provide anesthesia care at more than 90 hospitals, 100 ambulatory surgery centers and office-based practices with over 950 of our affiliated anesthesiologists. Following the care team model, our anesthesiologists work with both practice and hospital-employed certified registered nurse anesthetists (CRNAs), anesthesiologist assistants (AAs) and other clinicians to provide high quality, cost efficient and service-oriented anesthesia care to our patients. Our anesthesiologists are board-certified, or eligible-to-apply-for-certification, physicians who are responsible for administering anesthesia to relieve pain and for managing vital life functions, including breathing, heart rhythm and blood pressure, during surgery.

As an integral part of the surgical team, our anesthesiologists support the surgeons by providing medical care before, during and after surgery so that surgeons may concentrate on the surgical procedure. Our anesthesiologists provide this care by evaluating the patient and consulting with the surgical team before surgery, providing pain control and support of life functions during surgery, supervising care after surgery by maintaining the patient in a comfortable state during recovery and discharging the patient from the post-anesthesia care unit. They also support other departments within the hospital such as labor and delivery, imaging and the hospital s emergency room. In addition to their board certification in anesthesiology, many of our anesthesiologists have completed fellowships in subspecialties such as obstetrical, critical care, cardiac and pediatric anesthesia.

Pain Management

We also provide acute and chronic pain management services in over 20 pain management centers through our network of physicians and physician assistants. Our physicians are board-certified in anesthesiology or neurology and board-certified, or eligible-to-apply-for-certification, in pain medicine. This advanced training and education expands treatment options available for both acute and chronic pain sufferers. The physicians develop treatment plans specific to the patients individual needs that include interventional techniques such as trigger point and facet injections, pain pumps, nerve stimulators, radiofrequency ablation and catheters, as well as medication management.

Maternal-Fetal Care

We provide inpatient and office-based clinical care to expectant mothers and their unborn babies through our over 245 affiliated maternal-fetal medicine subspecialists as well as obstetricians and other clinicians, such as maternal-fetal nurse practitioners, 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 primarily in metropolitan areas where we have affiliated neonatologists to provide coordinated care for women with complicated pregnancies whose babies are often admitted to a 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

We provide inpatient and office-based pediatric cardiology care of the fetus, infant, child, and adolescent patient with congenital heart defects and acquired heart disease, as well as adults with congenital heart defects

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through our approximately 115 affiliated pediatric cardiologist subspecialists and other related clinical professionals such as pediatric nurse practitioners, echocardiographers and other diagnostic technicians, and exercise physiologists. Pediatric cardiologists are board-certified, or eligible-to-apply for certification, pediatricians who have additional education and training in congenital heart defects and pediatric acquired heart disorders.

We provide specialized cardiac care to the fetus, neonatal and 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. Our affiliated pediatric cardiologists work collaboratively with neonatologists and maternal-fetal medicine subspecialists to provide a coordinated continuum of care.

Other Pediatric Subspecialty Care

Our network includes other pediatric subspecialists such as pediatric intensivists, pediatric hospitalists and pediatric surgeons. In addition, our affiliated physicians seek to provide support services in other areas of hospitals, particularly in the pediatric emergency room, labor and delivery area, and nursery and pediatric departments, where immediate accessibility to specialized care may be critical.

Pediatric Intensive Care. Pediatric intensivists are hospital-based pediatricians with additional education and training in caring for critically ill or injured children and adolescents. We have approximately 125 affiliated physicians who provide this clinical care. They staff and manage pediatric intensive care units (PICUs) at over 40 hospitals.

Pediatric Hospitalists. Pediatric hospitalists are hospital-based pediatricians specializing in inpatient care and management of acutely ill children. We have over 90 affiliated hospital-based physicians who provide inpatient pediatric and newborn care as well as provide care in PICUs, NICUs and pediatric emergency rooms at more than 25 hospitals.

Pediatric Surgery. Pediatric surgeons provide specialized care for patients ranging from newborns to adolescents, for all problems or conditions that require surgical intervention, and often have particular expertise in the areas of neonatal, prenatal, trauma, and pediatric oncology. We have approximately 20 affiliated physicians in this subspecialty including pediatric urologists, pediatric plastic and craniofacial surgeons and general and thoracic pediatric surgeons. Areas of particular expertise include management of neonatal and congenital anomalies, prenatal counseling, trauma management, pediatric oncology, gastrointestinal surgery, as well as common pediatric surgical conditions.

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 consists 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.

Newborn Hearing Screening Program. Our affiliated physicians also oversee our newborn hearing screening program. Since we launched this program in 1994, we believe that we have become the largest provider of newborn hearing screening services in the United States. In 2014, we screened over 750,000 babies for potential hearing loss at more than 370 hospitals across the nation. 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. We contract or coordinate with hospitals to provide newborn hearing screening services.

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Clinical Research and Quality

As part of our ongoing commitment to improving patient care through evidence-based medicine, we also 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. Our physician-centric approach to clinical research and continuous quality improvement initiatives has demonstrated improvements in outcomes, while at the same time reducing the costs associated with complications as well as variability in protocols. We believe that referring and collaborating physicians, hospitals, third-party payors and patients all benefit from our clinical research, education and quality initiatives.

Demand for Our Services

Neonatal Medicine. Of the approximately four million births in the United States annually, we estimate that approximately 13% require NICU admission. Numerous institutions conduct research to identify potential causes of premature birth and medical complications that often require NICU admission. 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 neonatologist. Babies who are born prematurely or have a low birth weight often require neonatal intensive care services because of an 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, such as our affiliated professional contractors, to staff and manage these units. As a result, NICUs within the United States tend to be concentrated in hospitals with higher volumes of births. There are approximately 5,000 board-certified neonatologists in the United States.

Anesthesia Medicine. An estimated 46 million inpatient procedures and 35 million ambulatory procedures are performed annually in the United States. Anesthesiologists generally provide or participate in the administration of anesthetics in these procedures. According to the U.S. Census Bureau, the U.S. population continues to expand and the fastest-growing segment of the population consists of individuals over the age of 65. The growth in population and, in particular the age 65 or greater segment, has resulted in an increase in demand for surgical services and a correlating increase in demand for anesthesia services. The growth of ambulatory surgical centers and expansion of office-based procedures has also contributed to the demand for anesthesia services. There are approximately 47,000 anesthesiologists in the United States.

Pain Management. According to the American Academy of Pain Medicine, more than 76 million people suffer from pain and 15% of those who suffer from pain will consult with a pain specialist. As the population ages, we believe that the number of people suffering from acute or chronic pain will continue to increase. Lifestyle also plays an important part in the demand for pain management services. We believe that the combination of the growing population of people who suffer from pain, the lifestyle expectations of this population and the ability for patients to seek out a pain specialist without having to be referred by a physician will increase the demand for pain management services.

Maternal-Fetal Medicine. Expectant mothers with pregnancy complications often seek or are referred by their obstetricians to maternal-fetal medicine subspecialists. These subspecialists provide inpatient and office-based care to women with conditions such as diabetes, heart disease, hypertension, 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 demonstrates 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. There are approximately 1,900 board-certified maternal-fetal medicine subspecialists in the United States.

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Other Pediatric Subspecialty Medicine. Other areas of pediatric subspecialty medicine are closely associated with maternal-fetal-newborn medical care. For example, pediatric intensivists are subspecialists who care for critically ill or injured children and adolescents in PICUs. There are approximately 1,600 board-certified pediatric intensivists in the United States. As another example, pediatric hospitalists are pediatricians who provide care in many hospital areas, including labor and delivery and the newborn nursery. In addition, pediatric surgeons provide specialized care for patients ranging from newborns to adolescents, for all problems or conditions affecting children that require surgical intervention, and often have particular expertise in the areas of neonatal, prenatal, trauma, and pediatric oncology. There are approximately 800 board-certified pediatric surgeons in the United States.

Pediatric Cardiology Medicine. Pediatric cardiologists provide inpatient and office-based cardiology care of the fetus, infant, child, and adolescent with congenital heart defects and acquired heart disease, as well as providing care to adults with congenital heart defects. We estimate that approximately one in every 120 babies is born with some form of heart defect. With advancements in care, there are approximately one million adults in the United States today living with congenital heart disease. There are approximately 2,100 board-certified pediatric cardiologists in the United States.

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 and collaborating physicians and third-party payors. In an effort to improve outcomes and manage costs, hospitals typically employ or contract with physician specialists to provide specialized care in many hospital-based units or settings. Hospitals traditionally staff these units or settings through affiliations with local physician groups or independent practitioners. However, management of these units and settings presents significant operational challenges, including variable admissions rates, increased operating costs, complex reimbursement systems and other administrative burdens. As a result, some hospitals choose to 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 and settings in the current healthcare environment. Demand for hospital-based physician services, including neonatology and anesthesiology, is determined by a national market in which qualified physicians with advanced training compete for hospital contracts.

Practice Administration. Administrative demands and cost containment pressures from a number of sources, principally commercial and government payors, make it increasingly difficult for physicians to effectively manage patient care, remain current on the latest procedures and efficiently administer non-clinical activities. As a result, we believe that physicians 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, 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 applicable laws, rules and regulations.

Our Business Strategy

Our business objective is to enhance our position as a leading provider of physician services. The key elements of our strategy to achieve this objective are:

Build upon core competencies. We have developed significant administrative expertise relating to neonatal, anesthesia, maternal-fetal and other pediatric subspecialty services. We have also facilitated the development of a clinical approach to the practice of medicine among our affiliated physicians

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through a clinical data warehouse that includes research, education and quality initiatives intended to advance the practice of neonatology, maternal-fetal, pediatric cardiology medicine and pediatric intensive care, improve the quality of care provided to acutely ill newborns and expectant mothers with pregnancy complications and reduce long-term health system costs. We also have a clinical data warehouse that is being implemented across our anesthesiology practices through which we are collecting patient information throughout the continuum of care. This program allows us to provide feedback to our physicians and hospital partners and to develop and implement best practices, all with the goal of improving outcomes, creating perioperative efficiencies and ensuring patient satisfaction across our anesthesiology practices. As healthcare organizations are expected to increasingly be held accountable for the quality and cost of the care they provide, we believe that our ability to capture this data within our clinical data warehouse adds value to our hospital and physician partners.

Promote same-unit and organic growth. We seek opportunities for increasing revenue from our hospital- and office-based operations. For example, our affiliated hospital-based neonatal, maternal-fetal and other pediatric physicians are well situated to, and, in some cases, provide physician services in other departments, such as pediatric emergency rooms, newborn nurseries, or in situations where immediate accessibility to specialized obstetric and pediatric care may be critical. Our hospital-based and office-based physicians continue to pursue an organic growth strategy that involves working with our hospital partners to develop integrated service programs for which we become a provider of solutions across the maternal-fetal, newborn, pediatric continuum of care. An integrated program results in a broader offering of care across our specialties and permits the extension of our service lines in our markets. We are successfully executing this organic growth strategy and market partnership in many metropolitan areas and intend to continue this growth initiative in the future. In addition, we market our capabilities to obstetricians, pediatricians and family physicians to attract referrals to our hospital-based units and our office-based practices. We also market the services of our affiliated physicians to other hospitals to attract maternal, neonatal and pediatric transport admissions. In addition, we may pursue new contractual arrangements with hospitals, including possibly through joint ventures, either where we currently provide or do not currently provide physician services. We are developing similar opportunities with our affiliated anesthesiologists.

We continue to expand our services in telemedicine, which is the use of telecommunication and information technology in order to provide clinical health care at a distance. Many pediatric subspecialties as well as maternal-fetal medicine, will benefit in the future from having a robust platform in telemedicine. Telemedicine services are well documented as high quality, safe and efficient means of expanding physician services into metropolitan and rural communities. We have begun to expand our services to provide these remote programs to our hospital partners. These programs enhance the standing of our hospital partners while creating another portal of entry of pediatric patients to our inpatient service lines.

Additionally, with the goal of further expanding our organic growth strategy, we are in the process of creating and developing a national sales team to pursue opportunities across our service lines. This sales team will work with existing hospital partners and will also focus on building new relationships with hospitals in which we do not currently provide services in order to offer clinical solutions and respond to requests for proposals. The ultimate goal is for MEDNAX to be viewed by hospitals and other partners as a multi-specialty solutions provider across all of our service lines.

Acquire physician practice groups. We continue to seek to expand our operations by acquiring established physician practices in our specialties which include neonatology, anesthesiology, maternal-fetal medicine and pediatric cardiology. We also pursue complementary pediatric subspecialty physician groups, such as pediatric intensivists, pediatric hospitalists and pediatric surgeons. In addition, both independently and in collaboration with our hospital partners, we are actively pursuing expansion into additional pediatric surgery subspecialties in order to meet the needs of our hospital partners. These include groups with expertise in pediatric ear nose and throat, pediatric orthopedics and neurosurgery as well as newborn congenital heart disease. During 2014, we added 11 physician groups

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to our national network through acquisitions consisting of eight anesthesiology practices, one neonatology practice, one maternal-fetal medicine practice and one pediatric cardiology practice.

Acquire complementary service businesses. In addition to our national physician network, during 2014 we added two complementary businesses that offer services to medical providers, including ours, consisting of a revenue cycle management company and a consulting services company. We expect that the development of our service offerings will function as support for our own physician practices as well as a revenue generating outsourced service capability. We will pursue additional opportunities in order to expand our service offerings to address the evolving needs of our hospital partners and other customers.

Strengthen and broaden relationships with our partners. By managing many of the operational challenges associated with physician practices, encouraging clinical research, education and quality initiatives, and promoting timely intervention by our physicians, we believe that our business model is focused on improving the quality of care delivered to patients, promoting the appropriate length of their hospital stays and optimizing efficient use of health system resources. We believe that referring and collaborating physicians, hospitals, third-party payors and patients all benefit to the extent that we are successful in implementing our business model. In addition, we will continue to concentrate efforts in becoming more responsive and proactive in broadening our existing hospital relationships to expand the scope of services that we provide across all specialties. We believe this will be critical as hospitals and health systems seek to expand their service offerings and as the broader healthcare market seeks new solutions to operate more efficiently.

CLINICAL RESEARCH, EDUCATION AND QUALITY

As part of our patient focus and ongoing commitment to improving patient care through evidenced-based medicine, we engage in clinical research, continuous quality improvement and education initiatives. We discover, understand and teach healthcare practices that enhance the abilities of clinicians to deliver quality care, thereby contributing to better patient outcomes and reduced long-term health system costs. Our investment in these initiatives benefits our patients, clinicians, referring and collaborating physicians, hospital partners and third-party payors. We believe that these initiatives help us, among other things, to enhance the value of our services, attract new and retain existing clinicians, improve clinical operations and enhance practice communication.

