Table of Contents

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

Form 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2019

☐ **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	Trading Symbol	Name of Each Exchange on Which Registered
Common Stock, par value $.01 per share	**MD**	**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 ☒ 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 ☒

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 ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted 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 such files). Yes ☒ No ☐

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

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

The aggregate market value of shares of Common Stock of the registrant held by non-affiliates of the registrant on June 28, 2019, the last business day of the registrant's most recently completed second fiscal quarter, was $2,051,190,371 based on a $25.23 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 February 14, 2020 was 84,277,494.

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 2020 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.

MEDNAX, INC.
ANNUAL REPORT ON FORM 10-K
For the Year Ended December 31, 2019
INDEX

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," "estimate," "project," "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.

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.

PART I

ITEM 1. BUSINESS

OVERVIEW

MEDNAX is a leading provider of physician services including newborn, anesthesia, maternal-fetal, radiology and teleradiology, pediatric cardiology and other pediatric subspecialty care. Our national network is comprised of affiliated physicians who provide clinical care in 39 states and Puerto Rico. At December 31, 2019, our national network comprised over 4,325 affiliated physicians, including 1,290 physicians who provide neonatal clinical care, primarily within hospital-based neonatal intensive care units (“NICUs”), to babies born prematurely or with medical complications. We have 1,300 affiliated physicians who provide anesthesia care to patients in connection with surgical and other procedures, as well as pain management. In addition, we have 400 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 220 physicians providing pediatric intensive care, 105 physicians providing pediatric cardiology care, 150 physicians providing hospital-based pediatric care, 25 physicians providing pediatric surgical care, 10 physicians providing pediatric ear, nose and throat services, and five physicians providing pediatric ophthalmology services. We also provide radiology services including diagnostic imaging and interventional radiology through a network of over 810 affiliated radiologists. In addition to our national physician network, we provide services nationwide to healthcare facilities and physicians, including ours, through a consulting services company.

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 affiliated neonatal physician subspecialists (“neonatologists”), neonatal nurse practitioners and other pediatric clinicians who staff and manage clinical activities at over 375 NICUs in 36 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

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 over 145 hospitals, 140 ambulatory surgery centers and office-based practices across 14 states. Following the "care team" model, our affiliated 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 during surgery, including breathing, heart rhythm and blood pressure.

As an integral part of the surgical team, our affiliated anesthesiologists support the surgeons by providing medical care before, during and after surgery so that surgeons may concentrate on the surgical procedure. Our affiliated 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 board certification in anesthesiology, many of our affiliated 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 30 pain management centers through our network of affiliated physicians and physician assistants. Our affiliated 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 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

through our affiliated pediatric cardiologist subspecialists and other related clinical professionals such as pediatric nurse practitioners, echocardiographers, 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, pediatric surgeons, pediatric ophthalmologists and pediatric ear, nose and throat physicians. 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. Our affiliated physicians who provide this clinical care staff and manage pediatric intensive care units (“PICUs”) at over 65 hospitals.

Pediatric Hospitalists. Pediatric hospitalists are hospital-based pediatricians specializing in inpatient care and management of acutely ill children. Our affiliated hospital-based physicians provide this inpatient pediatric and newborn care in PICUs, NICUs and pediatric emergency rooms at approximately 50 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. Our affiliated physicians in this subspecialty include 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.

Pediatric Ear, Nose and Throat (“ENT”). Pediatric ENT physicians treat conditions that affect a child’s ear, nose, throat and neck. Our affiliated physicians in this subspecialty provide all aspects of ear, nose and throat medical, audiology and surgical services, including ear tubes, tonsillectomies and sinus surgery.

Pediatric Ophthalmology. Pediatric ophthalmologists focus on the development of the visual system and various diseases that disrupt visual development in children. Our affiliated physicians in this subspecialty specialize in retinopathy of prematurity screening and visual care consulting services.

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 2019, we screened almost 900,000 babies for potential hearing loss at 465 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.

Radiology and Teleradiology

Radiology. We provide radiology services including diagnostic imaging, interventional radiology, women's imaging, cardiac imaging and nuclear medicine, among others, through a network of over 390 affiliated physicians. We believe that we bring a unique value proposition to radiology physician groups, in that we can provide practice management support and a technology platform enabling radiology to be practiced at a national level, as well as teleradiology capabilities that can enhance their efficiency, provide subspecialty access and help them to grow strategically and remain competitive while meeting the demands of their hospital partners, third-party payors and regulatory bodies.

We continue to make progress in two programs that we launched in 2018: the MEDNAX Radiology Artificial Intelligence Incubator ("AI Incubator") and the MEDNAX Radiology Centers of Excellence ("Centers of Excellence"). Our AI Incubator program brings together radiologists, a rich and diverse clinical dataset, and a growing ecosystem of partners to build future tools for radiology with the primary goal of improving patient care. Through a strong partnership between clinical and technical leadership as well as a key group of external partners with shared goals, the program aims to improve the overall quality of patient care by increasing radiologists' accuracy and efficiency, ultimately impacting patient outcomes. The Centers of Excellence program is designed to provide added value to our hospital partners and patients alike, including continuous access to radiologist subspecialty expertise, world-class information technology and quality metrics for patient safety. Additionally, we continue to expand our cardiac imaging Centers of Excellence, which is based in Miami, Florida, throughout Florida and Texas.

Teleradiology. Teleradiology represents a component of the broader radiology industry whereby radiographic images are transmitted from one location to another for interpretation. Through our vRad business, we provide teleradiology services to approximately 2,100 client hospitals, health systems and radiology groups across the country. With over 420 U.S. board-certified and board-eligible radiologists currently reading images in the network, the majority of whom are subspecialty trained, we are able to interpret approximately six million patient studies annually and process over 2.8 billion images on what we believe is the world's largest and most advanced telemedicine platform, which is covered by 20 patents. This telemedicine platform enables referring physicians to quickly and securely pass patient imaging and information to radiologists, improving the speed, accuracy and cost of clinical diagnoses.

We have also invested heavily in cloud-based technology to develop our radiology workflow system that supports the distribution, prioritization and completion of imaging studies. Each component of our radiology workflow system, from our submittal process, to our post-diagnostic analytics and benchmarking capabilities, provides evidence-based insight to help clients make better decisions for the health of patients and their practice of radiology. Our radiology workflow system allows for real-time personal connections between our radiologists and our hospital, health system and radiology group partners.

We believe that teleradiology services are poised for growth and that there are numerous opportunities for cross-selling vRad's services within MEDNAX's existing customer base. We believe that teleradiology will play a significant role in the practice of radiology in the future. Our teleradiology business has continued to identify opportunities throughout the country for our radiology physician group practices to expand their presence, and we believe this is becoming a key differentiator as we continue building a broader radiology business.

Consulting Services

Our perioperative consulting company is comprised of a collaborative team of anesthesiologists, operating room nurse executives and perioperative business strategists who develop and provide solutions to optimize the performance, resources and capacity within hospital operating rooms and across the care continuum. Our services include strategic assessments and transformations, central sterile redesign, physician engagement and governance, and staffing/workforce support. With our peer-to-peer consulting model, we partner with our clients to deliver sustainable and actionable results with the goal of streamlining patient throughput, enhancing anesthesia service levels, increasing surgeon and patient satisfaction, decreasing costs and implementing strategic perioperative growth plans to hospitals and health systems.

Clinical Research, Education, Quality and Safety

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 has demonstrated improvements in clinical outcomes, while reducing the costs of care associated with complications as well as variability in protocols. We provide extensive continuing medical education and continuing nursing education to our affiliated clinicians in an effort to ensure that they have access to current treatment methodologies, national best practices and evidence-based guidelines. We believe that referring and collaborating physicians, hospitals, third-party payors and patients all benefit from our clinical research, education, quality and safety initiatives.

DEMAND FOR OUR SERVICES

Hospital-Based Care. Hospitals generally must provide cost-effective, quality care in order to enhance their reputations within their communities and desirability to patients, referring 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. With continuing shifts to value-based reimbursement models, we anticipate that hospitals will continue to seek out experienced organizations with documented success in improving quality indicators and reducing costs. 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.

Neonatal Medicine . Of the approximately 3.8 million births in the United States annually, we estimate that 14%-15% 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 6,100 board-certified neonatologists in the United States.

Anesthesia Medicine. An estimated 50 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 providers. There are approximately 54,000 board certified/eligible anesthesiologists in the United States.

Pain Management. According to the American Academy of Pain Medicine, more than 75 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. Given the current opioid epidemic in the United States and the resulting increased scrutiny by federal and state regulators, we expect that primary care physicians and other non-pain specialists may increase patient referrals to pain specialists to manage this challenging population.

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 2,400 board-certified maternal-fetal medicine subspecialists 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 125 babies is born with some form of heart defect. With advancements in care, there are approximately 1.4 million adults in the United States today living with congenital heart disease. There are approximately 3,000 board-certified pediatric cardiologists in the United States.

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 2,500 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 1,000 board-certified pediatric surgeons in the United States.

Radiology. Radiology is the branch of medical science that uses a variety of medical imaging technology to diagnose injury and disease and sometimes treat diseases in the body. A variety of imaging techniques such as X-ray, fluoroscopy, ultrasound, computed tomography (CT), nuclear medicine, including positron emission tomography (PET), and magnetic resonance imaging (MRI) are used. Interventional radiology is the performance

of typically minimally invasive medical procedures with the guidance of imaging technologies. 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, is expected to result in an increase in demand for radiology services as the increased medical needs of this population require more imaging. There are approximately 34,000 board-certified radiologists in the United States.

Teleradiology and Telemedicine . Teleradiology is the transmission of radiographic images from one location to another for interpretation. Teleradiology represents a component of the broader radiology industry. Within this market, teleradiology is a fast-growing segment of the physician services sector. We believe that there are several factors prompting growth of the teleradiology model. Around-the-clock subspecialty coverage is becoming a standard of care; the idea that a general radiologist practicing in a single hospital has the ability to read all types of images is no longer prevalent. On behalf of their patients, healthcare facilities increasingly seek to have diagnostic images evaluated by radiologists who have expertise in specific subspecialty areas such as neuroradiology, cardiac imaging and vascular surgery. In addition, facilities wish to have this subspecialty service available to them immediately because timing is critical for treatment and recovery. Advances in technology now make this around-the clock expert attention possible; using remote/onsite integration and data analytics, teleradiologists can read diagnostic images from anywhere at any time and seamlessly deliver results. This not only provides the ability to determine optimal treatment decisions for the patient, but also enhances a healthcare facility's ability to efficiently and effectively meet its patients' needs. Since most teleradiology work is completed remotely, the pool of qualified radiologists who are subspecialty trained is significantly greater than would be available in a single geographic area.

Another key driver, we believe, is how we support forward-thinking radiology groups that are attempting to become high-performance providers in their markets. Traditionally, radiology groups have had to staff to their peak volume creating periods where they are overstaffed as volume ramps up or down. With us as a partner, radiology groups can staff to meet typical demand, as opposed to overstaffing, and leverage our solutions for additional coverage at all times, not just the overnight hours. Likewise, radiology groups can more quickly expand their services to other geographies and locations with us as a partner reducing or eliminating the time it takes to recruit physicians for growth. Similarly, teleradiology coverage can be provided for other physician group staffing challenges such as physician retirement and attrition, or to provide expertise in specific subspecialty areas that may not be covered by the physicians in the practice.

Further, we believe there are broader applications across the larger telemedicine industry for the use of the proprietary technology and workflow platform utilized within our teleradiology business. 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 and believe that this will become more relevant as more healthcare providers integrate remote healthcare solutions into their healthcare practices.

Physician 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 and other complementary healthcare services. The key elements of our strategy to achieve this objective are:

- ***Build upon core competencies*** . We have developed significant administrative expertise relating to our practice physician services. We have also facilitated the development of a clinical approach to the practice of medicine among our affiliated physicians through clinical data warehouses that include research, education and quality initiatives intended to advance the practice of medicine and care, improve the quality of care provided to our patients and reduce long-term health system costs. Analysis of the data within our clinical data warehouses across our neonatology, anesthesia and other pediatric subspecialty services 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 efficiencies and ensuring patient satisfaction. 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 warehouses adds value to our patients and 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 have successfully executed 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 have had success developing other programs with our hospital partners. One of these programs relates to obstetric hospitalists (“OB hospitalists”) whereby we have collaborated with hospitals to design programs for which an OB hospitalist is on site at the hospital on a shift basis to provide care for laboring patients and managing obstetrical emergencies. We believe this program is valuable to our hospital partners as the program improves patient safety in part by preventing unattended deliveries and allowing for swifter emergency treatment. An additional benefit from such a program for our hospital partners is that local obstetricians unable to attend deliveries can be confident that there are dedicated in-house obstetricians available to attend such deliveries, and they may therefore choose to deliver at hospitals with such programs.

  We also continue to expand our services in telemedicine, which is the use of telecommunication and information technology in order to provide clinical healthcare at a distance. Our acquisition of vRad was a significant milestone in this rapidly evolving area of healthcare and provided us with vRad’s proprietary technology and workflow platform. Similarly, we expect that 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 expanded 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, our national sales team pursues opportunities across our service lines by employing a targeting strategy with a specific focus and prioritization. This sales team works with existing hospital and other healthcare partners and also focuses on building new relationships with hospitals and other service providers to which we do not currently provide services in order to offer clinical and other solutions and respond to requests for proposals. Our growth teams are managed under one collaborative group that addresses acquisition and organic growth opportunities with the shared goal of MEDNAX being viewed by hospitals and other partners as a multi-specialty health solutions partner across all of its service lines. The growth team partners with the operational leadership across each of our medical groups to execute our overall growth strategy.

- ***Acquire physician practice groups.*** We continue to seek to expand our operations by acquiring established physician practices in our core physician specialties and pursuing complementary pediatric subspecialty physician groups outside of our core specialties when appropriate. During 2019, we added nine physician group practices, including one radiology practice, two neonatology practices, two maternal-fetal medicine practices and four other pediatric subspecialty practices. We currently expect a modest level of acquisition activity during 2020 and currently intend to primarily focus that acquisition activity in our radiology, neonatology and other pediatric subspecialty service lines. However, our ability to consummate these acquisitions is subject to risks and uncertainties; see, for example, Item 1A. Risk Factors — “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.”
- ***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.
- ***Focus on transformation and restructuring initiatives***. We have developed a number of strategic initiatives across our organization, in both our shared services functions and our operational infrastructure, with a goal of generating improvements in our general and administrative expenses and our operational infrastructure. We have broadly classified these workstreams in broad categories, consisting of practice operations, revenue cycle management, information technology and human resources. We have included the expenses, which in certain cases represent estimates, related to such activity on a separate line item in our consolidated statements of income beginning in 2019, and we expect these activities to continue through at least 2020. In our shared services departments, we are focused on improving processes, using our resources more efficiently and utilizing our scale more effectively to improve cost and service performance across our operations. Within our operational infrastructure, we have developed specific operational plans within each of our service lines and affiliated physician practices, with specific milestones and regular reporting, with the goal of generating long-term operational improvements and fostering even greater collaboration across our national medical group. We currently intend to make a series of information technology and other investments to improve processes and performance across our enterprise, using both internal and

external resources. We believe these strategic initiatives, together with our continued plans to invest in focused, targeted and strategic organic and acquisitive growth, position us well to deliver a differentiated value proposition to our stakeholders while continuing to provide the highest quality care for our patients.

CLINICAL RESEARCH, EDUCATION, QUALITY AND SAFETY

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, safety 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 and share our discoveries throughout the medical community through submissions to peer-reviewed literature. To help facilitate and support research efforts, MEDNAX established a Research Advisory Committee (“RAC”). The goal of the RAC is to design, implement and maintain a program for clinical research oversight and support that enables our practices to conduct research that is safe, effective, financially viable and legally compliant, while optimizing research opportunities. The RAC’s multi-disciplinary approach involves the collaboration of both clinical and business professionals, including finance, legal and compliance, and has ultimately enhanced our research efforts and improved overall process flow. With participating clinicians located throughout the country, the RAC supports a comprehensive scope of research efforts, allowing for a more in-depth look at our specialties. This nationwide perspective allows us to better anticipate future needs and opportunities.
- ***Quality and Safety.*** Through the leadership of our affiliated clinicians, we have cultivated a culture of continuous quality improvement and safety, which is the cornerstone of our success and helps us to fulfill our mission. Our team of clinical experts leads and provides oversight for several national quality and safety programs across various specialties and subspecialties.
  - ***Continuous Quality Improvement (“CQI”)*** . CQI initiatives are important for all of our physician specialties. As part of our dedication to improving quality across our affiliated practices, we provide our clinicians with the opportunity to collaborate and share best practices and facilitate access to valuable information, resources and professional development tools. From these collaborations, our affiliated physicians can identify areas for improvement, and then systematically monitor, study, learn, and implement change. There are several complex initiatives that are derived and based on our long-standing CQI efforts, such as our 100,000 Babies and 100,000 Women Campaigns, our value-based care initiatives, several clinical quality collaboratives, and our National High Reliability Organization (“HRO”) program. For anesthesia care, we have continued our Comprehensive Enhanced Recovery After Surgery program and continue to offer a Centers for Medicare and Medicaid Service (“CMS”) certified Qualified Clinical Data Registry (“QCDR”). We recently added a multidisciplinary Enhanced Recovery After Cesarean Surgery program and a Maternal Mortality Reduction program, both of which apply evidence-based practices, HRO concepts and Lean Six Sigma principles. 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 Safety Organization (“PSO”).*** We have a federally-listed 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. Both our anesthesiology HRO program and Women's and Children's HRO program aim to provide "Just Culture" training to our clinicians. The complex curriculum has been customized to meet our affiliated physician practices' needs and is based on principles outlined by the Agency for Healthcare Research and Quality ("AHRQ"), Institute for Healthcare Improvement, National Patient Safety Foundation and Team STEPPS, the teamwork system developed by the AHRQ and the Department of Defense.

- ***Simulation.*** Practicing critical decision-making, communication, task and teamwork skills with *in situ* scenarios promotes optimized clinical performance for high-risk, low-volume critical situations. To meet the needs of our health care providers, hospital and ASC partners, as well as our patients, MEDNAX offers a variety of customized simulation programs with the aim of instilling competence and confidence with one goal in mind: improved outcomes. Our Simulation Program has gained provisional accreditation by the Society for Simulation in Healthcare, a required first step towards attaining full accreditation, and currently offers highly interactive programs for neonatology, anesthesiology and hospital-based medicine practices. The effects of simulation are proven as a performance improvement method and are known to lead to enhanced communication and improved patient outcomes.

- ***Education.*** Our commitment to clinical and research excellence is evidenced by our comprehensive educational and professional development opportunities offered. We provide extensive continuing medical education and continuing nursing education to our affiliated clinicians in an effort to ensure that they have access to current treatment methodologies, national best practices and evidence-based guidelines. As an Accreditation Council for Continuing Medical Education accredited provider, we offer a variety of live and online educational credit opportunities that can be accessed on demand by our providers and are in synergy with latest research publications and healthcare industry standards. We strive to expand our learning materials to new subspecialties. In addition, each year, thousands of healthcare providers worldwide take advantage of educational programs hosted by MEDNAX. We believe that the number of clinicians both nationally and internationally who participate in these activities is evidence of the depth and breadth of our clinical expertise and position as an industry leader.

- ***Innovation.*** We believe collaborative innovation is a pathway towards excellence in research, education, quality and safety. Because of the critical role innovation plays, our team strives to integrate the latest technological advances, artificial or augmented intelligence, genetic discoveries and mobile applications into everyday care. Tele- and mobile health, virtual reality, next generation sequencing, point-of-care diagnostics and advanced data analytics are currently shaping the future of medicine. Our team is actively engaged in designing projects that we believe will allow us to prevent disease, offer precision care and further optimize patient outcomes.

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."

OUR INFORMATION SYSTEMS

We maintain several information systems that support our day-to-day operations, ongoing clinical initiatives and business analysis.

- ***BabySteps®.*** BabySteps is a clinical electronic documentation system used by our affiliated neonatal physicians and other clinicians to record clinical progress notes and certain laboratory and radiology reports and provides a decision tree to assist them in certain situations with the selection of appropriate billing codes. BabySteps is in the process of moving to a cloud-based application known as the

MEDNAX Clinical App (“MCA”). The NICU version will be referred to as “BabySteps 2.0,” but this advance provides an opportunity to expand use of the application to our other hospital-based specialties. MCA/BabySteps 2.0 is currently being piloted in certain locations with a plan to roll it out across additional NICUs in 2020. The plan for broader use across other hospital-based specialties is under development.

- ***Clinical Data Warehouse.*** BabySteps enables our affiliated practices to capture a consistent set of clinical information about the patients we treat. We de-identify and transfer data from our electronic health records that reside in BabySteps to our “clinical data warehouse” that since inception has accumulated clinical information on more than 1.5 million patients and over 27 million patient days. 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, our de-identified data warehouse also helps us track medication and procedure interactions, link treatments to outcomes and identify opportunities to enhance patient outcomes. Our clinical data warehouse also helps us to identify which prospective clinical trials are most important and allows us to monitor the impact of our continuous quality improvement initiatives.
- ***MEDNAX Qualified Clinical Data Registry (“QCDR”)***. MEDNAX QCDR is a quality metric acquisition and database that has been implemented in our anesthesiology, interventional pain and radiology physician practices. QCDR collects patient level data which is then stored, analyzed and reported to physicians and to CMS to address Merit-Based Incentive Payment System (“MIPS”) requirements within the CMS Quality Payment Program. Our affiliated 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, all with the goal of improving outcomes and efficiency and ensuring patient satisfaction. CMS has certified the MEDNAX QCDR as an appropriate platform for reporting under MIPS, and CMS approved our self-nomination for the 2020 MIPS reporting year.
- ***Nextgen®*** **.** We have licensed the Nextgen Electronic Medical Record (“EMR”) and Electronic Patient Management (“EPM”) system for our affiliated office-based physicians and other clinicians to record clinical documentation related to their patients and to 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 compliant billing codes, promotion of consistent documentation, and data for research and education. We are continuing the process of implementing EMR and EPM throughout our office-based practices.
- ***Charge Capture.*** Our electronic charge capture system is used to appropriately record and bill for pediatric intensive care clinicians, hospitalist clinicians and other clinical care providers. We also use administrative data derived from this system to drive quality assurance and quality improvement programs.
- ***Radiology Clinical Data Warehouse.*** Our extensive database of aggregated and normalized radiology studies powers our sophisticated analytics capabilities. Our analytics technology provides evidence-based insights to our own practice and to key decision makers at hospitals and healthcare systems, as well as to onsite radiology groups regarding optimal staffing, imaging utilization and clinical outcomes, all to help them more efficiently manage their radiology service lines and practices. Our analytics tools are relevant for both hospitals trying to better manage costs and improve operating efficiencies, as well as to radiology groups trying to demonstrate value in an increasingly challenging and evolving healthcare reimbursement environment. Our analytics tools differentiate us as a strategic partner to both existing and new clients who rely on our insight to efficiently manage their radiology service lines and practices.
- ***MEDNAX Learning Center®.*** In addition to providing continuing education, our web-based education platforms also function as important educational adjuncts to our affiliated physician groups, providing

a rich source of ongoing medical education for our physicians and enabling physicians to discuss cases with one another through various clinical resources.

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 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.

PHYSICIAN PRACTICE GROUP ADMINISTRATION

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

- ***Unit Management***. A senior physician practicing medicine in each physician specialty or subspecialty practice that we manage acts as the medical director for that practice. Each medical director is responsible for the overall management of his or her practice, including staffing and scheduling, quality of care, professional discipline, utilization review, coordinating physician recruitment and monitoring of the financial success within the 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 neonatologists, maternal-fetal medicine physicians, anesthesiologists and other pediatric subspecialty physicians and are working to develop such a database for radiologists. 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 assisting our affiliated physicians with contracting with third-party payors. 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 and other clinicians with a training curriculum that emphasizes detailed documentation of and compliant coding protocols for all procedures performed and services provided, and we provide comprehensive internal auditing processes, all of which are designed to achieve compliant 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 understanding and complying with the increasingly complex laws, rules and regulations that govern the provision of healthcare 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.

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 and Other Customers

Our relationships with our hospital partners and other customers are critical to our operations. Hospitals control access to their units and operating rooms through the awarding of contracts and hospital privileges. We have been retained by approximately 545 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. 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 work with our hospital partners to enhance their reputation and market our services to referring physicians within the communities served by those hospitals. We also provide radiology physician services to hospitals and other physician groups. 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 11% of our net revenue during 2019. 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 ("GHC Programs"), including Medicare and Medicaid, and with managed care organizations and commercial health insurance payors are vital to our business. We seek to maintain professional working relationships with our third-party payors, 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 among payors. A significant portion of our net revenue is received from GHC Programs, principally state Medicaid and federal Medicare programs.

Medicaid programs, which are jointly funded by the federal government and state governments, pay for medical and health-related services for certain categories of individuals and families generally who have low incomes or disabilities. 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 generally much lower in comparison to private-sector health plan rates.

The Affordable Care Act ("ACA") allows states to expand their Medicaid programs to enroll more individuals 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. As of December 31, 2019, 36 states and the District of Columbia have expanded Medicaid eligibility to cover this additional low income patient population (including states that have adopted but not yet implemented expansion and those that are using an alternative approach to eligibility expansion) and other states are considering such expansion. 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, and some states offer expanded coverage, with state eligibility thresholds that may range from 133% to 400% of the federal poverty level based on a combination of federal mandates and voluntary state expansions. In light of changes to the ACA, some of these states may eliminate, reduce or otherwise modify expanded enrollment eligibility. See Item 1A. Risk Factors — "State budgetary constraints and the uncertainty over the future Medicaid expansion could have an adverse effect on our reimbursement from Medicaid programs" and "The ACA and potential changes to it may have a significant effect on our business."

Medicare is a health insurance program primarily for individuals 65 years of age and older, younger individuals with certain disabilities and individuals 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. In 2019, the majority of the 64 million people on Medicare were covered by traditional fee-for-service Medicare, but approximately one-third were enrolled in Medicare Advantage plans. Enrollment in Medicare Advantage has been increasingly annually over the past decade and is projected to continue such growth. Because we provide services to a wide array of patients, including Medicare beneficiaries, a portion of our patients' services are reimbursed by Medicare.

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 Regulatory 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 employer-sponsored coverage 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 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. Our contracts with commercial payors typically also grant each party the right to terminate the contracts without cause upon prior written notice and various notice periods. Recently, UnitedHealthcare, one of the country's largest commercial payors, unilaterally terminated multiple contracts of our affiliated practices across four states, and covering all services that our affiliated physicians provide in those states, including anesthesia, neonatology, and maternal-fetal medicine.

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, which Congress or states may continue to enact. See Item 1A. Risk Factors – "Congress or states may enact laws restricting the amount out-of-network providers of services can charge and recover for such services." 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.

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 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 seven 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 clinical 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 as 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

The physician services industry is highly fragmented. 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, anesthesiology and radiology, 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. In addition, we compete in our teleradiology service line with other teleradiology service providers where costs to provide services may be lower and turnaround times may be faster. We also compete directly with hospitals themselves as they may consider reading images with their own employed radiologists rather than outsource those reads to our affiliated radiologists.

Hospitals control access to their NICUs and operating rooms by awarding contracts and hospital clinical privileges, and our relationships with our hospital partners are critical to our operations. 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, anesthesiologists or radiologists 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 from within or outside the surrounding community. 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, radiology and teleradiology, 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. The resources and costs required to comply with these laws, rules and regulations are high. 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. The ACA made numerous changes that have reshaped the United States healthcare delivery system. Further healthcare reform, including potential repeal of or changes to the ACA, continues to attract significant legislative and administrative interest, legal challenges, regulatory and compliance requirements, 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 securities. See Item 1A. Risk Factors — “The ACA and potential changes to it may have a significant effect on our business.” Additional changes at the state level, including changes in Medicaid Program administration, eligibility and coverage, as well as changes in the regulatory framework governing the provision of telemedicine services, and other legal developments, could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

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 federal and 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 or our affiliated physicians 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.

Fraud and Abuse Provisions

Existing federal laws, as well as similar state laws, governing Medicare, Medicaid, other GHC Programs and other non-governmental arrangements and interactions, 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 (“OIG”), the Department of Justice (“DOJ”), CMS, and various state agencies.

Federal and state fraud and abuse laws apply to and affect our financial relationships and other ordinary and common business interactions with hospitals, referring physicians and other healthcare entities. In particular, the federal anti-kickback statute makes it a crime to knowingly and willfully solicit, receive, offer, or pay any remuneration, in cash or in kind, in return for either referring items or services for which payment may be made in whole or in part by a GHC Program or purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or ordering of any service or item for which payment may be made in whole or in part by a GHC Program. In addition, the federal physician self-referral law, commonly known as the “Stark Law,” is a strict liability statute that prohibits a physician from making a referral to an entity for certain “designated health services” payable by Medicare if the physician, or an immediate family member of the physician, has a financial relationship with that entity, unless an exception applies. The entity is further prohibited from billing the Medicare program for designated health services furnished pursuant to a prohibited referral. Further, the Stark Law, through the addition of section 1903(s) to the Social Security Act, prohibits the federal government from making federal financial participation payments to state Medicaid programs for designated health services furnished as a result of a referral that would violate the Stark Law if Medicare “covered the service to the same

extent and under the same conditions" as the state Medicaid Program. The DOJ and several state agencies have successfully argued that Section 1903(s) expands the Stark Law to Medicaid-covered claims, even absent a separate state self-referral law prohibiting the same conduct. These laws 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. Additionally, many of the states in which we operate also have similar anti-kickback and self-referral laws that apply to our government and non-government business, including in some cases, to patient self-pay services.

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 federal anti-kickback statute and certain state anti-kickback laws), exclusion from participation in GHC Programs and forfeiture of amounts collected in violation of such laws. The government may also assert that a claim to a GHC Program for covered items or services resulting from a violation of the federal anti-kickback statute constitutes a false or fraudulent claim for purposes of the federal civil False Claims Act ("FCA").

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 GHC Programs. These laws include the federal civil FCA, which prohibits knowingly presenting, or causing to be presented, 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 where payments include federal funds. The FCA also makes the knowing retention of an identified overpayment from a GHC Program a separate basis for FCA liability. Substantial civil fines and treble damages, along with other remedies, including exclusion from GHC Programs, can be imposed for violating the FCA. Furthermore, the FCA does not require that the individual or company that presented or caused to be presented an allegedly false claim have actual knowledge of its falsity. The statute applies where the individual or company acted in "reckless disregard" or in "deliberate ignorance" of the truth or falsity of the claim. The FCA includes "whistleblower" provisions that permit private citizens to sue a claimant on behalf of the government and share in the amounts recovered under the law. In recent years, many cases have been brought against healthcare companies by the government and by "whistleblowers," which have resulted in judgments and settlements involving substantial payments to the government by the companies involved. The cost to defend against allegations, even when the government declines to intervene, can be substantial.

In addition, the Civil Monetary Penalties Law imposes substantial civil monetary penalties against a person or entity that engages in other prohibited activities, such as presenting or causing to be presented a claim to a GHC Program that the person knows or should know is for an item or service that was not provided as claimed or for a claim that is false or fraudulent, or providing remuneration to a GHC Program beneficiary that the person or entity knows or should know is likely to influence the beneficiary's selection of a provider or supplier. Regulators also have the authority to exclude individuals and entities from participation in GHC Programs under the Civil Monetary Penalties Law.

The civil and administrative false claims statutes are being applied in a broad range of circumstances. For example, claims for services that are medically unnecessary or fail to meet applicable coverage standards may, under certain circumstances, violate these statutes. Claims for services that were induced by kickbacks and Stark Law violations may also form the basis for FCA liability. 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 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. 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." Additionally, federal and state fraud and abuse laws, rules and regulations are not static and amendments, clarifications, revisions, or other modifications to these laws may occur from time to time. For instance, on October 9, 2019, both CMS and the OIG proposed substantial modifications to the anti-kickback statute, Civil Monetary Penalty Law, and the Stark Law regulations to foster arrangements that would promote care coordination, advance the delivery of value-based care, and protect consumers from harms caused by fraud and abuse. Changes reflected in OIG and CMS's final rules may affect our operations and require us to modify certain arrangements, transactions, or other financial relationships, when finalized.

Government Regulatory 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 regulatory 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, private insurers or state laws and regulations 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, manual guidance, 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 GHC Programs generally provide for reimbursement on a fee-schedule, per-service or per-discharge 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 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 these increased costs to non-governmental payors. In addition, the health care industry is increasing the use of value-based reimbursement methodologies and accordingly, our reimbursement may be dependent upon our ability to achieve quality targets that change year over year. See Item 1A. Risk Factors – "The ACA and potential changes to it may have a significant effect on our business." 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 GHC Programs.

Our business also could be adversely affected by reductions in or limitations of funding of GHC Programs or restrictions on 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 ("FTC"), the Antitrust Division of 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, 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, results of operations, cash flows and the trading price of our securities.

HIPAA and Other Privacy, Security and Breach Notification Laws

Numerous federal and state laws, rules and regulations govern the collection, dissemination, use, privacy, security and confidentiality of personal information. For example, the federal Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations (collectively, "HIPAA") impose requirements to protect the privacy and security of protected health information ("PHI") and to provide notification in the event of a breach of PHI. Violations of HIPAA are punishable by civil money penalties and, in some cases, criminal penalties and imprisonment. The U.S. Department of Health and Human Services ("HHS") Office for Civil Rights ("OCR"), which is responsible for enforcing HIPAA, also may enter into resolution agreements requiring the payment of a civil money penalty and/or the establishment of a corrective action plan to address violations of HIPAA. OCR may also take other actions short of requiring payment of a civil money penalty or a corrective action plan, such as providing technical assistance on compliance with particular provisions of HIPAA. 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, HHS has adopted privacy regulations, known as the privacy rule, to govern the use and disclosure of PHI (the "Privacy Rule"). The Privacy Rule applies to "Covered Entities," which are health plans, health care clearinghouses, and health care providers that engage in standardized transactions under HIPAA, and, as discussed further below, "Business Associates," which are entities that perform functions or services for or on behalf of Covered Entities that involve the use or disclosure of PHI. The term "Business Associate" also includes "Subcontractors," which means any entity to whom a Business Associate delegates any function, activity or service, other than in the capacity of a member of the Business Associate's workforce. PHI is broadly defined as any individually identifiable health information transmitted or maintained in any form, including electronic, paper or oral. As a general rule, a Covered Entity or Business Associate may not use or disclose PHI except as permitted under the Privacy Rule. We have implemented privacy policies and procedures, including training programs, and signed Business Associate Agreements, designed to comply with the requirements set forth in the Privacy Rule, as amended to reflect changes required by HITECH, as discussed further below.

HHS has also adopted data security regulations (the "Security Rule") that require Covered Entities (including health care providers) and Business Associates to implement administrative, physical and technical safeguards to protect the integrity, confidentiality and availability of PHI that is electronically created, received, maintained or transmitted (such as 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 Rule.

In addition, Congress enacted the Health Information Technology for Economic and Clinical Health ("HITECH") Act as part of the American Recovery and Reinvestment Act. Among other changes to the laws governing PHI, HITECH required OCR to strengthen and expand HIPAA requirements, increase penalties for violations, give patients new rights to restrict uses and disclosures of their PHI, and impose a number of privacy and security requirements directly on Business Associates, which are now directly subject to penalties under

HIPAA as a result of HITECH. Notably, as a result of HITECH, a Covered Entity is liable for violations of HIPAA resulting from the acts or omissions of any Business Associate acting as its agent, as determined by the federal common law of agency.

