

UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, DC 20549  
**Form 10-K**

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934  
For the fiscal year ended December 31, 2023

or

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934  
For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission File Number 001-39391



**CareMax, Inc.**

(Exact Name of Registrant as Specified in Its Charter)

**Delaware**

(State or Other Jurisdiction of  
Incorporation or Organization)

**85-0992224**

(I.R.S. Employer Identification No.)

**1000 NW 57th Court, Suite 400  
Miami, FL 33126  
(786) 360-4768**

(Address, including zip code, and telephone number,  
including area code, of principal executive offices)

**Securities registered pursuant to Section 12(b) of the Act:**

| Title of each class  | Trading Symbols | Name of each exchange on which registered |
|--|-----------------|---|
| Class A common stock, par value \$0.0001 per share                                       | CMAX            | The Nasdaq Stock Market LLC               |
| Warrants, each whole warrant exercisable for 1/30th of one share of Class A common stock | CMAXW           | The Nasdaq Stock Market LLC               |

**Securities registered pursuant to Section 12(g) of the Act: None.**

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes  No

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes  No

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

Large accelerated filer

Non-accelerated filer

Accelerated filer

Smaller reporting company

Emerging growth Company

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

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report.

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements.

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b).

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

The aggregate market value of common stock held by non-affiliates of the registrant based on the closing price of the registrant's Class A common stock as reported on the Nasdaq Global Select Market on June 30, 2023, which was the last business day of the registrant's most recently completed second fiscal quarter, as adjusted for the 1-for-30 reverse stock split of CareMax, Inc.'s Class A common stock effected on January 31, 2024, was \$226,149,828.

As of March 11, 2024, the registrant had 3,802,883 shares of Class A common stock, \$0.0001 par value per share, and no shares of Class B common stock, \$0.0001 par value per share, issued and outstanding.

**Documents Incorporated by Reference**

Portions of the registrant's definitive Proxy Statement for its 2024 Annual Meeting of Stockholders are incorporated by reference into Part III of this Annual Report on Form 10-K where indicated. Such Proxy Statement will be filed with the Securities and Exchange Commission no later than 120 days after the end of the registrant's fiscal year ended December 31, 2023.

---

## CAUTIONARY LANGUAGE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K (the “Annual Report”) contains forward-looking statements within the meaning of the safe harbor provisions of the U.S. Private Securities Litigation Reform Act of 1995. Such forward-looking statements, which represent our belief or current expectations, plans or forecasts of future events based on assumptions and information currently available to our management, involve a number of known and unknown risks, uncertainties, assumptions and other important factors, many of which are outside the Company’s control. The words “anticipate,” “believe,” “continue,” “plan,” “expect,” “estimate,” “may,” “could,” “should,” “project,” “will,” or the negative or other variations thereof and similar words or phrases or comparable terminology may identify forward-looking statements, but the absence of these words does not mean that a statement is not forward-looking. Actual results could differ materially from those discussed in these forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those identified in Part I, Item 1A, “Risk Factors” in this Annual Report. Due to the uncertain nature of these factors, management cannot assess the impact of each factor on the business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements.

Any forward-looking statement speaks only as of the date on which statement is made, and we undertake no obligation to update any of these statements or circumstances occurring after the date of this Annual Report. New factors may emerge, and it is not possible to predict all factors that may affect our business and prospects.

---

## Table of Contents

|  | <u>Page</u> |
|--|-------------|
| <b>PART I</b>  |             |
| Item 1. <a href="#">Business</a>   | 2           |
| Item 1A. <a href="#">Risk Factors</a>  | 22          |
| Item 1B. <a href="#">Unresolved Staff Comments</a>   | 63          |
| Item 1C. <a href="#">Cybersecurity</a>   | 63          |
| Item 2. <a href="#">Properties</a>   | 64          |
| Item 3. <a href="#">Legal Proceedings</a>  | 64          |
| Item 4. <a href="#">Mine Safety Disclosures</a>  | 65          |
| <b>PART II</b>   |             |
| Item 5. <a href="#">Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities</a> | 65          |
| Item 6. <a href="#">Reserved</a>   | 65          |
| Item 7. <a href="#">Management’s Discussion and Analysis of Financial Condition and Results of Operations</a>                        | 66          |
| Item 7A. <a href="#">Quantitative and Qualitative Disclosures About Market Risk</a>  | 82          |
| Item 8. <a href="#">Financial Statements and Supplementary Data</a>  | 82          |
| Item 9. <a href="#">Changes in and Disagreements With Accountants on Accounting and Financial Disclosure</a>                         | 83          |
| Item 9A. <a href="#">Controls and Procedures</a>   | 83          |
| Item 9B. <a href="#">Other Information</a>   | 84          |
| Item 9C. <a href="#">Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.</a>  | 85          |
| <b>PART III</b>  |             |
| Item 10. <a href="#">Directors, Executive Officers and Corporate Governance</a>  | 85          |
| Item 11. <a href="#">Executive Compensation</a>  | 85          |
| Item 12. <a href="#">Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters</a>              | 85          |
| Item 13. <a href="#">Certain Relationships and Related Transactions, and Director Independence</a>                                   | 85          |
| Item 14. <a href="#">Principal Accounting Fees and Services</a>  | 85          |
| <b>PART IV</b>   |             |
| Item 15. <a href="#">Exhibits, Financial Statement Schedules</a>   | 85          |
| Item 16. <a href="#">Form 10-K Summary</a>   | 88          |

## PART I

### Item 1. Business.

#### Overview

CareMax, Inc. (“CareMax,” the “Company,” “we,” “us,” and “our”), formerly Deerfield Healthcare Technology Acquisitions Corp. (“DFHT”), a Delaware corporation, is a technology-enabled care platform providing high-quality, value-based care and chronic disease management through physicians and health care professionals committed to the overall health and wellness continuum of care for its patients.

On November 10, 2022, CareMax acquired the Medicare value-based care business of Steward Health Care System (“Steward Value-Based Care”), which is a highly integrated physician network and managed care contracting business that includes approximately 1,300 primary care physicians (the “Steward Acquisition”). Steward Value-Based Care participates in multiple Medicare value-based programs including Medicare Shared Savings Program (“MSSP”), Medicare Advantage (“MA”) and ACO REACH.

As of December 31, 2023, CareMax operated 56 centers in Florida, New York, Tennessee, and Texas. CareMax offers a comprehensive range of medical services, including primary and preventative care, specialist services, diagnostic testing, chronic disease management and dental and optometry services under global capitation contracts.

CareMax’s comprehensive, high touch approach to health care delivery is powered by its CareOptimize technology platform. CareOptimize is a purpose-built end-to-end technology platform that aggregates data and analyzes that data using proprietary algorithms and machine learning to support more informed care delivery decisions and to focus care decisions on preventative chronic disease management and the social determinants of health. CareMax believes that CareOptimize is designed to drive better outcomes and lower costs. CareMax has shifted from selling the CareOptimize platform to new outside customers for a software subscription fee and is instead focused on providing the software to affiliated practices of its managed services organization (“MSO”) to further improve financial, clinical and quality outcomes from the affiliated providers.

CareMax’s centers offer 24/7 access to care through employed providers and provide a comprehensive suite of high-touch health care and social services to its patients, including primary care, specialty care, telemedicine, health & wellness, optometry, dental, pharmacy and transportation. CareMax’s differentiated healthcare delivery model is focused on care coordination with vertically integrated ambulatory care and community-centric services. The goal of CareMax is to intercede as early as possible to manage chronic conditions for its patient members in a proactive, holistic, and tailored manner to provide a positive influence on patient outcomes and a reduction in overall healthcare costs. CareMax focuses on providing access to high quality care in underserved communities.

While CareMax’s primary focus is providing care to Medicare eligible seniors who are mostly over the age of 65 (approximately 78% of revenue for the years ended December 31, 2023 and 2022 came from these patients), we also provide services to children and adults through Medicaid programs as well as through commercial insurance plans. Substantially all of the Medicare patients cared for in CareMax’s centers are enrolled in MA plans which are run by private insurance companies and are approved by and under contract with Medicare. With MA, patients get all of the same coverage as traditional Medicare, including emergency care, and most plans also include prescription drug coverage. In many cases, MA plans offer more benefits than traditional Medicare, including dental, vision, hearing and wellness programs. We contract with nearly all major national MA plans.

In addition to MA contracts, through our MSO we service traditional Medicare patients through a variety of value-based contracts, such as MSSP and ACO REACH.

#### Reverse Stock Split

At the Company’s special meeting of stockholders held on January 23, 2024 (the “Special Meeting”), the Company’s stockholders approved the proposal to authorize the Company’s Board of Directors (the “Board”) to amend the Company’s Third Amended and Restated Certificate of Incorporation (the “Amended and Restated Charter”) to effect a reverse stock split of the Company’s outstanding shares of Class A common stock, par value \$0.0001 per share (the “Class A Common Stock”), at a reverse stock split ratio range of 1-for-10 through 1-for-40, as determined by the Board at a later date, together with a corresponding reduction in the authorized number of shares of the Company’s common stock. On January 29, 2024, the Board approved a 1-for-30 reverse stock split (the “Reverse Split”), effective on January 31, 2024 (the “Effective Date”). As a result of the Reverse Split, every 30 shares of Class A Common Stock issued and outstanding as of the Effective Date were automatically converted into one share of Class A Common Stock. No fractional shares were issued in connection with the Reverse Split. In lieu of issuing fractional shares, stockholders of record who otherwise would have been entitled to receive fractional shares were entitled to rounding up of the fractional share to the nearest whole number. The Reverse Split automatically and proportionately adjusted, based on a 1-for-30 split ratio, all issued and outstanding shares of the Company’s

Class A Common Stock, as well as the terms of warrants and other derivative securities outstanding at the time of the effectiveness of the Reverse Split. Proportionate adjustments were made to the per share exercise price and the number of shares issuable upon the exercise of all outstanding stock options and warrants to purchase shares of Class A Common Stock. There was no change in the par value of our common stock or preferred stock.

References to numbers of shares of Class A Common Stock and per share data in the foregoing discussion for periods ended prior to January 31, 2024 have been adjusted to reflect the Reverse Split on a retroactive basis for all periods presented. Unless we indicate otherwise, all share amounts and references to Class A Common Stock and the Class A Common Stock per share data amounts in this Annual Report on Form 10-K reflect the Reverse Split, and the accompanying financial statements and notes to the financial statements give effect to the Reverse Split and have been retroactively applied.

## **CareMax's Key Differentiators**

### ***Vertically Integrated Model Provides a “One Stop Shop” Solution***

CareMax is primarily focused on serving the Medicare population through value-based care contracts, including patients that live in medically underserved communities that face significant social barriers to accessing care. CareMax’s vertically integrated, one-stop-shop solution is able to address these barriers by focusing on whole-person health that includes primary care, specialty care, dental, optometry, pharmacy and transportation services, as well as through its wellness centers that offer health educational classes, fitness programs and social services. We provide our members with comprehensive, coordinated, and high-quality care, which leads to our best in class patient outcomes. As part of our focus on providing preventative care, we target seeing our members on at least a quarterly basis.

Further, CareMax employs home health providers and provides mobile clinic services to patients in their homes and in the community. This assists with seeing patients who may be unable or unwilling to come to the centers, thus allowing CareMax to continue to medically care for these patients.

### ***CareOptimize Proprietary Technology Platform Enables Value Based Care***

CareMax’s purpose built, end-to-end technology platform, CareOptimize, aggregates and analyzes data using proprietary algorithms and machine learning to support point of care guidance and automated interventions. This process is designed to improve provider efficiency by enabling providers to provide consistent and coordinated care with the aim of improving outcomes and lowering costs.

### ***Value-Based Relationships***

CareMax has value-based care contracts with nearly all major national and most regional, local Medicare Advantage plans. These contracts are structured in a way that CareMax benefits from providing high-quality care rather than driving a high volume of services. This has historically resulted in higher unit economics than fee-for-service practices. Because plan payments from the Center for Medicare and Medicaid Services (“CMS”) are enhanced when a contracted plan achieves high quality scores (the STARS program), CareMax is incentivized to deliver and drive improvements in the efficiency and quality of care to its members. In 2023 and 2022, CareMax centers achieved the highest quality rating possible, 5 STARS.

Typically, when CareMax enters into a new value-based care agreement, the contract has partial or no financial risk in the first few years of the agreement period. In our contracts, we typically transition, within an 18 to 24 month period, from a limited or partial risk model to a full-risk value-based model, which generally maximizes the financial benefits.

### ***MSO Services***

Through our MSO services, we provide value-based care clinical transformation and population health management to independent providers and medical groups. Additionally, we partner with our providers in value-based care practice transformation. CareMax provides administrative practice management and payor contracting services. Our technology integrates with our MSO services and leverages best practices from our centers. Over time, we anticipate targeting providers to employ in our de novo centers. Our risk contracts are designed to share in the financial economics with those independent providers.

In connection with the closing of the Steward Acquisition, CareMax and Steward Health Care Network, Inc. (“SHCN”) entered into an exclusive access agreement pursuant to which SHCN is required to exclusively make its participating provider network available to CareMax for the provision of services to MA members under MA risk agreements for an initial period of ten years, with a ten-year automatic renewal term, unless either party provides 180 days’ notice prior to the expiration of the initial term of its decision not to renew. In connection with the access agreement and other ancillary agreements, SHCN delegated its rights, duties and obligations with

respect to MA risk contracting to CareMax, including, without limitation, SHCN's right to enforce certain exclusivity provisions in its agreements with participating providers. For a period of two years following the date of the Steward Acquisition, SHCN is contractually obligated to remove any participating provider from its network who terminates its provider agreement contract with CareMax. Further, CareMax entered into exclusive direct participating provider agreements with Steward Health Care System's captive physician practices for an initial term of ten years with a ten-year automatic renewal term unless either party provides 180 days' notice prior to the expiration of the initial term of its decision not to renew.

### ***Focus on Underserved Communities***

CareMax primarily operates centers in underserved communities, resulting in a higher number of dual eligible patients. Dual eligible patients are seniors and people with disabilities who are enrolled in both Medicaid and Medicare. These patients typically use more services due to their greater risk of chronic health issues. Such communities were historically underserved by primary care providers due to fewer resources in these communities and the historically lower fee-for-service rates for government payors. Furthermore, dual eligible patients receive higher reimbursement due to the correlation between socioeconomic status, comorbidities and barriers to care. With CareMax's whole person health model, CareMax has shown the ability to provide high-quality care to these underserved communities.

### ***Affordable Housing Locations***

CareMax has collaborated with The Related Companies, L.P. ("Related"), one of the largest private owners of affordable housing in the United States, to develop centers near affordable senior housing locations across the country.

### **CareMax's Strategy**

**Key elements of CareMax's strategy include:**

- ***Focus on providing quality medical care to our patients and improve patient outcomes.*** CareMax is committed to providing high-quality medical services and promoting overall wellness among its patient population. The Company believes that the most effective approach to improving patient outcomes lies in proactive health management and preventive measures. Through comprehensive screenings, patient education initiatives, lifestyle counseling, and timely interventions, the Company aims to empower individuals to take control of their health and mitigate the onset of preventable diseases. By prioritizing preventive care, CareMax not only enhances patient well-being but also contributes to reducing healthcare costs and alleviating the burden on the broader healthcare system. CareMax's commitment to providing quality medical care extends beyond addressing existing health concerns to actively fostering a culture of wellness and proactive health maintenance, with a goal of ensuring a healthier future for its patients and communities alike.
- ***Expanding our care management platform to provide additional patient resources and manage patient utilization.*** In CareMax's commitment to delivering exceptional medical services and optimizing patient care, the Company recognizes the pivotal role that its care management platform plays in facilitating seamless coordination and enhancing patient outcomes. As such, CareMax is dedicated to making strategic investments to expand the capabilities and functionalities of its platform with the following objectives: to provide its patients with additional resources and support to empower them in their healthcare journey, and to better manage patient utilization through streamlined processes and data-driven insights. By enhancing its care management platform, CareMax aims to strengthen communication channels, facilitate proactive interventions, further support its members in managing their chronic conditions, and personalize care plans to meet the unique needs of each patient.
- ***Optimizing performance of the MSO network and of our centers.*** CareMax embarked on a series of strategic initiatives to optimize the performance of its MSO network and centers. One key focus area involves enhancing supply chain management practices to streamline the utilization of supplies and reduce unnecessary costs. Furthermore, the Company is prioritizing the implementation of proactive measures to identify and manage high-risk patients, thus mitigating potential health complications and reducing the likelihood of emergency room visits. By strategically aligning these initiatives with our overarching goal of optimizing performance, we are poised to enhance the quality of care and improve patient outcomes.
- ***Consolidate and divest non-profitable centers, including de novo centers.*** As the Company continues to strategize for sustainable profits and operational optimization, CareMax is reviewing the portfolio of its centers. Through a thoughtful approach of consolidation and divestment, CareMax aims to optimize its resources and refocus its efforts on maximizing profitability and enhancing the overall financial performance of the Company's centers. While recognizing the importance of each center within its portfolio, CareMax understands the necessity of aligning resources with areas that offer the greatest potential for success. By consolidating operations and divesting non-profitable centers, CareMax can reallocate resources to bolster the strength of its core business, invest in innovative strategies, and drive long-term value for its stakeholders.

- **Reviewing our portfolio of payor contracts.** As part of its commitment to provide the highest quality care to members, CareMax continuously evaluates its payor arrangements. This entails a thorough assessment of the value proposition associated with each arrangement and their alignment with CareMax business objectives. CareMax plans to proactively manage its contractual commitments, so that it can direct its efforts and resources towards cultivating mutually beneficial partnerships to ensure provision of high-quality care for our members, driving sustainable profits and fostering long-term success.
- **Right size operational expenses.** In 2023, the Company initiated a number of strategic cost optimization initiatives. Recognizing the critical balance between cost management and sustaining high quality patient care, CareMax is committed to rightsizing its expenditures without compromising on the quality of our services. Through rigorous evaluation and targeted initiatives, the Company aims to streamline its operations, improve efficiency, and achieve a sustainable financial position. This entails evaluation of staffing levels, compensation structures, and facility utilization to ensure optimal resource allocation while maintaining the highest standards of care. By implementing strategic cost-saving measures and fostering a culture of fiscal responsibility across the organization, CareMax aims to align its commitment to achieving financial profitability and preserving its ability to fulfill its mission of providing exceptional healthcare to the community.

## CareMax's History

Co-founded by Carlos de Solo and Alberto de Solo in 2011, CareMax evolved to serve the needs of Medicare Advantage patients by providing a comprehensive suite of high-touch health care and social services to its patients through its centers and technology platform, CareOptimize. On December 18, 2020, DFHT entered into a Business Combination Agreement (the "Business Combination Agreement") with CareMax Medical Group, L.L.C., ("CMG"), the entities listed in Annex I to the Business Combination Agreement (the "CMG Sellers"), IMC Medical Group Holdings, LLC, ("IMC"), IMC Holdings, LP, ("IMC Parent"), and Deerfield Partners, L.P. Upon completion (the "Closing") of the transactions contemplated by the Business Combination Agreement and the related financing transactions on June 8, 2021 (the "Business Combination"), DFHT acquired 100% of the equity interests in CMG and 100% of the equity interests in IMC, with CMG and IMC becoming wholly owned subsidiaries of DFHT, and the name of the combined company was changed to CareMax, Inc. Unless the context otherwise requires, "CareMax," "the Company," "we," "us," and "our" refer, for periods prior to the completion of the Business Combination, to CMG and its subsidiaries, and, for periods upon or after the completion of the Business Combination, to CareMax, Inc. and its subsidiaries, together with its affiliated professional corporations or limited liability companies ("affiliated professional contractors").

Prior to the Business Combination, CareMax owned and operated 11 multi-specialty centers throughout Miami-Dade and Broward Counties in South Florida that provide clinical care, ancillary care services, and health and wellness services. CareMax also established a full-risk MSO.

Prior to the Business Combination, IMC owned and operated 13 medical clinics and wellness centers strategically located in Miami-Dade, Broward and Orange Counties in Florida that provide clinical care, ancillary care services and health and wellness services to more than 48,000 members of Medicare Advantage, Medicaid and commercial insurance plans. While IMC's primary focus was providing care to Medicare-eligible seniors who are mostly over the age of 65, IMC also provided services to children and adults through Medicaid programs as well as through commercial insurance plans.

Subsequent to the Business Combination, the Company made a number of strategic acquisitions throughout 2021 and 2022, including the Steward Acquisition in November 2022.

## The U.S. Healthcare System

### Market Overview

The senior population of the United States is expected to grow, with seniors expected to represent approximately 21% of the population by 2030 according to the 2023 National Population Projections based on the U.S. Census. This aging population is expected to drive growth in the already large Medicare market, spending in which was projected to exceed \$1.0 trillion in 2023, and is projected by CMS to grow at an average growth rate of 7.7% per year through 2031. Value-based primary care has been advocated by CMS as a potential way to lower healthcare spending. Value-based, patient-centered medical home models have garnered bipartisan support and are expected to continue to grow in popularity irrespective of changes in presidential administration. CareMax believes that its model of care is poised for growth in the Medicare market.

We estimate that the core addressable market for our services in Florida is approximately 1.6 million Medicare eligible patients in our target demographic. We believe this market represents approximately \$21.8 billion of annual healthcare expenditures based on multiplying an average annual expenditure of \$13,652 per Florida member, according to CMS. Our existing market today represents a

small fraction of this massive market opportunity. Our future success will depend on the competitive dynamics in those markets in which we operate, and our ability to attract patients and deploy our care model in those markets.

### ***Unsustainable and rising healthcare costs***

Healthcare spending in the United States reached \$4.5 trillion in 2022 according to CMS, representing approximately 17.3% of U.S. Gross Domestic Product (“GDP”), or \$13,493 per person. Over 2022-2031, average annual growth of healthcare spending, 5.4%, is projected to outpace that of average annual GDP growth of 4.6%, resulting in an increase in the healthcare spending share of GDP from 18.3% in 2021 to 19.6% in 2031.

Healthcare expenditures are particularly concentrated in the Medicare-eligible population due to the high rate of chronic conditions. While representing only 17% of the United States population, the 65 and older age group accounted for 37% of all healthcare spending in 2020, with an average spend of \$22,356 per person, almost 2.5 times higher than for working adults.

Healthcare expenditures are also particularly high for populations with chronic conditions, such as diabetes and obesity. According to the Centers for Disease Control and Prevention, chronic disease accounts for approximately 90% of aggregate healthcare spending in the United States. With 65.6 million people on Medicare in 2023, and half of whom have two or more chronic conditions, there is great opportunity for potential savings for Medicare.

### ***Prevalence of wasteful spending and sub-optimal outcomes***

A 2019 study published in the Journal of the American Medical Association estimated that approximately 25% of all healthcare spending is for unnecessary services, excessive administrative costs, fraud and other problems creating waste, implying approximately \$760 billion to \$935 billion of annual wasteful spending at current levels.

In 2022, hospital care accounted for the largest portion of healthcare spending in the United States, representing approximately 30% of the total. Proper management of chronic conditions can significantly reduce the incidence of acute episodes, which are the main drivers of trips to the emergency room and hospitalization, particularly among the elderly. According to CMS, in 2022, approximately 37% of total Medicare expenditures, or approximately \$353 billion, were dedicated to hospitalization.

Emergency department overutilization is a common symptom of patients, particularly elderly patients, who often do not understand how to navigate an overly complex healthcare system. Because elderly patients are more likely to have chronic and complex conditions, they are often admitted to the hospital for expensive treatment following these unnecessary emergency room visits.

Despite high levels of spending, the United States healthcare system struggles to produce better health outcomes and to keep doctors and patients satisfied. According to the Centers for Disease Control and Prevention, life expectancy in the United States was 77.5 years in 2022, compared to 82.4 years in comparable developed countries, and patient satisfaction with the healthcare system is low.

### ***New payment structures have begun to address the problem***

Policymakers and healthcare experts generally acknowledge the fundamental challenges and opportunities for improvement in the delivery of healthcare in the United States. Historically, healthcare delivery was centered around reactive care to acute events, which resulted in the development of a fee-for-service payment model. By linking payments to volume of encounters and pricing for higher complexity interventions, the fee-for-service model does not reward prevention, but rather incentivizes the treatment of acute care episodes as they occur.

Policymakers have taken note of the negative impacts created by the fee-for-service model and have realized that an aging population with high prevalence of chronic disease requires a new payment structure. They have responded by creating programs like Medicare Advantage, Medicare Shared Savings Program and the ACO REACH, and pushing for transitions to value-based reimbursements.

### ***Medicare Advantage***

Medicare Advantage works as an alternative to traditional fee-for-service Medicare. In Medicare Advantage, CMS pays health plans a monthly sum per member to manage all health expenses of a participating member. This provides the health plans with an incentive to deliver lower-cost, high-quality care.

Medicare Advantage has been well received since it was introduced, according to the Kaiser Family Foundation (the “KFF”). According to KFF, in January 2024, for the first time in Medicare’s history, more than half of all eligible people with Medicare, or 30.8 million

people in 2023, are enrolled in private Medicare Advantage plans. Medicare Advantage enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2024 to 60% by the end of 2030.

### ***Value-based care payments***

Value-based care refers to the goal of incentivizing healthcare providers to simultaneously increase quality while lowering the cost of care. In 2021, CMS established a goal to have 100% of Medicare beneficiaries and the vast majority of Medicaid beneficiaries in value-based care relationships by 2030.

### ***Legacy Healthcare delivery infrastructure has been slow to transition from reactive and episodic care to proactive and comprehensive care models***

In order for shifts to value-based payment models to drive meaningful results, there must be a corresponding shift in care delivery models. To date, such care delivery models have been slow to develop. While there has been significant investment by providers, payors and technology companies in developing solutions to drive higher quality and lower cost of care, these investments have not resulted in meaningful change within a healthcare delivery infrastructure that remains optimized for the fee-for-service model.

In order to maintain economically viable practices in a fee-for-service payment model, typical primary care providers need to see an ever-increasing number of patients per day with limited support from staff, which limits the time providers are able to spend with each patient during office visits. In addition, financial constraints further limit the ability of primary care providers to invest in technology and other capabilities that would enable them to have more personalized patient engagement and prevent primary care providers from providing their patients with many of the supplemental services that they need, such as home-based primary care, medication management and behavioral health services that are often not reimbursed at a sufficient level to enable providers to offer these services.

Many payors have been early adopters of value-based payment models, but their ability to influence the care delivery model is limited. Any particular payor represents a small portion of the average provider's panel, making it difficult for the payor to gain sufficient provider mindshare to meaningfully influence the way that any one provider delivers care. Some payors attempt to solve this problem by directly investing in provider assets; however, the provider assets available for investment are primarily optimized for the legacy fee-for-service model.

There is demand for technology-driven disruption that would shift the healthcare system to a value-based model. However, technology-based solutions alone have been unable to drive significant change without also addressing the constraints on providers' time and resources.

The healthcare system has seen a shift to quality focused metrics, including social determinants of health, that are driving the level of payments being received.

### **CareMax Centers**

The foundation of CareMax's model is its centers. A typical center ranges in size from approximately 5,000 to 15,000 square feet with the capacity for three to five full clinical care teams, depending on size. Each clinical care team can provide high-touch preventive care to up to 600 Medicare Advantage members. For example, once fully-staffed with four full clinical care teams, that center could provide care to up to 2,400 members.

It typically takes about 12 to 18 months to complete the buildout of each center and up to three years for each center to gain sufficient membership to reach break-even, when the center is approximately 50% filled to capacity, depending upon payor allocation, location and capacity of the center.

CareMax's centers are located throughout South and Central Florida, New York, Tennessee, and Texas. A fleet of vans provide transportation for members between their homes and the center and other medical appointments outside of the center. Medications can be delivered directly to members' homes from CareMax's central fill pharmacy, negating the burden of an additional trip to a retail pharmacy for members, which may otherwise impede medication compliance. Medical personnel are available to serve members in their homes following discharge from the hospital or if travel to a center is burdensome for a member. Centers may include an Optometry service to provide patients with frames and lenses made in-house at the CareMax optical lab. Further, centers in Florida may include a pharmacy dispensary supplied by CareMax's owned central fill pharmacy, and nonpharmacological pain management, such as massage therapy and acupuncture, through the wellness center. Most of CareMax's centers also include health and wellness centers that offer health educational classes, fitness programs, and social services intended to address the social barriers to accessing care faced by many of CareMax's Medicare Advantage members. In Florida, each wellness center includes an ACCESS center, licensed by the Florida Department of Children and Families, who is able to connect members with additional social services, such as food and housing

assistance. Each wellness center typically extends these social services to the surrounding community through community outreach personnel, who host health fairs and events open to non-members. In New York, Tennessee and Texas, we partner with non-profit organizations to connect members to additional social services. As a result, each CareMax center is a “one-stop-shop” health and wellness solution for members.

**CareMax’s Clinical Care Teams**

CareMax utilizes a team-based approach. Each clinical care team is led by a primary care physician, who may work with a physician’s assistant or advanced practice registered nurse and each of which is supported by a medical assistant to deliver value-based, coordinated care. As a center grows, CareMax increases the number of clinical care teams serving members. Each of CareMax’s clinical care teams is trained in preventive and comprehensive care designed to address the whole person and provide a comprehensive, high touch approach to health care delivery.

Each of CareMax’s team members has a specific role to play in delivering CareMax’s care model, as described below:

|  |  |
|--|--|
| Primary Care Physician                                     | Leads the clinical care team and implements CareMax’s comprehensive, high touch approach to health care    |
| Physician’s Assistant or Advance Practice Registered Nurse | Educate and manage clinical needs between visits and provide group education on chronic disease management |
| Medical Assistant  | Manage clinical workflows and act as guides for patient visits   |

The following additional care and service providers typically support clinical care teams at our centers:

|                     |                           |                                    |
|---------------------|---------------------------|------------------------------------|
| Phlebotomist        | Front Desk                | Access Representative              |
| Pharmacy Technician | Referral Coordinator      | Community Outreach Representative  |
| Administrator       | Transportation Dispatcher | Wellness Staff & Massage Therapist |

Additional care and service providers allow members to receive laboratory services, ultrasounds, electrocardiograms, x-rays, and limited procedures, such as joint injections, centrally at a center. Specialty providers, ranging from cardiology, dermatology, pulmonology, gastroenterology, podiatry, psychiatry, neurology, optometry, ophthalmology, and dental, are also available to members.

Additionally, CareMax’s centers are supported by a centralized office which contains a 24/7 inbound call center, member outreach outbound call center, referrals processing, medical records and clinical documentation reviewers. Members are guided through the entirety of the healthcare system by referrals and care coordinators who handle the appointment scheduling and medical record retrieval that would otherwise be the responsibility of the member to coordinate, thereby addressing another potential barrier to care for most members.

**CareOptimize**

CareOptimize is CareMax’s technology platform that powers its comprehensive, high touch approach to health care delivery. CareOptimize is a proprietary end-to-end technology platform that does the following:

- **Aggregates Data.** CareOptimize collects health-related data from CareMax members and the patients served by healthcare organizations in the CareOptimize network from a broad set of sources, including state level health information exchanges, payor claims data, laboratory results, eligibility data and data gathered from remote monitoring. CareOptimize is designed to structure and sort these data sets to develop a comprehensive understanding of member and patient medical and social attributes.
- **Data Analytics.** CareOptimize utilizes proprietary algorithms and machine learning to support more informed care delivery decisions and to focus care decisions on preventative chronic disease management and the social determinants of health. CareMax uses these analytics and data science to generate insights that CareMax and the healthcare organizations in the CareOptimize network use in care decisions for members and patients.
- **Informed Care Decisions.** Based on the data and analysis, CareOptimize saves time for providers and improves the consistent and coordinated application of care delivery

- Offers providers curated patient data accessible by providers during office visits, which allows providers to review medical histories more easily, identify relevant data points, and reduce the administrative burden of the practice of medicine;
- Alerts providers to changes in conditions between visits, making interventions between visits possible without the need for a patient to contact the provider, thereby reducing another potential barrier for care;
- Identifies where a patient may have not yet completed preventative tests;
- Helps providers to identify specialists convenient to patients' geography; and
- Identifies care events, such as hospitalizations, or other care provided outside the care network, to give providers a complete picture of patients' medical status.

As a result, CareOptimize stratifies risk for providers and helps providers build meaningful relationships with patients.

### ***CareMax's Impact***

CareMax is improving health and quality of life for our members through our delivery of comprehensive, preventive and coordinated care for our members via our whole person health model. Many of our Medicare Advantage members suffer from one or more chronic conditions and are dual-eligible and low-income subsidy eligible. Our whole person health model provides a number of services, such as primary care, specialty, virtual care, transportation, wellness and fitness, among other services.

During the outbreak of the COVID-19 pandemic, approximately 90% of our patients' appointments were conducted through real-time audio/video telehealth sessions. Where members faced technological barriers to accessing telehealth, CareMax provided tablets to those members.

In order to support continued in-person visits, all CareMax employees, staff and members were provided with personal protective equipment and other medical supplies. CareMax clinical teams were also staggered with alternating schedules and staffing redundancies to prevent disruption in member care. Consistent with CareMax's commitment to whole person wellness, during the peak of the COVID-19 pandemic, CareMax coordinated a number of social supports for members, including the delivery of over 2,300 meals to members per day, weekly check-in calls to members that also supported COVID-19 related education and virtual exercise and wellness classes and virtual social activities to reduce member loneliness and maintain community among members.

### ***Capitation arrangements***

From its founding, CareMax has focused its business on Medicare Advantage or similar capitation arrangements, which CareMax believes aligns provider incentives with both quality and efficiency of care. Under capitation arrangements, payors pay a fixed per member per month ("PMPM") amount for every plan member that selects CareMax as its primary care provider. Each patient who selects CareMax as his or her primary care provider thus becomes a member, giving CareMax a significant portion of the responsibility and risk for managing patient care. CareMax believes this approach to care management improves the quality of care for patients and the potential profitability for efficient care providers.

The PMPM rates for CareMax's capitation arrangements are determined as a percent of the premium the Medicare Advantage plan receives from CMS for CareMax's at-risk patients. Those premiums are determined via the Medicare Advantage plans' competitive bidding process with CMS and are based upon the cost of care in a local market and the average utilization of services by the patients enrolled. Medicare pays capitation using a "risk adjustment model," which compensates providers based on health status (acuity) of each individual patient. Payors with higher acuity patients receive more, and those with lower acuity patients receive less. Under the risk adjustment model, capitation is paid on an interim basis based on enrollee data submitted for the preceding year and is adjusted in subsequent periods after the final data is compiled. As premiums are adjusted via the risk adjustment model, CareMax's PMPM payments will change in unison with how CareMax's payors' premiums change with CMS' rates of reimbursement. In certain contracts, PMPM fees also include adjustments for items such as performance incentives or penalties based on the achievement of certain clinical quality metrics as contracted with payors.

CareMax also serves Medicaid patients under capitation arrangements. Similar to the capitation arrangements with Medicare Advantage plans, under Medicaid plans, CareMax is allocated an agreed percentage of the premium the Medicaid plan receives from Florida's Agency for Health Care Administration ("AHCA"). Premiums are determined by Florida's AHCA and base rates are adjusted annually using historical utilization data projected forward by a third-party actuarial firm. The rates are established based on specific cohorts by age and sex and geographical location. AHCA uses a "zero sum" risk adjustment model that establishes acuity for certain cohorts of patients and quarterly, depending on the scoring of that acuity, may shift premiums from health plans with lower acuity members to health plans with higher acuity members.

The premiums paid under capitation are often higher than under fee-for-service arrangements. Consequently, the revenue and, when costs for providing service are effectively managed, profit opportunity available under a capitation arrangement are more attractive.

### ***MSSP***

The MSSP revenue is sponsored by CMS. The MSSP allows accountable care organization (“ACOs”) participants to receive a share of cost savings they generate in connection with the management of costs and quality of medical services rendered to Medicare beneficiaries. Payments to ACO participants, if any, are calculated annually and paid once a year by CMS on cost savings generated by the ACO participant relative to the ACO participants’ CMS benchmark. Under the MSSP, an ACO must meet certain qualifications to receive the full amount of its allocable cost savings or they either receive nothing or are responsible for shared losses. The MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings. An ACO that meets the MSSP’s quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below the medical expenditure benchmark provided by CMS. A Minimum Savings Rate (“MSR”), which varies depending on the number of beneficiaries assigned to the ACO, must be achieved before the ACO can receive up to 75% of share of the savings if quality performance standards are met; the ACO is also responsible for 40% of the deficit. Once the MSR is surpassed, all the savings below the benchmark provided by CMS will be shared with the ACO.

CareMax believes that the advantages, savings and efficiencies made possible by the capitation model are most pronounced when the care demands of the population are the most severe and require the most coordination, such as for older patients and patients with chronic, complex and follow-on diseases that CareMax serves. While organized coordination of care is central to the capitation model, it is also well suited to the implementation of preventive care and disease management over the long term. The capitation model gives practitioners a financial incentive to control costs by improving the overall health of their patient population by managing chronic conditions, offering preventive care and avoiding expensive hospital stays and emergency department visits. Although capitation arrangements involve a certain degree of risk that patients’ medical expenses will exceed the capitation amount, CareMax believes that it has the scale, comprehensive medical delivery resources, infrastructure and care management knowledge to spread this risk across a large patient population. See “Risk Factors — Risks Related to Our Business and Industry — Under most of our agreements with health plans, we assume some or all of the risk that the cost of providing services will exceed our compensation.”

### ***Fee-for-service arrangements***

Under traditional fee-for-service reimbursement models, payors pay a specified amount for each service or procedure performed during a patient visit. As a result, compensation under fee-for-service arrangements is closely tied to the volume of patient visits and procedures performed, thus offering limited financial incentive to focus on cost containment and preventative care. In 2023, less than 1% of CareMax’s revenue was derived from fee-for-service arrangements.

### ***Payor Relationships***

CareMax’s ability to consistently attract patients across multiple geographic markets depends on its ability to contract with payors in each market. By opening centers in locations where CareMax’s current payors have large numbers of Medicare members, CareMax believes it is creating net benefits for payors, as CareMax is able to reduce unnecessary costs and consistently raise the quality of the payors’ plans, driving Medicare quality bonuses that increase their revenue.

As of December 31, 2023, CareMax had contractual relationships with approximately 30 payors. Refer to “Risk Factors — Risks Related to Our Business and Industry — Our revenues and operations are dependent upon a limited number of key payors, the loss of any of which could adversely affect our business.” While length of contract and economic terms are often negotiated, payors generally use form contracts that contain usual and customary terms and conditions. CareMax’s contracts with payors provide for terms of varying lengths with annual renewals following the initial term; however, certain of these payor contracts also permit either party to terminate the contract for convenience upon 60 to 90 days’ notice. CareMax’s agreements with each payor may also include terms and conditions to incentivize CareMax and facilitate its ability to provide quality care to that plan’s members, such as care coordination or stabilization fees, quality adjustments, marketing support and other usual and customary provisions.

The contracts governing CareMax’s relationships with payors include key terms which may include the period of performance, revenue rates, advanced billing terms, service level agreements and termination clauses. Typically, these contracts provide for a PMPM payment to CareMax determined as a percentage of the Medicare Advantage premium received by the applicable plan. The specified percentage varies depending on the plan and the terms of the particular contract. In some cases, CareMax’s contracts also include other shared medical savings arrangements. In addition, certain of CareMax’s contracts provide that if CareMax fails to meet specified implementation targets, it may be subject to financial penalties.

Most of CareMax's contracts include cure periods for certain breaches, during which time CareMax may attempt to resolve any issues that would trigger a payor's ability to terminate the contract. Certain of CareMax's contracts may be terminated immediately by the payor if CareMax loses applicable licenses, becomes insolvent, loses liability insurance, or receives an exclusion, suspension or debarment from state or federal government authorities. Additionally, if a payor were to lose applicable licenses, lose liability insurance, become insolvent, or receive an exclusion, suspension or debarment from state or federal government authorities, CareMax's contract with such payor could in effect be terminated. The loss, termination or renegotiation of any contract could negatively impact CareMax's results. In addition, as payors' businesses respond to market dynamics and financial pressures, and as they make strategic business decisions in respect of the lines of business they pursue and programs in which they participate, CareMax expects that certain of its payors will, from time to time, seek to restructure their agreements with CareMax. See "Risk Factors Risks Related to Our Business and Industry — The termination or non-renewal of the MA contracts held by the health plans with which we contract, or the termination or non-renewal of our contracts with those plans, could have a material adverse effect on our revenue and our results of operations." The contracts with CareMax's payors impose other obligations on CareMax. For example, CareMax typically agrees that all services provided under the payor contract and all employees providing such services will comply with the payor's policies and procedures. In addition, in most instances, CareMax has agreed to indemnify CareMax's payors against certain third-party claims, which may include claims that CareMax's services infringe the intellectual property rights of such third parties.

## Regulation

CareMax's operations and those of its affiliated physician entities are subject to extensive federal, state and local governmental laws and regulations. These laws and regulations require CareMax to meet various standards relating to, among other things, billings and reports to government payment programs, primary care centers and equipment, dispensing of pharmaceuticals, management of centers, personnel qualifications, maintenance of proper records, and quality assurance programs and patient care. If any of CareMax's operations or those of its affiliated physicians are found to violate applicable laws or regulations, CareMax could suffer severe consequences that would have a material adverse effect on CareMax's business, results of operations, financial condition, cash flows, reputation and stock price, including:

- suspension or termination of CareMax's participation in government and/or private payment programs;
- refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- loss of CareMax's licenses required to operate healthcare facilities or administer pharmaceuticals in the jurisdictions in which CareMax operates;
- criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Civil Monetary Penalties Law, the federal Physician Self-Referral Law (the "Stark Law"), the federal False Claims Act (the "FCA") and state analogs to these federal enforcement authorities, or other regulatory requirements;
- enforcement actions by governmental agencies and/or state law claims for monetary damages by patients who believe their health information has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including with respect to violations of the Health Insurance Portability and Accountability Act of 1996, as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act, also known as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, and the regulations promulgated thereunder (collectively, "HIPAA");
- enforcement actions by governmental agencies or monetary penalties for violations of the 21st Century Cures Act;
- mandated changes to CareMax's practices or procedures that significantly increase operating expenses or decrease CareMax's revenue;
- imposition of and compliance with corporate integrity agreements that could subject CareMax to ongoing audits and reporting requirements as well as increased scrutiny of CareMax's billing and business practices which could lead to potential fines, among other things;
- termination of various relationships and/or contracts related to CareMax's business, including joint venture arrangements, contracts with payors, real estate leases and provider employment arrangements;
- changes in and reinterpretation of rules and laws by a regulatory agency or court, such as state corporate practice of medicine laws, that could affect the structure and management of CareMax's business and its affiliated physician practice corporations;
- negative adjustments to government payment models including, but not limited to, Medicare Parts A, B and C and Medicaid; and

- harm to CareMax’s reputation, which could negatively impact CareMax’s business relationships, the terms of payor contracts, CareMax’s ability to attract and retain patients and physicians, CareMax’s ability to obtain financing and CareMax’s access to new business opportunities, among other things.

CareMax expects that the U.S. healthcare industry will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. CareMax’s activities could be subject to investigations, audits and inquiries by various government and regulatory agencies and private payors with whom CareMax contracts at any time in the future. See “Risk Factors — Risks Related to Regulation.” Adverse findings from such investigations and audits could bring severe consequences that could have a material adverse effect on CareMax’s business, results of operations, financial condition, cash flows, reputation and stock price. In addition, private payors could require pre-payment audits of claims, which can negatively affect cash flow, or terminate contracts for repeated deficiencies.

There is no requirement in the jurisdictions in which CareMax currently operates for a risk-bearing provider to register as an insurance company and CareMax has not registered as such in any of the jurisdictions in which CareMax currently operates.

***Federal Anti-Kickback Statute***

The federal Anti-Kickback Statute is a criminal law that prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, in cash or in kind, to induce or reward either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made under federal and state healthcare programs such as Medicare and Medicaid.

Federal civil and criminal penalties that may be imposed for violations of the federal Anti-Kickback Statute include imprisonment, fines and exclusion of the provider from future participation in the federal healthcare programs, including Medicare and Medicaid. Specifically, violations of the federal Anti-Kickback Statute are punishable by imprisonment for up to ten years, fines of up to \$100,000 per kickback or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the federal Anti-Kickback Statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals. The Affordable Care Act (“ACA”) amended the federal Anti-Kickback Statute to clarify that a defendant does not need to have actual knowledge of the federal Anti-Kickback Statute or have the specific intent to violate it. In addition, the ACA amended the federal Anti-Kickback Statute to provide that any claims for items or services resulting from a violation of the federal Anti-Kickback Statute may be considered false or fraudulent for purposes of the FCA, as discussed below.

The federal Anti-Kickback Statute includes statutory exceptions and regulatory safe harbors that protect certain arrangements. Compliance with these exceptions and safe harbors is voluntary. Business transactions and arrangements that are structured to comply fully with an applicable safe harbor will generally be considered outside the ambit of the federal Anti-Kickback Statute. However, transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the law. When an arrangement does not satisfy a safe harbor, the arrangement must be evaluated on a facts and circumstances basis in light of the parties’ intent and the arrangement’s potential for abuse. Arrangements that do not satisfy a safe harbor may be subject to greater scrutiny by enforcement agencies. If any of CareMax’s business transactions or arrangements were found to violate the federal Anti-Kickback Statute, CareMax could face, among other things, criminal, civil or administrative sanctions, including possible exclusion from participation in Medicare, Medicaid and other state and federal healthcare programs. Any findings that CareMax has violated these laws, or even accusations of the same, could have a material adverse impact on CareMax’s business, results of operations, financial condition, cash flows, reputation and stock price.

As part of the Department of Health and Human Services’ (the “HHS”) Regulatory Sprint to Coordinated Care (“Regulatory Sprint”), the Office of Inspector General (the “OIG”) of HHS issued a request for information in August 2018 seeking input on regulatory provisions that may act as barriers to coordinated care or value-based care. Specifically, the OIG sought to identify ways in which it might modify or add new safe harbors to the Anti-Kickback Statute (as well as exceptions to the definition of “remuneration” in the beneficiary inducements provision of the Civil Monetary Penalty Law) to foster arrangements that promote care coordination and advance the delivery of value-based care, while also protecting against harms caused by fraud and abuse. Numerous federal agencies have requested comments and information from the public and have published proposed regulations as part of the Regulatory Sprint on areas that have historically been viewed as barriers to innovative care coordination arrangements.

On November 20, 2020, the OIG released final rules clarifying and revising the Anti-Kickback Statute safe harbors. The new rules are intended to reduce regulatory barriers, accelerate the shift in service reimbursement from volume to value-based payments, and advance coordinated care across healthcare settings. OIG’s final rule adds seven new safe harbor provisions for certain coordinated care and value-based arrangements, modifies four existing safe harbor protections, and codifies one new exception under the civil monetary penalty prohibitions against beneficiary inducements related to telehealth technologies furnished to certain in-home dialysis patients.

In coordination with the exceptions under the Stark Law, OIG established three “new safe harbors for remuneration exchanged between or among participants in a value-based arrangement.” OIG also finalized a new safe harbor related to patient engagement tools and supports furnished by a participant in a value-based enterprise to a patient in a target patient population, and a safe harbor for participants in CMS-sponsored model arrangements and model patient incentives (e.g., Medicare Shared Savings Program) to provide greater predictability and uniformity across models. The other safe harbor provisions include cybersecurity technology, tools, and related services, and electronic health records (“EHR”) items and services, along with revisions to safe harbors addressing personal services arrangements, warranties, and local transportation.

These changes in federal regulations have made and are anticipated to continue to make a significant impact on health care providers and other stakeholders. These and similar changes may cause OIG, CMS or other regulators to change the parameters of rules and regulations that CareMax must follow and thus impact CareMax’s business, results of operations and financial condition.

### ***Risk Bearing Provider Regulation***

Certain of the jurisdictions where CareMax currently operates or may choose to operate in the future regulate the operations and financial condition of risk bearing providers like CareMax and its affiliated providers with respect to their risk-sharing arrangements, such as global risk and other value-based arrangements. These regulations can include capital requirements, licensing or certification, governance controls and other similar matters. In some states, statutes, regulations and/or formal guidance explicitly address whether and in what manner the state regulates the transfer of risk by a payor to a downstream entity. However, the majority of states do not explicitly address the issue, and in such states, regulators may nonetheless interpret statutes and regulations to regulate such activity. If risk-sharing arrangements are not regulated directly in a particular state, the state regulatory agency may nonetheless require oversight by the licensed payor as the party to such a risk-sharing arrangement. Such oversight is accomplished via contract and may include the imposition of significant financial reserve requirements, as well as reporting or other disclosure obligations. Further, state regulatory stances regarding risk-sharing arrangements can change rapidly and codified provisions may not keep pace with evolving risk-sharing mechanisms. While these regulations have not had a material impact on CareMax’s business to date, as CareMax continues to expand, these rules may require additional resources and capitalization and add complexity to CareMax’s business.