Clinical Research. We conduct clinical research to discover ways to improve clinical care for our patients. We share our discoveries throughout the medical community through submissions to peer-reviewed literature. Recent research activity includes:

In neonatal medicine, we published our analysis of the data collected during one of the largest trials ever reported in neonatal nutrition, entitled *Gestational Age and Age at Sampling Influence Metabolic Profiles in Premature Infants.* This trial enrolled nearly 1,000 patients and demonstrated the complexity of evaluating metabolic profiles during the weeks following a premature birth. Additional papers are being prepared from this complex study that will have a substantial impact upon approaches to neonatal nutrition. A second trial, entitled *Etiologies of NICU Deaths,* which examined the causes of mortality in the NICU, has been accepted for publication in early 2015. This study demonstrated the areas of NICU and pre-NICU care that may be best amenable to quality improvement initiatives to reduce mortality. Several manuscripts produced with data extracted from our clinical data warehouse are also currently in press or in review and examine such diverse areas as the use of inhaled nitric oxide in the NICU and the growing national admission numbers of babies with neonatal abstinence syndrome as a result of the exposure to addictive opiate drugs while in the mother s womb. Additional prospective trials are currently being carried out by our neonatology group.

In maternal-fetal medicine, our affiliated physicians published their study on *Noninvasive Prenatal Screening For Fetal Trisomies 21, 18, And 13 And The Common Sex Aneuploides From*

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Maternal Blood Using Massively Parallel Genomic Sequencing Of DNA. This trial represents one of the first large trials to evaluate this important new technological approach to non-invasive fetal diagnosis. In addition, we reported the results of a trial entitled *Removal Versus Retention of Cerclage in Preterm Premature Rupture of Membranes: a Randomized Controlled Trial*. This study was an important evaluation of optimal management of mothers who required a cerclage in this clinical situation. Additional maternal-fetal medicine trials are currently underway.

Our pediatric cardiology research continues to rapidly develop. Our groups are currently evaluating the role of newborn screening for congenital cardiac disease in collaboration with many of our neonatology practices. This study will enroll approximately 6,000 infants and will be completed during 2015. In addition, a study that examines the relationship between long QTc Syndrome and hearing loss is underway. Many of our pediatric cardiology practices are involved in a variety of important collaborative research studies as part of both regional and national projects.

We also continue to publish research based on data from our clinical information systems, our clinical trials, and from our individual practice efforts. In 2014, more than 90 peer-reviewed papers were published as a result of this research addressing many different areas of neonatal, maternal-fetal, and pediatric cardiology care. Our clinical data warehouse has also remained a major reference source at a national level, and continued to be highlighted and cited in several publications, as well as in numerous national forums and presentations during 2014. Our clinical data warehouse now has accumulated clinical information from more than 1,050,000 infants and more than 19 million patient days and is frequently used in collaboration with universities and government agencies.

In anesthesiology, we both conduct and support clinical research across a spectrum of clinical efficacy, quality, therapeutic and device investigations, all with the goal of bringing better care to our patients. Our findings are shared throughout the medical community through the peer-reviewed literature, presentation at national medical meetings and through educational venues. Our anesthesiology practices are currently engaged in more than 40 clinical trials in a variety of specialty areas across six states. These range from anesthesia investigator initiated to quality/hospital database inquiry to industry-sponsored trials. Additionally, one of our clinicians is a co-investigator on a large multi-site study to investigate chronic pain syndromes after traumatic orthopedic injuries. We use our quality initiative tool, Quantum, to assess quality metrics and provide feedback to our clinicians. This database currently has over 750,000 audited patient encounters that enable us to illustrate and investigate best practices in anesthesia care in community based healthcare systems. Publications utilizing data from Quantum are in submission, and clinical trial results are now being accepted for publication. In 2014, there were approximately 10 publications with more data under review for publication. In addition, multiple presentations were given at national, regional and local meetings. We continue to establish ourselves to be attractive to clinical trials sponsorship, given our rich patient base and our pool of physician investigators.

Continuous Quality Improvement. As part of our dedication to improving quality across our affiliated practices, we provide our clinicians with powerful information resources. Our physicians have access to accumulated data and robust software tools that enable them to compare their practices to our national practice network across a variety of activity and outcome metrics. From these comparisons, our physicians can identify areas for improvement, and then systematically monitor, study, learn and implement change. We believe that our initiatives in continuous quality improvement have contributed to better patient care. One of our efforts in neonatal care has been dedicated to the role of antibiotic utilization in the NICU. This effort has dramatically altered antibiotic practice in our NICUs, resulting in an approximately 15% reduction in exposure to antibiotics in our NICU patients. Discussions are currently underway with two of the country s leading children s hospitals to apply for a grant to further evaluate antibiotic stewardship in the NICU. Our 100,000 Babies Campaign, that has been underway

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since 2009 has produced significant improvements in outcomes, and a major manuscript is being prepared that reports the results of this program. Continuous quality improvement initiatives are important for all of our physician specialties. For example, in anesthesia care, through our quality initiative tool, we measure more than 80 performance, quality, outcome, and patient satisfaction metrics. Our performance metrics, including efficiency and timeliness are crucial in improving the patient experience of care, optimizing the use of healthcare resources and controlling healthcare costs. An example is the decrease in post-anesthesia care unit length of stay due to the use of a protocol designed to significantly decrease nausea and vomiting after anesthesia. Our quality metrics are analyzed to include standard clinical outcome reporting, trend analysis and threshold performance, all of which are provided to our individual physicians. The quality committees and medical directors of the practices manage quality improvement programs and drive best practices that are adapted to the needs of the local care setting. Patient satisfaction is measured in the postoperative period to assess overall satisfaction, specific outcomes of anesthetic procedures and to understand the patient perception of quality of care.

Continuing Medical Education. We also make extensive physician continuing medical education and continuing nursing education resources available to our affiliated clinicians in an effort to ensure that they have access to current treatment methodologies. As an accredited provider for clinicians, we offer live continuing medical education through what we believe is one of the premier conferences in neonatal medicine *NEO: The Conference for Neonatology*. In 2014, we also held our *Specialty Review in Neonatology* course, which provides a broad review of the entire subspecialty of neonatal medicine. These two meetings, each held annually, had more than 1,100 attendees in 2014. In addition to live educational opportunities, we also offer online education through Pediatrix University A University Without Walls®, an interactive educational website, which we continue to enhance with live presentations that are recorded at our various in person conferences. In anesthesiology, ongoing medical education is crucial to our clinicians in order for them to stay abreast of the latest techniques, procedures, therapies and devices used in the perioperative period and to drive evidence-based best practices, guidelines, checklists and protocols. We accomplish this through a variety of formats including web-based and traditional meeting-based medical education. Our meeting-based medical education focuses on medical knowledge but also provides an opportunity for clinical skills workshops. Simulation has become increasing important to support a variety of efforts including critical event scenarios, teamwork practice and maintenance of certification in anesthesia.

Patient Safety Organization. We have established a federally listed Patient Safety Organization (PSO), the mission of which is to improve the quality and safety of care rendered by our clinical providers through the collection and analysis of quality data. As a federally listed PSO, our mission to improve the safety of care rendered is supported by the dissemination of best practices information and implementation of patient safety programs. Our primary program is our unique, multidisciplinary *high reliability organization training* (HRO) program, with the overarching goal of creating a culture of safety and establishing an expectation of accountability. The program was initially designed for the perioperative environment, and we are currently evaluating the adaption of this program to our multiple clinical settings including intensive care unit and outpatient medicine. Our HRO program trains clinicians through onsite assessment and coaching, leadership training and safety tool development. Our clinicians also use the patient safety culture assessment tools sponsored by the Agency for Healthcare Research and Quality. Further, our surgical and nursing colleagues participate in our HRO program, both as team members and to provide feedback on our performance. To date, we have made quantifiable safety improvements in teamwork, communication and the use of safety tools such as checklists and protocols. Further, we have developed a real time near miss reporting phone application that has facilitated systemic improvements in our hospital and ambulatory care settings with our partners.

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

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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. A senior physician practicing medicine in each NICU, anesthesia, PICU, maternal-fetal, pediatric cardiology and other subspecialty practice that we manage acts as the medical director for that unit or practice. Each medical director is responsible for the overall management of his or her unit or practice, including staffing and scheduling, quality of care, professional discipline, utilization review, coordinating physician recruitment and monitoring of the financial success within the unit or practice. Medical directors also serve as a liaison with hospital administration, other physicians and the community.

Staffing and Scheduling. We assist with staffing and scheduling physicians and advanced practice nurses within the units and practices that we manage. For example, each NICU is staffed by at least one specialist on site or available on call. For our affiliated anesthesia physicians, CRNAs and AAs, we employ an operational system that assists with their staffing and scheduling. We are responsible for managing and coordinating the process for the salaries and benefits paid and provided to our affiliated physicians and practitioners. 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 physicians. We maintain an extensive nationwide database of maternal-fetal, neonatal and other pediatric subspecialty physicians and are continuing to develop such a database for anesthesiologists. Our medical directors and physician leaders play a central role in the recruiting and interviewing process before candidates are introduced to other practice group physicians and hospital administrators. We verify 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 with third-party payors on behalf of all of our affiliated physicians. We are responsible for billing, collection and reimbursement for services rendered by our affiliated physicians. In all instances, however, we do not assume responsibility for charges relating to services provided by hospitals or other physicians with whom we collaborate. Such charges are separately billed and collected by the hospitals or other physicians. We provide our affiliated physicians with a training curriculum that emphasizes detailed documentation of and proper coding protocols 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 revenue for physician services. Generally, our billing and collection operations are conducted from our business offices located across the United States and in Puerto Rico, as well as our corporate offices.

Risk Management. We maintain a risk management program focused on reducing risk, including the identification and communication of potential risk areas to our medical affairs staff. We maintain professional liability coverage for our national group of affiliated healthcare 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.

Compliance. We provide a multi-faceted compliance program that is designed to assist our affiliated practice groups in complying with the increasingly complex laws, rules and regulations that govern the provision of health care services.

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

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OUR INFORMATION SYSTEMS

We maintain several information systems that support our day-to-day operations, ongoing clinical research and business analysis. Since inception, our clinical information systems have accumulated clinical information from more than 19 million daily progress records relating to over 1,050,000 discharged patients.

BabySteps®. BabySteps is an electronic health record 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.

Clinical Data Warehouse. BabySteps enables our affiliated practices to capture a consistent set of information about the patients we treat. We transfer information from our electronic health records in BabySteps to what we call our clinical data warehouse. With comprehensive reporting tools, our physicians are able to use this information to benchmark outcomes, enhance clinical decision-making and advance best practices at the bedside. Using a variety of clinical performance markers, a de-identified version of the data warehouse also helps us track drug interactions, link treatments to outcomes and identify opportunities to enhance patient outcomes. Our clinical data warehouse also helps us to identify prospective clinical trials and continuous quality improvement initiatives.

Quantum. Quantum Clinical Navigation Systems (Quantum) is the quality metric acquisition and database tool that is being implemented throughout our anesthesiology physician practices. Quantum collects patient level data in real time through the continuum of care. Quantifiable metrics assess patient satisfaction, efficiency, physician performance and quality indicators. The data is then stored, analyzed and reported to physicians and hospitals. Our clinicians use the data, along with evidence-based medicine, to develop and implement best practices and standard operating procedures, for educational programs and for providing quality metrics to our hospital partners, all with the goal of improving outcomes and efficiency and ensuring patient satisfaction.

Nextgen®. We have licensed the Nextgen Electronic Medical Record (EMR) and Electronic Patient Management (EPM) system for our office-based physicians to record clinical documentation related to their patients and manage the revenue cycle for our office-based practices. This system has the ability to provide benefits to our office-based practices that are similar to what BabySteps provides 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 continuing the process of implementing EMR and EPM in all of our office-based maternal-fetal and pediatric cardiology practices. The version of our Nextgen system currently being used has been certified as a Complete Electronic Health Record system by CCHIT, in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services that support the Stage 1 meaningful use measures required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act (ARRA).

Pediatrix University® and American Anesthesiology University. In addition to providing continuing education, our web-based education platforms also function as important educational adjuncts to our physician groups, providing a rich source of ongoing medical education for our physicians.

Our management information systems are also an integral element of the billing and reimbursement process. We maintain systems that provide for electronic data interchange with payors that accept electronic submissions, 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 provide scalability and flexibility as payor groups upgrade their payment and reimbursement systems. We continually seek improvements to our systems to expedite the overall process, streamline information gathering from our clinical systems and improve efficiencies in the reimbursement 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

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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 a 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 and collaborating physicians, affiliated physicians and, most importantly, our patients.

Hospitals

Our relationships with our hospital partners are critical to our operations. We have been retained by over 450 hospitals to staff and manage clinical activities within specific hospital-based units and other departments. Our affiliated physicians are important components of obstetric, pediatric and surgical services provided at hospitals. 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. For example, our physicians may provide care in emergency rooms, nurseries, intensive care units and other departments where access to specialized obstetric, pediatric and anesthesia care may be critical. Because hospitals control access to their units and operating rooms through the awarding of contracts and hospital privileges, we must maintain good relationships with our hospital partners. Our hospital partners benefit from our expertise in managing critical care units and other settings 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 services to referring physicians within the communities served by those hospitals. In addition, our affiliated physicians work with our hospital partners to develop integrated services programs for solutions within the services we provide. Integrated programs provide our hospital partners and us with incremental growth and result in a broader spectrum of care across our specialties and permit us to extend our patient service lines into our existing markets. Our relationships with our hospital partners are continually evolving with the goal of being viewed by them as a solutions provider across all of our specialties.

Under our contracts with hospitals, we have the responsibility to manage, in many cases exclusively, the provision of physician services for hospital-based units, such as NICUs, and other hospital settings. 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 or other physicians to the same payors. Some of our hospital contracts require hospitals to pay us administrative fees. Some contracts provide for 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 7% of our net revenue during 2014. Some of our contracts with hospitals 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 terminated early 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 or funded healthcare programs (the GHC Programs), including Medicare and Medicaid, and with managed care organizations and commercial health insurance payors

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are vital to our business. We seek to maintain professional working relationships with our third-party payors, streamline the administrative process of billing and collection, and assist our patients and their families in understanding their health insurance coverage and any balances due for co-payments, co-insurance, deductibles or 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, but the payments we receive vary widely among payors. A significant portion of our net revenue is received from GHC Programs, principally state Medicaid programs.

Medicaid programs, which are jointly funded by the federal government and state governments, pay for medical and health-related services for certain individuals and families with low incomes and resources. 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 fee-for-service Medicaid programs are established by state governments and are not negotiated. Although Medicaid rates vary across the states, these rates are generally much lower in comparison to private-sector health plan rates. Rates under Medicaid managed care programs typically are negotiated, but are also much lower in comparison to private-sector health plan rates.

The Centers for Medicare & Medicaid Services (CMS) adopted a rule under the Patient Protection and Affordable Care Act (the ACA) that generally allowed physicians who provided eligible primary care services to be paid at the Medicare reimbursement rates in effect in calendar years 2013 and 2014, or if greater, the rates that would have been applicable in those years calculated using the 2009 Medicare conversion factor, instead of state-established Medicaid reimbursement rates. Generally, state Medicaid reimbursement rates are also lower than federally-established Medicare rates. Absent legislative action by Congress, federal funding for the enhanced Medicaid payments will no longer be available for dates of service beyond December 31, 2014. Advocacy efforts continue by various parties at both the federal and state level working with legislators to continue this program, but to date, only a limited number of states have committed to either extend this program, at least in part, for a limited period of time or increase their base Medicaid rates. The ACA also allows states to expand their Medicaid programs through federal payments that fund most of the cost of increasing the Medicaid eligibility income limit from a state s historical eligibility levels to 133% of the federal poverty level. To date, however, 20 states have expressed their intent not to expand Medicaid eligibility to cover this low income patient population. However, several states are exploring the opportunity to expand Medicaid eligibility in a manner that is different than set forth under the ACA. All of the states in which we operate, however, already cover children in the first year of life and pregnant women if their household income is at or below 133% of the federal poverty level. See Item 1A. Risk Factors State budgetary constraints could have an adverse effect on our reimbursement from Medicaid programs and The ACA may have a significant effect on our business.

