Risk Factors Comparison 2023-03-01 to 2022-02-28 Form: 10-K

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Investing in our common stock involves a high degree of risk. You should carefully consider the risks and uncertainties described below, together with all of the other information in this Annual Report on Form 10- K, including the section titled " Management' s Discussion and Analysis of Financial Condition and Results of Operations " in Part II, Item 7, and our consolidated financial statements and related notes, before making a decision to invest in our common stock. The risks and uncertainties described below may not be the only ones we face. If any of the risks actually occur, our business, financial condition, operating results, and prospects could be materially and adversely affected. In that event, the market price of our common stock could decline, and you could lose part or all of your investment. Summary of Risk Factors Our business is subject to numerous risks and uncertainties, discussed in more detail in the following section. These ~~risks~~ include, among others, the following key risks: • The ongoing coronavirus (COVID- 19) pandemic may negatively impact certain aspects of our business, financial condition, results of operations, and growth. • We may need to raise additional capital to grow, which might not be available. • Potential changes in laws, accounting principles, and regulations related to VIEs could impact our consolidation of total revenues derived from our affiliated physician groups. • The arrangements we have with our VIEs are not as secure as direct ownership of such entities. • We currently derive a substantial portion of our revenues in California and are vulnerable to changes in that state. • Our business strategy involves acquisitions and strategic partnerships, which can be costly, risky, and complex. • We may encounter difficulties in managing our growth, and the nature of our business and rapid changes in the healthcare industry make it difficult to reliably predict future growth and operating results. • We could experience significant losses under capitation contracts if our expenses exceed revenues. • If our agreements with affiliated physician groups are deemed invalid or are terminated under applicable law, our results of operations and financial condition will be materially impaired. • Our revenues and operations are dependent on a limited number of key payors. • We may be impacted by a shift in payor mix, including eligibility changes to government and private insurance programs. • Many of our agreements with hospitals and medical groups have limited durations, may be terminated without cause by them, and prohibit us from acquiring physicians or patients from or competing with them. • Changes to federal, state, and local healthcare law, including the ACA and / or the adoption of a primarily publicly funded healthcare system, may negatively impact our business. • The success of our emphasis on the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model is not guaranteed, due to political risks, uncertainties of **GPDC /** ~~NGACO~~ -- **ACO REACH** administration **, program economics** , and the requirement of the Company to maintain significant capital reserves. • Laws regulating the corporate practice of medicine could restrict the manner in which we are permitted to conduct our business and the failure to comply with such laws could subject us to penalties and restructuring. • The healthcare industry is intensely regulated at the federal, state, and local levels, and government authorities may determine that we fail to comply with applicable laws or regulations and take actions against us. • Controls designed to reduce inpatient services and associated costs may reduce our revenues. • If our affiliated physician groups are not able to satisfy California **regulations related to** financial solvency ~~regulations~~ **and operational performance** , they could become subject to sanctions and their ability to do business in California could be limited or terminated. • Our current principal stockholders, executive officers, and directors have significant influence over our operations and strategic direction **,** and they could cause us to take actions with which other stockholders might not agree and could delay, deter, or prevent a change of control or a business combination with respect to us. Risks Relating to Our General Business and Operations. In 2019, the Company, AP- AMH, and APC consummated a series of interrelated transactions that may expose the Company and its subsidiaries and VIEs to additional risks, including the inability to repay a significant loan made in connection with such transactions. On September 11, 2019, the Company, AP- AMH **,** and APC, concurrently consummated a series of interrelated transactions (collectively, the " APC Transactions "). As disclosed elsewhere in this Annual Report on Form 10- K and in the Company' s other reports on file with the SEC, the APC Transactions included the following agreements and transactions: (i) the Company made a $ 545. 0 million ten- year secured loan to AP- AMH; (ii) AP- AMH used all of the proceeds of that loan to purchase 1, 000, 000 shares of Series A Preferred Stock of APC; (iii) the Company obtained the funds to make the AP- AMH Loan (x) by entering into a credit agreement with Truist Bank, in its capacity as administrative agent for various lenders, and the lenders from time to time party thereto, for a $ 290. 0 million senior secured credit facility (the " Credit Agreement " and the credit facility thereunder, the " Credit Facility "), and then immediately drawing down $ 250. 0 million in cash, and (y) by selling $ 300. 0 million shares of the Company' s common stock to APC, the purchase price of which was offset against $ 300. 0 million of AP- AMH' s purchase price for its APC Preferred Stock. NMM guaranteed the obligations of the Company under the Credit Facility, and both the Company and NMM have granted the lenders a security interest in all of their assets, including, without limitation, in all stock and other equity issued by their subsidiaries (including the shares of NMM) and all rights with respect to the AP- AMH Loan. The Credit Agreement was amended and restated on June 16, 2021 by an amended and restated credit agreement (the " Amended Credit Agreement " and the credit facility thereunder, the " Amended Credit Facility ") among the Company, Truist Bank, in its capacity as administrative agent for the lenders, issuing bank, swingline lender and a lender, Truist Securities, Inc., JPMorgan Chase Bank, N. A., MUFG Union Bank, N. A., Preferred Bank, Royal Bank of Canada, and Fifth Third Bank, National Association, in their capacities as joint lead arrangers and / or lenders, and the lenders from time to time party thereto. The APC Transactions may expose the Company, its subsidiaries and its VIEs to additional risks, including without limitation, the following: AP- AMH may never be able to repay the AP- AMH Loan; even if AP- AMH does not, or cannot repay the loan, the Company will be obligated to pay principal and interest on the Amended Credit Facility; in connection with the Credit

Facility, the lenders were granted a first priority perfected security interest over all of the assets of the Company and its subsidiaries, and such lenders have the right to foreclose on those assets if the Company defaults on its obligations under the Amended Credit Facility; a disconnect could arise between APC achieving net income, declaring and paying dividends to AP- AMH, and AP- AMH making its required payments to the Company, which disconnect could materially impact the Company' s financial results and its ability to make its required payments under the Amended Credit Facility; APC may be prohibited from paying, or may be unable to pay the dividends on its Series A Preferred Stock, including under the California Corporations Code; regulators could determine that the current, post- APC Transactions consolidated structure amounts to the Company violating California' s corporate practice of medicine doctrine; and the Company may be deemed an investment company, which could impose burdensome compliance requirements on the Company and restrict its future activities. The " Risk Factors " section of the definitive proxy statement of the Company' s board of directors that the Company filed with the SEC on July 31, 2019 (the " 2019 Proxy Statement ") described these and certain other risks related to the APC Transactions, which are hereby incorporated herein by reference. If our internal controls over financial reporting are not considered effective, our business and stock price could be adversely affected. Section 404 of the Sarbanes- Oxley Act of 2002 requires us to evaluate the effectiveness of our internal controls over financial reporting as of the end of each fiscal year, and to include a management report assessing the effectiveness of our internal controls over financial reporting in our Annual Report on Form 10- K for that fiscal year. Section 404 also requires our independent registered public accounting firm to attest to, and report on, management' s assessment of our internal controls over financial reporting. Our management, including our principal executive officer and principal financial officer, does not expect that our internal controls over financial reporting will prevent all errors and all fraud. A control system, no matter how well- designed and operated, can provide only reasonable, not absolute, assurance that the control system' s objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud involving a company have been, or will be, detected. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and we cannot assure you that any design will succeed in achieving its stated goals under all potential future conditions. Over time, controls may become ineffective because of changes in conditions or deterioration in the degree of compliance with policies or procedures. Because of the inherent limitations in a cost- effective control system, misstatements due to error or fraud may occur and not be detected. We cannot assure you that we or our independent registered public accounting firm will not identify a material weakness in our internal controls in the future. A material weakness in our internal controls over financial reporting would require management and our independent registered public accounting firm to consider our internal controls as ineffective. If our internal controls over financial reporting are not considered effective, we may experience a loss of public confidence, which could have an adverse effect on our business and on the market price of our common stock. We may in the future require additional capital to grow our business and may have to raise additional funds by selling equity, issuing debt, borrowing, refinancing our existing debt, or selling assets or subsidiaries. These alternatives may not be available on acceptable terms to us or in amounts sufficient to meet our needs. The failure to obtain any required future financing may require us to reduce or curtail certain existing operations. Our net operating loss carryforwards and certain other tax attributes will be subject to limitations. If a corporation undergoes an " ownership change " within the meaning of Section 382 of the Internal Revenue Code of 1986, as amended, its net operating loss carryforwards and certain other tax attributes arising from before the ownership change are subject to limitations on use after the ownership change. In general, an ownership change occurs if there is a cumulative change in the corporation' s equity ownership by certain stockholders that exceeds 50 percentage points over a rolling three- year period. Similar rules may apply under state tax laws. Additional ownership changes in the future could result in additional limitations on our net operating loss carryforwards. Consequently, we may not be able to utilize a material portion of our net operating loss carryforwards and other tax attributes, to offset our tax liabilities, which could have a material adverse effect on our cash flows and results of operations. Uncertain or adverse economic conditions could adversely impact us. A downturn in economic conditions could have a material adverse effect on our results of operations, financial condition, business prospects, and stock price. Historically, government budget limitations have resulted in reduced spending. Given that Medicaid is a significant component of state budgets, an economic downturn would put continued cost containment pressures on Medicaid outlays for healthcare services in California. The existing federal deficit and continued deficit spending by the federal government can lead to reduced government expenditures, including for government- funded programs in which we participate such as Medicare. An economic downturn and sustained unemployment may also impact the number of enrollees in managed care programs and the profitability of managed care companies, which could result in reduced reimbursement rates. Although we attempt to stay informed, any sustained failure to identify and respond to these trends could have a material adverse effect on our results of operations, financial condition, business, and prospects. The ongoing COVID- 19 pandemic may impact certain aspects of our business, financial condition, results of operation, and growth. The global spread of the COVID- 19 pandemic and measures introduced by local, state, and federal governments to contain the virus and mitigate its public health effects have created significant impact to the global economy. We expect the evolving COVID- 19 pandemic to continue to impact certain aspects of our business, results of operations, and financial condition and liquidity, but given the uncertainty around the duration and severity of the pandemic, we cannot accurately predict at this time the future potential impact on our business, results of operations, financial condition, and liquidity. Throughout the pandemic, COVID- 19 impacted certain aspects of our business as community self- isolation practices and shelter- in- place requirements reduced our inpatient visits. Continued shelter- in- place, quarantine, executive order, or related measures to combat the spread of COVID- 19, as well as the perceived need by individuals to continue such practices to avoid infection, among other factors, have impacted and are expected to continue to impact certain aspects of our results of operations, business, and financial condition. These measures and practices resulted in temporary closures of outpatient clinics, and may result in delays in entry into new markets and expansion

