Risk Factors Comparison 2024-02-20 to 2023-02-17 Form: 10-K

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Our business is subject to a number of factors that could materially affect future developments and performance. In addition to factors affecting our business that have been described elsewhere in this Form 10- K, any of the following risks could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Additional risks and uncertainties not presently known to us or that we currently deem immaterial also may impair our business operations. We may update these risk factors in our periodic and other filings with the SEC. The following is a summary of the principal risk factors described in this section: ~~• Our financial condition and results of operations have been and may continue to be materially adversely affected by the ongoing COVID- 19 pandemic.~~ • Economic conditions could have an adverse effect on our business. • The birth rate in the United States has declined in past years and may decline further. • Unfavorable changes or conditions could occur in the states where our operations are concentrated. • Potential healthcare reform efforts may have a significant effect on our business. • COVID- 19 necessitated the delivery of certain healthcare services remotely via telehealth, which is subject to extensive federal and state regulation, as well as temporary waivers tied to the COVID- 19 public health emergency, and certain flexibilities afforded to the provision and reimbursement of telehealth may be rolled back. • The Medicare Access and CHIP Reauthorization Act of 2015 (" MACRA ") and potential changes to it may have a significant effect on our business. • The Transparency in Coverage Final Rule, which requires certain health plans and issuers to publish pricing information on in- network and out- of- network providers and make price comparison and cost-sharing information available to insureds, could have a material impact on our business. • State budgetary constraints and the uncertainty over the future of Medicaid could have an adverse effect on our reimbursement from Medicaid programs. • Congress or states have, and may continue to, enact surprise billing or other laws restricting the amount out- of- network providers of services can charge and recover for such services. • Expanding eligibility of GHC Programs could adversely affect our reimbursement. • Government- funded programs, private insurers, or state laws and regulations may limit, reduce, or make retroactive adjustments to reimbursement amounts or rates. • We may become subject to billing investigations by federal and state government authorities and private insurers, and government authorities may determine that we have failed to comply with applicable laws, rules or regulations. • Outsourcing internal business functions has significant risks, and our failure to manage these risks successfully could materially adversely affect our business, results of operations and financial condition. • We may not find suitable acquisition candidates or successfully integrate our acquisitions. Our acquisitions may expose us to greater business risks and could affect our payor mix. • We may not be able to successfully execute our same- unit and organic growth strategies. • We are subject to litigation risks. • We may not be able to collect reimbursements for our services from third- party payors. • Our current indebtedness and any future indebtedness could adversely affect us by reducing our flexibility to respond to changing business and economic conditions and expose us to interest rate risk to the extent of any variable rate debt. In addition, a certain portion of our interest expense may not be deductible. • We may not be able to successfully recruit, onboard and retain qualified physicians and other clinicians and other personnel, and our compensation expense for existing clinicians and other personnel may increase. • Our employees and business partners may not appropriately secure and protect confidential information in their possession. • Changes in federal and state information privacy and security laws could cause us to incur costs to comply, including potential changes to technology systems, legal and consulting services, and potential litigation risk. Risks Related to Macroeconomic Conditions Our operations and performance depend significantly on economic conditions. During the year ended December 31, ~~2022~~ **2023**, the percentage of our patient service revenue being reimbursed under GHC Programs remained relatively stable as compared to the year ended December 31, ~~2021~~ **2022**. If, however, economic conditions in the United States deteriorate, we could experience shifts toward GHC Programs, and patient volumes and reimbursement for services we provide could decline. Further, we could experience and have experienced shifts toward GHC Programs if changes occur in population demographics within geographic locations in which we provide services. Adverse economic conditions could also lead to additional increases in the number of unemployed and under- employed workers and a decline in the number of private employers that offer healthcare insurance coverage to their employees. Employers that do offer healthcare coverage may increase the required contributions from employees to pay for their coverage and increase patient responsibility amounts. In addition, certain private payors' poor experience with the healthcare insurance exchanges and any uncertainty around the future of the ACA **,** and healthcare insurance exchanges may result in those payors exiting the healthcare insurance exchange marketplaces or the cessation of the healthcare insurance exchanges. As a consequence, the number of patients who participate in GHC Programs or who are uninsured or underinsured could increase. Payments received from GHC Programs are substantially less than payments received from private healthcare insurance programs (managed care and other third- party payors). Payments under policies issued through the healthcare insurance exchanges may be less than payments from private healthcare insurance programs and in some cases, patients' responsibility for costs related to healthcare plans obtained through the healthcare insurance exchanges may be high and could increase in the future, and we may experience increased bad debt due to patients' inability to pay for certain services. A payor mix shift from private healthcare insurance programs to GHC Programs or to healthcare insurance exchanges has resulted and may continue to result in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net revenue, as well as a significant reduction in our average reimbursement rates. While we have developed a number of strategic initiatives across our organization, in both our shared services functions and our operational infrastructure, to address some of the effects of changes in economic conditions, there is no assurance that these initiatives will be successful in generating improvements in our general and administrative

expenses and our operational infrastructure. If these initiatives are unsuccessful, it could have an adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities. The erosion in the tax base caused by a general economic downturn can cause restrictions on the federal and state governments' abilities to obtain financing and a decline in spending. If the economy were to contract into a recession (for example, as a result of the global COVID- 19 pandemic, inflation, or as a result of a significant increase in prevailing interest rates), our government payors or other counterparties that owe us money could be delayed in obtaining, or may not be able to obtain, necessary funding and / or financing to meet their cash flow needs. As a result, we may face increased pricing pressure, termination of contracts, reimbursement rate cuts or reimbursement delays from Medicare and Medicaid and other governmental payors, which could have an adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities. The birth rate in the United States has declined and may decline further. ~~Final~~ **Preliminary** birth data for ~~2021~~ **2022** indicate that total births in the United States **remained effectively flat** ~~increased by approximately 1 %~~ as compared to ~~2020, the first increase in the number of births since 2014. However, the number of births in 2020 fell to a record low, with the decline attributed to COVID- 19. The number of births in~~ 2021 ~~was approximately 2 % lower than the number of births in 2019~~. Provisional data for ~~2022~~ **2023** is not yet available **. The flat birth rate suggests the rebound in births in 2021, the first increase in the number of births since 2014, was likely transient** . Future declines in births are possible, particularly if there is an economic recession, and could have an adverse effect on our patient volumes, net revenue, results of operations, cash flows, financial condition and the trading price of our securities. **of our securities.** A majority of our net revenue in ~~2023~~ **2022** was generated by our operations in five states.In particular,Texas accounted for approximately 32 % of our net revenue in ~~2023~~ **2022** .See Item 1.Business — " Geographic Coverage." Adverse changes or conditions affecting these particular states,such as healthcare reforms,changes in laws and regulations,increases in unreimbursed services arising from services furnished to undocumented noncitizens,reduced Medicaid eligibility or reimbursements and government investigations,economic conditions,weather conditions,and natural disasters may have an adverse effect on our business,financial condition,results of operations,cash flows and the trading price ~~of our securities.~~ Our financial condition and results of operations have been and may continue to be materially adversely affected by the ~~ongoing~~ coronavirus pandemic (COVID- 19) and its variants **, and any future pandemics or outbreaks** . ~~The~~ **In early 2020, the** outbreak of the SARS- Cov- 2 virus and the COVID- 19 disease that it causes (collectively, " COVID- 19 ") evolved into a global pandemic that spread to most regions of the world, including virtually all of the United States. With ~~multiple~~ variant strains still circulating, the extent to which COVID- 19 **may** ~~will continue to~~ impact our business and operating results is ~~highly~~ uncertain and cannot be accurately predicted, including new information that may emerge concerning COVID- 19, its variants and the actions to contain it or treat its impact ~~, such as the potential for further shutdown or stay at home orders, and shifts toward GHC Programs if changes occur in population demographics within geographic locations in which we provide services, including an increase in unemployment and underemployment as well as losses of commercial health insurance. Our office- based practices, which specialize in maternal-fetal medicine, pediatric cardiology, and numerous pediatric subspecialties, may experience an elevation of appointment cancellations as a result of COVID- 19 and any related new variant, similar to the patterns experienced in the first half of 2020 at the onset of the COVID- 19 pandemic. We believe COVID- 19, either directly or indirectly, also had an impact on our NICU patient volumes, and there is no assurance that impacts from COVID- 19 and its related variants will not further adversely affect our NICU patient volumes or otherwise adversely affect our NICU and related neonatology business~~ . Overall, our operating results were significantly impacted by the COVID- 19 pandemic beginning in mid- March 2020, but volumes began to normalize in May 2020 and substantially recovered during the months of June 2020 through December 2020. ~~During 2021 and 2022, volumes across our services returned to pre- COVID- 19 levels.~~ To the extent the COVID- 19 pandemic **or any future pandemic or outbreak** materially adversely affects our business and financial results, it may also have the effect of significantly heightening many of the other risks associated with our business and indebtedness, including those described in this Form 10- K. The foregoing and other continued disruptions to our business as a result of COVID- 19 or any future pandemic **or outbreak** could result in a material adverse effect on our business, results of operations, financial condition, prospects and the trading prices of our securities. A majority of......, cash flows and the trading price of our securities. The value of our common stock may fluctuate. There has been significant volatility in the market price of securities of healthcare companies generally that we believe in many cases has been unrelated to operating performance. In addition, we believe that certain factors, such as actual and potential legislative and regulatory developments, including announced regulatory investigations, quarterly fluctuations in our actual or anticipated results of operations, lower revenue or earnings than those anticipated by securities analysts, not meeting publicly announced expectations, general economic and financial market conditions, and the effect of short interest in our common stock could cause the price of our common stock to fluctuate substantially. Risks Related to Governmental Changes and the Healthcare Regulatory Environment We could be affected by potential changes to healthcare laws, rules and regulations, including changes to subsidies, healthcare insurance marketplaces and Medicaid expansion **and contraction** . The **status of the** ACA ~~has faced many~~ - **may be subject to change as a result of political, legislative, regulatory, and administrative developments, as well as judicial proceedings. While there have been multiple attempts to repeal or amend the ACA through legislative action and** legal challenges **, legislative attempts** ~~since its inception and may be subject~~ to ~~further modification as a result of court intervention. On~~ **completely repeal the ACA have been unsuccessful to date, and on** June 17, 2021, the United States Supreme Court ~~in California et al. v. Texas et al.~~ dismissed ~~a significant~~ **the most recent** judicial challenge to the ACA brought by several states **without specifically ruling on** ~~. If decided in favor of~~ the **constitutionality** ~~plaintiff states, the entirety~~ of the ACA ~~could have been jeopardized, but the Court sided with supporters of the ACA in a way that left the law in effect in its current form~~ . Another potentially existential challenge to the ACA is advancing in federal courts. ~~In~~ **Specifically, in** Braidwood Management v. Becerra, the plaintiffs argue that the ~~law~~ **ACA** ' s requirement that insurance cover certain preventive services **without cost sharing** is unconstitutional. In September 2022, a