Medicare is a health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities and people with end-stage renal disease. The program is available without regard to income or assets (with means-tested premiums for beneficiaries with relatively high incomes) and offers beneficiaries different ways to obtain their medical benefits. The most common option selected today by Medicare beneficiaries is the traditional fee-for-service payment system. The other options include managed care, preferred provider organizations, private fee-for-service and specialty plans. Medicare compensation rates are generally much lower in comparison to private-sector health plans. Because we provide anesthesia services to a wide array of patients, including Medicare beneficiaries, a portion of our patients services are reimbursed by Medicare.

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In order to participate in government programs, we and our affiliated practices must comply with stringent and often complex standards, including enrollment and reimbursement requirements. Different states also impose varying 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 Employee Retirement Income Security Act (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. Subject to applicable laws, rules 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 addition, these contracts generally give commercial payors the right to audit our billings and related reimbursements for professional and other services provided by or through 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 federal and state laws regulating such billing. 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 are based on the specific facts and circumstances related to each individual patient account.

Referring and Collaborating Physicians

Our relationships with our referring and collaborating physicians are critical to our success. Our affiliated physicians seek to establish and maintain professional relationships with referring physicians in the communities where they practice. Because patient volumes in 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.

Our affiliated anesthesiologists seek to establish and maintain professional relationships with collaborating physicians, such as surgeons, and other healthcare providers. Our affiliated anesthesiologists play an important role for surgeons because they provide medical care to the patient throughout the surgical experience. This care includes evaluation of the patient prior to surgery, consultations with the surgical team, providing pain control and support of life functions during surgery and supervising care following surgery through the discharge of the patient from the recovery unit. Accordingly, our affiliated anesthesiologists are focused on delivering quality services to enhance the reputation and satisfaction of collaborating surgeons.

Affiliated Physicians and Practice Groups

Our relationships with our affiliated physicians are important. Our affiliated physicians are organized in traditional practice group structures. In accordance with applicable state laws, our affiliated practice groups are

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responsible for the provision of medical care to patients. Our affiliated practice groups are separate legal entities organized under state law as business corporations or professional associations, professional corporations, limited liability companies 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 the Company through employment or another contractual relationship. Our national infrastructure enables more effective and efficient sharing of new discoveries and clinical outcomes data, including best demonstrated processes, access to our sophisticated information systems, clinical research and education.

Our business corporations and 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 typically having a term of three to five years. We are typically responsible for billing patients and third-party payors for services rendered by our affiliated physicians and, with respect to services provided in a hospital, 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 during employment and 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 in any particular case. 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 a subsidiary of MEDNAX, Inc. as the manager. These agreements are long-term in nature, and in most cases permanent, subject only to a right of termination by the manager (except in the case of gross negligence, fraud or illegal acts of the manager). Under the terms of these management agreements, and subject to state laws and other regulations, the manager is typically paid for its services based on the performance of the applicable practice group. See 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 anesthesia care, differs significantly from competition for our office-based practices. Our hospital-based practices compete nationally with other health services companies and physician groups for hospital contracts and qualified physicians. In some instances, our hospital-based physicians also compete on a regional or local basis. For example, our neonatologists compete for referrals from local 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, we compete with others for contracts with hospitals to provide services. We also compete with hospitals themselves to provide such services. Hospitals may employ neonatologists or anesthesiologists 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 begin to do so by opening a new NICU or operating facility, expanding the capacity of an existing NICU, adding operating room suites or, in the case of neonatal services, upgrading the level of its existing NICU. If the hospital chooses to do so, it may award the contract to operate the relevant facility to a competing group or company. Because hospitals control access to their NICUs and operating rooms by awarding

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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 healthcare industry is highly competitive. Companies in other segments of the industry as well as healthcare-focused and other private equity firms, some of which have financial and other resources greater than ours, may become competitors in providing neonatal, anesthesia, maternal-fetal and other pediatric subspecialty care.

GOVERNMENT REGULATION

The healthcare 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 or service businesses is found to have violated these laws, rules or regulations, our business, financial condition and results of operations could be materially, adversely affected. Moreover, the ACA contains numerous provisions that are reshaping the United States healthcare delivery system, and healthcare reform continues to attract significant legislative interest, legal challenges, regulatory activity, new approaches and public attention that create uncertainty and the potential for additional changes. Healthcare reform implementation, additional legislation or regulations, and other changes in government policy or regulation may affect our reimbursement, 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, cash flows and the trading price of our common stock. See Item 1A. Risk Factors The ACA may have a significant effect on our business.

Licensing and Certification

Each state imposes licensing requirements on individual physicians and clinical professionals, and on facilities operated or utilized by healthcare companies like us. Many states require regulatory approval, including certificates of need, before establishing certain types of healthcare facilities, offering certain services or expending amounts in excess of statutory thresholds for healthcare equipment, facilities or programs. We and our affiliated physicians are also required to meet applicable Medicare provider requirements under federal laws, rules and regulations and Medicaid provider requirements under state laws, rules and regulations.

Fee Splitting; Corporate Practice of Medicine

Many states have laws that prohibit business corporations, such as MEDNAX, 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 through our subsidiaries with affiliated professional contractors, which employ or contract with physicians to provide physician professional services. Under these arrangements, our manager subsidiaries perform only non-medical administrative services, do not represent that they offer medical services and do not exercise influence or control over the practice of medicine by the physicians employed by the affiliated professional contractors. In states where fee splitting with a business corporation or manager is prohibited, the fees that are received from the affiliated professional contractors have been established on a basis that we believe complies with applicable laws. Although the relevant laws in these states have been subject 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 or our manager subsidiaries are engaged in the corporate practice of medicine or that the contractual arrangements with the affiliated professional contractors constitute unlawful fee splitting, in which case we could be subject to administrative, civil or criminal remedies or penalties, the contracts could be found to be legally invalid and unenforceable, in whole or in part, or we could be required to restructure our contractual arrangements with our affiliated professional contractors.

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Fraud and Abuse Provisions

Existing federal laws, as well as similar state laws, governing Medicare, Medicaid and other GHC Programs, impose a variety of fraud and abuse prohibitions on healthcare companies like us. 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 Department of Justice (the DOJ) and various state agencies. In addition, in the Deficit Reduction Act of 2005, Congress established a Medicaid Integrity Program to enhance federal and state efforts to detect Medicaid fraud, waste and abuse and to provide financial incentives for states to enact their own false claims legislation as an additional enforcement tool against Medicaid fraud and abuse. Since then, a growing number of states have enacted or expanded healthcare fraud and abuse laws.

The fraud and abuse provisions include extensive federal and state laws, rules and regulations applicable to our financial relationships with hospitals, referring physicians and other healthcare entities. In particular, the federal anti-kickback statute has criminal provisions relating to the offer, payment, solicitation or receipt of any remuneration in return for either referring Medicare, Medicaid or other GHC Program business, or purchasing, leasing, ordering, or arranging for or recommending any service or item for which payment may be made by GHC Programs. In addition, the federal physician self-referral law, commonly known as the Stark Law, applies to physician ordering of certain designated health services reimbursable by Medicare from an entity with which the physician has a prohibited financial relationship. These laws are broadly worded and have been broadly interpreted by federal courts and agencies, and potentially subject many healthcare business arrangements to government investigation, enforcement and prosecution, which can be costly and time consuming.

Violations of these laws are punishable by substantial penalties and other remedies, including monetary fines, civil penalties, administrative remedies, criminal sanctions (in the case of the anti-kickback statute), exclusion from participation in GHC Programs and forfeiture of amounts collected in violation of such laws. 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 submitting false or fraudulent claims for reimbursement to government healthcare programs. These laws include the civil False Claims Act (FCA), which prohibits the submission of, or causing to be submitted, false claims to GHC Programs, including Medicare, Medicaid, TRICARE (the program for military dependents and retirees), the Federal Employees Health Benefits Program, and insurance plans purchased through the ACA insurance exchanges. Substantial civil fines and multiple damages, along with other remedies, 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 submitted or caused to be submitted an allegedly false claim acted in reckless disregard or in deliberate ignorance of the truth or falsity of the claim or with willful disregard, notwithstanding that there may have been no specific intent to defraud the government program and no actual knowledge that the claim was false (which typically are required to be shown to sustain a criminal conviction). The FCA also applies to the improper retention of identified overpayments and includes whistleblower provisions that permit private citizens to sue a claimant on behalf of the government and thereby share in the amounts recovered under the law and to receive additional remedies. In recent years, many cases have been brought against healthcare companies by such whistleblowers, which have resulted in judgments or, more often, settlements involving substantial payments to the government by the companies involved. It is anticipated that the number of such actions against healthcare companies will continue to increase with the enactment or enhancement of a growing number of state false claims acts, certain amendments to the FCA and enhanced government enforcement.

In addition, federal and state agencies that administer healthcare programs have at their disposal statutes, commonly known as civil money penalty laws, that authorize substantial administrative fines, along with legal

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and regulatory provisions that can lead to exclusion from participation in government programs in cases where an individual or company that filed a false claim, or caused a false claim to be filed, or 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 and remedies.

The civil and administrative false claims statutes are being applied in a broad range of circumstances. For example, government authorities have asserted 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, now with support in the FCA, 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. Many of the laws and regulations referenced above can be used in conjunction with each other.

If we or our affiliated professional contractors were excluded from participation in any GHC 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. It could also adversely affect our or our affiliated professional contractors ability to contract with, or to obtain payment from, non-governmental payors.

Although we intend to conduct our business in compliance with all applicable federal and state fraud and abuse laws, many of the laws, rules 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 alleged or found to violate applicable fraud and abuse laws. Moreover, the standards of business conduct expected of healthcare companies under these laws and regulations have become more stringent in recent years, even in instances where there has been no change in statutory or regulatory language. If there is a determination by government authorities that we have not complied with any of these laws, rules and regulations, our business, financial condition and results of operations could be materially, adversely affected. See Government Investigations.

Government Reimbursement Requirements

In order to participate in the Medicare program and in the various state Medicaid programs, we and our affiliated physician practices must comply with stringent and often complex enrollment and reimbursement requirements. Moreover, different states impose varying standards for their Medicaid programs. While our compliance program requires that we and our affiliated physician practices adhere to the laws, rules and regulations applicable to the government programs in which we participate, our failure to comply with these laws, rules and regulations could negatively affect our business, financial condition and results of operations. See Government Regulation Fraud and Abuse Provisions, Government Regulation Compliance Program, Government Investigations and Other Legal Proceedings, and Item 1A. Risk Factors Government-funded programs or private insurers may limit, reduce or make retroactive adjustments to reimbursement amounts or rates, We may become subject to billing investigations by federal and state government authorities and The healthcare industry is highly regulated, and government authorities may determine that we have failed to comply with applicable laws, rules or regulations.

In addition, GHC Programs 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 reimbursement on a fee-schedule basis rather than on a charge-related basis, we generally cannot increase our revenue through increases in the amount we charge for our services. To the extent our costs increase, we may not

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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 Medicare and 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 healthcare costs associated with Medicare, 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.

Antitrust

The healthcare industry is subject to close antitrust scrutiny. The Federal Trade Commission (the FTC), the DOJ and state Attorneys General all actively review and, in some cases, take enforcement action against business conduct and acquisitions in the healthcare industry. Violations of antitrust laws may be 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.

HIPAA and Other Privacy Laws

Numerous federal and state laws, rules and regulations govern the collection, dissemination, use, security and confidentiality of personal information. For example, the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and its implementing regulations governs the use, disclosure and security of protected health information (PHI) and violations of HIPAA are punishable by monetary fines, civil penalties and, in some cases, criminal sanctions. As part of our business operations, including in connection with medical record keeping, third-party billing, research and other services, we and our affiliated physician practices collect and maintain PHI regarding patients, which subjects us to compliance with HIPAA requirements.

Pursuant to HIPAA, the U.S. Department of Health and Human Services (HHS) has adopted privacy regulations, known as the privacy rule, to govern the uses and disclosures of PHI (the Privacy Rule). The Privacy Rule applies to PHI in any form, whether electronic, paper or oral, that is created, received, maintained or transmitted by healthcare providers, hospitals, health plans and healthcare clearinghouses, which are known as Covered Entities. We have implemented privacy policies and procedures, including training programs, designed to comply with the requirements set forth in the Privacy Rule.

HHS has also adopted data security regulations (the Security Rules) that require healthcare providers to implement administrative, physical and technical safeguards to protect the integrity, confidentiality and availability of individually identifiable health information that is electronically created, received, maintained or transmitted (including between us and our affiliated practices). We have implemented security policies, procedures and systems, including training programs, designed to comply with the requirements set forth in the Security Rules.

In addition, Congress enacted the Health Information Technology for Economic and Clinical Health Act (HITECH) as part of the ARRA. Among other changes to the laws governing PHI, HITECH strengthened and expanded HIPAA requirements, increased penalties for violations, gave patients new rights to restrict uses and disclosures of their health information, and imposed a number of privacy and security requirements directly on our Business Associates, which are third-parties that perform functions or services for us or on our behalf that involve the use or disclosure of PHI. Under HITECH, Covered Entities are required to report any unauthorized

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use or disclosure of PHI that meets the definition of a breach to the affected individuals, HHS and, depending on the number of affected individuals, the media for the affected market. In addition, HITECH requires that Business Associates report breaches to their Covered Entity customers. HITECH also authorizes state Attorneys General to bring civil actions in response to violations of HIPAA that threaten the privacy of state residents. We have adopted privacy policies and procedures aimed at ensuring compliance with HITECH requirements.

In addition to the federal HIPAA and HITECH requirements, numerous state and certain other federal laws protect the confidentiality of patient information and other personal information, including state medical privacy laws, state social security number protection, state data breach notification laws, state genetic privacy laws, human subjects research laws and federal and state consumer protection laws. In some cases, state laws are more stringent than HIPAA and therefore, are not preempted by HIPAA.

HIPAA Transaction Requirements

In addition to privacy and data security regulations, HIPAA and its implementing regulations establish electronic data transmission standards that all healthcare providers must use for electronic healthcare transactions. For example, claims for reimbursement that are transmitted electronically to third-party payors must comply with specific formatting standards, and these standards apply whether the payor is a government or a private entity. Effective October 1, 2015, we will be required to report medical diagnoses under new International Classification of Diseases, 10th Edition, (ICD-10), which replace the current ICD-9 medical coding diagnosis codes. ICD-10 codes are different from ICD-9 codes and will require entities to code with much greater detail and specificity than ICD-9 codes. If claims are not reported properly under ICD-10 due to technical or coding errors or other implementation issues involving systems, including ours and those of our third-party payors, there can be a delay in the processing and payment of such claims, or a denial of such claims, which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Environmental Regulations

Our healthcare operations generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our office-based operations are subject to compliance with various other environmental laws, rules and regulations. Such compliance does not, and we anticipate that such compliance will not, materially affect our capital expenditures, financial position or results of operations.