In the case of federal health care programs, initiatives and models, in which we participate, such as the Medicare Shared Savings Program and the ACO REACH, we are required to certify compliance with state insurance regulatory requirements as a risk bearing entity. If we fail to comply with applicable state law, including as a result of rapidly evolving state regulation of risk sharing arrangements, we may not be in compliance with such certifications under these models. Such non-compliance could result in termination of our agreements to participate in these models and other penalties, sanctions and liabilities.

### ***Stark Law***

The Stark Law prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing Designated Health Services (“DHS”) from referring Medicare patients to such entities for the furnishing of DHS, unless an exception applies.

Although uncertainty exists, federal agencies and at least two courts have taken the position that the Stark Law also applies to Medicaid. DHS is defined to include clinical laboratory services, physical therapy services, occupational therapy services, radiology services including magnetic resonance imaging, computerized axial tomography scans and ultrasound services, radiation therapy services and supplies, durable medical equipment and supplies, parenteral and enteral nutrients, equipment, and supplies, prosthetics, orthotics and prosthetic devices and supplies, home health services, outpatient prescription drugs, inpatient and outpatient hospital services and outpatient speech-language pathology services, if reimbursed by Medicare. The types of financial arrangements between a physician and an entity providing DHS that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements. The prohibition applies regardless of the reasons for the financial relationship and the referral. Unlike the federal Anti-Kickback Statute, the Stark Law is a strict liability statute where unlawful intent need not be demonstrated.

The Stark Law prohibits any entity providing DHS that has received a prohibited referral from presenting, or causing to be presented, a claim or billing for the services arising out of the prohibited referral. Similarly, the Stark Law prohibits an entity from “furnishing” a DHS to another entity in which it has a financial relationship when that entity bills for the service. The Stark Law also prohibits self-referrals within an organization by its own physicians, although broad exceptions exist that cover employed physicians and those referring DHS that are ancillary to the physician’s practice to the physician group.

If the Stark Law is implicated, the financial relationship must fully satisfy a Stark Law exception. There are a number of exceptions to the self-referral prohibition, including exceptions for many of the customary financial arrangements between physicians and providers,

such as employment contracts, leases, professional services agreements, and risk sharing arrangements, among others. If an exception is not satisfied, then the parties to the arrangement could be subject to sanctions. Sanctions for violation of the Stark Law include denial of payment for claims for services provided in violation of the prohibition, refunds of amounts collected in violation of the prohibition, a civil penalty of up to \$15,000 for each service arising out of the prohibited referral, a civil penalty of up to \$100,000 against parties that enter into a scheme to circumvent the Stark Law prohibition, civil assessment of up to three times the amount claimed and potential exclusion from the federal healthcare programs, including Medicare and Medicaid. Amounts collected on claims related to prohibited referrals must be reported and refunded generally within 60 days after the date on which the overpayment was identified. Furthermore, Stark Law violations and failure to return overpayments in a timely manner can form the basis for FCA liability, as discussed below.

If CMS or other regulatory or enforcement authorities determine that claims have been submitted for referrals by CareMax that violate the Stark Law, CareMax would be subject to the penalties described above. In addition, it might be necessary to restructure existing compensation agreements with CareMax's physicians. Any such penalties and restructuring or other required actions (including mere accusations) could have a material adverse effect on CareMax's business, results of operations, financial condition and cash flows.

In 2018, CMS issued a request for information seeking input on how to address any undue regulatory impact and burden of the Stark Law. CMS placed the request for information in the context of the Regulatory Sprint and stated that it identified aspects of the Stark Law that pose potential barriers to coordinated care. CMS has since issued a sweeping set of new regulations that introduce significant new value-based terminology, safe harbors and exceptions to the Stark Law. Those or other changes implemented by CMS may change the parameters of Stark Law exceptions that CareMax relies on and thus impact CareMax's business, results of operations and financial condition. On November 20, 2020, CMS and OIG issued new exceptions to promote coordinated services among healthcare providers and emphasize value-based payment and collaborative care. In the final rule, CMS finalized three new exceptions and definitions for certain value-based compensation arrangements between or among physicians, providers and suppliers, and amended the existing exception for EHR items. When it comes to value-based arrangements, CMS codified three "new, permanent exceptions to the physician self-referral law." The specific activities of the parties involved in these compensation relationships will be key to determining whether the proposed value-based arrangement qualifies for an exception under the Stark Law.

CMS also added two new exceptions—one for certain arrangements under which a physician receives limited remuneration for items or services actually provided by the physician, and the other, aligned with OIG, for donations of cybersecurity technology that includes hardware, software, and related services. The final rule also includes commentary and insight into how CMS now interprets numerous defined terms and various requirements scattered throughout the Stark Law.

The definition of DHS under the Stark Law does not include physician services. Because most services furnished to Medicare beneficiaries provided in CareMax's centers are physician services, CareMax's services generally do not implicate the Stark Law referral prohibition. However, certain ancillary services CareMax may provide, including pharmacy and certain diagnostic testing, may be considered DHS. CareMax also refers Medicare beneficiaries to third parties for the provision of DHS and CareMax's financial relationships with those third parties must satisfy a Stark Law exception.

CareMax has entered into several types of financial relationships with physicians, including compensation arrangements. If CareMax's centers were to bill for a DHS service and the financial relationships with the physician did not satisfy an exception, CareMax could be required to change CareMax's practices, face civil penalties, pay substantial fines, return certain payments received from Medicare and beneficiaries or otherwise experience a material adverse effect as a result of a challenge to payments made pursuant to referrals from these physicians under the Stark Law.

### ***Fraud and Abuse under State Law***

States also have laws similar to or more strict than the federal Anti-Kickback Statute and Stark Law that may affect CareMax's ability to receive referrals from physicians with whom CareMax has financial relationships. State laws of this nature are significant, particularly if they apply to all payors and not just to government-funded healthcare programs. Some states have laws prohibiting physicians from holding financial interests in various types of medical facilities to which they refer patients. These state prohibitions may differ from the Stark Law's prohibitions and exceptions may apply to a broader or narrower range of services and financial relationships. Some of these laws could potentially be interpreted broadly as prohibiting physicians who hold shares of CareMax's publicly traded stock or are physician owners from referring patients to CareMax's centers if the centers perform services for their patients or do not otherwise satisfy an exception to the law. State statutes and regulations also may require physicians or other healthcare professionals to disclose to patients any financial relationship the physicians or healthcare professionals have with a healthcare provider that is recommended to patients.

Some state anti-kickback laws include civil and criminal penalties. Some of these laws include exemptions that may be applicable to CareMax's physician relationships or for financial interests limited to shares of publicly traded stock. Some, however, may include no explicit exemption for certain types of agreements and/or relationships entered into with physicians. These laws and regulations vary

significantly from state to state, are often vague and, in many cases, have not been interpreted by courts or regulatory agencies. Exclusions and penalties, if applied to us, could result in significant loss of reimbursement to us, thereby significantly affecting CareMax's financial condition.

If these laws are interpreted to apply to physicians who hold equity interests in CareMax's centers or to physicians who hold CareMax's publicly traded stock, and for which no applicable exception exists, CareMax may be required to terminate or restructure CareMax's relationships with these physicians. Violations of these state laws may result in prohibition of payment for services rendered, loss of licenses, fines, criminal penalties, administrative sanctions, refund requirements and exclusions from government healthcare programs, including Medicare and Medicaid, which could have a material adverse effect on CareMax's business, results of operations, financial condition, cash flows, reputation and stock price.

Similarly, states may have beneficiary inducement prohibitions and consumer protection laws that may be triggered by the offering of inducements, incentives and other forms of remuneration to patients and prospective patients. Violations range from civil to criminal and could have a material adverse effect on CareMax's business, results of operations and financial condition.

### ***Corporate Practice of Medicine and Fee-Splitting***

The laws and regulations relating to the practice of medicine vary from state to state and many states limit general business corporations, such as CareMax, from practicing medicine, employing physicians to practice medicine, controlling physicians' medical decisions or engaging in some practices such as splitting professional fees with physicians. While CareMax believes that it is in substantial compliance with state laws prohibiting the corporate practice of medicine and fee-splitting, other parties may assert that CareMax is engaged in the corporate practice of medicine or unlawful fee-splitting. Were such allegations to be asserted successfully before the appropriate judicial or administrative forums, CareMax could be subject to adverse judicial or administrative penalties, certain contracts could be determined to be unenforceable and CareMax may be required to restructure CareMax's contractual arrangements. The laws of other states do not prohibit non-physician entities from employing physicians to practice medicine but may retain a ban on some types of fee-splitting arrangements.

Violations of the corporate practice of medicine restrictions vary by state and may result in physicians being subject to disciplinary action, as well as to forfeiture of revenues from payors for services rendered. For lay entities, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in medical practice without a license. Some of the relevant laws, regulations and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation. In limited cases, courts have required management services companies to divest or reorganize structures deemed to violate corporate practice restrictions. Third-party payors may also seek to terminate their contracts with, or recoup past amounts paid from, CareMax arising out of CareMax's alleged violation of corporate practice or fee-splitting laws. Moreover, state laws are subject to change. Any allegations or findings that CareMax has violated these laws could have a material adverse impact on CareMax's business, results of operations and financial condition.

### ***The False Claims Act***

The FCA is a means of policing false bills or false requests for payment in the healthcare delivery system. Among other things, the FCA authorizes the imposition of up to three times the government's damages and significant per claim civil penalties on any "person" (including an individual, organization or company) who, among other acts:

- knowingly presents or causes to be presented to the federal government a false or fraudulent claim for payment or approval;
- knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;
- knowingly makes, uses or causes to be made or used a false record or statement material to an obligation to pay the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the federal government; or
- conspires to commit the above acts.

The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including but not limited to coding errors, billing for services not rendered, the submission of false cost or other reports, billing for services at a higher payment rate than appropriate, billing for items or services provided by entities or individuals that are not appropriately licensed, billing for care that is not considered medically necessary and false reporting of risk-adjusted diagnostic codes to Medicare Advantage plans. The penalties for a violation of the FCA range from \$5,500 to \$11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On December 27, 2023, the Department of

Justice issued a final rule announcing adjustments to FCA penalties, under which the per claim penalty range increased to a range from \$13,508 to \$27,894 for penalties assessed after January 15, 2024, so long as the underlying conduct occurred after November 2, 2015.

The Fraud Enforcement and Recovery Act (“FERA”), enacted on May 20, 2009, greatly expanded the reach of the FCA by eliminating the prior requirement that a false claim be presented to a federal official, or that such a claim directly involves federal funds. FERA clarifies that liability attaches whenever an individual or entity makes a false claim to obtain money or property, any part of which is provided by the government, without regard to whether the individual or entity makes such claim directly to the federal government. Consequently, under FERA, liability attaches when such false claim is submitted to an agent acting on the government’s behalf or with a third party contractor, grantee or other recipient of such federal money or property. Additionally, under FERA, individuals and entities violate the FCA by knowingly retaining historic improper payments (overpayments/overprovisions) even if the individual or entity did not make claim for such payments. The ACA requires that overpayments be reported and returned within 60 days after the overpayment is identified or the corresponding cost report was due.

An overpayment impermissibly retained could subject CareMax to liability under the FCA, exclusion from government healthcare programs and penalties under the federal Civil Monetary Penalty Law. As a result of these provisions, CareMax’s procedures for identifying and processing overpayments may be subject to greater scrutiny.

In addition to actions being brought under the FCA by government officials, the FCA also allows a private individual with direct knowledge of fraud to bring a whistleblower, or qui tam, lawsuit on behalf of the government for violations of the FCA. The ACA also broadens the direct knowledge requirement so that the private individual is not required to have direct knowledge of the allegations, but must provide information to the government before it is publicly disclosed and that is independent of and materially adds to any publicly disclosed allegations. In that event, the whistleblower is responsible for initiating a lawsuit that sets in motion a chain of events that may eventually lead to the recovery of money by the government.

The ACA provides that claims tainted by a violation of the federal Anti-Kickback Statute are false for purposes of the FCA. Some courts have held that filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute individuals and entities who are alleged to have submitted false or fraudulent claims for payment to the federal government. Any allegations or findings that CareMax has violated the FCA could have a material adverse impact on CareMax’s business, results of operations and financial condition.

In addition to the FCA, various states have adopted their own analogs of the FCA. States are becoming increasingly active in using their false claims laws to police the same activities listed above, particularly with regard to Medicaid fee-for-service and Managed Medicaid programs.

#### ***Civil Monetary Penalties Law***

The Civil Monetary Penalties Law authorizes the imposition of civil monetary penalties, assessments and exclusion against an individual or entity based on a variety of prohibited conduct, including, but not limited to:

- presenting, or causing to be presented, claims for payment to Medicare, Medicaid or other third-party payors that the individual or entity knows or should know are for an item or service that was not provided as claimed or is false or fraudulent;
- offering remuneration to a federal health care program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive health care items or services from a particular provider;
- arranging contracts with an entity or individual excluded from participation in the federal health care programs;
- violating the federal Anti-Kickback Statute;
- making, using or causing to be made or used a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a federal health care program;
- making, using or causing to be made any false statement, omission or misrepresentation of a material fact in any application, bid or contract to participate or enroll as a provider of services or a supplier under a federal health care program; and
- failing to report and return an overpayment owed to the federal government.

Substantial civil monetary penalties may be imposed under the federal Civil Monetary Penalty Law and may vary depending on the underlying violation. In addition, an assessment of not more than three times the total amount claimed for each item or service may also apply and a violator may be subject to exclusion from federal and state health care programs. In addition, exclusion from the Medicare program may be imposed for violations.

CareMax could be exposed to a wide range of allegations to which the federal Civil Monetary Penalty Law would apply. CareMax performs monthly checks on CareMax's employees, affiliated providers and certain affiliates and vendors using government databases to confirm that these individuals have not been excluded from federal programs. However, should an individual become excluded and CareMax fails to detect it, a federal agency could require CareMax to refund amounts attributable to all claims or services performed or sufficiently linked to an excluded individual, assess significant penalties or, worse case scenario, exclude CareMax from participating in federal health care programs, including the Medicare program. Likewise, CareMax's patient programs, which can include enhancements, incentives, benefits and additional care coordination not otherwise covered by third-party payors (including Medicare and Medicaid), could be alleged to be intended to influence the patient's choice in obtaining services or the amount or types of services sought. Thus, CareMax cannot foreclose the possibility that CareMax will face allegations subject to the Civil Monetary Penalty Law with the potential for a material adverse impact on CareMax's business, results of operations and financial condition.

### ***HIPAA and Other Data Privacy Laws***

HIPAA as well as a number of other federal and state privacy and information security laws, extensively regulate the use and disclosure of personally identifiable information ("PII"), as well as "protected health information," or "PHI." HIPAA requires covered entities, including health plans and most health care providers, to implement administrative, physical and technical safeguards to protect the security of such information. These regulations also provide patients with substantive rights with respect to their PHI. As a HIPAA covered entity, CareMax is required to enter into written agreements with certain contractors, known as business associates, to whom CareMax discloses PHI. Covered entities may be subject to penalties for, among other activities, failing to enter into a business associate agreement where required by law or as a result of a business associate violating HIPAA. In instances where CareMax acts as a business associate to a covered entity, there is the potential for additional liability beyond CareMax's status as a covered entity.

Covered entities must notify affected individuals of breaches of unsecured PHI without unreasonable delay but no later than 60 days after discovery of the breach by a covered entity or its agents. Reporting must also be made to the HHS Office for Civil Rights and, for breaches of unsecured PHI involving more than 500 residents of a state or jurisdiction, to the media. All impermissible uses or disclosures of unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the PHI has been compromised. Various state laws and regulations may also require CareMax to notify affected individuals in the event of a data breach involving personal information without regard to the probability of the information being compromised.

Violations of HIPAA by providers like CareMax, including, but not limited to, failing to implement appropriate administrative, physical and technical safeguards, have resulted in enforcement actions and in some cases triggered settlement payments or civil monetary penalties. Penalties for impermissible use or disclosure of PHI were increased by the HITECH Act by imposing tiered penalties of more than \$50,000 per violation and up to \$1.5 million per year for identical violations. In addition, HIPAA provides for criminal penalties of up to \$250,000 and ten years in prison, with the severest penalties for obtaining and disclosing PHI with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Further, state attorneys general may bring civil actions seeking either injunction or damages in response to violations of the HIPAA privacy and security regulations. CareMax follows and maintains a HIPAA compliance plan which is designed to ensure CareMax is in compliance with the HIPAA privacy and security regulations, but there can be no assurance that OCR or other regulators will agree. There can be no assurance that CareMax will not be the subject of an investigation (arising out of a reportable breach incident, audit or otherwise) alleging non-compliance with HIPAA regulations. The HIPAA privacy and security regulations impose and will continue to impose significant costs on CareMax in order to comply with these standards.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns and CareMax remains subject to federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to alleged privacy and data security violations. The California Consumer Privacy Act ("CCPA") was recently amended and expanded by the California Privacy Rights Act (the "CPRA") passed on November 3, 2020. Most of the CPRA's substantive provisions took effect on January 1, 2023, however, the CPRA's expansion of the "Right to Know" has impacted personal information collected on or after January 1, 2022. The CCPA and CPRA, among other things, create new data privacy obligations for covered companies and provide new privacy rights to California residents, including the right to opt out of certain disclosures of their information. The CCPA also created a private right of action with statutory damages for certain data breaches, thereby potentially increasing risks associated with a data breach. Several other states have enacted comprehensive privacy legislation, and while these new laws generally include exemptions for HIPAA-covered data, they add layers of complexity to compliance in the U.S. market and could increase our compliance costs and adversely affect our business.

Additionally, Washington State recently passed the "My Health My Data Act" which will regulate "consumer health data" which is defined as "personal information that is linked or reasonably linkable to a consumer and that identifies a consumer's past, 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 additional states may adopt health-specific privacy laws that could impact our business activities depending on how they are interpreted. Additional states have contemplated new health-specific privacy laws, such as the new Washington My Health My Data Act.

In addition to the laws discussed above, CareMax may see more stringent state and federal privacy legislation in 2024 and beyond, as the increased cyberattacks during and since the COVID-19 pandemic have once again put a spotlight on data privacy and security in the U.S. and other jurisdictions. CareMax cannot predict where new legislation might arise, the scope of such legislation, or the potential impact to CareMax's business and operations.

HIPAA also created two federal crimes: healthcare fraud and false statements relating to healthcare matters. The healthcare fraud statute prohibits knowingly and willfully executing a scheme to defraud any healthcare benefit program, including private payors. A violation of this statute is a felony and may result in fines, imprisonment or exclusion from government sponsored programs. The false statements statute prohibits knowingly and willfully falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services.

In addition to privacy and security laws, we are subject to rules promulgated pursuant to the federal 21st Century Cures Act. In May 2020, the HHS Office of the National Coordinator for Health Information Technology and CMS issued complementary new rules under the 21st Century Cures Act that are intended to enhance interoperability and prevent information blocking. These rules create significant new requirements for healthcare industry participants, including requirements to (i) provide patients with convenient access to health care information, (ii) support electronic exchange of data for transitions of care, and (iii) require participation in trust networks to improve interoperability. 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 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 information blocking that has occurred after September 1, 2023, and the Office of the National Coordinator (the "ONC") and HHS proposed a rule on November 1, 2023 listing certain disincentives for actors that conduct information blocking. The 21st Century Cures Act authorizes civil monetary penalties up to \$1 million per information blocking "violation." It is 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.

Federal and state consumer protection laws, including laws that do not on their face specifically address data privacy or security, have been applied to data privacy and security matters by a range of government agencies and courts.

If we or third parties who transmit PHI and other PII or confidential information to us are found to have violated such laws, rules or regulations, it could result in government-imposed fines, orders requiring that we or these third parties change our or their practices, or criminal charges, which could adversely affect our business. Complying with these various laws and regulations could cause us to incur substantial costs or require us to change our business practices, systems and compliance procedures in a manner adverse to our business.

### ***Healthcare reform***

In March 2010, broad healthcare reform legislation was enacted in the United States through the ACA. The ACA altered how healthcare is delivered and reimbursed in the U.S. and contains various provisions, including the establishment of health insurance exchanges to facilitate the purchase of qualified health plans, expanded Medicaid eligibility, subsidized insurance premiums and additional requirements and incentives for businesses to provide healthcare benefits. Other provisions have expanded the scope and reach of the ACA and other healthcare fraud and abuse laws. Although many of the provisions of the ACA did not take effect immediately and continue to be implemented, and some have been and may be modified before or during their implementation, the reforms could continue to have an impact on CareMax's business in a number of ways. The status of the ACA 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 to completely repeal the ACA have been unsuccessful to date, and on June 17, 2021, the United States Supreme Court dismissed the most recent judicial challenge to the ACA brought by several states without specifically ruling on the constitutionality of the ACA.

While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. As a result, there is considerable uncertainty regarding the future with respect to the exchanges and other core aspects of the current health care marketplace. Future elections may create conditions for Congress to adopt new federal coverage programs that may disrupt CareMax's current commercial payor revenue streams. While specific changes and their timing are not yet apparent, such changes could lower CareMax's reimbursement rates or increase CareMax's expenses. CareMax cannot predict how employers, private payors or persons buying insurance might react to federal and state healthcare reform legislation, whether already enacted or enacted in the future, nor can CareMax predict what form many of these regulations will take before implementation. Any failure to successfully implement strategic initiatives that respond to future legislative, regulatory, and executive changes could have a material adverse effect on CareMax's business, results of operations and financial condition.

CMS and state Medicaid agencies also routinely adjust the risk adjustment factor which is central to payment under Medicare Advantage and Managed Medicaid programs in which CareMax participates. The monetary “coefficient” values associated with diseases that CareMax manages in its population are subject to change by CMS and state agencies. Such changes could have a material adverse effect on CareMax’s financial condition.

### ***Other regulations***

CareMax’s operations are subject to various state hazardous waste and non-hazardous medical waste disposal laws. Occupational Safety and Health Administration regulations require employers to provide workers who are occupationally subject to blood or other potentially infectious materials with prescribed protections. These regulatory requirements apply to all healthcare facilities, including primary care centers, and require employers to make a determination as to which employees may be exposed to blood or other potentially infectious materials and to have in effect a written exposure control plan. In addition, employers are required to provide or employ hepatitis B vaccinations, personal protective equipment and other safety devices, infection control training, post-exposure evaluation and follow-up, waste disposal techniques and procedures and work practice controls. Employers are also required to comply with various record-keeping requirements.

Federal and state law also governs the dispensing of controlled substances by physicians. For example, the Prescription Drug Marketing Act governs the distribution of drug samples. Physicians are required to report relationships they have with manufacturers of drugs, medical devices and biologics through the Open Payments Program database. Any allegations or findings that CareMax or its providers have violated any of these laws or regulations could have a material adverse impact on CareMax’s business, results of operations and financial condition.

In addition, while none of the jurisdictions in which CareMax currently operates have required it, certain jurisdictions in which CareMax may desire to do business in the future have certificate of need programs regulating the establishment or expansion of healthcare facilities, including primary care centers. These regulations can be complex and time-consuming. Any failure to comply with such regulatory requirements could adversely impact CareMax’s business, results of operations and financial condition.

### **Intellectual Property**

CareMax’s continued growth and success depend, in part, on its ability to protect its intellectual property and internally developed technology, including CareOptimize. CareMax primarily protects its intellectual property through a combination of copyrights, trademarks and trade secrets, intellectual property licenses and other contractual rights (including confidentiality, non-disclosure and assignment-of-invention agreements with CareMax’s employees, independent contractors, consultants and companies with which CareMax conducts business). CareMax does not currently hold a patent or other registered or applied for intellectual protection for the CareOptimize platform, and instead relies upon non-registered rights, including trade secrets, contractual provisions and restrictions on access, to protect its intellectual property rights in CareOptimize.

However, these intellectual property rights and procedures may not prevent others from competing with CareMax. CareMax may be unable to obtain, maintain and enforce CareMax’s intellectual property rights, and assertions by third parties that CareMax violates their intellectual property rights could have a material adverse effect on CareMax’s business, financial condition and results of operations. See “Risk Factors — Risks Related to Our Business and Industry — If we are unable to obtain, maintain and enforce intellectual property protection for our technology or if the scope of our intellectual property protection is not sufficiently broad, particularly with respect to the CareOptimize platform, others may be able to develop and commercialize technology substantially similar to ours, and our ability to successfully commercialize our technology may be adversely affected” and “Risk Factors — Risks Related to Our Business and Industry — Third parties may initiate legal proceedings alleging that we are infringing or otherwise violating their intellectual property rights, the outcome of which would be uncertain and could have a material adverse effect on our business, financial condition and results of operations.”

### **Insurance**

CareMax maintains insurance and excess coverage for property and general liability, professional liability, directors’ and officers’ liability, workers’ compensation, cybersecurity and other coverage in amounts and on terms believed adequate by management, based on CareMax’s actual claims experience and expectations for future claims. CareMax also utilizes stop-loss insurance for its patients, protecting CareMax for medical claims per episode in excess of certain levels which vary depending on the applicable payor. Future claims could, however, exceed CareMax’s applicable insurance coverage. CareMax provides malpractice insurance for the physician practicing at CareMax centers.

## **Employees and Human Capital Resources**

As of December 31, 2023, CareMax had approximately 1,450 employee team members. CareMax considers its relationship with its employees to be good. None of CareMax's employees are represented by a labor union or party to a collective bargaining agreement.

### **Seasonality**

Our ability to grow our patient population with capitation arrangements is dependent in part on our ability to successfully enroll MA patients during the annual enrollment period. During the annual enrollment period, we have the opportunity to attract new MA patients to select us as their primary care provider and existing patients to continue their medical care with us. CareMax typically sees large increases in ACA patients during the first quarter as a result of the annual enrollment period. CareMax's operational and financial results will experience some variability depending upon the time of year in which they are measured. This variability is most notable in the following areas:

#### ***Per-Patient Revenue***

CareMax's revenue derived from at-risk patients is a function of the percent of premium CareMax has negotiated with its payors as well as its ability to accurately and appropriately document the acuity of a patient. CareMax experiences some seasonality with respect to its per-patient revenue as it will generally decline over the course of the year. In January of each year, CMS revises the risk adjustment factor for each patient based upon health conditions documented in the prior year. As the year progresses, CareMax's average per-patient revenue declines as new patients join CareMax typically with less complete or accurate documentation (and therefore lower risk-adjustment scores) and patient mortality disproportionately impacts CareMax's higher-risk (and therefore greater revenue) patients.

#### ***Medical Costs***

Medical costs vary seasonally depending on a number of factors, but most significantly the weather. Certain illnesses, such as the influenza virus, are far more prevalent during colder months of the year, which results in an increase in medical expenses during these time periods. CareMax therefore expects to see higher levels of per-patient medical costs in the first and fourth quarters. Medical costs also depend upon the number of business days in a period. Shorter periods will have lower medical costs due to fewer business days. Business days can also create year-over-year comparability issues if one year has a different number of business days compared to another. CareMax also expects to experience an impact should there be a pandemic such as COVID-19, which may result in increased or decreased total medical costs depending upon the severity of the infection, the duration of the infection and the impact to the supply and availability of healthcare services for CareMax's patients.

During the second half of each year, the medical costs of certain patients, and accordingly, the Company's medical costs, are reduced due to the patients reaching certain pharmacy corridors, stop loss or reinsurance deductibles.

#### ***Payor Settlements***

As it relates to our MSSP contracts, settlements from the CMS typically take place during the fourth quarter of each year, which results in variability of our accounts receivable, cash flow from operations, and cash balances throughout the year.

### **Our Competition**

The U.S. healthcare industry is highly competitive. We compete with local and national providers of primary care services, including Leon Medical Centers locally in Florida, and Agilon Health and Oak Street Health on a national level, for, among other things, recruitment of physicians and other medical and non-medical personnel, individual patients and IPAs. Because of the low barriers of entry into the primary care business and the ability of physicians to own primary care centers and/or also be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. There have also been increasing indications of interest from non-traditional providers and others to enter the primary care space and/or develop innovative technologies or business activities that could be disruptive to the industry. For example, payors have and may continue to acquire primary care and other provider assets and in 2023, Amazon.com, Inc. completed its acquisition of One Medical. In addition, there has been disruption in the structure of our payors, for example, as a result of the 2018 acquisition of Aetna by CVS Health. Our growth strategy and our business could be adversely affected if we are not able to continue to acquire or open new centers, expand our healthcare providers serviced by CareOptimize, recruit qualified physicians, or attract new members and retain our existing members. Refer to "Risk Factors — Risks Related to Our Business and Industry — We face significant competition from primary care facilities and other healthcare services providers. Our failure to adequately compete could adversely affect our business."

### **Website Access to CareMax, Inc. SEC Reports**

We use our websites as channels of distribution of company information. Our Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, Proxy Statement related to our annual shareholders meeting, and all amendments to those reports are available free of charge at [www.caremax.com](http://www.caremax.com) and on the SEC's website at [www.sec.gov](http://www.sec.gov) as soon as reasonably practicable after we have electronically filed or furnished these reports with the SEC. In addition, you may automatically receive email alerts and other information when you enroll your email address by visiting the Investor Services section of our website. The content of any website referred to in this document is not incorporated by reference into this document.

## Risk Factors

### Item 1A. Risk Factors

*Our business is subject to a number of factors that could materially affect future developments and performance. In addition to factors affecting our business that have been described elsewhere in this Annual Report, 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 history of losses and our future profitability remains uncertain and our net losses, level of indebtedness and significant cash used in operating activities have raised substantial doubt regarding our ability to continue as a going concern;
- the execution of our growth strategy may include divesting certain assets or businesses, which we may be unable to successfully execute and we may be unable to achieve the benefits we expect from any such divestitures;
- we may be unable to successfully implement cost-saving measures or achieve expected benefits under our plans to optimize performance of the MSO network and our centers;
- the impact of our existing or future indebtedness and any associated debt covenants on our business and growth prospects;
- the impact of restrictions on our current and future operations contained in certain of our agreements;
- risks relating to lease termination, lease expense escalators, lease extensions, special charges and our inability to comply with provisions of our lease agreements;
- our ability to integrate acquired businesses, including Steward Value-Based Care, and realize the expected benefits of any such acquisitions;
- the viability of our growth strategy, including organic growth, and growth by acquisitions, and our ability to realize expected results, as well as our ability to access the capital necessary for such growth;
- our ability to manage our growth effectively, execute our business plan, maintain high levels of service and patient satisfaction and adequately address competitive challenges;
- our ability to attract new patients;
- the dependence of our revenue and operations on a limited number of key payors;
- the risk of termination, non-renewal or renegotiation of the MA contracts held by the health plans with which we contract, or the termination, non-renewal or renegotiation of our contracts with those plans;
- the impact on our business from changes in the payor mix of our patients and potential decreases in our reimbursement rates;
- competition from primary care facilities and other healthcare services providers;
- competition for physicians and nurses, and shortages of qualified personnel;
- the impact on our business of reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program, including the MA program;
- the impact of the COVID-19 pandemic or any other pandemic, epidemic or outbreak of an infectious disease in the United States or worldwide on our business, financial condition and results of operation;
- the impact on our business of state and federal efforts to reduce Medicaid spending;
- a shift in payor mix to Medicaid payors as well as an increase in the number of Medicaid patients may result in a reduction in the average rate of reimbursement;
- our assumption under most of our agreements with health plans of some or all of the risk that the cost of providing services will exceed our compensation;
- risks associated with estimating the amount of revenues and refund liabilities that we recognize under our risk agreements with health plans;

- the impact on our business of security breaches, loss of data, or other disruptions causing the compromise of sensitive information or preventing us from accessing critical information;
- the impact on our business of disruptions in our disaster recovery systems or management continuity planning;
- the potential adverse impact of legal proceedings and litigation;
- the impact of reductions in the quality ratings of the health plans we serve;
- our ability to maintain and enhance our reputation and brand recognition;
- our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems;
- our ability to obtain, maintain and enforce intellectual property protection for our technology;
- the potential adverse impact of claims by third parties that we are infringing on or otherwise violating their intellectual property rights;
- our ability to protect the confidentiality of our trade secrets, know-how and other internally developed information;
- the impact of any restrictions on our use of or ability to license data or our failure to license data and integrate third-party technologies;
- our ability to protect data, including personal health data, and maintain our information technology systems from cybersecurity breaches and data leakage;
- our ability to adhere to all of the complex government laws and regulations that apply to our business;
- the impact on our business if we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting U.S. healthcare reform;
- our ability to navigate rules and regulations that govern our licensing and certification, as well as credentialing processes with private payors, before we can receive reimbursement for their services;
- insolvency, credit problems or other financial difficulties that could confront our counterparties in strategic acquisitions, investments and other collaborations could expose us to significant financial risk and significantly impact our ability to expand our overall profitability;
- our reliance on strategic relationships with third-parties to implement our growth strategy;
- that estimates of market opportunity and forecasts of market and revenue growth included in this Annual Report may prove to be inaccurate;
- our operating results and stock price may be volatile;
- our failure to comply with continued listing requirements of the Nasdaq Global Select Market;
- risks associated with estimating the amount of revenues that we recognize under our risk agreements with health plans; and
- other risk factors listed in this “Risk Factors” section.

#### ***Risks Related to Our Business and Industry***

***We have a history of losses and our future profitability remains uncertain. Our net losses, level of indebtedness and significant cash used in operating activities have raised substantial doubt regarding our ability to continue as a going concern.***

As a combined entity, we incurred net losses of \$683.3 million for the year ended December 31, 2023 and net losses of \$37.8 million for the year ended December 31, 2022. Our cash flows from operating activities were negative for the year ended December 31, 2023. We expect that we will continue to incur losses and generate negative cash flows from operations due to the length of time it takes to convert newly acquired populations of lives to profitable, full risk contracts in our management services organization operations and the period of unprofitability of the de novo centers before they generate positive cash flows. We may not generate positive cash flow from operating activities in any given period, and our limited operating history as a combined company with IMC and other acquisitions made subsequent to the Business Combination may make it difficult to evaluate our current business and our future prospects. There is no guarantee that any of our investments will be successful or generate a net profit. Even if these investments result in additional revenue, we may not be able to effectively manage such growth or successfully execute our business plan and vision which could materially and adversely impact our ability to achieve profitability. If we are not able to achieve sustainable profitability as a combined company and

generate sufficient cash flow to support our business operations and debt obligations, then our ability to execute our business strategy and maintain our business operations could be materially adversely affected. In such a case, we may be required to seek additional financing, which may not be on terms satisfactory to us, and our business and growth prospects may suffer.

To raise capital, we may sell equity securities, convertible securities or other securities in one or more transactions at prices and in a manner we determine from time to time. Our ability to sell such securities will depend on many factors, some of which are not within our control, such as market conditions, and if we sell equity securities, convertible securities or other securities, our current stockholders may be materially diluted by subsequent sales. Additionally, the credit agreement, that the Company entered in May 2022 (the “Credit Agreement”) contains significant restrictions on our ability to issue new debt, which could further restrict our ability to raise capital. See *“The terms of the Credit Agreement, and certain of our other agreements, contain covenants restricting our current and future operations, particularly our ability to respond to changes in our business or to take certain actions, and any inability to comply with such covenants could have a material adverse effect on our business, results of operations, financial condition”* below for further discussion of the restrictions contained in the Credit Agreement. Further, we may not be able to refinance the Credit Agreement in the event we seek to incur additional debt, and our ability to refinance the Credit Agreement will depend, among other things, on the capital and credit markets and our financial condition at such time. We cannot guarantee that any such efforts to raise capital will be successful, and in the event we are unable to raise additional capital necessary to execute our business strategy, our business operations and financial condition could be materially adversely affected.

In addition, we were not in compliance with the maximum total leverage ratio under the Credit Agreement for the test period ended December 31, 2023. In March 2024, we received a waiver from the lenders to waive the violation of such covenant and certain other covenants and not to enforce their rights and remedies from the resulting events of default under the Credit Agreement through May 15, 2024, subject to an earlier termination of the waiver upon the occurrence of certain specified events. See “Item 9B - Other Information - Credit Agreement Amendment” for additional information. Certain of our long-term leases contain similar covenants to the Credit Agreement and are subject to provisions that provide for a cross default in the event any of our covenants under the Credit Agreement are breached. We cannot assure you that we will be able to maintain compliance with this covenant or other covenants under the Credit Agreement or any other agreement that contains similar covenants in the future and, if we fail to do so, that we will be able to obtain waivers from the lenders and/or amend the covenants. A breach of any of the covenants under the Credit Agreement or the occurrence of other events specified in the Credit Agreement could result in an event of default under the same and give rise to the lenders’ right to accelerate our debt obligations thereunder and pursue other remedial actions under such agreement and/or trigger a cross default under our other long-term leases, which could have a material adverse effect on our business, results of operations, and financial condition.

In addition, our failure to pay the rent or otherwise comply with the provisions of any of our lease agreements could result in an “event of default” under such lease agreement and also could result in a cross default under other lease agreements and agreements for our indebtedness. In March 2024, we failed to make rent payments due pursuant to certain leases on centers that we generally do not intend to operate. Upon an event of default, remedies available to our landlords generally include, without limitation, terminating such lease agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such lease agreement, including the difference between the rent under such lease agreement and the rent payable as a result of reletting the leased properties, and requiring us to pay the rent due for the balance of the term of such lease agreement, less proceeds from re-letting, if any. While to date our landlords have not exercised such remedies, the exercise of such remedies would have a material adverse effect on our business, financial position, results of operations and liquidity.

The report of our independent registered public accounting firm on our audited financial statements contains an explanatory paragraph regarding substantial doubt about our ability to continue as a going concern. Our audited financial statements do not include any adjustments that might result from the outcome of the uncertainty regarding our ability to continue as a going concern. This going concern opinion could materially limit our ability to raise additional funds through the issuance of equity or debt securities or otherwise. If we cannot continue as a going concern, our investors may lose their entire investment in our securities.

***From time to time, the execution of our growth strategy may include divesting certain assets or businesses, which we may be unable to successfully execute and we may be unable to achieve the benefits we expect from any such divestitures.***

To execute our growth strategy, we plan to continue to realign and enhance our business by divesting certain assets or non-core or less strategic portions of our business in order to, among other things, redeploy capital into our core strategies. We may not be able to complete such divestitures with favorable terms or timing or at all. The success of such transactions in the future will be subject to market conditions, availability of financing and other circumstances beyond our control. In addition, we may also evaluate potential divestiture opportunities with respect to portions of our business from time to time that support our growth initiatives and may determine to proceed with a divestiture opportunity if and when we believe such opportunity is consistent with our business strategy. We also may not recognize the anticipated benefits, including operating advantages and cost savings of dispositions or other divestitures that we may pursue. If we do not realize the expected strategic, economic or other benefits of any divestiture transaction or if we are unable to offset

impacts from the loss of revenue associated with such divestiture opportunities, it could materially and adversely affect our business, cash flows, financial condition and results of operations.

Furthermore, to execute our growth strategy, we may pursue strategic initiatives, including acquiring additional businesses and assets that complement or expand our existing business or improve our competitive position. See “*Risk Factor – We may invest in or acquire other businesses, and our business may suffer if we are unable to successfully integrate acquired businesses into our company or otherwise manage the growth associated with multiple acquisitions*” for additional information.

***We may not be successful in executing elements of our business strategy, which may have a material adverse impact on our business and financial results.***

We engage in strategic initiatives to, among other reasons, maximize long-term shareholder value, optimize the performance of our MSO network and centers, expand the capabilities and functionalities of our CareMax platform, strengthen our partnerships with local healthcare providers and improve health and patient outcomes. These strategic initiatives may not result in improvements in future financial performance. We cannot provide any assurance that we will be able to successfully execute these strategic initiatives, or that these initiatives will not result in additional unanticipated costs. The failure to realize the benefits of any strategic initiatives or successfully structure our business to meet market conditions could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***We may be unable to successfully implement cost-saving measures or achieve expected benefits under our plans to optimize performance of the MSO network and our centers which could negatively impact our financial position, results of operations and cash flow.***

As part of our ongoing focus to achieve a sustainable financial position, we have embarked on a series of strategic initiatives to optimize the performance of our MSO network and centers, including initiating a number of strategic cost optimization initiatives. We may be unable to successfully identify or implement plans targeting these initiatives or fail to realize the benefits of the plans we have already implemented, as a result of operational difficulties, a weakening of the economy, an increase in the cost of supplies or other factors. Further, strategic cost-saving measures may not lead to optimal performance of our centers, which could impact our business and reputation with our patients. It is possible that the costs we incur to implement improvement strategies may negatively impact our financial position, results of operations and cash flow.

***Our existing or future indebtedness could adversely affect our business and growth prospects.***

As of December 31, 2023, we had \$377.3 million outstanding under the Credit Agreement. Our indebtedness under the Credit Agreement, or any additional indebtedness we may incur, could require us to divert funds identified for other purposes for debt service and impair our liquidity position. If we cannot generate sufficient cash flow from operations to service our debt or maintain the minimum levels of liquidity or maximum leverage ratio specified in the Credit Agreement, we may need to refinance our debt, dispose of assets or issue equity to obtain necessary funds. We do not know whether we will be able to take any of these actions on a timely basis, on terms satisfactory to us or at all.

Our indebtedness, the cash flow needed to satisfy our debt, and the financial covenants, have important consequences, including:

- limiting funds otherwise available for financing our capital expenditures by requiring us to dedicate a portion of our cash flows from operations to the repayment of debt and the interest on this debt;
- increasing our vulnerability to adverse economic and industry conditions;
- making us more vulnerable to rising interest rates; and
- making us more vulnerable in the event of a downturn in our business.

Our level of indebtedness may place us at a competitive disadvantage to our competitors that are not as highly leveraged. Fluctuations in interest rates can increase borrowing costs. Increases in interest rates may directly impact the amount of interest we are required to pay and reduce earnings accordingly. In addition, developments in tax policy, such as the disallowance of tax deductions for interest paid on outstanding indebtedness, could have an adverse effect on our liquidity and our business, financial conditions and results of operations.

The ability to make these payments depends on our financial and operating performance, which is subject to prevailing economic, industry and competitive conditions and to certain financial, business, economic and other factors beyond our control.

***The terms of the Credit Agreement, and certain of our other agreements, contain covenants restricting our current and future operations, particularly our ability to respond to changes in our business or to take certain actions, and any inability to comply with such covenants could have a material adverse effect on our business, results of operations, financial condition.***

The Credit Agreement and long-term leases we enter into in connection with certain of our centers contain restrictive covenants that impose significant operating and financial restrictions on us and may limit our ability to engage in acts that may be in our long-term best interests. For example, the Credit Agreement contains restrictions on our ability to:

- incur or guarantee additional indebtedness, other than certain permitted debt;
- incur liens, other than certain permitted liens;
- pay dividends and distributions on, or redeem, repurchase or retire our capital stock;
- make investments, acquisitions, loans, or advances;
- engage in mergers, consolidations, liquidations or dissolutions;
- sell, transfer or otherwise dispose of assets, including capital stock of subsidiaries;
- engage in certain transactions with affiliates;
- make changes in accounting treatment or reporting practices;
- prepay, redeem or repurchase certain indebtedness; and
- amend our organizational documents.

In addition, the restrictive covenants in the Credit Agreement and certain long-term leases require us to satisfy certain financial maintenance tests. Our ability to satisfy those tests can be affected by events beyond our control. As a result of the restrictions described above, we will be limited as to how we conduct our business and we may be unable to raise additional debt or equity financing to compete effectively or to take advantage of new business opportunities. The terms of any future indebtedness we may incur could include more restrictive covenants. These restrictions, along with restrictions that may be contained in agreements evidencing or governing other future indebtedness, may affect our ability to grow in accordance with our growth strategy.

A breach of the covenants or restrictions under the Credit Agreement could result in an event of default thereunder that could result in acceleration of payment.

In the event the holders of our indebtedness accelerate the repayment, we may not have sufficient assets to repay that indebtedness or be able to borrow sufficient funds to refinance it. Even if we are able to obtain new financing, it may not be on commercially reasonable terms or on terms acceptable to us.

As further described under the sections “*Management’s Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources—Liquidity and Capital Resources*” and “*Other Information - Credit Agreement Amendment*”, we have in the past, and may in the future, fail to comply with certain operational or financial covenants in our credit facilities, requiring waivers from our lenders. For example, we were not in compliance with the maximum total leverage ratio under the Credit Agreement for the test period ended December 31, 2023. In March 2024, we received a waiver from the lenders to waive the violation of such covenant and certain other covenants and an agreement not to enforce their rights and remedies from the resulting events of default under the Credit Agreement through May 15, 2024, subject to an earlier termination of the waiver upon the occurrence of certain specified events. Certain of our long-term leases contain similar covenants to the Credit Agreement and are subject to provisions that provide for a cross default in the event any of our covenants under the Credit Agreement are breached. We cannot assure you that we will be able to maintain compliance with this covenant or other covenants under the Credit Agreement or any other agreement that contains similar covenants in the future and, if we fail to do so, that we will be able to obtain waivers from the lenders and/or amend the covenants. A breach of any of the covenants under the Credit Agreement or the occurrence of other events specified in the Credit Agreement could result in an event of default under the same and give rise to the lenders’ right to accelerate our debt obligations thereunder and pursue other remedial actions under such agreement and/or trigger a cross default under our other long-term leases, which could have a material adverse effect on our business, results of operations, financial condition.

Furthermore, any future credit facilities or debt instruments we may issue will likely contain similar, or potentially more expansive, events of default as compared to those set forth in the terms of the Credit Agreement, including those breaches or defaults with respect to any of our other outstanding debt instruments.

***We lease all of our facilities and may experience risks relating to lease termination, lease expense escalators, lease extensions, special charges and our inability to comply with provisions of our lease agreements.***

We currently lease or license all of our centers. Our leases are typically on terms ranging up to 20 years. Each of our lease or license agreements provides that the lessor may terminate the lease, subject to applicable cure provisions, for a number of reasons, including the defaults in any payment of rent, taxes or other payment obligations or the breach of any other covenant or agreement in the lease. Termination of certain of our lease agreements could result in a cross-default under our debt agreements or other lease agreements. If a lease agreement is terminated, there can be no assurance that we will be able to enter into a new lease agreement on similar or better terms or at all.

Our lease obligations often include annual fixed rent escalators ranging between 2% and 3% or variable rent escalators based on a consumer price index. These escalators could impact our ability to satisfy certain obligations and financial covenants. If the results of our operations do not increase at or above the escalator rates, it would place an additional burden on our results of operations, liquidity and financial position.

As we have leases or licenses with different start dates, it is likely that some number of our leases and licenses will expire each year. Our lease or license agreements often provide for renewal or extension options. There can be no assurance that these rights will be exercised in the future or that we will be able to satisfy the conditions precedent to exercising any such renewal or extension. In addition, if we are unable to renew or extend any of our leases or licenses, we may lose all of the facilities subject to that master lease agreement. If we are not able to renew or extend our leases or licenses at or prior to the end of the existing lease terms, or if the terms of such options are unfavorable or unacceptable to us, our business, financial condition and results of operation could be adversely affected.

Leasing facilities pursuant to binding lease or license agreements may limit our ability to exit markets and implement our strategy to consolidate and divest non-profitable centers. For instance, if one facility under a lease or license becomes unprofitable, we may be required to continue operating such facility or, if allowed by the landlord to close such facility, we may remain obligated for the lease payments on such facility. We could incur special charges relating to the closing of such facility, including lease termination costs, impairment charges and other special charges that would reduce our profits and could have a material adverse effect on our business, financial condition or results of operations.

Our failure to pay the rent or otherwise comply with the provisions of any of our lease agreements could result in an “event of default” under such lease agreement and also could result in a cross default under other lease agreements and agreements for our indebtedness. In March 2024, we failed to make rent payments due pursuant to certain leases on centers that we generally do not intend to operate, which triggered an event of default. Upon an event of default, remedies available to our landlords generally include, without limitation, terminating such lease agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such lease agreement, including the difference between the rent under such lease agreement and the rent payable as a result of reletting the leased properties, and requiring us to pay the rent due for the balance of the term of such lease agreement, less proceeds from re-letting, if any. While to date our landlords have not exercised such remedies, the exercise of such remedies would have a material adverse effect on our business, financial position, results of operations and liquidity.

***Our growth strategy, including organic growth and growth by acquisition, includes integration and other risks and, as a result, our growth strategy may not prove viable, and we may not realize expected results.***

We have historically sought growth opportunities organically through growth of de novo centers and geographic expansion, through acquisitions and through alliances with payors or other primary care providers.

Our ability to grow organically depends upon a number of factors, including our ability to obtain necessary capital, recruiting new patients, entering into contracts with additional payors, identifying appropriate facilities, obtaining leases, completing buildouts of new facilities within proposed timelines and budgets and hiring or engaging care teams and other personnel. We cannot guarantee that we will be successful in pursuing our strategy for organic growth. We have and may continue to enter into leases for new centers in markets where we do not currently have a presence, and there is considerable uncertainty related to the success of these new centers and their impact on our results of operations. For example, we are currently reviewing our portfolio of centers and are seeking to divest non-profitable centers. In addition, we are in breach of certain of our lease agreements for centers.