in existing markets. Governmental authorities in California began reopening and lifting or relaxing shelter- in- place and quarantine measures only to revert back to such restrictions in the face of increases in new COVID- 19 cases. In addition, due to the shelter- in- place orders across the country, we have implemented work- from- home policies for many employees, which may impact productivity and disrupt our business operations. Healthcare organizations around the world, including our medical offices, have faced, and will continue to face, substantial challenges in treating patients with COVID- 19, such as the diversion of hospital staff and resources from ordinary functions to the treatment of COVID- 19, supply, resource, and capital shortages, and overburdening of staff and resource capacity. In the United States, governmental authorities have also recommended, and in certain cases required, that elective, specialty, and other procedures and appointments, including certain primary care services, be suspended or canceled to avoid non- essential patient exposure to medical environments and potential infection with COVID- 19, and to focus limited resources and personnel capacity toward the treatment of COVID- 19. Some of these measures and challenges will likely continue for the duration of the pandemic, which is uncertain, and will harm the results of operations, liquidity, and financial condition of these healthcare organizations, including certain of our health network partners. We cannot accurately predict at this time the ultimate severity or duration that the foregoing measures and challenges may have on these healthcare organizations, including us and our health network partners. The COVID- 19 pandemic and similar crises could also diminish the public' s trust in healthcare facilities, especially facilities that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases. As certain of our medical offices treat patients with COVID- 19 or other infectious disease, patients may be discouraged from visiting our offices, including cancelling appointments. Our affiliated physician groups also face an increased risk of infection with COVID- 19, which may result in staffing shortages at our offices or increased workers' compensation claims. While the potential economic impact brought by and the duration of COVID- 19 may be difficult to assess or predict, the widespread pandemic has resulted in, and may continue to result in, significant disruption of global financial markets, potentially reducing our ability to access capital, which could in the future negatively affect our liquidity. In addition, a recession or market correction resulting from the spread of COVID- 19 could materially affect our business and the value of our common stock. The global outbreak of COVID- 19 continues to rapidly evolve. The ultimate impact of the COVID- 19 pandemic or a similar health epidemic is highly uncertain and subject to change. We cannot at this time precisely predict what effects the COVID- 19 outbreak will have on certain aspects of our business, results of operations, and financial condition, including due to uncertainties relating to the severity of the disease, the duration of the pandemic, and the governmental responses to the pandemic. We may be required to take write- downs or write- offs, restructuring, and impairment or other charges that could have a significant negative effect on our financial condition, results of operations, and stock price. There can be no assurances that all material issues that may be present in our operations, including from prior to the 2017 Merger, have been uncovered, or that factors outside of our control will not later arise. As a result, we may be forced to write- down or write- off assets, restructure operations, or incur impairment or other charges that could result in losses. Unexpected risks may arise and previously known risks may materialize in a manner not consistent with each company' s preliminary risk analysis. Even though these charges may not have an immediate impact on our liquidity, the fact that we report charges of this nature could contribute to negative market perceptions about us or our securities and may make our future financing difficult to obtain on favorable terms or at all. From time to time, our intangible assets are subject to impairment testing. Under current accounting standards, our goodwill, including acquired goodwill, is tested for impairment on an annual basis and may be subject to impairment losses as circumstances change (e. g., after an acquisition). If we record an impairment loss, it could have a material adverse effect on our results of operations for the year in which the impairment is recorded. A prolonged disruption of or any actual or perceived difficulties in the capital and credit markets may adversely affect our future access to capital, our cost of capital, and our ability to continue operations. Our operations and performance depend primarily on California and U. S. economic conditions and their impact on purchases of, or capitated rates for, our healthcare services, and our business is significantly exposed to risks associated with government spending and private payor reimbursement rates. As a result of inflation and the current impact on the market and the COVID- 19- related 2020 recession, general economic conditions deteriorated significantly. Although the markets have improved significantly, the overall economic recovery since that time has been uneven. Declines in consumer and business confidence, as well as private and government spending, together with significant reductions in the availability and increases in the cost of credit and volatility in the capital and credit markets, have adversely affected the business and economic environment in which we operate and our profitability. Market disruption, increases in interest rates, and / or sluggish economic growth in any future period could adversely affect our patients' spending habits, private payors' access to capital, and governmental budgetary processes, which, in turn, could result in reduced revenue for us. The continuation or recurrence of any of these conditions may adversely affect our cash flows, results of operations, and financial condition. As economic uncertainty may continue in future periods, our patients, private payors, and government payors may alter their purchasing activities of healthcare services. Our patients may scale back healthcare spending, and private and government payors may reduce reimbursement rates, which may also cause delay or cancellation of consumer spending for discretionary and non- reimbursed healthcare. This uncertainty may also affect our ability to prepare accurate financial forecasts or meet specific forecasted results, and we may be unable to adequately respond to or forecast further changes in demand for healthcare services. Volatility and disruption of capital and credit markets may adversely affect our access to capital and increase our cost of capital. Should current economic and market conditions deteriorate, our ability to finance ongoing operations and our expansion may be adversely affected, we may be unable to raise necessary funds, our cost of debt or equity capital may increase significantly, and future access to capital markets may be adversely affected. If there is a change in accounting principles or the interpretation thereof affecting consolidation of VIEs, it could impact our consolidation of total revenues derived from our affiliated physician groups. Our financial statements are consolidated and include the accounts of our majority- owned subsidiaries and various non- owned affiliated physician groups that are VIEs, which consolidation is effectuated in accordance with applicable accounting rules promulgated by the Financial Accounting Standards Board (" FASB

”). Such accounting rules require that, under some circumstances, the VIE consolidation model be applied when a reporting enterprise holds a variable interest (e. g., equity interests, debt obligations, certain management, and service contracts) in a legal entity. Under this model, an enterprise must assess the entity in which it holds a variable interest to determine whether it meets the criteria to be consolidated as a VIE. If the entity is a VIE, the consolidation framework next identifies the party, if one exists, that possesses a controlling financial interest in the VIE, and then requires that party to consolidate as the primary beneficiary. An enterprise' s determination of whether it has a controlling financial interest in a VIE requires that a qualitative determination be made, and is not solely based on voting rights. If an enterprise determines the entity in which it holds a variable interest is not subject to the VIE consolidation model, the enterprise should apply the traditional voting control model which focuses on voting rights. In our case, the VIE consolidation model applies to our controlled, but not owned, physician- affiliated entities. Our determination regarding the consolidation of our affiliates, however, could be challenged, which could have a material adverse effect on our operations. In addition, in the event of a change in accounting rules or FASB' s interpretations thereof, or if there were an adverse determination by a regulatory agency or a court or a change in state or federal law relating to the ability to maintain present agreements or arrangements with our affiliated physician groups, we may not be permitted to continue to consolidate the revenues of our VIEs. Breaches or compromises of our information security systems or our information technology systems or infrastructure could result in exposure of private information, disruption of our business, and damage to our reputation, which could harm our business, results of operation, and financial condition. As a routine part of our business, we utilize information security and information technology systems and websites that allow for the secure storage and transmission of proprietary or private information regarding our patients, employees, vendors, and others, including individually identifiable health information. A security breach of our network, hosted service providers, or vendor systems, may expose us to a risk of loss or misuse of this information, litigation, and potential liability. Hackers and data thieves are increasingly sophisticated and operate large- scale and complex automated attacks, including on companies within the healthcare industry. Although we believe that we take appropriate measures to safeguard sensitive information within our possession, we may not have the resources or technical sophistication to anticipate or prevent rapidly evolving types of cyber- attacks targeted at us, our patients, or others who have entrusted us with information. Actual or anticipated attacks may cause us to incur costs, including costs to deploy additional personnel and protection technologies, train employees, and engage third- party experts and consultants. We invest in industry- standard security technology to protect personal information. Advances in computer capabilities, new technological discoveries, or other developments may result in the technology used by us to protect personal information or other data being breached or compromised. In addition, data and security breaches can also occur as a result of non- technical failures. To our knowledge, we have not experienced any material breach of our cybersecurity systems. If we or our third- party service providers systems fail to operate effectively or are damaged, destroyed, or shut down, or there are problems with transitioning to upgraded or replacement systems, or there are security breaches in these systems, any of the aforementioned could occur as a result of natural disasters, software or equipment failures, telecommunications failures, loss or theft of equipment, acts of terrorism, circumvention of security systems, or other cyberattacks, we could experience delays or decreases in service, and reduced efficiency of our operations. Additionally, any of these events could lead to violations of privacy laws, loss of customers, or loss, misappropriation or corruption of confidential information, trade secrets or data, which could expose us to potential litigation, regulatory actions, sanctions, or other statutory penalties, any or all of which could adversely affect our business, and cause it to incur significant losses and remediation costs. We rely on complex software systems and hosted applications to operate our business, and our business may be disrupted if we are unable to successfully or efficiently update these systems or convert to new systems. We are increasingly dependent on technology systems to operate our business, reduce costs, and enhance customer service. These systems include complex software systems and hosted applications that are provided by third parties. Software systems need to be updated on a regular basis with patches, bug fixes, and other modifications. Hosted applications are subject to service availability and reliability of hosting environments. We also migrate from legacy systems to new systems from time to time. Maintaining existing software systems, implementing upgrades, and converting to new systems are costly and require personnel and other resources. The implementation of these systems upgrades, and conversions is a complex and time- consuming project involving substantial expenditures for implementation activities, consultants, system hardware and software, often requires transforming our current business and processes to conform to new systems, and therefore, may take longer, be more disruptive, and cost more than forecast and may not be successful. If the implementation is delayed or otherwise is not successful, it may hinder our business operations and negatively affect our financial condition and results of operations. There are many factors that may materially and adversely affect the schedule, cost, and execution of the implementation process, including, without limitation, problems in the design and testing of new systems; system delays and malfunctions; the deviation by suppliers and contractors from the required performance under their contracts with us; the diversion of management attention from our daily operations to the implementation project; reworks due to unanticipated changes in business processes; difficulty in training employees in the operation of new systems and maintaining internal control while converting from legacy systems to new systems; and integration with our existing systems. Some of such factors may not be reasonably anticipated or may be beyond our control. We may be unable to renew our leases on favorable terms or at all as our leases expire, which could adversely affect our business, financial condition, and results of operations. We operate several leased premises. There is no assurance that we will be able to continue to occupy such premises in the future. For example, we currently rent our corporate headquarters on a month- to- month basis. We could thus spend substantial resources to meet the current landlords' demands or look for other premises. We may be unable to timely renew such leases or renew them on favorable terms, if at all. If any current lease is terminated or not renewed, we may be required to relocate our operations at substantial costs or incur increased rental expenses, which could adversely affect our business, financial condition, and results of operations. We primarily operate in California. Any material changes with respect to consumer preferences, taxation, reimbursements, financial requirements, or other aspects of the healthcare delivery in California or the state' s economic