Compliance Program

We maintain a compliance program that includes the established elements of an effective program and reflects our commitment to complying with all laws, rules and regulations applicable to our business and that meets our ethical obligations in conducting our business (the Compliance Program). We believe our Compliance Program provides a solid framework to meet this commitment and our obligations as a provider of health care services, 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 and Treasurer (who is also our Chief Accounting Officer) and Vice President of Accounting and Finance;

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a disclosure program that includes a mechanism to enable individuals to disclose on a confidential or anonymous basis to the Chief 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 or of company policies or procedures;

an organizational structure designed to integrate our compliance objectives into our corporate offices, divisions, regions and practices; and

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

The foundation of our Compliance Program 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 thorough education regarding, 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 helpline to permit individuals to report compliance concerns on an anonymous basis and obtain answers to questions about our *Code of Conduct*. Our Compliance Program, including our *Code of Conduct*, is administered by our Chief Compliance Officer with oversight by our Chief Executive Officer, Compliance Committee and Board of Directors. Copies of our *Code of Conduct* and our *Code of Professional Conduct Finance* are available on our website, www.mednax.com. Our Internet website and the information contained therein or connected thereto are not incorporated into or deemed a part of this Form 10-K. 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.

GOVERNMENT INVESTIGATIONS

We expect that audits, inquiries and investigations from government authorities, agencies, contractors and payors will 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 and 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 and other clinicians. We may also become subject to other lawsuits that could involve large claims and significant defense costs. We believe, based upon a 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, cash flows and the trading price of our common stock.

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 risk, we self-insure a significant portion of this risk through our wholly owned captive 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.

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PROFESSIONAL AND GENERAL LIABILITY COVERAGE

We maintain professional and general liability insurance policies with third-party insurers generally on a claims-made basis, subject to deductibles, 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, clinicians and us. We contract and pay premiums for professional liability insurance that indemnifies us and our affiliated healthcare professionals generally 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 primarily 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 information, claim emergence patterns and various actuarial assumptions. 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, results of operations and cash flows could be materially, adversely affected.

EMPLOYEES AND PROFESSIONALS UNDER CONTRACT

In addition to the over 2,625 practicing physicians affiliated with us as of December 31, 2014, we employed or contracted with over 3,000 other clinical professionals and approximately 4,550 other full-time and part-time employees.

GEOGRAPHIC COVERAGE

We provide physician services in 34 states, including Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Idaho, Indiana, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington and West Virginia, and Puerto Rico. During 2014, approximately 62% of our net revenue was generated by operations in our five largest states. Our operations in Texas accounted for approximately 24% of our net 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. In addition, through our complementary service businesses, we provide revenue cycle management and consulting services to medical providers in over 40 states. Adverse changes or conditions affecting states, in which our operations are concentrated, such as healthcare reforms, changes in laws, rules and regulations, reduced Medicare or Medicaid reimbursements, an increase in the income level required to qualify for government healthcare programs or government investigations, may have a material adverse effect on our business, financial condition and results of operations.

SERVICE MARKS

We have registered with the United States Patent and Trademark Office the service marks MEDNAX National Medical Group and Design, Pediatrix Medical Group and Design, Obstetrix Medical Group and Design, American Anesthesiology and Design, BabySteps, the Baby Desi Pediatrix University, Pediatrix University-A University Without Walls, QualitySteps, Quantum Clinical Navigation Systems, Pediatrix Cardiology and Design, NEO Conference and Design and MedData, among others.

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AVAILABLE INFORMATION

Our annual proxy statements, annual 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.mednax.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.

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ITEM 1A. RISK FACTORS

Our business is subject to a number of factors that could materially affect future developments and performance. In addition to factors affecting our business that have been described elsewhere in this Form 10-K, any of the following risks could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our common stock.

Economic conditions could have an adverse effect on our business.

Although economic conditions in the United States have gradually improved, the number of unemployed and under-employed workers remains significant despite increases in economic activity. During the year ended December 31, 2014, the percentage of our patient service revenue being reimbursed under GHC Programs decreased slightly as compared to the year ended December 31, 2013. We could, however, experience shifts to GHC Programs, and possible lower patient volumes, if economic conditions do not continue to improve or if they deteriorate. Adverse economic conditions could also lead to additional increases in the number of unemployed and under-employed workers and a decline in the number of private employers that offer healthcare insurance coverage to their employees. Employers that do offer healthcare coverage may increase the required contributions from employees to pay for their coverage and increase patient responsibility amounts. As a consequence, the number of patients who participate in GHC Programs or are uninsured could increase. In addition, due to the rising costs of managed care premiums and patient responsibility amounts, we may experience increased bad debt due to patients inability to pay for certain services. Further, it is too early to determine whether the ACA will increase or decrease the number of our patients with private healthcare insurance, obtained either through employers or the recently established insurance exchanges. Payments received from GHC Programs are substantially less than payments received from private healthcare insurance programs (managed care and other third-party payors). In addition, payments under the recently established health care exchanges may be less than payments from private healthcare insurance programs. A payor mix shift from private healthcare insurance programs to government payors may result in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net 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.

State budgetary constraints could have an adverse effect on our reimbursement from Medicaid programs.

As a result of recent economic conditions, many states are continuing to collect less revenue than they did in prior years and as a consequence are facing budget shortfalls and underfunded pension and other obligations. Although shortfalls for the more recent budgetary years have declined, they are still significant by historical standards. The financial condition of the states in which the Company does business could lead to reduced or delayed funding for Medicaid programs and, in turn, reduced or delayed reimbursement for physician services, which could adversely affect our results of operations, cash flows and financial condition.

The birth rate in the United States may decline.

Final birth data for 2013 indicate that total births in the United States were essentially flat compared to 2012 and 2011. Although the provisional data for the full year of 2014 are not yet available, we expect that birth trends may have continued to stabilize. However, any future declines in births could have an adverse effect on our patient volumes and revenue.

The ACA may have a significant effect on our business.

The ACA contains a number of provisions that have affected us and could affect us over the next several years. These provisions include the recent establishment of health insurance exchanges to facilitate the purchase of qualified health plans, expanding Medicaid eligibility, subsidizing insurance premiums and creating

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requirements and incentives for businesses to provide healthcare benefits. Other provisions contain changes to healthcare fraud and abuse laws and expand the scope of the FCA.

The ACA contains numerous other measures that could also affect us. For example, payment modifiers are being developed that will differentiate payments to physicians under federal healthcare programs based on quality and cost of care. In addition, other provisions authorize voluntary demonstration projects relating to the bundling of payments for episodes of hospital care and the sharing of cost savings achieved under the Medicare program. CMS also issued a final rule under the ACA establishing a Medicare Shared Savings Program (MSSP) that allows physicians, hospitals and other health care providers to coordinate care for Medicare beneficiaries through Accountable Care Organizations (ACOs). ACOs are entities consisting of healthcare providers and suppliers organized to deliver services to Medicare beneficiaries and eligible under the MSSP to receive a share of any cost savings the entity can achieve by delivering services to those beneficiaries at a cost below a set baseline and based upon established quality of care standards. We will continue to evaluate the impact of the MSSP on our business and operations.

Many of the ACA s most significant reforms, such as the establishment of state-based and federally facilitated insurance exchanges that provide a marketplace for eligible individuals and small employers to purchase health care insurance, only became effective in the beginning of 2014. Following some well-publicized technical issues in accessing and enrolling in the federal online exchange, enrollment in the federal and state exchange healthcare plans met the 7 million first-year target established by the Congressional Budget Office. In the second enrollment period for the exchanges, which runs through February 15, 2015, it has been projected that approximately 9 million people, including new applicants and returning customers, will be enrolled. In November 2014, however, the Supreme Court granted certiorari to hear an appeal challenging the legality of an Internal Revenue Service (IRS) regulation providing subsidies for insurance purchased on the federal exchanges and arguing that the text of the ACA only allows for subsidies on state-based exchanges. Only 13 states created their own exchanges; the remainder of states provided insurance coverage on the federal exchanges. A ruling in that case, *King v. Burwell*, is expected by June 2015. If the challenge is successful, approximately 5 million people who obtained healthcare coverage through the federal facilitated insurance exchanges could lose their subsidies and their health insurance coverage. In addition, in some cases, the patient responsibility costs related to healthcare plans obtained through the insurance exchanges may be high and could increase in the future, and we may experience increased bad debt due to patients inability to pay for certain services.

The ACA also allows states to expand their Medicaid programs through federal payments that fund most of the cost of increasing the Medicaid eligibility income limit from a state s historic eligibility levels to 133% of the federal poverty level. To date, however, 20 states have expressed their intent not to expand Medicaid eligibility to cover this low income patient population. However, several states are exploring the opportunity to expand Medicaid eligibility in a manner that is different than set forth under the ACA. As a result of these and other uncertainties, we cannot predict whether there will be more uninsured patients than was anticipated when the ACA was enacted.

Federal and state agencies are expected to continue to develop regulations and implement provisions of the ACA. However, given the complexity and the number of changes expected as a result of the ACA, as well as the implementation timetable and delays for many of them, we cannot predict the ultimate impacts of the ACA, as they may not be known for several years. The ACA also remains subject to continuing legislative scrutiny, including efforts by Congress to amend or repeal a number of its provisions as well as administrative actions delaying the effectiveness of key provisions. As a result, we cannot predict with any assurance the ultimate effect of the ACA on our Company, nor can we provide any assurance that its provisions will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

Expanding eligibility of government-sponsored programs could adversely affect our reimbursement.

In February 2009, Congress reauthorized the State Children s Health Insurance Program (SCHIP) through September 2013 and expanded its eligibility coverage. The ACA extended the reauthorization through September

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2015. Further expansion of SCHIP eligibility and the ACA s expansion of Medicaid coverage could cause patients who otherwise would have participated in private healthcare insurance programs to participate in GHC Programs. Additional reform efforts could change the eligibility requirements for Medicaid and for other GHC Programs and could increase the number of patients who participate in such programs or the number of uninsured patients. Payments received from government-sponsored programs are substantially less than payments received from private healthcare insurance programs (managed care and other third-party payors). A payor mix shift from private healthcare insurance programs to government payors may result in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net revenue. Further increases in the government component of our payor mix at the expense of other third-party payors could also result in a significant reduction in our average reimbursement rates.

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

A significant portion of our net revenue is derived from payments made by GHC Programs, principally Medicare and Medicaid. These government-funded programs, as well as private insurers, have taken and may continue to take steps, including a movement toward increased use of managed care organizations, value-based purchasing, and new patient care models to control the cost, eligibility for, use and delivery of healthcare services as a result of budgetary constraints and cost containment pressures due to unfavorable economic conditions, rising healthcare costs and for other reasons, including those described above under Item 1. Business Government Regulation Government Reimbursement Requirements. These government-funded 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 not only for Medicare patients, but also for patients covered under Medicaid and other third-party payors, because Medicaid and other third-party payors often base their reimbursement rates on a percentage of Medicare rates. Our business may also be materially affected by limitations on, or reductions in, reimbursement amounts or rates or elimination of coverage for certain individuals or treatments. Moreover, because government-funded programs generally provide for reimbursements on a fee-schedule basis rather than on a charge-related basis, we generally cannot increase our revenue from these programs through increases in 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-government-funded 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 adverse effect on our financial condition, results of operations, cash flows and the trading price of our common stock.

In addition, Medicare reimbursement rates could be reduced due to statutory formulas. Presently, Medicare pays for all physician services based upon a national fee schedule which contains a list of uniform rates. The payment rates under the fee schedule are determined based on national uniform relative value units for the services provided, a geographic adjustment factor and a conversion factor. The fee schedule is adjusted annually based on a complex formula that is linked in part to the use of services by Medicare beneficiaries and the growth in gross domestic product. Since 2002, this formula has resulted in negative payment updates under the fee schedule that have grown increasingly larger, and Congress has had to take repeated legislative action to reverse scheduled payment reductions, most recently in March 2014, when legislation was enacted to avert a rate reduction and temporarily increase Medicare physician payment rates through the end of March 2015. If Congress does not take further action, the Medicare fee schedule will be reduced by approximately 20% effective April 1, 2015. Fee reductions will continue to be scheduled annually unless Congress takes action in the future to modify or reform the mechanism by which payment rates are updated. In addition to the reductions under the Medicare fee schedule, the Budget Control Act of 2011 sets forth across-the-board cuts (sequestrations) to

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Medicare reimbursement rates which began in April 2013. These annual reductions of 2% apply to mandatory and discretionary spending in the years 2013 to 2021, and were extended through fiscal year 2024 by the Bipartisan Budget Act of 2013 and Public Law 113-82. Unless Congress takes action in the future to modify these sequestrations, Medicare reimbursements will be reduced by 2% annually. If no action is taken, reductions in the fee schedule and reductions as a result of the sequestrations could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our common stock.

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

Federal and state laws, rules and regulations impose substantial penalties, including criminal and civil fines, monetary penalties, exclusion from participation in government healthcare programs and imprisonment, on entities or individuals (including any individual corporate officers or physicians deemed responsible) that fraudulently or wrongfully bill government-funded programs or other third-party payors for healthcare services. CMS issued a final rule requiring states to implement a Medicaid Recovery Audit Contractor (RAC) program effective January 1, 2012. States are required to contract with one or more eligible Medicaid RACs to review Medicaid claims for any overpayments or underpayments, and to recoup overpayments from providers on behalf of the state. In addition, federal laws, along with a growing number of state laws, allow a private person to bring a civil action in the name of the government for false billing violations. See Item 1. Business Government Regulation Fraud and Abuse Provisions. We believe that audits, inquiries and investigations from government agencies will occur from time to time in the ordinary course of our business, which could result in substantial 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 healthcare industry is highly regulated, and government authorities may determine that we have failed to comply with applicable laws, rules or regulations.

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

- federal laws (including the federal False Claims Act) that prohibit entities and individuals from knowingly or recklessly making claims to Medicare, Medicaid and other government-funded programs that contain false or fraudulent information or from improperly retaining known overpayments;

- a provision of the Social Security Act, commonly referred to as the anti-kickback statute, 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 Medicare and Medicaid;

- a provision of the Social Security Act, commonly referred to as the Stark Law, that, subject to certain exceptions, prohibits physicians from referring 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;

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

- provisions of 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;

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federal and state laws related to confidentiality, privacy and security of personal information, including medical information and records, that limit the manner in which we may use and disclose that information, impose obligations to safeguard information and require that we notify third parties in the event of a breach;

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;

federal and state laws governing participation in GHC Programs could result in denial of our application to become a participating provider, that could in turn cause us to not be able to treat patients covered by the applicable program or prohibit us from billing for the treatment services provided to such patients;

federal and state laws that prohibit providers from billing and receiving payment from Medicare and Medicaid 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 may in the future become the subject of regulatory or other investigations, audits 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 or that we have submitted false claims or otherwise failed to comply with government program reimbursement requirements. 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 GHC 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, results of operations, cash flows and the trading price of our common stock.