federal district court in Texas ruled **partly** in favor of the plaintiffs **and partly in favor of the Department of Health and Human Services, which is defending the ACA** , finding, among other things, that the requirement that self- funded plans and insurers cover certain preventive services violates the plaintiffs' rights under the Religious Freedom Restoration Act. The **federal government appealed this decision to the Fifth Circuit Court of Appeals, which subsequently issued an administrative stay of the district court' s ruling, thereby allowing the federal government to continue enforcing the preventive services requirement while the 5th Circuit considers the** case **. The case** ~~is likely to be appealed and~~ may ultimately be resolved by the United States Supreme Court. If the case succeeds, millions of Americans could lose access to preventive care guaranteed by the ACA or be forced to pay out of pocket for these services **, and such an outcome could materially impact our business** . The ACA provided premium tax credits to help make insurance more affordable for individuals and families with incomes between 100 % and 400 % of the federal poverty limit. The American Rescue Plan Act (" ARPA") enacted in March 2021, temporarily extended these tax credits to individuals with incomes above 400 % of the federal poverty level and made the subsidy more generous for those below 400 %. The ARPA tax credits were originally set to expire on January 1, 2023, but Congress through the Inflation Reduction Act, enacted in mid- 2022, extended the expanded tax credits through 2025. Partially because of these changes, millions of people newly enrolled in health exchange plans. If these tax credits are allowed to lapse, many Americans could lose insurance coverage, and that change could have a material impact on our business. We expect the current Administration to continue to advance changes to the U. S. healthcare system, including changes to the ACA and further expanding government- funded health insurance options and potentially replacing current healthcare financing mechanisms with systems that would be entirely administered by the federal government. ~~Any~~ **We cannot say for certain whether there will be additional future challenges to the ACA or what impact, if any, such challenges may have on our business. Changes resulting from these proceedings, and any** legislative or administrative change to the current healthcare ~~delivery or~~ financing ~~systems~~ - **system,** could have a material adverse effect on our **business,** financial condition, results of operations, cash flows and the trading price of our securities. In addition ~~to the potential impacts~~ to the ACA, there could be changes to other GHC Programs, such as a change to the ~~structure of~~ Medicaid **program design or Medicaid coverage and reimbursement rates set forth under federal or state law** . **Historically,** ~~Congressional~~ ----- **Congress** and **the** ~~administrative~~ **Administration** ~~proposals, in recent years, have~~ sought to convert Medicaid into a block grant or to institute per capita spending caps, among other things. ~~More recently~~ **These changes** , ~~Democrats in Congress have sought to expand~~ **if implemented, could eliminate the guarantee that everyone who is eligible and applies for** Medicaid **benefits would receive them and could potentially give states new authority to restrict eligibility, cut benefits and / or make it more difficult** ~~or~~ **for people to enroll. Additionally, several states are considering and pursuing changes to their** Medicaid **programs, such as requiring recipients** ~~- like coverage in states that have not yet expanded Medicaid. ARPA included provisions intended~~ to ~~incentivize non- expansion states to expand Medicaid~~ **engage in employment or education activities as a condition of** eligibility for ~~all~~ **most** adults ~~with~~ **, disenrolling recipients for failure to pay a premium, or adjusting premium amounts based on** income ~~up to 138 % of the federal poverty limit by providing a five- percentage- point increase in the Medicaid federal matching assistance percent or FMAP for eight calendar quarters. This FMAP increase was only available to states that have not yet expanded coverage and have not yet started paying for the expansion population prior the enactment of the law. Other changes, if enacted and implemented, could materially impact our business. Former administrators of CMS, the agency responsible for administering Medicaid at the federal level, have indicated that they intend to increase state flexibility in the administration of Medicaid programs, and states have continued to explore payment and delivery reform initiatives, including beneficiary work requirements and quality of care incentives. However, it is unclear whether this trend toward encouraging state flexibility in the administration of Medicaid will continue under the current administration or under future administrations~~ . Many states have **transitioned** ~~recently shifted~~ a **substantial portion** ~~majority or all~~ of their Medicaid program beneficiaries into Managed Medicaid Plans **, which are administered by commercial insurance companies** . Managed Medicaid Plans have some flexibility to set rates for providers, but many states require minimum provider rates in their contracts with such plans. In July of each year, CMS releases the annual Medicaid Managed Care Rate Development Guide which provides federal baseline rules for setting reimbursement rates in managed care plans. We could be affected by lower reimbursement rates in some or all of the Managed Medicaid Plans with which we participate. We could also be materially impacted if we are dropped from the provider network in one or more of the Managed Medicaid Plans with which we currently participate. In Florida, more than 75 % of the Medicaid population participates in a Managed Medicaid Plan, with even higher participation rates for children. In response to the COVID- 19 Public Health Emergency (~~"~~ **"** PHE ~~"~~ **"**), Congress **passed the Family First Coronavirus Response Act, which** provided state Medicaid programs a 6. 2 percentage point increase in the ~~federal~~ **Federal** ~~share~~ **Medical Assistance Percentage (" FMAP ")** if states meet certain maintenance of eligibility (~~"~~ **"** MOE ~~"~~ **"**) requirements that ensure continuous coverage for current enrollees. As a result, all Medicaid beneficiaries ~~are~~ **were** continuously enrolled in Medicaid **during much** ~~until the end~~ of the COVID- 19 PHE. Legislation enacted in late 2022 ~~allows~~ **phased down the FMAP increase from April 1, 2023 to December 31, 2023. To continue receiving the increased FMAP during that transition period,** states **were required** to ~~begin~~ **conduct** Medicaid eligibility redeterminations and renewals beginning April 1, 2023 ~~, regardless of whether the COVID- 19 PHE has ended~~ . ~~After~~ **As of** December 31, 2023, there will be no additional increase in FMAP. **More** ~~It is estimated that~~ **than 13** ~~as many as 15~~ million people ~~currently~~ enrolled in Medicaid ~~may lose~~ **lost** coverage as a result **of these changes, and more disenrollments are expected** . This change could have a material impact on our business. Moreover, certain potentially material changes seem likely with respect to government reimbursement and the healthcare industry in general. For instance, the ~~2023~~ **2024** Medicare Physician Fee Schedule Final Rule decreased the ~~2023~~ **2024** conversion factor (i. e., the amount Medicare pays per relative value unit (wRVU)) by nearly **3.** 4 ~~. 5~~ % from the ~~2022~~ **2023** amount **.** ~~, following expiration of the 3 % increase to last year' s conversion factor mandated by~~ Congress **may** ~~. While Congress passed~~ -- **pass** legislation to absorb ~~half~~ **some** of these cuts, **but** ~~physicians face a 2 % decrease in~~ Medicare payments **to physicians are**

expected to ~~in 2023 and a 3. 5 %~~ decrease in 2024. This reduction will adversely affect reimbursement for physician services and could also negatively impact other GHC Program reimbursement and commercial payor reimbursement **. These changes could materially impact our business** . We cannot predict with any assurance the ultimate effect of these laws and resulting changes to payments under GHC Programs, nor can we provide any assurance that they will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, any fiscal tightening impacting GHC Programs or changes to the structure of any GHC Programs could have an adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities. **Finally, the expiration of the COVID- 19 national emergency and PHE declarations in May 2023 also ended waivers for the provision of certain services, and returning our services to a pre- pandemic regulatory state similarly may increase our exposure to legal, regulatory, compliance and clinical risks.** In an effort to address 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 and to provide safe access to care for our patients, we ~~have~~ converted certain in- person visits to telehealth visits **and have continued to provide services in this manner** . There is significant variation in demand, consumer acceptance, and market adoption of telehealth services. The provision of telehealth is largely regulated at the state level and can include, among other things, variations in the definition of telehealth, physician / patient relationship requirements, informed consent for telehealth services, licensure, scope of practice, covered modalities, electronic prescribing, coverage and reimbursement, and privacy and security requirements. Our ability to conduct telehealth services and provide medical services in a particular jurisdiction is directly dependent upon the applicable laws governing remote healthcare, the practice of medicine and healthcare delivery in general in such location, which are subject to changing political, regulatory and other influences. While numerous federal agencies ~~have~~ released waivers to ease regulatory obstacles to the adoption of telehealth, many of these waivers do not override applicable state laws. States have adopted waivers as well but differ in the scope and application of such waivers and also on the time period the waiver is available. Many state waivers in relation to COVID- 19 have already expired **. On a federal level** , ~~despite~~ **CMS created flexibilities for the provision and reimbursement of telehealth for Medicare beneficiaries during the PHE. While some of these flexibilities have been permanently extended, recent federal legislation authorized** the extension of **many of** the **Medicare** ~~federal public health~~ **telehealth** ~~emergency declaration~~ **flexibilities through December 31, 2024** . Evolving interpretations and acceptance of telehealth by medical boards, state attorneys general and other regulatory or administrative bodies require us to monitor our compliance with law in every jurisdiction in which we operate, on an ongoing basis, and we cannot provide assurance that our activities and arrangements, if challenged, will be found to be in compliance with the law. Monitoring regulatory changes at the federal and state levels has and will continue to incur costs for us and may result in making changes to our business operations to ensure continued compliance. Challenges also exist with respect to coverage and reimbursement of telehealth services by both commercial and governmental payors. ~~On a federal level, CMS created flexibilities for the provision and reimbursement of telehealth for Medicare beneficiaries during the PHE. However, unless~~ **Unless** Congress enacts permanent telehealth coverage, ~~these~~ -- **the** flexibilities and additional billing codes that are currently available ~~,~~ will not be available indefinitely. If telehealth services achieve coverage, there is no guarantee that reimbursement will be equivalent to in- person care and may negatively impact our financial condition. ~~Negative publicity in any of our markets concerning our products or services or the telehealth market as a whole could limit market acceptance of our services. Similarly, individual~~ **Individual** and healthcare industry concerns or negative publicity regarding patient confidentiality and privacy in the context of telehealth could limit market acceptance of our healthcare services when delivered remotely. If any of these events occur, it could have an adverse effect on our business, financial condition, results of operations and the trading price of our securities. The Medicare Access and CHIP Reauthorization Act of 2015 (" MACRA ") and potential changes to it may have an adverse effect on our business. MACRA contains numerous measures that could affect us, including, requirements that physicians participate in quality measurement programs that differentiate payments to physicians under Medicare based on quality and cost of care, rather than the quantity of procedures performed. **The** ~~Beginning in 2020, the~~ Merit- based Incentive Payment System (" MIPS ") ~~allowed~~ **allows** eligible physicians to receive incentive payments based on the achievement of certain quality and cost metrics, among other measures, and be reduced for those who are underperforming against those same metrics and measures. We currently anticipate that our affiliated physicians will continue to be eligible to receive bonus payments in ~~2023~~ **2024** through participation in the MIPS, although the amounts of such bonus payments are not expected to be material. We will continue to operationalize the provisions of MACRA and assess any further changes to the law or additional regulations enacted pursuant to the law. We cannot predict with any assurance the ultimate effect of MACRA and resulting changes to payments under GHC Programs, nor can we provide any assurance that they will not have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, any fiscal tightening impacting GHC Programs or changes to the structure of any GHC Programs could have an adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities. The Transparency in Coverage Final Rule, published November 12, 2020, aims to put health pricing information into the hands of consumers and allow them to select their providers based, in part, on cost. The final rule imposes two main requirements. First, **as of July 1, 2022,** certain health plans and insurers **are** ~~will be~~ required to publish on a public website machine- readable files containing information on their in- network negotiated rates, billed charges and allowed amounts paid for out- of- network providers, and the negotiated rate and historical net price for prescription drugs. **Second, as of** ~~Although the final rule required such files to be published by~~ January 1, ~~2022~~ **2023** ~~, the Departments of Labor, Health and Human Services, and the Treasury extended the deadline to July 1, 2022 for most items and services and delayed it indefinitely (pending further rulemaking) for prescription drugs. Second~~ , certain health plans and issuers must ~~begin reporting~~ --- **report** to their covered members certain pricing information (including the in- network rate and out- of- network allowed amounts) and cost- sharing obligations for covered items and services. ~~This information must be reported for 500 items and services as of January 1, 2023~~