We also may continue evaluating acquisitions of primary care centers and wellness centers, and some of these acquisitions may be large or in markets where we do not currently operate. When we evaluate a potential acquisition target, we might overestimate the target’s value and, as a result, pay too much for it. Additionally, acquisitions involve numerous risks, including difficulties in the integration of acquired operations and the diversion of management’s attention from other business concerns. We cannot be certain that we will be able to successfully integrate acquired assets or the operations of the acquired target with our operations. We may engage in other large acquisitions in the future, which could be much more difficult to integrate. Difficulties with integration could cause material disruption,

which could in turn reduce the efficiency of our operations. Additionally, we may not be able to integrate acquired primary care centers and wellness centers in a manner that permits us to realize the cost efficiencies and revenue improvements we anticipate in the time, manner, or amount we currently expect, or at all.

Our continued growth, of which there can be no assurance, could increase the strain on our resources and we could experience operating difficulties. Our growth strategy involves a number of risks and uncertainties, including that:

- management attention and key employees can be diverted from operating our business;
- we may not be able to successfully enter into contracts with payors on terms favorable to us or at all;
- competition for payor relationships may intensify due to the ongoing consolidation in the healthcare industry, which may increase our costs to pursue such opportunities;
- we may not be able to meet our goals for enrolling new patients to enable us to execute our growth strategy, we may incur substantial costs to enroll new patients and we may be unable to enroll a sufficient number of new patients to offset those costs;
- we may not be able to successfully maintain and enforce uniform standards, controls, procedures and policies;
- we may not be able to obtain necessary capital on acceptable terms, or at all;
- we may incur additional debt to assist in the funding of acquisitions, which may increase our financial leverage;
- when expanding our business into new states, we may be required to comply with laws and regulations that may differ from states in which we currently operate; and
- depending upon the nature of the local market, we may not be able to implement our business model in every local market that we enter, which could negatively impact our revenues and financial condition.

***If we fail to manage our growth effectively, we may be unable to execute our business plan, maintain high levels of service and patient satisfaction or adequately address competitive challenges.***

We have experienced rapid growth and organizational change, which has placed, and may continue to place, significant demands on our management and our operational and financial resources. Additionally, our organizational structure may become more complex as we enhance our operational, financial and management controls, as well as our reporting systems and procedures. We may require significant capital expenditures and the allocation of valuable management resources to grow and change in these areas. We will be unable to manage our business effectively if we are unable to alleviate the strain on resources caused by growth in a timely and successful manner. If we fail to effectively manage our growth and change, the quality of our services may suffer, which could negatively affect our brand and reputation and harm our ability to attract and retain patients and employees.

In addition, if our patient base continues to grow, we will need to expand our medical, patient services and other personnel, and our network of partners, to provide personalized patient service. If we are not able to continue to provide high quality medical care with high levels of patient satisfaction, our reputation, as well as our business, results of operations and financial condition could be adversely affected.

***If we are unable to attract new patients, our revenue growth will be adversely affected.***

To increase our revenue, we must continue to attract and retain a sufficient number of new patients. Although some of our facilities accept Medicaid-eligible patients, we are focused on the Medicare-eligible population and face competition from other primary healthcare providers for those Medicare-eligible patients. If we are unable to effectively promote to the Medicare-eligible population the benefits of our model or if potential or existing patients prefer the care provider model of one of our competitors, we may not be able to increase our patient census. In addition, our strategy is dependent on patients selecting us as their primary care provider under their MA plan.

MA is a federally funded health insurance program administered by private health plans and offered to Medicare beneficiaries as an alternative to fee-for-service Medicare. CMS, the federal agency that administers Medicare, contracts with private health plans, such as health maintenance organizations (“HMO”), to offer “all-in-one” coverage to Medicare beneficiaries for a fixed monthly amount per enrollee (i.e., a capitated payment model) paid by Medicare. MA plans also in turn contract with providers like us under which the providers deliver care to patients at negotiated rates.

Patients may elect a MA plan during an annual enrollment period from October into December of each year. Therefore, our ability to grow our patient population with capitation arrangements is dependent in part on our ability to successfully encourage, subject to

applicable law, MA patients to enroll in MA plans, in which we participate, during the annual enrollment period. During the annual enrollment period, we must convince new MA patients to select us as their primary care provider and existing patients to not select another provider. An inability to have new patients select us and retain existing patients, particularly those under managed care arrangements, would harm our ability to grow and may have a material adverse effect on our business operations and financial position.

***The integration of Steward Value-Based Care may be more difficult, costly, or time-consuming than expected, and we may not realize the anticipated benefits of the Steward Acquisition.***

To realize the anticipated benefits from the Steward Acquisition, we must successfully integrate and combine our business with that of Steward Value-Based Care. If we are not able to successfully achieve these objectives, the anticipated benefits of the Steward Acquisition may not be realized fully or at all or may take longer to realize than expected. In addition, the actual benefits of the Steward Acquisition could be less than anticipated, and integration may result in additional unforeseen expenses. In addition, we and Steward Value-Based Care operated independently until the completion of the Steward Acquisition. It is possible that the integration process could result in the loss of one or more key employees, the disruption of each company's ongoing businesses or inconsistencies in standards, controls, procedures, and policies that adversely affect each company's ability to maintain relationships with doctors, patients, and employees or to achieve the anticipated benefits of the Steward Acquisition. Integration efforts between the companies may also divert management attention and resources. These integration matters could have an adverse effect on us for an undetermined period following completion of the Steward Acquisition.

***Our revenues and operations are dependent upon a limited number of key payors, the loss of any of which could adversely affect our business.***

Our operations are dependent on a concentrated number of payors with whom we contract to provide services to patients. During the year ended December 31, 2023, our three largest payor relationships were Payor A, Payor C and Payor E, which generated 23%, 21% and 15% of our revenue, respectively.

We believe that a majority of our revenues will continue to be derived from a limited number of key payors, who may terminate their contracts with us, or our providers credentialed by them upon the occurrence of certain events. Additionally, if a payor were to lose applicable licenses, lose liability insurance, become insolvent, or receive an exclusion, suspension or debarment from state or federal government authorities, our contract with such payor could in effect be terminated. The sudden loss of any of our payor partners or the renegotiation of any of our payor contracts could adversely affect our operating results. If any of our contracts with our payors is terminated, we may not be able to recover all fees due under the terminated contract, which may adversely affect our operating results. Moreover, our inability to maintain our agreements with health plans with respect to their members or to negotiate favorable terms for those agreements in the future could result in the loss of members and could have a material adverse effect on our profitability and business.

Because we rely on a limited number of payors for a significant portion of our revenues, we depend on the creditworthiness of these payors. Our payors are subject to a number of risks, including reductions in payment rates from governmental programs, higher than expected health care costs and lack of predictability of financial results when entering new lines of business, particularly with high-risk populations. If the financial condition of our payor partners declines, our credit risk could increase. Should one or more of our significant payor partners declare bankruptcy, be declared insolvent, or otherwise be restricted by state or federal laws or regulation from continuing in some or all of their operations, this could adversely affect our ongoing revenues, the collectability of our accounts receivable, our bad debt reserves and our net income.

***The termination or non-renewal of the MA contracts held by the health plans with which we contract, or the termination or non-renewal of our contracts with those plans, could have a material adverse effect on our revenue and our results of operations.***

In addition to contracting directly with CMS to participate in Medicare, we also contract with other health plans to provide capitated care services with respect to certain of their MA members. If a plan with which we contract for these services loses its MA contracts with CMS, receives reduced or insufficient government reimbursement under the MA program, decides to discontinue its MA plans, decides to contract with another provider to render capitated care services to its members, or decides to directly provide care, our contract with that plan could be at risk and we could lose revenue. We have also entered into contracts with some of these same plans relating to Medicaid Managed Care. Termination of a contract relating to MA could also lead to, or occur concurrently with, termination of a contract relating to Medicaid.

Under most of our capitation agreements with health plans, the health plan is generally permitted to modify the benefit and risk obligations and compensation rights from time to time during the terms of the agreements. If a health plan exercises its right to amend its benefit and risk obligations and compensation rights, we are generally allowed a period of time to object to such amendment. If we object, under some of the risk agreements, the relevant health plan may terminate the applicable agreement upon 90 to 180 days written

notice. If we enter into capitation contracts with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, we could suffer losses with respect to such contract.

Certain of our contracts may be terminated immediately by the health plan if we lose applicable licenses, go bankrupt, lose our liability insurance, or receive an exclusion, suspension, or debarment from state or federal government authorities. In addition, certain of our contracts with health plans are terminable without cause. If any of these contracts were terminated, we may not be able to recover all fees due under the terminated contract, which may adversely affect our operating results. In addition, certain patients covered by such plans in the past have shifted to another primary care provider within their health plan's network and patients may continue to do so in the future. Moreover, our inability to maintain our agreements with health plans, in particular with key payors with respect to our MA members, or to renegotiate favorable terms for those agreements in the future, could result in the loss of patients and could have a material adverse effect on our profitability and business. Depending on the health plan at issue and the amount of revenue associated with the health plan's capitation agreement, the renegotiated terms or termination could have a material adverse effect on our business, results of operations, financial condition and cash flows.

***Changes in the payor mix of patients and potential decreases in our reimbursement rates as a result of consolidation among plans could adversely affect our revenues and results of operation.***

We have previously been negatively affected, and may continue to be negatively affected, if third-party payors take cost-containment measures, including lowering reimbursement rates or changing patient co-payments and deductibles. Any of these risks, among other economic factors, could have a material adverse effect on our financial condition.

The amounts we receive for services provided to patients are determined by a number of factors, including the payor mix of our patients and the reimbursement methodologies and rates utilized by our patients' plans. Reimbursement revenue is generally higher under capitation agreements than it is under fee-for-service arrangements, and capitation agreements provide us with an opportunity to capture any additional surplus we create by investing in preventive care to keep a particular patient's third-party medical expenses low. Under a capitation agreement such as with MA plans, we receive a fixed fee per member per month for services and, in some cases, additional compensation based on quality of care and other patient care metrics. Under a fee-for-service payor arrangement, we collect fees directly from the payor as services are provided. A decrease in the number of capitation arrangements could adversely affect our revenues and results of operations.

In addition, a shift in payor mix toward Medicaid payors as well as an increase in the number of uninsured patients may result in a reduction in our average rate of reimbursement or an increase in uncollectible receivables or uncompensated care. Changes in the eligibility requirements for governmental programs such as the Medicaid program and state decisions on whether to participate in any expansion of such programs also could impact the number of patients who participate in such programs and the number of uninsured patients. For those patients in private insurance plans, changes to those plans could increase patient financial responsibility, resulting in a greater risk of uncollectible receivables. These factors and events could have a material adverse effect on our business, financial condition, and results of operations.

Following the Business Combination, we experienced a shift in payor mix toward Medicaid due to more significant Medicaid membership in IMC. Acquisitions subsequent to the Business Combination have resulted in growth weighted more toward Medicare.

The healthcare industry has also experienced consolidation, resulting in fewer but larger payors that have significant bargaining power, given their market share. Payments from payors are the result of negotiated rates. These rates have declined in the past and may decline in the future based on renegotiations as larger payors have significant bargaining power to negotiate higher discounted fee arrangements with healthcare providers. As a result, payors increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk related to paying for care provided through capitation agreements. A decrease in the number of capitation arrangements could adversely affect our revenues and results of operation.

***Insolvency, credit problems or other financial difficulties that could confront our counterparties in strategic acquisitions, investments and other collaborations could expose us to significant financial risk and significantly impact our ability to expand our overall profitability.***

One of our key operating strategies is to pursue strategic initiatives that enhance our platform through certain strategic relationships. For example, as described in the section entitled "*Business – CareMax's Key Differentiators – MSO Services*", we entered into agreements with SHCN in connection with the Steward Acquisition pursuant to which we are dependent on SHCN to optimize performance of the MSO network and of our centers. These transactions involve inherent risks, such as integration risks and potentially increasing leverage and debt service requirements and combining company cultures and facilities, which could have a material and adverse effect on our business, results of operations or financial condition and could strain our resources. See Risk Factor – "*The integration of Steward*"

*Value-Base Care may be more difficult, costly, or time-consuming than expected, and we may not realize the anticipated benefits of the Steward Acquisition” for more information.*

There is a risk that a counterparty might fail to perform all its obligations under the applicable agreements or may be slow in performing its obligations, or that we have a dispute that harms our working relationship and requires significant resources to resolve, or that we are unable to resolve on our own, resulting in costly legal proceedings. In addition, we are also exposed to the risk that our counterparties in such strategic initiatives may confront insolvency, credit problems or other financial difficulties that could lead to disruption of our activities with them or impairment of assets acquired, which could expose us to financial risk and adversely affect future reported results of operations and stockholders’ equity. To the extent that our counterparties experience any business disruptions, insolvency, credit problems or other financial difficulties, our revenues could be negatively impacted. Furthermore, if we are unable to establish, on a timely basis, relationships with new strategic counterparties, our business and results of operations could be negatively impacted.

***We have in the past relied on strategic relationships with third parties to implement our growth strategy, and any failure to realize the expected benefits of such strategic relationships could adversely affect our business.***

As part of our growth strategy, we previously partnered with third parties to expand our operations and to open centers in new markets. For example, we have entered into a collaboration agreement with Elevance Health, a national health benefits company, through which we opened centers across a number of priority states. Additionally, we have entered into a collaboration with Related, pursuant to which Related advised us on opening new centers nationwide, including, but not limited to, within and proximate to affordable housing communities that may be owned by Related or affiliates of Related.

Our ability to realize the benefits of the arrangements with Elevance Health or Related is not certain. Currently we are reviewing our portfolio of centers, with the intent of consolidated operations and divesting non-profitable centers. There are many factors that could delay or ultimately prevent us from opening new centers in collaboration with Elevance Health or Related, including our ability to obtain necessary capital, a shift in our business strategy or that Elevance Health or Related does not perform its obligations under each of their respective agreements. Should any other expected benefits of the arrangements with Elevance Health or Related fail to materialize, our prospects for growth could be adversely affected. Additionally, we may be at a disadvantage to our competition, which in some cases already has a wider geographical presence, without assistance from our strategic partners. If we are not able to grow and continue our expansion outside of our core markets in Florida, our future business, results of operations and financial condition could be adversely affected.

***We face significant competition from primary care facilities and other healthcare services providers. Our failure to adequately compete could adversely affect our business.***

We compete directly with national, regional and local providers of healthcare for patients and physicians. There are many other companies and individuals currently providing healthcare services, many of which have been in business longer and/or have substantially more resources. Other companies could enter the healthcare industry in the future and divert some or all of our business. If we expand to other geographies, we expect competition may change based on a number of factors, including the number of competing primary care facilities in the local market and the types of services available at those facilities, our local reputation for quality care of patients, the commitment and expertise of our medical staff, our local service offerings and community programs, the cost of care in each locality, and the physical appearance, location, age and condition of our facilities. If we are unable to attract patients to our centers, our revenue and profitability will be adversely affected. Some of our competitors may have greater brand recognition and be more established in their respective communities than we are, and may have greater financial and other resources than we have. Competing primary care providers may also offer larger facilities or different programs or services than we do, which, combined with the foregoing factors, may result in our competitors being more attractive to our current patients, potential patients and referral sources. Furthermore, while we budget for routine capital expenditures at our facilities to keep them competitive in their respective markets, to the extent that competitive forces cause those expenditures to increase in the future, our financial condition may be negatively affected. In addition, our relationships with governmental and private third-party payors are not exclusive and our competitors have established or could seek to establish relationships with such payors to serve their covered patients. Additionally, as we expand into new geographies, we may encounter competitors with stronger relationships or recognition in the community in such new geography, which could give those competitors an advantage in obtaining new patients. Individual physicians, physician groups and companies in other healthcare industry segments, including those with which we have contracts, and some of which have greater financial, marketing and staffing resources, may become competitors in providing health care services, and this competition may have a material adverse effect on our business operations and financial position.

***Competition for physicians and nurses, shortages of qualified personnel or other factors could increase our labor costs and adversely affect our revenue, profitability and cash flows.***

Our operations are dependent on the efforts, abilities and experience of our physicians and other clinical personnel. We compete with other healthcare providers, primarily hospitals and other facilities, in attracting physicians, nurses and other medical staff to support our centers, recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our centers and in contracting with payors. We have employment contracts with physicians and other health professionals that include provisions preventing these physicians and other health professionals from competing with us both during and after the term of our contract with them. There can be no assurance that our non-compete agreements related to physicians and other health professionals will be found enforceable if challenged. In fact, the Federal Trade Commission (“FTC”) issued a proposed rule on January 5, 2023 to prohibit employers from imposing non-compete clauses on workers. The FTC’s proposed rule would require employers to rescind existing non-compete clauses with workers and actively inform their employees that the contracts are no longer in effect. If this proposed rule were to become finalized or states separately adopt similar laws, or our non-compete agreements are otherwise deemed unenforceable, we would be unable to prevent physicians and other health professionals formerly employed by us from competing with us, potentially resulting in the loss of some of our patients.

Key primary care physicians with large patient enrollment could retire, become disabled, terminate their provider contracts, or otherwise become unable or unwilling to continue practicing medicine or continue working with our practices. We may not be able to attract new physicians to replace the services of terminating physicians or to service our growing membership. Some patients may have loyalty to these physicians and have a desire to search for new physicians upon one of ours leaving the practice for any reason. In some markets, the lack of availability of clinical personnel, such as nurses and mental health professionals, has become a significant operating issue facing all healthcare providers. This shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled workers in each of the markets in which we operate.

If we are unable to recruit or retain our skilled, semi-skilled and unskilled personnel, our patients could choose to enroll with competitors’ physician organizations or could seek medical care elsewhere, which could reduce our revenues and profits. If our labor costs increase, our rates of reimbursement may not be sufficient to offset these increased costs. Because a significant percentage of our revenue consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual consumer price index basket update from Medicare, our results of operations and cash flows will likely be adversely affected. Any union activity at our facilities that may occur in the future could contribute to increased labor costs. Certain proposed changes in federal labor laws and the National Labor Relations Board’s modification of its election procedures could increase the likelihood of employee unionization attempts. Although none of our employees are currently represented by a collective bargaining agreement, to the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially. Our failure to recruit and retain qualified management and medical personnel, or to control our labor costs, could have a material adverse effect on our business, prospects, results of operations and financial condition.

***Reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program could have a material adverse effect on our financial condition and results of operations.***

We generated the majority of our revenue from Medicare full-risk contracts, which accounted for approximately 78% and 77% of our revenue for the years ended December 31, 2023 and 2022, respectively. In addition, many private payors base their reimbursement rates on the published Medicare rates and are reimbursed by Medicare for the services we provide. As a result, our results of operations are, in part, dependent on government funding levels for Medicare programs, particularly MA programs. Any changes that limit or reduce MA or general Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses payors, and by extension, value-based care providers such as ourselves, for our services. Budget pressures may lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past and could in the future result in substantial reductions in our revenue and operating margins.

For example, Congress established automatic spending reductions under the Budget Control Act of 2011, resulting in a 2% reduction in Medicare payments that began in 2013 and extend through the first six months of the fiscal year 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 The American Rescue Plan Act (“ARPA”), 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.

Each year, CMS issues a final rule to establish the MA benchmark payment rates for the following calendar year. Any reduction to MA rates impacting us may have a material adverse effect on our business, results of operations, financial condition and cash flows. The final impact of the MA rates can vary from any estimate we may have and may be further impacted by the relative growth of our MA patient volumes across markets as well as by the benefit plan designs submitted. It is possible that we may underestimate the impact of the MA rates on our business and that our MA revenues may continue to be volatile in the future, each of which could have a material adverse effect on our business, results of operations, financial condition and cash flows.

In addition, CMS often changes the rules governing the Medicare program, including those governing reimbursement. Changes that could adversely affect our business include:

- administrative or legislative changes to base rates or the bases of payment;
- limits on the services or types of providers for which Medicare will provide reimbursement;
- changes in methodology for patient assessment and/or determination of payment levels;
- the reduction or elimination of annual rate increases; or
- a change in co-payments or deductibles payable by beneficiaries.

Recent legislative, judicial and executive efforts to enact further healthcare reform legislation have caused the future state of the exchanges, other reforms under the ACA, and many core aspects of the current U.S. health care system to be unclear. While specific changes and their timing are not yet apparent, enacted reforms and future legislative, regulatory, judicial, or executive changes, particularly any changes to the MA program, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

There is also uncertainty regarding both MA payment rates and beneficiary enrollment, which, if reduced, would reduce our overall revenues and net income. For example, the Congressional Budget Office ("CBO") has predicted, without taking into account potential future reforms, that enrollment in MA (and other contracts covering Medicare Parts A and B) could reach 31 million people by 2027. Although MA enrollment increased by approximately 5.6 million people, or by 50%, between the enactment of the ACA in 2010 and 2015, there can be no assurance that this trend will continue. Further, CMS's announced annual changes in reimbursement rates have varied from year to year: for 2018, CMS announced an average increase of 0.45%; for 2019, 3.4%; for 2020, 2.53%; for 2021, 1.66%; for 2022, 4.08%; 8.50% for 2023; 3.32% in 2024; and an expected 3.7% in 2025. Uncertainty over MA enrollment and payment rates presents a continuing risk to our business.

According to KFF, MA enrollment continues to be highly concentrated among a few payors, both nationally and in local regions. In 2021, two payors accounted for 29% of MA enrollment and four payors accounted for 18% of MA enrollment. Further consolidation among MA plans in certain regions, or the Medicare program's failure to attract additional plans to participate in the MA program, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Reductions in reimbursement rates or the scope of services being reimbursed could have a material adverse effect on our financial condition and results of operations or even result in reimbursement rates that are insufficient to cover our operating expenses. Additionally, any delay or default by the government in making Medicare reimbursement payments could materially and adversely affect our business, financial condition and results of operations.

***State and federal efforts to reduce Medicaid spending could adversely affect our financial condition and results of operations.***

Medicaid is a joint federal-state program that provides healthcare services for low-income individuals as well as certain higher-income individuals with significant health needs. Under broad federal criteria, states establish rules for eligibility, services and payment. Although the program is state-administered, it is financed by both state funds and matching federal funds. Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets. This, combined with slower state revenue growth, has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending.

For example, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, such as financial arrangements commonly referred to as provider taxes. Under provider tax arrangements, states collect taxes from healthcare

providers and then use the revenue to pay the providers as a Medicaid expenditure, which allows the states to then claim additional federal matching funds on the additional reimbursements. Current federal law provides for a cap on the maximum allowable provider tax as a percentage of the provider's total revenue. There can be no assurance that federal law will continue to provide matching federal funds on state Medicaid expenditures funded through provider taxes, or that the current caps on provider taxes will not be reduced. Any discontinuance or reduction in federal matching of provider tax-related Medicaid expenditures could have a significant and adverse effect on states' Medicaid expenditures, and as a result could have an adverse effect on our business.

As part of the movement to repeal, replace or modify the ACA and as a means to reduce the federal budget deficit, there are renewed congressional efforts to move Medicaid from an open-ended program with coverage and benefits set by the federal government to one in which states receive a fixed amount of federal funds, either through block grants or per capita caps, and have more flexibility to determine benefits, eligibility or provider payments. If those changes are implemented, we cannot predict whether the amount of fixed federal funding to the states will be based on current payment amounts, or if it will be based on lower payment amounts, which would negatively impact those states that expanded their Medicaid programs in response to the ACA.

We expect these state and federal efforts to continue for the foreseeable future. The Medicaid program and its reimbursement rates and rules are subject to frequent change at both the federal and state level. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which our services are reimbursed by state Medicaid plans.

***We primarily depend on reimbursements by third-party payors, as well as payments by individuals, which could lead to delays and uncertainties in the reimbursement process.***

The reimbursement process is complex and can involve lengthy delays. Although we recognize revenue when we provide services to our patients, we may from time to time experience delays in receiving the associated capitation payments or, for our patients in fee-for-service arrangements, the reimbursement for the service provided. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that the patient is not eligible for coverage, certain amounts are not reimbursable under plan coverage or were for services provided that were not medically necessary or additional supporting documentation is necessary. Retroactive adjustments may change amounts realized from third-party payors. As described below, we are subject to audits by such payors, including governmental audits of our Medicare claims, and may be required to repay these payors if a finding is made that we were incorrectly reimbursed. Delays and uncertainties in the reimbursement process may adversely affect accounts receivable, increase the overall costs of collection and cause us to incur additional borrowing costs. Third-party payors are also increasingly focused on controlling healthcare costs, and such efforts, including any revisions to reimbursement policies, may further complicate and delay our reimbursement claims.

In addition, certain of our patients are covered under health plans that require the patient to cover a portion of their own healthcare expenses through the payment of copayments or deductibles. There also may be instances where physicians provide services to uninsured individuals. To the extent permitted by law, amounts not covered by third-party payors are the obligations of individual patients. Despite reasonable efforts, we may not be able to collect all, or any, of those amounts that are the patient's financial responsibility. Any increase in cost shifting from third-party payors to individual patients, including as a result of high deductible plans for patients, increases our collection costs and reduces overall collections. We have a financial assistance policy in which we assess patients for financial hardship and other criteria that are used to make a good-faith determination of financial need. If a patient is deemed to meet these criteria, we will waive or reduce that patient's obligation to pay copayments, coinsurance or deductible amounts owed for the services we provide to them. If we were to experience a substantial increase in the number of patients qualifying for such waivers or reductions or in the volume of patient receivables deemed uncollectible, our costs could increase significantly, and we may not be able to offset such additional costs with sufficient revenue.

In response to the COVID-19 pandemic, CMS made several changes to the manner in which Medicare will pay for telehealth visits, many of which relax previous requirements, including site requirements for both the providers and patients, telehealth modality requirements and others. While some of these flexibilities have been permanently extended, recent federal legislation authorized the extension of many of the Medicare telehealth flexibilities through December 31, 2024. State law applicable to telehealth, particularly licensure requirements, has also been relaxed in many jurisdictions as a result of the COVID-19 pandemic. These relaxed regulations have allowed us to continue operating our business and delivering care to our patients through telehealth modalities. It is unclear which, if any, of these state-level changes will remain in place permanently and which will be rolled-back following the COVID-19 pandemic. If regulations change to restrict our ability to or prohibit us from delivering care through telehealth modalities, our financial condition and results of operations may be adversely affected.

***Our business could be harmed if the ACA is overturned or by any legislative, regulatory or industry change that reduces healthcare spending or otherwise slows or limits the transition to more assumption of risk by healthcare providers.***

Our operating model, our platform and our revenue are dependent on the healthcare industry’s continued movement towards providers assuming more risk from payors for the cost of patient care. Any legislative, regulatory or industry changes that slow or limit that movement or otherwise reduce risk-based healthcare spending would most likely be detrimental to our business, revenue, financial projections and growth.

We are also impacted by the Medicare Access and CHIP Reauthorization Act, under which physicians must choose to participate in one of two payment formulas, the Merit-Based Incentive Payment System (“MIPS”), or Alternative Payment Models (“APMs”). Beginning in 2019, MIPS allows eligible physicians to receive upward or downward adjustments to their Medicare Part B payments based on certain quality and cost metrics, among other measures. As an alternative, physicians can choose to participate in an Advanced APM. Advanced APMs are exempt from the MIPS requirements, and physicians who are meaningful participants in APMs will receive bonus payments from Medicare pursuant to the law. In November 2021, CMS released its 2022 Physician Fee Schedule Final Rule, in which CMS expanded the list of MIPS-eligible clinicians to include clinical social workers and certified nurse midwives. CMS has proposed limiting the number of significant changes to the Quality Payment Program by continuing a gradual implementation timeline for MIPS and APMs. In November 2022, CMS released its 2023 Physician Fee Schedule Final Rule, including 2023 Quality Payment Program policies. In the final rule, CMS finalized reporting requirements for MIPS Value Pathways (“MVPs”), a subset of measures to meet MIPS reporting requirements, effective as of January 1, 2023. In November 2023, CMS released its 2024 Physician Fee Schedule Final Rule, in which it finalized five new MVPs. Accordingly, there will be a total of 16 MVPs available for reporting during the 2024 performance period. Finally, starting with the 2024 performance period, all Advanced APMs must require the use of certified EHR technology (“CEHRT”).

In addition, current and prior healthcare reform proposals have included the concept of creating a single payor or public option for health insurance. If enacted, these proposals could have an extensive impact on the healthcare industry, including us. We are unable to predict whether such reforms may be enacted or their impact on our operations.

We expect that additional state and federal healthcare reform measures will be adopted in the future, any of which could limit the amounts that federal and state governments and private payors will pay for healthcare services, which could harm our business, financial condition and results of operations.

***Under most of our agreements with health plans, we assume some or all of the risk that the cost of providing services will exceed our compensation.***

More than 92% of our revenue during the years ended December 31, 2023 and 2022, was derived from risk-based agreements with health plans. While there are variations specific to each agreement, we generally contract with health plans to receive a fixed fee per month for professional services and assume the financial responsibility for the healthcare expenses of our patients. This type of contract is referred to as a “capitation” contract. To the extent that patients require more care than is anticipated and/or the cost of care increases, aggregate fixed compensation amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical costs and expenses exceed estimates, except in very limited circumstances, and we are not able to increase the fee received under these risk agreements during their then-current terms, we could suffer losses with respect to such agreements.

Changes in our anticipated ratio of medical expense to revenue can significantly impact our financial results. Accordingly, the failure to adequately predict and control medical costs and expenses and to make reasonable estimates and maintain adequate accruals for incurred but not paid claims, could have a material adverse effect on our business, results of operations, financial condition and cash flows. Additionally, the Medicare expenses of our patients may be outside of our control in the event that patients take certain actions that increase such expenses, such as unnecessary hospital visits.

Historically, our medical costs and expenses as a percentage of revenue have fluctuated. Factors that may cause medical expenses to exceed estimates include:

- the health status of patients and higher levels of hospitalization;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations and practices;
- increased costs attributable to specialist physicians, hospitals and ancillary providers;
- changes in the demographics of our patients and medical trends;
- contractual or claims disputes with providers, hospitals or other service providers within and outside a health plan’s network;
- the occurrence of catastrophes, major epidemics, or pandemics; and

- the reduction of health plan premiums.

***The estimates of market opportunity and forecasts of market and revenue growth included in this Annual Report may prove to be inaccurate, and even if the market in which we compete achieves the forecasted growth, our business could fail to grow at similar rates, if at all.***

Market opportunity estimates and growth forecasts are subject to significant uncertainty and are based on assumptions and estimates that may not prove to be accurate. In particular, the size and growth of the overall U.S. healthcare market is subject to significant variables, including a changing regulatory environment and population demographic, which can be difficult to measure, estimate or quantify. Our business depends on member acquisition and retention, which further drives revenue from our contracts with health network partners. Estimates and forecasts of these factors in any given market is difficult and affected by multiple variables such as population growth, concentration of enterprise clients and population density, among other things. Further, we cannot assure you that we will be able to sufficiently penetrate certain market segments included in our estimates and forecasts, including due to limited deployable capital, ineffective marketing efforts or the inability to develop sufficient presence in a given market to gain members or contract with health network partners in that market. Once we acquire a member, apart from fixed annual membership fees and payments from health care partners, we derive revenue from patient in-office visits, which may be difficult to forecast over time, particularly as our billable service mix continues to expand. Finally, our contractual arrangements with health network partners typically have highly tailored capitation and other fee structures which vary across health network partners and are dependent on the number of members that receive healthcare services in a health network partner's network. As a result, we may not be able to accurately forecast revenue from our health network partners. For these reasons, the estimates and forecasts in this Annual Report relating to the size and expected growth of our target markets may prove to be inaccurate. Even if the markets in which we compete meet our size estimates and forecasted growth, our business could fail to grow at similar rates, if at all.

***There are significant risks associated with estimating the amount of revenue that we recognize under our risk agreements with health plans, and if our estimates of revenue are materially inaccurate, it could impact the timing and the amount of our revenue recognition or have a material adverse effect on our business, results of operations, financial condition and cash flows.***

There are significant risks associated with estimating the amount of revenues that we recognize under our risk agreements with health plans in a reporting period. The billing and collection process is complex due to ongoing insurance coverage changes, geographic coverage differences, differing interpretations of contract coverage and other payor issues, such as ensuring appropriate documentation. Determining applicable primary and secondary coverage for our patients, together with the changes in patient coverage that occur each month, requires complex, resource-intensive processes. Errors in determining the correct coordination of benefits may result in refunds to payors. Revenues associated with Medicare and Medicaid programs are also subject to estimating risk related to the amounts not paid by the primary government payor that will ultimately be collectible from other government programs paying secondary coverage, the patient's commercial health plan secondary coverage or the patient. Collections, refunds and payor recoupments typically continue to occur for up to three years and longer after services are provided. If our estimates of revenues are materially inaccurate, it could impact the timing and the amount of our revenues recognition and have a material adverse impact on our business, results of operations, financial condition and cash flows.

***We are dependent on information technology and our systems and infrastructure face certain risks, including from cybersecurity breaches and data leakage.***

We rely extensively on information technology systems, networks and services, including internet sites, data hosting and processing facilities and tools, physical security systems and other hardware, software and technical applications and platforms, some of which are managed, hosted provided and/or used for third-parties or their vendors, to assist in conducting our business. A significant breakdown, invasion, corruption, destruction or interruption of critical information technology systems or infrastructure, by our workforce, others with authorized access to our systems or unauthorized persons could negatively impact operations. The ever-increasing use and evolution of technology, including cloud-based computing, creates opportunities for the unintentional dissemination or intentional destruction of confidential information stored in our, or our third-party providers' systems, portable media or storage devices. We could also experience a business interruption, theft of confidential information or reputational damage from industrial espionage attacks, malware or other cyber-attacks, which may compromise our system infrastructure or lead to data leakage, either internally or at our third-party providers. Although the aggregate impact on our operations and financial condition has not been material to date, we have been the target of events of this nature and expect them to continue as cybersecurity threats have been rapidly evolving in sophistication and becoming more prevalent in the industry. We have invested in industry appropriate protections and monitoring practices of our data and IT to reduce these risks and continue to monitor our systems on an ongoing basis for any current or potential threats. While we maintain cyber insurance, this insurance may not be sufficient to cover the financial, legal, business or reputational losses that may result from an interruption or breach of our systems. There can be no assurance that our continuing efforts will prevent breakdowns or breaches to our or our third-party providers' databases or systems that could adversely affect our business.

***Security breaches, loss of data and other disruptions could compromise sensitive information related to our business or our patients or prevent us from accessing critical information and expose us to liability, which could adversely affect our business and our reputation.***

In the ordinary course of our business, we collect, store, use and disclose sensitive data, including PHI, and other types of personal data or PII relating to our employees, patients and others. We also process and store, and use third-party service providers to process and store, sensitive information, including intellectual property, confidential information and other proprietary business information. We manage and maintain such sensitive data and information utilizing a combination of on-site systems, managed data center systems and cloud-based computing center systems.

We are highly dependent on information technology networks and systems, including the internet, to securely process, transmit and store this sensitive data and information. Security breaches of this infrastructure, including physical or electronic break-ins, computer viruses, attacks by hackers and similar breaches, and employee or contractor error, negligence or malfeasance, can create system disruptions, shutdowns or unauthorized disclosure or modifications of such sensitive data or information, causing PHI or other PII to be accessed or acquired without authorization or to become publicly available. We utilize third-party service providers for important aspects of the collection, storage, processing and transmission of employee, user and patient information, and other confidential and sensitive information, and therefore rely on third parties to manage functions that could potentially have material cybersecurity risks. Because of the sensitivity of the PHI, other PII and other sensitive information we and our service providers collect, store, transmit and otherwise process, the security of our technology platform and other aspects of our services, including those provided or facilitated by our third-party service providers, are important to our operations and business strategy. We take certain administrative, physical and technological safeguards to address these risks, such as by requiring certain contractors and other third-party service providers who handle this PHI, other PII and other sensitive information for us to enter into agreements that contractually obligate them to use reasonable efforts to safeguard such PHI, other PII, and other sensitive information. Measures taken to protect our systems, those of our contractors or third-party service providers, or the PHI, other PII, or other sensitive information we or contractors or third-party service providers process or maintain, may not adequately protect us from the risks associated with the collection, storage, processing and transmission of such sensitive data and information. We may be required to expend significant capital and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, cyber-attacks are becoming more sophisticated and frequent. As a result, we or our third-party service providers may be unable to anticipate these techniques or to implement adequate protective measures.

A security breach or privacy violation that leads to disclosure or unauthorized use or modification of, or that prevents access to or otherwise impacts the confidentiality, security, or integrity of, patient information, including PHI or other PII, or other sensitive information we or our contractors or third-party service providers maintain or otherwise process, could harm our reputation, compel us to comply with breach notification laws, cause us to incur significant costs for remediation, fines, penalties, notification to individuals and for measures intended to repair or replace systems or technology and to prevent future occurrences, potential increases in insurance premiums, and require us to verify the accuracy of database contents, resulting in increased costs or loss of revenue. If we are unable to prevent or mitigate such security breaches or privacy violations or implement satisfactory remedial measures, or if it is perceived that we have been unable to do so, our operations could be disrupted, we may be unable to provide access to our systems, and we could suffer a loss of patients, and we may as a result suffer loss of reputation, adverse impacts on patient and investor confidence, financial loss, governmental investigations or other actions, regulatory or contractual penalties, and other claims and liability. In addition, security breaches and other inappropriate access to, or acquisition or processing of, information can be difficult to detect, and any delay in identifying such incidents or in providing any notification of such incidents may lead to increased harm.

Any such breach or interruption of our systems or those of any of our third-party service providers could compromise our networks or data security processes and sensitive information could be made inaccessible or could be accessed by unauthorized parties, publicly disclosed, lost, or stolen. Any such interruption in access, improper access, disclosure, or other loss of information could result in legal claims or proceedings, liability under laws and regulations that protect the privacy of member information or other personal information, such as HIPAA, regulatory penalties, and the compromise of our trade secrets and other proprietary information, which could adversely affect our business and competitive position. Unauthorized access, loss, or dissemination could also disrupt our operations, including our ability to perform our services, access patient health information, collect, process and prepare company financial information, provide information about our current and future services and engage in other patient and clinician education and outreach efforts. For example, in February 2024, UnitedHealth Group announced that its Change Healthcare information technology system was being taken offline for an undefined period, which could delay our ability to collect payments and confirm insurance eligibility of patients.

While we maintain insurance covering certain security and privacy damages and claim expenses, we may not carry insurance or maintain coverage sufficient to compensate for all liability and in any event, insurance coverage would not address the reputational damage that could result from a security incident.

***We may be subject to legal proceedings and litigation, including intellectual property and privacy disputes, which are costly to defend and could materially harm our business and results of operations.***

We may be party to lawsuits and legal proceedings in the normal course of business. We may face allegations, lawsuits and regulatory inquiries, audits and investigations regarding data privacy, security, labor and employment, consumer protection and intellectual property infringement, including claims related to privacy, patents, publicity, trademarks, copyrights and other rights. We may also face allegations or litigation related to our acquisitions or business practices. Certain of these matters may include speculative claims for substantial or indeterminate amounts of damages and include claims for injunctive relief. We may also become subject to periodic audits, which would likely increase our regulatory compliance costs and may require us to change our business practices, which could negatively impact our revenue growth.

The results of regulatory proceedings, litigation, claims and audits cannot be predicted with certainty, and determining reserves for pending litigation and other legal, regulatory and audit matters require significant judgment. There can be no assurance that our expectations will prove correct, and even if these matters are resolved in our favor or without significant cash settlements, these matters, and the time and resources necessary to litigate or resolve them, could harm our reputation, business, financial condition and results of operations.

If federal or state government officials audit or investigate our operations or arrangements with third parties, the challenge could potentially disrupt our business operations and we may incur substantial defense costs, even if we successfully defend our interpretation of applicable laws, rules and regulations. In addition, if the government successfully challenges our interpretation as to the applicability of laws, rules and regulations as they relate to our operations and arrangements with third parties, that may have a material adverse effect on our business, financial condition and results of operations. In the event regulatory action were to limit or prohibit us from carrying on our business as we presently conduct it or from expanding our operations to certain jurisdictions, we may need to make structural, operational and organizational modifications to our business and/or our contractual arrangements with third party payers. Our operating costs could increase significantly as a result.

We believe that audits, inquiries and investigations from government agencies will continue to occur from time to time in the ordinary course of our business, which could result in substantial defense costs to us and a diversion of management's time and attention. Such pending or future audits, inquiries or investigations, or the public disclosure of such matters, may have a material adverse effect on our business, financial condition and results of operations.

We also may be subject to lawsuits under the federal False Claims Act (the "FCA") and comparable state laws for submitting allegedly fraudulent or otherwise inappropriate bills for services to the Medicare and Medicaid programs. These lawsuits, which may be initiated by government authorities as well as private party relators, can involve significant monetary damages, fines, attorney fees and the award of bounties to private plaintiffs who successfully bring these suits, as well as to the government programs. In recent years, government oversight and law enforcement have become increasingly active and aggressive in investigating and taking legal action against potential fraud and abuse. With respect to our Medicare Advantage contracts with health plans, those health plans have been subject to increasing oversight and regulatory action by CMS, the OIG, the DOJ, and other federal agencies, along with the U.S. Congress with respect to fraud and abuse considerations, including overpayments by federal health care programs. For example, CMS periodically audits Medicare Advantage plans for compliance with CMS regulations and a plan's contract with CMS. Among other areas of focus, CMS conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each performance year. In connection with these audits, CMS has issued a final rule that changes the RADV audit methodology. Starting with performance year 2018, CMS will extrapolate audit findings, using audit methodologies that may vary from audit to audit. CMS projects that it will collect estimated recoveries from 2023 through 2032 in the amount of \$4.7 billion from Medicare Advantage plans. If CMS recovers overpayments from Medicare Advantage plans, with which we contract, those plans may seek to recover payments from their contracted health care providers, including us, that the plans believe are attributable to a particular provider's risk adjustment data. Given that this final rule has not yet become effective and audits beginning with performance year 2018 have not yet begun, we cannot predict how the results of the audits will impact our operating results, financial condition, or cash flows.

Furthermore, our business exposes us to potential medical malpractice, professional negligence, or other related actions or claims that are inherent in the provision of healthcare services. These claims, with or without merit, could cause us to incur substantial costs and could place a significant strain on our financial resources, divert the attention of management from our core business, harm our reputation and adversely affect our ability to attract and retain patients, any of which could have a material adverse effect on our business, financial condition and results of operations.

Managing legal proceedings, litigation and audits, even if we achieve favorable outcomes, is time-consuming and diverts management's attention from our business. Additionally, these matters are often expensive and disruptive to normal business operations and the costs of litigating these matters could be significant. Litigation and regulatory proceedings may be protracted and the results are difficult to predict. Adverse outcomes with respect to litigation or any of these legal proceedings may result in significant settlement costs or

judgments, penalties and fines, or require us to modify our services or require us to stop serving certain patients or geographies, all of which could negatively impact our geographical expansion and revenue growth.

Although we maintain third-party professional liability insurance coverage, it is possible that claims against us may exceed the coverage limits of our insurance policies. Even if any professional liability loss is covered by an insurance policy, these policies typically have substantial deductibles for which we are responsible. Professional liability claims in excess of applicable insurance coverage could have a material adverse effect on our business, financial condition and results of operations. In addition, any professional liability claim brought against us, with or without merit, could result in an increase of our professional liability insurance premiums. Insurance coverage varies in cost and can be difficult to obtain, and we cannot guarantee that we will be able to obtain insurance coverage in the future on terms acceptable to us or at all. If our costs of insurance and claims increase, then our earnings could decline.

***We may be subject to claims that our employees, consultants, or advisors have wrongfully used or disclosed alleged trade secrets of their current or former employers or claims asserting ownership of what we regard as our own intellectual property.***

Many of our employees, consultants and advisors are currently or were previously employed at other companies in our field, including our competitors or potential competitors. Although we try to ensure that our employees, consultants, and advisors do not use the proprietary information or know-how of others in their work for us, we may be subject to claims that we or these individuals have used or disclosed intellectual property, including trade secrets or other proprietary information, of any such individual's current or former employer. Litigation may be necessary to defend against these claims. If we fail in defending any such claims, in addition to paying monetary damages, we may lose valuable intellectual property rights or personnel. Even if we are successful in defending against such claims, litigation could result in substantial costs and be a distraction to management.

In addition, while it is our policy to require our employees and contractors who may be involved in the conception or development of intellectual property to execute agreements assigning such intellectual property to us, we may be unsuccessful in executing such an agreement with each party who, in fact, conceives or develops intellectual property that we regard as our own. The assignment of intellectual property rights may not be self-executing, or the assignment agreements may be breached, and we may be forced to bring claims against third parties, or defend claims that they may bring against us, to determine the ownership of what we regard as our intellectual property. Any of the foregoing could harm our competitive position, business, financial condition, results of operations and prospects.

***We face inspections, reviews, audits and investigations under federal and state government programs and contracts. These audits could have adverse findings that may negatively affect our business, including our results of operations, liquidity, financial condition and reputation.***

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental inspections, reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. Payors may also reserve the right to conduct audits. We also periodically conduct internal audits and reviews of our regulatory compliance. An adverse inspection, review, audit or investigation could result in:

- refunding amounts we have been paid pursuant to the Medicare or Medicaid programs or from payors;
- state or federal agencies imposing fines, penalties and other sanctions on us;
- temporary suspension of payment for new patients to the facility or agency;
- decertification or exclusion from participation in the Medicare or Medicaid programs or one or more payor networks;
- self-disclosure of violations to applicable regulatory authorities;
- damage to our reputation;
- the revocation of a facility's or agency's license; and
- loss of certain rights under, or termination of, our contracts with payors.

We have in the past and will likely in the future be required to refund amounts we have been paid and/or pay fines and penalties as a result of these inspections, reviews, audits and investigations. If adverse inspections, reviews, audits or investigations occur and any of the results noted above occur, it could have a material adverse effect on our business and operating results. Furthermore, the legal, document production and other costs associated with complying with these inspections, reviews, audits or investigations could be significant.

***Reductions in the quality ratings of the health plans we serve could have a material adverse effect on our business, results of operations, financial condition and cash flows.***

As a result of the ACA, the level of reimbursement each health plan receives from CMS is dependent, in part, upon the quality rating of the Medicare plan. Such ratings impact the percentage of any cost savings rebate and any bonuses earned by such health plan. Since a significant portion of our revenue is expected to be calculated as a percentage of CMS reimbursements received by these health plans with respect to our patients, reductions in the quality ratings of a health plan that we serve could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Given each health plan's control of its plans and the many other providers that serve such plans, we believe that we will have limited ability to influence the overall quality rating of any such plan. The Balanced Budget Act that passed in February 2018 implemented certain changes to prevent artificial inflation of STAR ratings for MA plans offered by the same organization. In addition, CMS has terminated plans that have had a rating of less than three STARS for three consecutive years, whereas MA plans with five STARS are permitted to conduct enrollment throughout almost the entire year. Because low quality ratings can potentially lead to the termination of a plan in which we participate, we may not be able to prevent the potential termination of a contracting plan or a shift of patients to other plans based upon quality issues which could, in turn, have a material adverse effect on our business, results of operations, financial condition and cash flows.

***If we are not able to maintain and enhance our reputation and brand recognition, including through the maintenance and protection of trademarks, our business and results of operations may be harmed.***

We believe that maintaining and enhancing our reputation and brand recognition is critical to our relationships with both patients and payors and to our ability to attract new patients. The promotion of our brand may require us to make substantial investments and we anticipate that, as our market becomes increasingly competitive, these marketing initiatives may become increasingly difficult and expensive. Our marketing activities may not be successful or yield increased revenue, and to the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur and our results of operations could be harmed. In addition, any factor that diminishes our reputation or that of our management, including failing to meet the expectations of or provide quality medical care for our patients, or any adverse publicity or litigation involving or surrounding us, one of our centers or our management, could make it substantially more difficult for us to attract new patients. Similarly, because our existing patients often act as references for us with prospective new patients, any existing patient that questions the quality of our care could impair our ability to secure additional new patients. In addition, negative publicity resulting from any adverse government payor audit could injure our reputation. If we do not successfully maintain and enhance our reputation and brand recognition, our business may not grow and we could lose our relationships with patients, which would harm our business, results of operations and financial condition.

The registered or unregistered trademarks or trade names that we own or license may be challenged, infringed, circumvented, declared generic, lapsed or determined to be infringing on or dilutive of other marks. We may not be able to protect our rights in these trademarks and trade names, which we need in order to build name recognition with patients, payors and other partners. In addition, third parties may in the future file for registration of trademarks similar or identical to our trademarks. If they succeed in registering or developing common law rights in such trademarks, and if we are not successful in challenging such third-party rights, we may not be able to use these trademarks to commercialize our technologies in certain relevant jurisdictions. If we are unable to establish name recognition based on our trademarks and trade names, we may not be able to compete effectively and our brand recognition, reputation and results of operations may be adversely affected.