conditions could have an adverse effect on our business, results of operations, and financial condition. Our success depends, to a significant degree, upon our ability to adapt to the ever- changing healthcare industry and continued development of additional services. Although we expect to provide a broad and competitive range of services, there can be no assurance of acceptance of current services by the marketplace. Our ability to procure new contracts may be dependent upon the continuing results achieved at the current facilities, upon pricing and operational considerations, and the potential need for continuing improvement to our existing services. Moreover, the markets for our new services may not develop as expected nor can there be any assurance that we will be successful in marketing any such services. Risks Relating to Our Growth Strategy and Business Model. Our growth strategy may not prove viable and we may not realize expected results. Our business strategy is to grow rapidly by building a network of medical groups and integrated physician networks and is significantly dependent on locating and acquiring, partnering or contracting with medical practices to provide healthcare delivery services. We seek growth opportunities both organically and through acquisitions of or alliances with other medical service providers. As part of our growth strategy, we regularly review potential strategic opportunities. Identifying and establishing suitable strategic relationships are time- consuming and costly. There can be no assurance that we will be successful. We cannot guarantee that we will be successful in pursuing such strategic opportunities or assure the consequences of any strategic transactions. If we fail to evaluate and execute strategic transactions properly, we may not achieve anticipated benefits and may incur increased costs. Our strategic transactions involve a number of risks and uncertainties, including ~~that~~ : • We may not be able to successfully identify suitable strategic opportunities, complete desired strategic transactions, or realize their expected benefits. In addition, we compete for strategic transactions with other potential players, some of whom may have greater resources than we do. This competition may intensify due to the ongoing consolidation in the healthcare industry, which may increase our costs to pursue such opportunities. • We may not be able to establish suitable strategic relationships and may fail to integrate them into our business. We cannot be certain of the extent of any unknown, undisclosed or contingent liabilities of any acquired business, including liabilities for failure to comply with applicable laws. We may incur material liabilities for past activities from strategic relationships. Also, depending on the location of the strategic transactions, we may be required to comply with laws and regulations that may differ from those of California, the state in which we currently operate. • We may form strategic relationships with medical practices that operate with lower profit margins as compared with ours or which have a different payor mix than our other practice groups, which would reduce our overall profit margin. Depending upon the nature of the local market, we may not be able to implement our business model in every local market that we enter, which could negatively impact our revenues and financial condition. • We may incur substantial costs to complete strategic transactions, integrate strategic relationships into our business, or expand our operations, including hiring more employees and engaging other personnel, to provide services to additional patients that we are responsible for managing pursuant to the new relationships. If such relationships terminate or diminish before we can realize their expected benefits, any costs that we have already incurred may not be recovered. • If we finance strategic transactions by issuing our equity securities or securities convertible thereto, our existing stockholders could be diluted. If we finance strategic transactions with debt, it could result in higher leverage and interest costs for us. If we are not successful in our efforts to identify and execute strategic transactions on beneficial terms, our ability to implement our business plan and achieve our targets could be adversely affected. The process of integrating strategic relationships also involves significant risks, including: • difficulties in coping with demands on management related to the increased size of our business; • difficulties in not diverting management' s attention from our daily operations; • difficulties in assimilating different corporate cultures and business practices; • difficulties in converting other entities' books and records and conforming their practices to ours; • difficulties in integrating operating, accounting, and information technology systems of other entities with ours and in maintaining uniform procedures, policies, and standards such as internal accounting controls; • difficulties in retaining employees who may be vital to the integration of the acquired entities; and • difficulties in maintaining contracts and relationships with payors of other entities. We may be required to make certain contingent payments in connection with strategic transactions from time to time. The fair value of such payments is reevaluated periodically based on changes in our estimate of future operating results and changes in market discount rates. Any changes in our estimated fair value are recognized in our results of operations. The actual payments, however, may exceed our estimated fair value. Increases in actual contingent payments compared to the amounts recognized may have an adverse effect on our financial condition. There can be no assurance that we will be able to effectively integrate strategic relationships into our business, which may negatively impact our business model, revenues, results of operations, and financial condition. In addition, strategic transactions are time- intensive, requiring significant commitment of our management' s focus. If our management spends too much time on assessing potential opportunities, completing strategic transactions, and integrating strategic relationships, our management may not have sufficient time to focus on our existing operations. This diversion of attention could have material and adverse consequences on our operations and profitability. Obligations in our credit or loan documents could restrict our operations, particularly our ability to respond to changes in our business or to take specified actions. An event of default could harm our business, and creditors having security interests over our assets would be able to foreclose on our assets. The terms of our credit agreements and other indebtedness from time to time require us to comply with a number of financial and other obligations, which may include maintaining debt service coverage and leverage ratios and maintaining insurance coverage, that impose significant operating and financial restrictions on us, including restrictions on our ability to take actions that may be in our interests. These obligations may limit our flexibility in our operations, and breaches of these obligations could result in defaults under the agreements or instruments governing the indebtedness, even if we had satisfied our payment obligations. Moreover, if we defaulted on these obligations, creditors having security interests over our assets could exercise various remedies, including foreclosing on and selling our assets. Unless waived by creditors, for which no assurance can be given, defaulting on these obligations could result in a material adverse effect on our financial condition and ability to continue our operations. We may encounter difficulties in managing our growth, and the nature of our business and rapid changes in the healthcare industry makes it difficult to reliably

predict future growth and operating results. We may not be able to successfully grow and expand. Successful implementation of our business plan will require management of growth, including potentially rapid and substantial growth, which could result in an increase in the level of responsibility for management personnel and strain on our human and capital resources. To manage growth effectively, we will be required, among other things, to continue to implement and improve our operating and financial systems, procedures, and controls and to expand, train, and manage our employee base. If we are unable to implement and scale improvements to our existing systems and controls in an efficient and timely manner or if we encounter deficiencies, we will not be able to successfully execute our business plans. Failure to attract and retain sufficient numbers of qualified personnel could also impede our growth. If we are unable to manage our growth effectively, it will have a material adverse effect on its business, results of operations, and financial condition. The evolving nature of our business and rapid changes in the healthcare industry makes it difficult to anticipate the nature and amount of medical reimbursements, third- party private payments, and participation in certain government programs and thus to reliably predict our future growth and operating results. Under a capitation contract, a health plan typically prospectively pays an IPA periodic capitation payments based on a percentage of the amount received by the health plan. Capitation payments, in the aggregate, represent a prospective budget from which an IPA manages care- related expenses on behalf of the population enrolled with that IPA. If our affiliated IPAs are able to manage care- related expenses under the capitated levels, we realize operating profits from capitation contracts. However, if care- related expenses exceed projected levels, our affiliated IPAs may realize substantial operating deficits, which are not capped and could lead to substantial losses. Additionally, factors beyond our control, such as natural disasters, the potential effects of climate change, major epidemics, pandemics, or newly emergent viruses (such as COVID- 19), could reduce our ability to effectively manage the costs of providing healthcare. There are various state laws, including laws in California, regulating the corporate practice of medicine, which prohibit us from directly owning medical professional entities. These prohibitions are intended to prevent unlicensed persons from interfering with or inappropriately influencing a physician' s professional judgment. These and other laws may also prevent fee- splitting, which is the sharing of professional service income with non- professional or business interests. The interpretation and enforcement of these laws vary significantly from state to state. We currently derive revenues from MSAs or similar arrangements with our affiliated IPAs, whereby we provide management and administrative services to them. If these agreements and arrangements were held to be invalid under laws prohibiting the corporate practice of medicine and other laws or if there are new laws that prohibit such agreements or arrangements, a significant portion of our revenues will be lost, resulting in a material adverse effect on our results of operations and financial condition. Because of corporate practice of medicine laws, we entered into contractual arrangements to manage certain affiliated physician practice groups, which allow us to consolidate those groups for financial reporting purposes. We do not have direct ownership interests in any of our VIEs and are not able to exercise rights as an equity holder to directly change the members of the boards of directors of these entities so as to affect changes at the management and operational level. Under our arrangements with our VIEs, we must rely on their equity holders to exercise our control over the entities. If our affiliated entities or their equity holders fail to perform as expected, we may have to incur substantial costs and expend additional resources to enforce such arrangements. Any failure by our affiliated entities or their owners to perform their obligations under their agreements with us would have a material adverse effect on our business, results of operations and financial condition. Our affiliated physician practice groups are owned by individual physicians who could die, become incapacitated, or become no longer affiliated with us. Although our MSAs with these affiliates provide that they will be binding on successors of current owners, as the successors are not parties to the MSAs, it is uncertain in case of the death, bankruptcy, or divorce of a current owner whether their successors would be subject to such MSAs. Our operations are dependent on a concentrated number of payors. Four payors accounted for an aggregate of **59. 0 % and** 49. 6 ~~% and 53. 4~~ % of our total net revenue for the years ended December 31, **2022 and** 2021 ~~and 2020~~, respectively. We believe that a majority of our revenues will continue to be derived from a limited number of key payors, which may terminate their contracts with us **,** or our physicians credentialed by them **,** upon the occurrence of certain events. They may also amend the material terms of the contracts under certain circumstances. Failure to maintain such contracts on favorable terms, or at all, would materially and adversely affect our results of operations and financial condition. An exodus of our patients could have a material adverse effect on our results of operations. We may also be impacted by a shift in payor mix, including eligibility changes to government and private insurance programs. A material decline in the number of patients that we and our affiliated physician groups serve, whether a government or a private entity is paying for their healthcare, could have a material adverse effect on our results of operations and financial condition, which could result from increased competition, new developments in the healthcare industry, or regulatory overhauls. In light of the repeal of the individual mandate requirement under the Patient Protection and Affordable Care Act of 2010 (also known as Affordable Care Act or Obamacare) via the Tax Cuts and Jobs Act of 2017, some people are expected to lose their health insurance and thus may not continue to afford services by our managed medical groups. In addition, due to potential decreased availability of healthcare through private employers, the number of patients who are uninsured or participate in governmental programs may increase. A shift in payor mix from managed care and other private payors to government payors or the uninsured may result in a reduction in our rates of reimbursement or an increase in our uncollectible receivables or uncompensated care, with a corresponding decrease our net revenue. Changes in the eligibility requirements for governmental programs could also change the number of patients who participate in such programs or the number of uninsured patients. For those patients who remain with private insurance, changes in those programs could increase patient responsibility amounts, resulting in a greater risk for uncollectible receivables. Such events could have a material adverse effect on our business, results of operations and financial condition. Our future growth could be harmed if we lose the services of our key management personnel. Our success depends to a significant extent on the continued contributions of our key management personnel, particularly our ~~Executive Chairman and~~ Co- Chief Executive Officer **and President**, Dr. ~~Sim~~ **Lam**, and our Co- Chief Executive Officer **Brandon Sim** ~~and President, Dr. Lam,~~ for the management of our business and implementation of our business strategy. The loss of their services could have a material adverse effect on our business, financial

condition, and results of operations. If having our key management personnel serving as nominee equity holders of our VIEs is invalid under applicable laws, or if we lost the services of key management personnel for any reason, it could have a material adverse impact on our results of operations and financial condition. There are various state laws, including laws in California, regulating the corporate practice of medicine, which prohibit us from owning various healthcare entities. These corporate practice of medicine prohibitions are intended to prevent unlicensed persons from interfering with or inappropriately influencing a physician' s professional judgment. The interpretation and enforcement of these laws vary significantly from state to state. As a result, many of our affiliated physician practice groups are either wholly owned or primarily owned by Dr. Lam as the nominee shareholder for our benefit. If these arrangements were held to be invalid under applicable laws, which may change from time to time, a significant portion of our consolidated revenues would be affected, which may result in a material adverse effect on our results of operations and financial condition. Similarly, if Dr. Lam died, was incapacitated, or otherwise was no longer affiliated with us, our relationships and arrangements with those VIEs could be in jeopardy, and our business could be adversely affected. We are dependent in part on referrals from third parties and preferred provider status with payors. Our business relies in part on referrals from third parties for our services. We receive referrals from community medical providers, emergency departments, payors, and hospitals in the same manner as other medical professionals receive patient referrals. We do not provide compensation or other remuneration to referral sources for referring patients to us. A decrease in these referrals due to competition, concerns about our services and other factors could result in a significant decrease in our revenues and adversely impact our financial condition. Similarly, we cannot assure that we will be able to obtain or maintain preferred provider status with significant third- party payors in the communities where we operate. If we are unable to maintain our referral base or our preferred provider status with significant third- party payors, it may negatively impact our revenues and financial performance. Partner facilities may terminate agreements with our affiliated physician groups or reduce their fees. Our hospitalist physician services net revenue is derived from contracts directly with hospitals and other inpatient and post- acute care facilities. Our current partner facilities may decide not to renew contracts with, impose unfavorable terms on, or reduce fees paid to our affiliated physician groups. Any of these events may impact the ability of our affiliated physician groups to operate at such facilities, which would negatively impact our revenues, results of operations, and financial condition. Many of our agreements with hospitals and medical groups are limited in their terms or may be terminated without cause by providing advance notice. If such agreements are not renewed or terminated, we would lose the revenue generated by them. Any such events could have a material adverse effect on our results of operations, financial condition, and future business plans. Because many of such agreements with hospitals and medical groups prohibit us from acquiring physicians or patients from or competing with them, our ability to hire physicians, attract patients, or conduct business in certain areas may be limited in some cases. Our business model depends on numerous complex management information systems, and any failure to successfully maintain these systems or implement new systems could undermine our ability to receive payments and otherwise materially harm our operations and may result in violations of healthcare laws and regulations. We depend on a complex, specialized, integrated management information system and standardized procedures for operational and financial information, as well as for our billing operations. We may be unable to enhance existing management information systems or implement new management information systems when necessary. We may experience unanticipated delays, complications, or expenses in implementing, integrating, and operating our systems. Our management information systems may require modifications, improvements, or replacements that may require both substantial expenditures, as well as interruptions in operations. Our ability to create and implement these systems depends on the availability of technology and skilled personnel. Our failure to successfully implement and maintain all of our systems could undermine our ability to receive payments and otherwise have a material adverse effect on our business, results of operations, and financial condition. Our failure to successfully operate our billing systems could also lead to potential violations of healthcare laws and regulations. Risks Relating to the Healthcare Industry. The healthcare industry is highly competitive. We compete directly with national, regional, and local providers of inpatient healthcare for patients and physicians. There are many other companies and individuals currently providing healthcare services, many of which have been in business longer and / or have substantially more resources. Since there are virtually no substantial capital expenditures required for providing healthcare services, there are few financial barriers to entry **into** the healthcare industry. Other companies could enter the healthcare industry in the future and divert some or all of our business. On a national basis, our competitors include, but are not limited to, Team Health, EmCare, Optum, and Heritage, each of which has greater financial and other resources available to them. We also compete with physician groups and privately- owned healthcare companies in local markets. In addition, our relationships with governmental and private third- party payors are not exclusive and our competitors have established or could seek to establish relationships with such payors to serve their covered patients. Competitors may also seek to compete with us for acquisitions, which could have the effect of increasing the price and reducing the number of suitable acquisitions, which would have an adverse impact on our growth strategy. Individual physicians, physician groups, and companies in other healthcare industry segments, including those with which we have contracts, and some of which have greater financial, marketing, and staffing resources, may become competitors in providing healthcare services, and this competition may have a material adverse effect on our business operations and financial position. We therefore may be unable to compete successfully and even after we expend significant resources. New physicians and other providers must be properly enrolled in governmental healthcare programs before we can receive reimbursement for their services, and there may be delays in the enrollment process. Each time a new physician joins us or our affiliated groups, we must enroll the physician under our applicable group identification number for Medicare and Medicaid programs and for certain managed care and private insurance programs before we can receive reimbursement for services the physician renders to beneficiaries of those programs. The estimated time to receive approval for the enrollment is sometimes difficult to predict and, in recent years, the Medicare program carriers often have not issued these numbers to our affiliated physicians in a timely manner. These practices result in delayed reimbursement that may adversely affect our cash flows. Hospitals where our affiliated physicians provide services may deny