~~and for all items and services by January 1, 2024.~~ These requirements remain subject to change, and we cannot predict how the availability of this health pricing information may impact our business operations and patient volumes **. Moreover, Congress is considering legislation that imposes additional transparency requirements on providers** . If patients choose to use services of less costly providers, we could see a reduction in patient volumes or decide to reduce the prices of our services to compensate, either of which could have an adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities. The ACA allowed states to expand their Medicaid programs through federal payments that fund most of the cost of increasing the Medicaid eligibility income limit from a state' s historic eligibility levels to 133 % of the federal poverty level. As of December 31, ~~2022~~ **2023** , ~~39~~ **40** states **,** and the District of Columbia **,** adopted the expansion of Medicaid eligibility. All of the states in which we operate, however, already cover children in the first year of life and pregnant women if their household incomes are at or below 133 % of the federal poverty level. If states that expanded Medicaid reduce or eliminate eligibility for certain individuals, the number of patients who are uninsured could increase. Some states may seek to maintain expanded eligibility and ~~to do so~~ could offset the cost by further reducing payments to providers of services. In some states, we could experience delayed or reduced Medicaid payment for services furnished to program enrollees. Moreover, **Democrats in** Congress **have sought** ~~is considering ways~~ to expand Medicaid **or Medicaid- like coverage** in states that have not **yet** expanded **Medicaid. They also have sought to reduce** ~~it on their own and may consider corresponding provider payment~~ **payments** ~~reductions~~ **to certain hospitals** in **some of** ~~those~~ **these** states **. Should any of these changes take effect, we cannot predict with any assurance the ultimate effect to reimbursements for our services** . Congress and the Biden Administration may also seek substantial reforms to Medicaid law and the ability of states to design Medicaid programs. Any changes, if enacted, could reduce or eliminate eligibility for certain individuals or reduce payments to providers of services. As a result, we could experience an increase in the number of uninsured patients and delayed or reduced Medicaid payment for services furnished to program enrollees. In addition, many states are continuing to collect less tax revenue than they did historically and as a consequence continue to face budget shortfalls and underfunded pension and other obligations. Although shortfalls have been declining in more recent budgetary years, they are still significant by historical standards. The financial condition of the states in which we do business could lead to reduced or delayed funding for Medicaid programs and, in turn, reduced or delayed reimbursement for physician services, which could adversely affect our results of operations, cash flows and financial condition. Any changes to Medicaid eligibility, enrollment, financing or reimbursement could have a material adverse effect on our financial condition, results of operations, cash flows and the trading price of our securities. Congress or states have, and may continue to, enact laws restricting the amount out- of- network providers of services can charge and recover for such services. In late 2020, Congress enacted legislation intended to protect patients from " surprise " medical bills when services are furnished by providers who are not in network with the patient' s insurer (the " No Surprises Act ~~"~~ **"** or the ~~"~~ NSA ~~"~~). Effective January 1, 2022, if the patient' s insurance plan is subject to the NSA, providers are not permitted to send patients an unexpected or " surprise " medical bill that arises from out- of- network emergency care provided at ~~an~~ **certain** out- of- network ~~facility~~ **facilities** or at **certain** in- network facilities by out- of- network **emergency** providers ~~and~~ **, as well as** out- of- network nonemergency care provided at **certain** in- network facilities without the patient' s informed consent. Many states have legislation on this topic and will continue to modify and review their laws pertaining to surprise billing. Under the NSA, patients are ~~only~~ required to ~~pay~~ **be charged no more than** the in- network cost- sharing amount **. Certain providers** , **including Pediatrix, are required to develop and disclose a " Good Faith Estimate " (" GFE ") that details the expected charges for furnishing an item or service to an uninsured or self- pay patient. The GFE will be required to include certain specific information such as, among other things, co- provider service cost estimates, and is subject to certain format, availability and dispute resolution requirements. Insurers are required to calculate the patient' s total cost- sharing amount pursuant to rules set forth in the NSA and its implementing regulations** which ~~has been determined through~~ **, in some cases,** ~~an~~ **can** ~~established regulatory formula~~ **be calculated by reference to the applicable qualifying payment amount for the items or services received. Patient cost- sharing amounts for items** and ~~will~~ **services subject to the NSA** count toward the patient' s health plan deductible and out- of- pocket cost- sharing limits. **For claims subject to the NSA,** ~~Providers~~ **providers** are generally not permitted to balance bill patients beyond this cost- sharing amount. An out- of- network provider is only permitted to bill a patient more than the ~~in- network~~ cost- sharing amount **allowed under the NSA** for ~~care~~ **certain types of services** if the provider **satisfies all aspects** ~~gives the patient notice~~ of **an informed consent process set forth in** the ~~provider~~ **NSA** ' s **implementing regulations** ~~network status and delivers to the patient or their health plan an estimate of charges within certain specified timeframes and obtains the patient' s written consent prior to the delivery of care~~ . Providers that violate these surprise billing prohibitions may be subject to state enforcement action or federal civil monetary penalties. ~~Also under~~ **The impact of the GFE requirements on the Company remains uncertain at this time, in part due to ongoing rulemaking around** the NSA **, as well as the delayed effective date of certain provisions of the GFE framework, uncertainty around operational timeframes, potential penalties and patient reaction, among other things. For claims subject to the NSA, including many emergency care services** , out of network providers **are** ~~will be~~ paid an amount determined by the patient' s insurer ~~for services rendered in the emergency care setting~~ ; if a provider is not satisfied with the amount paid for the services, the provider can pursue recourse through an independent dispute resolution (~~"~~ **"** IDR ~~"~~ **"**) process. ~~These~~ -- **The outcome of each** IDR ~~results will bind~~ **dispute is generally binding on** both the provider and payor ~~for a 90- day period~~ **with respect to the particular claims at issue in that dispute but may not affect an insurer' s future offers of payment. The interim final rules establishing the IDR process were subject to legal challenges that resulted in the Eastern District of Texas vacating certain provisions of such rules and related guidance documents in August 2023** . In ~~August~~ **response, on December 18,** ~~2022~~ **2023** , **CMS** ~~the United States Department of Health and Human Services, Department of Labor and Department of Treasury (the " Departments ")~~ issued ~~their~~ **a** final rule ~~and corresponding guidance implementing certain portions of~~ **that included new provisions governing payments associated with** the IDR process ~~under the NSA. The Departments plan to~~

~~publish additional rules and guidance in the coming months and years. Certain IDR- related provisions of the NSA are being challenged in courts by provider groups, and the result of this litigation may alter portions of the law. Accordingly, we cannot predict how these IDR results will compare to the rates that our affiliated physicians customarily receive for their services~~ . These measures could limit the amount we can charge and recover for services we furnish where ~~we provide care within healthcare facilities that participate with a patient' s insurer, but~~ we have not contracted with the patient' s insurer, and therefore could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Moreover, these measures could affect our ability to contract with certain payors and under historically similar terms and may cause, and the prospect of these changes may have caused, payors to terminate their contracts with us and our affiliated practices, further affecting our business, financial condition, results of operations, cash flows and the trading price of our securities. Additionally, the new federal law, as well as some of the existing state laws, require providers to make certain disclosures about these protections, as well as disclosures about expected charges. These requirements impose administrative burdens that could increase our cost of doing business and expose us to compliance risk. In ~~January~~ **February** 2018, Congress reauthorized the Children' s Health Insurance Program (" CHIP ") through ~~2023 and then in February 2018 lengthened this funding extension through~~ 2027. Changes to CHIP or the ACA' s expansion of Medicaid coverage could cause patients who otherwise would have participated in private healthcare insurance programs to participate in GHC Programs, or vice versa, or cause patients who otherwise would have been covered by CHIP or Medicaid to lose insurance coverage altogether. Additional reform efforts ~~,~~ could change the eligibility requirements for Medicaid and for other GHC Programs, including CHIP, and could increase the number of patients who participate in such programs or the number of uninsured patients ~~. In 2021, the results of the federal and state elections affected which persons and parties occupy the Office of the President of the United States and control both chambers of Congress and many states' governors and legislatures. The President' s healthcare agenda includes protecting and strengthening Medicaid as well as ACA marketplace participation~~ . In general, payments received from GHC Programs are substantially less than payments received from private healthcare insurance programs (managed care and other third- party payors). A shift in the mix of our payors from private healthcare insurance programs to government payors may result in an increase in our estimated provision for contractual adjustments and uncollectibles and a corresponding decrease in our net revenue, as well as a significant reduction in our average reimbursement rates. Additionally, if Congress does not act to extend CHIP beyond 2027, or if Congress extends CHIP but substantially alters the current program, we could be adversely affected if children in states where we do business lose Medicaid coverage or payments for services furnished to these children are delayed or reduced. Government- funded programs, private insurers or state laws and regulations may limit, reduce or make retroactive adjustments to reimbursement amounts or rates. A significant portion of our net revenue is derived from payments made by GHC Programs, principally ~~Medicare and~~ Medicaid, including the managed care plans under the ~~Medicare and~~ Medicaid ~~programs~~ **program** . These government- funded programs, as well as private insurers, have been and may continue to be subject to changes, including increased use of managed care organizations, value- based purchasing, and new patient care models to control the cost, eligibility for, use and delivery of healthcare services as a result of budgetary constraints and cost containment pressures due to unfavorable economic conditions, rising healthcare costs and for other reasons, including those described above under Item 1. Business — " Government Regulation — Government Regulatory Requirements. " Federal and state legislatures or administrators of these government- funded programs and private insurers may attempt other measures to control costs, including bundling of services and denial of, or reduction in, reimbursement for certain services and treatments. In addition, increased consolidation among private insurers is resulting in fewer and larger third- party payors with increased negotiating power. As a result, payments from government programs or private payors may decrease significantly. ~~Also~~ **In recent years** , **legislative and regulatory changes have resulted in limitations and reductions in payments to healthcare providers for certain services under the Medicare program. For example, Congress established automatic spending reductions under the Budget Control Act of 2011 (the " BCA "), resulting in a 2 % reduction in Medicare payments that began in 2013 and extend through the first six months of the FY 2032 sequestration order. As a result of the COVID- 19 pandemic, this reduction was temporarily suspended from May 1, 2020 through March 31, 2022, with subsequent reductions to 1 % from April 1, 2022 until June 30, 2022. The 2 % reduction was then reinstated and has been in effect since June 30, 2022. In addition, as a result of ARPA,** ~~any~~ **an additional Medicare payment reduction of up to 4 % was requested to take effect in January 2022; however, Congress has delayed implementation of this reduction until 2025. Any** adjustment in Medicare reimbursement rates may have a detrimental impact on our reimbursement rates not only for Medicare patients, but also for patients covered under Medicaid and other third- party payors, because a state' s Medicaid payments cannot exceed the payments it would have made had those patients been enrolled in traditional Medicare, and other third- party payors often base their reimbursement rates on a percentage of Medicare rates. ~~The 2023 Medicare Physician Fee Schedule Final Rule decreased~~ **It is difficult to predict whether, when or what** ~~the~~ **other deficit reduction initiatives may be proposed** ~~2023 conversion factor (i. e., the amount Medicare pays per relative value unit (" wRVU ")) by nearly 4. 5 % from the 2022 amount, following expiration of the 3 % increase to last year' s conversion factor mandated~~ by Congress. **We anticipate that** ~~On December 20, 2022, Congress unveiled~~ the **federal deficit will continue** ~~Consolidated Appropriations Act of 2023, offering some reprieve from the Medicare physician payment cuts; namely, the 2023 spending package reduces the physician payment cuts~~ to **place pressures on GHC Programs** ~~2 % in 2023 and 3. 5 % in 2024. Unless Congress or the Medicare agency intervenes, more payment reductions could be made in 2025 and subsequent years~~ . Our business may also be materially affected by limitations on, or reductions in, reimbursement amounts or rates or elimination of coverage for certain individuals or treatments. Our business may also be materially affected by changes in medical codes for services that our affiliated clinicians provide if services under a new code are reimbursed at a lower rate. For example, the medical code for certain of our hearing screen services was recently changed by CMS to a code that could provide for lower reimbursement rates. While we have not yet experienced any material decrease in reimbursement rates as a result of this coding change, we are still evaluating the result