Under HIPAA, as amended by regulations promulgated pursuant to HITECH, Covered Entities are required to report any unauthorized use or disclosure of PHI that meets the definition of a breach to affected individuals, HHS and, depending on the number of affected individuals, the media for the affected market. In addition, HIPAA requires that Business Associates report breaches to their Covered Entity customers. HITECH further authorizes state Attorneys General to bring civil actions in response to violations of HIPAA that threaten the privacy of state residents. We have adopted breach notification policies and procedures designed to comply with the applicable requirements set forth in HIPAA.

HIPAA establishes a federal "floor" with respect to privacy, security, and breach notification requirements and does not supersede any state laws insofar as they are broader or more stringent than HIPAA. Numerous state and certain other federal laws protect the confidentiality of health information and other personal information, including but not limited to state medical privacy laws, state laws protecting personal information, state data breach notification laws, state genetic privacy laws, human subjects research laws and federal and state consumer protection laws. These additional federal and state privacy and security-related laws may be more restrictive than HIPAA and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority under Section 5 of the Federal Trade Act to initiate enforcement actions in response to alleged privacy violations and data breaches. California recently enacted the California Consumer Privacy Act ("CCPA"), which went into effect on January 1, 2020. The CCPA, among other things, creates new data privacy obligations for covered companies and provides new privacy rights to California residents, including the right to opt out of certain disclosures of their information. The CCPA also creates a private right of action with statutory damages for certain data breaches, thereby potentially increasing risks associated with a data breach. Legislators have stated that they intend to propose amendments to the CCPA and the California Attorney General will issue clarifying regulations. It remains unclear what, if any, modifications will be made to this legislation or how it will be interpreted. In addition to California, other states have strengthened their data security laws and others are indicated their intention to do so as well. In addition, industry groups such as the payment card industry have developed self-regulatory guidelines for privacy and data security that are more stringent than HIPAA. In order to accept payments from payment cards, merchants must use payment card processing applications that have been validated under the Payment Application Data Security Standard ("PA-DSS"), and complete a self-assessment questionnaire that complies with the Payment Card Industry Data Security Standard ("PCI-DSS"). Failure to comply with PA-DSS and PCI-DSS may result in fines and penalties imposed by payment card brands, and/or termination of the merchant's relationship with the bank it relies on to process payment card payments.

These requirements are also subject to change. Compliance with new privacy, security, and breach notification laws, regulations, requirements and self-regulatory guidelines may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, changes to HIPAA promulgated pursuant to HITECH further restricted our ability to collect, disclose and use PHI and imposed additional compliance requirements on us.

Although we currently maintain liability insurance coverage intended to cover cyber liability and certain other privacy and security breach-related claims, we cannot ensure 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. Liabilities in excess of our insurance coverage, including coverage for cyber liability and certain other privacy and security breach-related claims, could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

HIPAA Transaction Requirements

In addition to privacy, security, and breach notifications requirements, HIPAA establishes uniform 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. We report medical diagnoses under International Classification of Diseases, 10th Edition ("ICD-10"). 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, cash flows and the trading price of our securities.

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. Some states, such as Florida, require us to be licensed by the state in order to dispose biomedical waste.

Compliance Program

We maintain a compliance program that includes the OIG's seven 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 healthcare 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 Senior 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 Chief Accounting Officer;
- 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, 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 of 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 securities.

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, results of operations, cash flows and the trading price of our securities. 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 securities.

On July 10, 2018, a securities class action lawsuit was filed against our company and certain of our officers and a director in the U.S. District Court for the Southern District of Florida (Case No. 0:18-cv-61572-WPD) that purports to state a claim for alleged violations of Sections 10(b) and 20(a) of the Exchange Act, and Rule 10b-5 thereunder, based on statements made by the defendants primarily concerning our anesthesiology business. The complaint was seeking unspecified damages, interest, attorneys' fees and other costs. We filed a motion to dismiss in April 2019, which was granted in October 2019; however, the plaintiff filed a second amended complaint on October 25, 2019. On November 25, 2019, we filed a motion to dismiss the second amended complaint, and on February 7, 2020 a final order granting our motion to dismiss the second amended complaint with prejudice was issued.

On March 20, 2019, a separate derivative action was filed by plaintiff Beverly Jackson on behalf of MEDNAX, Inc. against MEDNAX, Inc. and certain of its officers and directors in the Seventeenth Judicial Circuit in and for Broward County, Florida (Case Number CACE-19-006253). The plaintiff purports to bring suit derivatively on behalf of our company against certain of our officers and directors for breach of fiduciary duties and unjust enrichment. The derivative complaint repeats many of the allegations in the securities class action described above. The derivative complaint seeks unspecified damages, restitution, attorneys' fees and costs and governance relief. We believe this action to be without merit and intend to vigorously defend against it. The action is in the early stages and, at this time, no assessment can be made as to its likely outcome or whether the outcome will be material to us.

Although we currently maintain liability insurance coverage intended to cover professional liability and certain other claims, we cannot ensure 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, results of operations, cash flows and the trading price of our securities. See “Professional and General Liability Coverage.”

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 predict whether any pending or future claim would be successful or, if successful, would 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 4,325 practicing physicians affiliated with us as of December 31, 2019, we employed or contracted with approximately 4,315 other clinical professionals and approximately 5,165 other full-time and part-time employees.

GEOGRAPHIC COVERAGE

We provide physician services across all 50 states, the District of Columbia and Puerto Rico. In addition, through our complementary service business, we provide consulting services to healthcare facilities and physicians nationwide. During 2019, approximately 52% of our net revenue was generated by operations in our five largest states. Our operations in Texas accounted for approximately 20% 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. 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, results of operations, cash flows and the trading price of our securities.

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 Design,” “iNewborn,” “NEO Conference and Design,” and “vRad,” among others.

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 Securities and Exchange Commission ("SEC"). Our proxy statements and reports may also be obtained directly from the SEC's Internet website at www.sec.gov. Our internet website and the information contained therein or connected thereto are not incorporated into or deemed a part of this Form 10-K.

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 securities.

Economic conditions could have an adverse effect on our business.

Our operations and performance depend significantly on economic conditions. During the year ended December 31, 2019, the percentage of our patient service revenue being reimbursed under GHC Programs remained relatively consistent as compared to the year ended December 31, 2018. If, however, economic conditions in the United States deteriorate, we could experience shifts toward GHC Programs, and patient volumes could decline. Further, we could experience and have experienced shifts toward GHC Programs if changes occur in population demographics within geographic locations in which we provide services. 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. In addition, certain private payors' poor experience with the healthcare insurance exchanges and uncertainty around the future of the ACA and healthcare insurance exchanges may result in those payors exiting the healthcare insurance exchange marketplaces or the cessation of the healthcare insurance exchanges. As a consequence, the number of patients who participate in GHC Programs or who are uninsured or underinsured could increase. Payments received from GHC Programs are substantially less than payments received from private healthcare insurance programs (managed care and other third-party payors). Payments under policies issued through the healthcare insurance exchanges may be less than payments from private healthcare insurance programs and in some cases, patients' responsibility for costs related to healthcare plans obtained through the healthcare 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. A payor mix shift from private healthcare insurance programs to GHC Programs or to healthcare insurance exchanges may result and has resulted in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net revenue, as well as a significant reduction in our average reimbursement rates. While we have developed a number of strategic initiatives across our organization, in both our shared services functions and our operational infrastructure, to address some of the effects of changes in economic conditions, there is no assurance that these initiatives will be successful in generating improvements in our general and administrative expenses and our operational infrastructure. If these initiatives are unsuccessful, it could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities.

The ACA and potential changes to it may have a significant effect on our business.

The ACA contains a number of provisions that have affected us and may continue to affect us over the next several years. These provisions include the establishment of health insurance exchanges to facilitate the purchase of qualified health plans, expanded Medicaid eligibility, subsidized insurance premiums and additional requirements and incentives for businesses to provide healthcare benefits. Moreover, we could be affected by potential changes to various aspects of the ACA, including changes to subsidies, healthcare insurance marketplaces and Medicaid expansion.

The ACA remains subject to continuing legislative and administrative flux and uncertainty. In 2017, Congress unsuccessfully sought to replace substantial parts of the ACA with different mechanisms for facilitating insurance coverage in the commercial and Medicaid markets. Congress may again attempt to enact material changes to the ACA in the future. Additionally, CMS has administratively revised a number of provisions and may seek to advance additional significant changes through regulation, guidance and enforcement in the future.

At the end of 2017, Congress repealed the part of the ACA that required most individuals to purchase and maintain health insurance or face a tax penalty, known as the individual mandate. In light of these changes, in December 2018, a federal district court in Texas declared that key portions of the ACA were inconsistent with the United States Constitution and that the entire ACA is invalid as a result. Several states appealed this decision, and in December 2019, a federal Court of Appeals upheld the district court's conclusion that part of the ACA is unconstitutional, but remanded for further evaluation whether in light of this defect the entire ACA must be invalidated. These legal proceedings are likely to continue for several years, and the fate of the ACA will be unresolved and uncertain during this period. Actions by the Court of Appeals or eventually the Supreme Court of the United States could invalidate portions or all of the ACA. Changes resulting from these proceedings could have a material impact on our business. In the meantime, it also is possible that as a result of these actions, enrollment in healthcare exchanges could decline.

In 2020, there will be federal and state elections that could affect which persons and parties occupy the Office of the President of the United States, control one or both chambers of Congress and many states' governors and legislatures. Many candidates running for President of the United States are proposing sweeping changes to the U.S. healthcare system, including expanding government-funded health insurance options and replacing current healthcare financing mechanisms with systems that would be entirely administered by the federal government. Any legislative or administrative change to the current healthcare financing system could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities.

If the ACA is repealed or further substantially modified by judicial, legislative or administrative action, or if implementation of certain aspects of the ACA are diluted or delayed, such repeal, modification or delay may impact our business, financial condition, results of operations, cash flows and the trading price of our securities. We are unable to predict the impact of any repeal, modification or delay in the implementation of the ACA, including the repeal of the individual mandate, on us at this time.

In addition to the potential impacts to the ACA, there could be changes to other GHC Programs, such as a change to the structure of Medicaid. Congress and the Administration have sought to convert Medicaid into a block grant or to institute per capita spending caps, among other things. These changes, if implemented, could eliminate the guarantee that everyone who is eligible and applies for benefits would receive them and could potentially give states new authority to restrict eligibility, cut benefits and make it more difficult for people to enroll. Additionally, several states are considering and pursuing changes to their Medicaid programs, such as requiring recipients to engage in employment or education activities as a condition of eligibility for most adults, disenrolling recipients for failure to pay a premium, or adjusting premium amounts based on income. Many states have recently shifted a majority or all of their Medicaid program beneficiaries into Managed Medicaid Plans. Managed Medicaid Plans have some flexibility to set rates for providers, but many states require minimum provider rates in their contracts with such plans. In July of each year, CMS releases the annual Medicaid Managed Care Rate Development Guide which provides federal baseline rules for setting reimbursement rates in managed care plans. We could be affected by lower reimbursement rates in some of all of the Managed Medicaid Plans with which we participate. We could also be materially impacted if we are dropped from the provider network in one or more of the Managed Medicaid Plans with which we currently participate. In Florida, more than 75% of the Medicaid population participates in a Managed Medicaid Plan, with even higher participation rates for children.

We cannot predict with any assurance the ultimate effect of these laws and resulting changes to payments under GHC Programs, nor can we provide any assurance that they will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, any fiscal tightening impacting GHC Programs or changes to the structure of any GHC Programs could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities.

The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") and potential changes to it may have a significant effect on our business.

MACRA contains numerous measures that could affect us, including, requirements that physicians participate in quality measurement programs that differentiate payments to physicians under Medicare based on quality and cost of care, rather than the quantity of procedures performed. MACRA requires physicians to choose to participate in one of two payment formulas, MIPS or Alternative Payment Models ("APMs"). Beginning in 2020, MIPS allows eligible physicians to receive incentive payments based on the achievement of certain quality and cost metrics, among other measures, and be reduced for those who are underperforming against those same metrics and measures. As an alternative, physicians can choose to participate in an Advanced APM, and physicians who are meaningful participants in APMs will receive bonus payments from Medicare pursuant to the law. MACRA also remains subject to review and potential modification by Congress, as well as shifting regulatory requirements established by CMS. We currently anticipate that our affiliated physicians will continue to be eligible to receive bonus payments in 2020 through participation in the MIPS, although the amounts of such bonus payments are not expected to be material. We will continue to operationalize the provisions of MACRA and assess any further changes to the law or additional regulations enacted pursuant to the law.

We cannot predict with any assurance the ultimate effect of these laws and resulting changes to payments under GHC Programs, nor can we provide any assurance that they will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, any fiscal tightening impacting GHC Programs or changes to the structure of any GHC Programs could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities.

The Protecting Access to Medicare Act of 2014 ("PAMA") and potential changes to Medicare reimbursement enacted pursuant to the legislation may have a significant effect on our business.

PAMA required CMS to establish a new program to improve the appropriate ordering of advanced diagnostic imaging services, such as computed tomography (CT) and magnetic resonance imaging (MRI) services. Under regulations promulgated by CMS, practitioners that order advanced diagnostic imaging services for Medicare beneficiaries will be required to consult a qualified Clinical Decision Support Mechanism ("CDSM") to determine whether the order adheres to applicable appropriate use criteria ("AUC"). Starting January 1, 2021, CMS will require furnishing professionals and facilities that provide advanced diagnostic imaging services to report to CMS through the corresponding Medicare claim the name of the qualified CDSM consulted by the ordering professional and information indicating whether the service would adhere to applicable AUC. CMS will not pay claims that fail to include this information. Ultimately, CMS plans to review the AUC data from Medicare claims to identify provider ordering patterns that are considered outliers, and subject such ordering providers to prior authorization requirements.

We provide support to providers in hospitals, clinics and imaging centers who provide advanced diagnostic imaging services, as well as to providers who order advanced diagnostic imaging services. There is still some uncertainty as to how ordering providers will electronically communicate their consultation of CDSMs and the result of the AUC analysis to furnishing providers. Additionally, we may need to invest in new technology services to enable our ordering providers to consult one or more CDSMs. If we are unable to consistently send or receive CDSM consultation information on behalf of our providers, we could potentially jeopardize the Medicare reimbursement of the furnishing provider for advanced diagnostic imaging services. Required consultation of CDSMs under PAMA and the potential implementation of further prior authorization requirements could also result in a decrease in advanced diagnostic imaging services ordered for Medicare patients.

State budgetary constraints and the uncertainty over the future of Medicaid could have an adverse effect on our reimbursement from Medicaid programs.

Congress and the current Administration have expressed interest in repealing, and have attempted to repeal, the ACA and substantially reform the Medicaid program. Congress could, for example, repeal the provisions of

the ACA that encouraged states to expand Medicaid eligibility to more adults, including additional federal matching funds that enabled states to do so. The ACA allowed 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. As of December 31, 2019, 36 states and the District of Columbia adopted the expansion of Medicaid eligibility. All of the states in which we operate, however, already cover children in the first year of life and pregnant women if their household incomes are at or below 133% of the federal poverty level. If states that expanded Medicaid reduce or eliminate eligibility for certain individuals, the number of patients who are uninsured could increase. Some states may seek to maintain expanded eligibility and to do so could offset the cost by further reducing payments to providers of services. In some states, we could experience delayed or reduced Medicaid payment for services furnished to program enrollees.

Congress and the current Administration are also seeking substantial reforms to Medicaid law to grant states more autonomy and discretion to design Medicaid programs. These changes, if enacted, could reduce or eliminate eligibility for certain individuals, or allow states to reduce payments to providers of services. As a result, in some states, we could experience an increase in the number of uninsured patients and delayed or reduced Medicaid payment for services furnished to program enrollees.

As noted above, a federal district court in Texas declared that key portions of the ACA were inconsistent with the United States Constitution and that the entire ACA is invalid as a result. A Court of Appeals concurred with portions of the district court decision. This decision will continue to be subject to further proceedings and uncertainty.

In addition, many states are continuing to collect less tax revenue than they did historically and as a consequence continue to face budget shortfalls and underfunded pension and other obligations. Although shortfalls have been declining in more recent budgetary years, they are still significant by historical standards. The financial condition of the states in which we do 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.

Further, in November 2019, CMS proposed significant changes to state reporting requirements regarding supplemental payments in the Medicaid program, while also making structural and definitional changes that can decrease state flexibility in financing the state's share of its Medicaid program. These changes, if finalized, could affect various financial arrangements between states and providers, primarily hospitals, which could lower the amount of supplemental payments providers receive. Additionally, since the changes also affect a state's ability to finance its share of the Medicaid program, states may have to find other revenue sources, or reduce Medicaid provider payments or services.

Any changes to Medicaid eligibility, enrollment, financing or reimbursement could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities.

Congress or states may enact laws restricting the amount out-of-network providers of services can charge and recover for such services.

In 2019, Congress debated different measures intended to protect patients from "surprise" medical bills when services are furnished by providers who are not subject to contractual arrangements and payment limitations with the patient's insurer. In addition, several states have enacted or are considering similar changes. For example, Florida and Texas have adopted their own balance billing laws that, in certain cases, prohibit out-of-network providers from billing patients in excess of in-network rates. These measures, if enacted, could limit the amount we can charge and recover for services we furnish where we have not contracted with the patient's insurer, and therefore could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Moreover, these measures could affect our

ability to contract with certain payors and under historically similar terms and may cause, and the prospect of these changes may have caused, payors to terminate their contracts with us and our affiliated practices, further affecting our business, financial condition, results of operations, cash flows and the trading price of our securities.

The birth rate in the United States has declined and may decline further.

Final birth data for 2018 indicate that total births in the United States declined by approximately 2% as compared to 2017. Provisional data for 2019 is not yet available; however, we expect that birth trends at the hospitals where we provide services will continue to be soft in the near future. Future declines in births are possible and could have an adverse effect on our patient volumes, net revenue, results of operations, cash flows and financial condition.

Expanding eligibility of GHC Programs could adversely affect our reimbursement.

In January 2018, Congress reauthorized the Children's Health Insurance Program ("CHIP") through 2023 and then in February 2018 lengthened this funding extension through 2027. Changes to CHIP or 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, or vice versa, or cause patients who otherwise would have been covered by CHIP or Medicaid to lose insurance coverage altogether. Additional reform efforts, as well as legislative or administrative amendment or repeal of the ACA, could change the eligibility requirements for Medicaid and for other GHC Programs, including CHIP, and could increase the number of patients who participate in such programs or the number of uninsured patients.

In 2020, there will be federal and state elections that could affect which persons and parties occupy the Office of the President of the United States, control one or both chambers of Congress and many states' governors and legislatures. Many candidates running for President of the United States are proposing sweeping changes to the U.S. healthcare system, including expanding government-funded health insurance options and replacing current healthcare financing mechanisms with systems that would be entirely administered by the federal government.

In general, payments received from GHC Programs are substantially less than payments received from private healthcare insurance programs (managed care and other third-party payors). A shift in the mix of our payors 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, as well as a significant reduction in our average reimbursement rates. Additionally, if Congress does not act to extend CHIP beyond 2027, or if Congress extends CHIP but substantially alters the current program, we could be adversely affected if children in states where we do business lose Medicaid coverage or payments for services furnished to these children are delayed or reduced.

Government-funded programs, private insurers or state laws and regulations 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, including the managed care plans under the Medicare and Medicaid programs. These government-funded programs, as well as private insurers, have been and may continue to be subject to changes, including 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 Regulatory Requirements." Federal and state legislatures or administrators of 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. In addition, increased consolidation among private insurers is resulting in fewer and larger third-party payors with increased negotiating power. 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 a state's Medicaid payments cannot exceed the payments it would have made had those patients been enrolled in traditional Medicare, 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 business, financial condition, results of operations, cash flows and the trading price of our securities.

In addition, our agreements with certain third-party payors may be terminated for various reasons, requiring us to seek reimbursement as an out-of-network provider. For example, UnitedHealthcare recently unilaterally terminated multiple agreements with certain of our affiliated practices across four states, covering all of the services our affiliated physicians provide in those states, including anesthesia, neonatology, and maternal-fetal medicine, and public reports indicate that this same payor recently terminated in-network contracts across multiple states with other providers of physician services. In the event we attempt to balance-bill patients, we may be limited in our ability to do so by certain state laws and regulations. As these laws and regulations continue to develop in certain states, it could incentivize, and may have incentivized, certain third-party payors to terminate agreements as a business strategy which could lower overall reimbursement to providers. Any reductions in reimbursement amounts could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid and Medicare, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

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

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 individual providers deemed responsible) that fraudulently or wrongfully bill government-funded programs or other third-party payors for healthcare services. CMS requires states to maintain a Medicaid Recovery Audit Contractor ("RAC") program. 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." Moreover, the current Administration has expressed a desire to increase scrutiny of providers and payments for services to further minimize fraud and abuse in GHC Programs. In addition, our contracts with private insurers often provide such insurers with audit rights over payments made to us and the ability to seek

recoupment for overpayments. We believe that audits, inquiries and investigations from government agencies and private insurers 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. New regulations and heightened enforcement activity also could materially affect our cost of doing business and our risk of becoming the subject of an audit or investigation. We cannot predict whether any future audits, inquiries or investigations, or the public disclosure of such matters, likely would have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. 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 FCA) that prohibit entities and individuals from intentionally (or with reckless disregard or deliberate ignorance) presenting or causing to be presented false or fraudulent claims to Medicare, Medicaid and other government-funded programs, or improperly retaining known overpayments;
    - When an entity is determined to have violated the federal FCA, it must pay three times the actual damages sustained by the government, plus mandatory civil penalties of between $11,463 and $22,927 for each separate false claim. Suits filed under the federal FCA, known as "qui tam" actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. In addition, certain states have enacted laws modeled after the federal FCA. Qui tam actions have increased significantly in recent years, causing greater numbers of healthcare companies to have to defend a false claim action, even before the validity of the claim is established and even if the government decides not to intervene in the lawsuit. Healthcare entities may decide to agree to large settlements with the government and/or whistleblowers to avoid the cost and negative publicity associated with litigation.
    - The ACA amended federal law to provide that the government may assert that a claim including items or services resulting from a violation of the federal anti-kickback statute constitutes a false or fraudulent claim for purposes of the federal civil FCA. Criminal prosecution is possible for knowingly making or presenting a false or fictitious or fraudulent claim to the federal government.
- a provision of the Social Security Act, commonly referred to as the federal "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, or for the purchasing, leasing, ordering or arranging for, items and services for which payment may be made, in whole or in part, by federal healthcare programs, such as Medicare and Medicaid;
    - The definition of "remuneration" has been broadly interpreted to include anything of value, including such items as gifts, discounts, the furnishing of supplies or equipment, credit arrangements, waiver of payments, and providing anything at less than its fair market value. The HHS Office of the Inspector General has issued regulations, commonly known as safe harbors, that set forth certain provisions which, if satisfied in their entirety, will assure healthcare providers and other parties that they will not be prosecuted under the federal anti-kickback statute. The failure of a transaction or arrangement to fit precisely within one or more safe harbors does not necessarily mean that it is illegal or that prosecution will be pursued. However, conduct and business arrangements that do not fully satisfy each applicable safe harbor element may result in

increased scrutiny by government enforcement authorities or invite litigation by private citizens under state or federal false claims statutes.

- Our relationships with referral sources, including GHC Program patients, are subject to scrutiny under the federal anti-kickback statute and must be structured in a manner to promote compliance.
- The penalties for violating the federal anti-kickback statute include imprisonment for up to ten years, fines of up to $100,000 per violation and possible exclusion from federal healthcare programs such as Medicare and Medicaid. Many states have adopted prohibitions similar to the federal Anti-Kickback Statute, some of which apply to the referral of patients for healthcare services reimbursed by any source, not only by the government programs such as Medicare and Medicaid.

- a provision of the Social Security Act, the federal Physician Self-Referral Law, commonly referred to as the Stark Law, that, subject to certain exceptions, prohibits physicians from making a referral to an entity for certain "designated health services" or "DHS" payable by Medicare if the physician, or an immediate family member of the physician, has a direct or indirect financial relationship (including ownership interests and compensation arrangements) with the entity. The Stark Law also prohibits such an entity from presenting or causing to be presented a claim to Medicare for DHS provided pursuant to a prohibited referral, and provides that certain collections related to any such claims must be refunded in a timely manner. Although the Stark Law is drafted to apply only to Medicare claims, the DOJ has taken the position that it applies to Medicaid claims under an extension of the federal FCA and several courts, including courts in Florida and Texas, have agreed.
  - The Stark Law is a strict liability statute and therefore, any referrals for Medicare DHS pursuant to a financial relationship that does not meet an exception will be nonpayable and subject to refund to Medicare. In 2010, Congress instructed that any Medicare "overpayment" (that is, Medicare funds to which a person is not entitled) must be returned within 60 days of identification—or risk liability under the FCA's "obligation" provision. Therefore, claims relating to Stark Law violations must be timely refunded to Medicare or we would risk liability under the federal FCA.
  - All of our relationships with referring physicians will implicate the Stark Law, including our ownership, physician employment, independent contractor physicians, lease arrangements with physicians, nonmonetary compensation to physicians, and our relationships with hospitals and other entities. Each such financial relationship must satisfy a Stark Law exception.
  - Because our practices provide DHS within the practice (e.g., radiology services, outpatient drugs, laboratory services, etc.), an exception to the Stark Law must be met with respect to those referrals. Generally, the In-Office Ancillary Services ("IOAS") Exception is utilized for referrals of DHS made within a physician's group practice. Alternatively, the Physician Services Exception could also be used to shield referrals of physician services within a physician group. In order to utilize both the IOAS Exception and the Physician Services Exception, the group must, among other things, satisfy the Stark Law's definition of a "group practice." The group practice definition also encompasses how a physician practice may compensate its physician shareholders, employees, and independent contractors. For example, group practices are not permitted to distribute profits derived from DHS based directly on the volume or value of referrals. However, there are a number of ways that a group practice can distribute profits, including DHS profits, to its physicians, based indirectly upon referrals, without running afoul of the Stark Law. Our ancillary services revenues must be allocated in a compliant manner to avoid falling outside of the Group Practice definition, which would result in all of our Medicare (and potentially, Medicaid) DHS referral revenues becoming nonpayable and subject to refund.
- Violations of the Stark Law result in civil penalties and program exclusions for knowing violations, civil assessment of up to three times the amount claimed. federal law such as the Civil Monetary Penalties Law ("CMPL") that imposes substantial civil monetary penalties against an entity that

engages in prohibited activities including but not limited to violations of the Stark or Anti-Kickback laws, knowing submission of a false or fraudulent claim, employment of an excluded individual and the provision or offer of anything of value to a Medicare or Medicaid beneficiary that the transferring party knows or should know is likely to influence beneficiary selection of a particular provider for which payment may be made in whole or in part by Medicare or Medicaid;

  - "Remuneration" is defined under the CMPL as any transfer of items or services for free or for less than fair market value. There are certain exceptions to the definition of remuneration for offerings that meet the Financial Need, Preventative Care, or Promoting Access to Care exceptions. Sanctions for violations of the CMPL include civil monetary penalties and administrative penalties up to and including exclusion from participation in federal health care programs.

- similar state law provisions pertaining to anti-kickback, fee splitting, self-referral and false claims, and other fraud and abuse issues which typically are not limited to relationships involving government-funded programs. In some cases these laws prohibit or regulate additional conduct beyond what federal law affects, including applicability to items and services paid by commercial insurers and private pay patients. Penalties for violating these laws can range from fines to criminal sanctions;
- provisions of 18 U.S.C. § 1347 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;
- federal and state laws related to confidentiality, privacy and security of personal information such as HIPAA, including medical information and records, that limit the manner in which we may use and disclose that information, impose obligations to safeguard that information and require that we notify third parties in the event of a breach;
  - HIPAA violations can result in both civil monetary penalties and criminal sanctions. HIPAA has ranges of increasing minimum penalty amounts tiered according to the entity's degree of culpability, with a maximum penalty of $1,500,000 for all violations of an identical provision within a year. Further, HHS has obtained increasingly high dollar settlements from covered entities relating to HIPAA violations over the past several years.
  - Unsecured Breaches of PHI may also result in unexpected costs in the millions of dollars to us through third party litigation, contractual breaches, and breach notification and remediation. In addition, we may experience reputational harms and a negative market perception when it comes to protecting patient data that could influence our future operations.
- 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 or revocation of our participation or billing privileges, which in turn, could 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 services rendered;
- federal and state laws pertaining to the provision and coverage 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 federal healthcare programs, inappropriately reducing hospital inpatient 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 securities. 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 Regulatory 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 securities. Additionally, federal and state fraud and abuse laws, rules and regulations are not static and amendments, clarifications, revisions, or other modifications to these laws may occur from time to time. For instance, on October 9, 2019, both CMS and the Department of Health and Human Services Office of Inspector General ("OIG") proposed modifications to the Anti-Kickback Statute, Civil Monetary Penalty Law, and the Stark Law regulations to foster arrangements that would promote care coordination, advance the delivery of value-based care, and protect consumers from harms caused by fraud and abuse through additional new statutory definitions, safe harbors, and exceptions. Many of our relationships with physicians, referral sources, other health care providers, and patients may need to be re-evaluated if these new proposed rules are finalized. In such event, we will sustain additional legal costs and fees in order to ensure that our arrangements are compliant. We cannot predict with any assurance the ultimate effect of these proposed and potential changes, nor can we provide any assurance that they will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

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 liability if we are unable to fully comply with such laws.

Numerous federal and state laws, rules 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 covered entities 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 required the OCR to strengthen and expand the HIPAA Privacy Rule and Security Rule 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, and certain states have proposed or enacted legislation that will create new data privacy and security obligations for certain entities, such as the California Consumer Protection Act (CCPA);

- 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, federal or state action or otherwise, could have a significant effect on the manner in which we handle personal information, including PHI, 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 are alleged to not comply with existing or new laws, rules and regulations related to PHI or other personal information we could be subject to litigation and to sanctions that include monetary fines, civil or administrative penalties, civil damage awards or criminal penalties.

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 Antitrust Division of 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 and treble damages, 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, results of operations, cash flows and the trading price of our securities.

Our affiliated physicians and other individual providers may not appropriately record or document services that they provide.

Our affiliated physicians and other individual providers are responsible for appropriately recording and documenting the services that 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 healthcare providers, including medical coding. If our affiliated physicians or other individual providers 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. We are further obligated under the federal FCA to timely report and return any identified overpayments and to maintain reasonable internal audit mechanisms to identify overpayments. Failure to timely report and return overpayments to Medicare or Medicaid could subject us to liability under the federal FCA, and also equivalent false claims acts on the state level.

Failure to manage third-party service providers may adversely affect our ability to maintain the quality of service that we provide.

We outsource a certain portion of our revenue cycle management functions to third-party service providers, but we may increase the amount of revenue cycle management functions we outsource in the future. These functions are performed both domestically and in offshore locations, with our oversight. If our outsourcing partners fail to perform their obligations in a timely manner at satisfactory quality levels, in compliance with regulatory requirements, or if they are unable to attract or retain sufficient personnel with the necessary skill sets to meet our outsourcing needs, the efficiency, effectiveness and quality of our services could suffer. In addition, our reliance on a workforce in other countries exposes us to disruptions in the business, political and economic

environment in those regions. Further, any changes to existing laws or the enactment of new legislation restricting offshore outsourcing in the United States may adversely affect our ability to outsource functions to third-party offshore service providers. Our ability to manage any difficulties encountered could be largely outside of our control. In addition, federal government and third-party payors may have prohibitions or restrictions on the use of third-party service providers outside of the United States and/or require notice for the use of such third-party service providers. Diminished service quality from outsourcing, our inability to utilize offshore service providers or the failure to comply with restrictions on the use of third-party service providers could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

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 physician group practices. Also, both independently and in collaboration with our hospital partners, we may seek to expand into new specialties and subspecialties. In addition, we have acquired physician and other healthcare services companies that are complementary to our physician practices.

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 services companies or we may complete acquisitions on less favorable terms as a result of changes in tax laws, financial market or other economic or market conditions.
- 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 not only from those of the states in which our operations are currently conducted but from an expansion in the service offerings we provide in certain states for which the laws, rules and regulations may be different.
- 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 or that have business models with lower operating margins than ours. These acquisitions could affect our overall payor mix or operating results in future periods.

- Acquisitions of practices and services companies 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.

If we are not successful in integrating an acquisition, we may decide to dispose of such acquisition and may do so at a loss or record impairments in connection with such a disposition, such as in our disposition of MedData.

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 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 or the services provided by our services companies to their customers.
- 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 same-unit and organic growth performance, or we may experience a shift in the mix of services that certain of our customers request from us, 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. Despite our layered security controls, experienced computer programmers and hackers may be able to penetrate our information systems and misappropriate or compromise sensitive patient or personnel information or proprietary or confidential information, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms and other malicious software programs that disable our systems or otherwise exploit any security vulnerabilities. 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 disrupt our business, result in the release or misuse of PHI, confidential or proprietary business information or cause 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 reasonable and appropriate 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. Our remediation efforts may not be successful and could result in interruptions, delays or cessation of service and loss of existing or potential customers and disruption of our operations, including, without limitation, our billing processes. In addition, breaches of our security measures and the unauthorized dissemination of patient healthcare and other sensitive information, proprietary or confidential information about us, our patients, clients or customers, or other third-parties, could expose such persons' personal information to the risk of financial or medical identity theft or expose us or such persons to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our brand and reputation or otherwise harm our business. Additionally, under certain circumstances, we could be excluded temporarily or permanently from certain commercial or GHC Programs. Any of these disruptions or breaches of security could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

We may experience difficulties implementing new technology, software and processes.

As part of our broad transformational and restructuring initiatives, we are engaged in various implementation efforts for new technology, software and processes, including cloud-based solutions for an enterprise resource planning system ("ERP") and an enterprise-wide revenue cycle management ("RCM") platform, among others. These solutions are designed to provide greater efficiency and flexibility across our enterprise. The ERP and RCM cloud-based solution implementations will require significant investments of human and financial resources. In implementing these solutions, we may experience significant delays, increased costs and other difficulties. Any significant disruption or deficiency in the design and implementation of these solutions could adversely affect our ability to operate our business. While we have invested significant resources in planning and project management, unforeseen implementation issues may arise. In addition, our efforts to centralize various business processes and functions within our organization in connection with our system implementations may disrupt our operations. Any implementation issues or business operation disruptions could have a material effect on our business, financial condition, results of operations, cash flows, internal controls over financial reporting and the trading price of our securities.

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 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, results of operations, cash flows and the trading price of our securities.

We may not be able to successfully recruit, onboard and retain qualified physicians and other clinicians and other personnel, and our compensation expense for existing clinicians and other personnel may increase.

We are dependent upon our ability to recruit and retain a sufficient number of qualified physicians and other clinicians and other personnel to service existing units at hospitals and our affiliated practices, service our

existing customers' radiology read volumes 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 and services groups, for the services of qualified clinicians. We may not be able to continue to recruit new clinicians or other personnel or renew contracts with existing clinicians or other personnel on acceptable terms. We have and may seek to renew clinician contracts prior to their existing renewal date for various reasons, including to move clinicians to a different compensation structure. We may not be successful in these early renewal efforts, and further, clinical compensation may increase as a result of incremental compensation incentives that may be required by clinicians to agree to the change in compensation structure. In addition, the recruiting and onboarding process for certain of our physicians and other clinicians can take several months, or longer, to complete due to various requirements, including state licensing and hospital credentialing. In addition, if the demand exceeds the supply for physicians and other clinicians and personnel either in general or in specific markets, we could experience an increase in compensation expense, including premium pay and agency labor costs. If we are unable to recruit new physicians, renew contracts on acceptable terms or onboard physicians, clinicians and other personnel in a reasonable period of time, our ability to service existing or new hospital units, staff existing or new office-based practices and service our existing or new customer radiology read volumes could be adversely affected. In addition, if we experience a higher rate of growth in compensation expense, our business, financial condition, results of operations, cash flows and the trading price of our securities could be materially, 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. In addition, we have and may incur significant legal fees to pursue enforcement of such agreements and restrictive covenants. Our affiliated physicians or other clinicians may leave our affiliated practices for a variety of reasons, including in order 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, we could incur significant legal fees to pursue enforcement of certain covenants within employment agreements or if 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.