privileges to our physicians. In general, our affiliated physicians may only provide services in a hospital where they have maintained certain credentials, also known as privileges, which are granted by the medical staff according to the bylaws of the hospital. The medical staff could decide that our affiliated physicians can no longer receive privileges to practice there. Such a decision would limit our ability to furnish services at the hospital, decrease the number of our affiliated physicians, or preclude us from entering new hospitals. In addition, hospitals may attempt to enter into exclusive contracts for certain physician services, which would reduce our access to patient populations within the hospital. Changes associated with reimbursements by third- party payors may adversely affect our operations. The medical services industry is undergoing significant changes with government and other third- party payors that are taking measures to reduce reimbursement rates or, in some cases, denying reimbursement altogether. There is no assurance that government or other third- party payors will continue to pay for the services provided by our affiliated medical groups. Furthermore, there has been, and continues to be, a great deal of discussion and debate about the repeal and replacement of existing government reimbursement programs, such as the ACA. As a result, the future of healthcare reimbursement programs is uncertain, making long- term business planning difficult and imprecise. The failure of government or other third- party payors to cover adequately the medical services provided by us could have a material adverse effect on our business, results of operations, and financial condition. Our business may be significantly and adversely affected by legislative initiatives aimed at or having the effect of reducing healthcare costs associated with Medicare and other government healthcare programs and changes in reimbursement policies. In order to participate in the Medicare program, ~~we~~ **our affiliated provider groups** must comply with stringent and often complex enrollment and reimbursement requirements **, failing which the provider group' s participation in the federal health care programs may be terminated, or civil and / or criminal penalties may be imposed** . These programs generally provide for reimbursement on a fee- schedule basis rather than on a charge- related basis. As a result, we cannot increase our revenue by increasing the amount that we and our affiliates charge for services. To the extent that our costs increase, we may not be able to recover the increased costs from these programs. In addition, cost containment measures in non- governmental insurance plans have generally restricted our ability to recover, or shift to non- governmental payors, these increased costs. In attempts to limit federal and state spending, there have been, and we expect that there will continue to be, a number of proposals to limit or reduce Medicare reimbursement for various services. For example, the Medicare Access and CHIP Reauthorization Act of 2015 made numerous changes to Medicare, Medicaid, and other healthcare- related programs, including new systems for establishing annual updates to Medicare rates for physicians' services. We may have difficulty collecting payments from third- party payors in a timely manner. We derive significant revenue from third- party payors, and delays in payment or refunds to payors may adversely impact our net revenue. We assume the financial risks relating to uncollectible and delayed payments. In particular, we rely on some key governmental payors. Governmental payors typically pay on a more extended payment cycle, which could require us to incur substantial expenses prior to receiving corresponding payments. In the current healthcare environment, as payors continue to control expenditures for healthcare services, including through revising their coverage and reimbursement policies, we may continue to experience difficulties in collecting payments from payors that may seek to reduce or delay such payments. If we are not timely paid in full or if we need to refund some payments, our revenues, cash flows, and financial condition could be adversely affected. Decreases in payor rates could adversely affect us. Decreases in payor rates, either prospectively or retroactively, could have a significant adverse effect on our revenues, cash flows, and results of operations. Federal and state laws may limit our ability to collect monies owed by patients. We use third- party collection agencies whom we do not control to collect from patients any co- payments and other payments for services that our physicians provide. The federal Fair Debt Collection Practices Act of 1977 (the " FDCPA ") restricts the methods that third- party collection companies may use to contact and seek payment from consumer debtors regarding past due accounts. State laws vary with respect to debt collection practices, although most state requirements are similar to those under the FDCPA. Therefore, such agencies may not be successful in collecting payments owed to us and our affiliated physician groups. If practices of collection agencies utilized by us are inconsistent with these standards, we may be subject to actual damages and penalties. These factors and events could have a material adverse effect on our business, results of operations, and financial condition. We have established reserves for our potential medical claim losses, which are subject to inherent uncertainties, and a deficiency in the established reserves may lead to a reduction in our assets or net incomes. We establish reserves for estimated IBNR claims. IBNR estimates are developed using actuarial methods and are based on many variables, including the utilization of healthcare services, historical payment patterns, cost trends, product mix, seasonality, changes in membership, and other factors. The estimation methods and the resulting reserves are periodically reviewed and updated. Many of our contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such interpretations may not come to light until a substantial period of time has passed. The inherent difficulty in interpreting contracts and estimating necessary reserves could result in significant fluctuations in our estimates from period to period. Our actual losses and related expenses therefore may differ, even substantially, from the reserve estimates reflected in our financial statements. If actual claims exceed our estimated reserves, we may be required to increase reserves, which would lead to a reduction in our assets or net income. Competition for qualified physicians, employees, and management personnel is intense in the healthcare industry, and we may not be able to hire and retain qualified physicians and other personnel. We depend on our affiliated physicians to provide services and generate revenue. We compete with many types of healthcare providers, including teaching, research and government institutions, hospitals, and other practice groups, for the services of clinicians and management personnel. The limited number of residents and other licensed providers on the job market with the expertise necessary to provide services within our business makes it challenging to meet our hiring needs and may require us to train new employees, contract temporary physicians, or offer more attractive wage and benefit packages to experienced professionals, which could decrease our profit margins. The limited number of available residents and other licensed providers also impacts our ability to renew contracts with existing physicians on acceptable terms. As a result, our ability to provide services could be adversely affected. Even though our physician turnover

rate has remained stable over the last three years, if the turnover rate were to increase significantly, our growth could be adversely affected. Moreover, unlike some of our competitors who sometimes pay additional compensation to physicians who agree to provide services exclusively to that competitor, our affiliated IPAs have historically not entered into such exclusivity agreements and have allowed our affiliated physicians to affiliate with multiple IPAs. This practice may place us at a competitive disadvantage regarding the hiring and retention of physicians relative to those competitors who do enter into such exclusivity agreements. The healthcare industry is increasingly reliant on technology, which could increase our risks. The role of technology is greatly increasing in the delivery of healthcare, which makes it difficult for traditional physician- driven companies, such as us, to adopt and integrate electronic health records, databases, cloud- based billing systems, and many other technology applications in the delivery of healthcare services. Additionally, consumers are using mobile applications and care and cost research in selecting and usage of healthcare services. We may need to incur significant costs to implement these technology applications and comply with applicable laws. For example, the nature of our business and the requirements of healthcare privacy laws impose significant obligations on us to maintain privacy and protection of patient medical information. We rely on employees and third parties with technology knowledge and expertise and could be at risk if technology applications are not properly established, maintained, or secured. Any cybersecurity incident, even unintended, could expose us to significant fines and remediation costs and materially impair our business operations and financial position. If we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting the U. S. healthcare reform, our business may be harmed. Due to the importance of the healthcare industry in the lives of all Americans, federal, state, and local legislative bodies frequently pass legislation and promulgate regulations relating to healthcare reform or that affect the healthcare industry. As has been the trend in recent years, it is reasonable to assume that there will continue to be increased government oversight and regulation of the healthcare industry in the future. We cannot assure our stockholders as to the ultimate content, timing, or effect of any new healthcare legislation or regulations, nor is it possible at this time to estimate the impact of potential new legislation or regulations on our business. It is possible that future legislation enacted by Congress or state legislatures, or regulations promulgated by regulatory authorities at the federal or state level, could adversely affect our business or could change the operating environment of the hospitals and other facilities where our affiliated physicians provide services. It is possible that the changes to the Medicare, Medicaid, or other governmental healthcare program reimbursements may serve as precedent to possible changes in other payors' reimbursement policies in a manner adverse to us. Similarly, changes in private payor reimbursements could lead to adverse changes in Medicare, Medicaid, and other governmental healthcare programs, which could have a material adverse effect on our business, financial condition, and results of operations. Although we do not anticipate that a single- payer national health insurance system will be enacted by the current Congress, several legislative initiatives have been proposed by members of Congress and presidential candidates that would establish some form of a single public or quasi- public agency that organizes healthcare financing, but under which healthcare delivery would remain private. If enacted, such a system could adversely affect our business. Consolidation in the healthcare industry could have a material adverse effect on our business, financial condition, and results of operations. Many healthcare industry participants and payers are consolidating to create larger and more integrated healthcare delivery systems with greater market power. We expect regulatory and economic conditions to result in additional consolidation in the healthcare industry in the future. As consolidation accelerates, the economies of scale of our partners' organizations may grow. If a partner experiences sizable growth following consolidation, it may determine that it no longer needs to rely on us and may reduce its demand for our products and services. In addition, as healthcare providers consolidate to create larger and more integrated healthcare delivery systems with greater market power, these providers may try to use their market power to negotiate fee reductions for our products and services. Finally, consolidation may also result in the acquisition or future development by our partners of products and services that compete with our products and services. Any of these potential results of consolidation could have a material adverse effect on our business, financial condition and results of operations. Risks Relating to **GPDC /** ~~NGACO~~ -- **ACO REACH** . The success of our emphasis on the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model is uncertain. In **February 2022, CMS announced that APAACO, our subsidiary, was approved to participate in the GPDC Model and APAACO began operations under this new model in 2022. The current Administration made changes to the model, and renamed it to the ACO REACH Model. ACO REACH commenced on** January ~~2017~~ **1 , 2023** ~~CMS approved APAACO, our subsidiary, to participate in the NGACO Model~~ . To position us to participate in the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model and meet its requirements, we have invested significant resources in reshaping our business and organizations and in establishing related infrastructure, and expect to continue to devote ~~,~~ significant financial and other resources to the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model. These efforts have required us to refocus away from certain other parts of our historic business and revenue streams, which will receive less emphasis and could result in reduced revenue from these activities for us. ~~For example, we have converted physicians and patients from our MSSP ACOs to our NGACO. It is unknown whether this strategic decision will be eventually successful. The NGACO Model has certain political risks and is undergoing changes. If the Patient Protection and the ACA is amended, repealed, declared unconstitutional, or replaced, or if The Center for Medicare and Medicaid Innovation (" CMMI ") is terminated, the NGACO Model program could be discontinued or significantly altered. In addition, CMS and CMMI leadership could be changed and influenced by Congress or the current Biden Administration, and may elect to combine any existing programs, including bundled payments, which could greatly alter the NGACO Model program. The rules regarding NGACOs have also been altered and may be further altered in the future. Any material change to the NGACO requirements and governing rules or the discontinuation of the program as a whole could create significant uncertainties for us and alter our strategic direction, thereby increasing financial risks for our stockholders.~~ There are uncertainties regarding the design and administration of the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model and CMS' ~~initial~~ financial reports to **GPDC /** ~~NGACO~~ -- **ACO REACH** participants, which could negatively impact our results of operations. Due to the ~~newness~~ **novelty** of the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model ~~, and due to being the only participant in the AIPBP track~~ , we are subject to ~~initial~~ program