of this change on our hearing screen contracts and ultimate effect of this coding change is not known at this time. Moreover, because government- funded programs generally provide for reimbursements on a fee- schedule basis rather than on a charge- related basis, we generally cannot increase our revenue from these programs through increases in the amount we charge for our services. To the extent our costs increase, we may not be able to recover our increased costs from these programs, and cost containment measures and market changes in non- government- funded insurance plans have generally restricted our ability to recover, or shift to non- governmental payors, these increased costs. In addition, funds we receive from third- party payors are subject to audit with respect to the proper billing for physician and ancillary services and, accordingly, our revenue from these programs may be adjusted retroactively. Any retroactive adjustments to our reimbursement amounts could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. In addition, our agreements with certain third- party payors are terminable for various reasons. If an agreement with a third- party payor is terminated, we are generally required to seek reimbursement as an out- of- network provider. In the event we attempt to balance- bill patients, we may be limited in our ability to do so by certain state and federal laws and regulations, as discussed above. As these laws and regulations continue to develop, it could incentivize certain third- party payors to terminate agreements as a business strategy which could lower overall reimbursement to providers. Any reductions in reimbursement amounts could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Adverse **economic** developments in the United States could lead to a reduction in federal government expenditures, including GHC Programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the federal government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the federal government may stop or delay making payments on its obligations, including funding for government programs in which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Further, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicare and Medicaid, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected. We may become subject to billing investigations by federal and state government authorities and private insurers. Federal and state laws, rules and regulations impose substantial penalties, including criminal and civil fines, monetary penalties, exclusion from participation in government healthcare programs and imprisonment, on entities or individuals (including any individual corporate officers or individual providers deemed responsible) that fraudulently or wrongfully bill government- funded programs or other third- party payors for healthcare services. CMS contracts with a variety of contractors to audit providers, such as Medicare Administrative Contractors (" MACs "), Unified Program Integrity Contractors (" UPICs "), and Recovery Audit Contractors (" RACs "). These audits can result in overpayment determinations and recoupments from providers. CMS may also impose Medicare payment suspensions based on billing irregularities or credible allegations of fraud or Medicare enrollment revocations based on a number of reasons, including billing irregularities. CMS requires states to maintain a Medicaid RAC program. States are required to contract with one or more eligible Medicaid RACs to review Medicaid claims for any overpayments or underpayments, and to recoup overpayments from providers on behalf of the state. Federal laws, along with a growing number of state laws, allow a private person to bring a civil action in the name of the government for false billing violations. See Item 1. Business — " Government Regulation — Fraud and Abuse Provisions. " Further, identified overpayments from Medicare or Medicaid must be refunded to the government within 60 days of identification or the entity could be held liable under the federal **False Claims Act ("** FCA **")** , including for treble damages and substantial civil penalties **, currently set at $ 13, 946 up to $ 27, 894 per false claim or statement for penalties assessed after January 15, 2024** . In addition, our contracts with private insurers often provide such insurers with audit rights over payments made to us and the ability to seek recoupment for overpayments. We believe that audits, inquiries and investigations from government agencies, government contractors and private insurers will occur from time to time in the ordinary course of our business, which could result in substantial costs to us, legal actions by or against us, and a diversion of management' s time and attention. New regulations and heightened enforcement activity also could materially affect our cost of doing business and our risk of becoming the subject of an audit or investigation. We cannot predict whether any future audits, inquiries or investigations, or the public disclosure of such matters, likely would have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. See Item 1. Business — " Government Investigations. " The healthcare industry is highly regulated, and government authorities may determine that we have failed to comply with applicable laws, rules or regulations. The healthcare industry and physicians' medical practices, including the healthcare and other services that we and our affiliated physicians provide, are subject to extensive and complex federal, state and local laws, rules and regulations, compliance with which imposes substantial costs on us. ~~Of particular importance are~~ **Applicable U. S. federal and state and non- U. S. healthcare laws and regulations include** the ~~provisions summarized as follows~~ **following** : • **the** federal **Anti- Kickback Statute, a criminal** ~~laws~~ - **law, which** ~~(including the federal FCA) that prohibit~~ **prohibits , among other things, persons and** entities ~~and individuals~~ from knowingly and willfully ~~(or with reckless disregard or deliberate ignorance) presenting or causing to be presented false or fraudulent claims to Medicare, Medicaid and other government- funded programs, or improperly retaining known overpayments; oWhen an entity is determined to have violated the federal FCA, it may be required to pay three times the actual damages sustained by the government, plus significant mandatory civil penalties for each separate false claim, subject to annual inflation. Suits filed under the federal FCA can be brought directly by the government or be brought by an individual (known as a " relator " or, more commonly, as a " whistleblower ") on behalf of the government, known as " qui tam " actions. Relators bringing qui tam actions under the federal FCA receive a share of any amounts paid by the entity to the government in fines or settlement. In addition, certain states have enacted laws modeled after the federal FCA.~~

~~Qui tam actions have increased significantly in recent years, causing greater numbers of healthcare companies to have to defend a false claim action, even before the validity of the claim is established and even if the government decides not to intervene in the lawsuit. Healthcare entities may decide to agree to large settlements with the government and / or whistleblowers to avoid the cost and negative publicity associated with litigation. oThe ACA amended federal law to provide that the government may assert that a claim including items or services resulting from a violation of the federal anti- kickback statute constitutes a false or fraudulent claim for purposes of the federal civil FCA. Criminal prosecution is also possible for knowingly making or presenting a false or fictitious or fraudulent claim to the federal government. oRetention of a known overpayment from the government is also a false claim subject to the FCA. Failure to promptly identify and return overpayments to the government could subject us to substantial liability under the FCA, including potential qui tam actions. • a provision of the Social Security Act, commonly referred to as the federal " anti- kickback " statute, that prohibits the knowing and willful offer~~ **offering** , ~~payment~~ **paying** , ~~solicitation~~ --- **soliciting** or **receiving** ~~receipt of~~ any remuneration, ~~including a bribe, kickback, rebate,~~ directly or indirectly, in cash or in kind, ~~in return~~ **to induce** ~~for~~ - **or reward** ~~the referral, arrangement for, or recommendation of patients for, or for the~~ purchasing, leasing, ordering **,** or arranging for, ~~items and~~ **referring, or recommending the purchase, lease or order of any good or** ~~services~~ - **service** for which payment may be made, in whole or in part, **under GHC** ~~by federal healthcare programs~~ **Programs** ~~,~~ such as Medicare and Medicaid ~~; oThe definition of " remuneration " has been broadly interpreted to include anything of value, including such items as gifts, discounts, the furnishing of supplies or equipment, credit arrangements, waiver of payments, and providing anything at less than its fair market value~~ . A person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. **Violations** ~~Due to the broad sweep~~ of the federal ~~anti~~ **Anti** - ~~kickback~~ **Kickback** ~~statute~~ **Statute can result in significant civil monetary penalties** ~~, Congress established certain exceptions to the definition of remuneration under the statute~~ and **criminal fines** ~~also authorized the HHS Office of the Inspector General to issue regulations~~ , ~~commonly known~~ as ~~safe harbors, that remove certain arrangements from the definition of remuneration under the statute, provided that the arrangement satisfies, in their entirety, the provisions of the particular exception or safe harbor. Meeting a statutory exception or regulatory safe harbor under the federal anti- kickback statute will~~ **well as** ~~assure parties to the arrangement that they will not be prosecuted under the federal anti- kickback statute. The failure of a transaction or arrangement to fit precisely within one or more safe harbors does not necessarily mean that it is illegal or that prosecution will be pursued. However, conduct and business arrangements that do not fully satisfy each applicable safe harbor element may result in increased scrutiny by government enforcement authorities or invite litigation by private citizens under state or federal false claims statutes. oOur relationships with referral sources, including GHC Program patients, are subject to scrutiny under the federal anti- kickback statute and must be structured in a manner to promote compliance. oThe penalties for violating the federal anti- kickback statute include~~ imprisonment ~~for up to ten years, fines of up to $ 100, 000 per violation of~~ and ~~possible~~ exclusion from **participation in GHC Programs; • the** federal ~~healthcare~~ **civil False Claims Act, which may be enforced through civil whistleblower or qui tam actions and imposes significant civil penalties, treble damages and potential exclusion from GHC** ~~programs~~ **Programs against individuals or entities** ~~such as Medicare and Medicaid. A federal anti- kickback statute violation can also form the basis~~ for ~~a false claim under the FCA. Many states have adopted prohibitions similar to the federal anti- kickback statute, some of which apply to the referral of patients for healthcare items and services reimbursed by any source, not only by government programs such as Medicare and Medicaid. • a provision of the Social Security Act, the federal Physician Self- Referral Law, commonly referred to as the Stark Law, that, subject to certain exceptions, prohibits physicians from making a referral to an entity for certain " designated health services " or " DHS " payable by Medicare if the physician, or an immediate family member of the physician, has a direct or indirect financial relationship (including ownership interests and compensation arrangements) with the entity. The Stark Law also prohibits such an entity from presenting or causing to be presented a claim to Medicare for DHS provided pursuant to a prohibited referral, and provides that certain collections related to any such claims must be refunded in a timely manner. Although the Stark Law is drafted to apply only to Medicare claims, the DOJ has taken the position that it applies to Medicaid claims under an extension of the federal FCA and several courts, including federal district courts in Florida and Texas, have agreed. oThe Stark Law is a strict liability statute and therefore, any referrals for Medicare DHS pursuant to a financial relationship that does not meet an exception will be nonpayable and subject to refund to Medicare. In addition, any Medicare " overpayment " (that is, Medicare funds to which a person is not entitled) must be returned within 60 days of identification — or risk liability under the FCA' s " obligation " provision. Therefore, claims relating to Stark Law violations must be timely refunded to Medicare or we would risk liability under the federal FCA. oAll of our relationships with referring physicians will implicate the Stark Law, including our ownership, physician employment, independent contractor physicians, lease arrangements with physicians, nonmonetary compensation to physicians, and our relationships with hospitals and other entities. Each such financial relationship must satisfy a Stark Law exception. oBecause our practices perform and bill for DHS within the practice (e. g., outpatient drugs, laboratory services, etc.), an exception to the Stark Law must be met with respect to those referrals. Generally, the In- Office Ancillary Services (" IOAS ") Exception is utilized for referrals of DHS made within a physician' s group practice. Alternatively, the Physician Services Exception could also be used to shield referrals of physician services within a physician group. In order to utilize both the IOAS Exception and the Physician Services Exception, the group must~~ , among other things, ~~satisfy~~ **knowingly presenting, or causing to be presented, to** the ~~Stark Law' s definition of~~ **federal government, claims for payment that are false or fraudulent or for making** a ~~" group practice~~ **false record or statement material to an obligation to pay the federal government or for knowingly and improperly avoiding, decreasing or concealing an obligation to pay money to the federal government** . ~~"~~ **Further, a violation of the federal Anti- Kickback Statute can serve as a basis for liability under the federal civil False Claims Act.** ~~The~~ **There is** ~~group practice definition~~ also ~~encompasses how a physician practice may compensate its physician shareholders, employees, and independent contractors. Our ancillary services revenues must be allocated in a compliant manner to avoid falling outside of~~ the ~~Group Practice definition~~ **federal Criminal False Claims Act** ,