Our treatment of certain physicians and other clinicians as independent contractors may be challenged by taxing authorities or other governmental agencies.

Certain of our affiliated physicians and other clinicians are treated as independent contractors, as opposed to employees, and, accordingly, we do not withhold federal income, state income, The Federal Insurance Contributions Act ("FICA"), or other employment related taxes from these individuals' compensation, make federal income, state income, FICA, or unemployment tax or other related payments, provide workers' compensation insurance or allow them to participate in the benefits and retirement programs available to our employees, or apply federal or state employee requirements. The classification of physicians and other clinicians as independent contractors depends on the facts and circumstances of the relationship. Additionally, under current federal tax law, a safe harbor from reclassification, and consequently retroactive taxes and penalties, is available if our current treatment is consistent with a long-standing practice of a significant segment of our

industry and if we meet certain other requirements. In the past, there have been proposals to eliminate the safe harbor, and similar proposals may happen again in the future. If taxing authorities or other governmental agencies are successful in challenging our treatment of these physicians and other clinicians as independent contractors, and we do not prevail in demonstrating the applicability of the safe harbor to our operations or the safe harbor is eliminated, we may be required to pay retroactive employment taxes and penalties and reclassify such independent contractors to employees. In addition, such independent contractors could claim retroactive entitlements to various employee benefits. Any of these actions would increase our costs related to these physicians and our business, financial condition, results of operations and cash flows could be materially, adversely affected.

We are subject to medical malpractice and other lawsuits that may 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 securities. See Item 1. Business—“Other Legal Proceedings” and— “Professional and General Liability Coverage.”

The reserves that we have established related to 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 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 consists primarily of goodwill related to our acquisitions, is subject to testing at least annually, and more frequently if impairment indicators exist. 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. For example, during the third quarter of 2019 we recorded a non-cash impairment charge of $1.45 billion, nearly all of which related to our anesthesiology reporting unit. If we record additional impairment losses related to our goodwill, it could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

We may not effectively manage our growth.

We have experienced significant growth in our business, including growth outside of our core physician specialties. Growth in the number of our employees and affiliated physicians in recent years 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. 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 current indebtedness and any future indebtedness could adversely affect us by reducing our flexibility to respond to changing business and economic conditions and expose us to interest rate risk to the extent of any variable rate debt. In addition, a certain portion of our interest expense may not be deductible.

As of December 31, 2019, our total indebtedness was $1.75 billion, all of which was at fixed interest rates. We also had $1.2 billion of additional borrowing capacity under our revolving line of credit which was subject to a variable interest rate. Other debt we incur also could be variable rate debt. In addition, the Tax Cuts and Jobs Act of 2017 places certain limitations on the deductibility of interest expense at a percentage of taxable income. If interest rates increase, any variable rate debt will create higher debt service requirements, and if interest expense increases beyond a specified percentage of taxable income, a portion of that interest expense may not be deductible for income tax purposes, which could adversely affect our results of operations and cash flows.

We have limited restrictions on incurring substantial additional indebtedness in the future. Our current indebtedness and any future increases in leverage could have adverse consequences on us, including:

- a substantial portion of our cash flow from operations will be required to service interest and principal payments on our debt and will not be available for operations, working capital, capital expenditures, expansion, acquisitions, dividends or general corporate or other purposes;
- our ability to obtain additional financing in the future may be impaired;
- we may be more highly leveraged than our competitors, which may place us at a competitive disadvantage;
- our flexibility in planning for, or reacting to, changes in our business and industry may be limited; and
- we may be more vulnerable in the event of a downturn in our business, our industry or the economy in general.

Our ability to make payments on and to refinance our debt will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, business, financial, competitive, legislative, regulatory, and other factors that are beyond our control. We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available under our revolving line of credit in an amount sufficient to enable us to pay our debt or to fund our other liquidity needs. We may need to refinance all or a portion of our debt on or before maturity. We cannot assure you that we will be able to refinance any of our debt, including our revolving line of credit and senior notes, on commercially reasonable terms or at all.

Servicing our debt requires a significant amount of cash.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service requirements, we may be forced to reduce or delay acquisitions or other investments, or to seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in other defaults, disrupt our operations and cause a reduction of our credit rating, which could further harm our ability to finance or refinance our obligations and business operations. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

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.

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 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 within a certain time period (60 days for government payors), or we may become involved in disputes with payors and could be subjected to pre-payment and post-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, or they experience administrative issues that result in a delay in reimbursements. 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 or 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, we may choose to challenge certain GHC reimbursement decisions through administrative appeal mechanisms. Currently, many of those appeal pathways are backlogged and slow to provide resolution, further affecting our ability to collect reimbursement for services rendered.

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 and other services provided 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, may 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 or fail to meet certain performance metrics under those agreements. Further, consolidation of hospitals, health care systems or other customers could adversely affect our ability to negotiate with these entities. Adverse economic conditions, including decreased federal and state funding to hospitals, 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, including our existing affiliated 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 the MEDNAX Qualified Clinical Data Registry are used to support our day-to-day operations and ongoing clinical research and business analysis. If a hospital prohibits us from using our own management information systems, it may interrupt the efficient operation of our information systems which, in turn, may limit our ability to operate important aspects of our business, including billing and reimbursement as well as research and education initiatives. This inability to use our management information systems at hospital locations may have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our industry is highly 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. In addition, we face competition from other services companies in our teleradiology business.

Further, consolidation within the healthcare industry could strengthen certain competitors that provide services to hospitals and other customers. 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, radiology or other 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, cash flows and the trading price of our securities.

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

A majority of our net revenue in 2019 was generated by our operations in five states. In particular, Texas accounted for approximately 20% of our net revenue in 2019. 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 eligibility or 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, cash flows and the trading price of our securities.

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 securities.

We are subject to litigation risks.

From time to time, we are involved in various litigation matters and claims, including regulatory proceedings, administrative proceedings, governmental investigations, and contract disputes, as they relate to our services and business. We may face potential claims or liability for, among other things, breach of contract, defamation, libel, fraud or negligence. 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 face employment-related litigation, including claims of age discrimination, sexual harassment, gender discrimination, immigration violations, or other local, state, and federal labor law violations. Because of the uncertain nature of litigation and insurance coverage decisions, the outcome of such actions and proceedings 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 securities. In addition, legal fees and costs associated with prosecuting and defending litigation matters could have a material adverse effect on our business, financial condition, results of operation and the trading price of our securities.

Provisions of our articles and bylaws could deter takeover attempts, but our business could be negatively affected as a result of shareholder activism.

Our Amended and Restated Articles of Incorporation, as amended, 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, as amended, 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, however, there is no assurance that these provisions would have such an effect. These provisions could limit the price that some investors might be willing to pay in the future for our shares of common stock. Notwithstanding these provisions, we could, and have, become the target of activist shareholders who acquire ownership positions

in our common stock and seek to influence our company. For example, in late 2019 we were made aware that Starboard Value and Opportunity Master Fund Ltd ("Starboard") purchased shares of our common stock and submitted nominations for a majority slate of directors at our 2020 annual meeting of shareholders. Responding to actions by activist shareholders, such as Starboard, can be costly and time-consuming, disrupt our business and divert the attention of our Board of Directors, management and employees. Additionally, perceived uncertainties as to our future direction, including the composition of our Board of Directors, as a result of shareholder activism may lead to the perception of a change in the direction of our business or other instability, which may be exploited by our competitors, cause concern to our current or potential customers and acquisition candidates, and make it more difficult for us to attract and retain qualified personnel, which could have a material adverse effect on our business, financial condition, results of operations, and cash flows and the trading prices of our securities. In addition, the trading prices of our securities may experience periods of increased volatility as a result of shareholder activism.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our two corporate office buildings, which we own, are located in Sunrise, Florida and contain 260,000 square feet of office space. We also lease space in hospitals and other facilities for our business and medical offices, and other needs. 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.

PART II

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

Common Stock

Our common stock is traded on the New York Stock Exchange (the "NYSE") under the symbol "MD."

As of February 14, 2020, we had 296 holders of record of our common stock, and the closing sales price on that date for our common stock was $26.80 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."

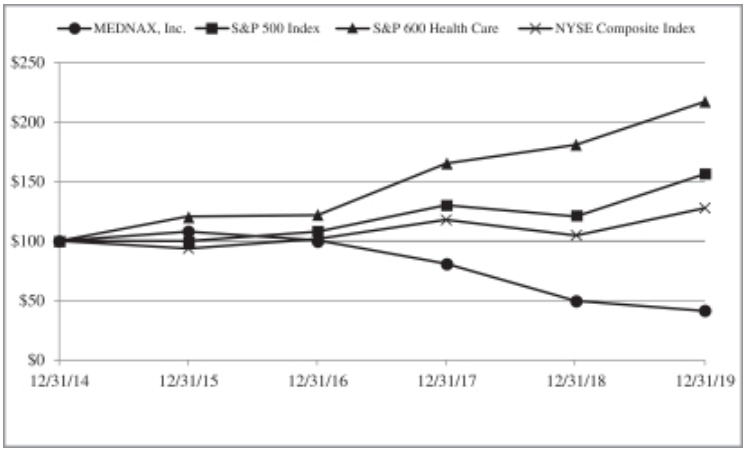
Dividend Policy

We did not declare or pay any cash dividends on our common stock in 2019, 2018, or 2017, 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 agreement (the "Credit Agreement") imposes certain limitations on our ability to declare and pay cash dividends. See Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—"Liquidity and Capital Resources."

Performance Graph

The following graph compares the cumulative total shareholder return on $100 invested on December 31, 2014 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, 2014 through December 31, 2019. 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.



Company/Index	Base Period 2014	Years Ended December 31, 2015	2016	2017	2018	2019
MEDNAX, Inc.	$ 100.00	$108.40	$100.83	$ 80.83	$ 49.92	$ 42.04
S&P 500 Index	$ 100.00	$ 99.27	$108.74	$129.86	$121.76	$156.92
S&P 600 Health Care	$ 100.00	$120.39	$122.73	$165.05	$181.17	$217.65
NYSE Composite Index	$ 100.00	$ 93.58	$102.01	$118.17	$104.94	$128.36

Issuer Purchases of Equity Securities

During the three months ended December 31, 2019, we repurchased 13,577 shares of our common stock that were withheld to satisfy minimum statutory withholding obligations in connection with the vesting of restricted stock.

Period	Total Number of Shares Repurchased (a)	Average Price Paid per Share	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 (a)
October 1 – October 31, 2019	—	$ —	—	(a)
November 1 – November 30, 2019	—	—	—	(a)
December 1 – December 31, 2019	13,577	$ 26.12(b)	—	(a)
Total	13,577	$ 26.12	—	(a)

(a) We have two active repurchase programs. Our July 2013 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 was estimated to be approximately 1.3 million shares for 2019, although no shares were repurchased under that program in 2019. Our August 2018 program allows us to repurchase up to an additional $500.0 million of shares of our common stock, of which we repurchased $392.8 million, leaving $107.2 million available as of December 31, 2019.

(b) Represents shares withheld to satisfy minimum statutory withholding obligations of $0.4 million in connection with the vesting of restricted stock.

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

Recent Sales of Unregistered Equity Securities

During the three months ended December 31, 2019, we did not sell any unregistered shares of our equity 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.

ITEM 6. SELECTED FINANCIAL DATA

The following table includes selected consolidated financial data set forth as of and for each of the three years in the period ended December 31, 2019 on a comparable basis. The balance sheet data at December 31, 2019 and 2018, and the income statement data for the years ended December 31, 2019, 2018 and 2017, 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. The selected consolidated financial data for the years ended December 31, 2016 and 2015 has not been restated to present our management services organization, MedData, that was divested on October 31, 2019 as assets held for sale and discontinued operations and is therefore not comparable. See Note 8 to the Consolidated Financial Statements for additional information on the divestiture of MedData.

(in thousands, except per share and other operating data)	2019	2018	2017	2016	2015
Consolidated Income Statement Data:					
Net revenue	$ 3,513,542	$3,454,810	$3,253,391	$3,183,159	$2,779,996
Operating expenses:					
Practice salaries and benefits	2,508,778	2,426,376	2,227,335	2,031,220	1,753,505
Practice supplies and other operating expenses	112,766	108,851	106,444	118,416	98,480
General and administrative expenses	404,643	403,934	385,864	372,572	305,915
Depreciation and amortization	78,860	83,832	78,856	89,264	64,228
Transformational and restructuring related expenses	95,329	—	—	—	—
Goodwill impairment	1,449,215	—	—	—	—
Total operating expenses	4,649,591	3,022,993	2,798,499	2,611,472	2,222,128
(Loss) income from operations	(1,136,049)	431,817	454,892	571,687	557,868
Investment and other income	5,671	5,211	4,385	2,019	1,844
Interest expense	(119,381)	(88,789)	(74,556)	(63,092)	(23,110)
Equity in earnings of unconsolidated affiliates	7,779	6,825	952	3,185	3,127
Total non-operating expenses	(105,931)	(76,753)	(69,219)	(57,888)	(18,139)
(Loss) income from continuing operations before income taxes	(1,241,980)	355,064	385,673	513,799	539,729
Income tax benefit (provision)	91,886	(96,453)	(80,231)	(189,203)	(204,038)
(Loss) income from continuing operations	(1,150,094)	258,611	305,442	324,596	335,691
(Loss) income from discontinued operations, net of tax	(347,608)	10,018	14,930	318	629
Net (loss) income	$(1,497,702)	$ 268,629	$ 320,372	$ 324,914	$ 336,320
Per Common and Common Equivalent Share Data:					
(Loss) income from continuing operations:					
Basic	$ (13.78)	$ 2.84	$ 3.31	—	—
Diluted	$ (13.78)	$ 2.82	$ 3.29	—	—

(in thousands, except per share and other operating data)	2019	2018	2017	2016	2015
(Loss) income from discontinued operations:					
Basic	$ (4.16)	$ 0.11	$ 0.16	—	—
Diluted	$ (4.16)	$ 0.11	$ 0.16	—	—
Net (loss) income:					
Basic	$ (17.94)	$ 2.95	$ 3.47	$ 3.52	$ 3.61
Diluted	$ (17.94)	$ 2.93	$ 3.45	$ 3.49	$ 3.58
Weighted average common shares:					
Basic	83,495	91,104	92,431	92,422	93,077
Diluted	83,495	91,606	92,958	93,109	93,960
Other Operating Data:					
Number of physicians at end of year	4,327	4,214	4,083	3,617	3,240
Number of births	792,040	793,918	808,465	807,285	803,311
NICU admissions	114,864	113,485	112,965	112,184	111,407
NICU patient days	2,014,166	1,977,516	1,990,521	1,977,204	1,960,768
Number of anesthesia cases	1,793,349	1,844,451	1,924,952	1,827,194	1,533,089
Number of radiology studies[(1)]	12,028,009	11,505,524	10,166,227	5,755,853	5,317,309
Consolidated Balance Sheet Data (Continuing Operations):					
Cash and cash equivalents	$ 112,767	$ 25,491	$ 46,357	$ 55,698	$ 51,572
Working capital	189,689	129,008	55,565	138,179	98,998
Total assets	4,145,901	5,246,297	5,160,065	5,339,400	4,547,214
Total liabilities	2,646,905	2,790,168	2,747,133	2,578,633	2,109,368
Borrowings under credit facility	—	739,500	1,110,500	963,500	533,500
Senior notes outstanding	1,750,000	1,250,000	750,000	750,000	750,000
Total equity	1,498,996	2,456,129	2,412,932	2,760,767	2,437,846

(1) Represents estimated annualized number of studies for years in which acquisitions took place. Does not include studies for the radiology practice acquisition that took place on December 31, 2019.

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, radiology and teleradiology, pediatric cardiology and other pediatric subspecialty care. Our national network is comprised of affiliated physicians who provide clinical care in 39 states and Puerto Rico. At December 31, 2019, our national network comprised over 4,325 affiliated physicians, including 1,290 physicians who provide neonatal clinical care, primarily within hospital-based NICUs, to babies born prematurely or with medical complications. We have 1,300 affiliated physicians who provide anesthesia care to patients in connection with surgical and other procedures, as well as pain management. In addition, we have 400 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 220 physicians providing pediatric intensive care, 105 physicians providing pediatric cardiology care, 150 physicians providing hospital-based pediatric care, 25 physicians providing pediatric surgical care, 10 physicians providing pediatric ear, nose and throat services, and five physicians providing pediatric ophthalmology services. MEDNAX also provides radiology services including diagnostic imaging and interventional radiology, through a network of more than 390 affiliated physicians, as well as teleradiology services in all 50 states, the District of Columbia and Puerto Rico through a network of over 420 affiliated radiologists. In addition to our national physician network, we provide services nationwide to healthcare facilities and physicians, including ours, through a consulting services company.

Reclassifications

Reclassifications have been made to certain prior period financial statements and footnote disclosures to conform to the current period presentation, specifically to reflect the impact of our management services organization being classified as discontinued operations. See – "Divestiture of the Management Services Organization" below.

2019 Acquisition Activity

During 2019, we completed nine physician group practice acquisitions, including two neonatology physician practices, two maternal-fetal physician practices, one radiology practice, and four other pediatric subspecialty practices. Based on our experience, we expect that we can improve the results of acquired physician practices through improved managed care contracting, improved collections, identification of growth initiatives and operating and cost savings based upon the significant infrastructure that we have developed.

Divestiture of the Management Services Organization

In November 2018, we announced the initiation of a process to divest our management services service line, which operated as MedData, to allow us to focus on our core physician services business. On October 10, 2019, we entered into a securities purchase agreement with an affiliate of Frazier Healthcare Partners to divest MedData, and the transaction closed on October 31, 2019. Pursuant to the terms and conditions of the agreement,

at the closing of the transaction, we received cash proceeds of $249.7 million, net of certain net working capital and similar adjustments, as well as contingent economic consideration in an indirect holding company of the buyer, the value of which is contingent on both short and long-term performance of MedData and the maximum amount payable in respect of which is $50.0 million. We also realized certain cash tax benefits from the transaction during the fourth quarter of 2019 and expect incremental cash tax benefits in the coming periods. The operating results of MedData were reported as discontinued operations in our consolidated statements of income for the year ended December 31, 2019, and prior period financial statements have been presented on a consistent basis.

Goodwill Impairment Charge

We test goodwill for impairment at a reporting unit level on at least an annual basis, in accordance with the subsequent measurement provisions of the accounting guidance for goodwill. Consistent with prior years, we performed our annual impairment test in the third quarter, specifically as of July 31, 2019. We used a combination of income and market-based valuation approaches to determine the fair value of our reporting units. Based on the analysis performed, we recorded a non-cash impairment charge of $1.30 billion during the year ended December 31, 2019, nearly all of which related to our anesthesiology reporting unit. Recognition of the non-cash charge against goodwill resulted in a tax benefit which generated an additional deferred tax asset of $147.2 million that increased the fair value of the reporting units. An incremental non-cash charge is then required to reduce the reporting units to their previously determined fair value. Accordingly, we recorded the incremental non-cash charge of $147.2 million for a total non-cash charge of $1.45 billion. The primary factors driving the non-cash impairment charge were (i) a change in management structure effective during the third quarter of 2019 that resulted in the determination of reporting units at one level below our single operating segment of physician services, which is also our single reportable segment, (ii) the decrease in our share price used in the market capitalization reconciliation and (iii) changes in the assumptions used in the valuation analysis, specifically the discount rate used in the cash flow analysis which included a company specific-risk premium. Our goodwill balance at December 31, 2019 was $2.71 billion. We believe that the current assumptions and estimates used in our goodwill analysis are reasonable, supportable and appropriate. A 1% change in the discount rate used in the cash flow analysis would have impacted the non-cash impairment charge in the range of $75.0 million to $90.0 million.

Transformation and Restructuring Initiatives

We have developed a number of strategic initiatives across our organization, in both our shared services functions and our operational infrastructure, with a goal of generating improvements in our general and administrative expenses and our operational infrastructure. We have broadly classified these workstreams in four broad categories including practice operations, revenue cycle management, information technology and human resources. We have included the expenses, which in certain cases represent estimates, related to such activity on a separate line item in our consolidated statements of income beginning in 2019, and we expect these activities to continue through at least 2020. In our shared services departments, we are focused on improving processes, using our resources more efficiently and utilizing our scale more effectively to improve cost and service performance across our operations. Within our operational infrastructure, we have developed specific operational plans within each of our service lines and affiliated physician practices, with specific milestones and regular reporting, with the goal of generating long-term operational improvements and fostering even greater collaboration across our national medical group. We currently intend to make a series of information-technology and other investments to improve processes and performance across our enterprise, using both internal and external resources. We believe these strategic initiatives, together with our continued plans to invest in focused, targeted and strategic organic and acquisitive growth, position us well to deliver a differentiated value proposition to our stakeholders while continuing to provide the highest quality care for our patients.

Senior Notes

In February 2019, we completed a private offering of $500.0 million aggregate principal amount of 6.25% senior unsecured notes due 2027 (the "Additional 2027 Notes"), which are treated as a single class together with the 6.25% senior unsecured notes due 2027 that we issued in November 2018 ("the Initial 2027 Notes" and, collectively with the Additional 2027 Notes, the "2027 Notes"). Our obligations under the 2027 Notes are guaranteed on an unsecured senior basis by the same subsidiaries and affiliated professional contractors that guarantee our credit agreement (the "Credit Agreement"). We used the net proceeds of $491.7 million from the issuance of the Additional 2027 Notes to repay a portion of the indebtedness outstanding under our Credit Agreement. Interest on the 2027 Notes accrues at the rate of 6.25% per annum and is payable semi-annually in arrears on January 15 and July 15.

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 allows us to make open market purchases from time-to-time based on general economic and market conditions and trading restrictions. The repurchase program also allows 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. We did not repurchase any shares under this program during the twelve months ended December 31, 2019.

In August 2018, we announced that our Board of Directors had authorized the repurchase of up to $500.0 million of shares of our common stock in addition to our existing share repurchase program, of which $250.0 million remained available as of January 1, 2019. Under this share repurchase program, during the twelve months ended December 31, 2019, we repurchased 5.1 million shares of our common stock for $145.3 million, inclusive of 96,918 shares withheld to satisfy minimum statutory withholding obligations of $2.5 million in connection with the vesting of restricted stock. As of December 31, 2019, $107.2 million remained available under this share repurchase program.

We may utilize various methods to effect any future share repurchases, including, among others, open market purchases and accelerated share repurchase programs.

General Economic Conditions and Other Factors

Our operations and performance depend significantly on economic conditions. During the year ended December 31, 2019, the percentage of our patient service revenue being reimbursed under GHC Programs remained relatively consistent as compared to the year ended December 31, 2018. If economic conditions in the United States deteriorate, we could experience shifts toward GHC Programs, and patient volumes could decline. Further, we could experience and have experienced shifts toward GHC Programs if changes occur in population demographics within geographic locations in which we provide services. 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 lower net revenue resulting from 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 have affected us and, absent amendment or repeal, may continue to affect us over the next several years. These provisions include the establishment of health insurance exchanges to facilitate the purchase of qualified health

plans, expanded Medicaid eligibility, subsidized insurance premiums and additional requirements and incentives for businesses to provide healthcare benefits. Other provisions have expanded the scope and reach of the Federal Civil False Claims Act and other healthcare fraud and abuse laws. Moreover, we could be affected by potential changes to various aspects of the ACA, including changes to subsidies, healthcare insurance marketplaces and Medicaid expansion.

The ACA remains subject to continuing legislative and administrative flux and uncertainty. In 2017, Congress unsuccessfully sought to replace substantial parts of the ACA with different mechanisms for facilitating insurance coverage in the commercial and Medicaid markets. Congress may again attempt to enact substantial or target changes to the ACA in the future. Additionally, Centers for Medicare & Medicaid Services ("CMS") has administratively revised a number of provisions and may seek to advance additional significant changes through regulation, guidance and enforcement in the future.

At the end of 2017, Congress repealed the part of the ACA that required most individuals to purchase and maintain health insurance or face a tax penalty. In light of these changes, in December 2018, a federal district court in Texas declared that key portions of the ACA were inconsistent with the United States Constitution and that the entire ACA is invalid as a result. Several states appealed this decision, and in December 2019, a federal court of appeals upheld the district court's conclusion that part of the ACA is unconstitutional but remanded for further evaluation whether in light of this defect the entire ACA must be invalidated. These legal proceedings are likely to continue for several years, and the fate of the ACA will be unresolved and uncertain during this period.

In 2020, there will be federal and state elections that could affect which persons and parties occupy the Office of the President of the United States, control one or both chambers of Congress and many states' governors and legislatures. Many candidates running for President of the United States are proposing sweeping changes to the U.S. healthcare system, including replacing current healthcare financing mechanisms with systems that would be entirely administered by the federal government.

If the ACA is repealed or further substantially modified by judicial, legislative or administrative action, or if implementation of certain aspects of the ACA are diluted, delayed or replaced with a "Medicare for All" or single payor system, such repeal, modification or delay may impact our business, financial condition, results of operations, cash flows and the trading price of our securities. We are unable to predict the impact of any repeal, modification or delay in the implementation of the ACA, including the repeal of the individual mandate or implementation of a single payor system, on us at this time.

In addition to the potential impacts to the ACA, there could be changes to other GHC Programs, such as a change to the structure of Medicaid. Congress and the Administration have sought to convert Medicaid into a block grant or to institute "per capita spending caps", among other things. These changes, if implemented could eliminate the guarantee that everyone who is eligible and applies for benefits would receive them and could potentially give states new authority to restrict eligibility, cut benefits and make it more difficult for people to enroll. Additionally, several states are considering and pursuing changes to their Medicaid programs, such as requiring recipients to engage in employment or education activities as a condition of eligibility for most adults, disenrolling recipients for failure to pay a premium, or adjusting premium amounts based on income.

As a result, we cannot predict with any assurance the ultimate effect of these laws and resulting changes to payments under GHC Programs, nor can we provide any assurance that they will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, any fiscal tightening impacting GHC Programs or changes to the structure of any GHC Programs could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities.

The Medicare Access and CHIP Reauthorization Act

Medicare pays for most physician services based upon a national service-specific fee schedule. The Medicare Access and CHIP Reauthorization Act ("MACRA") provided physicians 0.5% annual increases in

reimbursement through 2019 as Medicare transitioned to a payment system designed to reward physicians for the quality of care provided, rather than the quantity of procedures performed. MACRA requires physicians to choose to participate in one of two payment formulas, Merit-Based Incentive Payment System ("MIPS") or Alternative Payment Models ("APMs"). Beginning in 2020, MIPS will allow eligible physicians to receive incentive payments based on the achievement of certain quality and cost metrics, among other measures, and be reduced for those who are underperforming against those same metrics and measures. As an alternative, physicians can choose to participate in advanced APMs, and physicians who are meaningful participants in APMs will receive bonus payments from Medicare pursuant to the law. MACRA also remains subject to review and potential modification by Congress, as well as shifting regulatory requirements established by CMS. Our affiliated physicians achieved bonus payments in 2020 through participation in the MIPS, although the amounts of such bonus payments is not currently known. We will continue to operationalize the provisions of MACRA and assess any further changes to the law or additional regulations enacted pursuant to the law.

We cannot predict the ultimate effect that these changes will have on us, nor can we provide any assurance that its provisions will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

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 federal poverty level. To date, 36 states and the District of Columbia have expanded Medicaid eligibility to cover this additional low-income patient population, and other states are considering expansion. 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.

"Surprise" Billing Legislation

"Surprise" medical bills arise when an insured patient receives care from an out-of-network provider resulting in costs that were not expected by the patient. The bill is a "surprise" either because the patient did not expect to receive care from an out-of-network provider, or because their cost-sharing responsibility is higher than the patient expected. For the past several years, state legislatures have been enacting laws that are intended to address the problems associated with surprise billing or balance billing.

More recently, Congress and President Trump have proposed bipartisan solutions to address this circumstance, either by working in tandem with, or in the absence of, applicable state laws. Several committees of jurisdiction in the U.S. House of Representatives and in the U.S. Senate have proposed solutions to address surprise medical bills, but it is unclear whether any of the proposed solutions will become law. In addition, state legislatures and regulatory bodies continue to address and modify existing laws on the same issue. Any state or federal legislation on the topic of surprise billing may have an unfavorable impact on out-of-network reimbursement that we receive. In addition, actual or prospective legislative changes in this area may impact, and may have impacted, our ability to contract with private payors at favorable reimbursement rates or remain in contract with such payors.

Although our out-of-network revenue is currently immaterial, we cannot predict the ultimate effect that these changes will have on us, nor can we provide any assurance that future legislation or regulations will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.

Medicare Sequestration

The Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, required across-the-board cuts ("sequestrations") to Medicare reimbursement rates. These annual reductions of 2%, on average, apply to mandatory and discretionary spending through 2025. Unless Congress acts in the future to modify these sequestrations, Medicare reimbursements will be reduced by 2%, on average, annually. However, this reduction in Medicare reimbursement rates is not expected to have a material adverse effect on our business, financial condition, results of operations, cash flows or the trading price of our securities.

Geographic Coverage

During 2019, 2018, and 2017, approximately 52%, 52% and 51%, respectively, of our net revenue was generated by operations in our five largest states. During 2019, 2018 and 2017, our five largest states consisted of Texas, Florida, Georgia, Tennessee, and North Carolina. During 2019, 2018 and 2017, our operations in Texas accounted for approximately 20%, 20% and 18%, 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.

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

	Years Ended December 31,		
	2019	2018	2017
Contracted managed care	69%	70%	70%
Government	24%	24%	25%
Other third-parties	5%	4%	4%
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 GHC Programs for the years ended December 31, 2019, 2018 and 2017 represented approximately 55% 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, 2019.

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 19 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. 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. Our performance obligations relate to the delivery of services to patients and are satisfied at the time of service. Accordingly, there are no performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period with respect to patient service revenue. 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. Collection of patient service revenue we expect to receive is normally a function of providing complete and correct billing information to the GHC Programs and third-party insurance payors within the various filing deadlines and typically occurs within 30 to 60 days of billing. 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, 2019, 2018, or 2017.

Some of our agreements require hospitals to pay us administrative fees. Some agreements 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 or other services at the hospital.

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, 2019, our DSO was 50.7 days. We had approximately $1.94 billion in gross accounts receivable outstanding at December 31, 2019, 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 $9.7 million to $29.2 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 18 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 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 four 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, 2019, based on our historical experience, a reasonably likely change of 4% to 13% in our estimates would result in an increase or decrease to net income of $4.0 million to $14.2 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 purchase price over the fair value of the net assets acquired. We test goodwill for impairment at a reporting unit level on an annual basis, and more frequently if impairment indicators exist. We use a single-step quantitative test with any goodwill impairment measured as the amount by which a reporting unit's carrying value exceeds its fair value. We use income and market-based valuation approaches to determine the fair value of our reporting units. These approaches focus on various significant assumptions, including the weighted average cost of capital discount factor, revenue growth rates and market multiples for revenue and earnings before interest, taxes and depreciation and amortization ("EBITDA"). We also consider the economic outlook for the healthcare services industry and various other factors during the testing process, including hospital and physician contract changes, local market developments, changes in third-party payor payments, and other publicly available information.

Other Matters

Other significant accounting policies, not involving the same level of measurement uncertainties as those discussed above, are nevertheless important to an understanding of our Consolidated Financial Statements. For example, our Consolidated Financial Statements are presented on a consolidated basis with our affiliated professional contractors because we or one of our subsidiaries have entered into management agreements with our affiliated professional contractors meeting the "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.

Non-GAAP Measures

In our analysis of our results of operations, we use certain non-GAAP financial measures. Prior to January 1, 2019, we reported EBITDA and adjusted earnings per common share ("Adjusted EPS"). During 2019, we incurred and anticipate we will continue to incur certain expenses related to transformational and restructuring related expenses that are expected to be project-based and periodic in nature. In addition, beginning with the first quarter of 2019 through the divestiture date of October 31, 2019, we reported MedData as assets held for sale and discontinued operations. Accordingly, beginning with the first quarter of 2019, we began reporting Adjusted EBITDA from continuing operations, defined as income (loss) from continuing operations before interest, taxes, depreciation and amortization, and transformational and restructuring related expenses. Adjusted EPS from continuing operations has also been further adjusted for these items and beginning with the first quarter of 2019 consists of diluted income (loss) from continuing operations per common and common equivalent share adjusted for amortization expense, stock-based compensation expense and transformational and restructuring related expenses. Adjusted EPS from continuing operations is being further adjusted to reflect the impacts from discrete tax events. Adjusted EBITDA and Adjusted EPS have also been adjusted for the non-cash goodwill impairment charge recorded during the third quarter of 2019. Historical periods do not include any material items that meet the current definition of transformational and restructuring related expenses or goodwill impairment, so although we are retrospectively presenting historical periods for the new definitions, we do not reflect any adjustments for these items.

We believe these measures, in addition to income (loss) from continuing operations, net income (loss) and diluted net income (loss) from continuing operations per common and common equivalent share, provide investors with useful supplemental information to compare and understand our underlying business trends and performance across reporting periods on a consistent basis. These measures should be considered a supplement to, and not a substitute for, financial performance measures determined in accordance with GAAP. In addition, since these non-GAAP measures are not determined in accordance with GAAP, they are susceptible to varying calculations and may not be comparable to other similarly titled measures of other companies.

For a reconciliation of each of Adjusted EBITDA from continuing operations and Adjusted EPS from continuing operations to the most directly comparable GAAP measures for the years ended December 31, 2019, 2018 and 2017, refer to the tables below (in thousands, except per share data). In addition, historical reconciliations of Adjusted EBITDA from continuing operations and Adjusted EPS from continuing operations are available on our internet website at www.mednax.com under the Investors tab. Our internet website and the information contained therein or connected thereto are not incorporated into or deemed a part of this Form 10-K.

	Years Ended December 31,		
	2019	2018	2017
(Loss) income from continuing operations	$(1,150,094)	$258,611	$305,442
Interest expense	119,381	88,789	74,556
Income tax (benefit) provision	(91,886)	96,453	80,231
Depreciation and amortization	78,860	83,832	78,856
Transformational and restructuring related expenses	95,329	—	—
Goodwill impairment	1,449,215	—	—
Adjusted EBITDA from continuing operations	$ 500,805	$527,685	$539,085

	Years Ended December 31,					
	2019		2018		2017	
Weighted average diluted shares outstanding	83,495		91,606		92,958	
(Loss) income from continuing operations and diluted income from continuing operations per share	$(1,150,094)	$(13.78)	$258,611	$2.82	$305,442	$ 3.29
Adjustments[(1)]:						
Amortization (net of tax of $13,192, $14,793 and $20,452)	35,668	0.43	39,743	0.43	32,042	0.34
Stock-based compensation (net of tax of $9,544, $10,284 and $11,223)	25,807	0.31	27,626	0.30	17,555	0.19
Transformational and restructuring related expenses (net of tax of $25,739)	69,590	0.83	—	—	—	—
Goodwill impairment (net of tax of $147,215)	1,302,000	15.59	—	—	—	—
Net impact from discrete tax events	(773)	—	—	—	(70,014)	(0.75)
Adjusted income and diluted EPS from continuing operations	$ 282,198	$ 3.38	$325,980	$3.55	$285,025	$ 3.07

(1) Tax rates of 27.0%, 27.1% and 39.0% were used to calculate the tax effects of the adjustments for the year ended December 31, 2019, 2018 and 2017, respectively. The tax rates used for the years ended December 31, 2019 and 2017 exclude the impact of discrete tax events.