***Our business depends on our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems.***

Our business is highly dependent on maintaining effective information systems as well as the integrity and timeliness of the data we use to serve our patients, support our care teams and operate our business. Because of the large amount of data that we collect and manage, it is possible that hardware failures or errors in our systems could result in data loss or corruption or cause the information that we collect to be incomplete or contain inaccuracies that our partners regard as significant. If our data were found to be inaccurate or unreliable due to fraud or other error, or if we, or any of the third-party service providers we engage, were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our patients and care teams and hinder our ability to provide services, establish appropriate pricing for services, retain and attract patients, manage our patient risk profiles, establish reserves, report financial results timely and accurately and maintain regulatory compliance, among other things.

Our information technology strategy and execution are critical to our continued success. We must continue to invest in long-term solutions that will enable us to anticipate patient needs and expectations, enhance the patient's experience, act as a differentiator in the market and protect against cybersecurity risks and threats. Our success is dependent, in large part, on maintaining the effectiveness of existing technology systems and continuing to deliver and enhance technology systems that support our business processes in a

cost-efficient and resource-efficient manner. Increasing regulatory and legislative changes will place additional demands on our information technology infrastructure that could have a direct impact on resources available for other projects tied to our strategic initiatives. In addition, recent trends toward greater patient engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Connectivity among technologies is becoming increasingly important. We must also develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and patient needs. Failure to do so may present compliance challenges and impede our ability to deliver services in a competitive manner. Further, because system development projects are long-term in nature, they may be more costly than expected to complete and may not deliver the expected benefits upon completion. Our failure to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems could adversely affect our results of operations, financial position and cash flow.

***If we are unable to obtain, maintain and enforce intellectual property protection for our technology or if the scope of our intellectual property protection is not sufficiently broad, particularly with respect to the CareOptimize platform, others may be able to develop and commercialize technology substantially similar to ours, and our ability to successfully commercialize our technology may be adversely affected.***

Our business depends on internally developed technology and content, including software, databases, confidential information and know-how, the protection of which is crucial to the success of our business. We rely on a combination of trademark, trade-secret, and copyright laws and confidentiality procedures and contractual provisions to protect our intellectual property rights in our internally developed technology and content. We may, over time, increase our investment in protecting our intellectual property through additional trademark, patent and other intellectual property filings that could be expensive and time-consuming. Effective trademark, trade-secret and copyright protection is expensive to develop and maintain, both in terms of initial and ongoing registration requirements and the costs of defending our rights. These measures, however, may not be sufficient to offer us meaningful protection. Additionally, CareMax does not currently hold a patent or other registered or applied for intellectual property protection for the CareOptimize platform, and instead relies upon non-registered rights, including trade secrets, contractual provisions and restrictions on access, to protect our intellectual property rights in CareOptimize. Furthermore, because CareMax does not currently have a patent portfolio, if a competitor sues CareMax for patent infringement, our ability to counterclaim or settle through patent cross-licenses may be diminished. If we are unable to protect our intellectual property and other rights, particularly with respect to the CareOptimize platform, our competitive position and our business could be harmed, as third parties may be able to commercialize and use technologies and software products that are substantially the same as ours without incurring the development and licensing costs that we have incurred. Any of our owned or licensed intellectual property rights could be challenged, invalidated, circumvented, infringed, or misappropriated, our trade secrets and other confidential information could be disclosed in an unauthorized manner to third parties, or our intellectual property rights may not be sufficient to permit us to take advantage of current market trends or otherwise to provide us with competitive advantages, which could result in costly redesign efforts, discontinuance of certain offerings or other competitive harm.

Monitoring unauthorized use of our intellectual property is difficult and costly. From time to time, we seek to analyze our competitors' services, and may in the future seek to enforce our rights against potential infringement. However, the steps we have taken to protect our intellectual property rights may not be adequate to prevent infringement or misappropriation of our intellectual property. We may not be able to detect unauthorized use of, or take appropriate steps to enforce, our intellectual property rights. Any inability to meaningfully protect our intellectual property rights could result in harm to our ability to compete and reduce demand for our technology. Moreover, our failure to develop and properly manage new intellectual property could adversely affect our market positions and business opportunities. Also, some of our services rely on technologies and software developed by or licensed from third parties, and we may not be able to maintain our relationships with such third parties or enter into similar relationships in the future on reasonable terms or at all.

Uncertainty may result from changes to intellectual property legislation and from interpretations of intellectual property laws by applicable courts and agencies. Accordingly, despite our efforts, we may be unable to obtain and maintain the intellectual property rights necessary to provide us with a competitive advantage. Our failure to obtain, maintain and enforce our intellectual property rights could therefore have a material adverse effect on our business, financial condition and results of operations.

***Third parties may initiate legal proceedings alleging that we are infringing or otherwise violating their intellectual property rights, the outcome of which would be uncertain and could have a material adverse effect on our business, financial condition and results of operations.***

Our commercial success depends on our ability to develop and commercialize our services and use our internally developed technology without infringing the intellectual property or proprietary rights of third parties. Intellectual property disputes can be costly to defend and may cause our business, operating results and financial condition to suffer. As the market for healthcare in the United States expands and more patents are issued, the risk increases that there may be patents issued to third parties that relate to our technology of which we are not aware or that we must challenge to continue our operations as currently contemplated. Whether merited or not, we may face allegations that we, our partners or parties indemnified by us have infringed or otherwise violated the patents, trademarks, copyrights or

other intellectual property rights of third parties. Such claims may be made by competitors seeking to obtain a competitive advantage or by other parties. Additionally, in recent years, individuals and groups have begun purchasing intellectual property assets for the purpose of making claims of infringement and attempting to extract settlements from companies like ours. We may also face allegations that our employees have misappropriated the intellectual property or proprietary rights of their former employers or other third parties. It may be necessary for us to initiate litigation to defend ourselves in order to determine the scope, enforceability and validity of third-party intellectual property or proprietary rights, or to establish our respective rights. We may not be able to successfully settle or otherwise resolve such adversarial proceedings or litigation. If we are unable to successfully settle future claims on terms acceptable to us we may be required to engage in or to continue claims, regardless of whether such claims have merit, which can be time-consuming, divert management's attention and financial resources and can be costly to evaluate and defend. Results of any such litigation are difficult to predict and may require us to stop commercializing or using our technology, obtain licenses, modify our services and technology while we develop non-infringing substitutes or incur substantial damages, settlement costs or face a temporary or permanent injunction prohibiting us from marketing or providing the affected services. If we require a third-party license, it may not be available on reasonable terms or at all, and we may have to pay substantial royalties, upfront fees or grant cross-licenses to intellectual property rights for our services. We may also have to redesign our services so they do not infringe third-party intellectual property rights, which may not be possible or may require substantial monetary expenditures and time, during which our technology may not be available for commercialization or use. Even if we have an agreement to indemnify us against such costs, the indemnifying party may be unable to uphold its contractual obligations. If we cannot or do not obtain a third-party license to the infringed technology at all, license the technology on reasonable terms or obtain similar technology from another source, our revenue and earnings could be adversely impacted.

From time to time, we may be subject to legal proceedings and claims in the ordinary course of business with respect to intellectual property. We are not currently subject to any claims from third parties asserting infringement of their intellectual property rights. Some third parties may be able to sustain the costs of complex litigation more effectively than we can because they have substantially greater resources. Even if resolved in our favor, litigation or other legal proceedings relating to intellectual property claims may cause us to incur significant expenses, and could distract our technical and management personnel from their normal responsibilities. Moreover, any uncertainties resulting from the initiation and continuation of any legal proceedings could have a material adverse effect on our ability to raise the funds necessary to continue our operations. Assertions by third parties that we violate their intellectual property rights could therefore have a material adverse effect on our business, financial condition and results of operations.

***If we are unable to protect the confidentiality of our trade secrets, know-how and other proprietary and internally developed information, the value of our technology could be adversely affected.***

We may not be able to protect our trade secrets, know-how and other internally developed information, including in relation to our CareOptimize platform, adequately. Although we use reasonable efforts to protect this internally developed information and technology, our employees, consultants and other parties (including independent contractors and companies with which we conduct business) may unintentionally or willfully disclose our information or technology to competitors. Enforcing a claim that a third party illegally disclosed or obtained and is using any of our internally developed information or technology is difficult, expensive and time-consuming, and the outcome is unpredictable. In addition, courts outside the United States are sometimes less willing to protect trade secrets, know-how and other proprietary information. We rely, in part, on non-disclosure, confidentiality and assignment-of-invention agreements with our employees, independent contractors, consultants and companies with which we conduct business to protect our trade secrets, know-how and other intellectual property and internally developed information. These agreements may not be self-executing, or they may be breached and we may not have adequate remedies for such breach. Moreover, third parties may independently develop similar or equivalent proprietary information or otherwise gain access to our trade secrets, know-how and other internally developed information.

***Any restrictions on our use of, or ability to license, data, or our failure to license data and integrate third-party technologies, could have a material adverse effect on our business, financial condition and results of operations.***

We depend upon licenses from third parties for some of the technology and data used in our CareOptimize platform. We expect that we may need to obtain additional licenses from third parties in the future in connection with the development of our services. In addition, we obtain a portion of the data that we use from government entities, public records and from our partners for specific partner engagements. We believe that we have all rights necessary to use the data that is incorporated into our services. We cannot, however, assure you that our licenses for information will allow us to use that information for all potential or contemplated applications.

In the future, data providers could withdraw their data from us or restrict our usage for any reason, including if there is a competitive reason to do so, if legislation is passed restricting the use of the data, or if judicial interpretations are issued restricting use of the data that we currently use to support our services. In addition, data providers could fail to adhere to our quality control standards in the future, causing us to incur additional expense to appropriately utilize the data. If a substantial number of data providers were to withdraw or restrict their data, or if they fail to adhere to our quality control standards, and if we are unable to identify and contract with suitable alternative data suppliers and integrate these data sources into our service offerings, our ability to provide appropriate services to our

patients would be materially adversely impacted, which could have a material adverse effect on our business, financial condition and results of operations.

We also integrate into our internally developed applications and use third-party software to support our technology infrastructure. Some of this software is proprietary and some is open source software. These technologies may not be available to us in the future on commercially reasonable terms or at all and could be difficult to replace once integrated into our own internally developed applications. Most of these licenses can be renewed only by mutual consent and may be terminated if we breach the terms of the license and fail to cure the breach within a specified period of time. Our inability to obtain, maintain or comply with any of these licenses could delay development until equivalent technology can be identified, licensed and integrated, which would harm our business, financial condition and results of operations.

Most of our third-party licenses are non-exclusive and our competitors may obtain the right to use any of the technology covered by these licenses to compete directly with us. Our use of third-party technologies exposes us to increased risks, including, but not limited to, risks associated with the integration of new technology into our solutions, the diversion of our resources from development of our own internally developed technology and our inability to generate revenue from licensed technology sufficient to offset associated acquisition and maintenance costs. In addition, if our data suppliers choose to discontinue support of the licensed technology in the future, we might not be able to modify or adapt our own solutions.

***We depend on our senior management team and other key employees, and the loss of one or more of these employees or an inability to attract and retain other highly skilled employees could harm our business.***

Our success depends largely upon the continued services of our senior management team and other key employees. We rely on our leadership team in the areas of operations, provision of medical services, information technology and security, marketing, and general and administrative functions. From time to time, there may be changes in our executive management team resulting from the hiring or departure of executives, which could disrupt our business. The loss of one or more of the members of our senior management team, or other key employees, could harm our business. In particular, the loss of the services of CareMax's co-founder and Chief Executive Officer, Carlos A. de Solo, could significantly delay or prevent the achievement of our strategic objectives. Changes in our executive management team may also cause disruptions in, and harm to, our business.

***Our primary care centers are concentrated in South and Central Florida, and we may not be able to successfully establish a presence in new geographic markets.***

A majority of our revenue is derived from our primary care centers in Florida, particularly in South and Central Florida. As a result, our exposure to many of the risks described herein is not mitigated by a diversification of geographic focus. Furthermore, due to the concentration of our operations in these regions, our business may be adversely affected by economic conditions that disproportionately affect this region as compared to other regions. To continue to expand our operations to other regions of the United States, we will have to devote resources to identifying and exploring such perceived opportunities. Thereafter, we will have to, among other things, recruit and retain qualified personnel, develop new primary care centers and establish new relationships with physicians and other healthcare providers. In addition, we would be required to comply with laws and regulations of states that may differ from the ones in which we currently operate, and could face competitors with greater knowledge of such local markets. We anticipate that further geographic expansion will require us to make a substantial investment of management time, capital and/or other resources. There can be no assurance that we will be able to continue to successfully expand our center operations in any new geographic markets.

***Our overall business results may suffer from an economic downturn.***

During periods of high unemployment, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at federal, state and local government entities have decreased, and may continue to decrease, spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payor sources of revenue for our centers. Other risks we face during periods of high unemployment include potential declines in the population covered under capitation agreements, potential increases in the uninsured and underinsured populations and further difficulties in our collecting patient co-payment and deductible receivables.

***General economic conditions and constraints in the supply chain could adversely affect our results of operations.***

The global economy, including credit and financial markets, has experienced extreme volatility and disruptions, including severely diminished liquidity and credit availability, declines in consumer confidence, declines in economic growth, increases in unemployment rates, increases in inflation rates and uncertainty about economic stability. For example, the COVID-19 pandemic resulted in increased unemployment, economic slowdown, and extreme volatility in the capital markets. Similarly, the current Russia-Ukraine conflict has created extreme volatility in the global capital markets and is expected to have further global economic consequences, including

disruptions to the global supply chain and energy markets. Continuing concerns over United States health care reform legislation have also contributed to increased volatility. Any such volatility and disruptions may have adverse consequences on us or the third parties on whom we rely. If the equity and credit markets deteriorate, including as a result of political unrest, it may make any necessary debt or equity financing more difficult to obtain in a timely manner, more costly or more dilutive.

In addition, recent developments in the national and worldwide supply chain slowdown have resulted in increased cost and reduced supply for most supplies and materials, including healthcare supplies and equipment and building materials necessary for the build-out and completion of new centers. It is impossible to predict how long this supply chain slowdown will last or how much it will impact our business operations, but it is likely that our costs will increase for supplies and equipment and our ability to quickly open new centers on budget will be impaired.

***If certain of our suppliers do not meet our needs, if there are material price increases on supplies, if we are not reimbursed or adequately reimbursed for drugs we purchase or if we are unable to effectively access new technology or superior products, it could negatively impact our ability to effectively provide the services we offer and could have a material adverse effect on our business, results of operations, financial condition and cash flows.***

We have significant suppliers that may be the sole or primary source of products critical to the services we provide, or to which we have committed obligations to make purchases, sometimes at particular prices. If any of these suppliers do not meet our needs for the products they supply, including in the event of a product recall, shortage or dispute, and we are not able to find adequate alternative sources, if we experience material price increases from these suppliers that we are unable to mitigate, or if some of the products that we purchase are not reimbursed or not adequately reimbursed by commercial or government payors, it could have a material adverse impact on our business, results of operations, financial condition and cash flows. In addition, the technology related to the products critical to the services we provide is subject to new developments which may result in superior products. If we are not able to access superior products on a cost-effective basis or if suppliers are not able to fulfill our requirements for such products, we could face patient attrition and other negative consequences which could have a material adverse effect on our business, results of operations, financial condition and cash flows.

***Our corporate cultures have contributed to our success, and if we cannot maintain a positive corporate culture, we could lose innovation, creativity and teamwork and our business may be harmed.***

We believe that corporate culture has been a critical contributor to our success, particularly regarding our ability to attract highly skilled personnel. If we do not continue to develop corporate culture or maintain and preserve core values as we evolve, we may be unable to foster the innovation, curiosity, creativity, focus on execution, teamwork and the facilitation of critical knowledge transfer and knowledge sharing we believe we need to continue our success.

***Our records and submissions to a health plan may contain inaccurate or unsupported information regarding risk adjustment scores of members, which could cause us to overstate or understate our revenue and subject us to various penalties.***

The claims and encounter records that we submit to health plans may impact data that support the Medicare Risk Adjustment Factor (“RAF”) scores attributable to members. These RAF scores determine, in part, the revenue to which the health plans and, in turn, we are entitled for the provision of medical care to such members. The data submitted to CMS by each health plan is based, in part, on medical charts and diagnosis codes that we prepare and submit to the health plans. Each health plan generally relies on us and our affiliated physicians to appropriately document and support such RAF data in our medical records. Each health plan also relies on us and our affiliated physicians to appropriately code claims for medical services provided to members. Erroneous claims and erroneous encounter records and submissions could result in inaccurate revenue and risk adjustment payments, which may be subject to correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. We might also need to refund a portion of the revenue that we received, which, depending on its magnitude, could damage our relationship with the applicable health plan and could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Additionally, CMS performs Risk Adjustment Data Validation (“RADV”) audits of the diagnosis codes reported by MA plans to confirm they are supported by medical documentation and to determine if risk-adjustment calculations are accurate. The MA plans ask providers to submit the underlying documentation for members that they serve. CMS then compares the diagnoses reflected in the risk scores with underlying medical records to identify whether there are any codes that are not supported by the medical record. If this comparison of sample enrollees yields a difference, referred to as an error rate, CMS plans to extrapolate a contract-level error rate for payment years beginning in 2018 (i.e., the estimated error in payment if the errors found in the RADV audit were reflected in all similar cases for that contract).

It is possible that claims associated with members with higher RAF scores could be subject to more scrutiny in a CMS or plan audit. There is a possibility that a MA plan may seek repayment from us should CMS make any payment adjustments to the MA plan as a result of its audits. The plans also may hold us liable for any penalties owed to CMS for inaccurate or unsupported RAF scores provided by us or our affiliated physicians. In addition, we could be liable for penalties to the government under the FCA currently set at \$13,946 to \$27,894 per claim for penalties assessed after January 15, 2024, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim.

On February 1, 2023, CMS issued a final rule on RADV audit methodology and policies. For audits of payment years beginning with 2018, CMS will not limit payment adjustments to RAF scores for the specific MA enrollees for which errors are found but will extrapolate its audit findings to the entire MA plan subject to a particular CMS contract. CMS has described its audit process as plan-year specific and stated that it will not extrapolate audit results for plan years prior to 2018. As a result of this final rule, CMS is expecting estimated recoveries from 2023 through 2032 to amount to \$4.7 billion.

There can be no assurance that a health plan will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in our revenue and profitability, even if the information we submitted to the plan is accurate and supportable.

***A failure to accurately estimate incurred but not paid medical expense could adversely affect our results of operations.***

Patient care costs include estimates of future medical claims that have been incurred by the patient but for which the provider has not yet billed. These claim estimates are made utilizing actuarial methods and are continually evaluated and adjusted by management, based upon our historical claims experience and other factors, including an independent assessment by a nationally recognized actuarial firm. Adjustments, if necessary, are made to medical claims expense and capitated revenues when the assumptions used to determine our claims liability change and when actual claim costs are ultimately determined.

Due to the inherent uncertainties associated with the factors used in these estimates and changes in the patterns and rates of medical utilization, materially different amounts could be reported in our financial statements for a particular period under different conditions or using different, but still reasonable, assumptions. It is possible that our estimates of this type of claim may be inadequate in the future. In such event, our results of operations could be adversely impacted. Further, the inability to estimate these claims accurately may also affect our ability to take timely corrective actions, further exacerbating the extent of any adverse effect on our results of operations.

***Negative publicity regarding the managed healthcare industry generally could adversely affect our results of operations or business.***

Negative publicity regarding the managed healthcare industry generally, or the MA program in particular, may result in increased regulation and legislative review of industry practices that further increase our costs of doing business and adversely affect our results of operations or business by:

- requiring us to change our products and services;
- increasing the regulatory, including compliance, burdens under which we operate, which, in turn, may negatively impact the manner in which we provide services and increase our costs of providing services;
- adversely affecting our ability to market our products or services through the imposition of further regulatory restrictions regarding the manner in which plans and providers market to MA enrollees; or
- adversely affecting our ability to attract and retain patients.

***Our primary care centers may be negatively impacted by environmental and other factors beyond our control.***

Our results of operations may be adversely impacted by adverse conditions affecting our centers, including severe weather events such as hurricanes and flooding, public health concerns such as contagious disease outbreaks, violence or threats of violence or other factors beyond our control that cause disruption of patient scheduling, displacement of our patients, employees and care teams, or force certain of our centers to close temporarily. Regions in and around the southeastern United States commonly experience hurricanes and other extreme weather conditions. As a result, certain of our centers, especially those in Florida, are susceptible to physical damage and business interruption from an active hurricane season or a single severe storm. Moreover, global climate change could increase the intensity of individual hurricanes or the number of hurricanes that occur each year. Even if our centers are not directly damaged, we may experience considerable disruptions in our operations due to property damage or electrical outages experienced in storm-affected areas by our members, physicians, payors, vendors and others. Additionally, long-term adverse weather conditions, whether caused by global climate change or otherwise, could cause an outmigration of people from the communities where our centers are located. If any of the circumstances described above occurred, there could be a harmful effect on our business and our results of operations could be adversely affected. Given our concentration in South and Central Florida, most of our centers may be simultaneously affected by adverse

weather conditions or other events. Our future operating results may be adversely affected by these and other factors that disrupt the operation of our centers.

***Our offshore service providers involve inherent risks which could result in harm to our business.***

We have and may in the future engage outsourcing partners that provide offshore customer-facing activities. These international activities are subject to inherent risks that are beyond our control, including:

- risks related to government regulation or required compliance with local laws;
- local licensing and reporting obligations;
- difficulties in developing, staffing and simultaneously managing a number of varying foreign operations as a result of distance, language and cultural differences;
- different, uncertain, overlapping or more stringent local laws and regulations;
- political and economic instability, tensions, security risks and changes in international diplomatic and trade relations;
- state or federal regulations that restrict offshoring of business operational functions or require offshore partners to obtain additional licenses, registrations or permits to perform services on our behalf;
- geopolitical events, including natural disasters, public health issues, epidemics or pandemics, acts of war, and terrorism;
- the impact of, and response of local governments to, the COVID-19 pandemic;
- compliance with applicable U.S. laws and foreign laws related to consumer protection, intellectual property, privacy, data security, corruption, money laundering, and export/trade control;
- misconduct by our outsourcing partners and their employees or even unsubstantiated allegations of misconduct;
- risks due to lack of direct involvement in hiring and retaining personnel; and
- potentially adverse tax developments and consequences.

Violations of the complex foreign and U.S. laws, rules and regulations that apply to our international operations and offshore activities of our service providers may result in heightened regulatory scrutiny, fines, criminal actions or sanctions against us, our directors, our officers or our employees, as well as restrictions on the conduct of our business and reputational damage.

***The COVID-19 pandemic impacted our operations and, in the future, the COVID-19 pandemic or another pandemic, epidemic or outbreak of infectious disease, could materially adversely affect our financial condition and results of operations.***

The COVID-19 pandemic impacted our business and could materially adversely affect our business in the future. During the pandemic, we established a COVID-19 rapid response program that created operational initiatives throughout the various spikes and variants. Our internal processes and protocols were designed to ensure the safety and well-being of our employees and continuous access to care for our patients. Our centers provided continuous service to our members by remaining open throughout the duration of the pandemic.

We may take further actions that alter our business operations as may be required by local, state, or federal authorities or that we determine are in the best interests of our employees in response to COVID-19 and any new variants that may emerge. Such measures could negatively affect our sales and marketing efforts, sales cycles, employee productivity, or patient retention, any of which could harm our financial condition and business operations.

Additionally, the expiration of the federal government's COVID-19 national emergency and public health emergency declarations in May 2023 may impact the coverage for and access to certain services for Medicaid patients. Expiration of the national emergency and public health emergency declarations 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.

Another pandemic, epidemic, or outbreak of an infectious disease could occur in the United States or worldwide, and such an event could adversely affect our business in ways that are similar to or different from the COVID-19 pandemic. We may be unable to properly anticipate or prepare for these events and, as a result, our business may be materially adversely impacted.

***We may invest in or acquire other businesses, and our business may suffer if we are unable to successfully integrate acquired businesses into our company or otherwise manage the growth associated with multiple acquisitions.***

As part of our business strategy, we have made, and we may continue to make, acquisitions as opportunities arise to add new medical practices or other complementary businesses. In some cases, the costs of such acquisitions may be substantial, including as a result of professional fees and due diligence efforts. There is no assurance that the time and resources expended on pursuing any particular acquisition will result in a completed transaction, or that any completed transaction will ultimately be successful. In addition, we may be unable to identify suitable medical practices as candidates for acquisition, or we may be unable to obtain any required financing or regulatory approvals, and therefore may be unable to complete such acquisitions on favorable terms, if at all. We may decide to pursue acquisitions with which our investors may not agree and we cannot assure investors that any acquisition or investment will be successful or otherwise provide a favorable return on investment. In addition, acquisitions of medical practices and the integration thereof require significant time and resources and place significant demands on our management, as well as on our operational and financial infrastructure. In addition, if we fail to successfully close transactions or integrate new teams, or integrate the medical practices into our business, our business could be seriously harmed. Acquisitions may expose us to operational challenges and risks, including:

- the increased difficulty of managing a larger combined company and consolidating corporate and administrative infrastructures;
- the ability to profitably manage acquired medical practices or successfully integrate the acquired medical practices into our business;
- increased expense of integrating acquired businesses, including significant administrative, operational, economic, geographic or cultural challenges in managing and integrating the expanded or combined operations;
- the inability to realize any expected synergies and cost-savings;
- entry into jurisdictions or acquisition of products or technologies with which we have limited or no prior experience, and the potential of increased competition with new or existing competitors as a result of such acquisitions;
- underperformance of any acquired business relative to our expectations and the price we paid;
- negative near-term impacts on financial results after an acquisition, including acquisition-related earnings charges;
- diversion of management's attention and the over-extension of our existing operating business and our management systems, information technology systems, and internal controls and procedures, which may be inadequate to support growth since the Business Combination
- claims by terminated employees and shareholders of acquired companies or other third parties related to the transaction;
- problems in maintaining uniform procedures, controls and policies with respect to our financial accounting systems;
- the ability to fund our capital needs and any cash flow shortages that may occur if anticipated revenue is not realized or is delayed, whether by general economic or market conditions, or unforeseen internal difficulties; and
- the ability to retain or hire qualified personnel required for expanded operations including medical practitioners and support staff.

Our acquisition strategy may not succeed if we are unable to remain attractive to target companies or expeditiously close transactions. Issuing shares of our Class A Common Stock to fund any acquisition would cause economic dilution to existing stockholders. If we are unable to successfully integrate medical practices which we have or will acquire, or if target medical practices view our Class A Common Stock unfavorably, we may be unable to consummate key acquisition transactions essential to our corporate strategy and our business may be seriously harmed.

#### **Risks Related to Regulation**

*If we fail to adhere to all of the complex government laws and regulations that apply to our business, we could suffer severe consequences that could have a material adverse effect on our business, results of operations, financial condition, cash flows, stock price and reputation.*

Our operations are subject to extensive federal, state and local government laws and regulations, including without limitation:

- the federal Anti-Kickback Statute, a criminal law, which prohibits, among other things, persons and entities from knowingly and willfully offering, paying, soliciting or receiving any remuneration, directly or indirectly, in cash or in kind, to induce or reward purchasing, leasing, ordering, or arranging for, referring, or recommending the purchase, lease or order of any good or service for which payment may be made, in whole or in part, under government health care programs such as Medicare and Medicaid. 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 of the federal Anti-Kickback Statute can result in significant civil monetary penalties and criminal fines, as well as imprisonment and exclusion from participation in government health care programs;

- the federal 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 government health care programs against individuals or entities for, among other things, knowingly presenting, or causing to be presented, to the federal government, claims for payment that are false or fraudulent or for making a 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. There is also the federal Criminal False Claims Act, which is similar to the federal Civil False Claims Act and imposes criminal liability on those that make or present a false, fictitious or fraudulent claim to the federal government;
- the federal Civil Monetary Penalties Law, which authorizes the imposition of substantial civil monetary penalties against an entity that engages in activities including, among others (1) knowingly presenting, or causing to be presented, a claim for services not 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 Anti-Kickback Statute; or (4) failing to report and return a known overpayment;
- 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” for “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;
- 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;
- federal criminal statutes created by the Health Insurance Portability and Accountability Act (HIPAA), which impose criminal liability for, among other things, knowingly and willfully executing or attempting to execute a scheme to defraud any healthcare benefit program, including private insurance plans, or, in any matter involving a healthcare benefit program, for knowingly and willfully making materially false, fictitious or fraudulent statements in connection with the delivery of or payment for health care benefits;
- Medicare and Medicaid participation and reimbursement rules and regulations;
- federal and state laws regarding the collection, use, disclosure or other processing of patient health information or other PII (e.g., HIPAA and the 21st Century Cures Act’s information blocking rules);
- federal and state laws regarding the storage, handling, shipment, disposal and/or dispensing of pharmaceuticals, blood products, and other biological materials;
- federal and state statutes and regulations that govern risk bearing provider organizations and provider network contracting and operations, including such laws applicable to accountable care organizations;
- federal and state antitrust laws;
- federal and state statutes and regulations that govern workplace health and safety;
- 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; and, in some cases, to re-enroll in these programs when changes in direct or indirect ownership occur; and
- federal and state laws pertaining to the provision of services by nurse practitioners and physician assistants certain settings, physician supervision of those services, and reimbursement requirements that depend on the types of services provided and documented and relationships between physician supervisors and nurse practitioners and physician assistants.

In addition to the above laws, Medicare and Medicaid regulations, manual provisions, local coverage determinations, national coverage determinations and agency guidance also impose complex and extensive requirements upon healthcare providers. Moreover, the various laws and regulations that apply to our operations are often subject to varying interpretations, and additional laws and regulations potentially affecting providers continue to be promulgated that may impact us. A violation or departure from any of the legal requirements implicated by our business may result in, among other things, government audits, lower reimbursements, significant fines and penalties, the potential loss of certification or other applicable licenses and permits, recoupment actions, or voluntary repayments. These legal requirements are civil, criminal and administrative in nature depending on the law or requirement.

We endeavor to comply with all legal requirements. We further endeavor to structure all of our relationships with payors, physicians and providers to comply with state and federal anti-kickback statutes, the Stark Law and other applicable healthcare laws as described above. We dedicate compliance resources and maintain a formal compliance plan to monitor laws and regulations and implement necessary changes. However, the laws and regulations in these areas are complex, changing and often subject to varying interpretations. As a result, there is no guarantee that we will be able to adhere to all of the laws and regulations that apply to our business, and any failure to do so could have a material adverse impact on our business, results of operations, financial condition, cash flows and reputation. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, or otherwise challenge these arrangements, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse impact on our business, results of operations, financial condition, cash flows and reputation as a result. Similarly, we may face penalties under the FCA, the federal Civil Monetary Penalty Law or otherwise related to failure to report and return overpayments within 60 days of when the overpayment is identified and quantified. These obligations to report and return overpayments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made investments in resources to decrease the time it takes to identify, quantify and process overpayments, and may be required to make additional investments in the future.

Additionally, the federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare, Medicaid and other federally funded health care programs. Moreover, amendments to the federal Anti-Kickback Statute in the ACA make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including *qui tam* or whistleblower suits. The penalties for a violation of the FCA currently range from \$13,946 up to \$27,894 per false claim or statement for penalties assessed after January 15, 2024. Given the high volume of claims processed by our various operating units, the potential is high for substantial penalties in connection with any alleged FCA violations.

In addition to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government.

If any of our operations are found to violate these or other government laws or regulations, we could suffer severe consequences that would have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price, including:

- exclusion from, suspension or termination of our participation in government payment programs;
- refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- loss of our required government certifications or exclusion from government payment programs;
- loss of our licenses required to operate healthcare facilities or administer pharmaceuticals in the states in which we operate;
- criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Civil Monetary Penalties Law, Stark Law and FCA, or other failures to meet regulatory requirements;
- enforcement actions by governmental agencies and/or state law claims for monetary damages by patients who believe their PII or PHI has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including HIPAA and the Privacy Act of 1974;
- mandated changes to our practices or procedures that significantly increase operating expenses;
- imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines, among other things;
- termination of various relationships and/or contracts related to our business, including joint venture arrangements, medical director agreements, real estate leases and consulting agreements with physicians; and

- harm to our reputation which could negatively impact our business relationships, affect our ability to attract and retain patients and physicians, affect our ability to obtain financing and decrease access to new business opportunities, among other things.

We are, and may in the future be, a party to various lawsuits, demands, claims, *qui tam* suits, governmental investigations and audits (including investigations or other actions resulting from our obligation to self-report suspected violations of law) and other legal matters, any of which could result in, among other things, substantial financial penalties or awards against us, mandated refunds, substantial payments made by us, required changes to our business practices, exclusion from future participation in Medicare, Medicaid and other healthcare programs and possible criminal penalties, any of which could have a material adverse effect on our business, results of operations, financial condition, cash flows and materially harm our reputation.

Responding to subpoenas, investigations and other lawsuits, claims and legal proceedings as well as defending ourselves in such matters may continue to require management's attention and cause us to incur significant legal expense. Negative findings or terms and conditions that we might agree to accept as part of a negotiated resolution of pending or future legal or regulatory matters could result in, among other things, substantial financial penalties or awards against us, substantial payments made by us, harm to our reputation, required changes to our business practices, exclusion from future participation in the Medicare, Medicaid and other healthcare programs and, in certain cases, criminal penalties, any of which could have a material adverse effect on us. It is possible that criminal proceedings may be initiated against us and/or individuals in our business in connection with investigations by the federal government.

We, our affiliated physicians and the facilities in which we operate are subject to various federal, state and local licensing and certification laws and regulations and accreditation standards and other laws, relating to, among other things, the adequacy of medical care, equipment, privacy of patient information, physician relationships, personnel and operating policies and procedures. Failure to comply with these licensing, certification and accreditation laws, regulations and standards could result in our services being found non-reimbursable or prior payments being subject to recoupment, requirements to make significant changes to our operations and can give rise to civil or, in extreme cases, criminal penalties. We routinely take the steps we believe are necessary to retain or obtain all requisite licensure and operating authorities. While we have made reasonable efforts to substantially comply with federal, state and local licensing and certification laws and regulations and standards as we interpret them, we cannot assure you that agencies that administer these programs will not find that we have failed to comply in some material respects.

***If we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting U.S. healthcare reform, our business may be harmed.***

Due to the importance of the healthcare industry to the lives of all Americans, federal, state, and local legislative bodies frequently pass legislation and promulgate regulations relating to healthcare reform or that affect the healthcare industry. 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.

For example, the status of the ACA 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 to completely repeal the ACA have been unsuccessful to date, and on June 17, 2021, the United States Supreme Court dismissed the most recent judicial challenge to the ACA brought by several states without specifically ruling on the constitutionality of the ACA.

Another potentially existential challenge to the ACA is advancing in federal courts. Specifically, in *Braidwood Management v. Becerra*, the plaintiffs argue that the 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 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. 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 financing 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 ACA, certain potentially material changes seem likely with respect to government reimbursement and the healthcare industry in general. For instance, the 2024 Medicare Physician Fee Schedule Final Rule decreased the 2024 conversion factor (i.e., the amount Medicare pays per relative value unit (RVU)) by nearly 3.4% from the 2023 amount. Congress may pass legislation to absorb some of these cuts, but Medicare payments to physicians are expected to 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.

At this time, we are unable to determine the ultimate content or timing of any health reform legislation. We will not be able to determine the effect that any such legislation may have on our operations and business condition until such legislation is enacted, but such legislation may adversely affect our operations and business condition. It is reasonable to assume that there will continue to be increased government oversight and regulation of the healthcare industry in the future. We cannot assure our stockholders as to the ultimate content, timing or effect of any new healthcare legislation or regulations, nor is it possible at this time to estimate the impact of potential new legislation or regulations on our business. It is possible that future legislation enacted by Congress or state legislatures, or regulations promulgated by regulatory authorities at the federal or state level, could adversely affect our business or could change the operating environment of our primary care centers. It is possible that the changes to the Medicare, Medicaid or other governmental healthcare program reimbursements may serve as precedent to possible changes in other payors' reimbursement policies in a manner adverse to us. Similarly, changes in private payor reimbursements could lead to adverse changes in Medicare, Medicaid and other governmental healthcare programs, which could have a material adverse effect on our business, financial condition and results of operations.

While we believe that we have structured our agreements and operations in material compliance with applicable healthcare laws and regulations, there can be no assurance that we will be able to successfully address changes in the current regulatory environment. We believe that our business operations materially comply with applicable healthcare laws and regulations. However, some of the healthcare laws and regulations applicable to us are subject to limited or evolving interpretations, and a review of our business or operations by a court, law enforcement or a regulatory authority might result in a determination that could have a material adverse effect on us. Furthermore, the healthcare laws and regulations applicable to us may be amended or interpreted in a manner that could have a material adverse effect on our business, prospects, results of operations and financial condition.

***We are subject to complex rules and regulations that govern our licensing and certification, as well as credentialing processes with private payors before we can receive reimbursement for services. Our failure to comply with these rules and regulations or delays in the credentialing process could adversely affect our business.***

We are subject to various federal, state and local licensing and certification laws and regulations and accreditation standards and other laws relating to, among other things, the adequacy of medical care, equipment, personnel and operating policies and procedures. We are also subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing and accreditations.

Relevant laws and regulations may also require approvals to maintain or renew our operating authorities or require formal application and approval to continue providing services under certain government contracts. Failure to comply with these licensing, certification and accreditation laws, regulations and standards could result in our services being found non-reimbursable or prior payments being subject to recoupment, and can give rise to civil or, in extreme cases, criminal penalties.

Each time a new physician or other provider joins us, we must enroll such provider under our applicable group identification number for Medicare and Medicaid programs and for certain managed care and private insurance programs before we can receive reimbursement for services such provider renders to beneficiaries of those programs. The estimated time to receive approval for the enrollment is sometimes difficult to predict. These practices result in delayed reimbursement that may adversely affect our cash flows.

With respect to Medicare, providers can retrospectively bill Medicare for services provided 30 days prior to the effective date of the enrollment. In addition, the enrollment rules provide that the effective date of the enrollment will be the later of the date on which the enrollment application was filed and approved by the Medicare contractor, or the date on which the provider began providing services.

If we are unable to properly enroll physicians and other applicable healthcare professionals in a timely manner, we will be precluded from billing Medicare for any services which were provided to a Medicare beneficiary more than 30 days prior to the effective date of the enrollment. With respect to Medicaid, whether a state will allow providers to retrospectively bill Medicaid for services provided prior to submitting an enrollment application varies by state. Failure to timely enroll providers could reduce our revenues and have a material adverse effect on our business, financial condition, or results of operations.

The ACA, as currently structured, added additional enrollment requirements for Medicare and Medicaid, which have been further enhanced through implementing regulations and increased enforcement scrutiny. Every enrolled provider must revalidate its enrollment at regular intervals and must update the Medicare contractors and many state Medicaid programs with significant changes on a timely basis. If we fail to provide sufficient documentation as required to maintain our enrollment, Medicare and Medicaid could deny continued future enrollment or revoke our enrollment and billing privileges.

The requirements for enrollment, licensure, certification and accreditation may include notification or approval in the event of a transfer or change of ownership or certain other changes. Other agencies or payors with which we have contracts may have similar requirements, and some of these processes may be complex. Failure to provide required notifications or obtain necessary approvals may result in the delay or inability to complete an acquisition or transfer, loss of licensure, lapses in reimbursement, or other penalties. While we make reasonable efforts to substantially comply with these requirements, we cannot assure you that the agencies that administer these programs or have awarded us contracts will not find that we have failed to comply in some material respects. A finding of non-compliance and any resulting payment delays, refund demands, or other sanctions could have a material adverse effect on our business, financial condition, or results of operations.

***Our use, disclosure, and other processing of personally identifiable information, including health information, is subject to HIPAA and other federal and state privacy and security regulations, and our failure or perceived failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm and, in turn, a material adverse effect on our patient base and revenue.***

Numerous state and federal laws and regulations govern the collection, dissemination, use, privacy, confidentiality, security, availability, integrity, and other processing of PHI and PII. These laws and regulations include HIPAA. HIPAA establishes a set of national privacy and security standards for the protection of PHI by health plans, healthcare clearinghouses and certain healthcare providers, referred to as covered entities, and the business associates with whom such covered entities contract for services.

HIPAA requires covered entities and their business associates to develop and maintain policies and procedures with respect to PHI that is used or disclosed, including the adoption of administrative, physical and technical safeguards to protect such information. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

HIPAA imposes mandatory penalties for certain violations. Penalties for violations of HIPAA and its implementing regulations start at \$100 per violation and are not to exceed \$50,000 per violation, subject to a cap of \$1.5 million for violations of the same standard in a single calendar year. These amounts are subject to annual adjustments to take inflation into account. However, a single breach incident or enforcement action can result in violations of multiple standards. 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 duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, HIPAA mandates that the Secretary of the Department of Health and Human Services ("HHS") conduct periodic compliance audits of HIPAA covered entities and business associates for compliance with the HIPAA's privacy and security standards. It also tasks HHS with establishing a methodology whereby harmed individuals who were the victims of breaches of unsecured PHI may receive a percentage of the Civil Monetary Penalty fine paid by the violator.

HIPAA further requires that patients be notified of any unauthorized acquisition, access, use or disclosure of their unsecured PHI that compromises the privacy or security of such information, with certain exceptions related to unintentional or inadvertent use or disclosure by employees or authorized individuals. HIPAA specifies that such notifications must be made "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach." If a breach affects 500 patients or more, it must be reported to HHS without unreasonable delay, and HHS will post the name of the breaching entity on its public web site. Breaches affecting more than 500 patients in the same state or jurisdiction must also be reported to the media outlets serving the state or jurisdiction. If a breach involves fewer than 500 people, the covered entity must record it in a log and notify HHS at least annually.

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 under HIPAA, and accordingly, when business associate agreements must be executed between covered entities, like the Company, and such vendors. We may incur additional expense to comply with this bulletin and 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 risk to the Company in the future.

In addition to HIPAA, numerous other federal and state laws and regulations protect the confidentiality, privacy, availability, integrity and security of PHI and other types of PII. These laws include an increasing number of state comprehensive data protection laws, such as the CCPA (as amended by the CPRA), the Colorado Privacy Act, the Connecticut Data Privacy Act, the Virginia Consumer Data Protection Act, and the Utah Consumer Privacy Act. While these new comprehensive data protection laws generally include exemptions for HIPAA-covered data, they add layers of complexity to compliance in the U.S. market, and could increase our compliance costs and adversely affect our business. Additionally, states are increasingly regulating biometric information, such as the Illinois Biometric Information Privacy Act, the Texas Capture or Use of Biometric Identifier act, and the Washington Biometric Privacy Protection Act. State statutes and regulations vary from state to state, and these laws and regulations in many cases are more restrictive than, and may not be preempted by, HIPAA and its implementing rules. Some federal and state laws and regulations impose stricter requirements than HIPAA for particularly sensitive information, such as substance use disorder treatment records, HIV-related information, and mental health treatment records. Likewise, some states impose stringent data security requirements, such as New York's Stop Hacks and Improve Electronic Data Security Act and the Massachusetts Standards for the Protection of Personal Information of Residents of the Commonwealth. These data protection laws and regulations are often uncertain, contradictory, and subject to changed or differing interpretations, and we expect new laws, rules and regulations regarding privacy, data protection, and information security to be proposed and enacted in the future. In the event that new data privacy and security laws are implemented, we may not be able to timely comply with such requirements, or such requirements may not be compatible with our current processes. Changing our processes could be time consuming and expensive, and failure to timely implement required changes could subject us to liability for non-compliance. While we have implemented data privacy and security measures in an effort to comply with applicable laws and regulations relating to privacy and data protection, some PHI and other PII or confidential information is transmitted to us by third parties, who may not implement adequate security and privacy measures, and it is possible that laws, rules and regulations relating to privacy, data protection, or information security may be interpreted and applied in a manner that is inconsistent with our practices or those of third parties who transmit PHI and other PII or confidential information to us.

In addition to privacy and security laws, we are subject to rules promulgated pursuant to the federal 21st Century Cures Act. In May 2020, the HHS Office of the National Coordinator for Health Information Technology and CMS issued complementary new rules under the 21st Century Cures Act that are intended to enhance interoperability and prevent information blocking. These rules create significant new requirements for healthcare industry participants, including requirements to (i) provide patients with convenient access to health care information, (ii) support electronic exchange of data for transitions of care, and (iii) require participation in trust networks to improve interoperability. 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 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 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. The 21st Century Cures Act authorizes civil monetary penalties up to \$1 million per information blocking violation. It is 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.

Federal and state consumer protection laws, including laws that do not on their face specifically address data privacy or security, have been applied to data privacy and security matters by a range of government agencies and courts. 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.

We also publish statements to our patients and partners that describe how we handle and protect PHI. If federal or state regulatory authorities or private litigants consider any portion of these statements to be untrue, we may be subject to claims of deceptive practices, which could lead to significant liabilities and consequences, including, without limitation, costs of responding to investigations, defending against litigation, settling claims, and complying with regulatory or court orders. Any of the foregoing consequences could have a material adverse impact on our business and our financial results.

***Laws regulating the corporate practice of medicine could restrict the manner in which we are permitted to conduct our business, and the failure to comply with such laws could subject us to penalties or require a restructuring of our business.***

Some states have laws that prohibit or limit business entities from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians or engaging in certain arrangements, such as fee-splitting, with physicians (such activities generally referred to as the "corporate practice of medicine"). In some states these prohibitions are expressly stated in a statute

or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. Some state laws, such as Florida law, generally do not prohibit the corporate practice of medicine. With respect to fee-splitting prohibitions, in some jurisdictions, courts have interpreted fee-splitting statutes as prohibiting percentage of gross revenue and percentage of net profit fee arrangements, regardless of whether the parties to the arrangement have legitimate business purposes and are providing legitimate services. Courts may refuse to enforce contracts where they find the parties have violated state fee-splitting prohibitions.

Penalties for violations of the corporate practice of medicine vary by state and may result in physicians being subject to disciplinary action, as well as to forfeiture of revenues from payors for services rendered. For lay entities, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in medical practice without a license.

Some of the relevant laws, regulations and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change. Regulatory authorities and other parties may assert that, despite the management agreements and other arrangements through which we may operate in states that prohibit the corporate practice of medicine, we are engaged in the prohibited corporate practice of medicine or that our arrangements constitute unlawful fee-splitting. If this were to occur, we could be subject to civil and/or criminal penalties, our agreements could be found legally invalid and unenforceable (in whole or in part) or we could be required to restructure our contractual arrangements.

***Federal and state laws regulating insurance and managed care could restrict the manner in which we are permitted to conduct our business, and the failure to comply with such laws could subject us to penalties or require a restructuring of our business.***

Many states regulate provider risk-sharing arrangements, including, but not limited to, global risk and other value-based arrangements. These regulatory frameworks vary significantly from state to state. Some states require risk bearing entities – even if provider organizations or networks – to obtain an insurance license, a certificate of authority, or an equivalent authorization, in order to participate in risk-sharing arrangements with payors. In some states, statutes, regulations and/or formal guidance explicitly address whether and in what manner the state regulates the transfer of risk by a payor to a downstream entity. However, the majority of states do not explicitly address the issue, and in such states, regulators may nonetheless interpret statutes and regulations to regulate such activity. If risk-sharing arrangements are not regulated directly in a particular state, the state regulatory agency may nonetheless require oversight by the licensed payor as the party to such a risk-sharing arrangement. Such oversight is accomplished via contract and may include the imposition of significant financial reserve requirements, as well as reporting or other disclosure obligations. Further, state regulatory stances regarding risk-sharing arrangements can change rapidly and codified provisions may not keep pace with evolving risk-sharing mechanisms.

In the case of federal health care programs, initiatives, and models, in which we participate, such as the Medicare Shared Savings Program and the ACO REACH, we are required to certify compliance with state insurance regulatory requirements as a risk bearing entity. If we fail to comply with applicable state law, including as a result of rapidly evolving state regulation of risk sharing arrangements, we may not be in compliance with such certifications under these models. Such non-compliance could result in termination of our agreements to participate in these models and other penalties, sanctions, and liabilities.

***The soundness of financial institutions or the financial services industry generally, such as actual concerns or events involving liquidity, defaults or non-performance, may adversely affect us.***

Actual events involving limited liquidity, defaults, non-performance or other adverse developments that affect financial institutions or the financial services industry generally, or concerns or rumors about any events of these kinds, have in the past and may in the future lead to market-wide liquidity problems. We maintain depository accounts with financial institutions in the United States for daily cash flow needs. While depository accounts in the United States are covered by Federal Deposit Insurance Corporation ("FDIC") insurance, we have exposure with certain financial institutions to the extent our cash balances exceed the current \$250,000 in maximum FDIC coverage. If other banks and financial institutions enter receivership or become insolvent in the future in response to financial conditions affecting the banking system and financial markets, our ability to access our existing cash, including cash held at financial institutions in excess of the FDIC insured limit, cash equivalents and investments and conduct our business operations may be threatened. In addition, if any of our lenders or counterparties to any such instruments were to be placed into receivership, we may be unable to access such funds. Investor concerns regarding the U.S. or international financial systems could also result in less favorable commercial financing terms, including higher interest rates or costs and tighter financial and operating covenants, or systemic limitations on access to credit and liquidity sources, thereby making it more difficult for us to acquire financing on acceptable terms or at all. Any decline in available funding or access to our cash and liquidity resources could, among other risks, adversely impact our ability to meet our operating expenses, financial obligations or fulfill our other obligations, or result in breaches of our financial and/or contractual obligations. Further, if any of our customers, suppliers or other parties with whom we conduct business are unable to access funds pursuant to such instruments or lending arrangements with such a financial institution, such parties' ability to pay their obligations to us or to enter into new commercial arrangements requiring additional payments to us could be adversely affected. Any of these impacts, or any other impacts resulting from the factors described above or other related or similar factors not described above, could have material adverse impacts on our liquidity and our current and/or projected business operations and financial condition and results of operations.