challenges, including, but not limited to, process design, data, and other related aspects. We rely on CMS for design, oversight, and governance of the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model. If CMS cannot provide accurate data, claims benchmarking and calculations, make timely payments, and conduct periodic process reviews, our results of operations and financial condition could be materially and adversely affected. CMS relies on various third parties to effect the **GPDC /** ~~NGACO~~ -- **ACO REACH** program, including other departments of the U. S. government, such as **Centers for Medicare & Medicaid Services Innovation Center (“** CMMI **”)** . CMS also relies on multiple third- party contractors to manage the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model program, including claims and auditing. As a result, there is the potential for errors, delays, and poor communication among the differing entities involved, which are beyond our control. As CMS is implementing extensive reporting protocols for the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model, CMS has indicated that because of inherent biases in reporting the results, its initial financial reports under the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model may not be indicative of final results of actual risk sharing and revenues that we receive. Were that to be the case, we might not report accurately our revenues for relevant periods, which could result in adjustment in a later period when we receive final results from CMS. We ~~and our contracted providers have experienced various apparent errors in the NGACO Model, resulting in some providers terminating their relationships with us, and the resolution of these issues and impact on us remains uncertain. If we continue to experience such issues or new issues emerge, this could have a material adverse effect on our results of operations on a consolidated basis. We~~ chose to participate in the ~~AIPBP~~ **Total Care Capitation (“ TCC ”)** mechanism **and Global risk tracks of GPDC / ACO REACH** , which entails certain special risks. Under the ~~AIPBP~~ **TCC** mechanism, CMS estimates the total annual Part A and Part B Medicare expenditures of our assigned Medicare beneficiaries and ~~pay~~ **pays** us that projected amount in per beneficiary per month payments. We chose **“** ~~the~~ **Global** ~~Risk~~ **risk track** ~~Arrangement B~~ , **”** ~~comprising~~ **under which we assume** 100 % risk for Part A and Part B Medicare expenditures **where** ~~and a~~ shared savings and losses ~~cap of 15~~ **are less than 25** % ~~(or a 15 %~~ **of the benchmark, with adjusted risk corridors taking** ~~effective~~ **effect for any portion of** shared savings ~~and /~~ losses ~~cap when factoring in 100~~ **equaling or exceeding 25 % of the benchmark — for savings / losses of 25- 35 %, we assume 50** % risk ~~impact)~~ **, for savings / losses 35 %- 50 % we assume 25 % of the risk, and for savings / losses exceeding 50 % of the benchmark, we assume only 10 % of the risk** . Our **preliminary** benchmark **for** Medicare Part A and Part B expenditures for beneficiaries for the ~~2021~~ **2023** performance year ~~are~~ **, per CMS, is** approximately $ ~~436~~ **629** . ~~4~~ **2** million **. Therefore** , ~~and~~ under **“** ~~the~~ **Global** ~~Risk~~ **risk track** ~~Arrangement B ”~~ of the ~~AIPBP~~ **TCC** mechanism **,** we could ~~therefore~~ have profits or be liable for losses of up to ~~15~~ **100 % of the first 25** % of such benchmarked expenditures, or approximately $ ~~65~~ **157** . ~~5~~ **3** million **, with adjusted risk corridors taking effect afterwards** . While performance can be monitored throughout the year, end results for ~~the 2021~~ **any given** performance year will not be known until ~~late~~ **the third quarter of the subsequent year. Shared savings retained by APAACO are impacted by the amount of the Quality Withhold earned back. Throughout the GPDC and ACO REACH programs, a substantial portion of APAACO’ s spending benchmark is held at** ~~2022~~ **risk by CMS, subject to APAACO meeting certain quality measures as determined by CMS** . ~~AIPBP~~ **In the GPDC program, the portion of the benchmark held at- risk by CMS for quality was 5 % of the benchmark. In the ACO REACH program, the portion of the benchmark held at- risk by CMS for quality is 2 % of the benchmark. Failing to earn back all or part of the portion of APAACO’ s spending benchmark held at- risk by CMS for quality metrics could materially affect our financial performance in the GPDC and ACO REACH programs. GPDC / ACO REACH** operations and benchmarking calculations are complex and could result in uncertainties for us. ~~AIPBP~~ **GPDC / ACO REACH** operations and benchmarking calculations are complex and can lead to errors in the application of the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model, which could create reimbursement delays to our contracted, in- network providers and adversely affect our performance and results of operations. For example, **historically under the NGACO program,** we discovered a feature in the AIPBP claim processing system **did** ~~that does~~ not allow us to break down certain claims amounts by individual patient codes. This ~~has~~ created confusion for our in- network providers in reconciling payments, causing some providers to terminate their agreements with us. ~~This feature~~ **There is no guarantee that similar obstacles** and ~~other~~ complexities ~~within~~ **will be absent from** the ~~AIPBP mechanism~~ **GPDC / ACO REACH models, and** could also create uncertainties for our operations, including under agreements with our contracted, in- network providers **.** We may suffer losses and may not generate savings through our participation in the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model. Through the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model, CMS provides an opportunity to provider groups that are willing to assume higher levels of financial risk and reward, to participate in this new attribution- based risk- sharing model. The **GPDC /** ~~NGACO~~ -- **ACO REACH** Model uses a prospectively ~~-~~set ~~cost~~ **preliminary** benchmark **that** ~~, which~~ is ~~established prior to~~ **retrospectively adjusted at** the ~~start~~ **end** of ~~each~~ **the** performance year. The **preliminary** benchmark is based on ~~various factors~~ **baseline historical expenditures by Participant Providers in the benchmark years trended forward using the US Per Capita Cost (“ USPCC ”) growth trend** , ~~including~~ **and subsequently blended with regional expenditure rates, which are contained in the ACO REACH / Kidney Care Choices (“ KCC ”) Rate Book. The benchmark years are set at CY2017- 2019 for the duration of the model. In PY2023, historical** baseline expenditures ~~with~~ **are weighted at 65 %, regional expenditures are weighted at 35 %, and historical expenditures will be weighted less in future performance years. For full details on how** the ~~baseline updated each~~ **preliminary benchmark is calculated, please refer to CMS documentation. After the performance** year ~~to reflect~~ **concludes,** the **preliminary benchmark is adjusted for numerous factors, such as the** ~~NGACO~~ -- **ACO** ’ s ~~participant list~~ **final risk score and beneficiaries who became ineligible** for the ~~given year. Our 2021~~ **program over the course of the** performance year ~~baseline~~ **. If necessary at this stage, a Retrospective Trend Adjustment (“ RTA ”) may be applied as well. An RTA** is ~~based~~ **applied if the USPCC trend differs by at least 1 % from the observed expenditure trend in the National Reference Population. It adjusts the benchmark by the difference between the observed expenditure trend and the predicted USPCC trend. Once all adjustments are made to the preliminary benchmark, APAACO’ s expenditures will be compared to this final benchmark to calculate shared savings or shared**

losses. For full details on **how the final benchmark** ~~calendar year 2020 expenditures that are risk- adjusted and trended. A discount~~ is **calculated, please refer to CMS documentation** ~~then applied that incorporates regional and national effieiency. The benchmarked expenditures therefore could potentially underestimate our actual expenditures for assigned Medicare beneficiaries and there can be no assurance that we could successfully adjust such benchmarked expenditures~~. Under the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model, we are responsible for savings and losses related to care received by assigned patients by covering claims from physicians, nurses, and other medical professionals. If claim costs exceed the benchmarked expenditures, or the baseline years **used in benchmark calculations** are statistical anomalies, we could experience losses, which could be significant. Among other things, this could result from factors beyond our control, such as natural disasters, the potential effects of climate change, major epidemics, pandemics, or newly emergent viruses (such as COVID- 19). As we are providing care coordination through APAACO, but do not provide direct patient care, our influence could be limited. Because of our limited influence, it is possible that we may not be able to control care providers' behavior, utilization, and costs. As a result, we may not be able to generate savings through our participation in the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model to cover our administrative and care coordination operating costs, and any savings generated, if at all, will be earned in arrears and uncertain in both timing and amount **. Furthermore, the process by which the final benchmark is calculated from the preliminary benchmark is complex, and we may have limited ability to understand what the final benchmark may be before the value is reported to us by CMS. Due to this dynamic, we may have limited ability to predict our final performance and shared savings / losses amount prior to receiving a final report from CMS in third quarter of the year following any given performance year**. We do not control, but are responsible for savings and losses related to, care received by assigned patients at out- of- network providers, which could negatively impact our ability to control claim costs. Medicare beneficiaries in the **GPDC /** ~~NGACO~~ -- **ACO REACH** Model are not required to receive care from a specified network of contracted providers and facilities, which could make it difficult for us to control the financial risks of those beneficiaries ~~. CMS notified us that its Medicare beneficiaries historically had received approximately 62 % of care at non- contracted, out- of- network (" OON ") providers~~. While we are not responsible for directly paying claims for ~~OON~~ **out- of- network** providers, we may have difficulty managing patient care and costs in relation to such ~~OON~~ **out- of- network** providers as compared to contracted, in- network providers, which, could adversely impact our financial results as we are responsible for savings and losses of assigned beneficiaries, irrespective of whether they are using in- network or ~~OON~~ **out- of- network** providers. In addition, even if we are successful in encouraging more assigned patients to receive care from our contracted, in- network providers, there is the possibility that the monthly ~~AIPBP~~ **TCC** from CMS will be insufficient to cover our expenditures, since the ~~AIPBP~~ **TCC** is generally based on historical in- network / out- of- network ratios. If CMS fails to monitor the in- network / ~~OON~~ **out- of- network** provider ratio for our assigned patients on a frequent basis **,** or CMS' reconciliation payments to us are not timely made, this could result in negative cash flows for us, especially if increased payments will need to be made to our contracted, in- network providers ~~. Third parties used by us could hinder our performance. We use third parties to perform certain administrative and care coordination tasks. We have contracted with participating Part A and Part B providers and sometimes with discounted rates. This could, however, create operational and performance risk; for example, if a third party does not perform its responsibilities properly. In addition, such providers could increase their current rates or discontinue their agreements with us~~. We face competition from traditional MSSP ACOs and other ~~NGACOs~~ -- **ACOs**. Managed care providers experienced in coordinating care for populations of patients compete with each other to be selected by CMS to participate in the ~~NGACO~~ -- **ACO REACH** Model. Since MSSP and pioneer ACOs began in 2012, the number of Medicare ACOs continues to rise and have grown to several hundred nationwide, but there are still a growing number of ACOs in different program types that compete with us for resources and patients. Following CMS' s termination of the NGACO Model, our continued participation in other CMS Advanced Alternative Payment Models, such as the GPDC ~~Model~~ **/ ACO REACH**, cannot be guaranteed. APAACO and CMS entered into a Next Generation ACO Model Participation Agreement ~~(the " Participation Agreement ")~~ with a term of four performance years through December 31, 2020. Subsequently due to the COVID- 19 Public Health Emergency ~~(the " PHE ")~~, ~~CMS offered APAACO to amend~~ the **Next Generation ACO Model** Participation Agreement **was amended** to add one additional 12- month Performance Year, ~~extending the term of the Participation Agreement by one calendar year,~~ such that the final Performance Year ended on December 31, 2021. ~~In addition~~ **For PY2022, we were approved to participate in the GPDC Model, which was subsequently transitioned to ACO REACH for performance year 2023. APAACO participated in the GPDC Model in 2022 and has an active participation agreement with CMS for 2023. However**, the Participation Agreement **for the GPDC / ACO REACH Model** may be terminated sooner by CMS as specified therein and CMS has the flexibility to alter or change the program over time. Among many requirements to be eligible to participate in the ~~NGACO~~ -- **ACO REACH** Model, we must have at least ~~10~~ **5**, 000 aligned Medicare beneficiaries and must maintain that number throughout each performance year. ~~Although we started the 2021 performance year with approximately 30, 000 aligned Medicare beneficiaries, there can be no assurance that we will maintain the required number of assigned Medicare beneficiaries.~~ If that number were not maintained, we would become ineligible for the ~~NGACO~~ -- **ACO REACH** Model. In addition, we are required to comply with all applicable laws and regulations regarding provider- based risk- bearing entities. If these laws or regulations change, for example, to require a Knox- Keene license in California, which we do not currently have, we could be required to cease our ~~NGACO~~ -- **ACO REACH** operations. We could be terminated from the ~~NGACO~~ -- **ACO REACH** Model at any time if we do not continue to comply with the ~~NGACO~~ -- **ACO REACH** participation requirements. In October 2017, CMS notified us that our participation in the AIPBP mechanism for performance year 2018 would not be renewed due to alleged deficiencies in performance by us. We submitted a request for reconsideration to CMS. In December 2017, we received the official decision on our reconsideration request that CMS reversed the prior decision against our continued participation in the AIPBP mechanism. As a result, we were again eligible to receive monthly AIPBP from CMS. We, however, will need to continue to comply with all terms and conditions in the Participation Agreement and various