RESULTS OF OPERATIONS

The following table sets forth, for the periods indicated, certain information related to our continuing operations expressed as a percentage of our net revenue:

	Years Ended December 31,		
	2019	2018	2017
Net revenue	100.0%	100.0%	100.0%
Operating expenses:			
Practice salaries and benefits	71.4	70.2	68.5
Practice supplies and other operating expenses	3.2	3.2	3.2
General and administrative expenses	11.5	11.7	11.9
Depreciation and amortization	2.2	2.4	2.4
Transformational and restructuring related expenses	2.7	—	—
Goodwill impairment	41.3	—	—
Total operating expenses	132.3	87.5	86.0
(Loss) income from operations	(32.3)	12.5	14.0
Non-operating expense, net	3.0	2.2	2.1
(Loss) income from continuing operations before income taxes	(35.3)	10.3	11.9
Income tax benefit (provision)	2.6	(2.8)	(2.5)
(Loss) income from continuing operations	(32.7)%	7.5%	9.4%

Year Ended December 31, 2019 as Compared to Year Ended December 31, 2018

Our net revenue attributable to continuing operations was $3.51 billion for the year ended December 31, 2019, as compared to $3.45 billion for 2018. The increase in revenue of $58.7 million, or 1.7%, was attributable to an increase in same-unit net revenue, partially offset by a decline in revenue from the non-renewal of certain contracts. Same units are those units at which we provided services for the entire current period and the entire comparable period. Same-unit net revenue grew by $73.3 million, or 2.2%, in the year ended December 31, 2019, as compared to the same period in 2018. The increase in same-unit net revenue was comprised of a net increase of $40.2 million, or 1.2%, related to patient service volumes and a net increase of $33.1 million, or 1.0%, from net reimbursement-related factors. The net increase in revenue related to net reimbursement-related factors was primarily due to favorable rate impacts from our radiology services, modest increases from managed care contracting and an increase in administrative fees received from our hospital partners. The increase in revenue from patient service volumes was primarily related to growth across almost all of our services, driven by growth in neonatology and other pediatric services, including newborn nursery, and anesthesiology services.

Practice salaries and benefits attributable to continuing operations increased $82.4 million, or 3.4%, to $2.51 billion for the year ended December 31, 2019, as compared to $2.43 billion for 2018. This increase was primarily attributable to increased costs associated with physicians and other staff to support organic growth initiatives and growth at our existing units, as well as increases in malpractice expense due to unfavorable trends in claims experience. Of the $82.4 million increase, $39.2 million was related to salaries and $43.2 million was related to benefits and incentive compensation. We anticipate that we will continue to experience a higher rate of growth in clinician compensation expense and malpractice expense at our existing units over historic averages, which could adversely affect our business, financial condition, results of operations, cash flows and the trading price of our securities.

Practice supplies and other operating expenses attributable to continuing operations increased $3.9 million, or 3.6%, to $112.8 million for the year ended December 31, 2019, as compared to $108.9 million for 2018. The increase was primarily attributable to increases in other practice operating expenses as compared to the prior year.

General and administrative expenses attributable to continuing operations primarily 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 practices and services. General and administrative expenses were $404.6 million for the year ended December 31, 2019, as compared to $403.9 million for 2018. General and administrative expenses as a percentage of net revenue was 11.5% for the year ended December 31, 2019, as compared to 11.7% for the same period in 2018.

Transformational and restructuring related expenses attributable to continuing operations were $95.3 million for the year ended December 31, 2019 of which $65.7 million was related to external consulting costs for various process improvement and restructuring initiatives, $18.0 million was related to severance benefits for eliminated positions and $11.6 million was associated with contract terminations and other such activities.

Goodwill impairment charges attributable to continuing operations was $1.45 billion for the year ended December 31, 2019, nearly all of which related to our anesthesiology service line. See Note 7 – Goodwill and Intangible Assets for more information.

Depreciation and amortization expense attributable to continuing operations decreased $5.0 million, or 5.9%, to $78.9 million for the year ended December 31, 2019, as compared to $83.8 million for 2018, primarily related to a decrease in amortization expense underlying various finite lived intangible assets due to the expiration of amortization periods.

Loss from operations attributable to continuing operations was $1.14 billion for the year ended December 31, 2019, as compared to income from operations attributable to continuing operations of $431.8 million for 2018. Our operating margin was (32.3)% for the year ended December 31, 2019, as compared to 12.5% for 2018. The decrease in our operating margin was primarily due to the non-cash goodwill impairment charge recorded during 2019 as well as higher operating expense growth, including transformation and restructuring expenses, combined with lower revenue growth. Excluding the non-cash goodwill impairment charge and the transformation and restructuring expenses, our income from operations attributable to continuing operations was $408.5 million, and our operating margin was 11.6%. We believe excluding the impacts from the non-cash goodwill impairment charge and transformational and restructuring activity provides a more comparable view of our operating income and operating margin from continuing operations.

Net non-operating expenses attributable to continuing operations were $105.9 million for the year ended December 31, 2019, as compared to $76.8 million for 2018. The net increase of $29.1 million, or 38.0%, was primarily related to an increase in interest expense related to a higher average interest rate on our outstanding debt, driven by the incremental senior notes issuances in late 2018 and early 2019.

Our effective income tax rate attributable to continuing operations was 7.4% and 27.2% for the years ended December 31, 2019 and 2018, respectively. Excluding the income tax impacts from the non-cash goodwill impairment charge and other discrete tax items, our effective income tax rate was 27.0% for the year ended December 31, 2019. We believe excluding the impacts on our effective income tax rate related to the non-cash impairment charge and other discrete tax items provides a more comparable view of our effective income tax rate.

Loss from continuing operations was $1.15 billion for the year ended December 31, 2019, as compared to income from continuing operations of $258.6 million for 2018. Adjusted EBITDA from continuing operations was $500.8 million for the year ended December 31, 2019, as compared to $527.7 million for the same period in 2018.

Diluted loss from continuing operations per common and common equivalent share was $13.78 on weighted average shares outstanding of 83.5 million for the year ended December 31, 2019, as compared to diluted income from continuing operations of $2.82 on weighted average shares outstanding of 91.6 million for 2018. Adjusted

EPS from continuing operations was $3.38 for the year ended December 31, 2019, as compared to $3.55 for 2018. The decrease of 8.1 million in our weighted average shares outstanding is primarily due to the impact of shares repurchased under a 2018 accelerated share repurchase program and through open market repurchase activity in 2018 and 2019.

Loss from discontinued operations, net of tax, was $347.6 million for the year ended December 31, 2019, reflecting the loss on the initial classification of MedData as assets held for sale, the incremental impairment charge and the preliminary loss on sale recorded during the year ended December 31, 2019, as compared to income from discontinued operations, net of tax, of $10.0 million for 2018. Diluted loss from discontinued operations per common and common equivalent share was $4.16 for the year ended December 31, 2019, as compared to diluted income from discontinued operations per common and common equivalent share of $0.11 for 2018.

Net loss was $1.5 billion for the year ended December 31, 2019, as compared to net income of $268.6 million for 2018. Diluted net loss per common and common equivalent share was $17.94 for the year ended December 31, 2019, as compared to diluted net income per common and common equivalent share of $2.93 for 2018.

Year Ended December 31, 2018 as Compared to Year Ended December 31, 2017

Our net revenue attributable to continuing operations was $3.45 billion for the year ended December 31, 2018, as compared to $3.25 billion for the same period in 2017. The increase in revenue of $201.4 million, or 6.2%, was attributable to an increase in same-unit net revenue and revenue from acquisitions. Same units are those units at which we provided services for the entire current period and the entire comparable period. Same-unit net revenue grew by $98.7 million, or 3.3%, for the year ended December 31, 2018, as compared to the same period in 2017. The increase in same-unit net revenue was comprised of a net increase of $61.6 million, or 2.1%, related to net reimbursement-related factors and a net increase of $37.1 million, or 1.2%, from patient service volumes. The net increase in revenue related to net reimbursement-related factors was primarily due to modest improvements in managed care contracting, an increase in the administrative fees received from our hospital partners and the flow through of revenue from modest price increases, partially offset by a decrease in revenue caused by an increase in the percentage of our patients enrolled in GHC Programs. The increase in revenue from patient service volumes was related to growth across almost all of our services.

Practice salaries and benefits attributable to continuing operations increased $199.0 million, or 8.9%, to $2.43 billion for the year ended December 31, 2018, as compared to $2.23 billion for 2017. This increase was primarily attributable to increased costs associated with physicians and other staff to support acquisition-related growth, organic growth initiatives and growth at our existing units, of which $158.9 million was related to salaries and $40.1 million was related to benefits and incentive compensation. Included within practice salaries and benefits expense in 2018 is $18.1 million for certain physicians who remained employed through December 31, 2018 despite the non-renewal of an anesthesia services contract effective July 1, 2018, under which they had previously provided services.

Practice supplies and other operating expenses attributable to continuing operations increased $2.4 million, or 2.3%, to $108.8 million for the year ended December 31, 2018, as compared to $106.4 million for 2017. The increase was primarily attributable to practice supply, rent and other costs related to our acquisitions.

General and administrative expenses attributable to continuing operations primarily 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 practices and services. General and administrative expenses increased $18.1 million, or 4.7%, to $403.9 million for the year ended December 31, 2018, as compared to $385.9 million for 2017. The increase is attributable to the overall growth of the Company, including growth from acquisitions. Included within general and administrative expenses was an increase of $9.3 million of stock-based

compensation expense primarily resulting from the change in timing of our annual equity grants from June to March in order to align the timing with other compensation related activities. General and administrative expenses also included a decrease of $25.0 million resulting from cost improvements as part of our cost savings initiatives. General and administrative expenses as a percentage of net revenue was 11.7% for the year ended December 31, 2018, as compared to 11.9% for the same period in 2017.

Depreciation and amortization expense attributable to continuing operations increased $4.9 million, or 6.3%, to $83.8 million for the year ended December 31, 2018, as compared to $78.9 million for 2017. The increase was primarily attributable to the amortization of intangible assets related to acquisitions.

Income from operations attributable to continuing operations decreased $23.1 million, or 5.1%, to $431.8 million for the year ended December 31, 2018, as compared to $454.9 million for 2017. Our operating margin was 12.5% for the year ended December 31, 2018, as compared to 14.0% for 2017. The decrease of 148 basis points was primarily due to the impact of the non-renewal of an anesthesia services contract effective July 1, 2018, as well as higher operating expense growth as compared to revenue growth.

Net non-operating expenses attributable to continuing operations were $76.8 million for the year ended December 31, 2018, as compared to $69.2 million for 2017. The net increase in non-operating expenses attributable to continuing operations was primarily related to an increase in interest expense due to a higher effective interest rate on borrowings outstanding under our Credit Agreement.

Our effective income tax rate attributable to continuing operations was 27.2% for the year ended December 31, 2018, as compared to 20.8% for 2017. Our effective income tax rate attributable to continuing operations in 2017 was impacted by a $70.0 million income tax benefit resulting from the reduction of our net deferred tax liability related to the reduction in the corporate tax rate enacted under the Tax Cuts and Jobs Act of 2017 during the fourth quarter of 2017.

Net income from continuing operations was $258.6 million for the year ended December 31, 2018, as compared to $305.4 million for 2017. Adjusted EBITDA from continuing operations was $527.7 million for the year ended December 31, 2018, as compared to $539.1 million for 2017.

Diluted net income from continuing operations per common and common equivalent share was $2.82 on weighted average shares outstanding of 91.6 million for the year ended December 31, 2018, as compared to $3.29 on weighted average shares outstanding of 93.0 million for 2017. Adjusted EPS from continuing operations was $3.55 for the year ended December 31, 2018, as compared to $3.07 for 2017. The decrease of 1.4 million in our weighted average shares outstanding is primarily due to the impact of shares repurchased under our accelerated share repurchase program.

Income from discontinued operations, net of tax, was $10.0 million for the year ended December 31, 2018, as compared to $14.9 million for the same period in 2017. Diluted income from discontinued operations per common and common equivalent share was $0.11 for the year ended December 31, 2018, as compared to $0.16 for the same period in 2017.

Consolidated net income was $268.6 million for the year ended December 31, 2018, as compared to $320.4 million for the same period in 2017. Diluted net income per common and common equivalent share was $2.93 for the year ended December 31, 2018, as compared to diluted net income per common and common equivalent share of $3.45 for the same period in 2017.

LIQUIDITY AND CAPITAL RESOURCES

As of December 31, 2019, we had $112.8 million of cash and cash equivalents attributable to continuing operations as compared to $25.5 million at December 31, 2018. Additionally, we had working capital attributable

to continuing operations of $189.7 million at December 31, 2019, an increase of $60.7 million from our working capital from continuing operations of $129.0 million at December 31, 2018. This net increase in working capital is primarily due to 2019 earnings and an increase in our operating cash balance, partially offset by the use of funds for repurchases of our common stock and acquisitions.

Cash Flows

Cash provided by (used in) operating, investing and financing activities from continuing operations is summarized as follows (in thousands):

	Years Ended December 31,		
	2019	2018	2017
Operating activities	$ 338,467	$ 274,108	$ 483,367
Investing activities	121,878	(124,380)	(552,990)
Financing activities	(393,070)	(170,594)	90,345

Operating Activities

We generated cash flow from operating activities for continuing operations of $338.5 million, $274.1 million and $483.4 million for the years ended December 31, 2019, 2018 and 2017, respectively. The net increase in cash flow provided of $64.4 million for the year ended December 31, 2019, as compared to the year ended December 31, 2018, was primarily related to a combination of favorable impacts from lower tax payments in 2019 and a decrease in cash flow in 2018 for tax payments made in the first quarter of 2018 for 2017 taxes that were deferred by the Internal Revenue Service for companies impacted by the 2017 hurricanes. Cash flow from operating activities in 2019 was also impacted by cash payments made for transformation and restructuring related expenses which resulted in cash outflows of $69.0 million.

During the year ended December 31, 2019, cash flow provided by accounts receivable for continuing operations was $7.9 million, as compared to cash used of $43.4 million for the same period in 2018. The increase in cash flow from accounts receivable for the year ended December 31, 2019 was primarily due to decreases in ending accounts receivable balances at existing units due to timing of cash collections.

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 for continuing operations was 50.7 days at December 31, 2019 as compared to 52.5 days at December 31, 2018.

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 Credit Agreement. 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.

We generated cash flow from operating activities for continuing operations of $274.1 million and $483.4 million for the years ended December 31, 2018 and 2017, respectively. Cash flow for the year ended December 31, 2018 was impacted by a decrease in cash flow from income taxes payable resulting from tax payments made in the first quarter of 2018 for 2017 taxes that were deferred by the Internal Revenue Service for companies impacted by the 2017 hurricanes, as well as a net decrease in cash flow related to accounts receivable, partially offset by an increase in cash flow related to changes in deferred taxes. Cash flow for the year ended December 31, 2017 was impacted by changes in the components of income taxes payable for income taxes payments that were deferred to 2018 as a result of the 2017 hurricanes, accounts receivable and professional liability reserves.

Investing Activities

During the year ended December 31, 2019, our net cash provided from investing activities for continuing operations of $121.9 million primarily included net proceeds of $249.7 million from the sale of MedData and net proceeds of $16.0 million related to the purchase and maturity of investments, partially offset by acquisition payments of $112.0 million and capital expenditures of $31.9 million.

Financing Activities

During the year ended December 31, 2019, our net cash used in financing activities of $393.1 million consisted primarily of net repayments on our Credit Agreement of $739.5 million and the repurchase of $145.3 million of our common stock, partially offset by proceeds from our 2027 Notes of $500.0 million.

Liquidity

On March 28, 2019, we amended and restated our Credit Agreement to reduce the size of the revolving credit facility, extend the maturity and make other technical and conforming changes. As amended and restated, the Credit Agreement provides for a $1.2 billion unsecured revolving credit facility and includes a $37.5 million sub-facility for the issuance of letters of credit. The Credit Agreement matures on March 28, 2024 and is guaranteed by substantially all of our subsidiaries and affiliated professional associations and corporations. At our option, borrowings under the Credit Agreement will bear interest at (i) the alternate base rate (defined as the higher 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. The Credit Agreement also calls for other customary fees and charges, including an unused commitment fee ranging from 0.150% to 0.200% of the unused lending commitments, based on our consolidated leverage ratio. The Credit Agreement contains customary covenants and restrictions, including covenants that require us to maintain a minimum interest charge ratio, not to exceed a specified consolidated leverage ratio and to comply with laws, and restrictions on the ability to pay dividends and make certain other distributions, as specified therein. Failure to comply with these covenants would constitute an event of default under the Credit Agreement, notwithstanding the ability of the company to meet its debt service obligations. The 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 Credit Agreement.

At December 31, 2019, we had no borrowings outstanding on our Credit Agreement. We had outstanding letters of credit of $0.2 million, and the amount available on our Credit Agreement was $1.2 billion at December 31, 2019.

In February 2019, we completed a private offering of the Additional 2027 Notes. At December 31, 2019, the outstanding balance on the 2027 Notes was $1.0 billion. We also had an outstanding principal balance of $750.0 million on our 5.25% senior unsecured notes due 2023 (the “2023 Notes”). Our obligations under the 2023 Notes and the 2027 Notes are guaranteed on an unsecured senior basis by the same subsidiaries and affiliated professional contractors that guarantee our Credit Agreement. Interest on the 2023 Notes accrues at the rate of 5.25% per annum, or $39.4 million, and is payable semi-annually in arrears on June 1 and December 1. Interest on the 2027 Notes accrues at the rate of 6.25% per annum, or $62.5 million, and is payable semi-annually in arrears on January 15 and July 15.

The indenture under which the 2023 Notes and the 2027 Notes are issued, among other things, limits our ability to (1) incur liens and (2) enter into sale and lease-back transactions, and also limits our ability to merge or dispose of all or substantially all of our assets, in all cases, subject to a number of customary exceptions. Although we are not required to make mandatory redemption or sinking fund payments with respect to the 2023 Notes or the 2027 Notes, upon the occurrence of a change in control of MEDNAX, we may be required to repurchase the 2023 Notes and the 2027 Notes at a purchase price equal to 101% of the aggregate principal amount of the 2023 Notes and the 2027 Notes repurchased plus accrued and unpaid interest.

At December 31, 2019, we believe we were in compliance, in all material respects, with the financial covenants and other restrictions applicable to us under the Credit Agreement and the 2023 Notes and the 2027 Notes.

The exercise of employee stock options and the purchase of common stock by employees participating in our ESPP and SPP generated cash proceeds of $11.3 million, $16.3 million and $23.3 million for the years ended December 31, 2019, 2018 and 2017, respectively. Because stock option exercises and purchases under the ESPP and SPP 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, 2019 was $271.8 million, of which $44.9 million is classified as a current liability within accounts payable and accrued expenses in the Consolidated Balance Sheet. In addition, there is a corresponding insurance receivable of $29.8 million recorded as a component of other assets for certain professional liability claims that are covered by insurance policies.

We anticipate that funds generated from operations, together with our current cash on hand and funds available under our Credit Agreement, will be sufficient to finance our working capital requirements, fund anticipated acquisitions and capital expenditures, fund expenses related to our transformational and restructuring activities, fund our share repurchase programs and meet our contractual obligations as described below for at least the next 12 months from the date of issuance of this Form 10-K.

CONTRACTUAL OBLIGATIONS

At December 31, 2019, we had the following obligations and commitments (in thousands):

	Payments Due				
Obligation	Total	2020	2021 and 2022	2023 and 2024	2025 and Later
Senior notes[(1)]	$2,344,116	$101,875	$203,750	$911,094	$1,127,397
Operating leases	102,184	25,060	41,703	22,214	13,207
	$2,446,300	$126,935	$245,453	$933,308	$1,140,604

(1) Amounts include interest payments at the applicable rate as of December 31, 2019 and assume the amount outstanding under our 2023 Notes and the 2027 Notes will be paid on their maturity dates of December 1, 2023 and January 15, 2027, respectively.

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, 2019, cash payments of up to $2.7 million may be due through 2020 under all contingent consideration provisions.

At December 31, 2019, our total liability for uncertain tax positions was $8.0 million, all of which is included within other liabilities on our Consolidated Balance Sheets. The timing and amount of future cash flows for each year beyond 2019 cannot be reasonably estimated. See Note 13 to our Consolidated Financial Statements in this Form 10-K for more information regarding our uncertain tax positions.

OFF-BALANCE SHEET ARRANGEMENTS

We did not have any off-balance sheet arrangements as of December 31, 2019 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.

RECENTLY ADOPTED ACCOUNTING PRONOUNCEMENTS

In February 2016, the accounting guidance related to leases was issued that requires an entity to recognize leased assets and the rights and obligations created by those leased assets on the balance sheet and to disclose key information about the entity's leasing arrangements. This guidance became effective for us on January 1, 2019. The adoption of this guidance had a material impact on our Consolidated Balance Sheets and related disclosures, resulting from the recognition of significant right of use assets and related liabilities, primarily related to our operating lease arrangements for space in hospitals and certain other facilities for its business and medical offices. See Note 10 – Lease for more information.

NEW ACCOUNTING PRONOUNCEMENTS

In December 2019, accounting guidance related to income taxes was issued with the goal of enhancing and simplifying various aspects of the income tax accounting guidance, including requirements related to hybrid tax regimes, deferred taxes on step-up in tax basis of goodwill obtained in a transaction that is not a business combination, separate financial statements of entities not subject to tax, the intraperiod tax allocation exception to the incremental approach, deferred tax liabilities on outside basis differences, and interim-period accounting for enacted changes in tax law and certain year-to-date loss limitations. The guidance becomes effective on January 1, 2021, including interim periods therein, with early adoption permitted, including adoption in interim or annual periods for which financial statements have not yet been issued. We do not believe the adoption of this new guidance will have a material impact on our consolidated financial statements and related disclosures.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are subject to market risk primarily from exposure to changes in interest rates based on our financing, investing and cash management activities. We intend to manage interest rate risk through the use of a combination of fixed rate and variable rate debt. We borrow under our Credit Agreement at various interest rate options based on the Alternate Base Rate or LIBOR rate depending on certain financial ratios. At December 31, 2019, we had no outstanding borrowings on our Credit Agreement.

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

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of MEDNAX, Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of MEDNAX, Inc. and its subsidiaries (the "Company") as of December 31, 2019 and 2018, and the related consolidated statements of income, equity, and cash flows for each of the three years in the period ended December 31, 2019, including the related notes and financial statement schedule listed in the accompanying index (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control—Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on criteria established in *Internal Control—Integrated Framework* (2013) issued by the COSO.

Change in Accounting Principle

As discussed in Note 2 to the consolidated financial statements, the Company changed the manner in which it accounts for leases in 2019.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, 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 appearing under Item 9A. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. 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, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. 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.

Definition and Limitations of Internal Control over Financial Reporting

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.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Patient Services Accounts Receivable—Allowance for Contractual Adjustments and Uncollectibles

As described in Notes 2 and 4 to the consolidated financial statements, patient service revenue is recognized at the time services are provided by the Company's affiliated physicians. Payments for services rendered are generally less than billed charges. Contractual adjustments result from the difference between the physician rates for services performed and the reimbursements by third-party payors for such services. Patient service revenue is presented net of an estimated provision for contractual adjustments and uncollectibles. Management estimates the allowances for contractual adjustments and uncollectibles on accounts receivable based upon historical experience and other factors, including days sales outstanding 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. Patient services accounts receivable makes up a significant portion of the Company's consolidated net accounts receivable balance of $498.9 million as of December 31, 2019.

The principal considerations for our determination that performing procedures relating to the valuation of patient services accounts receivable—allowance for contractual adjustments and uncollectibles is a critical audit matter are there was significant judgment by management to determine the estimated allowance to adjust the patient services accounts receivable to the amount that will be collected in the future under the terms of third-party payor contracts. This in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating the audit evidence obtained related to the valuation of patient services accounts receivable.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to the valuation of patient accounts receivable, which included controls over management's

model, data, and assumptions used to estimate the allowance for contractual adjustments and uncollectibles from third parties. These procedures also included, among others (i) evaluating management's process for developing the allowance for contractual adjustments and uncollectibles, as well as the relevance and use of historical experience data as an input into the estimate, (ii) testing the completeness and accuracy of the charges and payments used by management in the estimate by testing a sample of revenue transactions, (iii) evaluating the historical accuracy of management's process for developing the estimate of the amount which will ultimately be collected by comparing actual cash collections to the previously recorded patient services accounts receivable, and (iv) developing an independent expectation of the amount expected to be collected by management. Developing an independent expectation involved calculating the percentage of cash collections as compared to the recorded patient services accounts receivable balance as of the end of the prior year and comparing that percentage to management's collection expectation used to determine the current year allowance for contractual adjustments and uncollectibles.

Goodwill Impairment Assessment of the Anesthesia and Radiology Reporting Units

As described in Notes 2 and 7 to the consolidated financial statements, the Company's consolidated goodwill balance was $2.7 billion as of December 31, 2019 and the Company recognized $1.4 billion of goodwill impairment during the year then ended. The goodwill balance of the Anesthesia and Radiology reporting units represents a portion of the total consolidated goodwill balance. Goodwill is tested for impairment at a reporting unit level on at least an annual basis in accordance with the subsequent measurement provisions of the accounting guidance for goodwill. The Company performs a single-step quantitative test with any goodwill impairment measured as the amount by which a reporting unit's carrying value exceeds its fair value. Management uses income and market-based valuation approaches to determine the fair value of the Company's reporting units. These approaches focus on discounted cash flows and revenue and EBITDA multiples based on the Company's market capitalization to derive the fair value of a reporting unit. Significant assumptions used in these valuations include the weighted average cost of capital discount factor, revenue growth rates and revenue and EBITDA multiples. The Company also considers 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.

The principal considerations for our determination that performing procedures relating to the goodwill impairment assessment of the Anesthesia and Radiology reporting units is a critical audit matter are there was significant judgment by management to determine the fair value of the Anesthesia and Radiology reporting units. In particular, the assumptions used in the determination of fair value, including the weighted average cost of capital discount factor, revenue growth rates, and revenue and EBITDA multiples, involve a high level of subjectivity. This in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures and evaluating the audit evidence obtained related to the assumptions used in the estimate of fair value of the Anesthesia and Radiology reporting units, and the audit effort involved the use of professionals with specialized skill and knowledge to assist in performing these procedures and evaluating the audit evidence obtained.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's goodwill impairment assessment of the Anesthesia and Radiology reporting units, including controls over the valuation of the reporting units. These procedures also included, among others (i) testing of management identification of reporting units, (ii) testing management's process for developing the fair value estimate of the Anesthesia and Radiology reporting units, (iii) evaluating the appropriateness of the discounted cash flow model and revenue and EBITDA multiples model, (iv) testing the completeness, accuracy, and relevance of underlying data used in the models, and (v) and evaluating the significant judgments and assumptions used by management, including the weighted average cost of capital discount factor, revenue growth rates, and revenue and EBITDA multiples. Evaluating management's assumptions related to the revenue growth rates involved evaluating whether the assumptions used by management were reasonable considering (i) the

current and past performance of the reporting units, (ii) the consistency with external market and industry data, and (iii) whether these assumptions were consistent with evidence in other areas of the audit. Professionals with specialized skill and knowledge were used to assist in the evaluation of the discounted cash flow model and certain significant assumptions, including the weighted average cost of capital discount factor, and revenue and EBITDA multiples.

/s/ PricewaterhouseCoopers LLP
Miami, Florida
February 20, 2020

We have served as the Company’s auditor since 1999.

MEDNAX, INC.
CONSOLIDATED BALANCE SHEETS
(in thousands)

	December 31, 2019	December 31, 2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 112,767	$ 25,491
Restricted cash	—	20,000
Short-term investments	74,510	21,923
Accounts receivable, net	498,869	506,723
Prepaid expenses	21,919	17,123
Other current assets	23,442	17,166
Assets held for sale	—	51,551
Total current assets	731,507	659,977
Investments	—	69,699
Property and equipment, net	94,492	90,434
Goodwill	2,710,292	4,061,439
Intangible assets, net	274,407	313,165
Operating lease right-of-use assets	82,824	—
Deferred income tax assets	162,385	21,910
Other assets	89,994	81,224
Assets held for sale	—	639,633
Total assets	$4,145,901	$5,937,481
LIABILITIES & SHAREHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued expenses	$ 511,866	$ 448,567
Current portion of finance lease liabilities	130	253
Current portion of operating lease liabilities	23,317	—
Income taxes payable	6,505	30,598
Liabilities held for sale	—	23,344
Total current liabilities	541,818	502,762
Line of credit	—	739,500
Long-term debt and finance lease liabilities, net	1,730,295	1,234,781
Long-term operating lease liabilities	67,005	—
Long-term professional liabilities	226,892	209,060
Deferred income tax liabilities	57,995	95,581
Other liabilities	22,900	31,828
Liabilities held for sale	—	36,085
Total liabilities	2,646,905	2,849,597
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; 84,248 and 87,820 shares issued and outstanding, respectively	842	878
Additional paid-in capital	987,942	992,647
Retained earnings	510,212	2,094,359
Total shareholders' equity	1,498,996	3,087,884
Total liabilities and shareholders' equity	$4,145,901	$5,937,481

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

MEDNAX, INC.
CONSOLIDATED STATEMENTS OF INCOME
(in thousands, except for per share data)

	Years Ended December 31,		
	2019	2018	2017
Net revenue	$ 3,513,542	$3,454,810	$3,253,391
Operating expenses:			
Practice salaries and benefits	2,508,778	2,426,376	2,227,335
Practice supplies and other operating expenses	112,766	108,851	106,444
General and administrative expenses	404,643	403,934	385,864
Depreciation and amortization	78,860	83,832	78,856
Transformational and restructuring related expenses	95,329	—	—
Goodwill impairment	1,449,215	—	—
Total operating expenses	4,649,591	3,022,993	2,798,499
(Loss) income from operations	(1,136,049)	431,817	454,892
Investment and other income	5,671	5,211	4,385
Interest expense	(119,381)	(88,789)	(74,556)
Equity in earnings of unconsolidated affiliates	7,779	6,825	952
Total non-operating expenses	(105,931)	(76,753)	(69,219)
(Loss) income from continuing operations before income taxes	(1,241,980)	355,064	385,673
Income tax benefit (provision)	91,886	(96,453)	(80,231)
(Loss) income from continuing operations	(1,150,094)	258,611	305,442
(Loss) income from discontinued operations, net of tax	(347,608)	10,018	14,930
Net (loss) income	$(1,497,702)	$ 268,629	$ 320,372
Per common and common equivalent share data:			
(Loss) income from continuing operations:			
Basic	$ (13.78)	$ 2.84	$ 3.31
Diluted	$ (13.78)	$ 2.82	$ 3.29
(Loss) income from discontinued operations:			
Basic	$ (4.16)	$ 0.11	$ 0.16
Diluted	$ (4.16)	$ 0.11	$ 0.16
Net (loss) income:			
Basic	$ (17.94)	$ 2.95	$ 3.47
Diluted	$ (17.94)	$ 2.93	$ 3.45
Weighted average common shares:			
Basic	83,495	91,104	92,431
Diluted	83,495	91,606	92,958

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

MEDNAX, INC.
CONSOLIDATED STATEMENTS OF EQUITY
(in thousands)

	Common Stock		Additional Paid-in Capital	Retained Earnings	Total Equity
	Number of Shares	Amount			
Balance at December 31, 2016	93,718	$ 937	$ 974,304	$ 1,785,526	$ 2,760,767
Net income	—	—	—	320,372	320,372
Common stock issued under employee stock option, employee stock purchase plan and stock purchase plan	528	5	23,271	—	23,276
Issuance of restricted stock	536	5	(5)	—	—
Issuance of restricted stock for acquisition consideration	69	1	2,657	—	2,658
Stock-based compensation expense	—	—	29,573	—	29,573
Forfeitures of restricted stock	(92)	(1)	1	—	—
Repurchased common stock	(1,038)	(10)	(12,473)	(57,709)	(70,192)
Balance at December 31, 2017	93,721	$ 937	$1,017,328	$ 2,048,189	$ 3,066,454
Net income	—	—	—	268,629	268,629
Common stock issued under employee stock option, employee stock purchase plan and stock purchase plan	495	5	18,914	—	18,919
Issuance of restricted stock	770	8	(8)	—	—
Stock-based compensation expense	—	—	38,703	—	38,703
Stock swaps	(56)	(1)	(2,660)		(2,661)
Forfeitures of restricted stock	(69)	(1)	1	—	—
Repurchased common stock	(7,041)	(70)	(79,631)	(222,459)	(302,160)
Balance at December 31, 2018	87,820	$ 878	$ 992,647	$ 2,094,359	$ 3,087,884
Net loss	—	—	—	(1,497,702)	(1,497,702)
Unrealized holding gain on investments, net of tax [(1)]				78	78
Common stock issued under employee stock option, employee stock purchase plan and stock purchase plan	533	5	11,942	—	11,947
Issuance of restricted stock	1,113	11	(11)	—	—
Stock-based compensation expense	—	—	42,758	—	42,758
Stock swaps	(20)	—	(689)		(689)
Forfeitures of restricted stock	(132)	(1)	1	—	—
Repurchased common stock	(5,066)	(51)	(58,706)	(86,523)	(145,280)
Balance at December 31, 2019	84,248	$ 842	$ 987,942	$ 510,212	$ 1,498,996

(1) Presented within retained earnings on both the Consolidated Balance Sheets and the Consolidated Statements of Equity as the balance is immaterial.

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

MEDNAX, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Years Ended December 31,		
	2019	2018	2017
Cash flows from operating activities:			
Net (loss) income	$ (1,497,702)	$ 268,629	$ 320,372
Loss (income) from discontinued operations	347,608	(10,018)	(14,930)
Adjustments to reconcile net income to net cash provided from operating activities:			
Depreciation and amortization	78,860	83,832	78,856
Goodwill impairment	1,449,215	—	—
Amortization of premiums, discounts and issuance costs	5,672	4,572	5,514
Stock-based compensation expense	35,351	37,910	28,778
Deferred income taxes	(177,000)	(25,647)	(61,233)
Other	389	(10,903)	(3,782)
Changes in assets and liabilities:			
Accounts receivable	7,854	(43,408)	10,784
Prepaid expenses and other current assets	(9,998)	(6,074)	(3,015)
Other long-term assets	37,989	68	(2,950)
Accounts payable and accrued expenses	104,161	45,943	34,882
Income taxes payable	(24,119)	(61,256)	73,050
Payments of contingent consideration liabilities	(1,170)	(1,093)	(750)
Long-term professional liabilities	9,844	(4,490)	18,478
Other liabilities	(28,487)	(3,957)	(687)
Net cash provided by operating activities – continuing operations	338,467	274,108	483,367
Net cash provided by operating activities – discontinued operations	8,170	15,817	28,011
Net cash provided by operating activities	346,637	289,925	511,378
Cash flows from investing activities:			
Acquisition payments, net of cash acquired	(111,975)	(114,491)	(531,232)
Purchases of investments	(35,101)	(15,884)	(27,723)
Proceeds from maturities or sales of investments	51,105	13,710	25,410
Purchases of property and equipment	(31,881)	(30,479)	(26,150)
Proceeds from sales of businesses	249,730	22,764	—
Other	—	—	6,705
Net cash provided by (used in) investing activities – continuing operations	121,878	(124,380)	(552,990)
Net cash used in investing activities – discontinued operations	(19,423)	(18,389)	(23,623)
Net cash provided by (used in) investing activities	102,455	(142,769)	(576,613)
Cash flows from financing activities:			
Borrowings on credit agreement	1,247,300	1,723,500	2,846,000
Payments on credit agreement	(1,986,800)	(2,094,500)	(2,699,000)
Proceeds from issuance of senior notes	500,000	500,000	—
Payments for financing costs	(9,194)	(7,090)	(3,525)
Payments of contingent consideration liabilities	(10,120)	(5,263)	(5,449)
Payments on finance lease obligations	(234)	(1,339)	(1,659)
Proceeds from issuance of common stock	11,258	16,258	23,276
Contribution from noncontrolling interests	—	—	894
Repurchases of common stock	(145,280)	(302,160)	(70,192)
Net cash (used in) provided by financing activities – continuing operations	(393,070)	(170,594)	90,345
Net cash used in financing activities – discontinued operations	—	(17)	(608)
Net cash (used in) provided by financing activities	(393,070)	(170,611)	89,737
Net increase (decrease) in cash and cash equivalents	56,022	(23,455)	24,502
Cash, cash equivalents and restricted cash at beginning of year	56,745	80,200	55,698
Less cash and cash equivalents of discontinued operations at end of year	—	(11,254)	(13,843)
Cash and cash equivalents and restricted cash at end of year	$ 112,767	$ 45,491	$ 66,357
Supplemental disclosure of cash flow information:			
Cash paid for:			
Interest	$ 95,444	$ 82,540	$ 73,837
Income taxes	$ 86,268	$ 185,416	$ 75,427
Non-cash investing and financing activities:			
Value of common stock issued for acquisitions	$ —	$ —	$ 2,657
Equipment financed through finance leases	$ —	$ —	$ 684
Property and equipment included in accounts payable	$ 2,400	$ 2,415	$ 1,918

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

MEDNAX, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. General:

The principal business activity of MEDNAX, Inc. ("MEDNAX" or the "Company") and its subsidiaries is to provide neonatal, anesthesia, radiology and teleradiology, maternal-fetal and other pediatric subspecialty physician services. The Company has contracts with affiliated business corporations or professional associations, limited liability companies and partnerships ("affiliated professional contractors"), which are separate legal entities that provide physician services in certain states and Puerto Rico. The Company and its affiliated professional contractors also have contracts with hospitals and other healthcare facilities to provide physician services, which include (i) fee-for-service contracts, whereby hospitals and other customers agree, in exchange for the Company's services, to authorize the Company and its healthcare professionals to bill and collect the charges for medical services rendered by the Company's affiliated healthcare professionals, and (ii) administrative fee contracts, whereby the Company is assured a minimum revenue level.