which ~~would result in all of~~ **is similar to the federal Civil False Claims Act and imposes criminal liability on those that make** ~~our~~ - **or present a false** ~~Medicare (and potentially~~ , **fictitious or fraudulent claim** ~~Medicaid) DHS referral revenues becoming nonpayable, and subject~~ to ~~refund.~~ **the federal government;** • ~~Violations of the Stark Law may result in civil penalties and program exclusions for knowing violations, civil assessment of up to three~~ -- **the** ~~times the amount claimed. oAnother~~ federal ~~law, the~~ Civil Monetary Penalties Law (“ CMPL ”) ~~provides for additional~~ **, which authorizes the imposition of substantial** civil monetary penalties against an entity that engages in ~~prohibited~~ activities including ~~but~~ **, among others (1) knowingly presenting, or causing to be presented, a claim for services** not ~~limited~~ **provided as claimed or that is otherwise false or fraudulent in any way; (2) arranging for or contracting with an individual or entity that is excluded from participation in federal health care programs** to **provide items or services reimbursable by a federal health care program; (3)** violations of the **federal** ~~Stark Law or anti~~ **Anti** - ~~kickback~~ **Kickback** ~~laws,~~ **Statute; or (4) failing to report and return a** ~~knowing~~ -- **known** ~~submission~~ **overpayment; • the Eliminating Kickbacks in the Recovery Act** of ~~a false~~ **2018 (“ EKRA ”) establishes criminal penalties** ~~or~~ **for paying** ~~fraudulent claim~~ , ~~employment of~~ **receiving, soliciting or offering any remuneration in return for referring a patient to a laboratory, clinical treatment facility or recovery home, or in exchange for** an ~~excluded~~ individual ~~and~~ **using the services of one of** ~~the~~ **these entities. The EKRA prohibitions apply** ~~provision or offer of anything of value~~ to ~~a Medicare or Medicaid beneficiary that~~ **services covered by GHC programs and by private health plans. •** the **federal Physician Payment Sunshine Act, which requires applicable manufacturers** ~~transferring party knows or should know is likely to influence beneficiary selection~~ of ~~a particular provider~~ **covered drugs, devices, biologics, and medical supplies** for which payment ~~may be made~~ **is available under Medicare, Medicaid or the Children’ s Health Insurance Program, among others, to annually track and report payments and other transfers of value provided to U. S.- licensed physicians, teaching hospitals, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, anesthesiologist assistants and certified nurse- midwives, as well as certain ownership and investment interests held** in ~~whole~~ **the manufacturer by physicians and their immediate families; • the federal Physician Self- Referral Law, commonly referred to as the Stark Law, is a strict liability civil law that prohibits physicians from making “ referrals ”** ~~or~~ **for** ~~in part~~ **“ designated health services, ” payable** by Medicare or Medicaid **, to entities with which the physician or an immediate family member of the physician has a “ financial relationship, ” unless an exception applies. The Stark Law further prohibits entities which have received such referrals from filing claims with Medicare (or billing another individual, entity or third- party payor) for those referred services. The term “ designated health services ” includes, among other things, inpatient and outpatient hospital services, home health services, and clinical laboratory services** ; ~~o “ Remuneration ” is defined under the CMPL as any transfer of items or services for free or for less than fair market value. There are certain exceptions to the definition of remuneration for offerings that meet the Financial Need, Preventative Care, or Promoting Access to Care exceptions. Sanctions for violations of the CMPL include civil monetary penalties and administrative penalties up to and including exclusion from participation in federal healthcare programs.~~ • similar state law provisions pertaining to anti- kickback, fee splitting, self- referral and false claims, and other fraud and abuse issues which typically are not limited to relationships involving government- funded programs. In some cases **,** these laws prohibit or regulate additional conduct beyond what federal law affects, including applicability to items and services paid by commercial insurers and private pay patients. Penalties for violating these laws can range from physician licensure sanctions, fines and criminal sanctions; • ~~provisions of 18 U. S. C. § 1347 that prohibit~~ **statutes created by HIPAA, which impose criminal liability for, among other things,** knowingly and willfully executing **or attempting to execute** a scheme ~~or artifice~~ to defraud ~~a~~ **any** healthcare benefit program **, including private insurance plans, or, in any matter involving a healthcare benefit program,** ~~or~~ **for knowingly and willfully** ~~falsifying, concealing or covering up a material fact or~~ making ~~any material~~ **materially** false, fictitious or fraudulent ~~statement~~ **statements** in connection with the delivery of or payment for ~~healthcare~~ ---- **health care** benefits ~~, items or services. A person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation~~ ; • federal and state regulations that broadly define provider and supplier affiliation and require providers to disclose to GHC Programs certain disclosable events including, without limitation, current or previous direct or indirect affiliations with providers or suppliers having uncollected debt to GHC Programs, being subject to payment suspension, being excluded from participation in GHC Programs or had such billing privileges denied or revoked, and that permit GHC Programs to deny or revoke provider or supplier enrollment based upon such affiliations upon determining that the affiliations pose an undue risk of fraud, waste, or abuse; • state laws that prohibit **or limit** general business corporations from practicing medicine, exercising control over physicians’ medical decisions or engaging in certain practices or financial arrangements, such as splitting fees with physicians. These laws and their interpretations vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion, and are subject to change and to evolving interpretations by state boards of medicine and state attorneys general, among others; • federal and state laws governing participation in GHC Programs could result in denial of our application to become a participating provider or revocation of our participation or billing privileges, which in turn, could cause us to not be able to treat patients covered by the applicable program or prohibit us from billing for the treatment services provided to such patients; • federal and state laws that prohibit providers from billing and receiving payment from Medicare and Medicaid for services unless the services are medically necessary, adequately and accurately documented, and billed using codes that accurately reflect the type and level of services rendered; • federal and state laws and policies that require healthcare providers to maintain licensure, certification, or accreditation to enroll and participate in the Medicare and Medicaid programs, to report certain changes in their operations to the agencies that administer these programs; • reassignment of payment rules that prohibit certain types of billing and collection practices in connection with claims payable by the Medicare or Medicaid programs; • laws that regulate debt collection practices, as applied to our debt collection practices; • federal and state laws pertaining to the provision and coverage of services by non- physician practitioners, such as advanced nurse practitioners, physician assistants and other clinical professionals,

physician supervision of such services and reimbursement requirements that may be dependent on the manner in which the services are provided and documented; and • federal laws that impose civil administrative sanctions for, among other violations, inappropriate billing of services to federal healthcare programs, inappropriately reducing hospital inpatient lengths of stay for such patients or employing individuals who are excluded from participation in federally funded healthcare programs. In addition, we believe that our business will continue to be subject to increasing regulation, the scope and effect of which we cannot predict. See Item 1. Business — " Government Regulation. " We may in the future become the subject of regulatory or other investigations, audits or proceedings, and our interpretations of applicable laws, rules and regulations may be challenged, which could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. For example, in some states, we are dependent on our relationship with affiliated practices, which we do not own, to provide physician and other clinical services, and our business would be adversely affected if those relationships were disrupted or if our arrangements with our providers are found to violate state laws prohibiting the corporate practice of medicine or fee splitting, or if our contractual relationships with such entities ~~ceases~~ - **cease** to continue. Our contracts include management services agreements among other agreements with such affiliated practices, to which these practices reserve exclusive control and responsibility for all aspects of the practice of medicine and delivery of medical services. While we seek to substantially comply with the applicable state prohibitions on the corporate practice of medicine and fee splitting, these laws could impact our business operations, and state officials who administer these laws or other third parties may successfully challenge our contractual arrangements, which could subject us to civil and criminal penalties and require us to restructure our relationships with providers to comply with these statutes, which could have a material adverse effect on our business, financial condition, and operations. Additionally, state corporate practice of medicine doctrines often impose penalties on physicians themselves for aiding the corporate practice of medicine, which could impact physicians participating with our affiliated practices. See Item 1. Business — " Government Regulation — Fee Splitting; Corporate Practice of Medicine. " Further, regulatory authorities or other parties also could assert that our relationships, including fee arrangements, among our affiliated professional contractors, hospital clients or referring physicians violate the anti- kickback, fee splitting **, EKRA,** or self- referral laws and regulations or that we have submitted false claims or otherwise failed to comply with government program reimbursement requirements. See Item 1. Business — " Government Regulation — Fraud and Abuse Provisions " and " — Government Regulatory Requirements. " In addition, ~~federal and state law enforcement agencies have indicated that funds distributed under the Coronavirus Aid, Relief, and Economic Security Act (" CARES Act ") to reimburse eligible healthcare providers for lost revenue and expenses attributable to COVID- 19 (" Provider Relief Funds ") will be subject to scrutiny and that any non- compliance with the terms and conditions for receiving Provider Relief Funds may require recipients to repay some or all amounts received and / or may subject recipients to investigations and potential fines and penalties, including liability under the FCA. Such investigations, proceedings and challenges could result in substantial defense costs to us and a diversion of management' s time and attention. In addition,~~ violations of these laws are punishable by monetary fines, civil and criminal penalties, exclusion from participation in GHC Programs, and forfeiture of amounts collected in violation of such laws and regulations, any of which could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Additionally, federal and state fraud and abuse laws, rules and regulations are not static and amendments, clarifications, revisions, or other modifications to these laws may occur from time to time. For instance, on December 2, 2020, both CMS and ~~the Department of Health and Human Services Office of Inspector General ("~~ OIG ~~")~~ issued Final Rules revising the federal anti- kickback statute, the CMPL **, EKRA** , and the Stark Law regulations to foster arrangements that would promote care coordination, advance the delivery of value- based care, and protect consumers from harms caused by fraud and abuse through additional new statutory definitions, safe harbors, and exceptions. Compliance with federal fraud and abuse laws such as the anti- kickback statute, the CMPL, and the Stark Law involves constant monitoring for regulatory changes, agency and court interpretations, and revisiting of arrangements based on new interpretations or clarifications, all of which will require ongoing compliance costs. In addition, these laws and their exceptions and safe harbors are complex and clear interpretations are not always available. Despite our efforts to comply, we cannot guarantee that a government agency will necessarily agree with our interpretations or that one or more of our arrangements will not be subject to challenge, nor can we provide any assurance that they will not have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Government authorities or other parties may assert that our business practices violate antitrust laws. The healthcare industry is subject to close antitrust scrutiny. The FTC, the Antitrust Division of the DOJ and state Attorneys General all actively review and, in some cases, take enforcement action against businesses, particularly in the healthcare industry, and can also bring antitrust suits. Violations of antitrust laws may be punishable by substantial penalties, including significant monetary fines and treble damages, civil penalties, criminal sanctions, and consent decrees and injunctions prohibiting certain activities or requiring divestiture or discontinuance of business operations. Any of these penalties could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Our affiliated physicians and other individual providers may not satisfy all conditions of payment or otherwise appropriately record or document services that they provide. Our affiliated physicians and other individual providers are responsible for maintaining all required professional licensures or certifications in good standing, which is generally a condition of reimbursement in GHC Programs and in private insurance, and for appropriately recording and documenting the services that they provide. We use this information to seek reimbursement for their services from third- party payors. In addition, we utilize third- party contractors to perform certain revenue cycle management functions for healthcare providers, including medical coding. If our affiliated physicians or other individual providers and third- party contractors do not appropriately document, or where applicable, code for their services or our customers' services, we could be subjected to administrative, regulatory, civil, or criminal investigations or sanctions and our business, financial condition, results of operations and cash flows could be materially adversely affected. We are further obligated under the federal FCA to timely