regulatory requirements to be eligible to participate in the ~~AIPBP~~ **TCC** mechanism and / or ~~NGACO~~ -- **ACO REACH** Model. If future compliance or performance issues arise, we may lose our current eligibility and may be subject to CMS' enforcement or contract actions, including our potential inability to participate in the ~~AIPBP~~ **TCC** mechanism (where the payment mechanism would default to traditional fee for service) or dismissal from the ~~NGACO~~ -- **ACO REACH** Model, which would have a material adverse effect on our revenues and cash flows. In addition, the payments from CMS to us will decrease if the number of beneficiaries assigned to our ~~NGACO~~ -- **ACO** declines ~~,~~ or **if** the contracted providers terminate their relationships with us, which could have a material adverse effect on our results of operations on a consolidated basis ~~. With the ending of the NGACO Model on December 31, 2021, CMS is allowing former NGACO participants including APAACO to apply to participate as a Direct Contracting Entity (" DCE ") in the standard track of CMS' s Global and Professional Direct Contracting (" GPDC ") Model (formerly known as the Direct Contracting Model for Global and Professional Options). APAACO has applied for the GPDC Model for Performance Year 2022 (" PY22 ") with CMS releasing the PY22 GPDC Model Participants at https: / / innovation. cms. gov / media / document / gpdc- model- participant- summary. CMS has redesigned the GPDC Model in response to Administration priorities, including their commitment to advancing health equity, stakeholder feedback, and participant experience. They have renamed the GPDC Model to ACO Realizing Equity, Access, and Community Health (" ACO REACH ") Model. The ACO REACH Model will begin participation on January 1, 2023. Any change to the transition from GPDC to ACO REACH could have a material adverse effect on our revenues and cash flows~~ . Risks Relating to Regulatory Compliance. Some states have laws that prohibit business entities from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians (also known collectively as the corporate practice of medicine) or engaging in some arrangements, such as fee- splitting, with physicians. In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. California is one of the states that prohibit the corporate practice of medicine. In California, we operate by maintaining contracts with our affiliated physician groups, which are each owned and operated by physicians **,** and which employ or contract with additional physicians to provide physician services. Under these arrangements, we or our subsidiaries provide management services, receive a management fee for providing management services, do not represent to offer medical services, and do not exercise influence or control over the practice of medicine by the physicians or the affiliated physician groups. In addition to the above management arrangements, in certain instances, we have contractual rights relating to the transfer of equity interests in our affiliated physician groups under physician shareholder agreements that we entered into with the controlling equity holder of such affiliated physician groups. However, even in such instances, such equity interests cannot be transferred to or held by us or by any non- professional organization. Accordingly, we do not directly own any equity interests in any affiliated physician groups in California. In the event that any of these affiliated physician groups or their equity holders fail to comply with these management or ownership transfer arrangements, these arrangements are terminated, we are unable to enforce such arrangements, or these arrangements are invalidated under applicable laws, there could be a material adverse effect on our business, results of operations, and financial condition and we may have to restructure our organization and change our arrangements with our affiliated physician groups, which may not be successful. ~~The healthcare industry is intensely regulated at the federal, state, and local levels and government authorities may determine that we fail to comply with applicable laws or regulations and take actions against us.~~ As a company involved in providing healthcare services, we are subject to numerous federal, state, and local laws and regulations. There are significant costs involved in complying with these laws and regulations. If we are found to have violated any applicable laws or regulations, we could be subject to civil and / or criminal damages, fines, sanctions, or penalties, including exclusion from participation in governmental healthcare programs, such as Medicare and Medicaid, and we may be required to change our method of operations and business strategy. These consequences could be the result of our current conduct or even conduct that occurred a number of years ago, including prior to the completion of the 2017 Merger. We could incur significant costs to defend ourselves if we become the subject of an investigation or legal proceeding alleging a violation of these laws and regulations. We cannot predict whether a federal, state, or local government will determine that we are not operating in accordance with law, or whether, when or how the laws will change in the future and impact our business. The following is a non- exhaustive list of some of the more significant healthcare laws and regulations that could affect us: • ~~the~~ **The** False Claims Act, that provides for penalties against entities and individuals who knowingly or recklessly make claims to Medicare, Medicaid, and other governmental healthcare programs, as well as third- party payors, that contain or are based upon false or fraudulent information; • ~~a~~ **A** provision of the Social Security Act, commonly referred to as the " Anti- Kickback Statute, " that prohibits the knowing and willful offering, payment, solicitation, or receipt of any bribe, kickback, rebate, or other remuneration, in cash or in kind, in return for the referral or recommendation of patients for items and services covered, in or in part, by federal healthcare programs such as Medicare and Medicaid; • ~~a~~ **A** provision of the Social Security Act, commonly referred to as the Stark Law or physician self- referral law, that (subject to limited exceptions) prohibits physicians from referring Medicare patients to an entity for the provision of specific " designated health services " if the physician or a member of such physician' s immediate family has a direct or indirect financial relationship with the entity, and prohibits the entity from billing for services arising out of such prohibited referrals; • ~~a~~ **A** provision of the Social Security Act that provides for criminal penalties on healthcare providers who fail to disclose known overpayments; • ~~a~~ **A** provision of the Social Security Act that provides for civil monetary penalties on healthcare providers who fail to repay known overpayments within 60 days of identification or the date any corresponding cost report was due, if applicable, and also allows improper retention of known overpayments to serve as a basis for False Claims Act violations; • ~~provisions~~ **Provisions** of the Social Security Act (emanating from the DRA) that require entities that make or receive annual Medicaid payments of $ 5 million or more from a single Medicaid program to provide its employees, contractors, and agents with written policies and employee handbook materials on federal and state false claims acts and related statutes, that establish a new Medicaid Integrity Program designed to enhance federal and state efforts to detect Medicaid fraud, waste, and abuse, and that increase financial incentives for both states and

individuals to bring fraud and abuse claims against healthcare companies; • ~~state~~ **State** law provisions pertaining to anti-kickback, self- referral, and false claims issues; • ~~provisions~~ **Provisions** of, and regulations relating to, HIPAA that provide penalties for knowingly and willfully executing a scheme or artifice to defraud a healthcare benefit program or falsifying, concealing, or covering up a material fact or making any material false, fictitious, or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items, or services; • ~~provisions~~ **Provisions** of HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 (" HITECH ") limiting how covered entities, business associates, and business associate sub- contractors may use and disclose PHI and the security measures that must be taken in connection with protecting that information and related systems, as well as similar or more stringent state laws; • ~~federal~~ **Federal** and state laws that provide penalties for providers for billing and receiving payments from a governmental healthcare program for services unless the services are medically necessary and reasonable, adequately and accurately documented, and billed using codes that accurately reflect the type and level of services rendered; • ~~state~~ **State** laws that provide for financial solvency requirements relating to risk- bearing organizations (" RBOs "), plan operations, plan- affiliate operations and transactions, plan-provider contractual relationships, and provider- affiliate operations and transactions, such as California Business & Professions Code Section 1375. 4 (§ 1375. 4; Cal. Code Regs., tit. 28, § 1300. 75. 4 et seq.); • ~~federal~~ **Federal** laws that provide for administrative sanctions, including civil monetary penalties for, among other violations, inappropriate billing of services to federal healthcare programs, payments by hospitals to physicians for reducing or limiting services to Medicare or Medicaid patients, or employing or contracting with individuals or entities who / which are excluded from participation in federal healthcare programs; • ~~federal~~ **Federal** and state laws and policies that require healthcare providers to enroll in the Medicare and Medicaid programs before submitting any claims for services, to promptly report certain changes in its operations to the agencies that administer these programs, and to re- enroll in these programs when changes in direct or indirect ownership occur or in response to revalidation requests from Medicare and Medicaid; • ~~state~~ **State** laws that prohibit general business entities from practicing medicine, controlling physicians' medical decisions or engaging in certain practices, such as splitting fees with physicians; • ~~state~~ **State** laws that require timely payment of claims, including § 1371. 38, et al, of the California Health & Safety Code, which imposes time limits for the payment of uncontested covered claims and required healthcare service plans to pay interest on uncontested claims not paid promptly within the required time period; • ~~laws~~ **Laws** in some states that prohibit non- domiciled entities from owning and operating medical practices in such states; • ~~federal~~ **Federal** and state laws and regulations restricting the techniques that may be used to collect past due accounts from consumers, such as our patients, for services provided to the consumer; and • ~~state~~ **State** laws that require healthcare providers that assume professional and institutional risk (i. e., global risk) to either obtain a license under the Knox- Keene Health Care Service Plan Act of 1975 or receive an exemption from the California Department of Managed Healthcare (" DMHC ") for the contract (s) under which the entity assumes global risk. Any violation or alleged violation of any of these laws or regulations by us or our affiliates could have a material adverse effect on our business, financial condition and results of operations. Changes in healthcare laws could create an uncertain environment and materially impact us. We cannot predict the effect that the ACA (also known as Obamacare) and its implementation, amendment, or repeal and replacement, may have on our business, results of operations, or financial condition. Any changes in healthcare laws or regulations that reduce, curtail, or eliminate payments, government-subsidized programs, government- sponsored programs, and / or the expansion of Medicare or Medicaid, among other actions, could have a material adverse effect on our business, results of operations, and financial condition. For example, the ACA dramatically changed how healthcare services are covered, delivered, and reimbursed. The ACA requires insurers to accept all applicants, regardless of pre- existing conditions, cover an extensive list of conditions and treatments, and charge the same rates, regardless of pre- existing condition or gender. The ACA and the Health Care and Education Reconciliation Act of 2010 (collectively, the " Health Care Reform Acts ") also mandated changes specific to home health and hospice benefits under Medicare. In 2012, the U. S. Supreme Court upheld the constitutionality of the ACA, including the " individual mandate " provisions of the ACA that generally require all individuals to obtain healthcare insurance or pay a penalty. However, the U. S. Supreme Court also held that the provision of the ACA that authorized the Secretary of the U. S. Department of Health and Human Services (" HHS ") to penalize states that choose not to participate in the expansion of the Medicaid program by removing all of its existing Medicaid funding was unconstitutional. In response to the ruling, a number of state governors opposed its state' s participation in the expanded Medicaid program, which resulted in the ACA not providing coverage to some low- income persons in those states. In addition, several bills have been, and are continuing to be, introduced in U. S. Congress to amend all or significant provisions of the ACA, or repeal and replace the ACA with another law. In December 2017, the individual mandate was repealed via the Tax Cuts and Jobs Act of 2017. Afterwards, legal and political challenges as to the constitutionality of the remaining provisions of the ACA resumed. Just as the fate of the ACA is uncertain, so is the future of care organizations established under the ACA such as ACOs and NGACOs. Under its NGACO Participation Agreement with CMS, our operations are always subject to the nation' s healthcare laws, as amended, repealed, or replaced from time to time. The net effect of the ACA on our business is subject to numerous variables, including the law' s complexity, lack of complete implementing regulations and interpretive guidance, gradual and potentially delayed implementation, or possible amendment, as well as the uncertainty as to the extent to which states will choose to participate in the expanded Medicaid program. The continued implementation of provisions of the ACA, the adoption of new regulations thereunder and ongoing challenges thereto, also added uncertainty about the current state of U. S. healthcare laws and could negatively impact our business, results of operations, and financial condition. Healthcare providers could be subject to federal and state investigations and payor audits. Due to our and our affiliates' participation in government and private healthcare programs, we are from time to time involved 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. Federal and state government agencies have active civil and criminal enforcement efforts against healthcare companies, and their executives and managers. The DRA,