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Federal and state laws that protect the privacy and security of personal information may increase our costs and limit our ability to collect and use that information and subject us to penalties if we are unable to fully comply with such laws.

Numerous federal and state laws and regulations govern the collection, dissemination, use, security and confidentiality of personal information, including individually identifiable health information. These laws include:

- Provisions of HIPAA that limit how healthcare providers and business associates may use and disclose PHI, provide certain rights to individuals with respect to that information and impose certain security requirements;
- HITECH, which strengthens and expands the HIPAA Privacy Rule and Security Rules and imposes data breach notification obligations;
- Other federal and state laws restricting the use and protecting the privacy and security of personal information, including health information, many of which are not preempted by HIPAA;
- Federal and state consumer protection laws; and
- Federal and state laws regulating the conduct of research with human subjects.

As part of our business operations, including our medical record keeping, third-party billing, research and other services, we collect and maintain PHI in paper and electronic format. Standards related to health information, whether implemented pursuant to HIPAA, HITECH, state laws, congressional or state action or otherwise, could have a significant effect on the manner in which we handle personal information, including healthcare-related data, and communicate with payors, providers, patients and others, 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 personal information we could be subject to remedies that include monetary fines, civil or administrative penalties, litigation, civil damage awards or criminal sanctions.

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

The healthcare industry is subject to close antitrust scrutiny. The FTC, the DOJ and state Attorneys General all actively review and, in some cases, take enforcement action against business conduct and acquisitions in the healthcare industry. Private parties harmed by alleged anticompetitive conduct can also bring antitrust suits. Violations of antitrust laws may be 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.

Our affiliated physicians and third-party contractors may not appropriately record or document services that they provide.

Our affiliated physicians are responsible for appropriately recording and documenting the services they provide. We use this information to seek reimbursement for their services from third-party payors. In addition, we utilize third-party contractors to perform certain revenue cycle management functions for medical providers, including medical coding. If our physicians and third-party contractors do not appropriately document, or where applicable, code for their services or our customers services, we could be subjected to administrative, regulatory, civil, or criminal investigations or sanctions and our business, financial condition, results of operations and cash flows could be materially adversely affected.

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We may not find suitable acquisition candidates or successfully integrate our acquisitions. Our acquisitions may expose us to greater business risks and could affect our payor mix.

We have expanded and continue to seek to expand our presence in new and existing metropolitan areas by acquiring established neonatal, anesthesia care, maternal-fetal, pediatric cardiology and other complementary pediatric subspecialty physician group practices. In addition, both independently and in collaboration with our hospital partners, we may seek to expand into other specialties and subspecialties.

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 healthcare industry, which may increase our acquisition costs.

We may not be able to complete acquisitions of physician practices or we may complete acquisitions on less favorable terms as a result of higher tax rates on high-income individuals resulting from the American Taxpayer Relief Act of 2012 or other potential changes to the tax code. Specifically, our acquisition candidates may require a higher purchase price to compensate them for any increased tax burden.

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, rules 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 revenue 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, or liabilities relating to medical malpractice claims. Generally we obtain indemnification agreements from the sellers of businesses acquired with respect to pre-closing acts, omissions and other similar risks. It is possible that we may seek to enforce indemnification provisions in the future against sellers who may no longer have the financial wherewithal to satisfy their obligations to us. Accordingly, we may incur material liabilities for past activities of acquired businesses.

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 GHC Programs than what we recognize on a consolidated basis. These acquisitions could affect our overall payor mix in future periods.

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

An acquisition could be subject to a challenge under the antitrust laws either before or after it is consummated. Such a challenge could involve substantial legal costs and divert management s attention and resources and could result in us having to abandon the

transaction or make a divestiture.

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We may not be able to successfully execute our same-unit and organic growth strategies.

In addition to our acquisition growth strategy, we seek opportunities for increasing revenue from our existing hospital- and office-based operations through same-unit and organic growth strategies. We also seek opportunities to grow organically outside of our existing operations. We may not be able to successfully execute our same-unit and organic growth strategies for reasons including the following:

- We may not be able to expand the services that our affiliated physicians provide to our hospital partners.
- We may not be able to attract referrals to our office-based practices or neonatology transports to our hospital-based units.
- We may not be able to execute new contractual arrangements with hospitals, including through joint ventures, where we either currently provide or do not currently provide physician services.
- We may not be able to work with our hospital partners to develop integrated services programs for which we become a multi-specialty provider of solutions within the maternal-fetal, newborn, pediatric continuum of care.
- We may not accurately project organic growth performance, potentially resulting in lower margins.

In addition, certain of our organic growth strategies may involve risks and uncertainties similar to those for our acquisition strategy. See We may not find suitable acquisition candidates or successfully integrate our acquisitions. Our acquisitions may expose us to greater business risks and could affect our payor mix.

We may not be able to maintain effective and efficient information systems or properly safeguard our information systems.

Our operations are dependent on uninterrupted performance of our information systems. Failure to maintain reliable information systems, disruptions in our existing information systems or the implementation of new 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.

In addition, information security risks have generally increased in recent years because of new technologies and the increased activities of perpetrators of cyber-attacks resulting in the theft of protected health, business or financial information. Outside parties may also attempt to fraudulently induce employees to take actions, including the release of confidential or sensitive information or to make fraudulent payments, through illegal electronic spamming, phishing or other tactics. A failure in or breach of our information systems as a result of cyber-attacks or other tactics could also disrupt our business, result in the release or misuse of confidential or proprietary information or financial loss, damage our reputation, increase our administrative expenses, and expose us to additional risk of liability to federal or state governments or individuals. Although we believe that we have robust information security procedures and other safeguards in place, which are monitored and routinely tested internally and by external parties, as cyber threats continue to evolve, we may be required to expend additional resources to continue to enhance our information security measures or to investigate and remediate any information security vulnerabilities. Any of these disruptions or breaches of security could have a material adverse effect on our business, regulatory compliance, financial condition and results of operations.

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

Each of our employees and business partners is responsible for the security of the information in our systems or under our control and to ensure that private and financial information is kept confidential. Should an

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employee or business partner not follow appropriate security measures, including those related to cyber threats or attacks or other tactics, as well as our privacy and security policies and procedures, the improper release of personal information, including PHI, or confidential business or financial information, or misappropriation of assets could result. The release of such information or misappropriation of assets could have a material adverse effect on our business, financial condition, regulatory compliance, results of operations and cash flows.

We may not be able to successfully recruit and retain qualified physicians and other clinicians.

We are dependent upon our ability to recruit and retain a sufficient number of qualified physicians and other clinicians to service existing units at hospitals and our affiliated practices and expand our business. We compete with many types of healthcare providers, including teaching, research and government institutions, hospitals and health systems and other practice groups, for the services of qualified clinicians. We may not be able to continue to recruit new clinicians or renew contracts with existing clinicians 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.

A significant number of our affiliated physicians or other clinicians 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. Certain of our employment agreements 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 may be reluctant to enforce non-compete agreements and restrictive covenants against physicians. Our affiliated physicians or other clinicians may leave our affiliated practices for a variety of reasons, including to provide services for other types of healthcare providers, such as teaching, research and government institutions, hospitals and health systems and other practice groups. If a substantial number of our affiliated physicians or other clinicians 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 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. Generally, we self-insure our liabilities to pay retention amounts for professional liability matters 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 that represent estimates involving actuarial projections. These actuarial projections are developed at a given point in time and represent our expectations of

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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 reserve estimates are based on actuarial valuations using historical claims, demographic factors, industry trends, severity and exposure factors and other actuarial assumptions. The estimates of projected ultimate losses are developed at least annually. 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 hamper 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. See Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations Application of Critical Accounting Policies and Estimates Professional Liability Coverage.

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

The carrying value of our intangible assets, which consist primarily of goodwill related to our acquisitions, is 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.

We may not effectively manage our growth.

We have experienced significant growth in our business and the number of our employees and affiliated physicians in recent years which places significant demands on our financial, operational and management resources. Continued 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.

Our quarterly results will likely fluctuate from period to period.

We have historically experienced and expect to continue to experience quarterly fluctuations in net 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 as well as discretionary matching contributions for participants in our qualified contributory savings plans (401(k) Plans). In addition, a significant number of our employees and associated professional contractors (primarily affiliated physicians) exceed the level of taxable wages for social security contributions 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-hours-a-day basis, 365 days a year, any reduction in service days will have a corresponding reduction in net revenue. In addition, any reduction in office days in our office-based practices or business days in our anesthesia practices will also have a corresponding reduction in net 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.

Our variable rate debt exposes us to interest rate risk which could adversely affect our cash flows.

The borrowings under our credit agreement bear interest at variable rates and expose us to interest rate risk. Other debt we incur also could be variable rate debt. If interest rates increase, our variable rate debt will create higher debt service requirements, which could adversely affect our results of operations and cash flows.

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The value of our common stock may fluctuate.

There has been significant volatility in the market price of securities of healthcare companies generally that we believe in many cases has been unrelated to operating performance. In addition, we believe that certain factors, such as actual and potential legislative and regulatory developments, including announced regulatory investigations, quarterly fluctuations in our actual or anticipated results of operations, lower revenue or earnings than those anticipated by securities analysts, not meeting publicly announced expectations, 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 revenue is derived from reimbursements from various third-party payors, including GHC Programs, 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 healthcare environment, payors continue their efforts to control expenditures for healthcare, including revisions to coverage and reimbursement policies. Due to the nature of our business and our participation in government-funded 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-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. In addition, GHC Programs may deny our application to become a participating provider that could cause us to not be able to provide services to patients or prohibit us from billing for such services. 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 revenue, cash flows and financial condition could be materially, adversely affected.

In addition, adverse economic conditions could affect the timeliness and amounts received from our third-party and government payors which would impact our short-term liquidity needs.

Hospitals or other customers 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 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 or other customers may cancel or not renew their contracts with us, reduce or eliminate our administrative fees in the future, or refuse to pay us our administrative fees if we fail to honor the terms of our agreement. Adverse economic conditions could influence future actions of our hospital partners or other customers. To the extent that our arrangements with our hospital partners or other customers 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 or employ 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 Quantum Clinical Navigation Systems are used to support our day-to-day operations and ongoing clinical research and business analysis. If a hospital

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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 healthcare industry is highly competitive and subject to continual changes in the methods by which services are provided and the manner in which healthcare providers are selected and compensated. Because our operations consist primarily of physician services provided within hospital-based units, we compete with other healthcare 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 healthcare industry segments, some of which have greater financial and other resources than ours, may become competitors in providing neonatal, anesthesia, maternal-fetal or pediatric subspecialty care. Additionally, we face competition from healthcare-focused and other private equity firms. 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 revenue in 2014 was generated by our operations in five states. In particular, Texas accounted for approximately 24% of our net revenue in 2014. See Item 1. Business Geographic Coverage. Adverse changes or conditions affecting these particular states, such as healthcare reforms, changes in laws and regulations, reduced Medicaid reimbursements and government investigations, economic conditions, weather conditions, and natural disasters 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 adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our common stock.

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 articles of incorporation and 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 MEDNAX 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.

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ITEM 2. PROPERTIES

Our corporate office building, which we own, is located in Sunrise, Florida and contains 80,000 square feet of office space. We own an additional office building covering an additional 180,000 square feet for other administrative functions in Sunrise, Florida. We also lease space in hospitals and other facilities for our business and medical offices, and other needs. See Note 16 to the Consolidated Financial Statements in this Form 10-K, which is incorporated herein by reference. We believe that our facilities and the equipment used in our business 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. MINE SAFETY DISCLOSURES

Not applicable

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PART II

ITEM 5. MARKET FOR 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 MD. The high and low sales prices for a share of our common stock for each quarter during our last two fiscal years, after giving effect for our two-for-one stock split effective December 19, 2013, are set forth below:

	High	Low
2014		
Fourth Quarter	$ 67.64	$ 49.82
Third Quarter	60.08	54.16
Second Quarter	64.51	56.13
First Quarter	63.93	52.50
2013		
Fourth Quarter	$ 56.45	$ 49.83
Third Quarter	51.49	45.29
Second Quarter	47.29	41.83
First Quarter	44.99	40.33

As of January 30, 2015, we had 294 holders of record of our common stock, and the closing sales price on that date for our common stock was $67.89 per share. We believe that the number of beneficial owners of our common stock is 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 2014 or 2013, 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 credit facility permits us to declare and pay cash dividends, subject to limitations as specified therein. 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, 2009 in our 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, 2009 through December 31, 2014, and gives effect to a two-for-one stock split effective December 19, 2013. The stock price performance included in the graph is not necessarily indicative of future stock price performance.

The performance graph shall not be deemed incorporated by reference by any general statement incorporating by reference this annual report into any filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except to the extent that we specifically incorporate this information by reference, and shall not otherwise be deemed filed under such acts.

	Base Period	Years Ending				
Company/Index	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
MEDNAX, Inc.	$ 100.00	$ 111.91	$ 119.76	$ 132.27	$ 177.58	$ 219.93
S&P 500 Index	$ 100.00	$ 112.47	$ 112.78	$ 127.90	$ 165.76	$ 184.64
S&P 600 Health Care	$ 100.00	$ 122.52	$ 139.37	$ 158.11	$ 245.89	$ 272.73
NYSE Composite Index	$ 100.00	$ 110.85	$ 104.07	$ 117.52	$ 144.75	$ 150.86

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Issuer Purchases of Equity Securities

During the three months ended December 31, 2014, we repurchased approximately 5.0 million shares of our common stock in connection with a share repurchase program that was approved by our board of directors in October 2014.

Period	Total Number of Shares Purchased	Average Price Paid per Share (a)	Total Number of Shares Purchased as part of the Repurchase Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Repurchase Programs
October 1 October 31, 2014		$		(b)
November 1 November 30, 2014	1,197,191	$ 63.31	1,197,191	(b)
December 1 December 31, 2014	3,774,480	$ 64.88	3,774,480	(b)
Total	4,971,671	$ 64.50	4,971,671	(b)

(a) This amount represents the weighted average price paid per share and includes a per share commission paid for all repurchases made through open market programs.

(b) We have two active repurchase programs. Our July 2013 repurchase program allows us to repurchase shares of our common stock up to an amount sufficient to offset the dilutive impact from the issuance of shares under our equity compensation programs, which is estimated to be approximately 1.2 million shares per year. Our October 2014 repurchase program allows us to repurchase up to an additional $600.0 million of shares of our common stock, of which we have repurchased approximately $360.7 million, inclusive of the aggregate value of common stock held back pending final settlement of our accelerated share repurchase program. See Note 14 to our Consolidated Financial Statements in this Form 10-K for additional information on our common stock repurchase programs, which note is incorporated herein by reference.

The amount and timing of future repurchases will depend upon several factors, including general economic and market conditions and trading restrictions.