report and return any identified overpayments and to maintain reasonable internal audit mechanisms to identify overpayments. Failure to timely report and return overpayments to Medicare or Medicaid could subject us to liability under the federal FCA, and also equivalent false claims acts on the state level. Risks Related to Our Business Strategy We **are undertaking a transformation of our revenue cycle management function from an outsourced provider to a hybrid function that utilizes both our corporate personnel as well as one or more third- party service providers. This transition will involve significant time and resources, and our failure to execute this transition efficiently and effectively may have a material impact on our business, financial condition, results of operations, cash flows and the trading price of our securities. On October 30, 2023, we provided notice to R1 RCM Holdco Inc. (f / k / a R1 RCM Inc.) (" R1RCM ") that we were terminating that certain Services Agreement, dated May 12, 2021, as amended, by and between our wholly- owned subsidiary PMG Services, Inc. and R1RCM (the " Services Agreement "), effective as of December 15, 2023. Our termination of the Services Agreement was in connection with R1RCM' s performance, specifically R1RCM' s failure to meet certain service levels set forth in the Services Agreement. Pursuant to the Services Agreement, R1RCM was the primary provider of our enterprise revenue cycle management services, and R1RCM is continuing to provide us with transition assistance pursuant to the terms of the Services Agreement. Following the termination of the Services Agreement, we are undertaking a transformation of our revenue cycle management function from R1RCM, as an outsourced provider, to a hybrid function that utilizes both our corporate personnel as well as one or more third- party service providers that we intend to engage to support these activities. The success of this plan depends, in part, on our ability to scale our internal operations to handle certain revenue cycle management functions internally, to engage one or more third- party service providers to handle other revenue cycle management functions, and to integrate those service providers with our systems in a timely and efficient manner. If we are not able to successfully achieve these objectives, the anticipated benefits of this transformation may not be realized fully or at all or may take longer to realize than expected. These activities may be complex and time consuming and involve delays or additional and unforeseen expenses. The process of transitioning to these third- party service providers, the integration process and other disruptions may also disrupt our ongoing businesses or cause inconsistencies in standards, controls, procedures and policies that could adversely affect our relationships with payors, patients, hospitals and others. The transformation may entail significant management and staff personnel time and a complicated phase- in process, where difficulties in training personnel in new technology can frequently occur. In connection with the transformation of our revenue cycle management function, we could experience a further reduction in revenue due to delays in collection efforts or the inability to collect from patients or third- party payors, claim denials, recoupments, or governmental and third- party audits, all of which may impact our profitability and cash flow. Further, the costs associated with the transformation of our revenue cycle management function, as well as the additional costs and risks associated with any operational problems, delays in collections from payors, and errors and control issues during the termination and transition process, may impact our ability to realize the intended benefits from transforming our revenue cycle management function and may have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. We** currently outsource, and from time to time in the future may outsource, a portion of our internal business functions to third- party providers. Outsourcing these functions has significant risks, and our failure to successfully manage these risks could materially adversely affect our business, results of operations and financial condition. We currently, and from time to time in the future ~~,~~ may **,** outsource portions of internal business functions, including our revenue cycle management functions, to third- party service providers. These functions are performed both domestically and in offshore locations, with our oversight. If our outsourcing partners fail to perform their obligations in a timely manner at satisfactory quality levels, in compliance with regulatory requirements, or if they are unable to attract or retain sufficient personnel with the necessary skill sets to meet our outsourcing needs, the efficiency, effectiveness and quality of our services could suffer. Reliance on third- party providers could have significant negative consequences, including significant disruptions in our operations and significantly increased costs to undertake such operations, either of which could damage our relationships with our patients and customers. In connection with the transition of our revenue cycle management function, we have and could experience a further reduction in revenue due to delays in collection efforts or the inability to collect from patients or third- party payors, claim denials, recoupments, or governmental and third- party audits, all of which have and may further impact our profitability and cash flow. In addition, our reliance on a workforce in other countries exposes us to disruptions in the business, political and economic environment in those regions. Further, any changes to existing laws or the enactment of new legislation restricting offshore outsourcing in the United States may adversely affect our ability to outsource functions to third- party offshore service providers. Our ability to manage any difficulties encountered could be largely outside of our control. In addition, federal government and third- party payors may have prohibitions or restrictions on the use of third- party service providers outside of the United States and / or require notice for the use of such third- party service providers. Diminished service quality from outsourcing, our inability to utilize offshore service providers or the failure to comply with restrictions on the use of third- party service providers could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. We have expanded and continue to seek to expand our presence in new and existing metropolitan areas by acquiring established physician group practices. Also, both independently and in collaboration with our hospital partners, we may seek to expand into new specialties and subspecialties. In addition, we have acquired physician and other healthcare services companies that are complementary to our physician practices. Our acquisition strategy involves numerous risks and uncertainties, including: • We may not be able to identify suitable acquisition candidates or strategic opportunities or implement successfully **,** or realize the expected benefits of **,** any suitable opportunities. In addition, we compete for acquisitions with other potential acquirers, some of which may have greater financial or operational resources than we do. This competition may intensify due to the ongoing consolidation in the healthcare industry, which may increase our acquisition costs. • We may

not be able to complete acquisitions of physician practices or services companies **,** or we may complete acquisitions on less favorable terms as a result of changes in tax laws, healthcare fraud and abuse laws, financial market or other economic or market conditions. • We may not be able to successfully integrate completed acquisitions, including our recent acquisitions. Integrating completed acquisitions into our existing operations involves numerous short- term and long- term risks, including diversion of our management' s attention, failure to retain key personnel, long- term value of acquired intangible assets and acquisition expenses. In addition, we may be required to comply with laws, rules and regulations that may differ not only from those of the states in which our operations are currently conducted but from an expansion in the service offerings we provide in certain states for which the laws, rules and regulations may be different. • We cannot be certain that any acquired business will continue to maintain its pre- acquisition revenue and growth rates or be financially successful. In addition, we cannot be certain of the extent of any unknown or contingent liabilities of any acquired business, including liabilities for failure to comply with applicable laws, or liabilities relating to medical malpractice claims. Generally, we obtain indemnification agreements from the sellers of businesses acquired with respect to pre- closing acts, omissions and other similar risks. It is possible that we may seek to enforce indemnification provisions in the future against sellers who may no longer have the financial wherewithal to satisfy their obligations to us. Accordingly, we may incur material liabilities for past activities of acquired businesses. • We could incur or assume indebtedness and issue equity in connection with acquisitions. The issuance of shares of our common stock for an acquisition may result in dilution to our existing shareholders and, depending on the number of shares that we issue, the resale of such shares could affect the trading price of our common stock. • We may acquire businesses that derive a greater portion of their revenue from GHC Programs than what we recognize on a consolidated basis or that have business models with lower operating margins than ours. These acquisitions could affect our overall payor mix or operating results in future periods. • Acquisitions of practices and services companies could entail financial and operating risks not fully anticipated. Such acquisitions could divert management' s attention and our resources. • An acquisition could be subject to challenge under the antitrust laws either before or after it is consummated. Such a challenge could involve substantial legal costs and divert management' s attention and resources and could result in us having to abandon the transaction or make a divestiture. If we are not successful in integrating an acquisition, we may decide to dispose of such acquisition and may do so at a loss or record impairments in connection with such a disposition, such as in our disposition of our anesthesiology and radiology medical groups in 2020. In addition to our acquisition growth strategy, we seek opportunities for increasing revenue from our existing operations through same- unit and organic growth strategies. We also seek opportunities to grow organically outside of our existing operations. We may not be able to successfully execute our same- unit and organic growth strategies for reasons including the following: • We may not be able to expand the services that our affiliated physicians provide to our hospital partners or the services provided by our services companies to their customers. • We may not be able to attract referrals to our office- based practices or neonatology transports to our hospital- based units. • We may not be able to execute new contractual arrangements with hospitals, including through joint ventures, where we either currently provide or do not currently provide physician services. • We may not be able to work with our hospital partners to develop integrated services programs for which we become a multi- specialty provider of solutions within the maternal- fetal, newborn, pediatric continuum of care. • We may not accurately project same- unit and organic growth performance, including projections of revenue and operating expenses, or we may experience a shift in the mix of services that certain of our customers request from us, potentially resulting in lower margins. In addition, certain of our organic growth strategies may involve risks and uncertainties similar to those for our acquisition strategy. See " We may not find suitable acquisition candidates or successfully integrate our acquisitions. Our acquisitions may expose us to greater business risks and could affect our payor mix. " We may not effectively manage our growth. We have historically experienced growth in our business, including growth outside of our core physician specialties. Growth in the number of our employees and affiliated physicians has in the past placed significant demands on our financial, operational and management resources. Significant growth may impair our ability to provide our services efficiently and to manage our employees adequately. **Our** ~~While we are taking steps to manage our growth, our~~ future results of operations could be adversely affected if we are unable to ~~do so~~ **manage our growth** effectively. Hospitals or other customers may terminate their agreements with us, our physicians may lose the ability to provide services in hospitals or administrative fees paid to us by hospitals may be reduced. Our net revenue is derived primarily from fee- for- service billings for patient care and other services provided by our affiliated physicians and from administrative fees paid to us by hospitals. See Item 1. Business — " Relationships with Our Partners — Hospitals. " Our hospital partners or other customers may cancel or not renew their contracts with us, may reduce or eliminate our administrative fees in the future, or refuse to pay us our administrative fees if we fail to honor the terms of our agreement or fail to meet certain performance metrics under those agreements. Further, consolidation of hospitals, healthcare systems or other customers could adversely affect our ability to negotiate with these entities. Adverse economic conditions, including decreased federal and state funding to hospitals, could influence future actions of our hospital partners or other customers. In addition, hospitals may from time to time cancel or delay certain elective procedures in order to address increasing demand for beds by other patients. To the extent that our arrangements with our hospital partners or other customers are canceled or are not renewed or replaced with other arrangements having at least as favorable terms, our business, financial condition and results of operations could be adversely affected. In addition, to the extent our affiliated physicians lose their privileges in hospitals or hospitals enter into arrangements with or employ other physicians, including our existing affiliated physicians, our business, financial condition, results of operations and cash flows could be adversely affected. Risks Related to Operating our Business We are dependent upon our key management personnel for our future success. Our success depends to a significant extent on the continued contributions of our key management personnel for the management of our business and implementation of our business strategy. Any losses of or changes in key management personnel could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. Our quarterly results will likely fluctuate from period to period. We have historically experienced and expect to

continue to experience quarterly fluctuations in net revenue and net income. For example, we typically experience negative cash flow from operations in the first quarter of each year, principally as a result of bonus payments to affiliated physicians as well as discretionary matching contributions for participants in our qualified contributory savings plans. In addition, a significant number of our employees and associated professional contractors (primarily affiliated physicians) exceed the level of taxable wages for social security contributions during the first and second quarters. As a result, we incur a significantly higher payroll tax burden and our net income is lower during those quarters. Moreover, a lower number of calendar days are present in the first and second quarters of the year as compared to the remainder of the year. Because we provide services in the NICU on a 24- hours- a- day basis, 365 days a year, any reduction in service days will have a corresponding reduction in net revenue. In addition, any reduction in office days in our office- based practices will also have a corresponding reduction in net revenue. We also have significant fixed operating costs, including costs for our affiliated physicians, and as a result, are highly dependent on patient volume and capacity utilization of our affiliated physicians to sustain profitability. Quarterly results may also be impacted by the timing of acquisitions and any fluctuation in patient volume. As a result, our results of operations for any quarter are not indicative of results of operations for any future period or full fiscal year. We may write- off intangible assets, such as goodwill. The carrying value of our intangible assets, which consists primarily of goodwill related to our acquisitions, is subject to testing at least annually, and more frequently if impairment indicators exist. Under current accounting standards, goodwill is tested for impairment on at least an annual basis and more frequently if impairment indicators exist, and we have been subject to impairment losses as circumstances have changed after acquisition. **For example, during the fourth quarter of 2023, we recorded a non- cash impairment charge of $ 148. 3 million.** If we record additional impairment losses related to our goodwill in the future, it could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. We are subject to medical malpractice and other lawsuits that may not covered by insurance. Our business entails an inherent risk of claims of medical malpractice against our affiliated physicians and us. We may also be subject to other lawsuits which may involve large claims and significant defense costs. Although we currently maintain liability insurance coverage intended to cover professional liability and other claims, there can be no assurance that our insurance coverage will be adequate to cover liabilities arising out of claims asserted against us where the outcomes of such claims are unfavorable to us. Generally, we self- insure our liabilities to pay retention amounts for professional liability matters through a wholly owned captive insurance subsidiary. Liabilities in excess of our insurance coverage, including coverage for professional liability and other claims, could have a material adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. See Item 1. Business — " Other Legal Proceedings " and — " Professional and General Liability Coverage. " The reserves that we have established related to our professional liability losses are subject to inherent uncertainties and if actual costs exceed our estimates this may lead to a reduction in our net earnings. We have established reserves for losses and related expenses that represent estimates involving actuarial projections. These actuarial projections are developed at a given point in time and represent our expectations of the ultimate resolution and administration of costs of losses incurred with respect to professional liability risks for the amount of risk retained by us. Insurance reserves are inherently subject to uncertainty. Our reserve estimates are based on actuarial valuations using historical claims, demographic factors, industry trends, severity and exposure factors and other actuarial assumptions. The estimates of projected ultimate losses are developed at least annually. Our reserves have been, and could further be, significantly affected should current and future occurrences differ from historical claim trends and expectations. While claims are monitored closely when estimating reserves, the complexity of the claims and wide range of potential outcomes often hamper timely adjustments to the assumptions used in these estimates. Actual losses and related expenses may deviate, perhaps substantially, from the reserve estimates reflected in our financial statements. If our estimated reserves are determined to be inadequate, we have been and could further be required to increase reserves at the time the deficiency is determined. See Item 7. Management' s Discussion and Analysis of Financial Condition and Results of Operations — " Application of Critical Accounting Policies and Estimates — Professional Liability Coverage. " From time to time, we are involved in various litigation matters and claims, including regulatory proceedings, administrative proceedings, governmental investigations, and contract disputes, as they relate to our services and business. We may face potential claims or liability for, among other things, breach of contract, defamation, libel, fraud, negligence or data breaches. Our contracts with hospitals generally require us to indemnify them and their affiliates for losses resulting from the negligence of our affiliated physicians and other clinicians. We may also face employment- related litigation, including claims of age discrimination, sexual harassment, gender discrimination, immigration violations, or other local, state, and federal labor law violations. Because of the uncertain nature of litigation and insurance coverage decisions, the outcome of such actions and proceedings cannot be predicted with certainty and an unfavorable resolution of one or more of them could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. In addition, legal fees and costs associated with prosecuting and defending litigation matters could have an adverse effect on our business, financial condition, results of operation and the trading price of our securities. A significant portion of our net revenue is derived from reimbursements from various third- party payors, including GHC Programs, private insurance plans and managed care plans, for services provided by our affiliated professional contractors. We are responsible for submitting reimbursement requests to these payors and collecting the reimbursements, and we assume the financial risks relating to uncollectible and delayed reimbursements. In the current healthcare environment, payors continue efforts to control expenditures for healthcare, including revisions to coverage and reimbursement policies. Due to the nature of our business and our participation in government- funded and private reimbursement programs, we are involved from time to time in inquiries, reviews, audits and investigations by governmental agencies and private payors of our business practices, including assessments of our compliance with coding, billing and documentation requirements. We may be required to repay these agencies or private payors if a finding is made that we were incorrectly reimbursed within a certain time period, or we may become involved in disputes with payors and could be subjected to pre- payment and post- payment reviews, which can be time- consuming and result in non- payment or delayed