which provides a financial incentive to states to enact their own false claims acts, and similar laws encourage investigations against healthcare companies by different agencies. These investigations could also be initiated by private whistleblowers. Responding to audit and investigative activities are costly and disruptive to our business operations, even when the allegations are without merit. If we are subject to an audit or investigation, a finding could be made that we or our affiliates erroneously billed or were incorrectly reimbursed, and we may be required to repay such agencies or payors, may be subjected to pre- payment reviews, which can be time- consuming and result in non- payment or delayed payments for the services we or our affiliates provide, and may be subject to financial sanctions or required to modify our operations. Controls imposed by Medicare, Medicaid, and private payors designed to reduce admissions and lengths of stay, commonly referred to as " utilization review, " have affected and are expected to continue to affect our operations. Federal law contains numerous provisions designed to ensure that services rendered by hospitals and other care providers to Medicare and Medicaid patients meet professionally recognized standards and are medically necessary and that claims for reimbursement are properly filed. These provisions include a requirement that a sampling of admissions of Medicare and Medicaid patients must be reviewed by quality improvement organizations, which review the appropriateness of Medicare and Medicaid patient admissions and discharges, the quality of care provided, and the appropriateness of cases of extraordinary length of stay or cost on a post- discharge basis. Quality improvement organizations may deny payment for services or assess fines and also have the authority to recommend to the HHS that a provider is in substantial non- compliance with the standards of the quality improvement organization and should be excluded from participation in the Medicare program. The ACA potentially expands the use of prepayment review by Medicare contractors by eliminating statutory restrictions on its use, and, as a result, efforts to impose more stringent cost controls are expected to continue. Utilization review is also a requirement of most non- governmental managed care organizations and other third- party payors. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by payor- required pre- admission authorization and utilization review and by third- party payor pressure to maximize outpatient and alternative healthcare delivery services for less acutely ill patients. Although we are unable to predict the effect these controls and any changes thereto may have on our operations, significant limits on the scope of our services reimbursed and on reimbursement rates and fees could have a material, adverse effect on our business, financial position, and results of operations. We do not have a Knox- Keene license. The Knox- Keene Health Care Service Plan Act of 1975 was passed by the California State Legislature to regulate California managed care plans and is currently administered by the DMHC. A Knox- Keene Act license is required to operate a healthcare service plan, e. g., an HMO, or an organization that accepts global risk, i. e., accepts full risk for a patient population, including risk related to institutional services, e. g., hospital, and professional services. Applying for and obtaining such a license is a time- consuming and detail- oriented undertaking. We currently do not hold any Knox- Keene license. If the DMHC were to determine that we have been inappropriately taking risk for institutional and professional services as a result of our various hospital and physician arrangements without having any Knox- Keene license or applicable regulatory exemption, we may be required to obtain a Knox- Keene license and could be subject to civil and criminal liability, any of which could have a material adverse effect on our business, results of operations, and financial condition. A Knox- Keene Act license or exemption from licensure, where applicable, is required to operate a healthcare service plan, e. g., an HMO, or an organization that accepts global risk, i. e., accepts full risk for a patient population, including risk related to institutional services, e. g., hospital, and professional services. The DMHC has instituted ~~financial solvency~~ regulations **that** ~~. The regulations~~ are intended to provide a formal mechanism for monitoring the financial solvency **and operational performance** of a RBO in California, including capitated physician groups. Under current DMHC regulations, our affiliated physician groups, as applicable, are required to, among other things: • Maintain, at all times, a minimum " cash- to- claims ratio " (which means the organization' s cash, marketable securities, and certain qualified receivables, divided by the organization' s total unpaid claims liability) of 0. 75; and • Submit periodic reports to the DMHC containing various data and attestations regarding their performance and financial solvency, including IBNR calculations ~~and~~ **,** documentation **,** and attestations as to whether or not the organization (i) was in compliance with the " Knox- Keene Act " requirements related to claims payment timeliness, (ii) had maintained positive tangible net equity (" TNE "), and (iii) had maintained positive working capital. In the event that a physician group is not in compliance with any of the above criteria, it would be required to describe in a report submitted to the DMHC the reasons for non- compliance and actions to be taken to bring it into compliance. Under such regulations, the DMHC can also make some of the information contained in the reports public, including, but not limited to, whether or not a particular physician organization met each of the criteria. In the event any of our affiliated physician groups are not able to meet certain of the financial solvency requirements, and fail to meet subsequent corrective action plans, it could be subject to sanctions, or limitations on, or removal of, its ability to do business in California. There can be no assurance that our affiliated physician groups, such as our IPAs, will remain in compliance with DMHC requirements or be able to timely and adequately rectify non- compliance. To the extent that we need to provide additional capital to our affiliated physician groups in the future in order to comply with DMHC regulations, we would have less cash available for other parts of our operations. Our revenue will be negatively impacted if our physicians fail to appropriately document their services. We rely upon our affiliated physicians to appropriately and accurately complete necessary medical record documentation and assign appropriate reimbursement codes for their services. Reimbursement is conditioned upon, in part, our affiliated physicians providing the correct procedure and diagnosis codes and properly documenting the services themselves, including the level of service provided and the medical necessity for the services. If our affiliated physicians have provided incorrect or incomplete documentation or selected inaccurate reimbursement codes, this could result in non- payment for services rendered or lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third- party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. Retroactive adjustments may change amounts realized from third- party payors and result in

recoupments or refund demands, affecting revenue already received. Primary care physicians may seek to affiliate with our and our competitors' IPAs at the same time. It is common in the medical services industry for primary care physicians to be affiliated with multiple IPAs. Our affiliated IPAs therefore may enter into agreements with physicians who are also affiliated with our competitors. However, some of our competitors at times have agreements with physicians that require the physician to provide exclusive services. Our affiliated IPAs often have no knowledge, and no way of knowing, whether a physician is subject to an exclusivity agreement without being informed by the physician. Competitors have initiated lawsuits against us alleging in part interference with such exclusivity arrangements, and may do so again in the future. An adverse outcome from any such lawsuit could adversely affect our business, cash flows , and financial condition. If we inadvertently employ or contract with an excluded person, we may face government sanctions. Individuals and entities can be excluded from participating in the Medicare and Medicaid programs for violating certain laws and regulations, or for other reasons such as the loss of a license in any state, even if the person retains other licensure. This means that the excluded person and others are prohibited from receiving payments for such person' s services rendered to Medicare or Medicaid beneficiaries, and if the excluded person is a physician, all services ordered (not just provided) by such physician are also non- covered and non- payable. Entities that employ or contract with excluded individuals are prohibited from billing the Medicare or Medicaid programs for the excluded individual' s services, and are subject to civil penalties if it does. The U. S. Department of Health and Human Services Office of the Inspector General maintains a list of excluded persons. Although we have instituted policies and procedures to minimize such risks, there can be no assurance that we will not inadvertently hire or contract with an excluded person, or that our employees or contracts will not become excluded in the future without our knowledge. If this occurs, we may be subject to substantial repayments and civil penalties, and the hospitals at which we furnish services may also be subject to repayments and sanctions, for which they may seek recovery from us, which could adversely affect our business, cash flows, and financial condition. Compliance with federal and state privacy and data security laws is expensive, and we may be subject to government or private actions due to privacy and security breaches. We must comply with various federal and state laws and regulations governing the collection, dissemination, access, use, security, and confidentiality of PHI, including HIPAA and HITECH. As part of our medical record keeping, third- party billing, and other services, we collect and maintain PHI in paper and electronic format. Privacy and data security laws and regulations thus could have a significant effect on the manner in which we handle healthcare- related data and communicates with payors. In addition, compliance with these standards could limit our ability to offer services, thereby negatively impacting the business opportunities available to us. Despite our efforts to prevent privacy and security breaches, it may still occur. If any non- compliance with such laws and regulations results in privacy or security breaches, we could be subject to monetary fines, suits, penalties, or sanctions. As a result of the expanded scope of HIPAA through HITECH, we may incur significant costs in order to minimize the amount of " unsecured PHI " that we handle and retain , and / or to implement improved administrative, technical, or physical safeguards to protect PHI. We may have to demonstrate and document our compliance efforts, even if there is a low probability that PHI has been compromised, in order to overcome the presumption that an impermissible use or disclosure of PHI results in a reportable breach. We may incur significant costs to notify the relevant individuals, government entities and, in some cases, the media, in the event of a breach and to provide appropriate remediation and monitoring to mitigate any potential damage. We may be subject to liability for failure to fully comply with applicable corporate and securities laws. We are subject to various corporate and securities laws. Any failure to comply with such laws could cause government agencies to take action against us, which could restrict our ability to issue securities and result in fines or penalties. Any claim brought by such an agency could also cause us to expend resources to defend ourselves, divert the attention of our management from our business and could significantly harm our business, operating results, and financial condition, even if the claim is resolved in our favor. A plaintiffs' securities law firm announced that it was investigating ApolloMed and its pre- 2017 Merger board of directors for potential federal law violations and breaches of fiduciary duties in connection with the 2017 Merger. This investigation purportedly focused on whether ApolloMed and its board of directors violated federal securities laws or breached their fiduciary duties to ApolloMed' s stockholders by failing to properly value the 2017 Merger and failing to disclose all material information in connection with the 2017 Merger. As of filing of this Annual Report on Form 10- K, no lawsuit has been filed against us by that firm. We cannot preclude the possibility that claims or lawsuits brought relating to any alleged securities law violations or breaches of fiduciary duty in connection with the 2017 Merger could potentially require significant time and resources to defend and / or settle and distract our management and board of directors from focusing on our business. We may face lawsuits not covered by insurance and related expenses may be material. Our failure to avoid, defend, and accrue for claims and litigation could negatively impact our results of operations or cash flows. We are exposed to and become involved in various litigation matters arising out of our business, including from time to time, actual or threatened lawsuits. Malpractice lawsuits are common in the healthcare industry. The medical malpractice legal environment varies greatly by state. The status of tort reform, availability of non- economic damages, or the presence or absence of other statutes, such as elder abuse or vulnerable adult statutes, influence the incidence and severity of malpractice litigation. We may also be subject to other types of lawsuits, such as those initiated by our competitors, stockholders, employees, service providers, contractors, or by government agencies, including when we terminate relationships with them, which may involve large claims and significant defense costs. Many states have joint and several liabilities for providers who deliver care to a patient and are at least partially liable. As a result, if one provider is found liable for medical malpractice for the provision of care to a particular patient, all other providers who furnished care to that same patient, including possibly us and our affiliated physicians, may also share in the liability, which could be substantial individually or in aggregate. The defense of litigation, including fees of legal counsel, expert witnesses, and related costs, is expensive and difficult to forecast accurately. Such costs may be unrecoverable even if we ultimately prevail in litigation and could consume a significant portion of our limited capital resources. To defend lawsuits, it may also be necessary for us to divert officers and other employees from our normal business functions to gather evidence, give testimony, and otherwise support litigation efforts. If we lose any material litigation, we