Recent Sales of Unregistered Securities

During the three months ended December 31, 2014, we did not sell any unregistered 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, 2014. All share and per share amounts give effect for our two-for-one stock split effective December 19, 2013. The balance sheet data at December 31, 2014 and 2013, and the income statement data for the years ended December 31, 2014, 2013 and 2012, have been derived from the Consolidated Financial Statements included in this Form 10-K. 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,				
	2014	2013	2012	2011	2010
Consolidated Income Statement Data:					
Net revenue (1)	$ 2,438,913	$ 2,154,012	$ 1,816,612	$ 1,588,248	$ 1,401,559
Operating expenses:					
Practice salaries and benefits	1,543,395	1,361,318	1,130,913	970,396	854,920
Practice supplies and other operating expenses	89,002	82,388	71,823	66,815	57,511
General and administrative expenses	247,527	218,209	193,540	170,356	154,267
Depreciation and amortization	45,990	39,966	30,816	25,292	21,950
Total operating expenses	1,925,914	1,701,881	1,427,092	1,232,859	1,088,648
Income from operations	512,999	452,131	389,520	355,389	312,911
Investment income	2,728	1,696	1,896	1,495	1,434
Interest expense	(8,891)	(5,415)	(3,245)	(3,639)	(3,193)
Equity in earnings of unconsolidated affiliate	1,780				
Total non-operating expenses	(4,383)	(3,719)	(1,349)	(2,144)	(1,759)
Income before income taxes	508,616	448,412	388,171	353,245	311,152
Income tax provision	191,413	167,895	147,264	135,248	108,461
Net Income	317,203	280,517	240,907	217,997	202,691
Net loss attributable to noncontrolling interests	78				
Net income attributable to MEDNAX, Inc.	$ 317,281	$ 280,517	$ 240,907	$ 217,997	$ 202,691
Per Common and Common Equivalent Share Data:					
Net income attributable to MEDNAX, Inc.:					
Basic	$ 3.22	$ 2.83	$ 2.47	$ 2.28	$ 2.17
Diluted	$ 3.18	$ 2.78	$ 2.42	$ 2.23	$ 2.13
Weighted average common shares:					
Basic	98,588	99,112	97,386	95,412	93,260
Diluted	99,887	100,969	99,382	97,592	95,140
Other Operating Data:					
Number of physicians at end of year	2,625	2,367	2,152	1,839	1,675
Number of births	799,868	790,597	761,698	745,929	736,191
NICU admissions	108,978	102,099	99,539	97,101	93,310
NICU patient days	1,919,579	1,847,577	1,828,605	1,754,401	1,710,904
Number of anesthesia cases	1,284,149	1,045,794	664,527	463,604	315,318

Consolidated Balance Sheet Data:					
Cash and cash equivalents	$ 47,928	$ 31,137	$ 21,280	$ 18,596	$ 26,251
Working capital	50,779	41,333	90,706	82,972	74,948
Total assets	3,608,795	3,008,716	2,750,337	2,272,648	2,037,646
Total liabilities	1,343,229	665,728	714,969	541,632	590,192
Borrowings under credit facility	568,000	27,000	144,000	29,000	146,500
Shareholders equity	2,265,566	2,342,988	2,035,368	1,731,016	1,447,454

(1) The increase in net revenue related to acquisitions was approximately $205.4 million, $265.0 million, $179.0 million, $140.1 million, and $96.6 million for the years ended December 31, 2014, 2013, 2012, 2011 and 2010, respectively.

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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 the explanatory note concerning Forward-Looking Statements preceding Part I of this Form 10-K and 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.

OVERVIEW

MEDNAX is a leading provider of physician services including newborn, anesthesia, maternal-fetal and other pediatric subspecialties. At December 31, 2014, our national network was composed of more than 2,625 affiliated physicians, including more than 1,080 physicians who provide neonatal clinical care in 34 states and Puerto Rico, primarily within hospital-based neonatal intensive care units, to babies born prematurely or with medical complications. We have over 950 physicians who provide anesthesia care to patients in connection with surgical and other procedures as well as pain management. We have approximately 245 affiliated physicians who provide maternal-fetal and obstetrical medical care to expectant mothers experiencing complicated pregnancies primarily in areas where our affiliated neonatal physicians practice. Our network also includes other pediatric subspecialists, including approximately 125 physicians providing pediatric intensive care, 115 physicians providing pediatric cardiology care, 90 physicians providing hospital-based pediatric care and 20 physicians providing pediatric surgical care.

In addition to our national physician network, we provide services in over 40 states to medical providers, including ours, through two complementary businesses, consisting of a revenue cycle management company and a consulting services company.

2014 Acquisition Activity and Joint Ventures

During the year ended December 31, 2014, we completed the acquisition of 11 physician group practices. These acquisitions consisted of eight anesthesiology practices, one neonatology practice, one maternal-fetal medicine practice and one pediatric cardiology practice. We also completed the acquisition of two complementary services businesses, consisting of a revenue cycle management company and a consulting services company. Based on our experience, we expect that we can improve the results of all of our acquired practices through improved managed care contracting, improved collections, identification of growth initiatives, as well as, operating and cost savings based upon the significant infrastructure that we have developed. We also expect that the development of our service offerings will function as support for our own physician practices as well as a revenue generating outsourced service capability.

In June 2014, we entered into a joint venture in which we own a 75% economic interest. The joint venture operates as a fully integrated physician practice within the specialty of pediatric cardiology providing services to certain hospital and clinical sites. Also in June 2014, we entered into a second joint venture in which we own a 37.5% economic interest. This joint venture operates as a provider-based venture on the campus of a hospital and will provide certain cardiology diagnostic services to inpatients and outpatients of the hospital.

Common Stock Repurchase Programs

In July 2013, our board of directors authorized the repurchase of shares of our common stock up to an amount sufficient to offset the dilutive impact from the issuance of shares under our equity compensation programs. The share repurchase program permits us to make open market purchases from time-to-time based

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upon general economic and market conditions and trading restrictions. This repurchase program was expanded to allow for the repurchase of shares of our common stock to offset the dilutive impact from the issuance of shares, if any, related to our acquisition program. In October 2014, we announced that our board of directors had authorized the repurchase of up to $600.0 million of shares of our common stock in addition to the existing share repurchase program approved in July 2013.

Under the share repurchase programs described above, we repurchased approximately 7.1 million shares of our common stock for approximately $488.4 million during the year ended December 31, 2014, inclusive of the aggregate value of common stock held back pending final settlement under an accelerated share repurchase program. We may utilize various methods to effect any future share repurchases made under these programs, including, among others, open market purchases and accelerated share repurchase programs. The amount and timing of repurchases will depend upon several factors, including general economic and market conditions and trading restrictions.

Credit Agreement Expansion

In October 2014, we entered into a new credit agreement (the New Credit Agreement), which replaced our amended and restated credit agreement. The New Credit Agreement provides for a $1.3 billion unsecured revolving credit facility and a $200 million term loan and includes a $75 million sub-facility for swingline loans and a $37.5 million sub-facility for the issuance of letters of credit. The new credit facility matures in October 2019 and is guaranteed by substantially all of our subsidiaries and affiliated professional contractors. Our credit facility provides a funding source for future acquisitions, our share repurchase programs, as well as other corporate purposes. In addition, we may increase the credit facility to up to $1.8 billion on an unsecured basis, subject to the satisfaction of specified conditions.

2013 Stock Split

In December 2013, we effected a two-for-one stock split of our common stock. All share and per share amounts presented in this Form 10-K reflect the effect of the two-for-one stock split.

General Economic Conditions

Although economic conditions in the United States have gradually improved, the number of unemployed and under-employed workers remains significant despite increases in economic activity. During the year ended December 31, 2014, the percentage of our patient service revenue being reimbursed under GHC Programs decreased slightly as compared to the year ended December 31, 2013. If, however, economic conditions do not continue to improve or if they deteriorate, we could experience additional shifts toward GHC Programs and patient volumes could decline. Payments received from GHC Programs are substantially less for equivalent services than payments received from commercial insurance payors. In addition, due to the rising costs of managed care premiums and patient responsibility amounts, we may experience increased bad debt due to patients inability to pay for certain services. See Item 1A. Risk Factors, in this Form 10-K for additional discussion on the general economic conditions in the United States and recent developments in the healthcare industry that could affect our business.

Healthcare Reform

The Patient Protection and Affordable Care Act (the ACA) contains a number of provisions that could affect us over the next several years. These provisions include the recent establishment of health insurance exchanges to facilitate the purchase of qualified health plans, expanding Medicaid eligibility, subsidizing insurance premiums and creating requirements and incentives for businesses to provide healthcare benefits, the effects of which are unpredictable and complex. Other provisions contain changes to healthcare fraud and abuse laws and expand the scope of the Federal False Claims Act.

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The ACA contains numerous other measures that could also affect us. For example, payment modifiers are to be developed that will differentiate payments to physicians under federal healthcare programs based on quality and cost of care. In addition, other provisions authorize voluntary demonstration projects relating to the bundling of payments for episodes of hospital care and the sharing of cost savings achieved under the Medicare program.

Many of the ACA s most significant reforms, such as the establishment of state-based and federally facilitated insurance exchanges that provide a marketplace for eligible individuals and small employers to purchase health care insurance, only became effective in the beginning of 2014. Following some well-publicized technical issues in accessing and enrolling in the federal online exchange, enrollment in the federal and state exchange healthcare plans met the 7 million first-year target established by the Congressional Budget Office. In the second enrollment period for the exchanges, which runs through February 15, 2015, it has been projected that approximately 9 million people, including new applicants and returning customers, will be enrolled. In November 2014, however, the Supreme Court granted certiorari to hear an appeal challenging the legality of an Internal Revenue Service (IRS) regulation providing subsidies for insurance purchased on the federal exchanges and arguing that the text of the ACA only allows for subsidies for insurance purchased on state-based exchanges. Only 13 states created their own exchanges; the remainder of states provided insurance coverage on the federal exchanges. A ruling in that case, *King v. Burwell*, is expected by June 2015. If the challenge is successful, approximately 5 million people who obtained healthcare coverage through the federal facilitated insurance exchanges could lose their subsidies and their health insurance coverage. In addition, in some cases, the patient responsibility costs related to healthcare plans obtained through the insurance exchanges may be high and could increase in the future, and we may experience increased bad debt due to patients inability to pay for certain services.

Federal and state agencies are expected to continue to implement provisions of the ACA. However, given the complexity and the number of changes expected as a result of the ACA, as well as the implementation timetable for many of them, we cannot predict the ultimate impacts of the ACA as they may not be known for several years. The ACA also remains subject to continuing legislative scrutiny, including efforts by Congress to amend or repeal a number of its provisions. In addition, there have been lawsuits filed by various stakeholders pertaining to the ACA that may have the effect of modifying or altering various parts of the law. As a result, we cannot predict with any assurance the ultimate effect of the ACA on our Company, nor can we provide any assurance that its provisions will not have a material adverse effect on our business, financial condition, results of operations or cash flows.

Medicaid to Medicare Payment Parity

In November 2012, the Centers for Medicare & Medicaid Services (CMS) adopted a rule under the ACA that generally allowed physicians who provided eligible primary care services to be paid at the Medicare reimbursement rates in effect in calendar years 2013 and 2014 instead of state-established Medicaid reimbursement rates that would have been applicable in those years (parity revenue).

During the years ended December 31, 2014 and 2013, we recognized approximately $65.0 million and $31.2 million, respectively, in parity revenue that contributed approximately $0.20 and $0.10, respectively, to our net income per diluted share, reflecting the impacts from incentive compensation and income taxes.

Absent legislative action by Congress, federal funding for the enhanced Medicaid payments will no longer be available for dates of service beyond December 31, 2014. Advocacy efforts continue by various parties at both the federal and state level working with legislators to continue this program, but to date, only a limited number of states have committed to either extend this program, at least in part, for a limited period of time or increase their pre-parity base Medicaid rates.

Medicaid Expansion

The ACA also allows states to expand their Medicaid programs through federal payments that fund most of the cost of increasing the Medicaid eligibility income limit from a state s historic eligibility levels to 133% of the

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federal poverty level. To date, however, 20 states have expressed their intent not to expand Medicaid eligibility. However, several states are exploring the opportunity to expand Medicaid eligibility in a manner that is different than set forth under the ACA. As a result of these and other uncertainties, we cannot predict whether there will be more uninsured patients than anticipated when the ACA was enacted. All of the states in which we operate, however, already cover children in the first year of life and pregnant women if their household income is at or below 133% of the federal poverty level.

Medicare Sequestration

In addition, the Budget Control Act of 2011 required across-the-board cuts (sequestrations) to Medicare reimbursement rates. These annual reductions of 2% began in April 2013 and apply to mandatory and discretionary spending in the years 2013 to 2021, and were extended through fiscal year 2024 by the Bipartisan Budget Act of 2013 and Public Law 113-82. This reduction in Medicare reimbursement rates is not expected to have a material adverse effect on our business, financial condition, results of operations or cash flows.

2014 Medicare Fee Schedule

Presently, Medicare pays for all physician services based upon a national fee schedule that contains a list of uniform rates. The fee schedule is adjusted annually based on a complex formula that is linked in part to the use of services by Medicare beneficiaries and the growth in gross domestic product (the Sustainable Growth Rate formula). Since 2002, this Sustainable Growth Rate formula has resulted in negative payment updates for physicians under the fee schedule that have grown larger, and Congress has had to take repeated legislative action to reverse scheduled payment reductions, most recently in March 2014, when legislation was enacted to avert a rate reduction and temporarily increase Medicare physician payment rates through the end of March 2015. If Congress does not take further action to modify or repeal the Sustainable Growth Rate formula, payments for physician services under the Medicare fee schedule will be reduced by approximately 20% effective April 1, 2015. Fee reductions will continue to be scheduled annually unless Congress takes action in the future to modify or reform the mechanism by which payment rates are updated.

Geographic Coverage

During 2014, 2013 and 2012, approximately 62%, 58% and 59%, respectively, of our net revenue was generated by operations in our five largest states. During 2014 and 2013, our five largest states consisted of Texas, North Carolina, Florida, Tennessee and Georgia. During 2012, our five largest states consisted of Texas, North Carolina, Florida, Georgia and California. During 2014, 2013 and 2012, our operations in Texas accounted for approximately 24%, 22% and 24%, respectively, of our net revenue.

Payor Mix

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 revenue based upon the difference between our gross fees for services and our estimated ultimate collections from payors. Net revenue differs from gross fees due to (i) managed care payments at contracted rates, (ii) GHC Program reimbursements at government-established 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 composed of contracted managed care, government, principally Medicare and Medicaid, 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.

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The following is a summary of our payor mix, expressed as a percentage of net revenue, exclusive of administrative fees and revenue related to our non-practice service offerings, for the periods indicated:

	Years Ended December 31,		
	2014	2013	2012
Contracted managed care	68%	69%	69%
Government	25%	24%	24%
Other third-parties	5%	5%	6%
Private-pay patients	2%	2%	1%
	100%	100%	100%

The payor mix shown in the table above is not necessarily representative of the amount of services provided to patients covered under these plans. For example, the gross amount billed to patients covered under government programs for the years ended December 31, 2014, 2013 and 2012 represented approximately 54%, 54% and 55%, respectively, of our total gross patient service revenue. These percentages of gross revenue and the percentages of net revenue provided in the table above include the payor mix impact of acquisitions completed through December 31, 2014. On a same-unit basis, however, the gross amount billed to patients covered under government programs for the years ended December 31, 2014, 2013 and 2012 represented approximately 56% of our total gross patient service revenue. Same units are those units at which we provided services for the entire current period and the entire comparable period.