payment for the services we provide. We may also experience difficulties in collecting reimbursements because third- party payors may seek to reduce or delay reimbursements to which we are entitled for services that our affiliated physicians have provided, they experience administrative issues that result in a delay in reimbursements, or pursuant to binding arbitration proceedings for out- of- network items or services. In addition, GHC Programs may deny or revoke our application to become a participating provider if we do not disclose certain events relating to our affiliates or for other reasons that could cause us to not be able to provide services to patients or prohibit us from billing for such services. GHC Programs may also suspend our payments pending an audit or investigation, which could last for an extended period of time. If we are not reimbursed fully or in a timely manner for such services or there is a finding that we were incorrectly reimbursed, our revenue, cash flows and financial condition could be materially, adversely affected. In addition, we may choose to challenge certain GHC reimbursement decisions through administrative appeal mechanisms. **Any backlog in** ~~Currently, many of those appeal~~ **appeals may** ~~pathways are backlogged and slow to provide resolution,~~ further ~~affecting~~ --- **affect** our ability to collect reimbursement for services rendered. In addition, adverse economic conditions could affect the timeliness and amounts received from our third- party and government payors which would impact our short- term liquidity needs. Risks Related to our Capital Structure As of December 31, ~~2022~~ **2023** , our total indebtedness was $ ~~644~~ **628** . ~~6~~ **1** million, of which $ 400. 0 million was at fixed interest rates and $ ~~244~~ **228** . ~~6~~ **1** million was at variable rates. We also had $ ~~446~~ **450** . 0 million of additional borrowing capacity under our revolving line of credit which was subject to a variable interest rate. Other debt we incur also could be variable rate debt. In addition, United States tax law places certain limitations on the deductibility of interest expense at a percentage of taxable income. If interest rates continue to increase, any variable rate debt will create higher debt service requirements, and if interest expense increases beyond a specified percentage of taxable income, a portion of that interest expense may not be deductible for income tax purposes, which could adversely affect our results of operations and cash flows. We have limited restrictions on incurring substantial additional indebtedness in the future. Our current indebtedness and any future increases in leverage could have adverse consequences on us, including: • a substantial portion of our cash flow from operations will be required to service interest and principal payments on our debt and will not be available for operations, working capital, capital expenditures, expansion, acquisitions, dividends or general corporate or other purposes; • our ability to obtain additional financing in the future may be impaired; • we may be more highly leveraged than our competitors, which may place us at a competitive disadvantage; • our flexibility in planning for, or reacting to, changes in our business and industry may be limited; and • we may be more vulnerable in the event of a downturn in our business, our industry or the economy in general. Our ability to make payments on and to refinance our debt will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, business, financial, competitive, legislative, regulatory, and other factors that are beyond our control. We cannot assure you that our business will generate sufficient cash flow from operations or that future borrowings will be available under our revolving line of credit in an amount sufficient to enable us to pay our debt or to fund our other liquidity needs. Any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in other defaults, disrupt our operations and cause a reduction of our credit rating, which could further harm our ability to finance or refinance our obligations and business operations. If our cash flows and capital resources are insufficient to fund our debt service requirements, we may be forced to reduce or delay acquisitions or other investments, or to seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. We cannot assure you that we will be able to refinance any of our debt, including our revolving line of credit and senior notes, on commercially reasonable terms or at all. Provisions of our articles and bylaws could deter takeover attempts, but our business could be negatively affected as a result of shareholder activism. Our Amended and Restated Articles of Incorporation, as amended, authorize our Board of Directors to issue up to 1, 000, 000 shares of undesignated preferred stock and to determine the powers, preferences and rights of these shares without shareholder approval. This preferred stock could be issued with voting, liquidation, dividend and other rights superior to those of the holders of common stock. The issuance of preferred stock under some circumstances could have the effect of delaying, deferring or preventing a change in control. In addition, provisions in our Amended and Restated Articles of Incorporation, as amended, and Bylaws, including those relating to calling shareholder meetings, taking action by written consent and other matters, could render it more difficult or discourage an attempt to obtain control of Pediatrix through a proxy contest or consent solicitation, however, there is no assurance that these provisions would have such an effect. These provisions could limit the price that some investors might be willing to pay in the future for shares of our common stock. Notwithstanding these provisions, we could, and have, become the target of activist shareholders who acquire ownership positions in our common stock and seek to influence our company. Responding to actions by activist shareholders can be costly and time- consuming, disrupt our business and divert the attention of our Board of Directors, management and employees. Additionally, perceived uncertainties as to our future direction, including the composition of our Board of Directors, as a result of shareholder activism may lead to the perception of a change in the direction of our business or other instability, which may be exploited by our competitors, cause concern to our current or potential customers and acquisition candidates, and make it more difficult for us to attract and retain qualified personnel, which could have a material adverse effect on our business, financial condition, results of operations, and cash flows and the trading prices of our securities. In addition, the trading prices of our securities may experience periods of increased volatility as a result of shareholder activism. Risks Related to Labor We are dependent upon our ability to recruit and retain a sufficient number of qualified physicians and other clinicians and other personnel to service existing units at hospitals and our affiliated practices and expand our business. We compete with many types of healthcare providers, including teaching, research and government institutions, hospitals and health systems and other practice and services groups, for the services of qualified clinicians. The U. S. is currently experiencing and is expected to continue to experience a nationwide healthcare professional shortage ~~, particularly as healthcare providers burn out from their work during the COVID- 19 pandemic~~ . Due to this increased exit from healthcare practice and lack of sufficient new talent to replace them, our recruiting efforts have become increasingly more

competitive. We may not be able to continue to recruit new clinicians or other personnel or renew contracts with existing clinicians or other personnel on acceptable terms. We have and may seek to renew clinician contracts prior to their existing renewal date for various reasons, including to move clinicians to a different compensation structure. We may not be successful in these early renewal efforts, and further, clinical compensation may increase as a result of incremental compensation incentives that may be required by clinicians to agree to the change in compensation structure. In addition, the recruiting and onboarding process for certain of our physicians and other clinicians can take several months, or longer, to complete due to various requirements, including state licensing and hospital credentialing. **Further** ~~In addition~~ , if the demand exceeds the supply for physicians and other clinicians and personnel either in general or in specific markets, we could experience an increase in compensation expense, including premium pay and agency labor costs. If we are unable to recruit new physicians, renew contracts on acceptable terms or onboard physicians, clinicians and other personnel in a reasonable period of time, our ability to service existing or new hospital units and staff existing or new office- based practices could be adversely affected. In addition, if we experience a higher rate of growth in compensation expense, our business, financial condition, results of operations, cash flows and the trading price of our securities could be adversely affected. A significant number of our affiliated physicians or other clinicians could leave our affiliated practices or our affiliated practices may be unable to enforce the non- competition covenants of departed physicians. Our affiliated professional contractors usually enter into employment agreements with our affiliated physicians. Certain of our employment agreements can be terminated without cause by any party upon prior written notice. In addition, substantially all of our affiliated physicians have agreed not to compete within a specified geographic area for a certain period after termination of employment. The law governing non- compete agreements and other forms of restrictive covenants varies from state to state. Although we believe that the non- competition and other restrictive covenants applicable to our affiliated physicians are reasonable in scope and duration and therefore enforceable under applicable state law, courts and arbitrators in some states may be reluctant to enforce non- compete agreements and restrictive covenants against physicians. In addition, we have and may incur significant legal fees to pursue enforcement of such agreements and restrictive covenants. Further, the Federal Trade Commission issued a proposed rule on January 5, 2023 that would prohibit employers from using non- compete clauses with workers **and certain states have enacted or proposed prohibitions on using non- compete clauses with workers, including healthcare providers** . Our affiliated physicians or other clinicians may leave our affiliated practices for a variety of reasons, including in order to provide services for other types of healthcare providers, such as teaching, research and government institutions, hospitals and health systems and other practice groups. If a substantial number of our affiliated physicians or other clinicians leave our affiliated practices, we could incur significant legal fees to pursue enforcement of certain covenants within employment agreements or if our affiliated practices are unable to enforce the non- competition covenants in the employment agreements, our business, financial condition, results of operations and cash flows could be adversely affected. Information Systems, Cybersecurity and Data Privacy Risks We may not be able to maintain effective and efficient information systems or properly safeguard our information systems. Our operations are dependent on uninterrupted performance of our information systems. Failure to maintain reliable information systems, disruptions in our existing information systems or the implementation of new systems could cause disruptions in our business operations, including errors and delays in billings and collections, difficulty satisfying requirements under hospital contracts, disputes with patients and payors, violations of patient privacy and confidentiality requirements and other regulatory requirements, increased administrative expenses and other adverse consequences. In addition, information security risks have generally increased in recent years ~~, and in particular during COVID-19,~~ because of new technologies and the increased activities of perpetrators of **cybersecurity** ~~cyber-~~ attacks resulting in the theft of protected health, business or financial information. Despite our layered security controls, experienced computer programmers and hackers have been and may be able to penetrate our information systems and may have and may be able to misappropriate or compromise sensitive patient or personnel information or proprietary or confidential information, create system disruptions or cause shutdowns. They also may be able to develop and deploy viruses, worms and other malicious software programs that disable our systems or otherwise exploit any security vulnerabilities. Outside parties may also attempt to fraudulently induce employees to take actions, including the release of confidential or sensitive information or to make fraudulent payments, through illegal electronic spamming, phishing or other tactics. A failure in or breach of our information systems as a result of **cybersecurity** ~~cyber-~~ attacks or other tactics could disrupt our business, has and may result in the disclosure or misuse of PHI, confidential or proprietary business information, and has or may cause financial loss, damage our reputation, increase our administrative expenses, and expose us to additional risk of liability to federal or state governments or individuals. Although we believe that we have reasonable and appropriate information security procedures and other safeguards in place, which are monitored and routinely tested internally and by external parties, as ~~cyber~~ **cybersecurity** threats continue to evolve, we have been and may be required to expend additional resources to continue to enhance our information security measures or to investigate and remediate any information security vulnerabilities. Our remediation efforts may not be successful and could result in interruptions, delays or cessation of service and loss of existing or potential customers and disruption of our operations, including, without limitation, our billing processes. In addition, breaches of our security measures and the unauthorized dissemination of patient healthcare and other sensitive information, proprietary or confidential information about us, our patients, clients or customers, or other third- parties, could expose such persons' personal information to the risk of financial or medical identity theft or expose us or such persons to a risk of loss or misuse of this information, have resulted in litigation and potential liability for us, and could damage our brand and reputation or otherwise harm our business. Additionally, under certain circumstances, we could be excluded temporarily or permanently from certain commercial or GHC Programs. Any of these disruptions or breaches of security could have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities. We may experience difficulties implementing or enhancing technology, software and processes. We are engaged in various implementation and enhancement efforts for new technology, software and processes ~~, including cloud- based solutions for an enterprise resource planning system (" ERP ") and telehealth support, among others~~ .