2. Summary of Significant Accounting Policies:

Principles of Presentation

The consolidated financial statements include all the accounts of the Company and its subsidiaries combined with the accounts of the affiliated professional contractors with which the Company currently has specific management arrangements. The Company's agreements with affiliated professional contractors provide that the term of the arrangements are in most cases permanent, subject only to termination by the Company, except in the case of gross negligence, fraud or bankruptcy of the Company. The Company has the right to receive income, both as ongoing fees and as proceeds from the sale of its interest in the Company's affiliated professional contractors, in an amount that fluctuates based on the performance of the affiliated professional contractors and the change in the fair value of the Company's interest in the affiliated professional contractors. The Company has exclusive responsibility for the provision of all non-medical services required for the day-to-day operation and management of the Company's affiliated professional contractors and establishes the guidelines for the employment and compensation of the physicians. In addition, the agreements provide that the Company has the right, but not the obligation, to purchase, or to designate a person(s) to purchase, the stock of the Company's affiliated professional contractors for a nominal amount. Separately, in its sole discretion, the Company has the right to assign its interest in the agreements. Based upon the provisions of these agreements, the Company has determined that the affiliated professional contractors are variable interest entities and that the Company is the primary beneficiary as defined in the accounting guidance for consolidation. All significant intercompany and interaffiliate accounts and transactions have been eliminated.

The Company is a party to a joint venture in which it owns a 37.5% economic interest and a second joint venture in which it owns a 49.0% economic interest. The Company accounts for these joint ventures under the equity method of accounting because the Company exercises significant influence over, but does not control, these entities.

In November 2018, the Company announced the initiation of a process to divest its management services organization, which operated as MedData, to allow the Company to focus on its core physician services business. On October 10, 2019, the Company entered into a securities purchase agreement with an affiliate of Frazier Healthcare Partners to divest MedData. The transaction closed on October 31, 2019. Pursuant to the terms and conditions of the agreement, at the closing of the transaction, the Company received a cash payment of $249.7 million, net of certain net working capital and similar adjustments, as well as contingent economic consideration in an indirect holding company of the buyer, the value of which is contingent on both short and long-term performance of MedData and the maximum amount payable in respect of which is $50.0 million. Upon completion of a valuation to determine the final net proceeds, the Company could record an additional gain or loss. The Company realized certain cash tax benefits from the transaction in the fourth quarter of 2019 and

anticipates additional cash tax benefits in future periods. In addition, in accordance with accounting guidance for discontinued operations, the operating results of the service line were reported as discontinued operations in the Company's Consolidated Statements of Income for the year ended December 31, 2019. Reclassifications have been made to certain prior period financial statements and footnote disclosures to reflect the impact of discontinued operations. See Note 8 – Discontinued Operations for more information.

Recently Adopted Accounting Pronouncements

In February 2016, the accounting guidance related to leases was issued that require an entity to recognize leased assets and the rights and obligations created by those leased assets on the balance sheet and to disclose key information about the entity's leasing arrangements. This guidance became effective for the Company on January 1, 2019. The adoption of this guidance had a material impact on the Company's Consolidated Balance Sheets and related disclosures, resulting from the recognition of significant right of use assets and related liabilities, primarily related to its operating lease arrangements for space in hospitals and certain other facilities for its business and medical offices. See Note 10 – Leases for more information.

New Accounting Pronouncements

In December 2019, accounting guidance related to income taxes was issued with the goal of enhancing and simplifying various aspects of the income tax accounting guidance, including requirements related to hybrid tax regimes, deferred taxes on step-up in tax basis of goodwill obtained in a transaction that is not a business combination, separate financial statements of entities not subject to tax, the intraperiod tax allocation exception to the incremental approach, deferred tax liabilities on outside basis differences, and interim-period accounting for enacted changes in tax law and certain year-to-date loss limitations. The guidance becomes effective for the Company on January 1, 2021, including interim periods therein, with early adoption permitted, including adoption in interim or annual periods for which financial statements have not yet been issued. The Company does not believe the adoption of this new guidance will have a material impact on its Consolidated Financial Statements and related disclosures.

Accounting Estimates and Assumptions

The preparation of financial statements in conformity with accounting principles generally accepted in the United States ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. Significant estimates and assumptions are involved in the calculation of the Company's allowance for contractual adjustments and uncollectibles on accounts receivable, liabilities for self-insured amounts and claims incurred but not reported related to the Company's professional liability risks and the fair value of goodwill. Actual results could differ from those estimates.

Segment Reporting

The Company changed its management structure during the third quarter of 2019 to combine its two historical operating segments into a single unified physician services operating segment. The results of the Company's operations continue to be presented as a single reportable segment for purposes of presenting financial information in accordance with the accounting guidance for segment reporting.

The following table summarizes the Company's net revenue from continuing operations by service line (in percentages):

	Years Ended December 31,		
	2019	2018	2017
Women's and Children's services	50%	49%	50%
Anesthesiology and related	36%	38%	41%
Radiology	14%	13%	9%
	100%	100%	100%

Revenue Recognition

Patient service revenue is recognized at the time services are provided by the Company's affiliated physicians. The Company's performance obligations related to the delivery of services to patients are satisfied at the time of service. Accordingly, there are no performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period with respect to patient service revenue. Almost all of the Company's patient service revenue is reimbursed by GHC Programs and third-party insurance payors. Payments for services rendered to the Company's patients are generally less than billed charges. The Company monitors its revenue and receivables from these sources and records 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. The Company 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.

Collection of patient service revenue the Company expects to receive is normally a function of providing complete and correct billing information to the GHC Programs and third-party insurance payors within the various filing deadlines and typically occurs within 30 to 60 days of billing.

Some of the Company's hospital agreements require hospitals to pay the Company administrative fees. Some agreements provide for fees if the hospital does not generate sufficient patient volume in order to guarantee that the Company receives a specified minimum revenue level. The Company also receives fees from hospitals for administrative services performed by its affiliated physicians providing medical director or other services at the hospital.

Accounts receivable are primarily amounts due under fee-for-service contracts from third-party payors, such as insurance companies, self-insured employers and patients and GHC Programs geographically dispersed throughout the United States and its territories. Concentration of credit risk relating to accounts receivable is limited by the number, diversity and geographic dispersion of the business units managed by the Company, as well as by the large number of patients and payors, including the various governmental agencies in the states in which the Company provides services. Receivables from GHC Programs made up approximately 20% and 19% of net accounts receivable at December 31, 2019 and 2018, respectively.

Cash and Cash Equivalents

Cash equivalents are defined as all highly liquid financial instruments with maturities of 90 days or less from the date of purchase. The Company's cash equivalents typically consist of demand deposits, amounts on

deposit in money market accounts, and funds invested in overnight repurchase agreements. Cash equivalent balances may, at certain times, exceed federally insured limits.

Certain cash equivalents carried by the Company are subject to the fair value provisions of the accounting guidance for fair value measurements. See “Fair Value Measurements” below.

Restricted Cash

Restricted cash consists of funds in escrow related to a potential future payment for contingent consideration for an acquisition completed in 2017.

Investments

Investments consist of municipal debt securities, federal home loan securities and certificates of deposit. During the year ended December 31, 2019, the Company changed the classification of its investments from held-to-maturity to available for sale. Although there is no stated expectation that the investments will be sold within one year, the investments are available for use, if needed, and accordingly are classified as short-term. Such investments are carried at fair value with any unrealized gains and losses reported as a component of other accumulated comprehensive income or loss.

Prior to January 1, 2019, the Company classified its investments as held-to-maturity and carried such investments at amortized cost. Investments with remaining maturities of less than one year were classified as short-term and investments classified as long-term had maturities of one year to five years.

Property and Equipment

Property and equipment are recorded at original purchase cost. Depreciation of property and equipment is computed using the straight-line method over the estimated useful lives of the underlying assets. Estimated useful lives are generally 30 years for buildings; three to seven years for medical equipment, computer equipment, software and furniture; and the lesser of the useful life or the remaining lease term for leasehold improvements and finance leases. Upon sale or retirement of property and equipment, the related cost and accumulated depreciation are eliminated from the respective accounts and any resulting gain or loss is included in earnings.

Business Acquisitions

The Company accounts for all business acquisitions at fair value and expenses acquisition costs as they are incurred. Any identifiable assets acquired and liabilities assumed are recognized and measured at their respective fair values on the acquisition date. If information about facts and circumstances existing as of the acquisition date is incomplete at the end of the reporting period in which a business acquisition occurs, the Company will report provisional amounts for the items for which the accounting is incomplete. The measurement period ends once the Company receives sufficient information to finalize the fair values; however, the period will not exceed one year from the acquisition date. Any adjustments to provisional amounts that are identified during the measurement period are recognized in the reporting period in which the adjustment amounts are determined.

In connection with certain acquisitions, the Company enters into agreements to pay additional amounts in cash or common stock based on the achievement of certain performance measures for up to five years ending after the acquisition dates. The Company measures this contingent consideration at fair value at the acquisition date and records such contingent consideration as a liability or equity on the Company’s Consolidated Balance Sheets on the acquisition date. The fair value of each contingent consideration liability is remeasured at each reporting period with any change in fair value recognized as income or expense within operations in the Company’s Consolidated Statements of Income. See Note 6 for more information on the Company’s business acquisitions.

Goodwill and Other Intangible Assets

The Company records acquired assets and assumed liabilities at their respective fair values under the acquisition method of accounting. Goodwill represents the excess of purchase price over the fair value of the net assets acquired. Intangible assets with finite lives, principally physician and hospital agreements, customer relationships, patented technology and trade names, are recognized apart from goodwill at the time of acquisition based on the contractual-legal and separability criteria established in the accounting guidance. Intangible assets with finite lives are amortized on either an accelerated basis based on the annual undiscounted economic cash flows associated with the particular intangible asset or on a straight-line basis over their estimated useful lives. Intangible assets with finite lives are amortized over periods of one to 20 years.

Goodwill is tested for impairment at a reporting unit level on at least an annual basis in accordance with the subsequent measurement provisions of the accounting guidance for goodwill. The Company performs a single-step quantitative test with any goodwill impairment measured as the amount by which a reporting unit's carrying value exceeds its fair value. The Company uses income and market-based valuation approaches to determine the fair value of its reporting units. These approaches focus on discounted cash flows and revenue and EBITDA multiples based on the Company's market capitalization to derive the fair value of a reporting unit. Significant assumptions used in these valuations include the weighted average cost of capital discount factor, revenue growth rates and revenue and EBITDA multiples. The Company also considers 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.

The Company completed its annual impairment test for 2019 in the third quarter, and based on that analysis the Company recorded a non-cash impairment charge of $1.45 billion, nearly all of which related to its anesthesiology reporting unit. See Note 7 – Goodwill and Intangible Assets for more information. The Company completed annual impairment tests in the third quarter of 2018 and 2017 and determined that goodwill was not impaired in those two years.

Long-Lived Assets

The Company is required to evaluate long-lived assets, including intangible assets subject to amortization, whenever events or changes in circumstances indicate that the carrying value of the assets may not be fully recoverable. The recoverability of such assets is measured by a comparison of the carrying value of the assets to the future undiscounted cash flows before interest charges to be generated by the assets. If long-lived assets are impaired, the impairment to be recognized is measured as the excess of the carrying value over the fair value. Long-lived assets held for disposal are reported at the lower of the carrying value or fair value less disposal costs. The Company does not believe there are any indicators that would require an adjustment to such assets or their estimated periods of recovery at December 31, 2019 pursuant to current accounting standards.

Common Stock Repurchases

The Company repurchases shares of its common stock as authorized from time to time by its Board of Directors. The Company treats repurchased shares of its common stock as retired as any repurchased shares become authorized but unissued shares. The reacquisition cost of repurchased shares is recorded as a reduction in the respective components of shareholders' equity.

Professional Liability Coverage

The Company maintains professional liability insurance policies with third-party insurers generally on a claims-made basis, subject to deductibles or self-insured retention, exclusions and other restrictions. The Company's self-insured retention under its professional liability insurance program is maintained primarily

through a wholly owned captive insurance subsidiary. The Company records an estimate of 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. Liabilities for claims incurred but not reported are not discounted.

Income Taxes

The Company records deferred income taxes using the liability method, whereby deferred tax assets and liabilities are determined based on the difference between the financial statement and tax bases of assets and liabilities using enacted tax rates in effect for the year in which the differences are expected to reverse. If it is more likely than not that all or a portion of deferred tax assets will not be realized, a valuation allowance is provided against such deferred tax assets. In making such determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax-planning strategies, and results of recent operations.

The accounting guidance for uncertain tax positions 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. The guidance also requires policy disclosures regarding penalties and interest and extensive 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 the Company’s reporting date.

Stock Incentive Plans

The Company grants stock-based awards consisting primarily of restricted stock to key employees under its Amended and Restated 2008 Incentive Compensation Plan. The Company measures the cost of employee services received in exchange for stock-based awards based on grant-date fair value and allocates the resulting compensation expense over the corresponding requisite service period using the graded vesting attribution method. The Company also performs analyses to estimate forfeitures of stock-based awards on an annual basis and adjusts the estimates as necessary based on the number of awards that ultimately vest.

Net Income Per Common Share

Basic net income per common share is calculated by dividing net income by the weighted average number of common shares outstanding during the period. Diluted net income per common share is calculated by dividing net income by the weighted average number of common and potential common shares outstanding during the period. Potential common shares consist of outstanding restricted stock, deferred stock and stock options and is calculated using the treasury stock method.

Fair Value Measurements

The accounting guidance establishes a fair value hierarchy that prioritizes valuation inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of three levels:

Level 1 – inputs are based upon unadjusted quoted prices for identical instruments traded in active markets.

Level 2 – inputs are based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – inputs are generally unobservable and typically reflect management's estimates of assumptions that market participants would use in pricing the asset or liability. The fair values are therefore determined using model-based techniques that include option pricing models, discounted cash flow models, and similar techniques.

The following table presents information about the Company's financial instruments that are accounted for at fair value on a recurring basis at December 31, 2019 and 2018 (in thousands):

	Fair Value Category	Fair Value December 31, 2019	Fair Value December 31, 2018
Assets:			
Money market funds	Level 1	$ 16,775	$ 481
Short-term investments	Level 2	74,510	— (1)
Company-owned life insurance	Level 2	—	10,464
Mutual funds	Level 1	14,264	—
Liabilities:			
Contingent consideration	Level 3	2,696	20,039

(1) Investments were measured at carrying value as of December 31, 2018. See table below.

The following table presents information about the Company's financial instruments that are not carried at fair value at December 31, 2019 and 2018 (in thousands):

	December 31, 2019		December 31, 2018	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Assets:				
Short-term investments	$ — (2)	$ — (2)	21,923	21,858
Long-term investments	— (2)	— (2)	69,699	69,090
Liabilities:				
2023 Notes	750,000	766,875	750,000	736,725
2027 Notes	1,000,000	1,025,600	500,000	482,500

(2) Investments were measured at fair value as of December 31, 2019. See table above.

The carrying amounts of cash equivalents, accounts receivable and accounts payable and accrued expenses approximate fair value due to the short maturities of the respective instruments. The carrying value of the line of credit approximates fair value. If the Company's line of credit was measured at fair value, it would be categorized as Level 2 in the fair value hierarchy.

3. Investments:

Investments held are summarized as follows (in thousands):

	December 31, 2019		December 31, 2018	
	Short-Term	Long-Term	Short-Term	Long-Term
Corporate securities	$ 32,962	$ —	$ —	$ —
Municipal debt securities	29,066	—	18,473	30,841
Federal home loan securities	8,013	—	2,000	34,393
Certificates of deposit	4,469	—	1,450	4,465
	$ 74,510	$ —	$ 21,923	$ 69,699

4. Accounts Receivable and Net Revenue:

Accounts receivable, net consists of the following (in thousands):

	December 31, 2019	December 31, 2018
Gross accounts receivable	$ 1,943,664	$ 1,993,395
Allowance for contractual adjustments and uncollectibles	(1,444,795)	(1,486,672)
	$ 498,869	$ 506,723

Net revenue consists of the following (in thousands):

	Years Ended December 31, 2019	2018	2017
Net patient service revenue	$ 3,091,987	$ 3,067,784	$ 2,915,648
Hospital contract administrative fees	396,814	363,368	315,778
Other revenue	24,741	23,658	21,965
	$ 3,513,542	$ 3,454,810	$ 3,253,391

The following is a summary of our payor mix, expressed as a percentage of net revenue, exclusive of administrative fees and revenue related to management services and other, for the periods indicated:

	Years Ended December 31, 2019	2018	2017
Contracted managed care	69%	69%	70%
Government	24%	24%	23%
Other third-parties	5%	5%	5%
Private-pay patients	2%	2%	2%
	100%	100%	100%

Accounts receivable consist primarily of amounts due from GHC Programs and third-party insurance payors for services provided by the Company's affiliated physicians.

Net revenue consists primarily of gross billed charges for services provided by the Company's affiliated physicians less an estimated allowance for contractual adjustments and uncollectibles to properly account for the anticipated differences between gross billed charge amounts and expected reimbursement amounts.

The Company's contractual adjustments and uncollectibles as a percentage of gross patient service revenue vary slightly each year depending on several factors, including improved managed care contracting, changes in reimbursement from state Medicaid programs and other GHC Programs, shifts in the percentage of patient services being reimbursed under GHC Programs and annual price increases.

The Company's annual price increases typically increase contractual adjustments as a percentage of gross patient service revenue. This increase is primarily due to Medicaid, Medicare and other GHC Programs that generally provide for reimbursements on a fee-schedule basis rather than on a gross charge basis. When the Company bills these programs, like other payors, on a gross-charge basis, it also increases its provision for contractual adjustments and uncollectibles by the amount of any price increase, resulting in a higher contractual adjustment percentage.

Some of the Company's hospital agreements require hospitals to pay the Company administrative fees. Some agreements provide for fees if the hospital does not generate sufficient patient volume in order to guarantee that the Company receives a specified minimum revenue level. The Company also receives fees from hospitals for administrative services performed by its affiliated physicians providing medical director or other services at the hospital.

5. Property and Equipment:

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

	December 31,	
	2019	2018
Building	$ 26,934	$ 26,934
Land	6,683	6,683
Equipment and other	262,977	237,400
	296,594	271,017
Accumulated depreciation	(202,102)	(180,583)
	$ 94,492	$ 90,434

The Company recorded depreciation expense of $30.0 million, $29.3 million and $26.4 million for the years ended December 31, 2019, 2018 and 2017, respectively.

6. Business Acquisitions:

During the year ended December 31, 2019, the Company completed nine acquisitions, consisting of two neonatology physician practices, two maternal-fetal physician practices, one radiology practice and four other pediatric subspecialty practices for total cash consideration of $112.0 million and accrued purchase consideration of $0.3 million. These acquisitions expanded the Company's national network of physician practices. In connection with these acquisitions, the Company recorded goodwill of $98.1 million, other intangible assets consisting primarily of physician and hospital agreements of $14.0 million and fixed assets of $0.2 million. The Company expects that $98.1 million of the goodwill recorded during the year ended December 31, 2019 will be deductible for tax purposes.

In addition, the Company paid $11.3 million for contingent consideration in connection with prior period acquisitions. The Company also recorded a decrease of $6.6 million related to the change in fair value of a contingent consideration agreement for which the probability of the achievement of certain performance measures was updated during the year ended December 31, 2019. This change in fair value of contingent consideration was recorded within operating expenses.

During the year ended December 31, 2018, the Company completed nine physician group practice acquisitions, including five radiology practices, two neonatology practices and two other pediatric subspecialty practices. The acquisition-date fair value of the total consideration for the nine acquisitions was $111.8 million, net of cash acquired. In connection with these acquisitions, the Company recorded goodwill of $95.0 million, other intangible assets consisting primarily of physician and hospital agreements of $17.2 million, current assets of $1.7 million and other liabilities of $2.1 million.

During the year ended December 31, 2018, in connection with certain prior-period acquisitions, the Company paid $6.4 million for contingent consideration and $1.2 million for purchase consideration that had been held back pending satisfaction of certain conditions. Of these amounts, all except for the accretion recorded during 2018 were accrued as of December 31, 2017. In addition, the Company recorded a decrease of $5.3 million related to the change in the fair value of a contingent consideration agreement for which the probability of the achievement of certain performance measures was updated. This change in fair value of contingent consideration was recorded within operating expenses.

During the year ended December 31, 2018, in connection with certain prior-period acquisitions, the Company also recorded a net increase in goodwill of $4.0 million composed of a decrease in current assets of $1.2 million, a decrease in noncurrent assets of $1.5 million and a decrease in liabilities of $0.2 million for measurement-period adjustments resulting from the finalization of acquisition accounting as well as additional cash consideration of $1.5 million related to a working capital true up.

In January 2018, the Company completed the sale of a controlling interest and the contribution of remaining assets to a joint venture related to the $46.0 million of assets held for sale at December 31, 2017. The Company accounts for its 49.0% economic interest in the joint venture as an equity method investment. The investment in this joint venture is included in other assets as presented in the Company's Condensed Consolidated Balance Sheet.

7. Goodwill and Intangible Assets:

Goodwill was $2.7 billion and $4.1 billion at December 31, 2019 and 2018, respectively. Goodwill is tested for impairment at a reporting unit level on at least an annual basis, in accordance with the subsequent measurement provisions of the accounting guidance for goodwill. Consistent with prior years, the Company performed its annual impairment test in the third quarter of 2019, specifically as of July 31, 2019. The Company changed its management structure during the third quarter of 2019 to combine its two historical operating segments into a single unified physician services operating segment. However, for goodwill testing purposes, the Company determined that its reporting units would be represented by the components that underly the unified physician services operating segment. The reporting units represent the service line medical groups of Women's and Children's, anesthesiology and radiology.

The Company used a combination of income and market-based valuation approaches to determine the fair value of its reporting units. Significant assumptions used in these valuations included the weighted average cost of capital discount factor, revenue growth rate, and revenue and EBITDA multiples. Based on the analysis performed, the Company recorded a non-cash impairment charge of $1.30 billion during the three months ended September 30, 2019, nearly all of which related to its anesthesiology reporting unit. Recognition of the non-cash charge against goodwill resulted in a tax benefit which generated an additional deferred tax asset of $147.2 million that increased the fair value of the reporting units. An incremental non-cash charge is then required to reduce the reporting units to their previously determined fair value. Accordingly, the Company recorded the incremental non-cash charge of $147.2 million for a total non-cash charge of $1.45 billion. The primary factors driving the non-cash impairment charge were (i) the change in management structure effective during the third quarter resulting in reporting units one level below the Company's single physician services operating segment, which is also its single reportable segment, (ii) the decrease in the Company's share price used in the market capitalization reconciliation and (iii) changes in the assumptions used in the valuation analysis, specifically the discount rate used in the cash flow analysis which included a company-specific risk premium.

Intangible assets, net, consist of the following (in thousands):

	December 31, 2019		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Physician and hospital agreements	$384,059	$ (269,889)	$ 114,170
Customer relationships	156,530	(29,595)	126,935
Trade names	19,990	(2,326)	17,664
Patented and other technology	34,528	(18,890)	15,638
	$595,107	$ (320,700)	$274,407

	December 31, 2018		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Physician and hospital agreements	$375,344	$ (222,818)	$ 152,526
Customer relationships	156,530	(29,595)	126,935
Trade names	19,990	(2,326)	17,664
Patented and other technology	33,129	(17,089)	16,040
	$584,993	$ (271,828)	$ 313,165

During the year ended December 31, 2019, the Company recorded intangible assets related to acquisitions totaling $14.0 million, consisting primarily of physician and hospital agreements. The weighted-average amortization period for these physician and hospital agreements is approximately eight years.

Amortization expense for intangible assets was $48.9 million, $54.5 million and $52.5 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Amortization expense for existing intangible assets for the next five years is expected to be as follows (in thousands):

2020	$42,502
2021	36,502
2022	29,482
2023	24,482
2024	10,590

8. Discontinued Operations:

In November 2018, the Company announced the initiation of a process to divest its management services organization, which operated as MedData, to allow the Company to focus on its core physician services business. On October 10, 2019, the Company entered into a securities purchase agreement with an affiliate of Frazier Healthcare Partners to divest MedData, and the transaction closed on October 31, 2019. Pursuant to the terms and conditions of the agreement, at the closing of the transaction, the Company received a cash payment of $249.7 million, net of certain net working capital and similar adjustments, as well as contingent economic consideration in an indirect holding company of the buyer, the value of which is contingent on both short and long-term performance of MedData and the maximum amount payable in respect of which is $50.0 million. The operating results of the management services service line were reported as discontinued operations in the Company's Consolidated Statements of Income for the year ended December 31, 2019 with prior periods recast to conform with the current period presentation.

The initial classification of the management services service line to assets held for sale during the three months ended March 31, 2019 impacted the net book value of the assets and liabilities expected to be transferred upon sale. The initial determination of the estimated fair value of the management services service line was based on an estimated market value along with estimated broker, accounting, legal and other costs to sell. The Company deemed the carrying amount of other assets within the service line, specifically accounts receivable and property and equipment, to represent fair value and therefore recorded a non-cash charge during the first quarter of 2019 of $285.0 million against goodwill, which represented the difference between the estimated fair value of the management services service line and the carrying amount of the net assets held for sale. Recognition of the charge against goodwill resulted in a tax benefit which generated an additional $36.6 million deferred tax asset that increased the fair value of the service line. An incremental non-cash charge is then required to reduce the service line to its previously determined fair value. Accordingly, the Company recorded the incremental non-cash charge of $36.6 million for a total non-cash charge of $321.6 million during the three months ended March 31, 2019, reducing the goodwill balance of the management services service line to zero.

During the three months ended June 30, 2019, an incremental non-cash charge of $50.0 million was recorded based on new information obtained during the quarter with respect to the estimated market value of the management services service line. This non-cash charge was recorded against amortizing intangible assets. Recognition of the incremental non-cash charge resulted in a tax benefit which generated an additional $16.4 million deferred tax asset that increased the fair value of the service line. An incremental non-cash charge is then required to reduce the service line to its previously determined fair value. Accordingly, the Company recorded the incremental non-cash charge of $16.4 million for a total non-cash charge of $66.4 million during the three months ended June 30, 2019.

During the three months ended December 31, 2019, the preliminary net proceeds for the management services service line were determined to be $242.5 million, net of cash sold and certain working capital adjustments, resulting in a preliminary loss on sale of $29.1 million. Upon completion of the valuation of the contingent economic consideration and the working capital true-up, final net proceeds will be determined, and the Company will adjust the loss on sale at that time.

The following table is a reconciliation of the major classes of assets and liabilities classified as assets and liabilities held for sale in the accompanying Consolidated Balance Sheets representing the management services service line as of December 31, 2018 (in thousands):

	December 31, 2018
Assets	
Cash and cash equivalents	$ 11,254
Accounts receivable, net	38,118
Prepaid expenses and other assets	2,505
Property and equipment, net	42,603
Goodwill	321,556
Intangible assets, net	275,148
	$ 691,184
Liabilities	
Accounts payable, accrued expenses and other liabilities	$ 23,770
Deferred income taxes	35,659
	$ 59,429

Income from discontinued operations, net of income taxes, as reported in the Company’s Consolidated Statements of Income for the years ended December 31, 2019, 2018 and 2017 includes net revenue of

$172.7 million, $220.9 million and $230.7 million, respectively. Operating income, excluding transaction related costs, for the years ended December 31, 2019, 2018 and 2017 was $20.1 million, $14.0 million and $25.2 million, respectively.

9. Accounts Payable and Accrued Expenses:

Accounts payable and accrued expenses consist of the following (in thousands):

	December 31,	
	2019	2018
Accounts payable	$ 39,610	$ 31,059
Accrued salaries and bonuses	268,619	242,888
Accrued payroll taxes and benefits	67,268	78,415
Accrued professional liabilities	44,869	34,931
Accrued contingent consideration	2,696	18,760
Accrued interest	32,910	9,477
Other accrued expenses	55,894	33,037
	$511,866	$448,567

10. Operating Leases:

Effective January 1, 2019, the Company adopted the new accounting guidance for leases using the modified retrospective method of applying the new guidance at the adoption date. The Company elected practical expedients permitted under the transition provisions, which allowed the Company to carryforward historical assessments of whether contracts are or contain leases and lease classification. Beginning with January 1, 2019, the Company's financial position is presented under the new guidance, while the prior period financial statements were not adjusted and continue to be reported in accordance with the previous guidance.

The Company primarily leases property under operating leases and has one material equipment operating lease for an aircraft. The Company's property leases are primarily for its regional, medical and business offices, storage space and temporary housing for medical staff.

For leases with terms greater than 12 months, the Company records the related asset and obligation at the present value of the lease payment using a discount rate that reflects the Company's estimated incremental borrowing rate. Certain of the Company's leases include rental escalation clauses and renewal options that are factored into the determination of lease payments when appropriate. Operating leases for office equipment are not material, and therefore are excluded from the Company's Consolidated Balance Sheet. Finance leases are not material but will continue to be reported on the Company's Consolidated Balance Sheets with the right-of-use assets included in property and equipment, net, and the liabilities included in current portion of long-term debt and finance lease obligations.

The table below presents the operating lease-related right-of-use assets and related liabilities recorded on the Company's balance sheet and the weighted average remaining lease term and discount rate as of December 31, 2019 (dollars in thousands):

	December 31, 2019
Assets:	
Operating lease right-of-use assets	$ 82,824
Liabilities:	
Current portion of operating lease liabilities	23,317
Long-term portion of operating lease liabilities	67,005
Other Information:	
Weighted-average remaining lease term	5.0 years
Weighted average discount rate	5.3%

The table below presents certain information related to the lease costs for operating leases during the year ended December 31, 2019 (in thousands):

	Year Ended December 31, 2019
Operating lease costs	$ 30,236
Variable lease costs	4,869
Other equipment rent	2,480
Other operating lease costs	4,578
Total operating lease costs	$ 42,163

The table below presents supplemental cash flow information related to operating leases during the year ended December 31, 2019 (in thousands):

	December 31, 2019
Operating cash flows for operating leases	$ 41,532

The table below reconciles the undiscounted cash flows for each of the first five years and total of the remaining years to the operating lease liabilities recorded on the balance sheet as of December 31, 2019 (in thousands):

	December 31, 2019
2020	$ 25,060
2021	23,270
2022	18,433
2023	13,794
2024	8,420
Thereafter	13,207
Total minimum lease payments	102,184
Less: Amount of payments representing interest	(11,862)
Present value of future minimum lease payments	90,322
Less: Current obligations	(23,317)
Long-term portion of operating leases	$ 67,005

11. Accrued Professional Liabilities:

At December 31, 2019 and 2018, the Company's total accrued professional liabilities of $271.8 million and $244.0 million, respectively, included incurred but not reported loss reserves of $187.3 million and

$139.1 million, respectively, and loss reserves for reported claims of $84.5 million and $104.9 million, respectively. Of the total liability, $44.9 million is classified as a current liability within accounts payable and accrued expenses in the Consolidated Balance Sheet. In addition, there is a corresponding insurance receivable of $29.8 million recorded as a component of other assets for certain professional liability claims that are covered by third-party insurance policies.

The activity related to the Company's total accrued professional liability for the years ended December 31, 2019, 2018, and 2017 is as follows (in thousands):

	Years Ended December 31,		
	2019	2018	2017
Balance at beginning of year	$243,991	$250,187	$202,052
Assumed liabilities through acquisition	—	1,276	20,716
Provision (adjustment) for losses related to:			
Current year	57,495	34,483	41,291
Prior years	23,191	10,299	9,983
Total provision for losses	80,686	44,782	51,274
Claim payments related to:			
Current year	(3,044)	(555)	(712)
Prior years	(49,873)	(51,699)	(23,143)
Total payments	(52,917)	(52,254)	(23,855)
Balance at end of year	$271,760	$243,991	$250,187

The net increase in the Company's total accrued professional liability for the year ended December 31, 2019 was primarily related to overall unfavorable trends in the Company's claims experience that impacted its provision for losses. The net decrease in the Company's total accrued professional liability for the year ended December 31, 2018 was primarily related to an increase in claims payments made in the current year, partially offset by overall unfavorable trends in the Company's claims experience that impacted its provision for losses.

12. Line of Credit, Long-Term Debt and Finance Lease Obligations:

On March 28, 2019, the Company amended and restated its Credit Agreement to reduce the size of the revolving credit facility, extend the maturity and make other technical and conforming changes. As amended and restated, the Credit Agreement provides for a $1.2 billion unsecured revolving credit facility and includes a $37.5 million sub-facility for the issuance of letters of credit. The Credit Agreement matures on March 28, 2024 and is guaranteed by substantially all of the Company's subsidiaries and affiliated professional associations and corporations. At the Company's option, borrowings under the Credit Agreement will bear interest at (i) the alternate base rate (defined as the higher 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 the Company's consolidated leverage ratio or (ii) the LIBOR rate plus an applicable margin rate ranging from 1.125% to 1.750% based on the Company's consolidated leverage ratio. The Credit Agreement also calls for other customary fees and charges, including an unused commitment fee ranging from 0.150% to 0.200% of the unused lending commitments, based on the Company's consolidated leverage ratio.

The Credit Agreement contains customary covenants and restrictions, including covenants that require the Company to maintain a minimum interest charge ratio, not to exceed a specified consolidated leverage ratio and to comply with laws, and restrictions on the ability of the Company to pay dividends and make certain other distributions, as specified therein. Failure to comply with these covenants would constitute an event of default under the Credit Agreement, notwithstanding the ability of the Company to meet its debt service obligations. The 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 Credit Agreement.