## Risks Related to Ownership of Our Securities and Being a Public Company

*The trading price of our securities could be volatile and subject to wide fluctuations in response to various factors, some of which are beyond our control. Any of the factors listed below could have a material adverse effect on any investment in our securities which may trade at prices significantly below the price you paid for them. In these circumstances, the trading price of our securities may not recover and may experience a further decline.*

Factors affecting the trading price of our securities may include:

- actual or anticipated fluctuations in our quarterly financial results or the quarterly financial results of companies perceived to be similar to us;
- changes in the market's expectations about our operating results;
- the public's reaction to our press releases, our other public announcements and our filings with the SEC;
- speculation in the press or investment community;
- success of competitors;
- our operating results failing to meet the expectation of securities analysts or investors in a particular period;
- changes in financial estimates and recommendations by securities analysts concerning us or the market in general;
- operating and stock price performance of other companies that investors deem comparable to us;
- our ability to market new and enhanced products and services on a timely basis;
- changes in laws and regulations affecting our business;
- commencement of, or involvement in, litigation;
- changes in our capital structure, such as future issuances of securities or the incurrence of additional debt;
- the volume of shares of our Class A Common Stock available for public sale;
- any major change in our Board of Directors or management;
- sales of substantial amounts of common stock by its directors, officers or significant stockholders or the perception that such sales could occur; and
- general economic and political conditions such as recessions, interest rates, fuel prices, international currency fluctuations and acts of war or terrorism.

Broad market and industry factors may materially harm the market price of our securities irrespective of our operating performance. The stock market in general and Nasdaq have experienced price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of the particular companies affected. The trading prices and valuations of these stocks, and of our securities, may not be predictable. A loss of investor confidence in the market for the stocks of other companies that investors perceive to be similar to us could depress our stock price regardless of our business, prospects, financial conditions or results of operations. A decline in the market price of our securities also could adversely affect our ability to issue additional securities and our ability to obtain additional financing in the future. In the past, securities class action litigation has often been initiated against companies following periods of volatility in their stock price. This type of litigation could result in substantial costs and divert management's attention and resources, and could also require us to make substantial payments to satisfy judgments or to settle litigation.

*We may be required to take write-downs or write-offs, restructuring and impairment or other charges that could have a significant negative effect on our financial condition, results of operations and the price of our securities, which could cause you to lose some or all of your investment.*

We could become subject to certain unknown liabilities of businesses we have acquired, and we may be forced to write-down or write-off assets, restructure our operations, or incur impairment or other charges that could result in reporting losses. Even though these charges may be non-cash items and not have an immediate impact on our liquidity, reporting charges of this nature could contribute to negative market perceptions about our securities. Our securityholders are unlikely to have a remedy for such charges unless they are able to successfully claim that the reduction was due to the breach by our officers or directors of a duty of care or other fiduciary duty owed to them, or if they are able to successfully bring a private claim under securities laws that the proxy materials, relating to the Business Combination or the Steward Acquisition contained an actionable material misstatement or material omission. In addition,

charges of this nature may cause us to violate covenants to which we may be subject as a result of or by virtue of our outstanding credit facility, which could have a material adverse effect on our business, financial condition, or results of operations.

***If the benefits of our acquisitions do not meet the expectations of investors, stockholders or financial analysts, the market price of our securities may decline.***

The integration of certain of our acquisitions subsequent to the Business Combination, including Steward Value-Based Care, remains subject to numerous uncertainties, some of which are unknown or may be outside of our control. We may not achieve the benefits of investments or acquisitions as quickly as expected or at all. If the benefits of our investments and acquisitions do not meet the expectations of investors or securities analysts, the market price of our securities may decline.

***We will continue to incur significantly increased costs as a result of operating as a public company, and management will be required to devote substantial time to compliance efforts.***

We will continue to incur significant legal, accounting, insurance and other expenses as a result of being a public company. The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the “Dodd-Frank Act”), and the Sarbanes-Oxley Act of 2002 (the “Sarbanes-Oxley Act”), as well as related rules implemented by the SEC, have required changes in corporate governance practices of public companies. We expect that compliance with these and other similar laws, rules and regulations, including compliance with Section 404 of the Sarbanes-Oxley Act, will substantially increase our expenses, including legal and accounting costs, and make some activities more time-consuming and costly. We also expect these laws, rules and regulations to make it more expensive to obtain director and officer liability insurance, and we may be required to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage, which may make it more difficult for us to attract and retain qualified persons to serve on the Board or as officers. Although the JOBS Act may, for a limited period of time, somewhat lessen the cost of complying with these additional regulatory and other requirements, we nonetheless expect a substantial increase in legal, accounting, insurance and certain other expenses in the future, which could negatively impact our results of operations and financial condition.

***Our management team has limited experience managing a public company, and our current resources may not be sufficient to fulfill the public company obligations.***

We are subject to various regulatory requirements, including those of the SEC and Nasdaq. These requirements include record keeping, financial reporting and corporate governance rules and regulations. Most of the members of our management team have limited experience managing a publicly traded company, interacting with public company investors, and complying with the increasingly complex laws pertaining to public companies. Our management team may not successfully or efficiently manage their new roles and responsibilities, and our internal infrastructure may not be adequate to support its increased reporting obligations. We may be unable to hire, train or retain necessary staff and may be reliant on engaging outside consultants or professionals to overcome our lack of experience or employees. These new obligations will require significant attention from our senior management and could divert their attention away from the day-to-day management of our business, especially if our internal infrastructure is inadequate or if we are unable to engage outside consultants to support our increased public company obligations, which could adversely affect our business, financial condition, and operating results.

***We may not be able to timely and effectively implement controls and procedures required by Section 404 of the Sarbanes-Oxley Act.***

As a public company, we are required to comply with the SEC’s rules implementing Sections 302 and 404 of the Sarbanes-Oxley Act, which require management to certify financial and other information in our quarterly and annual reports and provide an annual management report on the effectiveness of internal control over financial reporting. To comply with the requirements of being a public company, we will be required to provide attestation on internal controls, and we may need to undertake various actions, such as implementing additional internal controls and procedures and hiring additional accounting or internal audit staff. The standards required for a public company under Section 404 of the Sarbanes-Oxley Act are significantly more stringent than those previously required for privately held companies. Our management may not be able to effectively and timely implement controls and procedures that adequately respond to the increased regulatory compliance and reporting requirements applicable to us. If we are not able to implement the additional requirements of Section 404 in a timely manner or with adequate compliance, we may not be able to assess whether our internal controls over financial reporting are effective, which may subject us to adverse regulatory consequences and could harm investor confidence and the market price of our securities. Further, as an emerging growth company, our independent registered public accounting firm is not required to formally attest to the effectiveness of our internal controls over financial reporting pursuant to Section 404 until the date we are no longer an emerging growth company. At such time, our independent registered public accounting firm may issue a report that is adverse in the event that it is not satisfied with the level at which the controls of the post-combination company are documented, designed or operating effectively.

***We have identified certain material weaknesses in our internal control over financial reporting. If we are unable to remediate these material weaknesses, or if we identify additional material weaknesses in the future or otherwise fail to maintain effective internal control over financial reporting, we may not be able to accurately or timely report our financial condition or results of operations, which may adversely affect our business and stock price.***

We identified certain material weaknesses in our internal control over financial reporting. These material weaknesses have not been remediated as of December 31, 2023. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis.

The material weaknesses we identified include that we lack a sufficient complement of professionals with the appropriate level of knowledge, training and experience to appropriately analyze, record and disclose accounting matters commensurate with our accounting and reporting requirements as a public company. This material weakness contributed to the Company not designing and maintaining formal controls to analyze, account for and disclose complex transactions, including the accounting for financial instruments and contingent earnout liabilities. These material weaknesses resulted in:

- the restatement of the Company's previously filed consolidated financial statements as of and for the year ended December 31, 2020, as well as the quarterly condensed consolidated financial information for the 2020 interim period ended September 30, 2020 related to derivative warrant liabilities, Class A ordinary shares subject to possible redemption, additional paid-in-capital, retained earnings/(deficit), fair value adjustment on derivative warrant liabilities, earnings per share and the related disclosures;
- the restatement of the Company's previously filed quarterly condensed consolidated financial information for the 2021 interim periods ended June 30, 2021 and September 30, 2021 related to goodwill, contingent earnout liabilities, additional paid-in capital, retained earnings/(deficit), gain/(loss) on remeasurement of earnout liabilities, earnings per share and the related disclosures; and
- the restatement of the Company's previously filed consolidated financial statements as of and for the year ended December 31, 2021, as well as the quarterly condensed consolidated financial information for the 2021 interim period ended September 30, 2021 and the 2022 interim periods ended March 31, 2022, June 30, 2022, and September 30, 2022 related to other current assets and other assets.

Additionally, these material weaknesses could result in misstatements of substantially all accounts or disclosures that would result in a material misstatement to the annual or interim consolidated financial statements that would not be prevented or detected.

Since identifying the material weaknesses, management has developed a remediation plan and implemented measures to address the underlying causes of each material weakness. Our efforts to date included the following:

- We engaged an external advisor to assist in evaluating and documenting the design and operating effectiveness of our internal control over financial reporting.
- In 2022, we hired a Vice President of Financial Reporting and Technical Accounting and a Chief Accounting Officer, both with technical public company accounting and financial reporting experience.
- We enhanced access to accounting training, literature, research materials and documents for our finance and accounting departments.
- During the second and third quarters of 2023, we performed a financial statement risk assessment and identified areas where new key controls are needed, or existing controls needed to be enhanced.
- During the second and third quarters of 2023, we designed and implemented controls to address the entity level and financial reporting risks identified, including those involving accounting for complex transactions, including financial instruments and contingent earnout liabilities.
- During the second and third quarters of 2023, together with our external advisor, we designed a formal testing program to evaluate the design and operating effectiveness of key controls and began executing on the formal testing program.
- During the third and fourth quarters of 2023, our external advisor performed key control testing consistent with our formal testing program.

Although we have implemented and tested controls as of December 31, 2023, the controls have not been in place and operating effectively for a sufficient period to evaluate if the material weaknesses have been remediated. We believe we are making progress toward achieving the effectiveness of our internal control over financial reporting and disclosure controls and procedures. The actions that we are taking are subject to ongoing senior management review, as well as Audit Committee oversight. We may also conclude that

additional measures may be required to remediate the material weaknesses in our internal control over financial reporting, which may necessitate additional changes to the design and implementation of controls.

We cannot assure you that the measures we have taken to date and may take in the future, will be sufficient to remediate the control deficiencies that led to our material weaknesses in internal control over financial reporting or that they will prevent or avoid potential future material weaknesses. The effectiveness of our internal control over financial reporting is subject to various inherent limitations, including cost limitations, judgments used in decision making, assumptions about the likelihood of future events, the possibility of human error and the risk of fraud. Any failure to design or maintain effective internal controls over financial reporting or any difficulties encountered in their implementation or improvement could increase compliance costs, negatively impact share trading prices, or otherwise harm our operating results or cause us to fail to meet our reporting obligations.

***We may face litigation and other risks as a result of the material weaknesses in our internal control over financial reporting.***

As a result of the material weaknesses identified in our internal control over financial reporting and the restatement of certain of our financial statements, we face the potential for litigation or other disputes which may include, among others, claims invoking the federal and state securities laws, contractual claims or other claims arising from the restatement of our financial statements, material weaknesses in our internal control over financial reporting, and the preparation of our financial statements. As of the date of this Annual Report, we have no knowledge of any such litigation or dispute resulting from the material weaknesses in our internal control over financial reporting. However, we can provide no assurance that litigation or disputes will not arise in the future. Any such litigation or dispute, whether successful or not, could have a material adverse effect on our business, results of operations and financial condition.

***Our stock price has in the past and may in the future fail to meet minimum requirements for continued listing on the Nasdaq Global Select Market. Our ability to publicly or privately sell equity securities and the liquidity of our Class A Common Stock could be adversely affected if we are delisted from the Nasdaq Global Select Market or if we are unable to transfer our listing to another stock market.***

In the past we have received written notification from the Nasdaq Stock Market (“Nasdaq”), informing us that we were not in compliance with certain continued listing requirements of the Nasdaq Global Select Market. As previously disclosed, on January 5, 2024, we received a written notice from the Listing Qualifications Department of Nasdaq notifying us that, based on the closing bid price of our Common Stock for 33 consecutive business days, the Company no longer complied with the minimum bid price requirement for continued listing on The Nasdaq Global Select Market. Nasdaq Listing Rule 5450(a)(1) requires listed securities to maintain a minimum bid price of \$1.00 per share (the “Minimum Bid Price Requirement”), and Nasdaq Listing Rule 5810(c)(3)(A) provides that a failure to meet the Minimum Bid Price Requirement exists if the deficiency continues for a period of 30 consecutive business days.

We completed a 1-for-30 reverse stock split on Class A Common Stock on January 31, 2024. On February 15, 2024, we received a letter from Nasdaq notifying us that we had regained compliance with the Minimum Bid Price Requirement and have remained in compliance.

There can be no assurance that we will continue to maintain compliance with the requirements for listing our Class A Common Stock on Nasdaq. Any potential delisting of our common stock from the Nasdaq Global Select Market would likely result in decreased liquidity and increased volatility for our Class A Common Stock and would adversely affect our ability to raise additional capital or to enter into strategic transactions. Any potential delisting of our Class A Common Stock from the Nasdaq Global Select Market would also make it more difficult for our stockholders to sell our Class A Common Stock in the public market.

***A market for our securities may not continue, which would adversely affect the liquidity and price of our securities.***

The prices of our securities vary due to general economic conditions and forecasts, its general business condition and the release of its financial reports, and an active trading market for our securities is not guaranteed to continue to exist. If our securities become delisted from Nasdaq for any reason, and are quoted on the OTC Bulletin Board, an inter-dealer automated quotation system for equity securities that is not a national securities exchange, the liquidity and price of our securities may be more limited than if they were quoted or listed on Nasdaq or another national securities exchange. You may be unable to sell your securities unless a market for such securities can be sustained.

***We effected a reverse stock split on January 31, 2024 which may adversely impact the market price of our Class A Common Stock.***

We effected a reverse stock split of our outstanding Class A Common Stock at a ratio of 1-for-30 shares, which was effected at 11:59 p.m. Eastern Time on January 31, 2024. The effect of the Reverse Split upon the market price of our Class A Common Stock cannot be predicted with certainty and there is no assurance that our Class A Common Stock will trade at a price consistent with such Reverse Split. Accordingly, it is possible that the market price of our Class A Common Stock following the Reverse Split will decline, possibly more than would occur in the absence of a Reverse Split.

***Our quarterly operating results may fluctuate significantly and could fall below the expectations of securities analysts and investors due to seasonality and other factors, some of which are beyond our control, resulting in a decline in our stock price.***

Our quarterly operating results may fluctuate significantly because of several factors, including:

- labor availability and costs for hourly and management personnel;
- changes in interest rates;
- impairment of long-lived assets;
- macroeconomic conditions, both nationally and locally;
- extreme volatility in the global capital markets;
- national and global political unrest and instability;
- negative publicity relating to our services;
- changes in consumer preferences and competitive conditions;
- expansion to new markets; and
- fluctuations in commodity prices.

Any fluctuation in our operating results, especially if below the expectations of securities analysts, may result in a decline in our stock price, whether or not due to seasonality or other factors, some of which are beyond our control, and could adversely affect the market price of our securities. Any reduction in the market price of our securities could make it more difficult for us to raise additional funds through future offerings of shares of Class A Common Stock or other securities.

***If securities or industry analysts do not publish or cease publishing research or reports about us, our business, or our market, or if they change their recommendations regarding our securities adversely, then the price and trading volume of our securities could decline.***

The trading market for our securities is influenced by the research and reports that industry or securities analysts may publish about us, our business, our market, or our competitors. If securities or industry analysts cease coverage or commence negative coverage of us, our stock price and trading volume could be negatively impacted. If any of the analysts who may cover us change their recommendation regarding our securities adversely, or provide more favorable recommendations regarding our competitors than us, the price of our securities may decline. If any analyst who may cover us were to cease coverage of us or fail to regularly publish reports on us, we could lose visibility in the financial markets, which could cause the prices or trading volume of our securities to decline.

***The issuance of equity securities in connection with the Steward Acquisition has resulted, and may in the future result, in dilution to our stockholders and may adversely affect us, including the market price of our securities.***

We issued 783,333 shares of Class A Common Stock in connection with the closing of the Steward Acquisition, representing approximately 21% of our Class A Common Stock issued and outstanding as of the closing date, which resulted in a significant, immediate dilution to our stockholders. Additionally, upon the issuance of any shares earned pursuant to the earnout in the Steward Acquisition (the "Steward Earnout Shares"), there will be significant additional dilution to the Company's stockholders, and even in the event that the Steward Earnout Shares are not issued, the potential for the issuance of the Steward Earnout Shares may negatively affect the trading price of our securities in anticipation of such dilution. Additionally, the dilution caused by the shares issued in connection with the Steward Acquisition could, among other things, limit the ability of our current stockholders to influence management of the Company.

Sales of a substantial number of the shares issued in connection with the Steward Acquisition in the public market, or the perception that such sales may occur, could adversely affect the market price of our securities.

***Our Warrants are exercisable for our Class A Common Stock and we have outstanding contingent earnout consideration, which could increase the number of shares eligible for future resale in the public market and result in dilution to our stockholders.***

We issued public warrants to purchase 95,833 shares of Class A Common Stock as part of our Initial Public Offering (the "IPO") and concurrently with our IPO, we issued 97,222 warrants in a private placement, each of which entitles the holder to purchase one thirtieth (1/30th) of one share of Class A Common Stock at \$345.00 per whole share. Also, as it relates to the Steward Acquisition, we estimate

that 1.3 million shares of Class A Common Stock will become issuable if certain performance thresholds are met by the Steward Value-Based Care business. There can be no assurance that all of, or any of the warrants will be exercised, or that the Steward Earnout Shares will be issued, but shares of Class A Common Stock, which may be issued upon exercise of our warrants and/or the achievement of performance thresholds by the Steward Value-Based Care business, will result in dilution to the then existing holders of our Class A Common Stock and increase the number of shares eligible for resale in the public market. Sales of substantial numbers of shares in the public market could adversely affect the market price of our Class A Common Stock.

***Future issuances of debt securities and equity securities may adversely affect us, including the market price of our securities and may be dilutive to existing stockholders.***

We have authorized up to 1,000,000 shares of preferred stock. In the future, we may incur debt or issue equity ranking senior to the Class A Common Stock. Those securities will generally have priority upon liquidation. Such securities also may be governed by an indenture or other instrument containing covenants restricting its operating flexibility. Additionally, any convertible or exchangeable securities that we issue in the future may have rights, preferences and privileges more favorable than those of the Class A Common Stock. Because our decision to issue debt or equity in the future will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing, nature or success of our future capital raising efforts. As a result, future capital raising efforts may reduce the market price of Class A Common Stock and be dilutive to existing stockholders.

Additionally, as of December 31, 2023, we had approximately 0.2 million shares of Class A Common Stock available for issuance pursuant to the CareMax, Inc. 2021 Long-Term Incentive Award Plan (the “2021 Plan”). Historical and future awards under the 2021 Plan may reduce the market price of Class A Common Stock and be dilutive to existing stockholders.

***Anti-takeover provisions contained in the Amended and Restated Charter, as well as provisions of Delaware law, could impair a takeover attempt.***

Our third amended and restated certificate of incorporation (the “Amended and Restated Charter”) contains provisions that may discourage unsolicited takeover proposals that stockholders may consider to be in their best interests. For instance, the Amended and Restated Charter authorizes 1,000,000 shares of preferred stock and provides that shares of preferred stock may be issued from time to time in one or more series and the Board will be authorized to fix the voting rights, if any, designations, powers, preferences, the relative, participating, optional or other special rights and any qualifications, limitations and restrictions thereof, applicable to the shares of each series. The Board will be able to, without stockholder approval, issue shares of preferred stock with voting and other rights that could adversely affect the voting power and other rights of the holders of the common stock and could have anti-takeover effects. The ability of the Board to issue shares of preferred stock without stockholder approval could have the effect of delaying, deferring or preventing a change of control of or the removal of existing management.

We are also subject to anti-takeover provisions under Delaware law, including Section 203 of the General Corporation Law of the State of Delaware (the “DGCL”) regulating corporate takeovers. This statute prevents certain Delaware corporations, under certain circumstances, from engaging in a “business combination” with:

- a stockholder who owns 15% or more of our outstanding voting stock (otherwise known as an “Interested Stockholder”);
- an affiliate of an Interested Stockholder; or
- an associate of an Interested Stockholder, for three years following the date that the stockholder became an Interested Stockholder.

A “business combination” includes a merger or sale of more than 10% of our assets. However, the above provisions of Section 203 do not apply if:

- the Board approves the transaction that made the stockholder an Interested Stockholder prior to the date of the transaction;
- after the completion of the transaction that resulted in the stockholder becoming an Interested Stockholder, that stockholder owned at least 85% of our voting stock outstanding at the time the transaction commenced, other than statutorily excluded shares of common stock; or
- on or subsequent to the date of the transaction, the initial business combination is approved by the Board and authorized at a meeting of our stockholders, and not by written consent, by an affirmative vote of at least two-thirds of the outstanding voting stock not owned by the Interested Stockholder.

Together these provisions may make more difficult the removal of management and may discourage transactions that otherwise could involve payment of a premium over prevailing market prices for our securities.

***Our Amended and Restated Charter includes a forum selection clause, which could discourage claims or limit stockholders' ability to make a claim against us, our directors, officers, other employees or stockholders.***

Our Amended and Restated Charter includes a forum selection clause that provides, unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware shall be the sole and exclusive forum for any stockholder (including a beneficial owner) to bring any: (i) derivative action or proceeding brought on behalf of us; (ii) action asserting a claim of breach of fiduciary duty owed by any of our directors, officers or other employees to us or our stockholders; (iii) action asserting a claim against us, our directors, officers or employees arising pursuant to any provision of the DGCL, our Amended and Restated Charter or Amended and Restated Bylaws; or (iv) action asserting a claim against us, our directors, officers or employees governed by the internal affairs doctrine, and if brought outside of Delaware, the stockholder bringing the suit will be deemed to have consented to service of process on such stockholder's counsel, except for, as to each of (i) through (iv) above, any claim (A) as to which the Court of Chancery determines that there is an indispensable party not subject to the jurisdiction of the Court of Chancery (and the indispensable party does not consent to the personal jurisdiction of the Court of Chancery within ten days following the determination), (B) that is vested in the exclusive jurisdiction of a court or forum other than the Court of Chancery, (C) for which the Court of Chancery does not have subject matter jurisdiction, or (D) any action arising under the Securities Act of 1933, as amended (the "Securities Act") as to which the Court of Chancery and the federal district court for the District of Delaware shall have concurrent jurisdiction.

Under the Securities Act, federal and state courts have concurrent jurisdiction over all suits brought to enforce any duty or liability created by the Securities Act, and stockholders cannot waive compliance with the federal securities laws and the rules and regulations thereunder. Accordingly, there is uncertainty as to whether a court would enforce such a forum selection provision as written in connection with claims arising under the Securities Act.

This forum selection clause may also discourage claims or limit stockholders' ability to submit claims in a judicial forum that they find favorable and may result in additional costs for a stockholder seeking to bring a claim. While we believe the risk of a court declining to enforce this forum selection clause is low, if a court were to determine the forum selection clause to be inapplicable or unenforceable in an action, we may incur additional costs in conjunction with our efforts to resolve the dispute in an alternative jurisdiction, which could have a negative impact on our results of operations and financial condition.

Notwithstanding the foregoing, the forum selection clause will not apply to suits brought to enforce any liability or duty created by the Securities Exchange Act of 1934, as amended (the "Exchange Act") or any other claim for which the federal district courts of the United States of America have exclusive jurisdiction. Section 27 of the Exchange Act creates exclusive federal jurisdiction over all suits brought to enforce any duty or liability created by the Exchange Act or the rules and regulations thereunder.

***We are an emerging growth company within the meaning of the Securities Act, and if we take advantage of certain exemptions from disclosure requirements available to emerging growth companies, this could make our securities less attractive to investors and may make it more difficult to compare our performance with other public companies.***

We are an "emerging growth company" within the meaning of the Securities Act, as modified by the JOBS Act, and we may take advantage of certain exemptions from various reporting requirements that are applicable to other public companies that are not emerging growth companies including, but not limited to, not being required to comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act, reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements, and exemptions from the requirements of holding a nonbinding advisory vote on executive compensation and stockholder approval of any golden parachute payments not previously approved. As a result, our stockholders may not have access to certain information they may deem important. We could be an emerging growth company for up to five years after our IPO, although circumstances could cause us to lose that status earlier, including if the market value of our common stock held by non-affiliates exceeds \$700.0 million as of the last business day of our most recently completed second fiscal quarter, in which case we would no longer be an emerging growth company as of the following December 31. We cannot predict whether investors will find our securities less attractive because we will rely on these exemptions. If some investors find our securities less attractive as a result of our reliance on these exemptions, the trading prices of our securities may be lower than they otherwise would be, there may be a less active trading market for our securities and the trading prices of our securities may be more volatile.

Further, Section 102(b)(1) of the JOBS Act exempts emerging growth companies from being required to comply with new or revised financial accounting standards until private companies (that is, those that have not had a Securities Act registration statement declared effective or do not have a class of securities registered under the Exchange Act) are required to comply with the new or revised financial accounting standards. The JOBS Act provides that a company can elect to opt out of the extended transition period and comply with the requirements that apply to non-emerging growth companies but any election to opt out is irrevocable. We have elected not to opt out of the extended transition period which means that when a standard is issued or revised and it has different application dates for public or private companies, we, as an emerging growth company, can adopt the new or revised standard at the time private companies adopt the new or revised standard. This may make comparison of our financial statements with another public company which is neither an

emerging growth company nor an emerging growth company which has opted out of using the extended transition period difficult or impossible because of the potential differences in accountant standards used.

Additionally, we are a “smaller reporting company” as defined in Item 10(f)(1) of Regulation S-K. Smaller reporting companies may take advantage of certain reduced disclosure obligations, including, among other things, providing only two years of audited financial statements. We will remain a smaller reporting company until the last day of the fiscal year in which (1) the market value of our common stock held by non-affiliates equaled or exceeded \$250.0 million as of the end of the prior June 30th, and (2) our annual revenues equaled or exceeded \$100.0 million during such completed fiscal year or the market value of our common stock held by non-affiliates equaled or exceeded \$700.0 million as of the prior June 30th. To the extent we take advantage of such reduced disclosure obligations, it may also make comparison of our financial statements with other public companies difficult or impossible.

***The accounting treatment of our warrants and contingent earnout liabilities could have a material impact on, and could significantly increase the volatility of, our reported operating results, even though there is no related liquidity, cash flow or revenue impact to us.***

Because our outstanding warrants and contingent earnout consideration are classified as liabilities, we are required to “mark to market” these liabilities as of the end of each reporting period and record changes in their fair value in our financial statements. As such, when our stock price increases, the fair value of the warrant and contingent earnout liabilities would increase, and we would be required to recognize an expense associated with this change in fair value. Similarly, when our stock price decreases, the fair value of the warrant and contingent earnout liabilities would decrease, and we would be required to recognize a gain associated with this change in fair value. This accounting treatment could have a material impact on, and could significantly increase the volatility of, our reported operating results, even though there is no related liquidity, cash flow or revenue impact to us.

***Unanticipated changes in effective tax rates or adverse outcomes resulting from examination of our income or other tax returns could adversely affect our financial condition and results of operations.***

We will be subject to income taxes in the United States, and our domestic tax liabilities will be subject to the allocation of expenses in differing jurisdictions. Our future effective tax rates could be subject to volatility or adversely affected by a number of factors, including:

- changes in the valuation of our deferred tax assets and liabilities;
- expected timing and amount of the release of any tax valuation allowances;
- tax effects of stock-based compensation;
- costs related to intercompany restructurings;
- changes in tax laws, regulations or interpretations thereof; and
- lower than anticipated future earnings in jurisdictions where we have lower statutory tax rates and higher than anticipated future earnings in jurisdictions where we have higher statutory tax rates.

In addition, we may be subject to audits of our income, sales and other transaction taxes by U.S. federal and state authorities. Outcomes from these audits could adversely affect our financial condition and results of operations.

***We do not intend to pay dividends for the foreseeable future.***

We have never declared or paid any cash dividends on our capital stock and do not intend to pay any cash dividends in the foreseeable future. We expect to retain future earnings, if any, to fund the development and growth of our business. Any future determination to pay dividends on our capital stock will be at the discretion of our Board and subject to any covenants that may apply in respect of outstanding debt, including, but not limited to, the restrictive covenants in connection with the Credit Agreement. Accordingly, investors must rely on sales of our securities after price appreciation, which may never occur, as the only way to realize any future gains on their investments.

## **General Risk Factors**

***Disruptions in our disaster recovery systems or management continuity planning could limit our ability to operate our business effectively.***

Our information technology systems facilitate our ability to conduct our business. While we have disaster recovery systems and business continuity plans in place, any disruptions in our disaster recovery systems or the failure of these systems to operate as expected could, depending on the magnitude of the problem, adversely affect our operating results by limiting our capacity to effectively monitor and control our operations. Despite our implementation of a variety of security measures, our information technology systems could be subject to physical or electronic break-ins, and similar disruptions from unauthorized tampering or any weather-related disruptions

where our headquarters are located. In addition, in the event that a significant number of our management personnel were unavailable in the event of a disaster, our ability to effectively conduct business could be adversely affected.

***Our use of “open source” software could adversely affect our ability to offer our services and subject us to possible litigation.***

We may use open source software in connection with our services. Companies that incorporate open source software into their technologies have, from time to time, faced claims challenging the use of open source software and/or compliance with open source license terms. As a result, we could be subject to suits by parties claiming ownership of what we believe to be open source software or claiming noncompliance with open source licensing terms. Some open source software licenses require users who distribute software containing open source software to publicly disclose all or part of the source code to such software and/or make available any derivative works of the open source code, which could include valuable proprietary code of the user, on unfavorable terms or at no cost. While we monitor the use of open source software and try to ensure that none is used in a manner that would require us to disclose our internally developed source code or that would otherwise breach the terms of an open source agreement, such use could inadvertently occur, in part because open source license terms are often ambiguous. Any requirement to disclose our internally developed source code or pay damages for breach of contract could have a material adverse effect on our business, financial condition and results of operations and could help our competitors develop services that are similar to or better than ours.

***Changes in laws, regulations or rules, or a failure to comply with any laws, regulations or rules, may adversely affect our business.***

We are subject to laws, regulations and rules enacted by national, regional and local governments and Nasdaq. In particular, we are required to comply with certain SEC, Nasdaq and other legal or regulatory requirements. Compliance with, and monitoring of, applicable laws, regulations and rules may be difficult, time consuming and costly. Those laws, regulations or rules and their interpretation and application may also change from time to time and those changes could adversely affect our business, investments and results of operations. In addition, a failure to comply with applicable laws, regulations or rules, as interpreted and applied, could adversely affect our business and results of operations.

A recent ruling by the Court of Chancery in Delaware introduced uncertainty as to whether Section 242(b)(2) of the Delaware General Corporation Law (the “DGCL”) required a separate vote in favor of at least a majority of the outstanding shares of Class A Common Stock, in addition to a vote in favor of at least a majority of the outstanding shares of Class A and Class B common stock, \$0.0001 par value per share (“Class B Common Stock”), voting together as a single class, to properly authorize an increase in the aggregate number of authorized shares of such Class A Common Stock. At a special meeting of the stockholders of the Company held on June 4, 2021, a majority of the then-outstanding shares of the Company’s Class A Common Stock and Class B Common Stock, voting together as a single class, voted to approve the Company’s Third Amended and Restated Certificate of Incorporation, which, among other things, increased the total number of authorized shares of all classes of capital stock (the “Charter Amendment”). Notwithstanding the fact that the proxy statement relating to the special meeting of stockholders did not disclose that a separate vote of the Class A Common Stock was required, a majority of the then-outstanding shares of Class A Common Stock voted in favor of the 2021 Charter Amendment. Accordingly, we do not believe that the Delaware ruling applies to us. However, if the Court of Chancery in Delaware were to determine that this ruling does apply to us, this or any other failure to comply with applicable laws, regulations or rules, as interpreted and applied, could have a material adverse effect on our business and results of operations and, with respect to the 2021 Charter Amendment, require us to seek relief with the Delaware Court of Chancery.

**Item 1B. Unresolved Staff Comments**

None.

**Item 1C. Cybersecurity**

***Cyber Risk Management and Strategy***

We have a process in place for assessing, identifying, and managing material risks from cybersecurity threats. This process is integrated into the Company’s overall risk management framework, as overseen by the Company’s Board of Directors.

We design and assess our program based on various cybersecurity frameworks, such as the National Institute of Standards & Technology. Our process includes overseeing and identifying risks from cybersecurity threats associated with the use of third-party service providers. The Company conducts security assessments of third-party providers before engagement and has established monitoring procedures in its effort to mitigate risks related to data breaches or other security incidents originating from third parties. The Company from time to time engages third-party consultants and legal advisors in evaluating and testing the Company’s risk management framework and assessing and remediating certain potential cybersecurity incidents as appropriate.

For information regarding cybersecurity risks that may materially affect our Company, see “Risk Factors — Risks Related to Our Business and Industry — We are dependent on information technology and our systems and infrastructure face certain risks, including from cybersecurity breaches and data leakage — and — Security breaches, loss of data and other disruptions could compromise sensitive information related to our business or our patients or prevent us from accessing critical information and expose us to liability, which could adversely affect our business and our reputation.” To date we have not identified any breaches from known cybersecurity threats, including as a result of any prior cybersecurity incidents, that have materially affected or are reasonably likely to materially affect us, including our business strategy, results of operations, or financial condition.

Given the increasing cybersecurity threats in the healthcare industry, there can be no assurance we will not experience business interruptions; data loss, ransom, misappropriation or corruption, theft, or misuse of proprietary data, patient or other personally identifiable information; or litigation, investigation, or regulatory action related to any of those, any of which could have a material adverse effect on our patient care, ability to admit patients and to bill and collect for services provided on a timely basis, financial position, and results of operations and could harm our business reputation. Accordingly, no matter how well our program is designed or implemented, we will not be able to anticipate all security breaches, and we may not be able to implement effective preventive measures against such security breaches in a timely manner.

### ***Governance Related to Cybersecurity Risks***

Management is responsible for the day-to-day management of cybersecurity risks we face, while our Board of Directors has responsibility for the oversight of risk management. The Audit Committee of our Board of Directors oversees the management of our risks from cybersecurity threats. In addition, the Board of Directors discusses with management our major risk exposures, their potential impact on us, and the steps we take to manage them.

Our Vice President of Information Technology is responsible for developing, implementing, and maintaining our cybersecurity risk management policies and procedures. The Vice President of Information Technology has over twenty years of information technology management experience. The Vice President of Information Technology and his team hold regular meetings focused on prevention and detection of cybersecurity threats, business continuity and identity protection.

The Vice President of Information Technology reports to our Chief Digital Officer and provides semi-annual cybersecurity updates to the Audit Committee of our Board of Directors. In the event of the detection of an actual or suspected cybersecurity incident, a designated management committee is engaged to investigate the incident, manage response, and report the incident to securities counsel to assist with assessment of materiality. A member of the executive team would inform our Board of Directors as warranted.

### **Item 2. Properties**

Our principal executive offices are located in Miami, Florida, where we occupy facilities totaling approximately 21,100 square feet under a lease that expires in April 2028.

We currently lease or license all of our centers, and as of December 31, 2023, we leased approximately 600,000 gross square feet relating to 56 centers located in Florida, New York, Tennessee and Texas. Our leases are typically on terms ranging from 10 to 20 years. Each of our lease or license agreements provides that the lessor may terminate the lease, subject to applicable cure provisions, for a number of reasons, including the defaults in any payment of rent, taxes or other payment obligations or the breach of any financial covenants or restrictions related to our business, or other covenants in the lease. Termination of certain of our lease agreements could result in a cross-default under our debt agreements or other lease agreements. If a lease agreement is terminated, there can be no assurance that we will be able to enter into a new lease agreement on similar or better terms or at all.

Our lease obligations often include annual fixed rent escalators ranging between 2% and 3% or variable rent escalators based on a consumer price index. These escalators could impact our ability to satisfy certain obligations and financial covenants. If the results of our operations do not increase at or above the escalator rates, it would place an additional burden on our results of operations, liquidity and financial position.

We believe that our facilities are adequate to meet our needs for the immediate future, and that, should it be needed, suitable additional space will be available to accommodate any such expansion of our operations.

In March 2024, we failed to make rent payments due pursuant to certain leases on centers that we generally do not intend to operate. See Risk Factors – “We lease all of our facilities and may experience risks relating to lease termination, lease expense escalators, lease extensions, special charges and our inability to comply with provisions of our lease agreements.”

### **Item 3. Legal Proceedings**

The Company is involved in various legal proceedings and subject to claims that arise in the ordinary course of business. Although the results of litigation and claims are inherently unpredictable and uncertain, we are not currently a party to any legal proceedings the outcome of which, if determined adversely to us, are believed to, either individually or taken together, have a material adverse effect on our business, operating results, cash flows or financial condition. Regardless of the outcome, litigation has the potential to have an adverse impact on our financials, because of defense and settlement costs, diversion of management resources, and other factors.

**Item 4. Mine Safety Disclosures**

None.

**PART II**

**Item 5. Market for Registrant’s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.**

**Market Information**

Our Class A Common Stock and Public warrants are listed on the Nasdaq Global Select Market under the symbol “CMAX” and “CMAXW”, respectively.

**Holders**

As of March 11, 2024, there were 71 record holders of our Class A Common Stock. In addition to holders of record of our Class A Common Stock we believe there is a substantially greater number of “street name” holders or beneficial holders whose Class A Common Stock is held of record by banks, brokers and other financial institutions.

**Dividends**

We have not paid any cash dividends on the Class A Common Stock to date and do not intend to pay any cash dividends in the foreseeable future. The payment of cash dividends in the future will be dependent upon our revenue and earnings, if any, capital requirements, liabilities and related reserves, and general financial condition. The payment of any cash dividends will be within the discretion of our Board of Directors from time to time and subject to applicable Delaware law. It is our present intention to retain all earnings, if any, for use in business operations and, accordingly, the Board does not anticipate declaring any dividends in the foreseeable future. Further, our ability to declare dividends is currently limited by restrictive covenants in connection with the Credit Agreement.

**Unregistered Sales of Equity Securities**

None.

**Item 6. Reserved**

None.

## **Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations.**

*Unless the context otherwise requires, references in this section to “CareMax,” “we,” “us,” “our,” and the “Company” refer to CareMax, Inc. together with its consolidated subsidiaries. The following discussion and analysis summarizes the significant factors affecting the consolidated operating results, financial condition, liquidity, capital resources and cash flows of our company as of and for the periods presented below. The following discussion and analysis should be read in conjunction with our consolidated financial statements and the related notes thereto included elsewhere in this Annual Report on Form 10-K.*

### **Our Business**

As of December 31, 2023, CareMax operated 56 centers in Florida, New York, Tennessee, and Texas. CareMax offers a comprehensive range of medical services, including primary and preventative care, specialist services, diagnostic testing, chronic disease management and dental and optometry services under global capitation contracts.

CareMax’s comprehensive, high touch approach to health care delivery is powered by its CareOptimize technology platform. CareOptimize is a purpose built end-to-end technology platform that aggregates data and analyzes that data using proprietary algorithms and machine learning to support more informed care delivery decisions and to focus care decisions on preventative chronic disease management and the social determinants of health. CareMax believes that CareOptimize is designed to drive better outcomes and lower costs. CareMax has shifted from selling the CareOptimize platform to new outside customers for a software subscription fee and is instead focused on providing the software to affiliated practices of its MSO to further improve financial, clinical and quality outcomes from the affiliated providers.

CareMax’s centers offer 24/7 access to care through employed providers and provide a comprehensive suite of high-touch health care and social services to its patients, including primary care, specialty care, telemedicine, health & wellness, optometry, dental, pharmacy and transportation. CareMax’s differentiated healthcare delivery model is focused on care coordination with vertically integrated ambulatory care and community-centric services. The goal of CareMax is to intercede as early as possible to manage chronic conditions for its patient members in a proactive, holistic, and tailored manner to provide a positive influence on patient outcomes and a reduction in overall healthcare costs. CareMax focuses on providing access to high quality care in underserved communities.

While CareMax’s primary focus is providing care to Medicare eligible seniors who are mostly over the age of 65 (approximately 78% and 77% of revenue for the years ended December 31, 2023 and 2022, respectively, came from these patients), we also provide services to children and adults through Medicaid programs as well as through commercial insurance plans. Substantially all of the Medicare patients cared for in CareMax’s centers are enrolled in MA plans which are run by private insurance companies and are approved by and under contract with Medicare. With MA, patients get all of the same coverage as original Medicare, including emergency care, and most plans also include prescription drug coverage. In many cases, MA plans offer more benefits than original Medicare, including dental, vision, hearing and wellness programs. We contract with nearly all national and most regional, local MA plans.

In addition to MA contracts, through our MSO we service other Medicare patients through a variety of value-based contracts, such as MSSP and ACO REACH.

### **Reverse Stock Split**

We completed our 1-for-30 Reverse Split that became effective on January 31, 2024. As a result of the Reverse Split, every thirty shares of Class A Common Stock issued and outstanding as of the Effective Date automatically converted into one share of Class A Common Stock. No fractional shares were issued in connection with the Reverse Split. In lieu of issuing fractional shares, stockholders of record who otherwise would have been entitled to receive fractional shares were entitled to rounding up of the fractional share to the nearest whole number. The Reverse Split automatically and proportionately adjusted, based on a 1-for-30 reverse split ratio, all issued and outstanding shares of the Company’s Class A Common Stock, as well as the terms of warrants and other derivative securities outstanding at the time of the effectiveness of the Reverse Split. Proportionate adjustments were made to the per share exercise price and the number of shares issuable upon the exercise of all outstanding stock options and warrants to purchase shares of Class A Common Stock. There was no change in the par value of our common stock or preferred stock.

References to numbers of shares of Class A Common Stock and per share data in the foregoing discussion for periods ended prior to January 31, 2024, including the accompanying financial statements and notes to the financial statements have been adjusted to reflect the Reverse Split on a retroactive basis for all periods presented.

### **Comparability of Financial Results**

In May 2022, the Company entered into a credit agreement (the “Credit Agreement”) that provided for an aggregate of up to \$300.0 million in term loans, comprised of (i) initial term loans in aggregate principal amount of \$190.0 million (the “Initial Term Loans”) and (ii) a delayed term loan facility in the aggregate principal amount of \$110.0 million (the “Delayed Draw Term Loans” or “DDTL”). In May 2022, the Company drew \$190.0 million of the Initial Term Loans and used approximately \$121.0 million of the net proceeds from this borrowing to repay its outstanding obligations under the credit agreement dated June 8, 2021, as amended (the “Existing Credit Agreement”) and recognized related debt extinguishment losses of \$6.2 million.

On March 8, 2023 (the “Amendment Closing Date”), the Company entered into a Second Amendment (the “Second Amendment”) to the Credit Agreement. See “Management’s Discussion and Analysis of Financial Condition and Results of Operations --Credit Facilities – Credit Agreement” below for more information.

During the years ended December 31, 2023 and 2022, the Company drew \$125.0 million and \$45.0 million of the Delayed Draw Term Loans, respectively. We expect a material increase in interest expense as a result of increased debt balances and higher interest rates.

In November 2022, we completed the Steward Acquisition. The Steward Acquisition was accounted for as a business combination. Accordingly, assets acquired, including separately identifiable intangible assets, were recorded at their fair value. The Steward Acquisition drove, among other things, an increase of \$80.4 million in amortizable intangible assets and \$304.2 million in goodwill on our balance sheet as of December 31, 2022. As a result of the Steward Acquisition, in 2023 there was a material increase in revenue, external provider costs and cost of care expenses, and an increase in noncash amortization of acquired intangibles.

In November 2022, the Company entered into a Loan and Security Agreement for a Term Loan in the aggregate principal amount of \$35.5 million (the “Term Loan”). The Company used the proceeds of the Term Loan to fund the Financed Net Pre-Closing Medicare AR acquired in connection with the Steward Acquisition. The Term Loan bore interest at 12.0% per annum. In addition, the Borrowers paid a facility fee equal to 3.0% of the aggregate principal amount of the Term Loan. Any additional interest (if applicable) accrued and owing during the term of the Loan and Security Agreement was paid in kind and capitalized to principal monthly in arrears. In October 2023, the Company paid off all outstanding indebtedness of \$35.5 million due under the Loan and Security Agreement with the proceeds of the MSSP payment from the federal government, and the Loan and Security Agreement was terminated.

Our results of operations include the results of Steward Value-Based Care from November 10, 2022 through December 31, 2022 and full year results of Steward Value-Based Care for the year ended December 31, 2023. Accordingly, our consolidated results of operations for the year ended December 31, 2023 are not comparable to our consolidated results of operations for prior periods and may not be comparable with our consolidated results of operations for future periods.

## Key Factors Affecting Our Performance

### Our Patients

As discussed above, the Company partners with Medicare, Medicaid, and commercial insurance plans. While CareMax currently services mostly Medicare patients, we also accept Medicare fee-for-service patients. The chart below shows a breakdown of membership as of the dates indicated.

| Patient Count as of*    | Dec 31, 2021 | Mar 31, 2022 | Jun 30, 2022 | Sep 30, 2022 | Dec 31, 2022 | Mar 31, 2023 | Jun 30, 2023 | Sep 30, 2023 | Dec 31, 2023 |
|-------------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Medicare Advantage      | 33,500       | 34,000       | 37,000       | 39,500       | 93,500       | 95,500       | 102,500      | 107,000      | 111,500      |
| Medicare Government VBC | —            | —            | —            | —            | 109,500      | 107,000      | 101,000      | 99,500       | 97,500       |
| Medicaid                | 28,000       | 28,500       | 29,500       | 31,500       | 33,500       | 33,500       | 30,500       | 28,500       | 25,500       |
| Commercial              | 21,500       | 21,500       | 21,500       | 22,000       | 22,000       | 34,500       | 38,500       | 38,000       | 36,000       |
| Total Count             | 83,500       | 84,000       | 88,000       | 93,000       | 258,500      | 271,000      | 272,500      | 273,000      | 270,000      |

\*Figures may not sum due to rounding

Because CareMax accepts multiple insurance types, it uses a Medicare-Equivalent Member (“MCREM”) value in reviewing key factors of its performance. To determine the Medicare-Equivalent, CareMax estimates the amount of support typically received by one Medicare patient as equivalent to the level of support received by three Medicaid or Commercial patients. This is due to Medicare patients on average having significantly higher levels of chronic and acute conditions that need higher levels of care. Due to this dynamic, a 3:1 ratio is applied to make year over year comparisons of total membership more comparable. The breakdown of membership for MCREM is below:

| MCREM Count as of*      | Dec 31, 2021 | Mar 31, 2022 | Jun 30, 2022 | Sep 30, 2022 | Dec 31, 2022 | Mar 31, 2023 | Jun 30, 2023 | Sep 30, 2023 | Dec 31, 2023 |
|-------------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Medicare Advantage      | 33,500       | 34,000       | 37,000       | 39,500       | 93,500       | 95,500       | 102,500      | 107,000      | 111,500      |
| Medicare Government VBC | —            | —            | —            | —            | 109,500      | 107,000      | 101,000      | 99,500       | 97,500       |
| Medicaid                | 9,400        | 9,400        | 9,900        | 10,600       | 11,100       | 11,200       | 10,100       | 9,500        | 8,400        |
| Commercial              | 7,200        | 7,200        | 7,100        | 7,300        | 7,400        | 11,400       | 12,900       | 12,700       | 11,900       |
| Total Count             | 50,100       | 50,600       | 54,000       | 57,400       | 221,500      | 225,100      | 226,500      | 228,700      | 229,300      |

\*Figures may not sum due to rounding

### **Medicare Advantage Patients**

As of December 31, 2023, CareMax had approximately 111,500 MA patients of which 98% were in value-based agreements. Approximately 33% of patients in the Medicare Advantage value-based care agreements were in full-risk contracts. This means CareMax has been selected as the patient's primary care provider and is financially responsible for substantially all of the patient's medical costs, CareMax is attributed an agreed percentage of the premium the Medicare plan receives from the Centers for Medicare and Medicaid Services ("CMS") (typically a substantial majority of such premium given the risk assumed by the Company). A reconciliation is performed periodically and if premiums exceed medical costs paid by the MA plan, CareMax receives payment from the Medicare plan. If medical costs paid by the Medicare plan exceed premiums, CareMax is responsible to reimburse the Medicare plan.