These solutions are designed to provide greater efficiency and flexibility across our enterprise. ~~The ERP cloud- based solution implementation has required and may require additional significant investments of human and financial resources.~~ In implementing and enhancing **various** ~~this and other~~ solutions **and processes** , we may experience significant delays, increased costs and other difficulties. Any significant disruption or deficiency in the design and implementation of these solutions **and processes** could adversely affect our ability to operate our business. While we have invested significant resources in planning and project management, unforeseen implementation or enhancement issues may arise. In addition, our efforts to centralize various business processes and functions within our organization in connection with our system implementations may disrupt our operations. Any implementation or enhancement issues or business operation disruptions could have a material effect on our business, financial condition, results of operations, cash flows, internal control over financial reporting and the trading price of our securities. Hospitals could limit our ability to use our information management systems in our units by requiring us to use their own information management systems. Our information management systems are used to support our day- to- day operations and ongoing clinical research and business analysis. If a hospital prohibits us from using our own information management systems, it may interrupt the efficient operation of our information systems which, in turn, may limit our ability to operate important aspects of our business, including billing and reimbursement as well as research and education initiatives. This inability to use our information management systems at hospital locations may have an adverse effect on our business, financial condition, results of operations and cash flows. Federal and state laws **concerning** ~~that protect~~ the privacy and security of personal information may increase our costs and limit our ability to collect and use that information ~~and subject~~ **. Any failure or perceived failure by** us to ~~liability if we are unable to fully~~ comply with such laws **and regulations may harm our business and operations** . **The global data protection landscape is rapidly evolving, and we may be or become subject to or affected by** ~~Numerous~~ **numerous** federal and state laws, rules and regulations govern the collection, dissemination, use, security and confidentiality of personal information, including individually identifiable health information. These laws include: • Federal and state laws related to **the** confidentiality, privacy and security of personal information, including PHI, that limit the manner in which we may use and disclose that information, impose obligations to safeguard that information and require that we notify third parties in the event of a breach. For example, HIPAA **and the HITECH** ~~limits~~ **limit** how covered entities and business associates may use and disclose PHI, provides certain rights to individuals with respect to their PHI, and imposes certain security requirements with respect to PHI and information systems containing PHI **, among other things** ; • HIPAA requires covered entities and business associates to develop and maintain policies with respect to the protection of, use and disclosure of PHI, including the adoption of administrative, physical and technical safeguards to protect such information, and certain notification requirements in the event of a breach of unsecured PHI ~~. Additionally, under HIPAA, covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay, not to exceed 60 days following discovery of the breach by a covered entity or its agents. Notification also must be made to the HHS Office for Civil Rights, and, in certain circumstances involving large breaches, to the media. Business associates must report breaches of unsecured PHI to covered entities within 60 days of discovery of the breach by the business associate or its agents, unless the business associate agreements require a shorter notification period. Unless an exception applies, unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach under HIPAA unless the covered entity or business associate establishes that there is a low probability the information has been compromised, consistent with requirements enumerated under HIPAA~~ ; • Other federal and state laws ~~restricting the use and~~ **establish additional requirements for** protecting the privacy and security of personal information, including health information, **and in** many **cases** ~~of which~~ are not preempted by HIPAA. In addition, certain states have proposed or enacted legislation **. For instance, the state of Washington recently passed the " My Health My Data Act " which will regulate " consumer health data " which is defined as " personal information** that ~~will create new~~ **is linked or reasonably linkable to a consumer and that identifies a consumer' s past** , ~~extensive~~ **present, or future physical or mental health. " The " My Health My Data Act " provides exemptions for personal data used or shared in research, including data subject to 45 C. F. R. Parts 46, 50, and 56. Nevada also recently enacted a consumer health** data privacy **bill,** and ~~security obligations for certain entities and~~ **additional states may adopt health- specific privacy laws** that ~~gives data subjects various rights with respect to their personal information~~ **could impact our business activities depending on how they are interpreted. Additional states have contemplated new health- specific privacy laws** , such as the ~~California Consumer Privacy~~ **new Washington My Health My Data** Act ~~("~~ **; • Several states have enacted comprehensive privacy laws with data privacy rights, such as the** CCPA ~~")~~, as amended by the California Privacy Rights Act **. While these new laws generally include exemptions for HIPAA- covered and clinical trial data, they add layers of complexity to compliance in the U. S. market, and could increase our compliance costs and adversely affect our business** ; • Federal and state consumer protection laws, including the **FTC** ~~Federal Trade Commission~~ ' s authority under Section 5 of the Federal Trade Commission Act **. The FTC and many state attorneys general are interpreting existing federal and state consumer protection laws to impose evolving standards for the collection, use, dissemination and security of health- related and other personal information, and in particular health information.** ; and • Federal and state laws regulating the conduct of research with human subjects, which include restrictions and requirements relating to the confidentiality of information collected or generated ~~regarding~~ **about** human subjects participating in research. As part of our business operations, including our medical record keeping, third- party billing, research and other services, we collect and maintain PHI and other personal information in paper and electronic format. Standards related to personal information, whether implemented pursuant to HIPAA, HITECH, state laws, federal or state **agency** ~~action~~ **actions** or otherwise, could have a significant effect on the manner in which we handle and our ability to collect, generate, and maintain personal information, including PHI, and how we communicate with payors, providers, patients and others. Compliance with these standards, which are diverse and complex, could impose significant costs on us or limit our ability to offer services, thereby negatively impacting the business opportunities available to us. In addition to the laws above, we may see more stringent state and federal privacy legislation in **future years** ~~2023 and beyond~~ , including potential changes to

HIPAA, the enactment of a broad federal consumer privacy ~~law~~ **laws** , and the enactment of broad consumer **privacy laws or health** privacy laws in various states. The enactment of such legislation and increased focus on data protection may be more likely as the ~~increased~~ - **increase in** cyber ~~-~~attacks **has** ~~during COVID- 19 have~~ once again put a spotlight on data privacy and security in the U. S. and ~~other jurisdictions, and as federal and state lawmakers look to the EU General Data Protection Regulation as an example of a stringent data protection law enacted in~~ other jurisdictions. We cannot predict where new legislation might arise, the scope of such legislation, or the potential impact to our business and operations. Further, we are also subject to a provision of the federal 21st Century Cures Act that is intended to facilitate the appropriate exchange of health information. In ~~March~~ 2020, the ~~HHS~~ **U. S. Department of Health and Human Services'** Office of the National Coordinator for Health Information Technology **(" ONC ")** and ~~CMS issued complementary new~~ **the Centers for Medicare and Medicaid Services promulgated final** rules ~~that are intended~~ to ~~clarify provisions~~ **support access, exchange, and use of electronic health information (" EHI "). Specifically, the information blocking rules were implemented as part** of the 21st Century Cures Act ~~regarding~~ **, and are primarily designed to facilitate technology** interoperability and **enable the free flow of healthcare information for healthcare treatment, payment or operation purposes. On June 27, 2023, the Department of Health and Human Services Office of the Inspector General (" HHS- OIG ") published its final rule implementing** information blocking ~~and create significant new~~ **penalties for " actors, " which is supplemented by ONC' s January 9, 2024 final rule enhancing certain information blocking** requirements **. HHS- OIG may impose penalties** for ~~healthcare industry participants~~ **information blocking that has occurred after September 1, 2023, and ONC and HHS proposed a rule on November 1, 2023 listing certain disincentives for actors that conduct information blocking** . ~~It~~ **The impact on the information blocking rules to our business** is **currently** unclear ~~at this time what the costs of compliance with the new rules will be, and what additional risks there may be to our business~~ . **On** ~~Additionally, on~~ December 1, 2022, the HHS Office for Civil Rights issued a bulletin on the requirements under HIPAA for online tracking technologies (e. g., cookies, pixels) to protect the privacy and security of health information. This bulletin outlined the HHS Office for Civil Rights' position on the use of online tracking technology vendors, when certain information received by such vendors constitutes **PHI** ~~protected health information~~ under HIPAA, and accordingly, when business associate agreements must be executed between covered entities, like the Company, and such vendors. ~~It is unclear at~~ **We may incur additional expense to comply with** this ~~time what the costs of compliance with the~~ bulletin ~~will be,~~ and ~~what additional~~ **future guidance from the HHS Office for Civil Rights on website tracking technologies, and agency' s heightened focus on website tracking technologies could pose enforcement** ~~risks~~ - **risk to** ~~there~~ -- **the Company in the future** ~~may be to our business~~ . If we are alleged to not comply with existing or new laws, rules and regulations related to PHI or other personal information we could be subject to litigation and to sanctions that include monetary fines, civil or administrative penalties, civil damage awards or criminal penalties, and incur reputational harm and a negative market perception. For example, entities that are found to be in violation of HIPAA as a result of a breach of unsecured PHI, a complaint about privacy practices or an audit by HHS may be subject to significant civil, criminal and administrative fines and penalties and / or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non- compliance. HIPAA has ranges of increasing minimum penalty amounts tiered according to the entity' s degree of culpability. Breaches of unsecured PHI may also result in unexpected costs ~~in the~~ **to us, upwards of** millions of dollars **,** ~~to us~~ through third party litigation, contractual ~~breaches~~ -- **breach resolution** , ~~and~~ breach notification and remediation. In addition, we may experience reputational ~~harms~~ - **harm** and a negative market perception when it comes to protecting patient data and other personal information that could influence our future operations. HIPAA also authorizes state Attorneys General to file suit on behalf of their residents. Courts may award damages, costs and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA, its standards have been used as the basis for **establishing the** duty of care in state civil suits such as those for negligence or recklessness ~~in the misuse or breach of PHI. Further, in addition to fines and penalties that may be imposed for failure to comply with state law, some states, such as California, also provide for private rights of action to individuals for misuse of or unauthorized access to personal information~~ . Our compliance with ~~these~~ **frequently** changing and increasingly burdensome ~~and sometimes conflicting~~ regulations and requirements may cause us to incur substantial costs or require us to change our business practices, which may impact our financial condition. Any such claim, proceeding or action could harm our reputation, brand and business, force us to incur significant expenses in defense of such proceedings, distract our management, increase our costs of doing business, result in a loss of customers and suppliers or an inability to process credit card payments and may result in the imposition of monetary penalties. We may also be contractually required to indemnify and hold harmless third parties from the costs or consequences of non- compliance with any laws, regulations or other legal obligations relating to privacy or consumer protection or any inadvertent or unauthorized use or disclosure of data that we store or handle as part of operating our business. Risks Related to Competition and Consolidation Our industry is highly competitive. The healthcare industry is highly competitive and subject to continual changes in the methods by which services are provided and the manner in which healthcare providers are selected and compensated. Because our operations consist primarily of physician services provided within hospital- based units, we compete with other healthcare services companies and physician groups for contracts with hospitals to provide our services to patients. We also face competition from hospitals themselves to provide our services. Further, consolidation within the healthcare industry could strengthen certain competitors that provide services to hospitals and other customers. Companies in other healthcare industry segments, some of which have greater financial and other resources than ours, may become competitors in providing neonatal, maternal- fetal or other pediatric subspecialty care. Additionally, we face competition from healthcare- focused and other private equity firms. We may not be able to continue to compete effectively in this industry, additional competitors may enter metropolitan areas where we operate, and this increased competition may have an adverse effect on our business, financial condition, results of operations, cash flows and the trading price of our securities.