Quarterly Results

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

There are fewer calendar days in the first and second quarters of the year, as compared to the third and fourth quarters of the year. Because we provide services in NICUs on a 24-hours-a-day basis, 365 days a year, any reduction in service days will have a corresponding reduction in net revenue.

The majority of physician services provided by our office-based and anesthesia practices consist of office visits and scheduled procedures that occur during business hours. As a result, volumes at those practices fluctuate based on the number of business days in each calendar quarter.

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.

We have significant fixed operating costs, including physician compensation, 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 affected 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 unaudited quarterly results are presented in further detail in Note 17 to our 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 (GAAP) requires estimates and assumptions that affect the reporting of assets, liabilities, revenue 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 GAAP.

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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 is 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.

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 GHC 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 GHC Programs and third-party insurance payors for such services. The evaluation of these historical and other factors involves complex, subjective judgments. On a routine basis, we compare our cash collections to recorded net patient service revenue and evaluate our historical allowance for contractual adjustments and uncollectibles based upon the ultimate resolution of the accounts receivable balance. These procedures are completed regularly in order to monitor our process of establishing appropriate reserves for contractual adjustments. We have not recorded any material adjustments to prior period contractual adjustments and uncollectibles in the years ended December 31, 2014, 2013 or 2012.

DSO is one of the key factors that we use to evaluate the condition of our accounts receivable and the related allowances for contractual adjustments and uncollectibles. DSO reflects the timeliness of cash collections on billed revenue and the level of reserves on outstanding accounts receivable. Any significant change in our DSO results in additional analyses of outstanding accounts receivable and the associated reserves. We calculate our DSO using a three-month rolling average of net revenue. Our net 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. As of December 31, 2014, our DSO was 49.8 days. We had approximately $1.2 billion in gross accounts receivable outstanding at December 31, 2014, and considering this outstanding balance, based on our historical experience, a reasonably likely change of 0.5% to 1.50% in our estimated collection rate would result in an impact to net revenue of approximately $6.0 million to $18.0 million. The impact of this change does not include adjustments that may be required as a result of audits, inquiries and investigations from government authorities and agencies and other third-party payors that may occur in the ordinary course of business. See Note 16 to our Consolidated Financial Statements in this Form 10-K.

Professional Liability Coverage

We maintain professional liability insurance policies with third-party insurers generally 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 primarily through a wholly owned captive insurance subsidiary. We record liabilities for self-insured amounts and claims incurred but not reported based on an

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actuarial valuation using historical loss information, claim emergence patterns and various actuarial assumptions. Liabilities for claims incurred but not reported are not discounted. The average lag period from the date a claim is reported to the date it reaches final settlement is approximately three and one half years, although the facts and circumstances of individual claims could result in lag periods that vary from this average. Our actuarial assumptions incorporate multiple complex methodologies to determine the best liability estimate for claims incurred but not reported and the future development of known claims, including methodologies that focus on industry trends, paid loss development, reported loss development and industry-based expected pure premiums. The most significant assumptions used in the estimation process include the use of loss development factors to determine the future emergence of claim liabilities, the use of frequency and trend factors to estimate the impact of economic, judicial and social changes affecting claim costs, and assumptions regarding legal and other costs associated with the ultimate settlement of claims. The key assumptions used in our actuarial valuations are subject to constant adjustments as a result of changes in our actual loss history and the movement of projected emergence patterns as claims develop. We evaluate the need for professional liability insurance reserves in excess of amounts estimated in our actuarial valuations on a routine basis, and as of December 31, 2014, based on our historical experience, a reasonably likely change of 4% to 6% in our estimates would result in an increase or decrease to net income of approximately $2.3 million to $3.5 million. However, because many factors can affect historical and future loss patterns, the determination of an appropriate professional liability reserve involves complex, subjective judgment, and actual results may vary significantly from estimates.

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. We test goodwill for impairment at a reporting unit level on an annual basis. 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 based on our market capitalization 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.

Uncertain Tax Positions

We account for uncertainty in income taxes in accordance with the accounting guidance for uncertain tax positions. This guidance prescribes a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. It also requires policy disclosures regarding penalties and interest and disclosures regarding increases and decreases in uncertain tax positions as a result of tax positions taken in a current or prior period, settlements with taxing authorities and any lapse of an applicable statute of limitations. Additional qualitative discussion is required for any tax position that may result in a significant increase or decrease in uncertain tax positions within a 12-month period from our reporting date. Accounting for uncertain tax positions under this guidance requires significant judgment and analyses as well as assumptions about future events. Future changes to our analyses and assumptions related to uncertain tax positions may have a material impact on our Consolidated Financial Statements.

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

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our affiliated professional contractors meeting the controlling financial interest criteria set forth in accounting guidance for consolidations. 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 below for matters that may affect our accounting policies in the future.

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 revenue (patient billings net of contractual adjustments and uncollectibles, and including administrative fees):

	Years Ended December 31,		
	2014	2013	2012
Net revenue	100.0%	100.0%	100.0%
Operating expenses:			
Practice salaries and benefits	63.3	63.2	62.2
Practice supplies and other operating expenses	3.7	3.8	4.0
General and administrative expenses	10.1	10.1	10.7
Depreciation and amortization	1.9	1.9	1.7
Total operating expenses	79.0	79.0	78.6
Income from operations	21.0	21.0	21.4
Non-operating expense, net	0.1	0.2	0.1
Income before income taxes	20.9	20.8	21.3
Income tax provision	7.9	7.8	8.0
Net income	13.0%	13.0%	13.3%

Year Ended December 31, 2014 as Compared to Year Ended December 31, 2013

Our net revenue increased $284.9 million, or 13.2%, to $2.44 billion for the year ended December 31, 2014, as compared to $2.15 billion for 2013. Of this $284.9 million increase, $205.4 million, or 9.4%, was attributable to revenue generated from acquisitions completed after December 31, 2012. Same-unit net revenue increased $79.5 million, or 3.8%, for the year ended December 31, 2014. Same units are those units at which we provided services for the entire current period and the entire comparable period. The change in same-unit net revenue was the result of an increase in revenue of approximately $47.2 million, or 2.3%, related to net reimbursement-related factors and a net increase of $32.3 million, or 1.5%, from higher overall patient service volumes. The net increase in revenue of $47.2 million related to reimbursement-related factors was primarily due to the favorable impact from the parity revenue recorded, continued improvements in managed care contracting and the flow through of revenue from modest price increases. The increase in revenue of $32.3 million from higher patient service volumes includes increases in our anesthesiology, neonatology and other pediatric services, primarily newborn nursery services, partially offset by declines in our maternal-fetal medicine and pediatric cardiology services.

Practice salaries and benefits increased by $182.1 million, or 13.4%, to $1.54 billion for the year ended December 31, 2014, as compared to $1.36 billion for 2013. This $182.1 million increase was primarily attributable to increased costs associated with new physicians and other staff to support acquisition-related growth and growth at existing units, of which $135.8 million was related to salaries and $46.3 million was related to benefits and incentive compensation.

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Practice supplies and other operating expenses increased $6.6 million, or 8.0%, to $89.0 million for the year ended December 31, 2014, as compared to $82.4 million for 2013. The increase was primarily attributable to practice supply, rent and other costs related to our acquisitions.

General and administrative expenses include all billing and collection functions and all other salaries, benefits, supplies and operating expenses not specifically related to the day-to-day operations of our physician group practices and those attributable to our non-practice service offerings. General and administrative expenses increased $29.3 million, or 13.4%, to $247.5 million for the year ended December 31, 2014, as compared to $218.2 million for 2013. This increase of $29.3 million is attributable to the overall growth of the Company including acquisition-related growth. General and administrative expenses as a percentage of net revenue were 10.1% for the years ended December 31, 2014 and 2013.

Depreciation and amortization expense increased by $6.0 million, or 15.1%, to $46.0 million for the year ended December 31, 2014, as compared to $40.0 million for 2013. The increase was primarily attributable to the amortization of intangible assets related to acquisitions.

Income from operations increased $60.9 million, or 13.5%, to $513.0 million for the year ended December 31, 2014, as compared to $452.1 million for 2013. Our operating margin was 21.0% for the years ended December 31, 2014 and 2013.

Net non-operating expenses were $4.4 million for the year ended December 31, 2014, as compared to $3.7 million for 2013. The net increase in non-operating expenses was primarily related to increases in interest expense due to higher outstanding borrowings under our credit facility and market value adjustments in the investments underlying our deferred compensation arrangements, partially offset by equity in earnings of an unconsolidated affiliate, the favorable impact from a settlement of litigation during the first quarter and a decrease in accretion expense. Interest expense consists of interest charges, commitment fees and amortized debt costs related to our credit facility and accretion expense related to our contingent consideration liabilities.

Our effective income tax rate was 37.6% for the year ended December 31, 2014, as compared to 37.4% for 2013.

Net income attributable to MEDNAX, Inc. increased by 13.1% to $317.3 million for the year ended December 31, 2014, as compared to $280.5 million for 2013.

Diluted net income attributable to MEDNAX, Inc. per common and common equivalent share was $3.18 on weighted average shares outstanding of 99.9 million for the year ended December 31, 2014, as compared to $2.78 on weighted average shares outstanding of 101.0 million for 2013. The decrease of 1.1 million in our weighted average shares outstanding during 2014 is primarily due to the impact of shares repurchased under our repurchase programs, partially offset by the exercise of employee stock options, the vesting of restricted and deferred stock and the issuance of shares under our 1996 Non-Qualified Employee Stock Purchase Plan, as amended and restated (the Stock Purchase Plan).

Year Ended December 31, 2013 as Compared to Year Ended December 31, 2012

Our net revenue increased $337.4 million, or 18.6%, to $2.15 billion for the year ended December 31, 2013, as compared to $1.82 billion for 2012. Of this $337.4 million increase, $265.0 million, or 78.5%, was attributable to revenue generated from acquisitions completed after December 31, 2011. Same-unit net revenue increased $72.4 million, or 4.2%, for the year ended December 31, 2013. The change in same-unit net revenue was the result of an increase in revenue of approximately $70.3 million, or 4.1%, related to net reimbursement-related factors and a net increase of $2.1 million, or 0.1%, from higher overall patient service volumes. The net increase in revenue of $70.3 million related to reimbursement-related factors was primarily due to the favorable impact from the parity revenue recorded, continued improvements in managed care contracting and the flow through of

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revenue from modest price increases, partially offset by a slight decrease in revenue caused by an increase in the percentage of our patients being enrolled in GHC Programs. The increase in revenue of $2.1 million from higher patient service volumes includes increases in our other pediatric services, primarily newborn nursery services, and increases in our anesthesiology and maternal-fetal medicine services, partially offset by declines in our neonatal and pediatric cardiology services.

Practice salaries and benefits increased by $230.4 million, or 20.4%, to $1.36 billion for the year ended December 31, 2013, as compared to $1.13 billion for 2012. This $230.4 million increase was primarily attributable to increased costs associated with new physicians and other staff to support acquisition-related growth and growth at existing units, of which $184.5 million was related to salaries and $45.9 million was related to benefits and incentive compensation.

Practice supplies and other operating expenses increased $10.6 million, or 14.7%, to $82.4 million for the year ended December 31, 2013, as compared to $71.8 million for 2012. The increase was primarily attributable to practice supply, rent and other costs related to our acquisitions, of which approximately $1.8 million was related to the net change in the fair value of contingent consideration liabilities.

General and administrative expenses include all billing and collection functions and all other salaries, benefits, supplies and operating expenses not specifically related to the day-to-day operations of our physician group practices. General and administrative expenses increased $24.7 million, or 12.8%, to $218.2 million for the year ended December 31, 2013, as compared to $193.5 million for 2012. This increase of $24.7 million is attributable to the overall growth of the Company including acquisition-related growth. General and administrative expenses as a percentage of net revenue were 10.1% for the year ended December 31, 2013 as compared to 10.7% for the year ended December 31, 2012 and grew at a rate considerably slower than the rate of revenue growth.

Depreciation and amortization expense increased by $9.2 million, or 29.7%, to $40.0 million for the year ended December 31, 2013, as compared to $30.8 million for 2012. The increase was primarily attributable to the amortization of intangible assets related to acquisitions.

Income from operations increased $62.6 million, or 16.1%, to $452.1 million for the year ended December 31, 2013, as compared to $389.5 million for 2012. Our operating margin was 21.0% for the year ended December 31, 2013, as compared to 21.4% for 2012. This decrease of 45 basis points was primarily due to the variability in margins related to the mix of practices acquired after December 31, 2011.

We recorded net non-operating expenses of $3.7 million for the year ended December 31, 2013, as compared to $1.3 million for 2012. The net increase was primarily due to increased interest expense related to higher outstanding borrowings and a higher effective interest rate on borrowings under our credit facility as well as increases in accretion expense related to our contingent consideration liabilities.

Our effective income tax rate was 37.4% for the year ended December 31, 2013, as compared to 37.9% for 2012.

Net income attributable to MEDNAX, Inc. increased by 16.4% to $280.5 million for the year ended December 31, 2013, as compared to $240.9 million for 2012.

Diluted net income attributable to MEDNAX, Inc. per common and common equivalent share was $2.78 on weighted average shares outstanding of 101.0 million for the year ended December 31, 2013, as compared to $2.42 on weighted average shares outstanding of 99.4 million for 2012. The increase of 1.6 million in our weighted average shares outstanding during 2013 is primarily due to the exercise of employee stock options, the vesting of restricted and deferred stock and the issuance of shares under our Stock Purchase Plan, partially offset by the impact of shares repurchased under our repurchase program.

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LIQUIDITY AND CAPITAL RESOURCES

As of December 31, 2014, we had $47.9 million of cash and cash equivalents on hand as compared to $31.1 million at December 31, 2013. Additionally, we had working capital of $50.8 million at December 31, 2014, an increase of $9.5 million from our working capital of $41.3 million at December 31, 2013. This net increase in working capital is primarily due to net borrowings on our credit facility, 2014 earnings, an increase in our long-term deferred tax liabilities and proceeds from the issuance of common stock under our stock incentive plan and Stock Purchase Plan, largely offset by the use of funds for repurchases of our common stock and acquisitions.

We generated cash flow from operating activities of $422.6 million, $405.4 million and $324.9 million for the years ended December 31, 2014, 2013 and 2012, respectively. The net increase of $17.2 million in cash flow provided from operating activities for the year ended December 31, 2014, as compared to the year ended December 31, 2013, was primarily due to improved operating results and a net increase in cash flow related to changes in the components of our accounts payable and accrued expenses, consisting primarily of a higher accrued incentive compensation liability, partially offset by a reduction in cash flow related to higher accounts receivable balances.

During the year ended December 31, 2014, accounts receivable increased by $66.8 million, as compared to an increase of $37.3 million for 2013. The increases in accounts receivable are primarily due to higher accounts receivable balances related to acquisitions as well as increases at our existing units, including accrued parity revenue.

Our accounts receivable are principally due from managed care payors, government payors, and other third-party insurance payors. We track our collections from these sources, monitor the age of our accounts receivable, and make all reasonable efforts to collect outstanding accounts receivable through our systems, processes and personnel at our corporate and regional billing and collection offices. We use customary collection practices, including the use of outside collection agencies, for accounts receivable due from private pay patients when appropriate. Almost all of our accounts receivable adjustments consist of contractual adjustments due to the difference between gross amounts billed and the amounts allowed by our payors. Any amounts written off related to private pay patients are based on the specific facts and circumstances related to each individual patient account.