In December 2015, the Company completed a private offering of $750.0 million aggregate principal amount of 2023 Notes. In November 2018, the Company completed a private offering of $500.0 million aggregate principal amount of 2027 Notes and in February 2019, the Company completed a private offering of $500.00 million aggregate principal amount of Additional 2027 Notes. At December 31, 2019, the outstanding balance on the 2027 Notes was $1.0 billion. The Company's obligations under the 2023 Notes and the 2027 Notes are guaranteed on an unsecured senior basis by the same subsidiaries and affiliated professional contractors that guarantee the Credit Agreement. Interest on the 2023 Notes accrues at the rate of 5.25% per annum, or $39.4 million, and is payable semi-annually in arrears on June 1 and December 1. Interest on the 2027 Notes accrues at the rate of 6.25% per annum, or $62.5 million, and is payable semi-annually in arrears on January 15 and July 15.

As of December 31, 2019, the Company may redeem all or a portion of the 2023 Notes, at the redemption prices of 101.313% in 2020 and 100% in 2021 and thereafter, plus accrued and unpaid interest to the redemption date.

At any time prior to January 15, 2022, the Company may redeem all or a portion of the 2027 Notes at a redemption price equal to 100% of the principal amount of the notes being redeemed plus an applicable redemption premium and accrued and unpaid interest to the redemption date. In addition, at any time prior to January 15, 2022, the Company may redeem up to 35% of the aggregate principal amount of the 2027 Notes at a redemption price of 106.250% of the principal amount thereof, plus accrued and unpaid interest, if any, to the redemption date, using proceeds from one or more equity offerings. On or after January 15, 2022, the Company may redeem all or a portion of the 2027 Notes, at the redemption prices of 104.688% in 2022, 103.125% in 2023, 101.563% in 2024 and 100% in 2025 and thereafter, plus accrued and unpaid interest to the redemption date.

The indenture under which the 2023 Notes and the 2027 Notes are issued, among other things, limits our ability to (1) incur liens and (2) enter into sale and lease-back transactions, and also limits our ability to merge or dispose of all or substantially all of our assets, in all cases, subject to a number of customary exceptions. Although we are not required to make mandatory redemption or sinking fund payments with respect to the 2023 Notes and the 2027 Notes, upon the occurrence of a change in control of MEDNAX, we may be required to repurchase the 2023 Notes or the 2027 Notes at a purchase price equal to 101% of the aggregate principal amount of the 2023 Notes and the 2027 Notes repurchased plus accrued and unpaid interest.

The carrying value of the Company's long-term debt was $1.7 billion and $2.0 billion at December 31, 2019 and 2018, respectively, and consisted of the following (in thousands):

	December 31, 2019		
	Principal	Unamortized Debt Issuance Costs	Total
Senior notes	$1,750,000	$ (19,762)	$ 1,730,238
Revolving line of credit	—	(2,664)	(2,664)
Total	$1,750,000	$ (22,426)	$ 1,727,574

	December 31, 2018		
	Principal	Unamortized Debt Issuance Costs	Total
Senior notes	$ 1,250,000	$ (15,408)	$1,234,592
Revolving line of credit	739,500	(4,274)	735,226
Total	$ 1,989,500	$ (19,682)	$1,969,818

The Company presents issuance costs related to long-term debt liabilities, other than revolving credit arrangements, as a direct deduction from the carrying value of that long-term debt. The Company has outstanding letters of credit which reduced the amount available under the Credit Agreement by $0.2 million at December 31, 2019. At December 31, 2019, the Company had an available balance on its Credit Agreement of $1.2 billion.

The carrying values of the Company's variable rate revolving line of credit approximates fair value due to the short-term nature of the interest rates. The estimated fair value of the Company's 2023 Notes and 2027 Notes were estimated using trading prices as of December 31, 2019 and 2018, respectively, as Level 2 inputs to estimate fair value and are summarized as follows (in thousands):

	December 31,	
	2019	2018
2023 Notes	$ 766,875	$736,725
2027 Notes	1,025,600	482,500

The Company's finance lease obligations consist of the following (in thousands):

	December 31,	
	2019	2018
Finance lease obligations	$ 188	$ 441
Less: Current portion	(130)	(253)
Long-term portion	$ 58	$ 188

13. Income Taxes:

The components of the income tax provision (benefit) are as follows (in thousands):

	December 31,		
	2019	2018	2017
Federal:			
Current	$ 73,333	$ 95,955	$122,379
Deferred	(141,359)	(21,386)	(63,981)
	(68,026)	74,569	58,398
State:			
Current	11,777	26,145	19,084
Deferred	(35,637)	(4,261)	2,749
	(23,860)	21,884	21,833
Total	$ (91,886)	$ 96,453	$ 80,231

The Company files its tax return on a consolidated basis with its subsidiaries, and its affiliated professional contractors file tax returns on an individual basis.

Beginning on January 1, 2018, the Company's statutory tax rate was reduced from 35.0% to 21.0% as a result of legislation enacted under the Tax Cuts and Jobs Act of 2017 ("TCJA"). The effective tax rate for continuing operations was 7.4%, 27.2% and 20.8% for the years ended December 31, 2019, 2018 and 2017, respectively. During the three months ended September 30, 2019, a $213.7 million income tax charge was recognized relating to the nondeductible portion of the Company's non-cash goodwill impairment charge. During the three months ended December 31, 2017, the Company recorded a $70.0 million income tax benefit related to the reduction of its net deferred tax liability resulting from the reduction in the corporate tax rate under the TCJA.

The differences between the effective rate and the United States federal income tax statutory rate are as follows:

	December 31,		
	2019	2018	2017
Tax at statutory rate	21.00%	21.00%	35.00%
State income tax, net of federal benefit	3.85	4.35	3.38
Non-deductible expenses	(0.22)	0.42	0.48
Change in accrual estimates relating to uncertain tax positions	0.36	0.02	—
Capital loss on liquidation	1.79	—	—
Change in valuation allowance	(1.73)	—	—
Impairments	(17.16)	—	—
Other, net	(0.49)	1.70	0.10
Change in tax law	—	(0.32)	(18.16)
Income tax provision	7.40%	27.17%	20.80%

All of the Company's deferred tax assets and liabilities are classified as long-term. The significant components of deferred income tax assets and liabilities are as follows (in thousands):

	December 31,	
	2019	2018
Allowance for uncollectible accounts	$ 202,464	$ 194,299
Reserves and accruals	72,132	56,583
Stock-based compensation	11,393	9,201
Loss carryforwards	36,017	24,864
Property and equipment	388	—
Other	631	1,197
Deferred tax assets before valuation allowance	323,025	286,144
Less: Valuation allowance	(24,139)	(2,628)
Deferred tax assets, net of valuation allowance	298,886	283,516
Gross deferred tax liabilities:		
Amortization	(119,481)	(247,239)
Accounting method changes	(74,684)	(109,418)
Accrual to cash adjustment	—	(39)
Other	(331)	(491)
Total deferred tax liabilities	(194,496)	(357,187)
Net deferred tax assets (liabilities)	$ 104,390	$ (73,671)

The Company's net deferred tax assets were $104.4 million as of December 31, 2019, as compared to net deferred tax liabilities of $73.7 million at December 31, 2018. The increase in net deferred tax assets of $178.1 million during the year ended December 31, 2019 was primarily related to the deferred tax benefit from the Company's non-cash goodwill impairment charge recorded during the year ended December 31, 2019. The increase in the Company's valuation allowance during the year ended December 31, 2019 was primarily related to a capital loss carryforward generated during 2019.

Beginning January 1, 2017, excess tax benefits or deficiencies associated with the exercise of stock options, the vesting of restricted and deferred stock and the purchase of shares under the Company's non-qualified employee stock purchase plan are recognized as income tax benefits or expenses in the income statement in the

reporting period in which they occur instead of an increase or decrease to additional paid-in-capital. For the years ended December 31, 2019, 2018 and 2017, income tax expense of $3.9 million, $1.4 million and $0.2 million, respectively, was recognized for excess tax deficiencies.

During the year ended December 31, 2019, the Company generated a $68.0 million capital loss carryforward which expires in 2024. As of December 31, 2019, the Company has provided a $17.1 million valuation allowance against this deferred tax asset based on management's determination that it is more likely than not that the tax benefits related to this asset will not be realized. Additionally, the Company has net operating loss carryforwards for federal and state tax purposes totaling $ 75.4 million, $100.7 million and $114.5 million at December 31, 2019, 2018 and 2017, respectively. With respect to the December 31, 2019 balance, $38.7 million expires at various times from 2021 through 2039, and $36.7 million does not expire.

As of December 31, 2019, 2018 and 2017, the Company's liability for uncertain tax positions, excluding accrued interest and penalties, was $7.4 million, $11.2 million and $11.0 million, respectively. As of December 31, 2019, the Company had $7.1 million of uncertain tax positions that, if recognized, would favorably impact its effective tax rate.

The following table summarizes the activity related to the Company's liability for uncertain tax positions for the years ended December 31, 2019, 2018 and 2017 (in thousands):

	Years Ended December 31,		
	2019	2018	2017
Balance at beginning of year	$11,185	$ 10,972	$ 9,469
Increases related to prior year tax positions	369	385	2,284
Decreases related to prior year tax positions	—	—	(143)
Increases related to current year tax positions	1,700	2,900	1,430
Decreases related to lapse of statutes of limitation	(5,845)	(3,072)	(2,068)
Balance at end of year	$ 7,409	$ 11,185	$10,972

During the years ended December 31, 2019 and 2018, the Company decreased its liability for uncertain tax positions by a total of $3.8 million and increased its liability for uncertain tax positions by $0.2 million, respectively, primarily related to additional taxes on current and prior year positions, partially offset by the expiration of statutes of limitation. In addition, the Company anticipates that its liability for uncertain tax positions will increase by $2.0 million over the next 12 months.

The Company includes interest and penalties related to income tax liabilities in income tax expense. The impact to income tax expense related to penalties and interest was not material during the years December 31, 2019, 2018 and 2017. At December 31, 2019 and 2018, the Company's accrued liability for interest and penalties related to income tax liabilities totaled $0.6 million and $1.1 million, respectively.

The Company is currently subject to U.S. Federal and various state income tax examinations for the tax years 2015 through 2018.

14. Common and Common Equivalent Shares:

The calculation of shares used in the basic and diluted net income per share calculation for the years ended December 31, 2019, 2018, and 2017 is as follows (in thousands):

	Years Ended December 31,		
	2019	2018	2017
Weighted average number of common shares outstanding	83,495	91,104	92,431
Weighted average number of dilutive common share equivalents[(a)]	—	502	527
Weighted average number of common and common equivalent shares outstanding	83,495	91,606	92,958
Antidilutive securities not included in the diluted net income per common share calculation	516	214	107

(a) Due to a loss for the year ended December 31, 2019, no incremental shares are included because the effect would be antidilutive.

15. Stock Incentive Plans and Stock Purchase Plans:

On May 16, 2019, the Company's shareholders approved the Company's Amended and Restated 2008 Incentive Compensation Plan (the "Amended and Restated 2008 Incentive Plan"). The amendments, among other things, increased the number of shares of common stock reserved for delivery under the under the Amended and Restated 2008 Incentive Plan from 19.5 million shares to 27.8 million shares, as well as extended the expiration date to ten years from the effective date of approval. The Amended and Restated 2008 Incentive Plan provides for grants of stock options, stock appreciation rights, restricted stock, deferred stock, and other stock-related awards and performance awards that may be settled in cash, stock or other property.

Under the Amended and Restated 2008 Incentive Plan, options to purchase shares of common stock may be granted at a price not less than the fair market value of the shares on the date of grant. The options must be exercised within 10 years from the date of grant and generally become exercisable on a pro rata basis over a three-year period from the date of grant. The Company issues new shares of its common stock upon exercise of its stock options. Restricted stock awards generally vest over periods of three years upon the fulfillment of specified service-based conditions and in certain instances performance-based conditions. Deferred stock awards generally vest upon the satisfaction of specified performance-based conditions and service-based conditions. The Company recognizes compensation expense related to its restricted stock and deferred stock awards ratably over the corresponding vesting periods. At December 31, 2019, the Company had 8.3 million shares available for future grants and awards under its Amended and Restated 2008 Incentive Plan.

Under the Company's 1996 Non-Qualified Employee Stock Purchase Plan, as amended (the "ESPP"), employees are permitted to purchase the Company's common stock at 85% of market value on January 1st, April 1st, July 1st and October 1st of each year. Under the Company's 2015 Non-Qualified Stock Purchase Plan (the "SPP"), certain eligible non-employee service providers are permitted to purchase the Company's common stock at 90% of market value on January 1st, April 1st, July 1st and October 1st of each year.

Each of the ESPP and the SPP provide for the issuance of an aggregate of 2.6 million shares of the Company's common stock less the number of shares of common stock purchased under the other plan. The Company recognizes stock-based compensation expense for the discount received by participating employees and non-employee service providers. During the year ended December 31, 2019, 0.5 million shares in the aggregate were issued under the ESPP and SPP. At December 31, 2019, the Company had approximately 1.1 million shares in the aggregate reserved for issuance under the ESPP and SPP.

The Company recognized $35.4 million, $37.9 million and $28.8 million of stock-based compensation expense related to its stock incentive plans, the ESPP and the SPP during the years ended December 31, 2019, 2018 and 2017, respectively.

The activity related to the Company's restricted stock and deferred stock awards and the corresponding weighted average grant-date fair values for the year ended December 31, 2019 are as follows:

	Number of Shares	Weighted Average Fair Value
Non-vested shares at January 1, 2019	1,310,853	$ 54.46
Awarded	1,112,773	$ 33.28
Forfeited	(137,091)	$ 48.37
Vested	(563,420)	$ 55.96
Non-vested shares at December 31, 2019	1,723,115	$ 40.77

The aggregate fair value of the restricted and deferred stock that vested during the years ended December 31, 2019, 2018 and 2017 was $31.5 million, $27.4 million and $29.3 million, respectively.

The weighted average grant-date fair value of restricted and deferred stock awards that were granted during the years ended December 31, 2019, 2018 and 2017 was $33.28, $51.99 and $54.22, respectively.

At December 31, 2019, the total stock-based compensation cost related to non-vested restricted and deferred stock remaining to be recognized as compensation expense over a weighted-average period of 1.4 years was $22.1 million.

The Company did not grant any stock options in 2019, 2018 or 2017, and all stock-based compensation cost related to stock options has been recognized. The activity and certain other information related to the Company's outstanding stock option awards for the year ended December 31, 2019 are as follows:

	Number of Stock Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value (in millions)
Outstanding at January 1, 2019	112,976	$ 27.65		
Exercised	(40,168)	$ 18.87		$ 0.6
Outstanding and exercisable at December 31, 2019	72,808	$ 32.49	0.8	$ —

The aggregate intrinsic value of stock options exercised during the years ended December 31, 2019, 2018 and 2017 was $0.6 million, $2.8 million and $5.5 million, respectively.

The cash proceeds received from the exercise of stock options for the years ended December 31, 2019, 2018 and 2017 were $0.1 million, $3.7 million and $4.8 million, respectively.

16. Common Stock Repurchase Programs:

In July 2013, the Company's Board of Directors authorized the repurchase of shares of the Company's common stock up to an amount sufficient to offset the dilutive impact from the issuance of shares under the Company's equity compensation programs. The share repurchase program allows the Company to make open

market purchases from time-to-time based on general economic and market conditions and trading restrictions. The repurchase program also allows for the repurchase of shares of the Company's common stock to offset the dilutive impact from the issuance of shares, if any, related to the Company's acquisition program. No shares were purchased under this program during the year ended December 31, 2019.

In August 2018, the Company announced that its Board of Directors had authorized the repurchase of up to $500.0 million of the Company's common stock in addition to its existing share repurchase program, of which $250.0 million remained available for repurchase as of December 31, 2018. Under this program, during the year ended December 31, 2019, the Company repurchased approximately 5.1 million shares of its common stock for $145.3 million, inclusive of 96,918 shares withheld to satisfy minimum statutory withholding obligations of $2.5 million in connection with the vesting of restricted stock during the year ended December 31, 2019.

During the year ended December 31, 2018, the Company repurchased approximately 7.0 million shares of its common stock for approximately $302.2 million, inclusive of 54,909 shares withheld to satisfy minimum statutory withholding obligations of $2.5 million in connection with the vesting of restricted stock and exercises of stock options during the second quarter of 2018.

The Company intends to utilize various methods to effect any future share repurchases, 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.

17. Retirement Plans:

The Company maintains four qualified contributory savings plans as allowed under Section 401(k) of the Internal Revenue Code and Section 1165(e) of the Puerto Rico Income Tax Act of 1954 (the "401(k) Plans"). The 401(k) Plans permit participant contributions and allow elective and, in certain situations, non-elective Company contributions based on each participant's contribution or a specified percentage of eligible wages. Participants may defer a percentage of their annual compensation subject to the limits defined in the 401(k) Plans. The Company recorded expense of $43.0 million, $54.6 million and $50.1 million for the years ended December 31, 2019, 2018 and 2017, respectively, primarily related to the 401(k) Plans.

18. Commitments and Contingencies:

The Company expects that audits, inquiries and investigations from government authorities and agencies 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 the Company's business, financial condition, results of operations, cash flows and the trading price of its securities. The Company has not included an accrual for these matters as of December 31, 2019 in its Consolidated Financial Statements, as the variables affecting any potential eventual liability depend on the currently unknown facts and circumstances that arise out of, and are specific to, any particular future audit, inquiry and investigation and cannot be reasonably estimated at this time.

In the ordinary course of business, the Company becomes involved in pending and threatened legal actions and proceedings, most of which involve claims of medical malpractice related to medical services provided by the Company's affiliated physicians. The Company's contracts with hospitals generally require the Company to indemnify them and their affiliates for losses resulting from the negligence of the Company's affiliated physicians. The Company may also become subject to other lawsuits which could involve large claims and significant costs. The Company believes, 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 its business, financial condition, results of operations, cash flows and the trading price of its securities. 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 the Company's business, financial condition, results of operations, cash flows and the trading price of its securities.

Although the Company currently maintains liability insurance coverage intended to cover professional liability and certain other claims, the Company cannot assure that its insurance coverage will be adequate to cover liabilities arising out of claims asserted against it in the future where the outcomes of such claims are unfavorable. With respect to professional liability risk, the Company generally self-insures a portion of this risk through its wholly owned captive insurance subsidiary. Liabilities in excess of the Company's insurance coverage, including coverage for professional liability and certain other claims, could have a material adverse effect on the Company's business, financial condition, results of operations, cash flows and the trading price of its securities.

19. Selected Quarterly Financial Information (Unaudited):

The following tables set forth a summary of the Company's selected quarterly financial information for each of the four quarters ended December 31, 2019 and 2018 (in thousands, except for per share data):

	2019 Quarters			
	First	Second	Third	Fourth
Net revenue	$ 851,183	$ 868,309	$ 888,675	$905,375
Operating expenses:				
Practice salaries and benefits	621,539	608,962	630,309	647,968
Practice supplies and other operating expenses	25,791	28,016	26,950	32,009
General and administrative expenses	101,821	103,540	102,356	96,926
Depreciation and amortization	20,033	19,809	19,608	19,410
Transformational and restructuring related expenses	3,544	27,482	19,992	44,311
Goodwill impairment	—	—	1,449,215	—
Total operating expenses	772,728	787,809	2,248,430	840,624
Income (loss) from operations	78,455	80,500	(1,359,755)	64,751
Investment and other income	1,647	1,222	1,373	1,429
Interest expense	(30,723)	(31,080)	(29,901)	(27,677)
Equity in earnings of unconsolidated affiliates	1,236	1,990	2,249	2,304
Total non-operating expenses	(27,840)	(27,868)	(26,279)	(23,944)
Income (loss) from continuing operations before income taxes	50,615	52,632	(1,386,034)	40,807
Income tax (provision) benefit	(8,962)	(17,116)	125,788	(7,824)
Income (loss) from continuing operations	41,653	35,516	(1,260,246)	32,983
(Loss) income from discontinued operations, net of tax	(284,525)	(43,761)	4,330	(23,652)
Net (loss) income	$(242,872)	$ (8,245)	$(1,255,916)	$ 9,331
Per common and common equivalent share data (1):				
Income (loss) from continuing operations:				
Basic	$ 0.48	$ 0.43	$ (15.29)	$ 0.40
Diluted	$ 0.48	$ 0.42	$ (15.29)	$ 0.40
(Loss) income from discontinued operations:				
Basic	$ (3.31)	$ (0.53)	$ 0.05	$ (0.29)
Diluted	$ (3.29)	$ (0.52)	$ 0.05	$ (0.29)
Net (loss) income:				
Basic	$ (2.82)	$ (0.10)	$ (15.24)	$ 0.11
Diluted	$ (2.81)	$ (0.10)	$ (15.24)	$ 0.11
Weighted average common shares:				
Basic	86,073	83,234	82,441	82,592
Diluted	86,545	83,689	82,441	83,288

(1) Basic and diluted per share amounts are computed for each of the periods presented. Accordingly, the sum of the quarterly per share amounts may not agree with the full year amount.

	2018 Quarters			
	First	Second	Third	Fourth
Net revenue	$852,628	864,987	$848,759	$888,436
Operating expenses:				
Practice salaries and benefits	603,955	593,047	599,326	630,048
Practice supplies and other operating expenses	27,403	28,329	27,249	25,870
General and administrative expenses	101,693	100,938	95,771	105,532
Depreciation and amortization	19,914	20,280	22,205	21,433
Total operating expenses	752,965	742,594	744,551	782,883
Income from operations	99,663	122,393	104,208	105,553
Investment and other income	1,474	1,225	1,531	981
Interest expense	(19,935)	(21,618)	(21,788)	(25,448)
Equity in earnings of unconsolidated affiliates	1,525	1,257	1,766	2,277
Total non-operating expenses	(16,936)	(19,136)	(18,491)	(22,190)
Income from continuing operations before income taxes	82,727	103,257	85,717	83,363
Income tax provision	(22,720)	(28,482)	(23,550)	(21,701)
Income from continuing operations	60,007	74,775	62,167	61,662
Income (loss) from discontinued operations, net of tax	3,421	4,637	3,408	(1,448)
Net income	$ 63,428	79,412	$ 65,575	$ 60,214
Per common and common equivalent share data (2):				
Income from continuing operations:				
Basic	$ 0.65	$ 0.80	$ 0.68	$ 0.70
Diluted	$ 0.64	$ 0.80	$ 0.68	$ 0.70
Income (loss) from discontinued operations:				
Basic	$ 0.04	$ 0.05	$ 0.04	$ (0.02)
Diluted	$ 0.04	$ 0.05	$ 0.04	$ (0.02)
Net income:				
Basic	$ 0.68	$ 0.85	$ 0.72	$ 0.68
Diluted	$ 0.68	$ 0.85	$ 0.72	$ 0.68
Weighted average common shares:				
Basic	92,859	92,987	90,984	87,810
Diluted	93,505	93,529	91,359	88,258

(2) Basic and diluted per share amounts are computed for each of the periods presented. Accordingly, the sum of the quarterly per share amounts may not agree with the full year amount.

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended). Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures were effective as of the end of the period covered by this report.

Management's Annual Report on Internal Control Over Financial Reporting

Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rule 13a-15(f) or 15d-15(f) promulgated under the Securities Exchange Act of 1934, as amended. The 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 the prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's financial statements.

Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with generally accepted accounting principles. 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.

Management assessed the effectiveness of the Company's internal control over financial reporting as of the end of the period covered by this report. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in "Internal Control—Integrated Framework (2013)." Based on our assessment we concluded that, as of the end of the period covered by this report, the Company's internal control over financial reporting was effective based on those criteria.

The Company's independent registered certified public accounting firm, PricewaterhouseCoopers LLP, has audited our internal control over financial reporting as of December 31, 2019 as stated in their report which appears in this Annual Report on Form 10-K.

Changes in Internal Control Over Financial Reporting

No change in our internal control over financial reporting occurred during our last fiscal quarter that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

ITEM 9B. OTHER INFORMATION

On February 13, 2020, we appointed Mr. Dominic J. Andreano, our General Counsel and Secretary and previously a Senior Vice President, and Mr. Nikos Nikolopoulos, our Chief Strategy and Growth Officer and also previously a Senior Vice President, as Executive Vice Presidents of our company. The appointments as

Executive Vice President reflect the additional responsibilities that each of Messrs. Andreano and Nikolopoulos and Mr. Stephen D. Farber, our Executive Vice President and Chief Financial Officer (together with Messrs. Andreano and Nikolopoulos, the "Executive Officers") have been assigned following the elimination of the President and Chief Operating Officer roles at our company since June and December 2019, respectively.

In connection with these appointments and assignments of additional responsibilities, also on February 13, 2020, we, through a wholly-owned subsidiary, entered into amended and restated employment agreements (the "Employment Agreements") with each of the Executive Officers. The Employment Agreements are substantially similar to and conformed to the employment agreement previously entered into between us and Mr. Farber on August 22, 2018, as described in the Current Report on Form 8-K filed by us on August 28, 2018, with certain updates, including (i) providing a 280G "valley" provision so that if in the event of a change in control of our company the amounts payable to an Executive Officer in connection with such change in control would be subject to excise tax under Section 4999 of the Code, we would reduce the payment to an amount equal to the largest portion of such payment that would result in no portion thereof being subject to excise tax (unless such reduction would result in the Executive Officer receiving, on an after tax basis, an amount lower than the unreduced payment after taking into account all applicable federal, state and local employment taxes, income taxes and excise taxes, in which case the payment amount would not be reduced); and (ii) aligning the period of severance payments and post-termination restrictive covenants in the cases of termination by an Executive Officer for Good Reason or of an Executive without Cause at 24 months.

There were no changes to the base salary or annual bonus targets of the Executive Officers in connection with the entrance into the Employment Agreements, the appointments as Executive Vice Presidents, or the assignments of the additional responsibilities. In connection with their appointments as Executive Vice Presidents and assignments of additional responsibilities, the annual equity compensation grant target amount for each of Messrs. Andreano and Nikolopoulos was increased by $300,000 to a minimum annual target of $1,350,000 and $1,300,000, respectively.

We expect to file the Employment Agreements as exhibits to our Quarterly Report on Form 10-Q for the quarter ending March 31, 2020. The foregoing description is qualified in its entirety by reference to the complete text of the Employment Agreements, when filed.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this Item is incorporated by reference to the applicable information in the definitive proxy statement for our 2020 Annual Meeting of Shareholders, which is to be filed with the SEC within 120 days after our fiscal year end.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is incorporated by reference to the applicable information in the definitive proxy statement for our 2020 Annual Meeting of Shareholders, which is to be filed with the SEC within 120 days after our fiscal year end.

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

SECURITIES AUTHORIZED FOR ISSUANCE UNDER EQUITY COMPENSATION PLANS

The following table provides information as of December 31, 2019, with respect to shares of our common stock that may be issued under existing equity compensation plans, including our Amended and Restated 2008 Incentive Compensation Plan (the "Amended and Restated 2008 Incentive Plan"), our ESPP and our SPP.

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	72,808(1)	$ 32.49	9,404,824(2)
Equity compensation plans not approved by security holders	N/A	N/A	N/A
Total	72,808	$ 32.49	9,404,824

(1) All shares are issuable under the Amended and Restated 2008 Incentive Plan.
(2) Under the Amended and Restated 2008 Incentive Plan, 8,321,355 shares remain available for future issuance, and under the ESPP and the SPP, an aggregate of 1,083,469 shares remain available for future issuance.

The remaining information required by this Item is incorporated by reference to the applicable information in the definitive proxy statement for our 2020 Annual Meeting of Shareholders, which is to be filed with the SEC within 120 days after our fiscal year end.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is incorporated by reference to the applicable information in the definitive proxy statement for our 2020 Annual Meeting of Shareholders, which is to be filed with the SEC within 120 days after our fiscal year end.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is incorporated by reference to the applicable information in the definitive proxy statement for our 2020 Annual Meeting of Shareholders, which is to be filed with the SEC within 120 days after our fiscal year end.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULE

(a)(1) Financial Statements

The information required by this Item is included in Item 8 of Part II of this Form 10-K.

(a)(2) Financial Statement Schedule

The following financial statement schedule for the years ended December 31, 2019, 2018 and 2017, is included in this Form 10-K as set forth below (in thousands).

MEDNAX, INC.
Schedule II: Valuation and Qualifying Accounts

	Years Ended December 31,		
	2019	2018	2017
Allowance for contractual adjustments and uncollectibles:			
Balance at beginning of year	$ 1,486,672	$ 1,284,565	$ 1,222,998
Amount charged against operating revenue	9,383,853	8,944,637	8,285,317
Accounts receivable contractual adjustments and write-offs (net of recoveries)	(9,425,730)	(8,742,530)	(8,223,750)
Balance at end of year	$ 1,444,795	$ 1,486,672	$ 1,284,565

All other schedules have been omitted because they are not applicable, not required or the information is included elsewhere herein.

(a)(3) Exhibits

See Item 15(b) of this Form 10-K.

(b) Exhibits

2.1	Agreement and Plan of Merger, dated as of December 29, 2008, between MEDNAX, Inc., Pediatrix Medical Group, Inc. and PMG Merger Sub, Inc. (incorporated by reference to Exhibit 2.1 to MEDNAX's Current Report on Form 8-K dated January 2, 2009).
2.2**	Securities Purchase Agreement, dated October 10, 2019, by and between MEDNAX Services, Inc. and FH MD Buyer, Inc. (incorporated by reference to Exhibit 2.1 to MEDNAX's Current Report on Form 8-K dated October 10, 2019).
3.1	Composite Articles of Incorporation of MEDNAX, Inc. (incorporated by reference to Exhibit 3.1 to MEDNAX's Annual Report on Form 10-K for the period ended December 31, 2013).
3.2	Amended and Restated By-laws of MEDNAX, Inc. (incorporated by reference to Exhibit 3.1 to MEDNAX's Current Report on Form 8-K dated November 6, 2018).
4.1	Form of 5.25% Senior Notes due 2023 (incorporated by reference to Exhibit A of the First Supplemental Indenture filed as Exhibit 4.3 to MEDNAX's Current Report on Form 8-K dated December 8, 2015).
4.2	Form of 6.25% Senior Notes due 2027 (incorporated by reference to Exhibit A of the Fifth Supplemental Indenture filed as Exhibit 4.3 to MEDNAX's Current Report on Form 8-K dated November 13, 2018).

4.3	Indenture, dated as of December 8, 2015, by and between MEDNAX, Inc. and U.S. Bank National Association, as Trustee. (incorporated by reference to Exhibit 4.2 to MEDNAX's Current Report on Form 8-K dated December 8, 2015).
4.4	First Supplemental Indenture dated as of December 8, 2015 to the Indenture, dated as of December 8, 2015, by and among MEDNAX, Inc., certain of its subsidiaries and U.S. Bank National Association, as Trustee. (incorporated by reference to Exhibit 4.3 to MEDNAX's Current Report on Form 8-K dated December 8, 2015).
4.5	Second Supplemental Indenture dated as of March 30, 2017 to the Indenture, dated as of December 8, 2015, by and among MEDNAX, Inc., certain of its subsidiaries and U.S. Bank National Association, as Trustee. (incorporated by reference to Exhibit 10.4 to MEDNAX's Annual Report on Form 10-K for the period ended December 31, 2017).
4.6	Third Supplemental Indenture dated as of November 9, 2017 to the Indenture, dated as of December 8, 2015, by and among MEDNAX, Inc., certain of its subsidiaries and U.S. Bank National Association, as Trustee. (incorporated by reference to Exhibit 10.5 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2017).
4.7	Fourth Supplemental Indenture dated as of November 13, 2018 to the Indenture, dated as of December 8, 2015, by and among MEDNAX, Inc., certain of its subsidiaries and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 10.7 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2018).
4.8	Fifth Supplemental Indenture dated as of November 13, 2018 to Indenture, dated as of December 8, 2015, by and among MEDNAX, Inc., certain of its subsidiaries and U.S. Bank National Association, as Trustee. (incorporated by reference to Exhibit 4.3 to MEDNAX's Current Report on Form 8-K dated November 13, 2018).
4.9	Sixth Supplemental Indenture dated as of February 21, 2019 to the Indenture, dated as of December 8, 2015, by and among MEDNAX, Inc., certain of its subsidiaries and U.S. Bank National Association, as Trustee (incorporated by reference to Exhibit 10.2 to MEDNAX's Quarterly Report on Form 10-Q for the period ended March 31, 2019).
4.10+	Description of Securities of MEDNAX, Inc.
10.1	Credit Agreement, dated as of October 30, 2017, among MEDNAX, Inc., certain of its domestic subsidiaries from time to time party thereto as Guarantors, the Lender parties thereto, JPMorgan Chase Bank, N.A. as Administrative Agent and Bank of America, N.A., Fifth Third Bank, Mizuho Bank, Ltd., SunTrust Bank, The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Wells Fargo Bank, National Association as Syndication Agents, and BBVA Compass, Citizens Bank, N.A., PNC Bank, Regions Bank, and U.S. Bank National Association, as Senior Documentation Agents and BB&T as Documentation Agent. JPMorgan Chase Bank, N.A, Fifth Third Bank, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Mizuho Bank, Ltd., SunTrust Robinson Humphrey, Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd., and Wells Fargo Securities, LLC, acted as Joint Lead Arrangers and Joint Bookrunners. (incorporated by reference to Exhibit 10.1 to MEDNAX's Quarterly Report on Form 10-Q for the period ended September 30, 2017).
10.2	Amendment No. 1, dated as of November 21, 2018, to the Credit Agreement, dated as of October 30, 2017, among MEDNAX, Inc. certain of its domestic subsidiaries from time to time party thereto as Guarantors, the Lenders parties thereto and JPMorgan Chase Bank, N.A. as Administrative Agent (incorporated by reference to Exhibit 10.10 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2018).