### **Medicare Government Value-Based Care ("VBC") Programs**

As of December 31, 2023, CareMax had approximately 97,500 patients enrolled in Medicare Government VBC Programs, of which approximately 92% were in the MSSP and 8% were in the ACO REACH program. The MSSP is sponsored by CMS. The MSSP allows participating ACOs to receive a share of cost savings they generate in connection with the management of costs and quality of medical services rendered to Medicare beneficiaries. Payments to the ACO participants, if any, are calculated annually and paid once a year by CMS on cost savings generated by the ACO participant relative to the ACO participants' CMS benchmark. Under the MSSP, the ACO must meet certain qualifications to receive the full amount of its allocable cost savings or they either receive nothing or are responsible for shared losses. The MSSP rules require CMS to develop a benchmark for savings to be achieved by each participant if the participant is to receive shared savings. An ACO that meets the MSSP's quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below the medical expenditure benchmark provided by CMS. MSRs vary depending on the number of beneficiaries assigned to the ACO, must be achieved before the ACO can receive up to a 75% share of the savings if quality performance standards are met; the ACO is also responsible for 40% of the deficit. Once the MSR is surpassed, all the savings below the benchmark provided by CMS will be shared with the ACO.

### **Medicaid Patients**

As of December 31, 2023, CareMax had approximately 25,500 Medicaid patients of which 100% were in value-based agreements. Approximately 90% of patients in the Medicaid value-based care agreements were in full-risk contracts. Using the MCREM metric, the level of support required to manage these Medicaid patients equates to that of approximately 8,400 Medicare patients. In Florida, most Medicaid recipients are enrolled in the Statewide Medicaid Managed Care program.

Similar to the risk it takes with Medicare, CareMax is attributed an agreed percentage of the premium the Medicaid plan receives from Florida's Agency for Health Care Administration ("AHCA") (typically a substantial majority of such premium given the risk assumed by the Company). A reconciliation is performed periodically and if premiums exceed medical costs paid by the Medicaid plan, CareMax receives payment from the Medicaid plan. If medical costs paid by the Medicaid plan exceed premiums, we are responsible to reimburse the Medicaid plan.

### **Commercial Patients**

As of December 31, 2023, CareMax managed approximately 36,000 commercial patients of which 96% were under a value-based agreement that provided upside only financial incentives for quality and utilization performance. Using the MCREM metric, the level of support required to manage these commercial patients equates to that of approximately 11,900 Medicare patients.

CareMax cares for a number of commercial patients (less than 1% of the Company's total patients) for whom it is reimbursed on a fee-for-service basis via their health plan in situations where it does not have a capitation relationship with that particular health plan.

CareMax fee for-service revenue, received directly from commercial plans, on a per patient basis is typically lower than its per patient revenue for at-risk patients based in part because its fee-for-service revenue covers only the primary care services that it directly provides to the patient, while the risk revenue is intended to compensate it for the services directly performed by CareMax as well as the financial risk that it assumes related to the third-party medical expenses of at-risk patients.

### **Contracts with Payors**

Our economic model relies on its capitated partnerships with payors which manage and market Medicare plans across the United States. CareMax has established strategic value-based relationships with a number of different payors for MA patients, Medicaid patients and ACA patients. During the year ended December 31, 2023, our three largest payor relationships were Payor A, Payor C and Payor E,

which generated 23%, 21% and 15% of our revenue, respectively. During the year ended December 31, 2022 our three largest payor relationships were Payor A, Payor B, and Payor C, which generated 29%, 18% and 18% of our revenue, respectively. These existing contracts and relationships with our national partners and their understanding of the value of the CareMax model reduces the risk of entering into new markets as CareMax typically seeks to have payor contracts in place before entering a new market. Maintaining, supporting, and growing these relationships, particularly as CareMax enters new markets, are critical to our long-term success. We believe CareMax's model is well-aligned with that of its payor partners to drive better health outcomes for their patients, enhance patient satisfaction, and drive incremental patient and revenue growth. This alignment of interests helps ensure our continued success with our payor partners.

### **Effectively Manage the Cost of Care for Our Patients**

The capitated nature of our contracting with payors requires us to prudently manage the medical expense of our patients. Our external provider costs are our largest expense category, representing 41% of our total operating expenses for the year ended December 31, 2023 and 57% of our total operating expenses for the year ended December 31, 2022. Our care model focuses on leveraging the primary care setting as a means of avoiding costly downstream healthcare costs, such as acute hospital admissions. Our patients retain the freedom to seek care at emergency rooms or hospitals; we do not restrict their access to care. Therefore, we could be liable for potentially large medical claims should we not effectively manage our patients' health. We utilize stop-loss insurance for our patients, protecting us from medical claims in excess of certain levels.

### **Seasonality in our Business**

Due to the large number of dual-eligible patients (meaning eligible for both Medicare and Medicaid) we serve, the annual enrollment period does not materially affect our growth during the year. We typically see large increases in ACA patients during the first quarter as a result of the ACA annual enrollment period (October to December). However, this is not a large portion of our business.

Our operational and financial results will experience some variability depending upon the time of year in which they are measured. This variability is most notable in the following areas:

#### ***Per-Patient Revenue***

The revenue derived from our at-risk patients is a function of the percentage of premium we have negotiated with our payor partners, as well as our ability to accurately and appropriately document the acuity of a patient. We experience some seasonality with respect to our per-patient revenue, as it will generally decline over the course of the year. In January of each year, CMS revises the risk adjustment factor for each patient based upon health conditions documented in the prior year, leading to changes in per-patient revenue. As the year progresses, our per-patient revenue declines as new patients join us, typically with less complete or accurate documentation (and therefore lower risk-adjustment scores), and patient mortality disproportionately impacts our higher-risk (and therefore greater revenue) patients.

#### ***External Provider Costs***

External Provider Costs will vary seasonally depending on a number of factors, but most significantly the weather. Certain illnesses, such as the influenza virus, are far more prevalent during colder months of the year, which can result in an increase in medical expenses during these time periods. We would therefore expect to see higher levels of per-patient medical costs in the first and fourth quarters. Medical costs also depend upon the number of business days in a period. Shorter periods will have lesser medical costs due to fewer business days. Business days can also create year-over-year comparability issues if one year has a different number of business days compared to another. We would also expect to experience an impact in the future should there be another pandemic such as COVID-19, which may result in increased or decreased total medical costs depending upon the severity of the infection, the duration of the infection and the impact to the supply and availability of healthcare services for our patients.

#### ***Payor Settlements***

As it relates to our MSSP contracts, settlements from the prior year from CMS typically take place during the fourth quarter of each year, which results in variability of our accounts receivable, cash flow from operations, and cash balances throughout the year.

### **Investments in Centers**

We have invested into new de novo centers both within and outside of Florida. De novo centers require upfront capital and operating expenditures, which typically are not fully offset by revenues in the near-term, as a result of which we expect a period of unprofitability in our de novo centers before they break even. Costs we incur prior to opening of a de novo center include (1) incremental payroll costs

from employees specifically associated with the operational, contractual, physical, or regulatory infrastructure for de novo centers, prior to their opening; (2) legal costs directly associated with the de novo centers, incurred prior to their opening, which includes services such as execution of leases, health plan contracts and other agreements; (3) other expenses related to diligence, design, permitting, and other “soft costs” at new sites; and (4) rent and facility expenses prior to center opening. Once a de novo center opens, we incur post-opening losses, which consist of center-level operating losses recognized at a de novo center until the center breaks even, up to 18 months after opening. The de novo post-opening losses consist of revenue, external provider costs and cost of care allocated to the de novo center. During the years ended December 31, 2023 and 2022, we incurred de novo pre-opening costs and post-opening losses, on a combined basis, of \$23.3 million and \$13.0 million, respectively.

### **Key Business Metrics**

In addition to our financial information which conforms with generally accepted accounting principles in the United States (“GAAP”), management reviews a number of operating and financial metrics, including the following key metrics, to evaluate its business, measure its performance, identify trends affecting its business, formulate business plans, and make strategic decisions.

### **Use of Non-GAAP Financial Information**

Certain financial information and data contained in this Annual Report is unaudited and does not conform to Regulation S-X. Accordingly, such information and data may not be included in, may be adjusted in, or may be presented differently in, any periodic filing, information or proxy statement, or prospectus or registration statement to be filed by the Company with the SEC. Some of the financial information and data contained in this Annual Report, such as Adjusted EBITDA and Platform Contribution have not been prepared in accordance with GAAP. These non-GAAP measures of financial results are not GAAP measures of our financial results or liquidity and should not be considered as an alternative to net income (loss) as a measure of financial results, cash flows from operating activities as a measure of liquidity, or any other performance measure derived in accordance with GAAP. The Company believes these non-GAAP measures of financial results provide useful information to management and investors regarding certain financial and business trends relating to the Company’s financial condition and results of operations. Management uses these non-GAAP measures for trend analyses and for budgeting and planning purposes.

The Company believes that the use of these non-GAAP financial measures provides an additional tool for investors to use in evaluating projected operating results and trends in and in comparing the Company’s financial measures with other similar companies, many of which present similar non-GAAP financial measures to investors. Management does not consider these non-GAAP measures in isolation or as an alternative to financial measures determined in accordance with GAAP. The principal limitation of these non-GAAP financial measures is that they exclude significant expenses and income that are required by GAAP to be recorded in the Company’s financial statements. In addition, they are subject to inherent limitations as they reflect the exercise of judgment by management about which expense and income are excluded or included in determining these non-GAAP financial measures. In order to compensate for these limitations, management presents non-GAAP financial measures in connection with GAAP results. You should review the Company’s GAAP financial statements, which are included in this Annual Report and on our publicly-filed reports.

### **Adjusted EBITDA**

Adjusted EBITDA is defined as net income or loss before interest expense, depreciation and amortization, remeasurement of warrant and contingent earnout liabilities, goodwill impairment, stock-based compensation, loss on extinguishment of debt, acquisition and integration related costs, Business Combination integration costs, income tax benefit, and other income or expenses that are considered one-time in nature as determined by management.

Adjusted EBITDA is intended to be used as a supplemental measure of our performance that is neither required by, nor presented in accordance with GAAP. Management believes that the use of Adjusted EBITDA provides an additional tool for investors to use in evaluating ongoing operating results and trends and in comparing its financial measure with those of comparable companies, which may present similar non-GAAP financial measures to investors. However, we may incur future expenses similar to those excluded when calculating these measures. In addition, our presentations of these measures should not be construed as an inference that our future results will be unaffected by unusual or non-recurring items. Our computation of Adjusted EBITDA may not be comparable to other similarly titled measures computed by other companies, because all companies may not calculate Adjusted EBITDA in the same fashion. Due to these limitations, Adjusted EBITDA should not be considered in isolation or as a substitute for performance measures calculated in accordance with GAAP.

## Reconciliation to Adjusted EBITDA

| <i>(in thousands)</i>                                       | Years Ended December 31, |                    | Y/Y Change          |
|---|--------------------------|--------------------|---------------------|
|   | 2023                     | 2022               |                     |
| <b>Net loss</b>   | <b>\$ (683,348)</b>      | <b>\$ (37,796)</b> | <b>\$ (645,552)</b> |
| Interest expense  | 54,434                   | 20,455             | 33,979              |
| Depreciation and amortization                               | 27,787                   | 21,719             | 6,069               |
| Remeasurement of warrant and contingent earnout liabilities | (23,868)                 | (80,696)           | 56,829              |
| Goodwill impairment   | 547,200                  | 70,000             | 477,200             |
| Stock-based compensation                                    | 10,599                   | 10,271             | 327                 |
| Loss on extinguishment of debt                              | —                        | 6,172              | (6,172)             |
| Business Combination integration costs <sup>(1)</sup>       | 2,718                    | 9,015              | (6,297)             |
| Acquisition and integration related costs <sup>(2)</sup>    | 3,158                    | 20,293             | (17,135)            |
| Other <sup>(3)</sup>  | (868)                    | (759)              | (109)               |
| Income tax benefit  | (863)                    | (19,542)           | 18,678              |
| <b>Adjusted EBITDA</b>                                      | <b>\$ (63,051)</b>       | <b>\$ 19,133</b>   | <b>\$ (82,183)</b>  |

(1) Represents initial costs to set up public company processes, incremental vendor expenses identified as temporary or duplicative and expected to be rationalized in the short term, and legal and professional expenses outside of the ordinary course of business, which are being incurred as part of the Company's efforts as it integrates the two privately held companies that were combined in the Business Combination. Significant components of Business Combination integration costs were as follows:

| <i>(in thousands)</i>         | Years Ended December 31, |                 |
|-------------------------------|--------------------------|-----------------|
|                               | 2023                     | 2022            |
| Consulting and legal fees (a) | \$ 1,039                 | \$ 5,058        |
| Severance costs               | —                        | 1,524           |
| Other (b)                     | 1,679                    | 2,433           |
|                               | <b>\$ 2,718</b>          | <b>\$ 9,015</b> |

(a) Represents consulting and legal costs directly associated with efforts related to integration of the two privately held companies that were combined in the Business Combination.

(b) Represents primarily vendor expenses identified as temporary or duplicative and/or expenses outside the ordinary course of business and not necessary to run the Company's business.

(2) Includes all costs recognized in acquisition related costs in our consolidated statements of operations and incremental payroll compensation expense for employees directly associated with services to achieve synergies related to closed transactions. Significant components of acquisition and integration related costs were as follows:

| <i>(in thousands)</i>                   | Years Ended December 31, |                  |
|---|--------------------------|------------------|
|   | 2023                     | 2022             |
| Advisor and other professional fees (a) | \$ 154                   | \$ 15,117        |
| Compensation costs (b)                  | 3,004                    | 5,177            |
|   | <b>\$ 3,158</b>          | <b>\$ 20,293</b> |

(a) Includes payments to our third-party transaction advisory firm associated with transaction contracts, including the Steward transaction that closed in November 2022. Also, costs include legal and accounting fees directly associated with contemplated or closed transactions.

(b) Includes incremental payroll compensation expense for employees directly associated with services to achieve synergies related to closed transactions.

(3) Components of other were as follows:

| <i>(in thousands)</i> | Years Ended December 31, |                 |
|-----------------------|--------------------------|-----------------|
|                       | 2023                     | 2022            |
| Interest income       | \$ (1,849)               | \$ (213)        |
| Other income          | (874)                    | (1,000)         |
| Tax-related costs     | —                        | 202             |
| Severance costs       | 1,639                    | —               |
| Other                 | 216                      | 252             |
|                       | <b>\$ (868)</b>          | <b>\$ (759)</b> |

## Operating Metrics and Non-GAAP Platform Contribution

In addition to our GAAP financial information, we review a number of operating and financial metrics, including the following key metrics, to evaluate our business, measure our performance, identify trends affecting our business, formulate business plans and make strategic decisions.

The following metrics are as of the indicated date, except for Platform Contribution, which is for the three month period ended as of the indicated date:

| Non-GAAP Operating Metrics                        | Dec 31, 2021 | Mar 31, 2022 | Jun 30, 2022 | Sep 30, 2022 | Dec 31, 2022 | Mar 31, 2023 | Jun 30, 2023 | Sep 30, 2023 | Dec 31, 2023 |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Centers   | 45           | 48           | 48           | 51           | 62           | 62           | 62           | 62           | 56           |
| Markets   | 4            | 6            | 6            | 7            | 7            | 7            | 7            | 7            | 7            |
| Patients (MCREM)*                                 | 50,100       | 50,600       | 54,000       | 57,400       | 221,500      | 225,100      | 226,500      | 228,700      | 229,300      |
| Patients in value-based care arrangements (MCREM) | 79.3 %       | 79.8 %       | 81.0 %       | 78.2 %       | 97.6 %       | 99.0 %       | 99.4 %       | 98.8 %       | 98.8 %       |
| Platform Contribution (\$, millions)              | \$ 16.0      | \$ 17.2      | \$ 21.6      | \$ 20.6      | \$ 25.6      | \$ 24.7      | \$ 28.6      | \$ 21.1      | \$ (55.6)    |

\* MCREM defined as Medicare Equivalent Members, which assumes the level of support received by a Medicare patient is equivalent to that received by three Medicaid or Commercial patients.

### Centers

We define our centers as those primary care centers open for business and open for enrollment of patients at the end of a particular period.

### Patients (MCREM)

MCREM patients include both at-risk MA patients (those patients for whom we are financially responsible for their total healthcare costs) as well as risk and non-risk, non-MA patients. We define our total at-risk patients as patients who have selected us as their provider of primary care medical services as of the end of a particular period and for whom we take responsibility for at least some degree of downside risk in capitated contracts. At-risk patient remains active in our system until we are informed by the health plan the patient is no longer active. As discussed above, CareMax calculates the amount of support typically received by one Medicare patient as equivalent to the level of support received by three Medicaid or Commercial patients.

### Platform Contribution

We define Platform Contribution as gross profit plus depreciation and amortization, stock-based compensation recognized within cost of care and other adjustments, as disclosed below. Gross profit is defined as revenue less the sum of (i) external provider costs; (ii) cost of care, including stock-based compensation, and (iii) depreciation and amortization expense. We believe this metric best reflects the economics of our care model as it includes all medical claims expense associated with our patients' care as well as the costs we incur to care for our patients at our centers. As a center matures, we expect the Platform Contribution from that center to increase both in terms of absolute dollars as well as a percentage of revenue. This increase will be driven by improving patient contribution economics over time, as well as our ability to generate operating leverage on the costs of our centers. Our aggregate Platform Contribution may not increase despite improving economics at our existing centers should we open new centers at a pace that skews our mix of centers towards newer centers.

The following table provides a reconciliation of gross profit, the most closely comparable GAAP financial measure, to Platform Contribution:

| <i>(in millions)</i>          | Dec 31,<br>2021 | Mar 31,<br>2022 | Jun 30,<br>2022 | Sep 30,<br>2022 | Dec 31,<br>2022 | Mar 31,<br>2023 | Jun 30,<br>2023 | Sep 30,<br>2023 | Dec 31, 2023     |
|-------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|------------------|
| Gross profit (a)              | \$ 9.6          | \$ 11.2         | \$ 15.4         | \$ 14.8         | \$ 17.2         | \$ 17.1         | \$ 20.4         | \$ 12.0         | \$ (63.5)        |
| Depreciation and amortization | 6.1             | 5.1             | 4.9             | 4.6             | 7.2             | 6.6             | 6.8             | 6.8             | 7.6              |
| Stock-based compensation      | 0.1             | 0.4             | 1.3             | 1.2             | 1.2             | 1.0             | 1.3             | 1.2             | 0.1              |
| Other adjustments (b)         | 0.2             | 0.5             | 0.1             | 0.1             | —               | —               | —               | 1.0             | 0.2              |
| Platform Contribution         | <u>\$ 16.0</u>  | <u>\$ 17.2</u>  | <u>\$ 21.6</u>  | <u>\$ 20.6</u>  | <u>\$ 25.6</u>  | <u>\$ 24.7</u>  | <u>\$ 28.6</u>  | <u>\$ 21.1</u>  | <u>\$ (55.6)</u> |

(a) Gross profit reflects the reclassification of stock-based compensation expense previously included in corporate, general and administrative expenses, which decreased gross profit by \$0.1 million during the three months ended December 31, 2021, \$0.4 million during the three months ended March 31, 2022, \$1.3 million during the three months ended June 30, 2022, \$1.2 million during the three months ended September 30, 2022, and \$1.2 million during the three months ended December 31, 2022.

(b) Other adjustments include incremental costs related to post-Business Combination integration initiatives and other one-time center-level costs. Other adjustments reflected during the three months ended March 31, 2022, include \$0.3 million of costs for a pilot project regarding outsourcing. During the three months ended September 30, 2023 and December 31, 2023, other adjustments include \$1.0 million and \$0.2 million, respectively, of severance costs related to center staff.

## Impact of COVID-19

The rapid spread of COVID-19 around the world and throughout the United States altered the behavior of businesses and people, with significant negative effects on federal, state and local economies. The virus disproportionately impacts older adults, especially those with chronic illnesses, which describes many of our patients.

Management cannot accurately predict the future impacts of COVID-19 due to the uncertainty surrounding future spikes in COVID-19 cases or new variants that may emerge in the future. We estimate our performance for the year ended December 31, 2022, was impacted by approximately \$1.0 million of direct COVID-19 costs.

## Components of Results of Operations

### Revenue

*Medicare Risk-Based Revenue and Medicaid Risk-Based Revenue.* Our Medicare and Medicaid risk-based revenue consists primarily of capitation fees for medical services provided by us or managed by our MSO under a global capitation arrangement made directly with various MA payors. Capitation is a fixed amount of money per patient per month paid in advance for the delivery of health care services, whereby we are generally liable for medical costs in excess of the fixed payment and are able to retain any surplus created if medical costs are less than the fixed payment. A portion of our capitated revenues are typically prepaid monthly to us based on the number of MA patients selecting us as their primary care provider. Our capitated rates are determined as a percentage of the premium the MA plan receives from CMS for our at-risk members. Those premiums are determined via a competitive bidding process with CMS and are based upon the cost of care in a local market and the average utilization of services by the patients enrolled. Medicare pays capitation using a “risk adjustment model,” which compensates providers based on the health status (acuity) of each individual patient. Payors with higher acuity patients receive more in premium, and those with lower acuity patients receive less in premium. Under the risk adjustment model, capitation is paid on an interim basis based on enrollee data submitted for the preceding year and is adjusted in subsequent periods after the final data is compiled. As premiums are adjusted via this risk adjustment model, our capitation payments will correlate with how our payor partners’ premiums change with CMS. Risk adjustment in future periods may be impacted by our inability to accurately document the health needs of our patients, which may have an adverse impact on our revenue.

For Medicaid, premiums are determined by Florida’s AHCA and base rates are adjusted annually using historical utilization data projected forward by a third-party actuarial firm. The rates are established based on specific cohorts by age and sex and geographical location. AHCA uses a “zero sum” risk adjustment model that establishes acuity for certain cohorts of patients quarterly, and depending on the scoring of that acuity, may periodically shift premiums from health plans with lower acuity members to health plans with higher acuity members.

*Government Value-Based Care Revenue.* Government value-based care revenue consists primarily of revenue derived from the MSSP. The MSSP is sponsored by CMS. The MSSP allows ACOs to receive a share in cost savings they generate in connection with the managing of costs and quality of medical services rendered to Medicare beneficiaries. Payments to ACO participants, if any, are calculated annually and paid once a year by CMS on cost savings generated by the ACO participant relative to the ACO participants’ CMS benchmark. Under the MSSP, an ACO must meet certain qualifications to receive the full amount of its allocable cost savings or they either receive nothing or are responsible for shared losses. The MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings. An ACO that meets the MSSP’s quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below the medical expenditure benchmark provided by CMS. A Minimum Savings Rate (“MSR”) must be achieved before the ACO can receive a share of the savings. Once the MSR is surpassed, all the savings below the benchmark provided by CMS will be shared at a certain percentage with the ACO. The MSR varies depending on the number of beneficiaries assigned to the ACO.

**Other Revenue.** Other revenue consists primarily of professional capitation payments and pharmacy revenue. Capitation revenues are a fixed amount of money per patient per month paid in advance for the delivery of primary care services only, whereby CareMax is not liable for medical costs in excess of the fixed payment. Capitated revenues are typically paid monthly to CareMax based on the number of patients selecting us as their primary care provider. Our capitated rates are fixed, contractual rates. Incentive payments for Healthcare Effectiveness Data and Information Set (“HEDIS”) and any services paid on a fee-for-service basis by a health plan are also included in other revenue. Other revenue also includes ancillary fees earned under contracts with certain payors for the provision of certain care coordination and other care management services. These services are provided to patients covered by these payors regardless of whether those patients receive their care from our affiliated medical groups. Revenue for primary care service for patients in partial risk or upside-only contracts and pharmacy revenue are reported in other revenue.

## Operating Expenses

**External Provider Costs.** External provider costs include services at-risk patients utilize that are rendered by providers other than CareMax. These include claims paid by the health plan and estimates for unpaid claims. The estimated reserve for incurred but not paid claims is included as a reduction to accounts receivable as we do not pay medical claims as well as the legal right of offset exists and we have the intent and ability to offset these expenses against receivables. Actual claims expense will differ from the estimated liability due to differences in estimated and actual patient utilization of health care services, the amount of charges, and other factors. We typically reconcile our medical claims expense with our payor partners on a monthly basis and adjust our estimate of incurred but not paid claims if necessary. To the extent we revise our estimates of incurred but not paid claims for prior periods up or down, there would be a correspondingly favorable or unfavorable effect on our current period results that may or may not reflect changes in long term trends in our performance. We expect our medical claims expenses to increase in both absolute dollar terms as well as on a PMPM basis given the healthcare spending trends within the Medicare population and the increasing disease burden of patients as they age.

The Company re-evaluated key assumptions and estimates and based on this analysis, the Company identified changes in estimates to revenue, external provider costs, short-term and long-term accounts receivable, net, and risk settlement liabilities. Accordingly, the Company recognized the following changes in prior year estimates in each respective period (*in thousands*):

| Increase (decrease)                               | Years Ended December 31, |          |
|---|--------------------------|----------|
|   | 2023                     | 2022     |
| Revenue   | \$ (42,934)              | \$ 9,046 |
| External provider costs                           | 900                      | 9,662    |
| Short-term and long-term accounts receivable, net | (34,542)                 | (616)    |
| Risk settlement liabilities                       | 9,292                    | —        |

For the year ended December 31, 2023, the decrease in revenue related to the prior year dates of service was primarily driven by updated information from MSO Medicare health plans, lower than expected revenue in our centers population from Medicare risk adjustment, an unseasonably early 2022-2023 flu season, and more current data from one Medicaid health plan. For the year ended December 31, 2022, the developments related to the prior year dates of service were driven by claims development from COVID-related utilization.

**Cost of Care.** Cost of care includes the costs of additional medical services we provide to patients that are not paid by the plan. These services include patient transportation, medical supplies, auto insurance and other specialty costs, like dental or vision. In some instances, we have negotiated better rates than the health plans for these health plan covered services. In addition, cost of care includes rent, utilities and facilities costs required to maintain and operate our centers, and compensation of the clinic and support staff.

Cost of care also includes distributions to affiliate IPA physicians and physician groups. Expenses from our physician groups that contract with our MSO are consolidated with other clinical and MSO expenses to determine profitability for our at-risk and fee-for-service arrangements. Physician group economics are not evaluated on an individual provider basis, as MSO related medical expenses are consolidated at the contract level.

We measure the incremental cost of our capitation agreements by starting with our center-level expenses, which are calculated based upon actual expenses incurred at a specific center for a given period of time and expenses that are incurred centrally and allocated to centers on a ratable basis. These expenses are allocated to our at-risk patients based upon the number of visit slots these patients utilized compared to the total slots utilized by all of our patients. All visits, however, are not identical and do not require the same level of effort and expense on our part. Certain types of visits are more time and resource intensive and therefore result in higher expenses for services provided internally. Generally, patients who are earlier in their tenure with CareMax utilize a higher percentage of these more intensive visits, as we get to know the patient and properly assess and document such patient’s health condition.

*Sales and Marketing Expenses.* Sales and marketing expenses represent employee-related expenses, such as salaries, commissions and related benefits, including stock-based compensation for sales and marketing departments. These expenses also include marketing and community relations related costs, such as radio and television advertising, events and promotional items.

*Corporate, General and Administrative Expenses.* Corporate, general, and administrative expenses represent employee-related expenses, such as salaries and related benefits, including stock-based compensation for support functions like finance, legal, human resources, and business development. In addition, these expenses include corporate technology, third party professional services and corporate occupancy costs.

*Depreciation and Amortization.* Depreciation and amortization expenses are primarily attributable to our capital investments and consist of fixed asset depreciation and amortization of intangibles considered to have definite lives.

## Nonoperating Income (Expense)

*Interest expense.* Interest expense consists primarily of interest payments, paid-in-kind interest, amortization of debt issuance costs and debt discount on our outstanding borrowings.

*Change in fair value of derivative warrant liabilities.* Change in fair value of derivative warrant liabilities consists of changes in fair value of the Public Warrants and Private Placement Warrants.

*Gain on remeasurement of contingent earnout liabilities.* Gain on remeasurement of contingent earnout liabilities consists of changes in the fair value of contingent earnout liabilities.

*Loss on extinguishment of debt.* Loss on extinguishment of debt consists primarily of write-offs of unamortized debt issuance costs upon early repayments of debt.

*Other income (expenses), net.* Other income (expenses), net, consists of miscellaneous non-operating corporate expenses and gains.

## Results of Operations

### Year Ended December 31, 2023, compared to Year Ended December 31, 2022.

The following table sets forth our consolidated statements of operations data for the periods indicated:

| (in thousands)  | Years Ended December 31, |                    |                     |                    |
|---|--------------------------|--------------------|---------------------|--------------------|
|   | 2023                     | 2022               | \$ Change           | % Change           |
| <b>Revenue</b>  |                          |                    |                     |                    |
| Medicare risk-based revenue                             | \$ 519,834               | \$ 486,718         | \$ 33,117           | 6.8 %              |
| Medicaid risk-based revenue                             | 105,893                  | 96,534             | 9,358               | 9.7 %              |
| Government value-based care revenue                     | 67,708                   | 6,389              | 61,320              | 959.8 %            |
| Other revenue   | 57,667                   | 41,492             | 16,175              | 39.0 %             |
| Total revenue   | 751,102                  | 631,132            | 119,970             | 19.0 %             |
| <b>Operating expenses</b>                               |                          |                    |                     |                    |
| External provider costs                                 | 572,329                  | 424,182            | 148,147             | 34.9 %             |
| Cost of care  | 164,872                  | 126,648            | 38,224              | 30.2 %             |
| Sales and marketing                                     | 14,274                   | 11,761             | 2,513               | 21.4 %             |
| Corporate, general and administrative                   | 80,684                   | 75,824             | 4,860               | 6.4 %              |
| Depreciation and amortization                           | 27,787                   | 21,719             | 6,069               | 27.9 %             |
| Goodwill impairment                                     | 547,200                  | 70,000             | 477,200             | 681.7 %            |
| Acquisition related costs                               | 108                      | 13,165             | (13,057)            | (99.2 %)           |
| Total operating expenses                                | 1,407,254                | 743,297            | 663,956             | 89.3 %             |
| <b>Operating loss</b>                                   | (656,152)                | (112,165)          | (543,986)           | (485.0 %)          |
| <b>Nonoperating income (expense)</b>                    |                          |                    |                     |                    |
| Interest expense  | (54,434)                 | (20,455)           | (33,979)            | (166.1 %)          |
| Change in fair value of derivative warrant liabilities  | 3,952                    | 4,401              | (449)               | (10.2 %)           |
| Gain on remeasurement of contingent earnout liabilities | 19,916                   | 76,295             | (56,380)            | (73.9 %)           |
| Loss on extinguishment of debt                          | —                        | (6,172)            | 6,172               | 100.0 %            |
| Other income, net                                       | 2,507                    | 759                | 1,748               | 230.3 %            |
| Total nonoperating expenses                             | (28,059)                 | 54,828             | (82,887)            | (151.2 %)          |
| <b>Loss before income taxes</b>                         | (684,211)                | (57,337)           | (626,873)           | (1,093.3 %)        |
| Income tax benefit                                      | (863)                    | (19,542)           | 18,678              | 95.6 %             |
| <b>Net loss</b>   | <u>\$ (683,348)</u>      | <u>\$ (37,796)</u> | <u>\$ (645,552)</u> | <u>(1,708.0 %)</u> |

*Medicare risk-based revenue.* Medicare risk-based revenue was \$519.8 million for the year ended December 31, 2023, an increase of \$33.1 million, or 6.8%, compared to \$486.7 million for the year ended December 31, 2022. This increase was driven primarily by a 20.6% increase in the total number of at-risk patients, partially offset by a 11.4% net decrease in rates, driven by member mix, and unfavorable net prior period development of \$18.3 million mainly due to more current membership updates.

*Medicaid risk-based revenue.* Medicaid risk-based revenue was \$105.9 million for the year ended December 31, 2023, an increase of \$9.4 million, or 9.7% compared to \$96.5 million for the year December 31, 2022. This increase was driven primarily by the 15.7% increase in patients, partially offset by a 5.2% decrease in rates driven by member mix.

*Government valued-based care revenue.* Government value-based care revenue was \$67.7 million for the year ended December 31, 2023, an increase of \$61.3 million, compared to \$6.4 million for the year December 31, 2022. This increase was driven by the current year activity having twelve months of revenue, as compared to one and a half months of revenue activity as a result of the timing of the Steward Acquisition.

*Other revenue.* Other revenue was \$57.7 million for the year ended December 31, 2023, an increase of \$16.2 million, or 39.0%, compared to \$41.5 million for the year ended December 31, 2022. The increase is mainly driven by growth in pharmacy revenues due to enhanced service offerings.

*External provider costs.* External provider costs were \$572.3 million for the year ended December 31, 2023, an increase of \$148.1 million, or 34.9%, compared to \$424.2 million for the year ended December 31, 2022. The increase was mostly driven by incremental costs to support the increase in membership over the same period and the impact of more current data from a single Medicaid health plan and an unseasonably early flu season, which began in the fourth quarter of 2022 and affected our costs in 2023.

*Cost of care.* Cost of care expenses were \$164.9 million for the year ended December 31, 2023, an increase of \$38.2 million, or 30.2%, compared to \$126.6 million for the year ended December 31, 2022. The increase was due to increases in rent expense, headcount, medical supplies, and other related costs to support and operate the higher number of centers, including de novo centers, and members in the current period, as compared to the prior period.

*Sales and marketing expenses.* Sales and marketing expenses were \$14.3 million for the year ended December 31, 2023, an increase of \$2.5 million, or 21.4%, compared to \$11.8 million for the year ended December 31, 2022. The increase was primarily due to expanding our sales staff and marketing efforts to increase membership levels in our centers, as the Company operated more centers, including de novo centers, in 2023 as compared to 2022.

*Corporate, general and administrative expenses.* Corporate, general and administrative expenses were \$80.7 million for the year ended December 31, 2023, an increase of \$4.9 million, or 6.4% compared to \$75.8 million for the year ended December 31, 2022. The increase was primarily from higher salaries, wages and professional fees as the Company grew its corporate infrastructure to support its operational growth.

*Depreciation and amortization.* Depreciation and amortization expense was \$27.8 million for the year ended December 31, 2023, an increase of \$6.1 million, or 27.9%, compared to \$21.7 million for the year ended December 31, 2022. This increase was primarily driven by the amortization of intangibles acquired as part of the Steward Acquisition.

*Goodwill impairment.* During the year ended December 31, 2023, the Company recognized a goodwill impairment of \$547.2 million, mainly driven by the reduction of the market value of the Company's Class A Common Stock, compared to \$70.0 million of goodwill impairment charges recognized during the year ended December 31, 2022.

*Acquisition related costs.* Acquisition related costs were \$0.1 million for the year ended December 31, 2023, a decrease of \$13.1 million, or 99.2%, compared to \$13.2 million for the year ended December 31, 2022.

*Interest expense.* Interest expense was \$54.4 million for the year ended December 31, 2023, an increase of \$34.0 million, or 166.1%, compared to \$20.5 million for the year ended December 31, 2022. This increase was due to the increased borrowings and higher weighted-average interest rate. Refer to Note 8, *Debt and Related Party Debt*, to our consolidated financial statements included in this Report for additional information on the borrowings outstanding as of December 31, 2023.

*Change in fair value of derivative warrant liabilities.* We recorded a gain of \$4.0 million during the year ended December 31, 2023, a decrease of \$0.4 million, or 10.2%, as compared to a gain of \$4.4 million during the year ended December 31, 2022. This decrease is primarily driven by the change in the market value of the Company's Class A Common Stock as of December 31, 2023, relative to that as of December 31, 2022.

*Gain on remeasurement of contingent earnout liabilities.* We recorded a gain of \$19.9 million during the year ended December 31, 2023, a decrease of \$56.4 million, or 73.9%, as compared to a gain of \$76.3 million during the year ended December 31, 2022. This decrease is primarily driven by the decrease in the market value of the Company's Class A Common Stock since December 31, 2022.

*Loss on extinguishment of debt.* For the year ended December 31, 2022, in connection with the early extinguishment and termination of the Existing Credit Agreement, the Company recognized a loss on extinguishment of debt of \$6.2 million.

*Other income, net.* Other income, net was \$2.5 million for the year ended December 31, 2023, an increase of \$1.7 million, or 230.3%, compared to other income, net of \$0.8 million for the year ended December 31, 2022. This increase was mainly due to interest earned in 2023 on our money market investments.

*Income tax benefit.* Income tax benefit was \$0.9 million for the year ended December 31, 2023, a decrease of \$18.7 million, or 95.6%, compared to income tax benefit of \$19.5 million for the year ended December 31, 2022. This decrease was mainly driven by the tax benefit generated in 2022 from the tax effects of intangibles acquired through the Steward Acquisition.

## **Liquidity and Capital Resources**

### **Overview**

As of December 31, 2023, we had cash and cash equivalents of \$65.5 million.

Our principal sources of liquidity have been cash generated by our centers and MSO operations, borrowings under our credit facilities and proceeds from equity issuances. We have used these funds to meet our capital requirements, which consist of salaries and labor, benefits and other employee-related costs, product and supply costs, third-party customer service, billing and collections and logistics costs, capital expenditures including patient equipment, center and office lease expenses, insurance premiums, acquisitions, and debt service.

Our future capital expenditures will depend on many factors, including patient volume, revenue growth rates, the pace and scale of our expansion in new and existing markets and any future acquisitions. Many of our capital expenditures are made in advance of patients beginning service. Certain operating costs are incurred at the beginning of the equipment service period and during initial patient set up. We may be required to seek additional equity or debt financing, in addition to cash on hand and borrowings under our credit facilities in connection with operating or growing our business, including debt financing that may be available to us from certain health plans for each new center that we open under the terms of our agreements with those health plans. In the event that additional financing is required from outside sources, we may not be able to raise it on acceptable terms or at all. If additional capital is unavailable when desired, our business, results of operations, and financial condition would be materially and adversely affected.

See Note 1, *Basis of Presentation and Significant Accounting Policies and Going Concern*, to the consolidated financial statements that appear elsewhere in this Annual Report on Form 10-K for details regarding our going concern consideration. As a result of our recent financial performance and current projections, we do not expect to be in compliance with the maximum leverage ratio and minimum liquidity covenants specified in the Credit Agreement for the twelve months from the date of issuance of the consolidated financial statements that appear elsewhere in this Annual Report on Form 10-K. As a result, the indebtedness outstanding under the Credit Agreement, was classified as current within the consolidated balance sheet included in the consolidated financial statements.

### **Credit Facilities**

#### *Credit Agreement*

In May 2022, the Company entered into the Credit Agreement that provided for the Initial Term Loans and Delayed Draw Term Loans. The Credit Agreement permits the Company to enter into certain incremental facilities subject to compliance with the terms, conditions and covenants set forth therein. In May 2022, the Company drew \$190.0 million of the Initial Term Loans and used approximately \$121.0 million of the net proceeds from this borrowing to repay its outstanding obligations under Existing Credit Agreement and recognized related debt extinguishment losses of \$6.2 million.

On the Amendment Closing Date, the Company entered into the Second Amendment to the Credit Agreement. The Second Amendment amended the Credit Agreement to, among other things, (i) provide for a new incremental delayed draw term loan B facility in an aggregate principal amount of \$60.0 million; (ii) revise the commitment expiration date for the Company's existing \$110.0 million Delayed Draw Term Loan to forty-five days following the Amendment Closing Date, (iii) extend the commencement of amortization payments on loans under the Credit Agreement from March 31, 2024 to May 31, 2025; (iv) reduce the amount of interest that the Company may elect to capitalize from 4.00% to 3.50% beginning on the second anniversary of the execution date of the Credit

Agreement, 3.00% beginning on the third anniversary of the execution date of the Credit Agreement, and 1.50% beginning on December 10, 2025; (v) increase the amount of the super-priority revolving credit facility that is permitted to be added to the Credit Agreement to \$45.0 million and provide that the entirety of such facility may be used for general corporate purposes; and (vi) amend the prepayment provisions of the Credit Agreement, including to have such provisions run as of the Amendment Closing Date.

During the years ended December 31, 2023 and 2022, the Company drew \$125.0 million and \$45.0 million of the Delayed Draw Term Loans, respectively. Based on the elections made by the Company, as of December 31, 2023, borrowings under the Credit Agreement bore interest of Term SOFR (calculated as the Secured Overnight Financing Rate published on the Federal Reserve Bank of New York's website, plus the applicable credit spread adjustment based on the elected interest period) plus an applicable margin rate of 9.00%. As permitted under the Credit Agreement, the Company elected to capitalize 4.00% of the interest as principal amount. As a result of this election, the cash interest component of the applicable margin increased by 0.50%. Amortization payments under the Credit Agreement are payable in quarterly installments, commencing on May 31, 2025, in aggregate principal amounts equal to 0.25% of the aggregate outstanding principal amount of Initial Term Loans and Delayed Draw Term Loans. All amounts owed under the Credit Agreement are due in May 2027.

The Credit Agreement contains certain covenants that limit, among other things, the ability of the Company and its subsidiaries to incur additional indebtedness, liens or encumbrances, to make certain investments, to enter into sale-leaseback transactions or sell certain assets, to make certain restricted payments or pay dividends, to enter into consolidations, to transact with affiliates and to amend certain agreements, subject in each case to the exceptions and other qualifications as provided in the Credit Agreement. The Credit Agreement also contains covenants that require the Company to satisfy a minimum liquidity requirement of \$50.0 million, which may be decreased to \$25.0 million if the Company achieves a certain adjusted EBITDA, and maintain a maximum total net leverage ratio based on the Company's consolidated EBITDA, as defined in the Credit Agreement, with de novo losses excluded from the calculation of such ratio for up to 36 months after the opening of a de novo center, which maximum total leverage ratio will initially be 8.50 to 1.00, commencing with the fiscal quarter ended September 30, 2022 and is subject to a series of step-downs. For the fiscal quarters ending September 30, 2026 and thereafter the Company must maintain a maximum total net leverage ratio no greater than 5.50 to 1.00.

The Company was in compliance with all of its financial covenants under the Credit Agreement, except for one instance where we were in violation of the maximum total leverage ratio, as of December 31, 2023. However, on such occasion, in March 2024, the lenders agreed to waive the violation of such covenant and certain other covenants and not enforce their rights and remedies from the resulting events of default under the Credit Agreement through May 15, 2024, subject to an earlier termination of the waiver upon the occurrence of certain specified events. Therefore, as of December 31, 2023, we were not considered in violation of the covenants set forth in the Credit Agreement. Refer to Note 18, *Subsequent Events*, for additional information related to the covenant waiver obtained subsequent to December 31, 2023. Our failure to comply with covenants under the Credit Agreement could give rise to the lenders' right to accelerate our debt obligations thereunder and pursue other remedial actions under such agreement and/or trigger a cross default under our other long-term leases.

#### *Loan and Security Agreement*

In November 2022, the Company entered into a Loan and Security Agreement (the "Loan and Security Agreement"), by and among Sparta Merger Sub I Inc., a Delaware corporation and wholly-owned subsidiary of the Company, Sparta Merger Sub II Inc., a Delaware corporation and wholly-owned subsidiary of the Company, Sparta Merger Sub I LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company ("Merger LLC I"), Sparta Merger Sub II LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company (together with Merger LLC I, the "Guarantors"), Steward Accountable Care Network, Inc. (n/k/a as Steward Accountable Care Network, LLC) and Steward National Care Network, Inc. (n/k/a Steward National Care Network, LLC), as borrowers (the "Borrowers"), CAJ Lending LLC ("CAJ") and Deerfield Partners L.P., as lenders (the "Lenders"), and CAJ, as administrative agent and collateral agent (in such capacity, the "Agent"). Mr. Carlos A. de Solo, a director of the Company and the Company's President and Chief Executive Officer, Mr. Alberto de Solo, the Company's Executive Vice President and Chief Operating Officer, and Mr. Joseph N. De Vera, the Company's Senior Vice President and Legal Counsel, have interests in CAJ.

Pursuant to the Loan and Security Agreement, the Lenders provided the Borrowers a term loan (the "Term Loan") in the aggregate principal amount of \$35.5 million. The Company used the proceeds of the Term Loan to fund the Financed Net Pre-Closing Medicare AR acquired in connection with the Steward Acquisition.

The Term Loan bore an interest rate at 12.0% per annum. In addition, the Borrowers paid a facility fee equal to 3.0% of the aggregate principal amount of the Term Loan.

The Loan and Security Agreement matured on the earlier of November 30, 2023, or three business days after the Borrowers receive payment for the Financed Net Pre-Closing Medicare AR from the federal government. In October 2023, the Company paid off all

outstanding indebtedness of \$35.5 million due under the Loan and Security Agreement with the proceeds of the MSSP payment from the federal government, and the Loan and Security Agreement was terminated.

#### *Elevance Health Collaboration Agreement*

In connection with our collaboration agreement with Elevance Health, which was announced in August of 2021, we may open centers across a number of priority states as part of our de novo strategy to open new centers. Elevance Health has agreed to provide debt financing of up to \$1.0 million for each new center opened in partnership with Elevance Health. We intend to use such funds to partially offset the costs of opening new centers in connection with our de novo growth strategy.

In October 2022, in connection with the Elevance Health Collaboration Agreement we entered into a promissory note for an amount of \$1.0 million due in October 2032. Funds received from Elevance Health pursuant to the aforementioned promissory note will be used to finance costs of one new center that was opened in partnership with Elevance Health.

#### *Finance Leases*

We lease certain of our center facilities under non-cancelable finance lease agreements. Refer to Note 14, *Leases*, in the Notes to Consolidated Financial Statements for additional information, including the schedule of remaining lease payments. The remaining duration of such leases ranges from 19 to 20 years.

Our finance leases require us to satisfy certain financial maintenance tests, such as maintaining the minimum stockholder's equity of \$100.0 million and minimum cash balance of \$25.0 million. Refer to Note 18, *Subsequent Events*, in the Notes to Consolidated Financial Statements for information regarding an event of default related to such leases that occurred subsequent to December 31, 2023.

#### **Cash Flows**

The following table summarizes our cash flows for the periods presented:

| <i>(in thousands)</i>                     | <b>Years Ended December 31,</b> |             |
|---|---------------------------------|-------------|
|   | <b>2023</b>                     | <b>2022</b> |
| Net cash used in operating activities     | \$ (46,913)                     | \$ (68,216) |
| Net cash used in investing activities     | (14,611)                        | (62,502)    |
| Net cash provided by financing activities | 85,427                          | 124,428     |

*Operating Activities.* Net cash used in operating activities for the year ended December 31, 2023 was \$46.9 million, a decrease of \$21.3 million, as compared to \$68.2 million used in operating activities during the year ended December 31, 2022. This decrease is primarily due to the collection on MSSP arrangement receivables during 2023. There were no collections on MSSP arrangement receivables during the year ended December 31, 2022.

*Investing Activities.* Net cash used in investing activities for the year ended December 31, 2023 of \$14.6 million consisted of the investments in leasehold improvements and medical equipment for our centers. Net cash used in investing activities for the year ended December 31, 2022, was \$62.5 million, which was driven by purchases of leasehold improvements and medical equipment for our centers, cash purchase consideration of \$55.8 million related to the Steward Acquisition and acquisition of medical practices, offset by the \$0.8 million return of funds held in escrow related to 2021 acquisitions.

*Financing Activities.* Net cash provided by financing activities for the year ended December 31, 2023 of \$85.4 million was driven by the \$122.0 million drawn on our Delayed Draw Term Facility, net of related discounts, payment of issuance costs of \$0.8 million, and repayment of the related party and third-party borrowings of \$35.8 million. Net cash provided by financing activities for the year ended December 31, 2022 was \$124.4 million, driven by the net proceeds of \$230.0 million from borrowings issued under the Credit Agreement, net proceeds of \$29.9 million from borrowings issued under the Loan and Security Agreement, offset by payment of related debt issuance costs of \$7.3 million, early repayment of our Existing Credit Agreement of \$122.0 million and issuance of cash collateral for letters of credit of \$5.4 million.

#### **Contractual Obligations and Commitments**

Our principal commitments consist of obligations under the Credit Agreement, and operating and finance leases for our centers.

#### **Off-Balance Sheet Arrangements**

We did not have any off-balance sheet arrangements as of December 31, 2023, or 2022, other than operating or finance leases which have not yet commenced.