Days sales outstanding (DSO) is one of the key factors that we use to evaluate the condition of our accounts receivable and the related allowances for contractual adjustments and uncollectibles. DSO reflects the timeliness of cash collections on billed revenue and the level of reserves on outstanding accounts receivable. Our DSO was 49.8 days at December 31, 2014 as compared to 46.3 days at December 31, 2013. The change in our DSO resulted primarily from increases in accounts receivable related to acquisitions as well as at our existing units, including accrued parity revenue. See Application of Critical Accounting Policies and Estimates Revenue Recognition for more information on our DSO.

Our cash flow from operating activities is significantly affected by the payment of physician incentive compensation. A large majority of our affiliated physicians participate in our performance-based incentive compensation program and almost all of the payments due under the program are made annually in the first quarter. As a result, we typically experience negative cash flow from operations in the first quarter of each year and fund our operations during this period with cash on hand or funds borrowed under our Line of Credit. In addition, during the first quarter of each year, we use cash to make any discretionary matching contributions for participants in our qualified contributory savings plans.

Cash flow provided from operating activities for the year ended December 31, 2013 was affected by a net increase in cash flow related to improved operating results, changes in the components of our accounts payable and accrued expenses, consisting primarily of a higher accrued incentive compensation liability. Cash flow

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provided from operating activities for the year ended December 31, 2012 was affected by a net increase in cash flow related to our accounts receivable, primarily due to improved cash collections at our existing units and improved operating results.

During the year ended December 31, 2014, our net cash used in investing activities of $503.6 million included acquisition payments of $479.4 million, capital expenditures of $18.1 million and net purchases of $6.1 million related to the purchase and maturity of investments. Our acquisition payments were related to the purchase of 11 physician practices and two complementary services businesses, consisting of a revenue cycle management company and a consulting services company. Our capital expenditures were for medical equipment, computer and office equipment, leasehold and other improvements, software and furniture and fixtures.

During the year ended December 31, 2014, our net cash provided from financing activities of $97.8 million consisted primarily of net borrowings on our credit facility of $541.0 million, proceeds from the exercise of employee stock options and the issuance of common stock under our Stock Purchase Plan of $42.9 million and excess tax benefits related to the exercise of employee stock options and the vesting of restricted and deferred stock of $17.5 million, offset by the repurchase of $488.4 million of our common stock and the payment of $11.7 million for contingent consideration liabilities.

On October 29, 2014, we entered into the New Credit Agreement, which replaced our amended and restated credit agreement. The New Credit Agreement provides for a $1.3 billion unsecured revolving credit facility and a $200 million term loan and includes a $75 million sub-facility for swingline loans and a $37.5 million sub-facility for the issuance of letters of credit. We may increase the credit facility to up to $1.8 billion on an unsecured basis, subject to the satisfaction of specified conditions. The Credit Agreement matures on October 29, 2019 and is guaranteed by substantially all of our subsidiaries and affiliated professional contractors. At our option, borrowings under the New Credit Agreement (other than swingline loans) will bear interest at (i) the Alternate Base Rate (defined as the highest of (a) the prime rate, (b) the Federal Funds Rate plus 1/2 of 1.00% and (c) LIBOR for an interest period of one month plus 1.00%) plus an applicable margin rate ranging from 0.125% to 0.750% based on our consolidated leverage ratio or (ii) the LIBOR rate plus an applicable margin rate ranging from 1.125% to 1.750% based on our consolidated leverage ratio. Swingline loans will bear interest at the alternate base rate plus the applicable margin. The New Credit Agreement also calls for other customary fees and charges, including an unused commitment fee ranging from 0.150% to 0.300% of the unused lending commitments, based on the our consolidated leverage ratio.

The New Credit Agreement contains customary covenants and restrictions, including covenants that require us to maintain a minimum interest coverage ratio, not to exceed a specified consolidated leverage ratio and to comply with laws. The New Credit Agreement permits us to pay dividends and make certain other distributions, subject to limitations specified therein. Failure to comply with these covenants would constitute an event of default under the New Credit Agreement, notwithstanding the ability of the company to meet its debt service obligations. The New Credit Agreement also includes various customary remedies for the lenders following an event of default, including the acceleration of repayment of outstanding amounts under the New Credit Agreement.

At December 31, 2014, we had an outstanding principal balance of $568.0 million on our New Credit Agreement, comprised of $368.0 under our revolving line of credit and a $200.0 million term loan. We also had outstanding letters of credit associated with our professional liability insurance program of $0.2 million which reduced the amount available on the New Credit Agreement to $931.8 million at December 31, 2014.

At December 31, 2014, we believe we were in compliance, in all material respects, with the financial covenants and other restrictions applicable to us under the New Credit Agreement.

The exercise of employee stock options and the purchase of common stock by employees participating in our Stock Purchase Plan generated cash proceeds of $42.9 million, $28.7 million and $28.8 million for the years

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ended December 31, 2014, 2013 and 2012, respectively. Because stock option exercises and purchases under the Stock Purchase Plan are dependent on several factors, including the market price of our common stock, we cannot predict the timing and amount of any future proceeds.

We maintain professional liability insurance policies with third-party insurers, subject to self-insured retention, exclusions and other restrictions. We self-insure our liabilities to pay self-insured retention amounts under our professional liability insurance coverage 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 information, claim emergence patterns and various actuarial assumptions. Our total liability related to professional liability risks at December 31, 2014 was $168.4 million, of which $19.7 million is classified as a current liability within accounts payable and accrued expenses in the Consolidated Balance Sheet.

We anticipate that funds generated from operations, together with our current cash on hand and funds available under our New Credit Agreement, will be sufficient to finance our working capital requirements, fund anticipated acquisitions and capital expenditures, fund our share repurchase programs and meet our contractual obligations as described below for at least the next 12 months.

CONTRACTUAL OBLIGATIONS

At December 31, 2014, we had certain obligations and commitments under our New Credit Agreement, capital leases and operating leases totaling approximately $711.5 million as follows (in thousands):

		Payments Due			
Obligation	**Total**	**2015**	**2016 and 2017**	**2018 and 2019**	**2020 and Later**
Credit Agreement (1)	$ 613,536	$ 20,575	$ 48,554	$ 544,407	$
Capital leases	1,320	465	746	109	
Operating leases	96,620	27,272	38,473	19,947	10,928
	$ 711,476	$ 48,312	$ 87,773	$ 564,463	$ 10,928

(1) Amounts include interest payments at the applicable rate as of December 31, 2014 and assume the amount outstanding under our revolving line of credit as of December 31, 2014 will be paid on the maturity date and amounts outstanding under our term loan as of December 31, 2014 will be paid according to the principal payment schedule.

Certain of our acquisition agreements contain contingent consideration provisions based on volume and other performance measures over an up to five-year period. Potential payments under these provisions are not contingent upon the future employment of the sellers. As of December 31, 2014, cash payments of up to $37.5 million may be due through 2019 under all contingent consideration provisions as follows (in thousands):

2015	$ 15,778
2016	9,792
2017	6,199
2018	3,938
2019	1,800
	$ 37,507

At December 31, 2014, our total liability for uncertain tax positions was $25.9 million, and is included within other liabilities on our Consolidated Balance Sheet. The timing and amount of future cash flows for each year beyond 2014 cannot be reasonably estimated. See Note 11 to our Consolidated Financial Statements in this Form 10-K for more information regarding our uncertain tax positions.

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OFF-BALANCE SHEET ARRANGEMENTS

At December 31, 2014, we did not have any off-balance sheet arrangements that have or are reasonably likely to have a current or future effect on our financial condition, changes in financial condition, revenue or expenses, results of operations, liquidity, capital expenditures or capital resources.

NEW ACCOUNTING PRONOUNCEMENTS

In May 2014, the accounting guidance related to revenue recognition was amended to outline a single, comprehensive model for accounting for revenue from contracts with customers. While the new guidance supersedes existing revenue recognition guidance, it closely aligns with current GAAP. The new guidance will become effective for us on January 1, 2017, and early adoption is not permitted. We are currently evaluating the impact, if any, the adoption of this guidance will have on our consolidated financial statements.

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ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We borrow under our New Credit Agreement at various interest rate options based on the Alternate Base Rate or LIBOR rate depending on certain financial ratios. Our New Credit Agreement is subject to market risk and interest rate changes. The outstanding principal balance on our New Credit Agreement was $568.0 million, composed of $368.0 million under our revolving line of credit and $200.0 million under our term loan at December 31, 2014. Considering the total outstanding balance of $568.0 million, a 1% change in interest rates would result in an impact to income before income taxes of approximately $5.7 million per year.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The following Consolidated Financial Statements and Financial Statement Schedule of MEDNAX, Inc. and its subsidiaries are included in this Form 10-K on the pages set forth below:

INDEX TO FINANCIAL STATEMENTS

AND FINANCIAL STATEMENT SCHEDULE

	Page
Consolidated Financial Statements	
Report of Independent Registered Certified Public Accounting Firm	59
Consolidated Balance Sheets at December 31, 2014 and 2013	60
Consolidated Statements of Income for the Years Ended December 31, 2014, 2013 and 2012	61
Consolidated Statements of Equity for the Years Ended December 31, 2014, 2013 and 2012	62
Consolidated Statements of Cash Flows for the Years Ended December 31, 2014, 2013 and 2012	63
Notes to Consolidated Financial Statements	64
Financial Statement Schedule	
Schedule II Valuation and Qualifying Accounts for the Years Ended December 31, 2014, 2013 and 2012	86

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Report of Independent Registered Certified Public Accounting Firm

To the Board of Directors and Shareholders of

MEDNAX, Inc.:

In our opinion, the consolidated financial statements listed in the accompanying index present fairly, in all material respects, the financial position of MEDNAX, Inc. and its subsidiaries at December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedule listed in the accompanying index presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company s management is responsible for these consolidated financial statements and financial statement schedule, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management s Annual Report on Internal Control over Financial Reporting under Item 9A. Our responsibility is to express opinions on these consolidated financial statements, on the financial statement schedule, and on the Company s internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the consolidated financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall consolidated financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

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

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

/s/ PricewaterhouseCoopers LLP

Ft. Lauderdale, Florida

February 9, 2015

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MEDNAX, INC.

CONSOLIDATED BALANCE SHEETS

(in thousands)

	December 31, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 47,928	$ 31,137
Short-term investments	6,035	6,457
Accounts receivable, net	352,191	285,397
Prepaid expenses	7,036	6,361
Deferred income taxes	45,961	30,766
Other assets	7,901	8,007
Total current assets	467,052	368,125
Investments	64,082	57,511
Property and equipment, net	66,048	59,911
Goodwill	2,776,188	2,393,731
Other assets, net	235,425	129,438
Total assets	$ 3,608,795	$ 3,008,716
LIABILITIES & EQUITY		
Current liabilities:		
Accounts payable and accrued expenses	$ 380,658	$ 308,754
Current portion of long-term debt and capital lease obligations	10,465	92
Income taxes payable	25,150	17,946
Total current liabilities	416,273	326,792
Line of credit	368,000	27,000
Long-term debt and capital lease obligations	190,855	143
Long-term professional liabilities	148,651	139,367
Deferred income taxes	160,487	111,441
Other liabilities	58,963	60,985
Total liabilities	1,343,229	665,728
Commitments and contingencies		
Shareholders equity:		
Preferred stock; $.01 par value; 1,000 shares authorized; none issued		
Common stock; $.01 par value; 200,000 shares authorized; 96,030 and 101,207 shares issued and outstanding, respectively	960	1,012
Additional paid-in capital	886,877	857,953
Retained earnings	1,376,782	1,484,023
Total MEDNAX, Inc. shareholders equity	2,264,619	2,342,988
Noncontrolling interests	947	
Total equity	2,265,566	2,342,988

Total liabilities and equity	$ 3,608,795	$ 3,008,716

The accompanying notes are an integral part of these Consolidated Financial Statements.

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MEDNAX, INC.

CONSOLIDATED STATEMENTS OF INCOME

(in thousands, except for per share data)

	Years Ended December 31,		
	2014	**2013**	**2012**
Net revenue	$ 2,438,913	$ 2,154,012	$ 1,816,612
Operating expenses:			
Practice salaries and benefits	1,543,395	1,361,318	1,130,913
Practice supplies and other operating expenses	89,002	82,388	71,823
General and administrative expenses	247,527	218,209	193,540
Depreciation and amortization	45,990	39,966	30,816
Total operating expenses	1,925,914	1,701,881	1,427,092
Income from operations	512,999	452,131	389,520
Investment income	2,728	1,696	1,896
Interest expense	(8,891)	(5,415)	(3,245)
Equity in earnings of unconsolidated affiliate	1,780		
Total non-operating expenses	(4,383)	(3,719)	(1,349)
Income before income taxes	508,616	448,412	388,171
Income tax provision	191,413	167,895	147,264
Net income	317,203	280,517	240,907
Net loss attributable to noncontrolling interests	78		
Net income attributable to MEDNAX, Inc.	$ 317,281	$ 280,517	$ 240,907
Per common and common equivalent share data:			
Net income attributable to MEDNAX, Inc.:			
Basic	$ 3.22	$ 2.83	$ 2.47
Diluted	$ 3.18	$ 2.78	$ 2.42
Weighted average common shares:			
Basic	98,588	99,112	97,386
Diluted	99,887	100,969	99,382

The accompanying notes are an integral part of these Consolidated Financial Statements.

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MEDNAX, INC.

CONSOLIDATED STATEMENTS OF EQUITY

(in thousands)

	Common Stock					
	Number of Shares	Amount	Additional Paid-in Capital	Retained Earnings	Noncontrolling Interests	Total Equity
Balance at December 31, 2011	97,866	$ 978	$ 724,157	$ 1,005,881	$	$ 1,731,016
Net income				240,907		240,907
Common stock issued under employee stock option and stock purchase plan	1,320	13	28,797			28,810
Issuance of restricted stock	930	9	(9)			
Stock-based compensation expense			28,437			28,437
Forfeitures of restricted stock	(78)					
Excess tax benefit related to employee stock incentive plans			6,198			6,198
Balance at December 31, 2012	100,038	1,000	787,580	1,246,788		2,035,368
Net income				280,517		280,517
Common stock issued under employee stock option and stock purchase plan	1,331	14	28,683			28,697
Issuance of restricted stock and vesting of deferred stock	922	9	(9)			
Stock-based compensation expense			31,288			31,288
Forfeitures of restricted stock	(28)					
Repurchased common stock	(1,056)	(11)	(8,570)	(43,282)		(51,863)
Excess tax benefit related to employee stock incentive plans			18,981			18,981
Balance at December 31, 2013	101,207	1,012	857,953	1,484,023		2,342,988
Contributions from noncontrolling interests					1,025	1,025
Net income (loss)				317,281	(78)	317,203
Common stock issued under employee stock option and stock purchase plan	1,412	13	42,863			42,876
Issuance of restricted stock and vesting of deferred stock	573	6	(6)			
Issuance of restricted stock for contingent consideration	12		705			