10.3	Amendment No. 2, dated as of March 28, 2019, to the Credit Agreement, dated as of October 30, 2017, among MEDNAX, Inc., certain of its domestic subsidiaries from time to time party thereto as Guarantors, the Lenders parties thereto, and JPMorgan Chase Bank, N.A. as Administrative Agent (incorporated by reference to Exhibit 10.1 to MEDNAX's Quarterly Report on Form 10-Q for the period ended March 31, 2019).
10.4	Amended and Restated Stock Option Plan of Pediatrix dated as of June 4, 2003 (incorporated by reference to Exhibit 10.5 to Pediatrix's Quarterly Report on Form 10-Q for the period ended June 30, 2003).*
10.5	First Amendment, dated December 29, 2008, to Pediatrix Medical Group, Inc. Amended and Restated Stock Option Plan (incorporated by reference to Exhibit 10.7 to MEDNAX's Current Report on Form 8-K dated January 2, 2009).*
10.6	Amended and Restated MEDNAX, Inc. 1996 Non-Qualified Employee Stock Purchase Plan (incorporated by reference to Exhibit A to MEDNAX's Definitive Proxy Statement on Schedule 14A, filed with the SEC on September 18, 2015).*
10.7	2015 Non-Qualified Stock Purchase Plan of MEDNAX, Inc., dated September 14, 2015 (incorporated by reference to Exhibit B to MEDNAX's Proxy Statement dated September 18, 2015).*
10.8	Executive Non-Qualified Deferred Compensation Plan of Pediatrix, dated October 13, 1997 (incorporated by reference to Exhibit 10.35 to Pediatrix's Quarterly Report on Form 10-Q for the period ended June 30, 1998).*
10.9	Amended and Restated Thrift and Profit Sharing Plan of Pediatrix (incorporated by reference to Exhibit 4.5 to Pediatrix's Registration Statement on Form S-8 (Registration No. 333-101222)).*
10.10	Pediatrix Medical Group of Puerto Rico Thrift and Profit Sharing Plan (incorporated by reference to Exhibit 4.3 to Pediatrix's Registration Statement on Form S-8 dated December 9, 2004).*
10.11	Pediatrix Medical Group, Inc. 2004 Incentive Compensation Plan (incorporated by reference to Exhibit A of Pediatrix's Proxy Statement on Schedule 14A dated April 9, 2004).*
10.12	Second Amendment, dated December 29, 2008, to Pediatrix Medical Group, Inc. 2004 Incentive Compensation Plan (incorporated by reference to Exhibit 10.8 to MEDNAX's Current Report on Form 8-K dated January 2, 2009).*
10.13	MEDNAX, Inc. Amended and Restated 2008 Incentive Compensation Plan (incorporated by reference to Exhibit A to MEDNAX's Definitive Proxy Statement on Schedule 14A dated March 29, 2019).*
10.14	Pediatrix Medical Group, Inc. Form of Stock Option Agreement for Stock Options Awarded Under the Amended and Restated Stock Option Plan (incorporated by reference to Exhibit 10.3 to Pediatrix's Current Report on Form 8-K dated February 23, 2005).*
10.15	Pediatrix Medical Group, Inc. Form of Incentive Stock Option Agreement for Incentive Stock Options Awarded Under the 2004 Incentive Compensation Plan (incorporated by reference to Exhibit 10.4 to Pediatrix's Current Report on Form 8-K dated February 23, 2005).*
10.16	Pediatrix Medical Group, Inc. Form of Non-Qualified Stock Option Agreement for Non-Qualified Stock Options Awarded Under the 2004 Incentive Compensation Plan (incorporated by reference to Exhibit 10.5 to Pediatrix's Current Report on Form 8-K dated February 23, 2005).*
10.17	Pediatrix Medical Group, Inc. Form of Restricted Stock Agreement for Restricted Stock Awarded Under the 2004 Incentive Compensation Plan (incorporated by reference to Exhibit 10.6 to Pediatrix's Current Report on Form 8-K dated February 23, 2005).*

10.18	MEDNAX, Inc. Form of Non-Qualified Stock Option Agreement for Non-Qualified Stock Options Awarded Under the 2008 Incentive Compensation Plan (incorporated by reference to Exhibit 10.17 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2008).*
10.19	MEDNAX, Inc. Form of Restricted Stock Agreement for Restricted Stock Awarded Under the 2008 Incentive Compensation Plan (incorporated by reference to Exhibit 10.18 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2008).*
10.20	Employment Agreement, dated August 7, 2011, by and between MEDNAX Services, Inc. and Roger J. Medel, M.D. (incorporated by reference to Exhibit 10.1 to MEDNAX's Current Report on Form 8-K dated August 10, 2011).*
10.21	First Amendment to Employment Agreement, dated October 4, 2017, by and between MEDNAX Services, Inc. and Roger J. Medel, M.D. (incorporated by reference to Exhibit 10.1 to MEDNAX's Current Report on Form 8-K dated October 4, 2017).*
10.22	Second Amendment to Employment Agreement, dated July 1, 2019, by and between MEDNAX Services, Inc. and Roger J. Medel, M.D. (incorporated by reference to Exhibit 10.1 to MEDNAX's Quarterly Report on Form 10-Q for the period ended September 30, 2019).*
10.23	Employment Agreement, dated August 22, 2018, by and between MEDNAX Services, Inc. and Stephen D. Farber (incorporated by reference to Exhibit 10.1 to MEDNAX's Current Report on Form 8-K dated August 28, 2018).*
10.24	Employment Agreement, dated February 12, 2019, by and between MEDNAX Services, Inc. and Dominic J. Andreano (incorporated by reference to Exhibit 10.35 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2018).*
10.25+	Employment Agreement, dated August 1, 2019, by and between MEDNAX Services, Inc. and John C. Pepia.*
10.26	Form of Indemnification Agreement between Pediatrix and each of its directors and executive officers. (incorporated by reference to Exhibit 10.6 to Pediatrix's Annual Report on Form 10-K for the year ended December 31, 2003).*
10.27	Form of Exclusive Management and Administrative Services Agreement with affiliated professional contractors (incorporated by reference to Exhibit 10.31 to MEDNAX's Annual Report on Form 10-K for the year ended December 31, 2011).
21.1+	Subsidiaries of the Registrant.
23.1+	Consent of PricewaterhouseCoopers LLP.
31.1+	Certification of Chief Executive Officer pursuant to Securities Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2+	Certification of Chief Financial Officer pursuant to Securities Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32++	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1+	Inline Interactive Data File
101.INS+	Inline XBRL Instance Document—the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH+	Inline XBRL Schema Document.
101.CAL+	Inline XBRL Calculation Linkbase Document.

101.DEF+	Inline XBRL Definition Linkbase Document.
101.LAB+	Inline XBRL Label Linkbase Document.
101.PRE+	Inline XBRL Presentation Linkbase Document.
104+	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101).

* Management contracts or compensation plans, contracts or arrangements.

** Portions of this exhibit have been omitted pursuant to Item 601(b)(2) of Regulation S-K because they are both (i) not material and (ii) would likely cause competitive harm to the registrant if publicly disclosed. The schedules and similar attachments to this exhibit have been omitted pursuant to Item 601(a)(5) of Regulation S-K.

\+ Filed herewith.

++ Furnished herewith.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

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

MEDNAX, INC.

Date: February 20, 2020

By: /s/ Roger J. Medel, M.D.
Roger J. Medel, M.D.
Chief Executive Officer

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

Signature	Title	Date
/s/ Roger J. Medel, M.D. Roger J. Medel, M.D.	Chief Executive Officer, Director (Principal Executive Officer)	February 20, 2020
/s/ Stephen D. Farber Stephen D. Farber	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 20, 2020
/s/ John C. Pepia John C. Pepia	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 20, 2020
/s/ Cesar L. Alvarez Cesar L. Alvarez	Director and Chairman of the Board	February 20, 2020
/s/ Manuel Kadre Manuel Kadre	Lead Independent Director	February 20, 2020
/s/ Karey D. Barker Karey D. Barker	Director	February 20, 2020
/s/ Waldemar A. Carlo, M.D. Waldemar A. Carlo, M.D.	Director	February 20, 2020
/s/ Michael B. Fernandez Michael B. Fernandez	Director	February 20, 2020
/s/ Paul G. Gabos Paul G. Gabos	Director	February 20, 2020
/s/ Pascal J. Goldschmidt, M.D. Pascal J. Goldschmidt, M.D.	Director	February 20, 2020
/s/ Carlos A. Migoya Carlos A. Migoya	Director	February 20, 2020
/s/ Michael A. Rucker Michael A. Rucker	Director	February 20, 2020
/s/ Enrique J. Sosa, Ph.D. Enrique J. Sosa, Ph.D.	Director	February 20, 2020

Exhibit 4.10

DESCRIPTION OF THE REGISTRANT'S SECURITIES REGISTERED PURSUANT TO SECTION 12 OF THE SECURITIES EXCHANGE ACT OF 1934

As of December 31, 2019, the only class of securities of MEDNAX, Inc., a Florida corporation (the "Company"), registered under Section 12 of the Securities Exchange Act of 1934, as amended, is common stock, par value $0.01 per share ("Common Stock"). The Common Stock is listed on the New York Stock Exchange under the symbol "MD".

Overview

The following summarizes certain material terms and provisions of the Common Stock. It does not purport to be complete, however, and is qualified in its entirety by reference to Florida law and by the actual terms and provisions contained in the Company's Amended and Restated Articles of Incorporation, as amended (the "Articles"), and the Company's Amended and Restated Bylaws (the "Bylaws").

The Articles authorize the Company's board of directors (the "Board of Directors") to issue up to 200,000,000 shares of Common Stock and 1,000,000 shares of preferred stock, par value $0.01 per share. As of February 14, 2020, there were 84,277,494 shares of Common Stock issued and outstanding and no shares of preferred stock issued and outstanding. All issued and outstanding shares of Common Stock are duly issued, fully paid and nonassessable.

General Description of Common Stock

Each share of Common Stock entitles its owner to one vote on all matters submitted to a vote of the Company's shareholders. Subject to the rights of the holders of the Company's preferred stock, the holders of Common Stock are entitled to receive dividends, when, as and if declared by the Board of Directors, in its discretion, from funds legally available for the payment of dividends, payable in cash, stock or otherwise. If the Company liquidates, dissolves or winds-up, whether voluntarily or involuntarily, the holders of Common Stock, to the exclusion of the holders of the Company's preferred stock, will be entitled to share proportionately in the Company's assets, if any, legally available for distribution to shareholders, but only after the Company has paid all of its debts and liabilities and after the holders of the Company's preferred stock have been paid in full the amounts to which they are entitled, if any, or a sum sufficient for such payment has been set aside.

The Common Stock has no preemptive rights, no sinking fund provisions and no subscription, redemption or conversion privileges, and it is not subject to any further calls or assessments by the Company. The Common Stock does not have cumulative voting rights. Moreover, directors are elected by a plurality of the votes cast by the shares entitled to vote in the election at a meeting in which a quorum is present; however, the Board of Directors adopted in 2012 a majority vote policy as part of the Company's corporate governance principles which provides that, in uncontested elections, which are those elections in which the number of nominees for election is less than or equal to the number of directors to be elected, any nominee for director who receives more "withheld" votes than "for" votes must submit a written offer to resign as director. Any such resignation will be reviewed by the Nominating and Corporate Governance Committee of the Board of Directors and, within 90 days after the election, the independent members of the Board of Directors will determine whether to accept, reject or take other appropriate action with respect to, the resignation, in furtherance of the best interests of the Company and its shareholders.

General Description of Preferred Stock

The Articles authorize the Board of Directors, without further shareholder approval, to:

- issue preferred stock in one or more class or series;
- establish the number of shares to be included in each such class or series, including increasing and decreasing the number of shares of preferred stock designated for any existing class or series; and
- fix the designations, powers, preferences and rights of the shares of each class or series and any qualifications, limitations or restrictions on those shares.

The Board of Directors may establish a class or series of preferred stock with preferences, powers and rights (including voting rights) senior to the rights of the holders of Common Stock. If the Company issues any preferred stock, it may have the effect of delaying, deferring or preventing a change in control.

The Articles of Amendment Designating Series A Junior Participating Preferred Stock designate 50,000 shares of preferred stock as Series A Junior Participating Preferred Stock, par value $0.01 per share ("Series A Preferred"). As of February 14, 2020, no shares of Series A Preferred were outstanding. Subject to the rights of the holders of preferred stock senior to the Series A Preferred, if any, and certain other conditions, the holders of Series A Preferred will be entitled to receive cumulative quarterly dividends, when, as and if declared by the Board of Directors, in its discretion, from funds legally available for the payment of dividends. Each share of Series A Preferred will be entitled to a minimum preferential quarterly dividend payment of $1.00 per share but will be entitled to an aggregate dividend of 2,000 times the dividend declared per share of Common Stock. Each share of Series A Preferred entitles the holder thereof to 2,000 votes on all matters submitted to a vote of the Company's shareholders and the Series A Preferred vote together with Common Stock as one class, unless otherwise required by any future articles of designation or by law. Notwithstanding the foregoing, the holders of Series A Preferred have no special voting rights and their consent is not required for taking any corporate action, except to the extent set forth in the Articles of Amendment Designating Series A Junior Participating Preferred Stock. In the event of liquidation, the holders of Series A Preferred will be entitled to a minimum preferential liquidation payment of $1.00 per share but will be entitled to an aggregate payment of 2,000 times the payment made per share of Common Stock. Finally, in the event of any merger, consolidation or other transaction in which Common Stock is exchanged, each share of Series A Preferred will be entitled to receive 2,000 times the amount received per share of Common Stock. These rights are protected by customary antidilution provisions.

If shares of Series A Preferred were to be issued, the voting and consent rights provided in the Articles of Amendment Designating Series A Junior Participating Preferred Stock may have the effect of delaying, deferring or preventing a change in control of the Company. The Series A Preferred has no preemptive rights, no sinking fund provisions and no subscription, redemption or conversion privileges, and it is not subject to any further calls or assessments by the Company. In addition, the Series A Preferred must rank, with respect to the payment of dividends and the distribution of assets, junior to all series of any other class of the preferred stock.

Material Provisions of the Company's Amended and Restated Articles of Incorporation and Amended and Restated Bylaws

The Articles and Bylaws contain material provisions that may make the acquisition of control of the Company more difficult.

Classified Board of Directors and Related Provisions. The Articles and Bylaws provide that the number of directors will be established from time to time by resolution of the Board of Directors. The Bylaws also provide that the Board of Directors may be divided into two or more classes of directors. Although the Board of Directors is not currently classified, a classified Board of Directors could prevent a party who acquires control of a majority of the Company's outstanding voting stock from obtaining control of the Board of Directors until annual shareholders meeting following the date on which the acquirer obtains its controlling interest.

The Articles provide that the Company's shareholders may only remove a director from office prior to the expiration of his or her term if such removal is for "cause" and only by an affirmative vote of two-thirds of all of the Company's outstanding capital stock entitled to vote for the election of directors. If there is a vacancy on the Board of Directors, a majority of the Company's remaining directors, although less than a quorum of the entire Board of Directors, may fill such vacancy for the unexpired term of his or her predecessor, or until the next election of one or more directors by the Company's shareholders if the vacancy is caused by an increase in the size of the Board of Directors. The Company's shareholders may not fill any vacancy on the Board of Directors.

Shareholder Action By Written Consent. The Bylaws provide that any actions which the Company's shareholders may take at a shareholders' meeting can be taken by written consent in lieu of a meeting. In order to effect a shareholder action by written consent in lieu of a meeting, holders of the Company's outstanding voting stock, having at least the minimum number of votes that would be necessary to authorize the action at a shareholders' meeting, must sign a written consent which states the action to be taken. If the shareholders take any action by written consent in lieu of a meeting, the Company must notify all of its shareholders that did not consent to the action in writing or that were not entitled to vote on the action within 10 days after receiving the written consent and describe the action to them.

Shareholder-Proposed Business. In addition to any other applicable requirements, for business to be properly brought by a shareholder before an annual meeting of the shareholders, the Articles require that such shareholder give timely notice thereof in writing to the Company's Secretary. If such notice is not timely given, the shareholder-proposed business will not be brought before such annual meeting. To be timely, a shareholder's notice must be delivered to or mailed and received at the Company's principal executive offices neither less than 120 days nor more than 180 days prior to the first anniversary of the date of the Company's notice of annual meeting provided to shareholders with respect to the previous year's annual meeting. If no annual meeting of shareholders was held in the previous year or the date of the current year's annual meeting has been changed to be more than 30 calendar days earlier than the date contemplated by the previous year's proxy statement, such shareholder's notice must be so delivered or received no later than the close of business on the tenth day following the date on which notice the current year's annual meeting is given to shareholders or made public, whichever occurs first.

Indemnification. The Articles provide that the Company shall indemnify, and may advance expenses to, its officers and directors to the fullest extent permitted by law.

Florida Anti-Takeover Statute

As a Florida corporation, the Company is subject to certain anti-takeover provisions that apply to public corporations under Florida law. Pursuant to Section 607.0901 of the Florida Business Corporation Act (the "Florida Act"), a publicly held Florida corporation may not engage in a broad range of business combinations or other extraordinary corporate transactions with an interested shareholder without the approval of the holders of two-thirds of the voting shares of the corporation (excluding shares held by the interested shareholder), unless, among other exceptions:

- the transaction is approved by a majority of disinterested directors;
- the interested shareholder has owned at least 80% of the corporation's outstanding voting shares for at least five years preceding the announcement date of any such business combination;
- the interested shareholder is the beneficial owner of at least 90% of the outstanding voting shares of the corporation, exclusive of shares acquired directly from the corporation in a transaction not approved by a majority of the disinterested directors; or
- the consideration paid to the holders of the corporation's voting stock is at least equal to certain fair price criteria.

Subject to certain exceptions, an interested shareholder is defined as a person who together with affiliates and associates beneficially owns more than 10% of a corporation's outstanding voting shares. Although permitted by the Florida Act, the Company has not made an election in its Articles to opt out of Section 607.0901.

In addition, the Company is subject to Section 607.0902 of the Florida Act which prohibits the voting of shares in a publicly held Florida corporation that are acquired in a control share acquisition unless (i) the Board of Directors approved such acquisition prior to its consummation or (ii) after such acquisition, in lieu of prior approval by the Board of Directors, the holders of a majority of the corporation's voting shares, exclusive of shares owned by officers of the corporation, employee directors or the acquiring party, approve the granting of voting rights as to the shares acquired in the control share acquisition. A control share acquisition is defined as an acquisition that immediately thereafter entitles the acquiring party to 20% or more of the total voting power in an election of directors.

Exhibit 10.25

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (this "Agreement") is made and entered into by and between **MEDNAX SERVICES, INC.**, a Florida corporation ("Employer") and **JOHN C. PEPIA** ("Employee") effective as the Effective Date.

RECITALS

WHEREAS, Employer is presently engaged in "Employer's Business" as defined on Exhibit A hereto; and

WHEREAS, Employer desires to continue to employ Employee and benefit from Employee's contributions to Employer; and

WHEREAS, Employee has previously served in various management positions with the Employer, and its predecessor company, and was promoted to Chief Accounting Officer of Employer in August 2016; and

WHEREAS, Employer and Employee previously entered in an Employment Agreement dated January 1, 2004, as amended (the "Prior Employment Agreement"); which will be superseded in its entirety upon execution of this Agreement; and

WHEREAS, in order to induce Employer to enter into this Agreement on the terms and conditions set forth herein, and disclose its trade secrets and confidential information in connection with Employee's employment by Employer and award from time to time equity based compensation, Employee hereby agrees to be bound by the terms of this Agreement, including the arbitration, non-competition and related restrictive covenants set forth herein.

NOW, THEREFORE, in consideration of the premises and mutual covenants set forth herein, the parties agree as follows:

1. Employment.

1.1. *Employment and Term*. Employer hereby agrees to employ Employee and Employee hereby agrees to serve Employer on the terms and conditions set forth herein for an "Initial Term" commencing August 1, 2019 (the "Effective Date") and continuing for a period of three (3) years, unless sooner terminated as hereinafter set forth. Thereafter, the employment of Employee hereunder shall automatically renew for successive one (1) year periods until terminated in accordance herewith. The Initial Term and any automatic renewals shall be referred to as the "Employment Period."

1.2. *Duties of Employee*. During the Employment Period, Employee shall serve as Senior Vice President, Chief Accounting Officer of Employer and perform such duties as are customary to the position Employee holds or as may be assigned to Employee from time to time by Employee's supervisor ("Employee's Supervisor"); *provided*, that such duties as assigned shall be

customary to Employee's role as an officer of Employer. Employee's employment shall be full-time and as such Employee agrees to devote substantially all of Employee's attention and professional time to the business and affairs of Employer. Employee shall perform Employee's duties honestly, diligently, competently, in good faith and in the best interest of Employer. Employee will devote best efforts to the promotion of the goodwill of Employer and of its employees and affiliates. During the Employment Term, Employer shall promote the proficiency of Employee by, among other things, providing Employee with Confidential Information, specialized professional development programs, and information regarding the organization, administration and operation of Employer. During the Employment Period, Employee agrees that Employee will not, without the prior written consent of Employer (which consent shall not be unreasonably withheld), serve as a director on a corporate board of directors or in any other similar capacity for any institution other than Employer. During the Employment Period, it shall not be a violation of this Agreement to (i) serve on civic or charitable boards or committees, or (ii) deliver lectures, fulfill speaking engagements or teach at educational institutions, so long as such activities have been approved by Employee's Supervisor and do not interfere with the performance of Employee's responsibilities as an employee of Employer in accordance with this Agreement, including the restrictions of Section 8 hereof.

1.3. *Place of Performance*. Employee shall be based at Employer's offices located in Sunrise, Florida, except for required travel relating to Employer's Business.

2. Base Salary-and Performance Bonus.

2.1. *Base Salary*. Employee shall be paid an annual base salary as determined by Employee's supervisor from time to time (the "Base Salary"), payable in installments consistent with Employer's customary payroll schedule and subject to applicable withholding for taxes and other Employee directed withholdings. Any increase to Employee's Base Salary that is approved by Employee's Supervisor shall become Employee's new Base Salary for purposes of this Agreement.

2.2. *Performance Bonus*. Employee shall be eligible for an annual bonus of up to the amount set forth on Exhibit B (the "Performance Bonus"). The amount of the actual bonus paid to Employee, if any, shall be based upon the achievement of specific objectives to be developed and agreed upon by Employee and Employee's Supervisor each year and the performance of Employer. Except in the situations described in Sections 4.1(d), 5.2, 5.3, 5.4, 5.5 and 5.7, the Performance Bonus shall only be payable to Employee if Employee is employed with Employer as of the date that the Performance Bonus is paid by Employer. Each Performance Bonus shall be paid in the calendar year immediately following the calendar year in which it is earned, as soon as practicable after the audited financial statements for Employer for the year for which the bonus is earned have been released; provided, however, that if calculation of Employee's Performance Bonus is not administratively practicable due to events beyond the control of Employer, then Employer may delay payment of the Performance Bonus provided that the payment is made during the first taxable year of Employee in which the calculation of the amount of the payment is administratively practicable.

3. Benefits.

3.1. *Expense Reimbursement*. Employer shall promptly reimburse Employee for all out-of-pocket expenses reasonably incurred by Employee during the Employment Period on behalf of or in connection with Employer's Business pursuant to the reimbursement standards and guidelines of Employer in effect from time to time. Employee shall account for such expenses and submit reasonable supporting documentation to Employer in accordance with Employer's policies in effect from time to time.

3.2 *Employee Benefits*. During the Employment Period, Employee shall be entitled to participate in such health, welfare, disability, retirement savings and other fringe benefit plans and programs (subject to the terms and conditions of such plans and programs) as may be provided from time to time to employees of Employer and to the extent that such plans and programs are applicable to other similarly situated employees of Employer.

3.3. *Leave Time*. During the Employment Period, Employee shall be entitled to paid vacation and leave days each calendar year in accordance with the leave policies established by Employer from time to time. Any leave time not used during each fiscal year of Employer may be carried over into the next year to the extent permitted by Employer policy.

3.4 *Equity Plans.* During the Employment Period, Employee shall be eligible to participate in MEDNAX, Inc.'s Amended and Restated 2008 Incentive Compensation Plan or any other similar plan adopted by MEDNAX, Inc. (each an "Equity Plan") that provides for the issuance of stock options, stock appreciation rights, restricted stock, deferred stock, bonus stock, awards payable in stock or any other stock based award (each an "Equity Award"). Employee's stock-based award each year shall be determined by the Compensation Committee of MEDNAX, Inc.'s Board of Directors based on Employee's performance and Employer's performance during the immediately preceding year. Every Equity Award made to Employee shall be subject to the terms and conditions of this Agreement, the applicable award agreement and the terms of the Equity Plan. Employee shall also be eligible to participate in MEDNAX, Inc.'s non-qualified employee stock purchase plan and any successor plan. Employee acknowledges Employee's participation in the Equity Plan pursuant to this Section 3 is sufficient consideration for Employee to enter into this Agreement, including the restrictive covenants set forth in Section 8 below.

4. Termination.

4.1. *Termination for Cause*. Employer may terminate Employee's employment under this Agreement for Cause. As used in this Agreement, the term "Cause" shall mean:

(a) Any act or omission of Employee, which is materially contrary (having reference to corporate and industry custom and standards) to the business interests, reputation or goodwill of Employer;

(b) A material breach by Employee of Employee's obligations under this Agreement, which breach is not promptly remedied upon written notice from Employer;

(c) Employee's refusal to perform Employee's duties as assigned pursuant to this Agreement other than a refusal which is remedied by Employee promptly after receipt of written notice thereof by Employer;

(d) The determination by Employer made in good faith that Employee's performance of Employee's duties hereunder is below Employer's standards for Employee's position with Employer; *provided*, that Employer has first provided Employee with written notice setting forth the basis for Employer's determination and Employee has failed to cure the matter(s) cited within thirty (30) days after receipt of notice; and *provided, further,* that if Employer provides such notice and Employee is able to cure the matter but is not able to sustain performance at an acceptable level, or, if such matter is incapable of cure, Employer may terminate Employee without further notice or opportunity to cure upon any future failure by Employee to perform Employee's duties consistent with Employer's standards; or

(e) Employee's failure or refusal to comply with a reasonable policy, standard or regulation of Employer in any material respect, including but not limited to Employer's sexual harassment, other unlawful harassment, workplace discrimination or substance abuse policies.

The termination date for a termination of Employee's employment under this Agreement pursuant to this Section 4.1 shall be the date specified by Employer in a written notice to Employee of finding of Cause, which may not be retroactive. Upon any termination of Employee's employment under this Agreement pursuant to this Section 4.1, Employee shall be entitled to the compensation specified in Section 5.1 hereof.

4.2. *Disability*. Employer may terminate Employee's employment under this Agreement upon the Disability (as defined below) of Employee. Subject to the requirements of applicable law, Employee shall be deemed to have a "Disability" for purposes of this Agreement in the event of (i) Employee's inability to perform Employee's duties hereunder, with or without a reasonable accommodation, as a result of physical or mental illness or injury, and (ii) a determination by an independent qualified physician selected by Employer and acceptable to Employee (which acceptance shall not be unreasonably withheld) that Employee is currently unable to perform such duties and in all reasonable likelihood such inability will continue for a period in excess of an additional ninety (90) or more days in any one hundred twenty (120) day period. The termination date for a termination of this Agreement pursuant to this Section 4.2 shall be the date specified by Employer in a notice to Employee, which date shall not be retroactive. Upon any termination of this Agreement pursuant to this Section 4.2, Employee shall be entitled to compensation and/or benefits in accordance with, and subject to, the provisions of Section 5.2 hereof.

4.3. *Death*. Employee's employment under this Agreement shall terminate automatically upon the death of Employee, without any requirement of notice by Employer to Employee's estate. The date of Employee's death shall be the termination date for a termination of Employee's employment under this Agreement pursuant to this Section 4.3. Upon any termination of Employee's employment under this Agreement pursuant to this Section 4.3, Employee shall be entitled to the compensation specified in Section 5.3 hereof.

4.4. *Termination by Employer Without Cause*. Employer may terminate Employee's employment without cause by giving Employee written notice of such termination. The termination date shall be the date specified by Employer in such notice, which may be up to ninety (90) days from the date of such notice. Upon any termination of Employee's employment under this Agreement pursuant to this Section 4.4, Employee shall be entitled to compensation and/or benefits in accordance with, and subject to, the provisions of Section 5.4 hereof.

4.5. *Termination by Employee Due to Poor Health*. Employee may terminate Employee's employment under this Agreement upon written notice to Employer if Employee's health should become impaired to any extent that makes the continued performance of Employee's duties under this Agreement hazardous to Employee's physical or mental health or Employee's life (regardless of whether such condition would be deemed a Disability under any other Section of this Agreement), *provided* that Employee shall have furnished Employer with a written statement from a qualified doctor to that effect, and *provided further* that, at Employer's written request and expense, Employee shall submit to a medical examination by an independent qualified physician selected by Employer and acceptable to Employee (which acceptance shall not be unreasonably withheld), which doctor shall substantially concur with the conclusions of Employee's doctor. The termination date shall be the date specified in Employee's notice to Employer, which date may not be earlier than thirty (30) days nor later than ninety (90) days from Employer's receipt of such notice. Upon any termination of Employee's employment under this Agreement pursuant to this Section 4.5, Employee shall be entitled to compensation and/or benefits in accordance with, and subject to, the provisions of Section 5.5 hereof.

4.6. *Termination by Employee*. Employee may terminate Employee's employment under this Agreement for any reason whatsoever upon not less than ninety (90) days prior written notice to Employer. Upon receipt of such notice from Employee, Employer may, at its option, require Employee to terminate employment at any time in advance of the expiration of such ninety (90) day period. The termination date under this Section 4.6 shall be the date specified by Employer, but in no event more than ninety (90) days after Employer's receipt of notice from Employee as contemplated by this Section. Upon any termination of Employee's employment under this Agreement pursuant to this Section 4.6, Employee shall be entitled to compensation and/or benefits in accordance with, and subject to, the provisions of Section 5.6 hereof.

4.7. *Termination by Employee for Good Reason.* Employee may terminate Employee's employment hereunder for Good Reason. For purposes of this Section, "Good Reason" shall mean:

(a) a decrease in Employee's Base Salary;

(b) a decrease in the Performance Bonus potential utilized by Employer in determining a Performance Bonus for Employee; or

(c) within a twelve (12) month period after a Change in Control (as defined below), Employee is either (i) terminated pursuant to Section 4.4 or Employee terminates Employee's employment pursuant to Section 4.7, (ii) assigned any position, duties, responsibilities or compensation that is inconsistent with the position, duties, responsibilities or compensation of Employee prior to such Change in Control, or (iii) required to perform services under this Agreement from another location more than twenty-five (25) miles from Employee's location prior to the Change in Control. For purposes of this Agreement, "Change in Control" shall mean (i) the acquisition by a person or an entity or a group of persons and entities, directly or indirectly, of more than fifty (50%) percent of MEDNAX, Inc.'s common stock in a single transaction or a series of transactions (hereinafter referred to as a "50% Change in Control"), (ii) a merger or other form of corporate reorganization of MEDNAX, Inc. resulting in an actual or *de facto* 50% Change in Control, or (iii) the failure of Applicable Directors (defined below) to constitute a majority of MEDNAX, Inc.'s Board of Directors (the "Board") during any two (2) consecutive year period after the date of this Agreement (the "Two-Year Period"). "Applicable Directors" shall mean those individuals who are members of the Board at the inception of a Two-Year Period and any new director whose election to the Board or nomination for election to the Board was approved (prior to any vote thereon by the shareholders) by a vote of at least two-thirds (2/3) of the directors then still in office who either were directors at the beginning of the Two-Year Period at issue or whose election or nomination for election during such Two-Year Period was previously approved as provided in this sentence; or

(d) the assignment to Employee of any position inconsistent with the present position Employee holds, or material diminution in Employee's authority, excluding for this purpose any isolated, insubstantial and inadvertent action not taken in bad faith and which is remedied by Employer promptly after receipt of written notice; or

(e) the requirement by Employer that Employee be based in any office or location outside of the metropolitan area where Employer's present corporate offices are located (it being understood that Employee may be presently based at another location), except for travel reasonably required in the performance of Employee's duties.

If Employee desires to terminate Employee's employment under this Agreement pursuant to this Section, Employee must, within one hundred eighty (180) days after the occurrence of events giving rise to the Good Reason, provide Employer with a written notice describing the Good Reason in reasonable detail. If Employer fails to cure the matter cited within thirty (30) days after the date of Employee's notice, then this Agreement shall terminate as of the end of such thirty (30) day cure period, *provided, however,* that Employer may, at its option, require Employee to terminate employment at any time in advance of the expiration of such thirty (30) day cure period. If Employee terminates Employee's employment under this Agreement pursuant to this Section 4.7, then Employee shall be entitled to compensation and/or benefits in accordance with, and subject to, the provisions of Section 5.7 hereof.

5. Compensation and Benefits Upon Termination.

5.1. *Cause*. If Employee's employment is terminated for Cause, Employer shall pay Employee's Base Salary through the termination date specified in Section 4.1 at the rate in effect at the termination date. In addition, if Employee's employment is terminated pursuant to Section 4.1(d), Employer shall continue Base Salary payments to Employee for a period of six (6) months after the termination date. Upon payment of such amounts, plus any amounts as may be due under Section 5.8 and 5.11 below, Employer shall have no further obligation to Employee under this Agreement.

5.2. *Disability*. In the event of Employee's Disability, Employee shall continue to receive Employee's Base Salary for the first ninety (90) days of Disability. If Employee's employment is terminated pursuant to Section 4.2 in connection with Employee's Disability, Employee shall receive fifty percent (50%) of Employee's annual Base Salary at the rate in effect at the termination date, payable in six (6) equal monthly installments after the termination date, plus a bonus calculated in accordance with Section 5.11 and any amounts as may be due under Section 5.8 and 5.9.

5.3. *Death*. Upon Employee's death during the Employment Period, Employer shall pay to the person or entity designated by Employee in a notice filed with Employer or, if no person is designated, to Employee's estate any unpaid amounts of Base Salary to the date of Employee's death, plus any amounts as may be due under Sections 5.8 and 5.11 below. Any payments Employee's spouse, beneficiaries or estate may be entitled to receive pursuant to any pension plan, employee welfare benefit plan, life insurance policy, or similar plan or policy then maintained by Employer shall be determined and paid in accordance with the written instruments governing the respective plans and policies. In the event of Employee's death during the Employment Period, Employer shall notify Employee's designee or estate of the Equity Awards held by Employee and the procedures pursuant to which all vested stock options may be exercised and other Equity Awards may be realized under the terms applicable to such awards.

5.4. *Termination by Employer Without Cause*. If Employer terminates Employee's employment in accordance with Section 4.4, then (i) Employer shall pay Employee's Base Salary through the termination date specified in Section 4.4 at the rate in effect at such termination date, plus any amount due under Section 5.8 hereof; (ii) pay Employee a bonus calculated in accordance with Section 5.11 hereof; (iii) Employer shall continue to pay Employee's monthly Base Salary for a period of twelve (12) months after the termination date (iv) within thirty (30) days of the first (1st) anniversary of the termination date, pay Employee an amount equal to the greater of Employee's Average Annual Performance Bonus (as defined below) or Employee's bonus for the year immediately preceding Employee's termination; and (v)if applicable, Employee shall vest into the Accelerated Awards (as defined below) as set forth in Section 5.14 hereof. For purposes of this Agreement, "Average Annual Performance Bonus" shall be equal to the average of the percentage of the Performance Bonus target achieved by Employee for the three (3) full calendar years prior to the termination date, and calculated based on Employee's Base Salary and target Performance Bonus in Employee's current position.

5.5. *Termination by Employee Due to Poor Health.* If Employee terminates Employee's employment under this Agreement pursuant to Section 4.5 hereof, Employer shall pay to Employee any unpaid amounts of Base Salary to the termination date specified in Section 4.5, plus any disability payments otherwise payable by or pursuant to plans provided by Employer, plus any amounts as may be due under Sections 5.8 and 5.11.

5.6. *Termination by Employee*. If Employee's employment under this Agreement terminates pursuant to Section 4.6 hereof, Employer shall pay to Employee any unpaid amounts of Base Salary to the termination date specified in Section 4.6, plus any amounts as may be due under Section 5.8 below. In the event that the termination date specified by Employer is less than ninety (90) days after the date of Employer's receipt of notice as contemplated by Section 4.6, then Employer shall continue Employee's Base Salary for a period of days equal to ninety (90) minus the number of days from Employee's notice to the termination date.

5.7. *Termination for Good Reason.* If Employee's employment under this Agreement is terminated pursuant to Section 4.7, then Employer shall (i) pay Employee's Base Salary through the termination date specified in Section 4.7 at the rate in effect at such termination date, (ii) pay any amounts as may be due under Section 5.8 and 5.11, (iii) continue to pay Employee's Base Salary for a period of twelve (12) months after the termination date, and (iv) if applicable, Employee shall vest into the Accelerated Awards (as defined below) as set forth in Section 5.14 hereof. In addition, notwithstanding any contrary provision in any Equity Plan, in the event of Employee's termination pursuant to Section 4.7(c), any unvested Equity Awards held by Employee on the termination date shall fully vest and in the case of stock options, become immediately exercisable.

5.8. *Expense Reimbursement.* Employee shall be entitled to reimbursement for reasonable business expenses incurred prior to the termination date, subject, however to the provisions of Section 3.1. Such reimbursement shall be made at the times and in accordance with Employer's normal procedures for reimbursements.

5.9. *Continuation of Benefit Plans*. Employee shall be entitled to continuation of health, medical, hospitalization and other similar health insurance programs on the same basis as regular, full-time employees of Employer and their eligible dependents during the period that Employee is receiving Base Salary payments under Section 5 of this Agreement and, in all cases, as provided by any applicable law. Following such period of continued benefit plan coverage, Employee and each of his eligible dependents shall be entitled to elect for continuation of coverage provided pursuant to Section 601 et. seq. of the Employee Retirement Income Security Act of 1974, 29 USC §1101 ("COBRA").