## **JOBS Act**

Section 102(b)(1) of the Jumpstart our Business Startups (JOBS) Act exempts emerging growth companies from being required to comply with new or revised financial accounting standards until private companies (that is, those that have not had a Securities Act registration statement declared effective or do not have a class of securities registered under the Exchange Act) are required to comply with the new or revised financial accounting standards. The JOBS Act provides that a company can elect to opt out of the extended transition period and comply with the requirements that apply to non-emerging growth companies, but any such election to opt out is irrevocable. We have elected not to opt out of such extended transition period, which means that when a standard is issued or revised and it has different application dates for public or private companies, as an emerging growth company, we can adopt the new or revised standard at the time private companies adopt the new or revised standard. This may make comparison of our consolidated financial statements with a public company which is neither an emerging growth company, nor an emerging growth company that has opted out of using the extended transition period, difficult or impossible because of the potential differences in accounting standards used.

## **Critical Accounting Policies and Estimates**

The discussion and analysis of our financial condition and results of operations are based upon our consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of these financial statements requires management to make estimates and judgments that affect the reported amounts of assets and liabilities, revenue and expenses and related disclosures of contingent assets and liabilities at the date of our financial statements. Actual results may differ from these estimates under different assumptions or conditions, impacting our reported results of operations and financial condition.

Certain accounting policies involve significant judgments and assumptions by management, which have a material impact on the carrying value of assets and liabilities and the recognition of income and expenses. Management considers these accounting policies to be critical accounting policies. The estimates and assumptions used by management are based on historical experience and other factors, which are believed to be reasonable under the circumstances. The significant accounting policies which we believe are the most critical to aid in fully understanding and evaluating our reported financial results are described below. Refer to Note 2 to the Consolidated Financial Statements, *Summary of Significant Accounting Policies*, for more detailed information regarding our significant accounting policies.

### ***Medicare and Medicaid Risk-Based Revenue***

Medicare and Medicaid Risk-Based Revenue consists primarily of fees for medical services provided under capitated arrangements directly with various Medicare Advantage and Medicaid managed care payors. The Company receives a fixed fee per patient under what is typically known as a “risk contract.” Risk contracting, or full risk capitation, refers to a model in which the Company receives from the third-party payor a fixed payment of at-risk premium less an administrative charge for reporting on enrollees on a per patient per month basis (“PMPM” payment) for a defined patient population, and the Company is then responsible for providing healthcare services required by that patient population. PMPM fees can fluctuate throughout the contract based on the health status (acuity) of each individual enrollee. In certain contracts, PMPM fees also include “risk adjustments” for items such as performance incentives, performance guarantees and risk shares. The capitated revenues are recognized based on the estimated PMPM fees earned net of projected performance incentives, performance guarantees, risk shares and rebates because we are able to reasonably estimate the ultimate PMPM payment of these contracts. We recognize revenue in the month in which eligible members are entitled to receive healthcare benefits. Subsequent changes in PMPM fees and the amount of revenue to be recognized are reflected through subsequent period adjustments to properly recognize the ultimate capitation amount.

For enrolled members in which we control healthcare services, we act as the principal and the gross fees under these contracts are reported as revenue and the cost of third-party medical care is included in external provider costs.

The Company generates MSO revenue for services it renders to independent physician associations (the “IPAs”) under administrative service contracts. The MSO revenue is recognized in the month in which the eligible members are entitled to receive healthcare benefits during the contract term. For MSO contracts in which the Company acts as a principal in coordinating and controlling the range of services provided (other than clinical decisions) and, thus, accepts full financial risk for members attributed to the IPA and is therefore responsible for the cost of all healthcare services required by those members, the fees are recognized on a gross basis, consistent with ASC 606, Revenue From Contracts with Customers (“ASC 606”). The related revenue is recorded in Medicare risk-based and Medicaid risk-based revenue.

### ***Government Value-Based Care Revenue***

Government Value-Based Care Revenue consists primarily of revenue derived from the Medicare Shared Savings Program (“MSSP”). The MSSP is sponsored by the Center for Medicare and Medicaid Services (“CMS”). The MSSP allows ACOs to receive a share of cost savings they generate in connection with the managing of costs and quality of medical services rendered to Medicare beneficiaries. Payments to ACO participants, if any, are calculated annually and paid once a year by CMS on cost savings generated by the ACO participant relative to the ACO participants’ CMS benchmark. Under the MSSP, an ACO must meet certain qualifications to receive the full amount of its allocable cost savings or they either receive nothing or are responsible for shared losses. The MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings. An ACO that meets the MSSP’s quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below the medical expenditure benchmark provided by CMS. A Minimum Savings Rate (“MSR”) must be achieved before the ACO can receive a share of the savings. Once the MSR is surpassed, all the savings below the benchmark provided by CMS will be shared at a certain percentage with the ACO. The MSR varies depending on the number of beneficiaries assigned to the ACO.

The promised services under the Company's MSSP arrangements are to provide the population health services to beneficiaries for a given performance period. As part of these arrangements, the Company stands ready to provide the population with health services throughout the performance period.

The Company estimates the variable consideration that constitutes the transaction price of these arrangements by utilizing third-party data and historical experience. As the Company’s performance obligation is met, revenue is recorded over time using its estimation methods and consideration is made, to the extent possible, that it is probable that a significant reversal will not occur once any uncertainty associated with the variable consideration is subsequently resolved. Since the Company has determined it only has one performance obligation under each of these arrangements, it allocates the full transaction price towards each arrangement’s individual performance obligation. From time to time, but at least annually, we assess our estimates with an independent actuarial expert to ensure our estimates represent the best, most reasonable estimate given the data available to us at the time the estimates are made.

Government Value-Based Care Revenue is recognized on a net basis, because the Company does not coordinate or control the range of services provided and, thus, accepts partial financial risk.

#### ***External Provider Costs***

External Provider Costs include all costs of caring for our at-risk patients and for third-party healthcare service providers that provide medical care to our patients for which we are contractually obligated to pay (through our full-risk capitation arrangements). The estimated reserve for liability for unpaid claims is included in "Accounts receivable, net" in the consolidated balance sheets where the legal right of offset exists and there is the intent and ability to offset. Actual claims expense will differ from the estimated liability due to differences in estimated and actual member utilization of health care services, the amount of charges and other factors. From time to time, but at least annually, we assess our estimates with an independent actuarial expert to ensure our estimates represent the best, most reasonable estimate given the data available to us at the time the estimates are made. Certain third-party payor contracts include a Medicare Part D payment related to pharmacy claims, which is subject to risk sharing through accepted risk corridor provisions. Under certain agreements the fund risk allocation is established whereby we, as the contracted provider, receive only a portion of the risk and the associated surplus or deficit. We estimate and recognize an adjustment to medical expenses for Part D claims related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual risk contract were to terminate at the end of the reporting period.

#### ***Business Combinations***

The Company accounts for business combinations under the acquisition method of accounting, in accordance with ASC 805, Business Combinations, which requires assets acquired and liabilities assumed to be recognized at their fair values on the acquisition date. Any excess of the fair value of purchase consideration over the fair value of the assets acquired less liabilities assumed is recorded as goodwill. The fair values of the assets acquired, and liabilities assumed are determined based upon the valuation of the acquired business and involves management making significant estimates and assumptions.

The Company's acquisitions, at times, has included earn-out provisions, also referred to as contingent consideration, which provide for additional consideration to be paid to the seller if certain conditions are met. These provisions are recorded as liabilities or as equity at fair value on the acquisition date and re-assessed or re-measured at fair value each reporting period until they expire or settle.

#### ***Goodwill and Other Intangible Assets***

Goodwill represents the excess of the purchase price consideration of an acquired business over the fair value of the underlying net tangible and intangible assets acquired. We test goodwill for impairment at least annually on December 31st or more frequently if

triggering events occur or other impairment indicators arise which might impair recoverability. These events or circumstances would include a significant change in the business climate, legal factors, operating performance indicators, competition, sale, disposition of a significant portion of the business or other factors.

ASC 350, Intangibles—Goodwill and Other, allows entities to first use a qualitative approach to test goodwill for impairment by determining whether it is more likely than not (a likelihood of greater than 50%) that the fair value of a reporting unit is less than its carrying value. If the qualitative assessment supports that it is more likely than not that the fair value of the asset exceeds its carrying value, a quantitative impairment test is not required. If the qualitative assessment indicates that it is more likely than not that the fair value of the reporting unit is less than its carrying value, the Company will perform the quantitative goodwill impairment test, in which we compare the fair value of the reporting unit, determined using an income approach based on the present value of expected future cash flows, a market approach, or combination of both, given each assessment period's specific facts and circumstances, to the respective carrying value, which includes goodwill. If the fair value of the reporting unit exceeds its carrying value, then goodwill is not considered impaired. If the carrying value is higher than the fair value, the difference would be recognized as an impairment loss.

Goodwill impairment testing involves judgment, including the identification of reporting units, qualitative evaluation of facts and circumstances to determine if it is more likely than not that an impairment exists, and, if necessary, the estimation of the fair value of the applicable reporting unit. During the years ended December 31, 2023 and 2022, we performed impairment testing and recognized goodwill impairment charges of \$547.2 million and \$70.0 million, respectively. Because our total shareholders' equity exceeded our market capitalization at each goodwill impairment testing date, we estimated the fair value of our single reporting unit primarily on the basis of the Company's market capitalization after considering reasonable control premiums which could be expected in transactions with third-party market participants. As a result, goodwill impairments in each period were primarily driven by the reduction of the market value of our stock price. As of December 31, 2023, if all other assumptions were held constant and the share price decreased by 1%, the estimated fair value would decrease by approximately 1.0% or \$0.5 million. There is no assurance that actual results will not differ materially from the underlying assumptions used in estimating the Company's fair value. Further adverse changes to macroeconomic conditions or our earnings forecasts could lead to additional goodwill or intangible asset impairment charges in future periods and such charges could be material to our results of operations.

The Company does not have any indefinite-lived intangibles. Our definite-lived intangibles primarily consist of risk-based contracts and provider networks. Risk contracts and provider networks represent the estimated values of customer relationships or provider networks, respectively, of acquired businesses and have definite lives. We amortize our intangibles on a straight-line basis over their estimated useful lives ranging from two to eleven years, except for certain risk contracts, which are amortized using the accelerated method.

The determination of fair values and useful lives requires us to make significant estimates and assumptions. These estimates include, but are not limited to, future expected cash flows from acquired capitation arrangements from a market participant perspective, patient attrition rates, discount rates, and costs and years to replicate acquired provider networks.

#### ***Derivative Warrant Liabilities***

We do not use derivative instruments to hedge exposures to cash flow, market, or foreign currency risks. We evaluate all of our financial instruments, including issued stock purchase warrants, to determine if such instruments are derivatives or contain features that qualify as embedded derivatives, pursuant to ASC 480, *Distinguishing Liabilities from Equity*, and ASC 815-15, *Derivatives and Hedging - Embedded Derivatives*. The classification of derivative instruments, including whether such instruments should be recorded as liabilities or as equity, is re-assessed at the end of each reporting period.

DFHT issued 193,056 common stock warrants in connection with our initial public offering (95,833) and a simultaneous private placement (97,222), which are recognized as derivative liabilities in accordance with ASC 815-40. Accordingly, we recognize the warrant instruments as liabilities at fair value and adjust the instruments to fair value at each reporting period. The liabilities are subject to re-measurement at each balance sheet date until exercised, and any change in fair value is recognized in the Company's statement of operations. At each measurement date, fair value of warrants issued has been estimated using Monte Carlo simulations.

#### **Item 7A. Quantitative and Qualitative Disclosures About Market Risk.**

We are a smaller reporting company as defined by Rule 12b-2 of the Exchange Act and are not required to provide the information otherwise required under this item.

#### **Item 8. Financial Statements and Supplementary Data.**

Please refer to our Financial Statements beginning on page F-1 of this Annual Report.

**Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.**

None.

**Item 9A. Controls and Procedures.**

**Evaluation of Disclosure Controls and Procedures**

We maintain disclosure controls and procedures that are designed to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely decisions regarding required disclosures.

Under supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we evaluated the effectiveness of our disclosure controls and procedures (as that term is defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act as of December 31, 2023. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls were not effective as of December 31, 2023, based on the material weaknesses in internal control over financial reporting described below.

Notwithstanding the identified material weaknesses described further below, we believe the consolidated financial statements included in this Form 10-K fairly represent in all material respects the financial condition, results of operations and cash flows of the Company for the periods presented.

**Management's Report on Internal Control over Financial Reporting**

Management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are made only in accordance with authorizations of management and directors, and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on the financial statements.

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

Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we evaluated the effectiveness of our internal control over financial reporting as of December 31, 2023 using criteria established in "Internal Control – Integrated Framework" (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Based on that evaluation, management concluded that due to the material weaknesses described below, our internal control over financial reporting was not effective as of December 31, 2023.

A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis.

The material weaknesses we identified include that we lack a sufficient complement of professionals with the appropriate level of knowledge, training and experience to appropriately analyze, record and disclose accounting matters commensurate with our accounting and reporting requirements as a public company. This material weakness contributed to the Company not designing and maintaining formal controls to analyze, account for and disclose complex transactions, including the accounting for financial instruments and contingent earnout liabilities. These material weaknesses resulted in:

- the restatement of the Company's previously filed consolidated financial statements as of and for the year ended December 31, 2020, as well as the quarterly condensed consolidated financial information for the 2020 interim period ended September 30, 2020 related to derivative warrant liabilities, Class A ordinary shares subject to possible redemption, additional

- paid-in-capital, retained earnings/(deficit), fair value adjustment on derivative warrant liabilities, earnings per share and the related disclosures;
- the restatement of the Company's previously filed quarterly condensed consolidated financial information for the 2021 interim periods ended June 30, 2021 and September 30, 2021 related to goodwill, contingent earnout liabilities, additional paid-in capital, retained earnings/(deficit), gain/(loss) on remeasurement of earnout liabilities, earnings per share and the related disclosures; and
- the restatement of the Company's previously filed consolidated financial statements as of and for the year ended December 31, 2021, as well as the quarterly condensed consolidated financial information for the 2021 interim period ended September 30, 2021 and the 2022 interim periods ended March 31, 2022, June 30, 2022, and September 30, 2022 related to other current assets and other assets.

Additionally, these material weaknesses could result in misstatements of substantially all accounts or disclosures that would result in a material misstatement to the annual or interim consolidated financial statements that would not be prevented or detected.

### **Remediation Plan for the Material Weaknesses**

Since identifying the material weaknesses, management has developed a remediation plan and implemented measures to address the underlying causes of each material weakness. Our efforts to date included the following:

- We engaged an external advisor to assist in evaluating and documenting the design and operating effectiveness of our internal control over financial reporting.
- In 2022, we hired a Vice President of Financial Reporting and Technical Accounting and a Chief Accounting Officer, both with technical public company accounting and financial reporting experience.
- We enhanced access to accounting training, literature, research materials and documents for our finance and accounting departments.
- During the second and third quarters of 2023, we performed a financial statement risk assessment and identified areas where new key controls are needed, or existing controls needed to be enhanced.
- During the second and third quarters of 2023, we designed and implemented controls to address the entity level and financial reporting risks identified, including those involving accounting for complex transactions, including financial instruments and contingent earnout liabilities.
- During the second and third quarters of 2023, together with our external advisor, we designed a formal testing program to evaluate the design and operating effectiveness of key controls and began executing the formal testing program.
- During the third and fourth quarters of 2023, our external advisor performed key control testing consistent with our formal testing program.

Although we have implemented and tested controls as of December 31, 2023, the controls have not been in place and operating effectively for a sufficient period to evaluate if the material weaknesses have been remediated. Although no assurance can be made that such remediation will occur, or that additional material weaknesses will not be identified, we believe we are making progress toward achieving the effectiveness of our internal control over financial reporting and disclosure controls and procedures. The actions that we are taking are subject to ongoing senior management review, as well as Audit Committee oversight. We may also conclude that additional measures may be required to remediate the material weaknesses in our internal control over financial reporting, which may necessitate additional changes to the design and implementation of controls.

### **Changes in Internal Control over Financial Reporting**

There have been no changes in our internal control over financial reporting during the quarter ended December 31, 2023 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

### **Item 9B. Other Information.**

#### **Credit Agreement Amendment**

On March 15, 2024 (the "Third Amendment Effective Date"), we entered into a Waiver and Third Amendment to Credit Agreement (the "Third Amendment") among us, certain of our subsidiaries, as guarantors, the lenders party thereto and Jefferies Finance LLC, as administrative agent and collateral agent. The Third Amendment amended the Credit Agreement to, among other things, (i) waive certain

events of default under the Credit Agreement in the limited manner set forth therein through May 15, 2024 (the “Third Amendment Specified Period”), subject to an earlier termination of the waiver upon the occurrence of certain specified events, (ii) increase the applicable margin rate by 2.00% during the Third Amendment Specified Period, which additional interest we may elect to capitalize as principal amount on the outstanding loans and (iii) modify certain covenants contained in the Credit Agreement, including, but not limited to, reducing the minimum liquidity requirement to \$10 million during the Third Amendment Specified Period and providing for additional reporting to the lenders. Refer to Note 1, *Basis of Presentation and Significant Accounting Policies and Going Concern*, to the consolidated financial statements that appear elsewhere in this Annual Report on Form 10-K for details regarding our going concern consideration.

#### **Letter Agreement**

On March 14, 2024, we entered into a Letter Agreement with Kevin Wirges, our Executive Vice President, Treasurer and Chief Financial Officer (the “Letter Agreement”). Pursuant to the Letter Agreement, we agreed to pay Mr. Wirges a lump sum cash bonus payment of \$700,000 (the “Bonus Payment”). The Bonus Payment is subject to clawback of the after-tax value of the Bonus Payment if, prior to the earlier of (i) the one-year anniversary of the date the Bonus Payment is paid, (ii) the consummation of certain events regarding the Company’s capital structure, including, without limitation, a refinancing of our existing secured indebtedness and (iii) a Change in Control of the Company (as defined in our 2021 Long-Term Incentive Plan), Mr. Wirges’ employment is terminated by us for “Cause” or due to his voluntary resignation without “Good Reason” (each as defined in Mr. Wirges’ employment agreement).

#### **Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections**

Not Applicable

### **PART III**

#### **Item 10. Directors, Executive Officers and Corporate Governance.**

The information required by this Item relating to our directors and corporate governance is incorporated herein by reference to the definitive Proxy Statement to be filed pursuant to Regulation 14A of the Exchange Act for our 2024 Annual Meeting of Stockholders (the “Definitive Proxy Statement”).

#### **Item 11. Executive Compensation.**

The information required by this Item is incorporated herein by reference to the Definitive Proxy Statement.

#### **Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.**

The information required by this Item is incorporated herein by reference to the Definitive Proxy Statement.

#### **Item 13. Certain Relationships and Related Transactions, and Director Independence.**

The information required by this Item is incorporated herein by reference to the Definitive Proxy Statement.

#### **Item 14. Principal Accounting Fees and Services.**

The information required by this Item is incorporated herein by reference to the Definitive Proxy Statement.

### **PART IV**

#### **Item 15. Exhibits, Financial Statement Schedules.**

##### **(a) Financial Statements and Financial Statements Schedules**

(1) Financial Statements are listed in the Index to Consolidated Financial Statements on page F-1 of this Annual Report.

(2) No financial statement schedules are included because such schedules are not applicable, are not required, or because required information is included in the consolidated financial statements or notes thereto.

##### **(b) Exhibits**

## Exhibit Index

| Exhibit No. | Description  |
|-------------|--|
| 2.1†        | <a href="#"><u>Business Combination Agreement, dated as of December 18, 2020, by and among the Company, the entities listed in Annex I to the Business Combination Agreement, Deerfield Healthcare Technology Acquisitions Corp., IMC Holdings, LP, CareMax Medical Group, L.L.C., IMC Medical Group Holdings, LLC, and Deerfield Partners, L.P. (Incorporated by reference to the corresponding exhibit to the Company's Current Report on Form 8-K/A, filed with the SEC on December 21, 2020).</u></a>  |
| 2.2†        | <a href="#"><u>Agreement and Plan of Merger, dated May 31, 2022, by and among, CareMax, Inc., Sparta Merger Sub I Inc., Sparta Merger Sub II Inc., Sparta Merger Sub III Inc., Sparta Merger Sub I LLC, Sparta Merger Sub II LLC, Sparta Merger Sub III LLC, Sparta Sub Inc., SNCN Holdco Inc., SICN Holdco Inc., Sparta Holding Co. LLC, and Steward Health Care System LLC (Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K, filed with the SEC on June 1, 2022).</u></a>  |
| 3.1         | <a href="#"><u>Third Amended and Restated Certificate of Incorporation (Incorporated by reference to Exhibit 3.1 to the Company's Amendment No. 1 to the Registration Statement on Form 8-A, filed with the SEC on June 9, 2021).</u></a>  |
| 3.2         | <a href="#"><u>Certificate of Amendment to the Third Amended and Restated Certificate of Incorporation of CareMax, Inc. (Incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K, filed with the SEC on February 5, 2024).</u></a>  |
| 3.3         | <a href="#"><u>Amended and Restated Bylaws (Incorporated by reference to Exhibit 3.2 to the Company's Amendment No. 1 to the Registration Statement on Form 8-A filed with the SEC on June 9, 2021).</u></a>   |
| 3.4         | <a href="#"><u>Certificate of Designation of Series A Preferred Stock of CareMax, Inc. (Incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K, filed with the SEC on November 14, 2022).</u></a>  |
| 4.1         | <a href="#"><u>Specimen Class A Common Stock Certificate (Incorporated by reference to Exhibit 4.1 to the Company's Amendment No. 1 to the Registration Statement on Form 8-A filed with the SEC on June 9, 2021).</u></a>   |
| 4.2         | <a href="#"><u>Specimen Warrant Certificate (Incorporated by reference to Exhibit 4.2 to the Company's Amendment No. 1 to the Registration Statement on Form 8-A filed with the SEC on June 9, 2021).</u></a>  |
| 4.3         | <a href="#"><u>Warrant Agreement, dated as of July 16, 2020, by and between the Company and Continental Stock Transfer &amp; Trust Company, as warrant agent (Incorporated by reference to Exhibit 4.1 the Company's Current Report on Form 8-K, filed with the SEC on July 21, 2020).</u></a>   |
| 4.4         | <a href="#"><u>Description of Securities (Incorporated by reference to Exhibit 4.4 to the Company's Annual Report on Form 10-K, filed with the SEC on March 30, 2023).</u></a>   |
| 10.1        | <a href="#"><u>Amended and Restated Registration Rights Agreement, dated as of December 18, 2020, by and among the Company, DFHTA Sponsor LLC, Deerfield Partners and the other parties thereto (Incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K/A, filed with the SEC on December 21, 2020).</u></a>  |
| 10.2        | <a href="#"><u>Form of Subscription Agreement (Incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K/A (File No. 001-39391), filed with the SEC on December 21, 2020).</u></a>   |
| 10.3        | <a href="#"><u>Form of Deerfield Subscription Agreement (Incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K/A, filed with the SEC on December 21, 2020).</u></a>  |
| 10.4†       | <a href="#"><u>Credit Agreement, dated as of May 10, 2022, by and among the Company, certain of the Company's subsidiaries as guarantors, Jefferies Finance LLC, as Administrative Agent, Collateral Agent, Sole Lead Arranger and Bookrunner, BlackRock Financial Management, as Lead Manager, Crestline Direct Finance, L.P., as Documentation Agent, and certain other banks and financial institutions serving as lenders (Incorporated by reference to Exhibit 10.24 to the Company's Amendment No. 1 to the Registration Statement on Form S-1 (File No. 333-264654), filed with the SEC on May 18, 2022).</u></a> |
| 10.5†       | <a href="#"><u>First Amendment to Credit Agreement, dated December 30, 2021, by and among the Company, Royal Bank of Canada, as Administrative Agent, Collateral Agent, Swing Line Lender and Issuing Bank, RBC Capital Markets, LLC and Truist Securities, Inc., as Syndication Agents, Joint Lead Arrangers and Joint Book Runners, and certain other banks and financial institutions serving as lenders (Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K, filed with the SEC on January 5, 2022).</u></a>  |
| 10.6        | <a href="#"><u>Second Amendment to Credit Agreement, dated as of March 8, 2023, by and among the Company, certain of the Company's subsidiaries as guarantors, Jefferies Finance LLC, as Administrative Agent, Collateral Agent, Sole Lead Arranger and Bookrunner, BlackRock Financial Management, as Lead Manager, Crestline Direct Finance, L.P., as Documentation Agent, and certain other banks and financial institutions serving as lenders (Incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q, for the period ended March 31, 2023).</u></a>                              |
| 10.7**      | <a href="#"><u>Form of Indemnification Agreement (Incorporated by reference to Exhibit 10.8 to the Company's Current Report on Form 8-K, filed with the SEC on June 14, 2021).</u></a>   |

- 10.8\*\* [CareMax, Inc. 2021 Long-Term Incentive Plan \(Incorporated by reference to Exhibit 10.9 to the Company's Current Report on Form 8-K, filed with the SEC on June 14, 2021\).](#)
- 10.9\*\* [Form of Nonstatutory Stock Option Agreement under the CareMax, Inc. 2021 Long-Term Incentive Plan \(Incorporated by reference to Exhibit 10.2 to the Company's Registration Statement on Form S-8 \(File No. 333-260477\), filed with the SEC on December 17, 2021\).](#)
- 10.10\*\* [Form of Restricted Stock Units Agreement under the CareMax, Inc. 2021 Long-Term Incentive Plan \(Incorporated by reference to Exhibit 10.3 to the Company's Registration Statement on Form S-8 \(File No. 333-260477\), filed with the SEC on December 17, 2021\).](#)
- 10.11\*\* [Form of Incentive Stock Option Agreement under the CareMax, Inc. 2021 Long-Term Incentive Plan \(Incorporated by reference to Exhibit 10.4 to the Company's Registration Statement on Form S-8 \(File No. 333-260477\), filed with the SEC on December 17, 2021\).](#)
- 10.12\*\* [Form of Restricted Stock Agreement under the CareMax, Inc. 2021 Long-Term Incentive Plan \(Incorporated by reference to Exhibit 10.5 to the Company's Registration Statement on Form S-8 \(File No. 333-260477\), filed with the SEC on December 17, 2021\).](#)
- 10.13† [MSO Risk Agreement, dated as of July 1, 2009, by and among Healthsun Health Plans, Inc. and Managed Healthcare Partners, LLC \(Incorporated by reference to Exhibit 10.10 to the Company's Current Report on Form 8-K, filed with the SEC on June 14, 2021\).](#)
- 10.14†+ [First Amendment to MSO Risk Agreement, dated as of December 17, 2015, by and among Healthsun Health Plans, Inc. and Managed Healthcare Partners, LLC \(Incorporated by reference to Exhibit 10.11 to the Company's Current Report on Form 8-K, filed with the SEC on June 14, 2021\).](#)
- 10.15 [Securities Purchase Agreement, dated as of March 8, 2021, by and among Interamerican Medical Center Group, LLC, Senior Medical Associates, LLC, Stallion Medical Management, LLC and Mohsin Jaffer \(Incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K, filed with the SEC on June 21, 2021\).](#)
- 10.16 [Asset Purchase Agreement, dated as of July 5, 2021, by and among CareMax, Inc., CareMax Medical Centers of Central Florida, LLC, Unlimited Medical Services of Florida, LLC and the other parties thereto \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K, filed with the SEC on July 7, 2021\).](#)
- 10.17 [Exclusive Real Estate Advisory Agreement, dated as of July 13, 2021, by and between CareMax, Inc., Related CM Advisor, LLC and, with respect to certain sections thereof, The Related Companies, L.P. \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K, filed with the SEC on July 13, 2021\).](#)
- 10.18\*\* [Separation and Release Agreement, dated September 30, 2021, by and between CareMax, Inc. and William C. Lamoreaux \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K, filed with the SEC on October 6, 2021\).](#)
- 10.19\*\* [Executive Employment Agreement, dated December 13, 2021, by and between Managed Healthcare Partners, L.L.C. and Carlos A. de Solo \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K, filed with the SEC on December 17, 2021\).](#)
- 10.20\*\* [Executive Employment Agreement, dated December 13, 2021, by and between Managed Healthcare Partners, L.L.C. and Alberto de Solo \(Incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K, filed with the SEC on December 17, 2021\).](#)
- 10.21\*\* [Executive Employment Agreement, dated December 13, 2021, by and between Managed Healthcare Partners, L.L.C. and Kevin Wirges \(Incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K, filed with the SEC on December 17, 2021\).](#)
- 10.22† [Investor Rights Agreement, dated as of November 10, 2022, by and between CareMax, Inc., Dr. Ralph de la Torre, Dr. Michael Callum, and certain other equity holders \(Incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K, filed with the SEC on November 14, 2022\).](#)
- 10.23 [Amendment to that certain Amended and Restated Registration Rights Agreement, dated as of November 10, 2022, by and among CareMax, Inc. and certain investors, including the Majority Deerfield Investors, the Majority IMC Investors, and the Majority CareMax Investors \(Incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K, filed with the SEC on November 14, 2022\).](#)
- 10.24 [Amendment to that certain Registration Rights Agreement, dated as of November 10, 2022, by and among CareMax, Inc. and Related CM Advisor, LLC \(Incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K, filed with the SEC on November 14, 2022\).](#)
- 10.25 [Consent and First Amendment to Credit Agreement, dated as of November 10, 2022, by and among CareMax, Inc., the subsidiary guarantors party thereto, the lenders party thereto and Jefferies Finance LLC, as administrative agent \(Incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K, filed with the SEC on November 14, 2022\).](#)
- 21.1\* [List of Subsidiaries.](#)
- 23.1\* [Consent of PricewaterhouseCoopers LLP.](#)

|          |   |
|----------|---|
| 31.1*    | <a href="#">Certification of Principal Executive Officer Pursuant to Securities Exchange Act Rules 13a-14(a) and 15(d)-14(a), as adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.</a> |
| 31.2*    | <a href="#">Certification of Principal Financial Officer Pursuant to Securities Exchange Act Rules 13a-14(a) and 15(d)-14(a), as adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.</a> |
| 32.1*    | <a href="#">Certification of Principal Executive Officer Pursuant to 18 U.S.C. Section 1350, as adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.</a>                                  |
| 32.2*    | <a href="#">Certification of Principal Financial Officer Pursuant to 18 U.S.C. Section 1350, as adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.</a>                                  |
| 97.1*    | <a href="#">CareMax, Inc. Compensation Clawback Policy</a>  |
| 101.INS* | Inline XBRL Instance Document   |
| 101.SCH* | Inline XBRL Taxonomy Extension Schema Document  |
| 101.CAL* | Inline XBRL Taxonomy Extension Calculation Linkbase Document  |
| 101.DEF* | Inline XBRL Taxonomy Extension Definition Linkbase Document   |
| 101.LAB* | Inline XBRL Taxonomy Extension Label Linkbase Document  |
| 101.PRE* | Inline XBRL Taxonomy Extension Presentation Linkbase Document   |
| 104*     | Cover Page Interactive Data File (formatted as Inline XBRL)   |

+ Certain portions of this exhibit have been omitted pursuant to Regulation S-K, Item (601)(b)(10).

† Certain of the exhibits and schedules to this Exhibit have been omitted in accordance with Regulation S-K Item 601(a)(5). The Registrant agrees to furnish a copy of all omitted exhibits and schedules to the SEC upon its request.

\* Filed or furnished herewith.

\* \* Management contracts or compensation plans, contracts or arrangements.

**Item 16. Form 10-K Summary**

None.

## SIGNATURES

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

Date: March 18, 2024

**CareMax, Inc.**

/s/ Carlos A. de Solo

Name: Carlos A. de Solo

Title: President and Chief Executive Officer

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

| <u>Signature</u>  | <u>Capacity</u>  | <u>Date</u>    |
|---|--|----------------|
| <u>/s/ Carlos A. de Solo</u><br>Carlos A. de Solo         | President, Chief Executive Officer and Director (Principal Executive Officer)                                | March 18, 2024 |
| <u>/s/ Kevin Wirges</u><br>Kevin Wirges                   | Executive Vice President, Treasurer and Chief Financial Officer (Principal Financial and Accounting Officer) | March 18, 2024 |
| <u>/s/ Jose R. Rodriguez</u><br>Jose R. Rodriguez         | Chairman of the Board of Directors   | March 18, 2024 |
| <u>/s/ Kevin Berg</u><br>Kevin Berg                       | Director   | March 18, 2024 |
| <u>/s/ Bryan Cho</u><br>Bryan Cho                         | Director   | March 18, 2024 |
| <u>/s/ Dr. Vincent Omachonu</u><br>Dr. Vincent Omachonu   | Director   | March 18, 2024 |
| <u>/s/ Ryan O'Quinn</u><br>Ryan O'Quinn                   | Director   | March 18, 2024 |
| <u>/s/ Dr. Ralph de la Torre</u><br>Dr. Ralph de la Torre | Director   | March 18, 2024 |

## INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

|   |     |
|---|-----|
| <a href="#"><u>Report of Independent Registered Public Accounting Firm (PCAOB ID 238)</u></a>                         | F-2 |
| <a href="#"><u>Consolidated Balance Sheets as of December 31, 2023 and 2022</u></a>                                   | F-4 |
| <a href="#"><u>Consolidated Statements of Operations for the Years Ended December 31, 2023 and 2022</u></a>           | F-5 |
| <a href="#"><u>Consolidated Statements of Stockholders' Equity for the Years Ended December 31, 2023 and 2022</u></a> | F-6 |
| <a href="#"><u>Consolidated Statements of Cash Flows for the Years Ended December 31, 2023 and 2022</u></a>           | F-7 |
| <a href="#"><u>Notes to Consolidated Financial Statements</u></a>   | F-9 |

## Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of CareMax, Inc.

### ***Opinion on the Financial Statements***

We have audited the accompanying consolidated balance sheet of CareMax, Inc. and its subsidiaries (the “Company”) as of December 31, 2023 and 2022, and the related consolidated statements of operations, of changes in stockholders’ equity and of cash flows for the years then ended, including the related notes (collectively referred to as the “consolidated financial statements”). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

### ***Substantial Doubt About the Company’s Ability to Continue as a Going Concern***

The accompanying consolidated financial statements have been prepared assuming that the Company will continue as a going concern. As discussed in Note 1 to the consolidated financial statements, the Company has incurred recurring losses from operations and negative cash flows from operations which caused the Company to fail a financial covenant in its Credit Agreement as of December 31, 2023, but for which it received a limited waiver from the lenders. The Company expects to continue to generate losses and negative cash flows, which are expected to cause it to continue to fail its financial covenants. These conditions raise substantial doubt about the Company’s ability to continue as a going concern. Management’s plans in regard to these matters are also described in Note 1. The consolidated financial statements do not include any adjustments that might result from the outcome of this uncertainty.

### ***Change in Accounting Principle***

As discussed in Note 2 to the consolidated financial statements, the Company changed the manner in which it accounts for leases in 2022.

### ***Basis for Opinion***

These consolidated financial statements are the responsibility of the Company’s management. Our responsibility is to express an opinion on the Company’s consolidated financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits of these consolidated financial statements in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits we are required to obtain an understanding of internal control over financial reporting but not for the purpose of expressing an opinion on the effectiveness of the Company’s internal control over financial reporting. Accordingly, we express no such opinion.

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

/s/ PricewaterhouseCoopers LLP

Miami, Florida  
March 18, 2024

We have served as the Company’s auditor since 2022.



**CAREMAX, INC.**  
**CONSOLIDATED BALANCE SHEETS**  
(in thousands, except share and per share data)

|  | December 31,<br>2023 | December 31,<br>2022 |
|--|----------------------|----------------------|
| <b>ASSETS</b>  |                      |                      |
| <b>Current Assets</b>  |                      |                      |
| Cash and cash equivalents  | \$ 65,528            | \$ 41,626            |
| Accounts receivable, net   | 114,754              | 151,743              |
| Other current assets   | 3,066                | 3,968                |
| <b>Total Current Assets</b>  | <b>183,348</b>       | <b>197,336</b>       |
| Property and equipment, net  | 47,918               | 21,006               |
| Operating lease right-of-use assets  | 109,215              | 108,937              |
| Goodwill, net  | 156,841              | 700,643              |
| Intangible assets, net   | 101,243              | 123,585              |
| Deferred debt issuance costs   | —                    | 1,685                |
| Other assets   | 24,737               | 17,550               |
| <b>Total Assets</b>  | <b>\$ 623,301</b>    | <b>\$ 1,170,743</b>  |
| <b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>  |                      |                      |
| <b>Current Liabilities</b>   |                      |                      |
| Accounts payable   | \$ 6,275             | \$ 7,687             |
| Accrued expenses   | 16,224               | 16,854               |
| Risk settlement liabilities  | 42,602               | 14,171               |
| Related party liabilities  | 190                  | 1,777                |
| Related party debt, net  | —                    | 30,277               |
| Current portion of third-party debt, net   | 364,380              | 253                  |
| Current portion of operating lease liabilities   | 8,975                | 5,512                |
| Other current liabilities  | 165                  | 790                  |
| <b>Total Current Liabilities</b>   | <b>438,812</b>       | <b>77,322</b>        |
| Derivative warrant liabilities   | 22                   | 3,974                |
| Long-term debt, net  | 21,443               | 230,725              |
| Long-term operating lease liabilities  | 97,136               | 96,539               |
| Contingent earnout liability   | —                    | 134,561              |
| Other liabilities  | 4,443                | 8,075                |
| <b>Total Liabilities</b>   | <b>561,856</b>       | <b>551,196</b>       |
| <b>COMMITMENTS AND CONTINGENCIES (NOTE 16)</b>   |                      |                      |
| <b>STOCKHOLDERS' EQUITY</b>  |                      |                      |
| Preferred stock (1,000,000 shares authorized; one share issued and outstanding as of December 31, 2023 and December 31, 2022)  | —                    | —                    |
| Class A common stock (\$0.0001 par value; 8,333,333 shares authorized; 3,744,732 and 3,711,086 shares issued and outstanding as of December 31, 2023 and December 31, 2022, respectively) <sup>1</sup> | 11                   | 11                   |
| Additional paid-in-capital   | 782,371              | 657,126              |
| Accumulated deficit  | (720,938)            | (37,590)             |
| <b>Total Stockholders' Equity</b>  | <b>61,444</b>        | <b>619,547</b>       |
| <b>Total Liabilities and Stockholders' Equity</b>  | <b>\$ 623,301</b>    | <b>\$ 1,170,743</b>  |

<sup>1</sup> Share amounts have been restated to reflect the 1-for-30 reverse stock split that the Company completed on January 31, 2024.

The accompanying notes are an integral part of these consolidated financial statements.

**CAREMAX, INC.**  
**CONSOLIDATED STATEMENTS OF OPERATIONS**  
(in thousands, except share and per share data)

|   | Years Ended December 31, |                    |
|---|--------------------------|--------------------|
|   | 2023                     | 2022               |
| <b>Revenue</b>  |                          |                    |
| Medicare risk-based revenue                                     | \$ 519,834               | \$ 486,718         |
| Medicaid risk-based revenue                                     | 105,893                  | 96,534             |
| Government value-based care revenue                             | 67,708                   | 6,389              |
| Other revenue   | 57,667                   | 41,492             |
| Total revenue   | <u>751,102</u>           | <u>631,132</u>     |
| <b>Operating expenses</b>                                       |                          |                    |
| External provider costs   | 572,329                  | 424,182            |
| Cost of care  | 164,872                  | 126,648            |
| Sales and marketing   | 14,274                   | 11,761             |
| Corporate, general and administrative                           | 80,684                   | 75,824             |
| Depreciation and amortization                                   | 27,787                   | 21,719             |
| Goodwill impairment   | 547,200                  | 70,000             |
| Acquisition related costs                                       | 108                      | 13,165             |
| Total operating expenses  | <u>1,407,254</u>         | <u>743,297</u>     |
| Operating loss  | <u>(656,152)</u>         | <u>(112,165)</u>   |
| <b>Nonoperating income (expense)</b>                            |                          |                    |
| Interest expense  | (54,434)                 | (20,455)           |
| Change in fair value of derivative warrant liabilities          | 3,952                    | 4,401              |
| Gain on remeasurement of contingent earnout liabilities         | 19,916                   | 76,295             |
| Loss on extinguishment of debt                                  | —                        | (6,172)            |
| Other income, net   | 2,507                    | 759                |
| Total nonoperating expenses                                     | <u>(28,059)</u>          | <u>54,828</u>      |
| <b>Loss before income tax</b>                                   | <u>(684,211)</u>         | <u>(57,337)</u>    |
| Income tax benefit  | (863)                    | (19,542)           |
| <b>Net loss</b>   | <u>\$ (683,348)</u>      | <u>\$ (37,796)</u> |
| <b>Weighted-average basic shares outstanding</b> <sup>1</sup>   | 3,727,725                | 3,026,644          |
| <b>Weighted-average diluted shares outstanding</b> <sup>1</sup> | 3,727,725                | 3,026,644          |
| <b>Net loss per share</b>                                       |                          |                    |
| Basic   | \$ (183.31)              | \$ (12.49)         |
| Diluted   | \$ (183.31)              | \$ (12.49)         |

<sup>1</sup> Share amounts have been restated to reflect the 1-for-30 reverse stock split that the Company completed on January 31, 2024.

The accompanying notes are an integral part of these consolidated financial statements.

**CAREMAX, INC.**  
**CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY**  
(in thousands, except share data)

|  | Years Ended December 31, 2023 and 2022 |              |             |                   |                     |                  |
|--|--|--------------|-------------|-------------------|---------------------|------------------|
|  | Class A Common Stock <sup>1</sup>      |              | Preferred   | Additional        | Retained Earnings   | Total            |
|  | Shares                                 | Amount       | Stock       | Paid-in-capital   | (Deficit)           | Equity           |
| <b>BALANCE - DECEMBER 31, 2021</b>   | 2,912,266                              | \$ 9         | \$ —        | \$ 505,327        | \$ 33               | \$ 505,370       |
| Stock-based compensation expense   | —                                      | —            | —           | 10,271            | —                   | 10,271           |
| Issuance of shares upon vesting of stock-based compensation awards           | 17,854                                 | —            | —           | —                 | —                   | —                |
| Initial Share Consideration to acquire Steward Value-Based Care              | 783,333                                | 2            | —           | 134,418           | —                   | 134,420          |
| Cancellation of shares and return of cash held in escrow                     | (2,367)                                | —            | —           | (481)             | —                   | (481)            |
| Vesting of Series B Warrants under Advisory Agreement                        | —                                      | —            | —           | 7,590             | —                   | 7,590            |
| Other  | —                                      | —            | —           | —                 | 173                 | 173              |
| Net loss   | —                                      | —            | —           | —                 | (37,796)            | (37,796)         |
| <b>BALANCE - DECEMBER 31, 2022</b>   | <u>3,711,086</u>                       | <u>11</u>    | <u>—</u>    | <u>657,126</u>    | <u>(37,590)</u>     | <u>619,547</u>   |
| Stock-based compensation expense   | —                                      | —            | —           | 10,599            | —                   | 10,599           |
| Issuance of shares upon vesting of stock-based compensation awards           | 33,646                                 | —            | —           | —                 | —                   | —                |
| Reclassification of contingent consideration previously liability classified | —                                      | —            | —           | 114,645           | —                   | 114,645          |
| Net loss   | —                                      | —            | —           | —                 | (683,348)           | (683,348)        |
| <b>BALANCE - DECEMBER 31, 2023</b>   | <u>3,744,732</u>                       | <u>\$ 11</u> | <u>\$ —</u> | <u>\$ 782,371</u> | <u>\$ (720,938)</u> | <u>\$ 61,444</u> |

<sup>1</sup> Share amounts have been restated to reflect the 1-for-30 reverse stock split that the Company completed on January 31, 2024.

The accompanying notes are an integral part of these consolidated financial statements.

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

|   | Years Ended December 31, |                  |
|---|--------------------------|------------------|
|   | 2023                     | 2022             |
| <b>CASH FLOWS FROM OPERATING ACTIVITIES</b>                     |                          |                  |
| Net loss  | \$ (683,348)             | \$ (37,796)      |
| Adjustments to reconcile net loss to cash and cash equivalents: |                          |                  |
| Depreciation and amortization expense                           | 27,787                   | 21,719           |
| Amortization of debt issuance costs and discounts               | 8,314                    | 2,382            |
| Stock-based compensation expense                                | 10,599                   | 10,271           |
| Income tax benefit  | (863)                    | (19,542)         |
| Change in fair value of derivative warrant liabilities          | (3,952)                  | (4,401)          |
| Gain on remeasurement of contingent earnout liabilities         | (19,916)                 | (76,295)         |
| Loss on extinguishment of debt                                  | —                        | 6,172            |
| Payment-in-kind interest expense                                | 12,064                   | 5,277            |
| Non-cash finance lease expense                                  | 419                      | —                |
| Provision for credit losses                                     | (1,588)                  | 1,243            |
| Goodwill impairment   | 547,200                  | 70,000           |
| Amortization of right-of-use assets                             | 11,527                   | —                |
| Other non-cash, net   | 1,488                    | 853              |
| Changes in operating assets and liabilities:                    |                          |                  |
| Accounts receivable   | 25,941                   | (66,561)         |
| Other current assets  | 902                      | 2,505            |
| Risk settlement liabilities                                     | 32,560                   | 6,775            |
| Other assets  | (6,501)                  | (3,127)          |
| Operating lease liabilities                                     | (5,897)                  | 4,386            |
| Accounts payable  | 413                      | 1,730            |
| Accrued expenses  | (2,601)                  | 4,722            |
| Related party liabilities                                       | (1,069)                  | —                |
| Other liabilities   | (393)                    | 1,470            |
| Net cash used in operating activities                           | <u>(46,913)</u>          | <u>(68,216)</u>  |
| <b>CASH FLOWS FROM INVESTING ACTIVITIES</b>                     |                          |                  |
| Purchase of property and equipment                              | (14,611)                 | (7,450)          |
| Return of cash held in escrow                                   | —                        | 785              |
| Acquisition of businesses, net of cash acquired                 | —                        | (55,837)         |
| Net cash used in investing activities                           | <u>(14,611)</u>          | <u>(62,502)</u>  |
| <b>CASH FLOWS FROM FINANCING ACTIVITIES</b>                     |                          |                  |
| Proceeds from borrowings  | 122,000                  | 229,241          |
| Proceeds from related party borrowings                          | —                        | 29,876           |
| Principal payments of related party debt                        | (35,510)                 | (121,977)        |
| Principal payments of third-party debt                          | (253)                    | —                |
| Payments of debt issuance costs                                 | (810)                    | (7,272)          |
| Collateral for letters of credit                                | —                        | (5,439)          |
| Net cash provided by financing activities                       | <u>85,427</u>            | <u>124,428</u>   |
| <b>NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS</b>     |                          |                  |
| Cash and cash equivalents - beginning of period                 | 41,626                   | 47,917           |
| <b>CASH AND CASH EQUIVALENTS - END OF PERIOD</b>                | <u>\$ 65,528</u>         | <u>\$ 41,626</u> |

The accompanying notes are an integral part of these consolidated financial statements.

**CAREMAX, INC.**  
**CONSOLIDATED STATEMENTS OF CASH FLOW - CONTINUED**

|   | Years Ended December 31, |          |
|---|--------------------------|----------|
|   | 2023                     | 2022     |
| <b>SUPPLEMENTAL SCHEDULE OF NON-CASH ACTIVITIES:</b>                              |                          |          |
| Equity and warrant consideration issued to The Related Companies, L.P.            | \$ —                     | \$ 7,590 |
| Equity consideration issued in acquisitions                                       | —                        | 134,420  |
| Contingent consideration issued in business combination                           | —                        | 210,856  |
| Additions to property and equipment funded through accounts payable               | 1,039                    | 2,847    |
| Cancellation of shares held in escrow   | —                        | 821      |
| Accrued purchase consideration  | —                        | 1,225    |
| Financed property and equipment purchases   | 957                      | 607      |
| Reclassification of contingent consideration previously liability classified      | 114,645                  | —        |
| Decrease in right-of-use assets and lease liabilities due to lease remeasurements | 3,747                    | —        |
| Right-of-use assets obtained in exchange for operating lease obligations          | 16,745                   | 44,184   |
| Right-of-use assets obtained in exchange for finance lease obligations            | 19,193                   | —        |
| <b>SUPPLEMENTAL CASH FLOW INFORMATION:</b>  |                          |          |
| Cash paid for interest  | 34,307                   | 12,797   |

The accompanying notes are an integral part of these consolidated financial statements.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements**

**NOTE 1. DESCRIPTION OF BUSINESS AND GOING CONCERN**

CareMax, Inc. (“CareMax” or the “Company”), formerly Deerfield Healthcare Technology Acquisitions Corp. (“DFHT”), is a Delaware corporation, which announced its initial public offering in July 2020 (the “IPO”) as a publicly traded special purpose acquisition company for the purpose of effecting a merger, capital stock exchange, asset acquisition, stock purchase, reorganization, or similar business combination involving one or more businesses. CareMax provides high-quality, value-based care and chronic disease management through physicians and health care professionals committed to the overall health and wellness continuum of care for its patients. As of December 31, 2023, the Company operated 56 centers and managed affiliated providers across 10 states that offer a comprehensive suite of healthcare and social services, and a proprietary software and services platform that provides data, analytics, and rules-based decision tools/workflows for physicians across the United States.