could face material judgments or awards against them. An unfavorable resolution of one or more of the proceedings in which we are involved now or in the future could have a material adverse effect on our business, cash flows, and financial condition. We may also in the future find it necessary to file lawsuits to recover damages or protect our interests. The cost of such litigation could also be significant and unrecoverable, which may also deter us from aggressively pursuing even legitimate claims. We currently maintain malpractice liability insurance coverage to cover professional liability and other claims for certain hospitalists and clinic physicians. All of our affiliated physicians are required to carry first dollar coverage with limits of coverage equal to $ 1. 0 million for all claims based on occurrence up to an aggregate of $ 3. 0 million per year. We cannot be certain that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us, our affiliated professional organizations, or our affiliated physicians. Liabilities incurred by us or our affiliates 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, and results of operations. Our professional liability insurance coverage generally must be renewed annually and may not continue to be available to us in future years at acceptable costs and on favorable terms, which could increase our exposure to litigation. We may also be subject to laws and regulations not specifically targeting the healthcare industry. Certain regulations not specifically targeting the healthcare industry also could have material effects on our operations. For example, the California Finance Lenders Law (the " CFLL "), Division 9, Sections 22000- 22780 of the California Financial Code, could be applied to us as a result of our various affiliate and subsidiary loans and similar arrangements. If a regulator were to take the position that such loans were covered by the California Finance Lenders Law, we could be subject to regulatory action that could impair our ability to continue to operate and may have a material adverse effect on our profitability and business as we currently do not hold a CFLL licensure. Pursuant to an exemption under the CFLL, a person may make five or fewer commercial loans in a 12- month period without a CFLL licensure if the loans are " incidental " to the business of the person. This exemption, however, creates some uncertainty as to which loans could be deemed as incidental to our business. In addition, a person without a CFLL licensure may also make a single commercial loan in a 12- month period without the loan being " incidental " to such person' s business but this single- loan exemption is currently set to expire on January 1, 2022. Risks Relating to the Ownership of ApolloMed' s Common Stock. We have to meet certain requirements in order to remain as a NASDAQ- listed public company. As a public company, ApolloMed is required to comply with various regulatory and reporting requirements, including those required by the SEC. ~~After~~ **Because** ApolloMed uplisted to NASDAQ in December 2017, it is also subject to NASDAQ listing rules. Complying with these requirements is time- consuming and expensive. No assurance can be given that ApolloMed can continue to meet the SEC reporting and NASDAQ listing requirements. ApolloMed' s common stock may continue to be thinly traded and its market price may be subject to fluctuations and volatility. Stockholders may be unable to sell their shares at a profit and might incur losses. The trading price of ApolloMed' s common stock was volatile and may continue to be so from time to time. The price at which ApolloMed' s common stock trades could be subject to significant fluctuation and may be affected by a variety of factors, including the trading volume, our results of operations, the announcement and consummation of certain transactions, our ability or inability to raise additional capital and the terms thereof, and therefore could fluctuate, and decline, significantly. Other factors that may cause the market price of ApolloMed' s common stock to fluctuate include: • ~~variations~~ **Variations** in our operating results, such as actual or anticipated quarterly and annual increases or decreases in revenue, gross margin or earnings; • ~~changes~~ **Changes** in our business, operations, or prospects, including announcements relating to strategic relationships, mergers, acquisitions, partnerships, collaborations, joint ventures, capital commitments, or other events by us or our competitors; • ~~announcements~~ **Announcements** of acquisitions, dispositions, and other corporate transactions, as well as financings and other capital- raising transactions; • ~~developments~~ **Developments** , conditions, or trends in the healthcare industry; • ~~changes~~ **Changes** in the economic performance or market valuations of other healthcare- related companies; • ~~general~~ **General** market conditions or domestic or international macroeconomic and geopolitical factors unrelated to our performance or financial condition, including economic or political instability, wars, civil unrest, terrorism, epidemics (including COVID- 19), outbreak, and natural disasters; • ~~sales~~ **Sales** of stock by ApolloMed' s stockholders generally and ApolloMed' s larger stockholders, including insiders, in particular, including sale or distributions of large blocks of common stock by our executives and directors; • ~~volatility~~ **Volatility** and limitations in trading volumes of ApolloMed' s common stock and the stock market; • ~~approval~~ **Approval** , maintenance, and withdrawal of our and our affiliates' certificates, permits, registration, licensure, certification, and accreditation by the applicable regulatory or other oversight bodies; • ~~our~~ **Our** financing activities, including our ability to obtain financings and prices that we sell our equity securities, including notes convertible to and warrants to purchase shares of ApolloMed' s common stock; • ~~failures~~ **Failures** to meet external expectations or management guidance; • ~~changes~~ **Changes** in our capital structure and cash position; • ~~analyst~~ **Analyst** research reports on ApolloMed' s common stock, including analysts' recommendations and changes in recommendations, price targets, and withdrawals of coverage; • ~~departures~~ **Departures** and additions of our key personnel, including our officers or directors; • ~~disputes~~ **Disputes** and litigations related to intellectual properties, proprietary rights, and contractual obligations; • ~~changes~~ **Changes** in applicable laws, rules, regulations, or accounting practices and other dynamics; and • ~~other~~ **Other** events or factors, many of which may be out of our control. There may continue to be a limited trading market for ApolloMed' s common stock. A lack of an active market may contribute to stock price volatility or supply / demand imbalances, make an investment in ApolloMed' s common stock less attractive to certain investors, **and / or** impair the ability of ApolloMed' s stockholders to sell shares at the time they desire or at a price that they consider favorable. The lack of an active market may also reduce the fair market value of ApolloMed' s common stock, impair our ability to raise capital by selling shares of ApolloMed' s common stock **,** or use such stock as consideration to attract and retain talent or engage in business transactions. If analysts do not report about us, or negatively evaluate us, ApolloMed' s stock price could decline. The trading market for ApolloMed' s common stock will rely in part on the availability of research and reports that third- party analysts publish about us. There are many large companies active in the healthcare industry, which make it more difficult for us to

receive widespread coverage. Furthermore, if one or more of the analysts who do cover us downgrade ApolloMed' s common stock, its price would likely decline. If one or more of these analysts cease coverage of us, we could lose market visibility, which in turn could cause ApolloMed' s stock price to decline. **Our current principal stockholders, executive officers, and directors have significant influence over our operations and strategic direction and they could cause us to take actions with which other stockholders might not agree and could delay, deter, or prevent a change of control or a business combination with respect to us.** As of December 31, ~~2021~~ **2022** , our executive officers, directors, five percent or greater stockholders, and their respective affiliated entities in the aggregate own approximately ~~29~~ **25** . ~~9~~ **2** % of our outstanding common stock. As a result, these stockholders, who are entitled to vote their shares in their own interests, acting together, exert a significant degree of influence over our management and affairs and over matters requiring stockholder approval, including the election of directors and approval of significant corporate transactions. This concentration of ownership may have the effect of delaying or preventing a change of control, merger, consolidation, sale of all or substantially all of our assets or other corporate transactions that other stockholders may view as beneficial, or conversely, this concentrated control could result in the consummation of a transaction that other stockholders may not support. This may harm the value of our shares and discourage investors from investing in us. Provisions under Delaware law and ApolloMed' s charter and bylaws could deter takeover attempts or attempts to remove its board members or management that might otherwise be beneficial to its stockholders. ApolloMed is subject to Section 203 of the Delaware General Corporation Law, which makes the acquisition of ApolloMed and the removal of its incumbent officers and directors more difficult for potential acquirers by prohibiting stockholders holding 15 % or more of its outstanding voting stock from acquiring it without the consent of its board of directors for at least three years from the date they first hold 15 % or more of the voting stock. These provisions and others that could be adopted in the future could deter unsolicited takeovers or delay or prevent changes in ApolloMed' s control or management, including transactions in which ApolloMed' s stockholders might otherwise receive a premium for their shares over then current market prices. These provisions may also limit the ability of ApolloMed' s stockholders to approve transactions that they may deem to be in their best interests. Additionally, ApolloMed' s charter and bylaws contain additional provisions, such as the authorization for its board of directors to issue one or more classes of preferred stock and determine the rights, preferences, and privileges of the preferred stock, which could cause substantial dilution to a person or group that attempts to acquire ApolloMed on terms not approved by the board, and the ownership requirement for ApolloMed' s stockholders to call special meetings, that could deter, discourage, or make it more difficult for a change in control of ApolloMed or for a third party to acquire ApolloMed, even if such a change in control could be deemed in the interest of ApolloMed' s stockholders, or if such an acquisition would provide ApolloMed' s stockholders with a substantial premium for their shares over the market price of ApolloMed' s common stock. As such, these provisions could discourage a potential acquirer from acquiring us or otherwise attempting to obtain our control and increase the likelihood that our incumbent directors and officers will retain their positions. We may issue additional equity securities in the future, which may result in dilution to existing investors. If ApolloMed issues additional equity securities, its existing stockholders may experience substantial dilution. ApolloMed may sell equity securities and may issue convertible notes and warrants in one or more transactions at prices and manners as we may determine from time to time, including at prices (or exercise prices) below the market price of ApolloMed' s common stock, for capital- raising purposes, including in any debt financing, registered offering, or private placement, and new investors could have superior rights such as liquidation and other preferences. To attract and retain the right talent, ApolloMed may also issue equity awards under its equity compensation plans to its officers, other employees, directors, and consultants from time to time. ApolloMed may also issue additional shares of its common stock or other securities that are convertible into or exercisable for common stock in connection with future acquisitions or for other business purposes. In addition, the exercise or conversion of outstanding options or warrants to purchase shares of ApolloMed' s stock may result in dilution to its existing stockholders upon any such exercise or conversion.