5.10 *Period for Exercising Stock Options After Termination.* Except as to incentive stock options granted in accordance with Section 422 of the Internal Revenue Code, after termination of Employee's employment under this Agreement for any reason other than pursuant to Section 4.1, Employee shall be allowed a period of twelve months during which to exercise any vested options to purchase MEDNAX, Inc.'s common stock or vested stock appreciation rights and realize any other vested Equity Awards that may be granted or made under any Equity Plan; provided, however, that in no event shall the period during which Employee may exercise any vested stock option or vested stock appreciation right be extended pursuant to this Section 5.10 to a date that is later than the earlier of (i) the latest date upon which the stock right could have expired by its original terms under any circumstances or (ii) the tenth (10^{th}) anniversary of the original date of grant of the stock right. In all other respects, the terms of the applicable Equity Plan shall control the terms and conditions of any Equity Awards.

5.11. *Performance Bonus.* In the situations described in Sections 4.1(d), 5.2, 5.3, 5.4, 5.5 and 5.7, upon termination of this Agreement, Employee will be paid, solely in consideration of services rendered by Employee prior to termination, a bonus with respect to Employer's fiscal year in which the termination date occurs, equal to the Performance Bonus, if any, that would have been payable to Employee, based on Employee and Employer meeting certain goals and objectives, for the fiscal year if Employee's employment had not been terminated, multiplied by the number of days in the fiscal year prior to and including the date of termination and divided by three hundred sixty five (365). The amount of the Post-Termination Performance Bonus paid in the situations described in Sections 4.1(d), 5.2, 5.3, 5.4 5.5 and 5.7 shall be determined in good faith by Employer in its sole discretion at the time that Employer distributes bonuses to similarly situated employees. Any amount payable under this Section 5.11 shall be paid to Employee when Employer pays performance bonuses to its eligible employees, which shall be in the calendar year following the termination date of this Agreement. In addition, in the situations described in Section 5.7, Employee will be paid, solely in consideration of services rendered by Employee prior to termination, an additional bonus with respect to Employer's fiscal year in which the termination date occurs, equal to the greater of Employee's Average Annual Performance Bonus (as defined in Section 5.4) or Employee's bonus for the year immediately preceding Employee's termination. Such additional bonus shall be payable to Employee within ninety (90) days of Employee's termination date pursuant to Section 4.7.

5.12. *Section 409A Compliance*.

(a) General. It is the intention of both Employer and Employee that the benefits and rights to which Employee could be entitled in connection with termination of employment comply with Section 409A of the Code and the Treasury Regulations and other guidance promulgated or issued thereunder ("Section 409A"), and the provisions of this Agreement shall be construed in a manner consistent with that intention. If Employee or Employer believes, at any time, that any such benefit or right does not so comply, it shall promptly advise the other and shall negotiate reasonably and in good faith to amend the terms of such benefits and rights such that they comply with Section 409A of the Code (with the most limited possible economic effect on Employee and on Employer).

(b) Distributions on Account of Separation from Service. If and to the extent required to comply with Section 409A, no payment or benefit required to be paid under this Agreement on account of termination of Employee's employment shall be made unless and until Employee incurs a "separation from service", within the meaning of Section 409A.

(c) 6 Month Delay for Specified Employees.

(i) If Employee is a "specified employee", then no payment or benefit that is payable on account of Employee's "separation from service", as that term is defined for purposes of Section 409A, shall be made before the date that is six months after Employee's "separation from service" (or, if earlier, the date of Employee's death) if and to the extent that such payment or benefit constitutes deferred compensation (or may be nonqualified deferred compensation) under Section 409A and such deferral is required to comply with the requirements of Section 409A. Any payment or benefit delayed by reason of the prior sentence shall be paid out or provided in a single lump sum at the end of such required delay period in order to catch up to the original payment schedule.

(ii) For purposes of this provision, Employee shall be considered to be a "specified employee" if, at the time of his or her separation from service, Employee is a "key employee", within the meaning of Section 416(i) of the Code, of Employer (or any person or entity with whom Employer would be considered a single employer under Section 414(b) or Section 414(c) of the Code) any stock in which is publicly traded on an established securities market or otherwise.

(iii) Unless otherwise required to comply with Section 409A, a payment or benefit shall not be deferred pursuant to this provision if:

(x) it is not made on account of Employee's "separation from service", (y) it is required to be paid no later than within 2 ½ months after the end of the taxable year of Employee in which the payment or benefit is no longer subject to a "substantial risk of forfeiture", as that term is defined for purposes of Section 409A, or (z) the payment satisfies the following requirements: (A) it is being paid or provided due to Employer's termination of Employee's employment without Cause (Section 4.4) or Employee's termination of employment after a Change in Control for the reasons set forth in Section 4.7 hereof, (B) it does not exceed two times the lesser of (1) Employee's annualized compensation from Employer for the calendar year prior to the calendar year in which the termination of Employee's employment occurs, and (2) the maximum amount of compensation that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the year in which Employee's employment terminates, and (C) the payment is required under this Agreement to be paid no later than the last day of the second calendar year following the calendar year in which Employee incurs a "separation from service".

(d) No Acceleration of Payments. Neither Employer nor Employee, individually or in combination, may accelerate any payment or benefit that is subject to Section 409A, except in compliance with Section 409A and the provisions of this Agreement, and no amount shall be paid prior to the earliest date on which it may be paid without violating Section 409A.

(e) Treatment of Each Installment as a Separate Payment. For purposes of applying the provisions of Section 409A to this Agreement, each separately identified amount to which Employee is entitled under this Agreement shall be treated as a separate payment. In addition, to the extent permissible under Section 409A, any series of installment payments under this Agreement shall be treated as a right to a series of separate payments.

(f) Reimbursements and In-Kind Benefits.

(i) Any reimbursements by Employer to Employee of any eligible expenses pursuant to Section 3.1 or 5.8 of this Agreement, that are not excludible from Employee's income for Federal income tax purposes ("Taxable Reimbursements") shall be made on or before the last day of the taxable year of Employee following the year in which the expense was incurred.

(ii) The amount of any Taxable Reimbursements, and the value of any in-kind benefits to be provided to Employee under this Agreement, during any taxable year of Employee shall not affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year of Employee.

(iii) The right to Taxable Reimbursements, or in-kind benefits, shall not be subject to liquidation or exchange for another benefit.

5.13. *Release.* Employer shall provide Employee with a general release in the form attached as Exhibit C (subject to such modifications as Employer may reasonably request) within seven (7) days after Employee's termination date. Payments or benefits to which Employee may be entitled pursuant to this Section 5 (other than any accrued but unpaid Base Salary and employee benefits as of the end of the Employment Period) (the "Severance Amounts") shall be conditioned upon Employee executing the general release within 21 days after receiving it from Employer and the general release becoming irrevocable upon the expiration of 7 days following the Employee's execution of it. Payment of the Severance Amounts shall be suspended during the period (the "Suspension Period") that begins on Employee's termination date and ends on the date ("Suspension Termination Date") that is thirty-five (35) days after Employee's termination date; provided, however, that this suspension shall not apply, and Employer shall be required to provide, any continued health insurance coverage that would be required under Section 5.9 hereof during the Suspension Period. If Employee executes the general release and the general release becomes irrevocable by no later than the Suspension Termination Date, then payment of any Severance Amounts that were suspended pursuant to this provision shall be made in the first payroll period that follows the Suspension Termination Date, and any Severance Amounts that are payable after the Suspension Termination Date shall be paid at the times provided in Section 5.

5.14. *Vesting of Incentive Awards.* Notwithstanding any contrary provision in this Agreement or any Equity Plan then maintained by MEDNAX, Inc., if , during the first twelve (12) months after a Change in Control, Employee's employment is terminated pursuant to Section 4.4 or 4.7(a),(b)(d) or (e), then all of the Accelerated Awards will be fully vested and exercisable as of the effective date of such termination.

6. Successors; Binding Agreement.

6.1. *Successors*. Employer shall require any successor (whether direct or indirect, by purchase, merger, consolidation or otherwise) acquiring a majority of Employer's voting common stock or any other successor to all or substantially all of the business and/or assets of Employer to expressly assume and agree to perform this Agreement in the same manner and to the same extent

that Employer would be required to perform it if no such succession had taken place and Employee hereby consents to any such assignment. In such event, "Employer" shall mean Employer as previously defined and any successor to its business and/or assets which executes and delivers the agreement provided for in this Section 6 or which otherwise becomes bound by all the terms and provisions of this Agreement by operation of law. This Section shall not limit Employee's ability to terminate this Agreement in the circumstances described in Section 4.7 in the event of a Change in Control.

6.2. *Benefit*. This Agreement and all rights of Employee under this Agreement shall inure to the benefit of and be enforceable by Employee's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees and legatees. If Employee should die after the termination date and amounts would have been payable to Employee under this Agreement if Employee had continued to live, including under Section 5 hereof, then such amounts shall be paid to Employee's devisee, legatee, or other designee or, if there is no such designee, Employee's estate.

7. Conflicts. This Agreement constitutes the entire agreement among the parties pertaining to the subject matter hereof and supersedes and revokes any and all prior or existing agreements, written or oral, relating to the subject matter hereof, and this Agreement shall be solely determinative of the subject matter hereof.

8. Restrictive Covenants; Confidential Information; Work Product; Injunctive Relief.

8.1. *No Material Competition*. Employer and Employee acknowledge and agree that a strong relationship and connection exists between Employer and its current and prospective patients, referral sources, and customers as well as the hospitals and healthcare facilities at which it provides professional services. Employer and Employee further acknowledge and agree that the restrictive covenants described in this Section are designed to enforce, and are ancillary to or part of, the promises contained in this Agreement and are reasonably necessary to protect the legitimate interests of Employer in the following: (1) the use and disclosure of the Confidential Information as described in Section 8.4; (2) the professional development activities described in Section 1.2; and (3) the goodwill of the Employer, as promoted by Employee as provided in Section 1.2. The foregoing listing is by way of example only and shall not be construed to be an exclusive or exhaustive list of such interests. Employee acknowledges that the restrictive covenants set forth below are of significant value to Employer and were a material inducement to Employer in agreeing to the terms of this Agreement. Employee further acknowledges that the goodwill and other proprietary interest of Employer will suffer irreparable and continuing damage in the event Employee enters into competition with Employer in violation of this Section.

Therefore, Employee agrees that, except with respect to services performed under this Agreement on behalf of Employer, **Employee shall not**, at any time during the Restricted Period (as defined below), for Employee or on behalf of any other person, persons, firm, partnership, corporation or employer, participate or engage in or own an interest in, directly or indirectly, any individual proprietorship, partnership, corporation, joint venture, trust or other form of business entity, whether as an individual proprietor, partner, joint venturer, officer, director, member, employee, consultant,

independent contractor, stockholder, lender, landlord, finder, agent, broker, trustee, or in any manner whatsoever, if such entity or its affiliates is engaged in, directly or indirectly, "Employer's Business," as defined on Exhibit A hereto. Employee acknowledges that, as of the date hereof, Employee's responsibilities will include matters affecting the businesses of Employer listed on Exhibit A. For purposes of this Section 8, the "Restricted Period" shall mean the Employment Period plus twenty-four (24) months in the event the Agreement is terminated for any other reason.

8.2. *No Hire*. Employee further agrees that **Employee shall not**, at any time during the Employment Period and for a period of twenty-four (24) months immediately following termination of this Agreement for any reason, for Employee or on behalf of any other person, persons, firm, partnership, corporation or employer, intentionally, knowingly, or willingly employ, or intentionally, knowingly, or willingly permit any company or business directly or indirectly controlled by Employee to employ or otherwise engage (a) any person who is a then current employee or independent contractor of Employer or one of its affiliates, or (b) any person who was an employee or independent contractor of Employer or one of its affiliates in the prior six (6) month period, or in any manner seek to induce such persons to leave his or her employment or engagement with Employer or one of its affiliates (including without limitation for or on behalf of a subsequent employer of Employee).

8.3 *Non-solicitation.* Employee further agrees that **Employee shall not**, at any time during the Employment Period and for a period of twenty-four (24) months immediately following termination of this Agreement for any reason, for Employee or on behalf of any other person, persons, firm, partnership, corporation or employer, solicit or accept business from or take any action that would interfere with, diminish or impair the valuable relationships that Employer or its affiliates have with (i) hospitals or other health care facilities with which Employer or its affiliates have contracts to render professional services or otherwise have established relationships, (ii) patients, (iii) referral sources, (iv) vendors, (v) any other clients of Employer or its affiliates, or (vi) prospective hospitals, patients, referral sources, vendors or clients whose business Employee was aware that Employer or any affiliate of Employer was in the process of soliciting at the time of Employee's termination (including potential acquisition targets).

8.4. *Confidential Information*. At all times during the term of this Agreement, Employer shall provide Employee with access to "Confidential Information." As used in this Agreement, the term "Confidential Information" means any and all confidential, proprietary or trade secret information, whether disclosed, directly or indirectly, verbally, in writing or by any other means in tangible or intangible form, including that which is conceived or developed by Employee, applicable to or in any way related to: (i) patients with whom Employer has a physician/patient relationship; (ii) the present or future business of Employer; or (iii) the research and development of Employer. Without limiting the generality of the foregoing, Confidential Information includes: (a) the development and operation of Employer's medical practices, including information relating to budgeting, staffing needs, marketing, research, hospital relationships, equipment capabilities, and other information concerning such facilities and operations and specifically including the procedures and business plans developed by Employer for use at the hospitals where Employer conducts its business; (b) contractual arrangements between the Employer and insurers or managed care associations or other payors; (c) the databases of Employer; (d) the clinical and research protocols of Employer, including coding guidelines; (e) the referral sources of Employer; (f) other confidential

information of Employer that is not generally known to the public that gives Employer the opportunity to obtain an advantage over competitors who do not know or use it, including the names, addresses, telephone numbers or special needs of any of its patients, its patient lists, its marketing methods and related data, lists or other written records used in Employer's business, compensation paid to employees and other terms of employment, accounting ledgers and financial statements, contracts and licenses, business systems, business plan and projections, and computer programs. The parties agree that, as between them, this Confidential Information constitutes important, material, and confidential trade secrets that affect the successful conduct of Employer's business and its goodwill. Employer acknowledges that the Confidential Information specifically enumerated above is special and unique information and is not information that would be considered a part of the general knowledge and skill Employee has or might otherwise obtain.

Notwithstanding the foregoing, Confidential Information shall not include any information that (i) was known by Employee from a third party source before disclosure by or on behalf of Employer, (ii) becomes available to Employee from a source other than Employer that is not, to Employee's knowledge, bound by a duty of confidentiality to Employer, (iii) becomes generally available or known in the industry other than as a result of its disclosure by Employee, or (iv) has been independently developed by Employee and may be disclosed by Employee without breach of this Agreement, provided, in each case, that the Employee shall bear the burden of demonstrating that the information falls under one of the above-described exceptions.

Employee agrees that the terms of this Agreement shall be deemed Confidential Information for purposes of this Section. Employee shall keep the terms of this Agreement strictly confidential and will not, without the prior written consent of Employer, disclose the details of this Agreement to any third party in any manner whatsoever in whole or in part, with the exception of Employee's representatives (such as tax advisors and attorneys) who need to know such information.

Employee agrees that Employee will not at any time, whether during or subsequent to the term of Employee's employment with Employer, in any fashion, form or manner, unless specifically consented to in writing by Employer, either directly or indirectly, use or divulge, disclose, or communicate to any person, firm or corporation, in any manner whatsoever, any Confidential Information of any kind, nature, or description, subject to applicable law. The parties agree that any breach by Employee of any term of this Section is a material breach of this Agreement and shall constitute "cause" for the termination of Employee's employment hereunder. In the event that Employee is ordered to disclose any Confidential Information, whether in a legal or a regulatory proceeding or otherwise, Employee shall provide Employer with prompt written notice of such request or order so that Employer may seek to prevent disclosure or, if that cannot be achieved, the entry of a protective order or other appropriate protective device or procedure in order to assure, to the extent practicable, compliance with the provisions of this Agreement. In the case of any disclosure required by law, Employee shall disclose only that portion of the Confidential Information that Employee is ordered to disclose in a legally binding subpoena, demand or similar order issued pursuant to a legal or regulatory proceeding.

All Confidential Information, and all equipment, notebooks, documents, memoranda, reports, files, samples, books, correspondence, lists, other written and graphic records, in any media (including electronic or video) containing Confidential Information or relating to the business of Employer, which Employee shall prepare, use, construct, observe, possess, or control shall be and remain Employer's sole property (collectively "Employer Property"). Upon termination or expiration of this Agreement, or earlier upon Employer's request, Employee shall promptly deliver to Employer all Employer Property, retaining none.

8.5. *Ownership of Work Product.* Employee agrees and acknowledges that (i) all copyrights, patents, trade secrets, trademarks, service marks, or other intellectual property or proprietary rights associated with any ideas, concepts, techniques, inventions, processes, or works of authorship developed or created by Employee during the course of performing work for Employer and any other work product conceived, created, designed, developed or contributed by Employee during the term of this Agreement that relates in any way to Employer's Business (collectively, the "Work Product"), shall belong exclusively to Employer and shall, to the extent possible, be considered a work made for hire within the meaning of Title 17 of the United States Code. To the extent the Work Product may not be considered a work made for hire owned exclusively by Employer, Employee hereby assigns to Employer all right, title, and interest worldwide in and to such Work Product at the time of its creation, without any requirement of further consideration. Upon request of Employer, Employee shall take such further actions and execute such further documents as Employer may deem necessary or desirable to further the purposes of this Agreement, including without limitation separate assignments of all right, title, and interest in and to all rights of copyright and all right, title, and interest in and to any inventions or patents and any reissues or extensions which may be granted therefore, and in and to any improvements, additions to, or modifications thereto, which Employee may acquire by invention or otherwise, the same to be held and enjoyed by Employer for its own use and benefit, and for the use and benefit of Employer's successors and assigns, as fully and as entirely as the same might be held by Employee had this assignment not been made.

8.6. *Clearance Procedure for Proprietary Rights Not Claimed by Employer.* In the event that Employee wishes to create or develop, *other than* on Employer's time or using Employer's resources, anything that may be considered Work Product but to which Employee believes Employee should be entitled to the personal benefit of, Employee agrees to follow the clearance procedure set forth in this Section. Before beginning any such work, Employee agrees to give Employer advance written notice and provide Employer with a sufficiently detailed written description of the work under consideration for Employer to make a determination regarding the work. Unless otherwise agreed in a writing signed by Employer prior to receipt, Employer shall have no obligation of confidentiality with respect to such request or description. Employer will determine in its sole discretion, within thirty (30) days after Employee has fully disclosed such plans to Employer, whether rights in such work will be claimed by Employer. If Employer determines that it does not claim rights in such work, Employer agrees to so notify Employee in writing and Employee may retain ownership of the work to the extent that such work has been expressly disclosed to Employer. If Employer fails to so notify Employee within such thirty (30) day period, then Employer shall be deemed to have agreed that such work is not considered Work Product for purposes of this Agreement. Employee agrees to submit for further review any significant improvement, modification, or adaptation that could reasonably be related to Employer's Business so that it can be determined whether the improvement, modification, or adaptation relates to the business or interests of Employer. Clearance under this procedure does not relieve Employee of the restrictive covenants set forth in this Section 8.

8.7. *Non-Disparagement.* For a period of ten (10) years after the termination of this Agreement, Employee will not, directly or indirectly, as an individual or on behalf of a firm, corporation, partnership or other legal entity, make any disparaging or negative comment to any other person or entity regarding Employer or any of its affiliates, agents, attorneys, employees, officers and directors, Employee's work conditions or circumstances surrounding Employee's separation from Employer or otherwise impugn or criticize the name or reputation of Employer, its affiliates, agents, attorneys, employees, officers or directors, orally or in writing.

8.8. *Review by Employee.* **Employee has carefully read and considered the terms and provisions of this Section 8, and having done so, agrees that the restrictions set forth in this Section 8 are fair and reasonably required for the protection of the interests of Employer.** In the event that any term or provision set forth in this Section 8 shall be held to be invalid or unenforceable by a court of competent jurisdiction, the parties hereto agree that such invalid or unenforceable term(s) or provision(s) may be severed from this Agreement without, in any manner, affecting the remaining portions hereof. Without limiting other possible remedies available to Employer, Employee agrees that injunctive or other equitable relief will be available to enforce the covenants set forth in this Section, such relief to be without the necessity of posting a bond. In the event that, notwithstanding the foregoing, any part of the covenants set forth in this Section shall be held to be invalid, overbroad, or unenforceable by an arbitration panel or a court of competent jurisdiction, the parties hereto agree that such invalid, overbroad, or unenforceable provision(s) may be modified or severed from this Agreement without, in any manner, affecting the remaining portions of this Section 8 (all of which shall remain in full force and effect). In the event that any provision of this Section 8 related to time period or areas of restriction shall be declared by an arbitration panel or a court of competent jurisdiction to exceed the maximum time period, area or activities such arbitration panel or court deems reasonable and enforceable, said time period or areas of restriction shall be deemed modified to the minimum extent necessary to make the geographic or temporal restrictions or activities reasonable and enforceable.

8.9. *Survival.* The provisions of this Section 8 shall survive the termination of this Agreement and Employee's employment with Employer. The provisions of this Section 8 shall apply during the time Employee is receiving Disability payments from Employer as a result of a termination of this Agreement pursuant to Section 4.2 hereof. In the event of a breach of this Section 8 by Employee, Employer retains the right to terminate any continuing payments to Employee provided for in Section 5 of this Agreement. The provisions of this Section 8 are expressly intended to benefit and be enforceable by other affiliated entities of Employer, who are express third party beneficiaries hereof. Employee shall not assist others in engaging in any of the activities described in the foregoing restrictive covenants.

9. Arbitration. Any controversy or claim arising out of or relating to this Agreement, or any alleged breach hereof shall be finally determined by a single arbitrator, jointly selected by the Employee and Employer, provided that if Employee and Employer are unable to agree upon a single arbitrator after reasonable efforts, the arbitrator shall be an impartial arbitrator selected by the American Arbitration Association. Each party hereto shall share equally the costs of the arbitrator, and the parties agree that the costs of arbitration shall not be subject to reapportionment by the arbitrator. The arbitration proceedings shall be held in Sunrise, Florida, unless otherwise mutually

agreed by the parties, and shall be conducted in accordance with the American Arbitration Association National Rules for the Resolution of Employment Disputes then in effect. Judgment on the award rendered by the arbitration panel may be entered and enforced by any court having jurisdiction thereof. Any such arbitration shall be treated as confidential by all parties thereto, except as otherwise provided by law or as otherwise necessary to enforce any judgment or order issued by the arbitrators.

Notwithstanding anything herein to the contrary, if Employer or Employee shall require immediate injunctive relief, then the party shall be entitled to seek such relief in any court having jurisdiction, and if the party elects to do so, the other party hereby consents to the jurisdiction of the state and federal courts sitting in the State of Florida and to the applicable service of process. Employee and Employer hereby waive and agree not to assert, to the fullest extent permitted by applicable law, any claim that (i) they are not subject to the jurisdiction of such courts, (ii) they are immune from any legal process issued by such courts and (iii) any litigation or other proceeding commenced in such courts is brought in an inconvenient forum. In the event that either party hereto brings suit seeking injunctive relief, the party found to be at fault shall pay all reasonable court costs and attorneys' fees of the other, whether such costs and fees are incurred in a court of original jurisdiction or one or more courts of appellate jurisdiction.

10. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida without regard to its conflict of laws principles to the extent that such principles would require the application of laws other than the laws of the State of Florida.

11. Notices. Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been given when delivered by hand or when deposited in the United States mail by registered or certified mail, return receipt requested, postage prepaid, addressed as follows:

If to Employer:

Mednax Services, Inc.
1301 Concord Terrace
Sunrise, FL 33323
Attention: General Counsel

If to Employee:

John C. Pepia
c/o MEDNAX Services, Inc.
1301 Concord Terrace
Sunrise, FL 33323

or to such other addresses as either party hereto may from time to time give notice of to the other in the aforesaid manner.

12. Benefits: Binding Effect. This Agreement shall be for the benefit of and binding upon the parties hereto and their respective heirs, personal representatives, legal representatives, successors and, where applicable, assigns. Notwithstanding the foregoing, Employee may not assign the rights or benefits hereunder without the prior written consent of Employer.

13. Severability. The invalidity of any one or more of the words, phrases, sentences, clauses or sections contained in this Agreement shall not affect the enforceability of the remaining portions of this Agreement or any part thereof, all of which are inserted conditionally on their being valid in law, and, in the event that any one or more of the words, phrases, sentences, clauses or sections contained in this Agreement shall be declared invalid, this Agreement shall be construed as if such invalid word or words, phrase or phrases, sentence or sentences, clause or clauses, or section or sections had not been inserted. If such invalidity is caused by length of time or size of area, or both, the otherwise invalid provision will be considered to be reduced to a period or area, which would cure such invalidity.

14. Waivers. The waiver by either party hereto of a breach or violation of any term or provision of this Agreement shall not operate nor be construed as a waiver of any subsequent breach or violation.

15. Damages. Nothing contained herein shall be construed to prevent Employer or Employee from seeking and recovering from the other damages sustained by either or both of them as a result of a breach of any term or provision of this Agreement.

16. No Third Party Beneficiary. Except as provided in Section 8.9, nothing expressed or implied in this Agreement is intended, or shall be construed, to confer upon or give any person (other than the parties hereto and, in the case of Employee, Employee's heirs, personal representative(s) and/or legal representative) any rights or remedies under or by reason of this Agreement. No agreements or representations, oral or otherwise, express or implied, have been made by either party with respect to the subject matter of this Agreement which agreements or representations are not set forth expressly in this Agreement, and this Agreement supersedes any other employment agreement between Employer and Employee.

17. Assignment. This Agreement may be assigned by Employer upon notice to Employee.

IN WITNESS WHEREOF, the undersigned have executed this Agreement this 1st day of August, 2019, effective as of the Effective Date.

EMPLOYER:

MEDNAX SERVICES, INC.

By: */s/ Stephen D. Farber*
Stephen D. Farber
Executive Vice President and
Chief Financial Officer

EMPLOYEE:

By: */s/ John C. Pepia*
John C. Pepia

EXHIBIT A

BUSINESS OF EMPLOYER

As of the date hereof, Employer, directly or through its affiliates, provides professional medical services and all aspects of practice management services in medical practice areas that include, but are not limited to, the following (collectively referred to herein as "Employer's Business"):

(1) Neonatology, including hospital well baby care;
(2) Maternal-Fetal Medicine, including general obstetrics services;
(3) Pediatric Cardiology;
(4) Pediatric Intensive Care, including Pediatric Hospitalist Care;
(5) Newborn hearing screening services;
(6) Pediatric Surgery;
(7) Pediatric Emergency Medicine;
(8) Anesthesiology, critical care medicine and pain management; and
(9) Radiology and Teleradiology.

References to Employer's Business in this Agreement shall include such other medical service lines, practice management services and other businesses in which Employer is engaged during the Employment Period; *provided*, that to be considered a part of Employer's Business, Employer must have engaged in such other service line, practice management service or other business at least six (6) months prior to the termination date of this Agreement. For purposes of this Exhibit A, businesses of Employer shall include the businesses conducted by Employer's subsidiaries, entities under common control and affiliates as defined under Rule 144 of the Securities Act of 1933, as amended. Such affiliates shall include the professional corporations and associations whose operating results are consolidated with Employer for financial reporting purposes.

Notwithstanding the foregoing, Employer acknowledges and agrees to the following exceptions and clarifications regarding the scope of Employer's Business.

A. *Hospital Services.* Employer and Employee acknowledge that, as of the date hereof, Employer does not currently operate hospitals, hospital systems or universities. Nevertheless, the businesses of hospitals, hospital systems and universities would be the same as Employer's Business where such hospitals, hospital systems or universities provide or contract with others to provide some or all of the medical services included in Employer's Business. Therefore, the parties desire to clarify their intent with respect to the limitations on Employee's ability to work for or contract with others to provide services for a hospital, hospital system or university during the Employment Period and during the Restricted Period. Section 8.1 shall not be deemed to restrict Employee's ability to work for a hospital, hospital system or university if the hospital, hospital system or university does not provide any of the medical services included in Employer's Business. Furthermore, even if a hospital, hospital system or university provides medical services that are included in Employer's

Business, Employee may work for such hospital, hospital system or university if Employee has no direct supervisory responsibility for or involvement in the hospital's, hospital system's or university's medical services that are Employer's Business. Finally, Employer agrees that Employee may hold direct supervisory responsibility for or be involved in the medical services of a hospital, hospital system or university that are included in Employer's Business so long as such hospital, hospital system or university is located at least ten (10) miles from a medical practice owned or operated by Employer or its affiliate. Subject to paragraph B below, the provisions of this paragraph shall not apply to the extent that, after the date hereof, Employer enters into the business of operating a hospital or hospital system.

B. *De Minimus Exception.* Employer agrees that a medical service line (other than those listed in items 1 through 9 above), practice management service or other business in which Employer is engaged shall not be considered to be a part of Employer's Business if such medical service line, practice management service or other business constitutes less than three percent (3%) of Employer's annual revenues.

C. *Certain Ownership Interests.* It shall not be deemed to be a violation of Section 8.1 for Employee to: (i) own, directly or indirectly, one percent (1%) or less of a publicly-traded entity that has a market capitalization of $1 billion or more; (ii) own, directly or indirectly, five percent (5%) or less of a publicly-traded entity that has a market capitalization of less than $1 billion; or (iii) own, directly or indirectly, less than ten percent (10%) of a privately-held business or company, if Employee is at all times a passive investor with no board representation, management authority or other special rights to control operations of such business or company.

EXHIBIT B

COMPENSATION

Performance Bonus: Up to 50% of Employee's Base Salary.

Equity Compensation: Employee shall be eligible for equity compensation as approved by the Compensation Committee of the Board of Directors of MEDNAX, Inc.

EXHIBIT C

FORM OF RELEASE

GENERAL RELEASE OF CLAIMS

1. _____ ("Employee"), for himself and his family, heirs, executors, administrators, legal representatives and their respective successors and assigns, in exchange for the consideration received pursuant to Section 5.[ ] of the Employment Agreement to which this release is attached as Exhibit C (the "Employment Agreement"), does hereby release and forever discharge _____ ("Employer"), its subsidiaries, affiliated companies, successors and assigns, and its current or former directors, officers, employees, shareholders or agents in such capacities (collectively with Employer, the "Released Parties") from any and all actions, causes of action, suits, controversies, claims and demands whatsoever, for or by reason of any matter, cause or thing whatsoever, whether known or unknown including, but not limited to, all claims under any applicable laws arising under or in connection with Employee's employment or termination thereof, whether for discrimination, harassment, retaliation, tort, breach of express or implied employment contract, wrongful discharge, intentional infliction of emotional distress, or defamation or injuries incurred on the job or incurred as a result of loss of employment. Employee acknowledges that Employer encouraged him to consult with an attorney of his choosing, and through this General Release of Claims encourages Employee to consult with his attorney with respect to possible claims under the Age Discrimination in Employment Act ("ADEA") and that he understands that the ADEA is a Federal statute that, among other things, prohibits discrimination on the basis of age in employment and employee benefits and benefit plans. Without limiting the generality of the release provided above, Employee expressly waives any and all claims under ADEA that he may have as of the date hereof. Employee further understands that by signing this General Release of Claims he is in fact waiving, releasing and forever giving up any claim under the ADEA as well as all other laws within the scope of this paragraph 1 that may have existed on or prior to the date hereof. Notwithstanding anything in this paragraph 1 to the contrary, this General Release of Claims shall not apply to (i) any actions to enforce rights to receive any payments or benefits which may be due Employee pursuant to Section 5.[ ] of the Employment Agreement, or under any of Employer's employee benefit plans, (ii) any rights or claims that may arise as a result of events occurring after the date this General Release of Claims is executed, (iii) any indemnification rights Employee may have as a former officer or director of Employer or its subsidiaries or affiliated companies, (iv) any claims for benefits under any directors' and officers' liability policy maintained by Employer or its subsidiaries or affiliated companies in accordance with the terms of such policy, and (v) any rights as a holder of equity securities of Employer.

2. Employee represents that he has not filed against the Released Parties any complaints, charges, or lawsuits arising out of his employment, or any other matter arising on or prior to the date of this General Release of Claims, and covenants and agrees that he will never individually or with any person file, or commence the filing of, any charges, lawsuits, complaints or proceedings with any governmental agency, or against the Released Parties with respect to any of the matters released by Employee pursuant to paragraph 1 hereof (a "Proceeding").

3. Notwithstanding anything in this Agreement to the contrary, nothing in this Agreement or any other agreement between Employer and Employee shall prevent Employee from filing a charge, sharing information and communicating in good faith, without prior notice to the Company, with any federal government agency having jurisdiction over the Company or its operations, and cooperating in any investigation by any such federal government agency; However, to the maximum extent permitted by law, Employee agrees that if such an administrative claim is made, Employee shall not be entitled to recover any individual monetary relief or other individual remedies.

4. Employee hereby acknowledges that Employer has informed him that he has up to twenty-one (21) days to sign this General Release of Claims and he may knowingly and voluntarily waive that twenty-one (21) day period by signing this General Release of Claims earlier. Employee also understands that he shall have seven (7) days following the date on which he signs this General Release of Claims within which to revoke it by providing a written notice of his revocation to Employer.

5. Employee acknowledges that this General Release of Claims will be governed by and construed and enforced in accordance with the internal laws of the State of Florida applicable to contracts made and to be performed entirely within such State.

6. Employee acknowledges that he has read this General Release of Claims, that he has been advised that he should consult with an attorney before he executes this general release of claims, and that he understands all of its terms and executes it voluntarily and with full knowledge of its significance and the consequences thereof.

7. This General Release of Claims shall take effect on the eighth day following Employee's execution of this General Release of Claims unless Employee's written revocation is delivered to Employer within seven (7) days after such execution.

_____

_____, 20__

Exhibit 21.1

Subsidiaries

Name of Subsidiary	State of Incorporation	Line of Business	Number of Omitted Subsidiaries Operating in the United States	Number of Omitted Subsidiaries Operating in Foreign Countries
Mednax Services, Inc.	Florida	Physician Services	13	0
Pediatrix Medical Group, Inc.	Florida	Physician Services	10	0
American Anesthesiology, Inc.	Florida	Physician Services	9	0

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 333-181667, 333-153397, 333-151272, 333-101225, 333-208698, and 333-231826) of MEDNAX, Inc. of our report dated February 20, 2020 relating to the financial statements and financial statement schedule and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Miami, Florida
February 20, 2020

Exhibit 31.1

CERTIFICATIONS

I, Roger J. Medel, M.D., certify that:

1. I have reviewed this annual report on Form 10-K of MEDNAX, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2020

By: /s/ Roger J. Medel, M.D.
Roger J. Medel, M.D.
Chief Executive Officer
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATIONS

I, Stephen D. Farber, certify that:

1. I have reviewed this annual report on Form 10-K of MEDNAX, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, 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;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 20, 2020

By: /s/ Stephen D. Farber
Stephen D. Farber
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

Exhibit 32

Certification Pursuant to 18 U.S.C Section 1350
(Adopted by Section 906 of the Sarbanes-Oxley Act of 2002)

In connection with the Annual Report of MEDNAX, Inc. on Form 10-K for the year ended December 31, 2019 (the "Report"), each of the undersigned hereby certifies, pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that (i) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934 and (ii) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of MEDNAX, Inc.

A signed original of this written statement required by Section 906 has been provided to MEDNAX, Inc. and will be retained by MEDNAX, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

February 20, 2020

By: /s/ Roger J. Medel, M.D.
Roger J. Medel, M.D.
Chief Executive Officer
(Principal Executive Officer)

By: /s/ Stephen D. Farber
Stephen D. Farber
Executive Vice President and
Chief Financial Officer
(Principal Financial Officer)