**The Business Combination and Acquisitions**

On December 18, 2020, DFHT entered into a Business Combination Agreement (the “Business Combination Agreement”) with CareMax Medical Group, L.L.C., a Florida limited liability company (“CMG”), and entities listed in the Business Combination Agreement (the “CMG Sellers”), IMC Medical Group Holdings, LLC, a Delaware limited liability company (“IMC”), IMC Holdings, LP, a Delaware limited partnership (“IMC Parent”), and Deerfield Partners, L.P. (“Deerfield Partners”). The Business Combination (as defined below) closed on June 8, 2021 (the “Closing Date”), whereby DFHT acquired 100% of the equity interests in CMG and 100% of the equity interests in IMC, with CMG and IMC becoming wholly owned subsidiaries of DFHT. Immediately upon completion (the “Closing”) of the transactions contemplated by the Business Combination Agreement and the related financing transactions (the “Business Combination”), the name of the combined company was changed to CareMax, Inc.

Unless the context otherwise requires, “the Company,” “we,” “us,” and “our” refer, for periods prior to the completion of the Business Combination, to CMG and its subsidiaries, and, for periods upon or after the completion of the Business Combination, to CareMax, Inc. and its subsidiaries.

Subsequent to consummation of the Business Combination, primarily during the second half of 2021, the Company acquired Senior Medical Associates, LLC (“SMA”), Stallion Medical Management, LLC (“SMM”), Unlimited Medical Services of Florida, LLC (“DNF”), Advantis Physician Alliance, LLC (“Advantis”), Business Intelligence & Analytics LLC (“BIX”), and three additional businesses (together with the acquisitions of SMA, SMM, DNF, Advantis and BIX, the “Acquisitions”). In November 2022, the Company acquired the Medicare value-based care business of Steward Health Care System (“Steward Value-Based Care”), further described in Note 4, *Acquisitions*. Refer to Note 6, *Goodwill and Other Intangible Assets*, for information about measurement period adjustments.

**Going Concern**

The Company’s consolidated financial statements have been prepared assuming the Company will continue as a going concern, which contemplates the realization of assets and the settlement of liabilities and commitments in the normal course of business. The Company has generated recurring losses and negative cash flows from operations since completion of the Business Combination, and based on projections following its fourth quarter 2023 results, management believes that, absent the Company successfully taking certain measures to reduce operating expenses and/or divest certain assets or businesses, as set forth below, the Company will continue to incur net losses and negative cash flows for the foreseeable future. The Company obtained a limited waiver of certain breaches of financial covenants under the Credit Agreement through May 15, 2024, subject to an earlier termination of the waiver upon the occurrence of certain specified events, as further explained in Note 18, *Subsequent Events*. Further, as of the date hereof, the Company has failed to pay rent under certain of its lease agreements. Although the Company had \$65.5 million in cash and cash equivalents and \$114.8 million of accounts receivable, net, at December 31, 2023, absent the Company successfully implementing management’s plans as set forth below, the Company believes it will not be able to comply with the minimum liquidity requirement and maximum leverage ratio covenants contained in its Credit Agreement once the current limited waiver expires. These conditions raise substantial doubt regarding the Company’s ability to continue as a going concern for one year after the date these consolidated financial statements are issued, and these financial statements do not include any adjustments that may result from the outcome of this uncertainty.

Management’s plans that are intended to mitigate the conditions that raise substantial doubt about the Company’s ability to continue as a going concern include selling certain assets, exiting certain markets and reducing operating expenses. The Company’s efforts to reduce operating expenses may include lowering external provider costs, exiting nonprofitable centers, consolidating certain medical centers, delaying capital expenditures and reducing non-essential spending. The Company may also seek to raise additional capital or refinance its indebtedness to provide additional liquidity to fund its losses until its operations become cash flow positive. There is no guarantee

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

that the Company will be able to implement its operational plans or raise additional equity or debt financing on acceptable terms, if at all.

**Reverse Stock Split**

As previously disclosed in the Company's Current Report on Form 8-K filed with the SEC on February 5, 2024, on January 31, 2024 (the "Effective Date"), the Company effected a 1-for-30 reverse stock split of the Company's Class A common stock, par value \$0.0001 (the "Reverse Split"). As a result of the Reverse Split, every thirty shares of the Class A Common Stock issued and outstanding as of the Effective Date automatically converted into one share of Class A Common Stock. No fractional shares were issued in connection with the Reverse Split. In lieu of issuing fractional shares, stockholders of record who otherwise would have been entitled to receive fractional shares were entitled to rounding up of the fractional share to the nearest whole number. The Reverse Split automatically and proportionately adjusted, based on a 1-for-30 split ratio, all issued and outstanding shares of the Company's common stock, as well as the terms of warrants outstanding at the time of the effectiveness of the Reverse Split. Proportionate adjustments were made to the per share exercise price and the number of shares issuable upon the exercise of all outstanding stock options and warrants to purchase shares of common stock. There was no change in the par value of our Common Stock or Preferred Stock.

References to number of shares of Class A Common Stock and per share data (except par value) in the accompanying financial statements and notes thereto for periods ended prior to January 31, 2024 have been adjusted to reflect the Reverse Split on a retroactive basis for all periods presented.

**NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Basis of Presentation and Principles of Consolidation**

The consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and in accordance with the instructions to Form 10-K and Article 8 of Regulation S-X of the Securities and Exchange Commission (the "SEC"). The consolidated financial statements include the accounts and operations of the Company and its wholly owned subsidiaries. All intercompany accounts and transactions are eliminated upon consolidation. Certain amounts in the prior year's consolidated financial statements have been reclassified to conform to the current year presentation.

**Variable Interest Entities**

The Company evaluates its ownership, contractual and other interests in entities to determine if it has any variable interest in a variable interest entity ("VIE"). These evaluations are complex, involve judgment, and the use of estimates and assumptions based on available historical information, among other factors. The Company considers itself to control an entity if it is the majority owner of or has voting control over such entity. The Company also assesses control through means other than voting rights and determines which business entity is the primary beneficiary of the VIE. The Company consolidates VIEs when it is determined that the Company is the primary beneficiary of the VIE. Management performs ongoing reassessments of whether changes in the facts and circumstances regarding the Company's involvement with a VIE will cause the consolidation conclusion to change. Changes in consolidation status are applied prospectively. Refer to Note 17, *Variable Interest Entities*, for additional information.

**Emerging Growth Company**

Section 102(b)(1) of the JOBS Act exempts emerging growth companies from being required to comply with new or revised financial accounting standards until private companies (that is, those that have not had a Securities Act registration statement declared effective or do not have a class of securities registered under the Exchange Act) are required to comply with the new or revised financial accounting standards. The JOBS Act provides that a company can elect to opt out of the extended transition period and comply with the requirements that apply to nonemerging growth companies, but any such election to opt out is irrevocable. The Company has elected not to opt out of such extended transition period, which means that when a standard is issued or revised and it has different application dates for public or private companies, the Company, as an emerging growth company, can adopt the new or revised standard at the time private companies adopt the new or revised standard. This may make comparison of the Company's consolidated financial statements with another public company which is neither an emerging growth company nor an emerging growth company that has opted out of using the extended transition period difficult or impossible because of the potential differences in accounting standards used. Additionally, as an emerging growth company, the Company is exempt from the auditor attestation requirements of Section 404(b) of the Sarbanes-Oxley Act of 2002, as amended, and the Company's independent registered public accounting firm is not required to evaluate and report on the effectiveness of internal control over financial reporting.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

**Segment Financial Information**

The Company's chief operating decision maker ("CODM"), who is the Company's Chief Executive Officer, regularly reviews financial operating results on a consolidated basis for purposes of allocating resources and evaluating financial performance. The Company identifies operating segments based on this review by its CODM and operates in and reports as a single operating segment, which is to care for its patients' needs. For the periods presented, all of the Company's long-lived assets were located in the United States, and all revenue was earned in the United States.

**Use of Estimates**

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas where significant estimates are used in the accompanying financial statements include, but are not limited to, revenues and related receivables from risk adjustments, costs of our services and related liabilities, purchase price allocations, including fair value estimates of intangibles and contingent consideration, the valuation and related impairment testing of long-lived assets, including goodwill and intangible assets, the valuation of derivative warrant liabilities, and the estimated useful lives of fixed assets and intangible assets, including internally developed software. Actual results could differ from those estimates.

**Business Combinations**

The Company accounts for business combinations under the acquisition method of accounting, in accordance with ASC 805, *Business Combinations*, which requires assets acquired and liabilities assumed to be recognized at their fair values on the acquisition date. Any excess of the fair value of purchase consideration over the fair value of the assets acquired less liabilities assumed is recorded as goodwill. The fair values of the assets acquired and liabilities assumed are determined based upon the valuation of the acquired business and involves management making significant estimates and assumptions.

The Company's acquisitions, at times, have included earn-out provisions, also referred to as contingent consideration, which provide for additional consideration to be paid to the seller if certain conditions are met. These provisions are recorded as liabilities or as equity at fair value on the acquisition date and re-assessed for balance sheet classification and re-measured at fair value each reporting period until they expire or settle.

**Cash and Cash Equivalents**

Cash and cash equivalents consist of currency on hand with banks and financial institutions and investments in money market funds. The Company considers all short-term, highly liquid investments with an original maturity of three months or less at the date of purchase to be cash equivalents.

The Company's cash balances with individual banking institutions are in excess of federally insured limits from time to time. The Company believes it is not exposed to any significant concentrations of credit risk from these financial instruments. The Company has not experienced any losses on its deposits of cash and cash equivalents.

**Medicare and Medicaid Risk-Based Revenue**

Medicare and Medicaid Risk-Based Revenue consists primarily of fees for medical services provided under capitated arrangements directly with various Medicare Advantage and Medicaid managed care payors. The Company receives a fixed fee per patient under what is typically known as a "risk contract." Risk contracting, or full risk capitation, refers to a model in which the Company receives from the third-party payor a fixed payment of at-risk premium less an administrative charge for reporting on enrollees on a per patient per month basis ("PMPM" payment) for a defined patient population, and the Company is then responsible for providing healthcare services required by that patient population. PMPM fees can fluctuate throughout the contract based on the health status (acuity) of each individual enrollee. In certain contracts, PMPM fees also include "risk adjustments" for items such as performance incentives, performance guarantees and risk shares. The capitated revenues are recognized based on the estimated PMPM fees earned net of projected performance incentives, performance guarantees, risk shares and rebates because we are able to reasonably estimate the ultimate PMPM payment of these contracts. We recognize revenue in the month in which eligible members are entitled to receive healthcare benefits. Subsequent changes in PMPM fees and the amount of revenue to be recognized are reflected through subsequent period adjustments to properly recognize the ultimate capitation amount.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

For enrolled members in which we control healthcare services, we act as the principal and the gross fees under these contracts are reported as revenue and the cost of third-party medical care is included in external provider costs.

The Company generates management services organization (“MSO”) revenue for services it renders to independent physician associations (the “IPAs”) under administrative service contracts. The MSO revenue is recognized in the month in which the eligible members are entitled to receive healthcare benefits during the contract term. For MSO contracts in which the Company acts as a principal in coordinating and controlling the range of services provided (other than clinical decisions) and, thus, accepts full financial risk for members attributed to the IPA and is therefore responsible for the cost of all healthcare services required by those members, the fees are recognized on a gross basis, consistent with ASC 606, *Revenue From Contracts with Customers* (“ASC 606”). The related revenue is recorded in Medicare risk-based or Medicaid risk-based revenue.

**Government Value-Based Care Revenue**

Government Value-Based Care Revenue consists primarily of revenue derived from the Medicare Shared Savings Program (“MSSP”). The MSSP is sponsored by the Center for Medicare and Medicaid Services (“CMS”). The MSSP allows accountable care organizations (“ACOs”) to receive a share of cost savings they generate in connection with the managing of costs and quality of medical services rendered to Medicare beneficiaries. Payments to ACO participants, if any, are calculated annually and paid once a year by CMS on cost savings generated by the ACO participant relative to the ACO participants’ CMS benchmark. Under the MSSP, an ACO must meet certain qualifications to receive the full amount of its allocable cost savings or they either receive nothing or are responsible for shared losses. The MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive shared savings. An ACO that meets the MSSP’s quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below the medical expenditure benchmark provided by CMS. A Minimum Savings Rate (“MSR”) must be achieved before the ACO can receive a share of the savings. Once the MSR is surpassed, all the savings below the benchmark provided by CMS will be shared at a certain percentage with the ACO. The MSR varies depending on the number of beneficiaries assigned to the ACO.

The promised services under the Company’s MSSP arrangements are to provide the population health services to beneficiaries for a given performance period. As part of these arrangements, the Company stands ready to provide the population with health services throughout the performance period.

The Company estimates the variable consideration that constitutes the transaction price of these arrangements by utilizing third-party data and historical experience. As the Company’s performance obligation is met, revenue is recorded over time using its estimation methods and consideration is made, to the extent possible, that it is probable that a significant reversal will not occur once any uncertainty associated with the variable consideration is subsequently resolved. Since the Company has determined it only has one performance obligation under each of these arrangements, it allocates the full transaction price towards each arrangement’s individual performance obligation. From time to time, but at least annually, we assess our estimates with an independent actuarial expert to ensure our estimates are reasonable given the data available to us at the time the estimates are made.

Government Value-Based Care Revenue is recognized on a net basis, because the Company does not control the range of services provided and, thus, accepts partial financial risk.

**Other Revenue**

Other Revenue primarily represents partial and no risk capitation, MSO and pharmacy revenue. Capitation revenue represents a fixed amount of money PMPM paid in advance for the delivery of primary care services only, whereby the Company is not liable for medical costs in excess of the fixed payment. Capitated revenues are typically prepaid monthly to the Company based on the number of patients selecting us as their primary care provider. Our capitated rates are fixed, contractual rates. Incentive payments for Healthcare Effectiveness Data and Information Set (“HEDIS”) and any services paid on a fee for service basis by a health plan are also included in other revenue. Other revenue also includes ancillary fees earned under contracts with certain payors for the provision of certain care coordination and other care management services. These services are provided to patients covered by these payors regardless of whether those patients receive their care from our affiliated medical groups. Revenue for primary care services for patients in a partial risk or upside-only contracts is reported in other revenue.

For MSO contracts in which the Company does not control the range of services provided and, thus, accepts partial or no financial risk for members attributed to the IPA, the revenue is recognized on a net basis, consistent with ASC 606, and is recorded in Other revenue.

**External Provider Costs**

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

External Provider Costs represents cost of care for our at-risk patients and for third-party healthcare service providers that provide medical care to our patients for which we are contractually obligated to pay (through our full-risk capitation arrangements). The estimated reserve for a liability for unpaid claims is included in "Accounts receivable, net" in the consolidated balance sheets. Actual claims expense will differ from the estimated liability due to differences in estimated and actual member utilization of health care services, the amount of charges and other factors. From time to time, but at least annually, we assess our estimates with an independent actuarial expert to ensure our estimates represent the best, most reasonable estimate given the data available to us at the time the estimates are made. Certain third-party payor contracts include a Medicare Part D payment related to pharmacy claims, which is subject to risk sharing through accepted risk corridor provisions. Under certain agreements the fund risk allocation is established whereby we, as the contracted provider, receive only a portion of the risk and the associated surplus or deficit. We estimate and recognize an adjustment to medical expenses for Part D claims related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual risk contract were to terminate at the end of the reporting period. External provider costs are included in "Accounts Receivable, net" or "other assets" in the consolidated balance sheets, based on the expected collectability time from financial statement date.

**Accounts Receivable**

Accounts receivable are carried at the amounts the Company deems collectible, which are expected to be collected within twelve months or less. Accordingly, an allowance is provided based on credit losses expected over the contractual term. This allowance is netted against the receivable balance with the loss being recognized within general and administrative expenses in the consolidated statements of operations. Accounts receivables are written off or reserved for when they are deemed uncollectible. As of December 31, 2023 and 2022, the Company's provision for credit losses was \$3.1 million and \$1.2 million, respectively.

Accounts receivable include MRA receivables which are accrued and estimated based on the health status (acuity) and demographic characteristics of members. These estimates are continually evaluated and adjusted by management based upon our historical experience and other factors. Amounts are only included as MRA receivables to the extent it is probable that a significant reversal of cumulative revenue will not occur once any uncertainty is resolved.

**Risk Settlement Liabilities**

Risk settlement liabilities represents net accruals from health plan agreements, for which the Company is financially responsible under its at-risk revenue arrangements, and accruals for payments to be made to providers as distributions pursuant to service agreements. These liabilities are expected to be paid within twelve months or less.

**Fair Value of Financial Instruments**

Fair value is defined as the price that would be received for sale of an asset or paid for transfer of a liability, in an orderly transaction between market participants at the measurement date. GAAP establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). These tiers include:

- Level 1 - defined as observable inputs such as quoted prices (unadjusted) for identical instruments in active markets.
- Level 2 - defined as inputs other than quoted prices in active markets that are either directly or indirectly observable such as quoted prices for similar instruments in active markets or quoted prices for identical or similar instruments in markets that are not active.
- Level 3 - defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions, such as valuations derived from valuation techniques in which one or more significant inputs or significant value drivers are unobservable.

In some circumstances, the inputs used to measure fair value might be categorized within different levels of the fair value hierarchy. In those instances, the fair value measurement is categorized in its entirety in the fair value hierarchy based on the lowest level input that is significant to the fair value measurement.

**Derivative Instruments**

We do not use derivative instruments to hedge exposures to cash flow, market, or foreign currency risks. We evaluate all of our financial instruments, including issued stock purchase warrants, to determine if such instruments are derivatives or contain features that qualify

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

as embedded derivatives, pursuant to ASC 480, *Distinguishing Liabilities from Equity*, and ASC 815-15, *Derivatives and Hedging - Embedded Derivatives*. The classification of derivative instruments, including whether such instruments should be recorded as liabilities or as equity, is re-assessed at the end of each reporting period.

The Company issued common stock warrants in connection with our initial public offering and private placements, which are recognized as derivative liabilities in accordance with ASC 815-40, *Contracts in Entity's Own Equity*. Accordingly, we recognize the warrant instruments as liabilities at fair value and adjust the instruments to fair value at each reporting period. The liabilities are subject to re-measurement at each balance sheet date until exercised, and any change in fair value is recognized in the Company's statement of operations. The fair value of the Private Placement warrants issued has been estimated using Monte Carlo simulations at each measurement date.

### **Goodwill and Other Intangible Assets**

Goodwill represents the excess of the purchase price consideration of an acquired business over the fair value of the underlying net tangible and intangible assets acquired. We test goodwill for impairment at least annually on December 31<sup>st</sup> or more frequently if triggering events occur or other impairment indicators arise which might impair recoverability. These events or circumstances would include a significant change in the business climate, legal factors, operating performance indicators, competition, sale, disposition of a significant portion of the business or other factors.

ASC 350, *Intangibles—Goodwill and Other*, allows entities to first use a qualitative approach to test goodwill for impairment by determining whether it is more likely than not (a likelihood of greater than 50%) that the fair value of a reporting unit is less than its carrying value. If the qualitative assessment supports that it is more likely than not that the fair value of the asset exceeds its carrying value, a quantitative impairment test is not required. If the qualitative assessment indicates that it is more likely than not that the fair value of the reporting unit is less than its carrying value, the Company will perform the quantitative goodwill impairment test, in which we compare the fair value of the reporting unit, determined using an income approach based on the present value of expected future cash flows, a market approach, or combination of both, given each assessment period's specific facts and circumstances, to the respective carrying value, which includes goodwill. If the fair value of the reporting unit exceeds its carrying value, then goodwill is not considered impaired. If the carrying value is higher than the fair value, the difference would be recognized as an impairment loss.

Goodwill impairment testing involves judgment, including the identification of reporting units, qualitative evaluation of facts and circumstances to determine if it is more likely than not that an impairment exists, and, if necessary, the estimation of the fair value of the applicable reporting unit. During the years ended December 31, 2023 and 2022, we performed impairment testing and recognized goodwill impairment charges of \$547.2 million and \$70.0 million, respectively. Because our total shareholders' equity exceeded our market capitalization at each goodwill impairment testing date, we estimated the fair value of our single reporting unit primarily on the basis of the Company's market capitalization after considering reasonable control premiums which could be expected in transactions with third-party market participants. As a result, the goodwill impairments in each period were primarily driven by the reduction of the market value of our stock price.

The Company does not have indefinite-lived intangibles. Our definite-lived intangibles primarily consist of risk-based contracts and provider networks. Risk-based contracts and provider networks represent the estimated values of customer relationships or provider networks, respectively, of acquired businesses and have definite lives. We amortize our intangibles on a straight-line basis over their estimated useful lives ranging from two to eleven years, except for certain risk contracts, which are amortized using the accelerated method.

The determination of fair values and useful lives requires us to make significant estimates and assumptions. These estimates include, but are not limited to, future expected cash flows from acquired capitation arrangements from a market participant perspective, patient attrition rates, discount rates, and costs and years to replicate acquired provider networks.

Refer to Note 6, *Goodwill and Other Intangible Assets*, for further information.

### **Property and Equipment**

Property and equipment is recorded at cost, net of accumulated depreciation and amortization. Maintenance and repairs are charged to expense as incurred. Depreciation is calculated using a straight-line method over the estimated useful life of each class of depreciable asset. Leasehold improvements are depreciated over the lesser of the length of the related lease plus any expected renewal options or the estimated life of the assets.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

A summary of estimated useful lives is as follows:

|                             |                                    |
|-----------------------------|------------------------------------|
| Leasehold Improvements      | Lesser of lease term or asset life |
| Assets under finance leases | Lease term                         |
| Furniture and Equipment     | 5 to 7 Years                       |
| Vehicles                    | 5 Years                            |
| Software                    | 1 to 5 Years                       |

**Impairment of Long-lived Assets**

Long-lived assets, such as property and equipment, right-of-use assets, prepaid warrants and definite-lived intangibles are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. The recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the use and eventual disposition of the asset. If the carrying amount of the asset exceeds its estimated future cash flows, an impairment charge is recognized in the amount by which the carrying amount of the asset exceeds the fair value.

The evaluation of long-lived assets is performed at the lowest level of identifiable cash flows. The determination of the fair value of the asset group requires management to estimate a number of factors including anticipated future undiscounted cash flows. Although we believe these estimates are reasonable, actual results could differ from those estimates due to uncertainty in the estimates being used.

**Debt**

The Company records debt in the consolidated balance sheets at carrying value, net of unamortized discounts and debt issuance costs.

The Company incurs specific incremental costs, other than those paid to lenders, in connection with the issuance of the Company's debt instruments. Those deferred financing costs include loan origination costs and other direct costs payable to third parties and are recorded as a direct deduction from the carrying value of the associated debt liability in the consolidated balance sheets when the debt is drawn. The Company amortizes the deferred financing costs as interest expense over the term of the related debt using the effective interest method in the consolidated statements of operations.

**Leases**

The Company leases operating facilities, office space, vehicles and IT equipment. These leases generally have initial lease terms from two years to twenty years, with options to extend, which are included in the lease term when it is reasonably certain that the Company will exercise that option. Our lease payments often include annual fixed rent escalators ranging between 2% and 3% or a consumer price index. Variable lease expense represents the payment of real estate taxes, insurance, and common area maintenance. The payment of variable real estate taxes, insurance and common area maintenance is generally based on the Company's pro-rata share of the total property, a portion of which is leased by the Company.

The Company determines if an arrangement is a lease at inception and evaluates the lease classification (i.e., operating or finance) at that time. Lease arrangements with an initial term of 12 months or less are considered short-term leases. The Company recognizes lease expense for short-term leases on a straight-line basis over the term of the lease within corporate, general and administrative expenses.

Finance leases are generally those leases that allow the Company to substantially utilize or pay for the entire asset over its estimated life. Finance lease right-of-use assets are recorded in Property and equipment, net. All other leases are categorized as operating leases.

Lease liabilities are recognized at the present value of the fixed lease payments, reduced by landlord incentives using a discount rate based on similarly secured borrowings available to the Company. Lease assets are recognized based on the initial present value of the fixed lease payments, reduced by landlord incentives, plus any direct costs from executing the leases or lease prepayments reclassified from Other assets upon lease commencement. Leasehold improvements are capitalized at cost and amortized over the lesser of their expected useful life or the lease term.

Costs associated with operating lease assets are recognized on a straight-line basis over the term of the lease within corporate, general and administrative expenses. Finance lease assets are amortized on a straight-line basis over the lease term within corporate, general and administrative expenses, except for the interest component, which is included in interest expense and is recognized using the effective interest method over the lease term.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

The Company uses its incremental borrowing rate on the commencement date for determining the present value of lease payments. The Company considers the likelihood of exercising options to extend or terminate the lease when determining the lease term. In addition, where applicable, the Company includes rent escalation provisions into the calculation of the expected lease payments.

The Company has lease agreements with lease and non-lease components. The Company has elected the package of practical expedients, which, among other things, allows us to account for the lease and non-lease components as a single lease component for all leases.

### **Income Taxes**

The Company follows the asset and liability method of accounting for income taxes under ASC 740, *Income Taxes* ("ASC 740"). Deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that included the enactment date. Valuation allowances are established, when necessary, to reduce deferred tax assets to the amount expected to be realized.

ASC 740 prescribes a recognition threshold and a measurement attribute for the financial statement recognition and measurement of tax positions taken or expected to be taken in a tax return. For those benefits to be recognized, a tax position must be more likely than not to be sustained upon examination by taxing authorities. There were no unrecognized tax benefits as of December 31, 2023 and 2022.

### **Stock-Based Compensation Expense**

The Company periodically issues Restricted Stock Units ("RSUs"), Performance Share Units ("PSUs"), and Stock Options ("Options") as share-based compensation to employees and non-employees in non-capital raising transactions for services. The Company accounts for such grants issued and vesting based on FASB ASC 718, *Compensation – Stock Compensation* ("ASC 718"), whereby the value of the award is measured on the date of grant and recognized as compensation expense on the straight-line basis over the vesting period.

The Company accounts for stock-based compensation issued to non-employees and consultants in accordance with the provisions of ASC 718. Measurement of share-based payment transactions with non-employees are recognized as compensation expense in the financial statements based on their fair values at grant date. That expense is recognized over the period during which a non-employee or consultant is required to provide services in exchange for the award, known as the requisite service period (usually the vesting period).

The fair value of the Company's Options and PSUs are estimated using the Black-Scholes-Merton Option Pricing model and a Monte Carlo simulation, respectively, which use certain assumptions related to risk-free interest rates, expected volatility, expected life of the stock options or stock, and future dividends. The assumptions used in the Black-Scholes Merton Option Pricing model and Monte Carlo Simulation could materially affect compensation expense recorded in future periods. The assumptions used in the model and related impact are discussed in Note 10, *Stock-Based Compensation*. The fair value of the Company's RSUs are estimated using the market value of the underlying common stock on the grant date.

The Company has elected to account for any forfeitures in the period that they occur. Any awards modified are accounted for in the periods of the modification and in accordance with ASC 718. The Company recognizes the fair value of stock-based compensation within its statements of operations.

### **Net Loss Per Share**

Net income (loss) per share is computed by dividing net income (loss) by the weighted-average number of shares of common stock outstanding during the period. The Company follows the provisions of ASC 260, *Earnings Per Share*, for determining whether contingently issuable shares are included for purposes of calculating net income (loss) per share and determining whether instruments granted in equity-based compensation arrangements are participating securities for purposes of calculating net income (loss) per share. Refer to Note 11, *Net Income (Loss) Per Share*.

### **Recently Adopted Accounting Pronouncements**

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

The Company elected to defer compliance with ASC Topic 842, *Leases* ("ASC 842"), consistent with the requirements for a private company due to the Company's status as an emerging growth company and the provisions of the JOBS Act. Accordingly, the adoption of ASC 842 was applicable for the Company for the annual reporting period beginning January 1, 2022, and interim reporting periods within the annual reporting period beginning after December 15, 2022. The Company elected to adopt practical expedients which permit it to not reassess its prior conclusions about lease identification, lease classification and initial direct costs under the new standard. The Company elected to combine lease and non-lease components for all lease contracts and also elected not to recognize right-of-use assets and lease liabilities for leases with terms of 12 months or less. The Company did not elect the hindsight practical expedient, which would have allowed the Company to revisit key assumptions, such as lease term, which were made when the lease was originally entered.

We implemented ASC 842 effective January 1, 2022, using the modified retrospective approach, which allows entities to either apply the new lease standard to the beginning of the earliest period presented or only to the consolidated financial statements in the period of adoption without restating prior periods. We elected to apply the new guidance at the date of the adoption, January 1, 2022, without restating prior periods. The financial effect of the adoption was an increase of \$73.7 million to the right-of-use asset and corresponding lease liabilities to the Company's balance sheet as of January 1, 2022.

**Accounting Pronouncements Not Yet Adopted**

In August 2020, the FASB issued ASU 2020-06, *Debt—Debt with Conversion and Other Options* (Subtopic 470-20) and *Derivatives and Hedging-Contracts in Entity's Own Equity* (Subtopic 815-40): Accounting for Convertible Instruments and Contracts in an Entity's Own Equity, which is intended to simplify the accounting for certain financial instruments with characteristics of liabilities and equity, including convertible instruments and contracts on an entity's own equity. The guidance allows for either full retrospective adoption or modified retrospective adoption. The guidance is effective for the Company in the first quarter of fiscal year 2025 and early adoption is permitted. The Company is evaluating the impact the adoption of this guidance will have on its consolidated financial statements.

In November 2023, the FASB issued ASU 2023-07, *Improvements to Reportable Segment Disclosures*. This guidance requires annual and interim disclosure of significant segment expenses that are provided to the CODM as well as interim disclosures for all reportable segment's profit or loss and assets. This guidance also requires disclosure of the title and position of the CODM and an explanation of how the CODM uses the reported measures of segment profit or loss in assessing segment performance and deciding how to allocate resources. This guidance is expected to improve financial reporting by providing additional information about a public company's significant segment expenses and more timely and detailed segment information reporting throughout the fiscal period. The ASU is effective for the Company's fiscal year beginning January 1, 2025. Early adoption is permitted. The Company does not expect adoption of ASU 2023-07 will have a significant impact on its consolidated financial statements.

In December 2023, the FASB issued ASU 2023-09, *Income Taxes (Topic 740): Improvements to Income Tax Disclosures* ("ASU 2023-09"). ASU 2023-09 requires disaggregated information about a reporting entity's effective tax rate reconciliation as well as information on income taxes paid. The ASU is effective for the Company's fiscal year beginning January 1, 2025. The guidance will be applied on a prospective basis with the option to apply the standard retrospectively. Early adoption is permitted. The Company does not expect adoption of ASU 2023-09 will have a significant impact on its consolidated financial statements.

**NOTE 3. ACCOUNTS RECEIVABLE**

The Company's accounts receivable are presented net of the unpaid external provider costs. A right of offset exists when all of the following conditions are met: 1) each of the two parties owed the other determinable amounts; 2) the reporting party has the right to offset the amount owed with the amount owed to the other party; 3) the reporting party intends to offset; and 4) the right of offset is enforceable by law. The Company believes all of the aforementioned conditions existed as of December 31, 2023 and 2022.

Composition of the Company's accounts receivable, net, and risk settlement liabilities was as follows:

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

|                                | As of December 31, |                   |
|--------------------------------|--------------------|-------------------|
|                                | 2023               | 2022              |
| Risk-based accounts receivable | \$ 170,397         | \$ 267,971        |
| IBNR claims liability          | (58,027)           | (121,823)         |
| Other receivables              | 2,384              | 5,595             |
| Accounts receivable, net       | <u>\$ 114,754</u>  | <u>\$ 151,743</u> |

|  | As of December 31, |                    |
|--|--------------------|--------------------|
|  | 2023               | 2022               |
| Risk-based accounts receivable (liability) | \$ 381             | \$ (5,993)         |
| IBNR claims liability                      | (37,401)           | —                  |
| Distribution liabilities                   | (5,583)            | (8,178)            |
| Risk settlement liabilities                | <u>\$ (42,602)</u> | <u>\$ (14,171)</u> |

The Company re-evaluated key assumptions and estimates and based on this analysis, the Company identified changes in estimates to revenue, external provider costs, short-term and long-term accounts receivable, net, and risk settlement liabilities. Accordingly, the Company recognized the following changes in prior year estimates in each respective period (*in thousands*):

| Increase (decrease)                               | Years Ended December 31, |          |
|---|--------------------------|----------|
|   | 2023                     | 2022     |
| Revenue   | \$ (42,934)              | \$ 9,046 |
| External provider costs                           | 900                      | 9,662    |
| Short-term and long-term accounts receivable, net | (34,542)                 | (616)    |
| Risk settlement liabilities                       | 9,292                    | —        |

For the year ended December 31, 2023, the decrease in revenue related to the prior year dates of service was primarily driven by updated information from MSO Medicare health plans, lower than expected revenue in our centers population from Medicare risk adjustment, an unseasonably early 2022-2023 flu season, and more current data from one Medicaid health plan. For the year ended December 31, 2022, the developments related to the prior year dates of service were driven by claims development from COVID-related utilization.

**Concentration of Credit Risk**

Composition of the Company's revenues and accounts receivable balances for the payors comprising 10% or more of revenue was as follows (n/a - indicates balance or activity that is less than 10%):

|         | Revenue                  |      |
|---------|--------------------------|------|
|         | Years Ended December 31, |      |
|         | 2023                     | 2022 |
| Payor A | 23%                      | 29%  |
| Payor B | n/a                      | 18%  |
| Payor C | 21%                      | 18%  |
| Payor D | 13%                      | 14%  |
| Payor E | 15%                      | 14%  |

|         | Short-Term and Long-Term Accounts Receivable, net |                   |
|---------|---|-------------------|
|         | December 31, 2023                                 | December 31, 2022 |
| Payor A | 10%   | 13%               |
| Payor B | 10%   | 11%               |
| Payor C | n/a   | 13%               |
| Payor D | n/a   | 13%               |
| Payor E | n/a   | n/a               |

**NOTE 4. ACQUISITIONS**

Share amounts below have been restated to reflect the Reverse Split described in Note 1, *Description of Business and Going Concern*.

**Steward Acquisition**

On November 10, 2022, the Company completed its previously announced acquisition, pursuant to the Agreement and Plan of Merger (the "Merger Agreement"), by and among (i) the Company, (ii) Sparta Merger Sub I Inc., a Delaware corporation and wholly-owned subsidiary of the Company ("Merger Sub I"), (iii) Sparta Merger Sub II Inc., a Delaware corporation and wholly-owned subsidiary of

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

the Company (“Merger Sub II”), (iv) Sparta Merger Sub III Inc., a Delaware corporation and wholly-owned subsidiary of the Company (“Merger Sub III” and, together with Merger Sub I and Merger Sub II, “Merger Subs” and each a “Merger Sub”), (v) Sparta Merger Sub I LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company (“Merger LLC I”), (vi) Sparta Merger Sub II LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company (“Merger LLC II”), (vii) Sparta Merger Sub III LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company (“Merger LLC III” and, together with Merger LLC I and Merger LLC II, “Merger LLCs” and each a “Merger LLC”), (viii) Sparta Sub Inc., a Delaware corporation (“SACN Holdco”), (ix) SNCN Holdco Inc. a Delaware corporation (“SNCN Holdco”), (x) SICN Holdco Inc., a Delaware corporation (“SICN Holdco” and, collectively with SACN Holdco, SNCN Holdco, Steward National Care Network, Inc. (n/k/a Steward National Care Network, LLC, “SNCN”), Steward Integrated Care Network, Inc., and Steward Accountable Care Network, Inc. (n/k/a as Steward Accountable Care Network, LLC, “SACN”), each a “target” and, collectively, the “Targets”), (xi) Sparta Holding Co. LLC, a Delaware limited liability company (the “Seller”), and (xii) Steward Health Care System LLC, a Delaware limited liability company (referred to collectively with the Seller, the “Seller Parties”), pursuant to which the Company acquired Steward Value-Based Care (such transaction, the “Steward Acquisition”).

The aggregate consideration paid to the Seller under the Merger Agreement on November 10, 2022, the date of the closing of the Steward Acquisition (the “Steward Closing”), consisted of (i) a cash payment of \$25.0 million, (ii) 783,333 shares, after giving the effect to the Reverse Split (the “Initial Share Consideration”), of the Company’s Class A common stock, par value \$0.0001 per share (the “Class A Common Stock”) and (iii) a cash payment of \$35.5 million, an amount equal to the estimated value of the Targets’ accounts receivable attributable to Medicare value-based payments for the period between January 1, 2022 and the Steward Closing, minus the amount of such payments payable to the affiliate physicians of the Targets (the “Financed Net Pre-Closing Medicare AR”).

In addition, the Merger Agreement provides that, following the Steward Closing, upon 100,000 Medicare lives from and/or attributable to the Seller Parties’ Medicare network participating in risk-based, value-based care arrangements contracted through the Company with a Medical Expense Ratio of less than 85% for two consecutive calendar quarters, the Company will issue the Seller, for immediate distribution to its equity holders, a number of shares of Class A Common Stock (the “Earnout Share Consideration” and together with the Initial Share Consideration, the “Share Consideration”) that, when added to the Initial Share Consideration, would have represented 41% of the issued and outstanding shares of the Company’s Class A Common Stock as of the Steward Closing, in each case after giving effect to issuances of Class A Common Stock between the Steward Closing and June 30, 2023 in connection with the exercise of warrants to purchase Class A Common Stock outstanding as of the Steward Closing, the potential earnout under the Company’s June 2021 Business Combination and any forfeitures, surrenders or other dispositions to the Company of Class A Common Stock outstanding as of the Steward Closing. If not previously issued, the Earnout Share Consideration will also be issuable upon a Change in Control (as defined in the Merger Agreement) of the Company. Refer to Note 9, *Stockholders’ Equity*, for additional information.

The following summarizes the consideration transferred at the Steward Closing (*in thousands*):

|   |           |                |
|---|-----------|----------------|
| Cash consideration                      | \$        | 25,000         |
| Initial Share Consideration (1)         |           | 134,420        |
| Earnout Share Consideration (2)         |           | 212,355        |
| Other consideration, net (3)            |           | 27,219         |
| Total Steward Acquisition consideration | <u>\$</u> | <u>398,994</u> |

- (1) Represents issuance of 0.8 million shares of Class A Common Stock of the Company using the closing price as of the date of the Steward Closing of \$171.6 per share.  
(2) Calculated as the 1.3 million shares of Class A Common Stock the Company estimated that it will be obligated to issue to the Seller Parties upon achievement of certain milestones as Earnout Share Consideration, multiplied by CareMax’s closing stock price as of the date of the Steward Closing of \$171.6 per share and the estimated probability of payout of 99%. Refer to Note 9, *Stockholders’ Equity*, for additional information.  
(3) Represents funding of the Financed Net Pre-Closing Medicare AR of \$35.5 million, offset by the Sellers’ reimbursement to the Company of the interest and original issue discount of \$6.8 million related to the Loan and Security Agreement (as defined in Note 8, *Debt and Related Party Debt*) and by non-cash purchase price adjustment of \$1.5 million.

The acquired assets and assumed liabilities of Steward Value-Based Care were recorded at their estimated fair values. The goodwill recorded as part of the acquisition included the expected synergies and other expected contribution to the Company’s overall growth strategy. None of the goodwill recognized as part of the Steward Acquisition is deductible for income tax purposes. Refer to Note 6, *Goodwill and Other Intangible Assets*, for additional information. The following table summarizes the initial and final fair values of the assets acquired and liabilities assumed at Steward Closing, with respective adjustments identified during the measurement period.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

|                                     | At Steward Closing<br>(preliminary) | Measurement Period<br>Adjustments | At Steward Closing (final) |
|-------------------------------------|-------------------------------------|-----------------------------------|----------------------------|
| Accounts receivable                 | \$ 43,060                           | \$ (9,069)                        | \$ 33,991                  |
| Other working capital adjustments   | (21,584)                            | 518                               | (21,066)                   |
| Distribution liabilities            | (7,032)                             | 5,153                             | (1,879)                    |
| Intangible asset - Risk contracts   | 37,500                              | —                                 | 37,500                     |
| Intangible asset - Provider network | 42,900                              | —                                 | 42,900                     |
| <b>Net assets acquired</b>          | <b>94,844</b>                       | <b>(3,397)</b>                    | <b>91,446</b>              |
| <b>Purchase consideration</b>       | <b>398,994</b>                      | <b>—</b>                          | <b>398,994</b>             |
| <b>Goodwill</b>                     | <b>\$ 304,150</b>                   | <b>\$ 3,397</b>                   | <b>\$ 307,547</b>          |

The operating results of Steward Value-Based Care from the date of the Steward Closing to December 31, 2022, consisted of government value-based care revenue of \$7.0 million and cost of care of \$1.1 million, are included in the consolidated statements of operations of the Company for the year ended December 31, 2022.

*Transaction Costs*

The Company incurred \$13.2 million for the year ended December 31, 2022, in advisory, legal, accounting and management fees in conjunction with the Steward Acquisition, which were included in acquisition related costs in the consolidated statements of operations. As of December 31, 2023 and 2022, we have accrued \$5.0 million, payment of which is contingent upon the Company's issuance of the Earnout Share Consideration to the Seller Parties.

*Unaudited Pro Forma Information*

The financial information in the table below summarizes the combined results of operations of the Company and Steward Value-Based Care, on a pro forma basis, as if the acquisition occurred on January 1, 2022. The pro forma financial information is presented for informational purposes only and is not indicative of the results of operations that would have been achieved if the acquisition had taken place on January 1, 2022 or of results that may occur in the future.

| <i>(in thousands)</i> | Year Ended December 31, 2022 |
|-----------------------|------------------------------|
| Revenue               | \$ 669,319                   |
| Net loss              | (34,315)                     |

These pro forma results were based on estimates and assumptions, which the Company believes are reasonable. The pro forma results include adjustments primarily related to the purchase accounting.

**Other Acquisitions**

During the year ended December 31, 2022, we acquired a number of small medical practices for total consideration of \$3.3 million and recognized goodwill of \$2.9 million and intangible assets of \$0.4 million.

There were no acquisitions during the year ended December 31, 2023.

**NOTE 5. REINSURANCE**

The Company purchased stop loss insurance on catastrophic costs to limit the exposure on patient losses. Premiums and policy recoveries are reported in external provider costs in the accompanying consolidated statements of operations.

The intent of the Company's stop loss coverage is to limit the benefits paid for any individual patient. The Company's stop loss limits are defined within each respective health plan contract or other third party contract and range typically from \$30,000 to \$200,000 per patient per year. Premium expense incurred was \$31.4 million for the year ended December 31, 2023 and \$19.4 million for the year ended December 31, 2022. Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. The Company monitors the financial performance and solvency of its stop loss providers. However, the Company remains financially responsible for health care services to its members in the event the health plans or other third parties are unable to fulfill their obligations under stop loss contractual terms.

Recoveries recognized were \$29.6 million for the year ended December 31, 2023 and \$27.8 million for the year ended December 31, 2022. Estimated recoveries under stop loss policies are reported within the accounts receivable, net, or risk settlement liabilities as the counterparty responsible for the payment of the claims and the stop loss is the respective health plan.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

**NOTE 6. GOODWILL AND OTHER INTANGIBLE ASSETS**

**Goodwill**

The following table shows changes in the carrying amount of goodwill (*in thousands*):

|                                | <b>Carrying Amount</b> |
|--------------------------------|------------------------|
| Balance at December 31, 2021   | \$ 464,566             |
| Goodwill acquired              | 307,062                |
| Measurement period adjustments | (985)                  |
| Impairment                     | (70,000)               |
| Balance at December 31, 2022   | 700,643                |
| Measurement period adjustments | 3,397                  |
| Impairment                     | (547,200)              |
| Balance at December 31, 2023   | \$ 156,841             |

During the years ended December 31, 2023 and 2022, the Company recorded goodwill impairment charges of \$547.2 million and \$70.0 million, respectively. Because our total shareholders' equity exceeded our market capitalization at each goodwill impairment testing date, we estimated the fair value of our single reporting unit primarily on the basis of the Company's market capitalization after considering reasonable control premiums which could be expected in transactions with third-party market participants. As a result, the goodwill impairments in each period were primarily driven by the reduction of the market value of our stock price.

The Company's cumulative goodwill impairment was \$617.2 million and \$70.0 million as of December 31, 2023 and 2022, respectively.

**Intangible Assets**

The following tables summarize the gross carrying amounts, accumulated amortization and net carrying amounts of intangible assets by major class (*in thousands*):

|                          | <u>Gross Carrying Amount</u> | <u>Accumulated Amortization</u> | <u>Net Carrying Value</u> | <u>Weighted-Average Amortization Period (years)</u> |
|--------------------------|------------------------------|---------------------------------|---------------------------|---|
| <b>December 31, 2023</b> |                              |                                 |                           |   |
| Risk contracts           | \$ 102,070                   | \$ (39,394)                     | \$ 62,676                 | 8   |
| Provider network         | 42,900                       | (6,980)                         | 35,920                    | 7   |
| Non-compete agreements   | 4,170                        | (2,343)                         | 1,827                     | 5   |
| Trademarks               | 1,862                        | (1,491)                         | 371                       | 2   |
| Other                    | 693                          | (244)                           | 449                       | 5   |
| Total                    | <u>\$ 151,695</u>            | <u>\$ (50,452)</u>              | <u>\$ 101,243</u>         |   |
|                          |                              |                                 |                           |   |
|                          | <u>Gross Carrying Amount</u> | <u>Accumulated Amortization</u> | <u>Net Carrying Value</u> | <u>Weighted-Average Amortization Period (years)</u> |
| <b>December 31, 2022</b> |                              |                                 |                           |   |
| Risk contracts           | \$ 102,070                   | \$ (24,217)                     | \$ 77,853                 | 8   |
| Provider network         | 42,900                       | (851)                           | 42,049                    | 7   |
| Non-compete agreements   | 4,170                        | (1,518)                         | 2,652                     | 5   |
| Trademarks               | 1,862                        | (1,352)                         | 510                       | 2   |
| Other                    | 693                          | (171)                           | 522                       | 5   |
| Total                    | <u>\$ 151,695</u>            | <u>\$ (28,109)</u>              | <u>\$ 123,585</u>         |   |

Amortization expense, excluding amortization related to the finance lease right-of-use asset, totaled \$22.3 million and \$16.8 million for the years ended December 31, 2023 and 2022, respectively.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

The estimated amortization for the intangible assets for each of the succeeding five years and thereafter was as follows (*in thousands*):

| Year       | Amount            |
|------------|-------------------|
| 2024       | \$ 20,613         |
| 2025       | 19,062            |
| 2026       | 17,641            |
| 2027       | 14,786            |
| 2028       | 11,854            |
| Thereafter | 17,287            |
| Total      | <u>\$ 101,243</u> |

**NOTE 7. PROPERTY AND EQUIPMENT**

Property and equipment at December 31, 2023 and 2022 consisted of the following (*in thousands*):

|  | December 31, 2023 | December 31, 2022 |
|--|-------------------|-------------------|
| Leasehold improvements   | \$ 19,200         | \$ 10,661         |
| Vehicles   | 2,892             | 3,743             |
| Furniture and equipment  | 12,765            | 8,871             |
| Software   | 3,865             | 3,725             |
| Assets under finance leases <sup>(1)</sup>                     | 18,552            | —                 |
| Construction in progress                                       | 5,074             | 4,621             |
| Total  | <u>62,349</u>     | <u>31,620</u>     |
| Less: Accumulated depreciation and amortization <sup>(2)</sup> | <u>(14,431)</u>   | <u>(10,614)</u>   |
| Total Property and equipment, net                              | <u>\$ 47,918</u>  | <u>\$ 21,006</u>  |

<sup>(1)</sup> Refer to Note 14, *Leases*, for information.

<sup>(2)</sup> Includes accumulated amortization related to finance lease right-of-use assets of \$0.6 million and \$0 as of December 31, 2023 and 2022, respectively.

Construction in progress primarily consists of leasehold improvements at the Company's centers which have not opened.

Depreciation expense and amortization of the finance lease right-of-use assets, totaled \$5.4 million and \$4.9 million for the years ended December 31, 2023 and 2022, respectively.

**NOTE 8. DEBT AND RELATED PARTY DEBT**

*Credit Agreement*

In May 2022, the Company entered into a credit agreement (the "Credit Agreement") that provided for an aggregate of up to \$300.0 million in term loans, comprised of (i) initial term loans in the aggregate principal amount of \$190.0 million (the "Initial Term Loans") and (ii) a delayed term loan facility in the aggregate principal amount of \$110.0 million (the "Delayed Draw Term Loans"). The Credit Agreement permits the Company to enter into certain incremental facilities subject to compliance with the terms, conditions and covenants set forth therein. In May 2022, the Company drew \$190.0 million of the Initial Term Loans and used approximately \$121 million of the net proceeds from this borrowing to repay its outstanding obligations under the credit agreement dated June 8, 2021, as amended, and recognized related debt extinguishment losses of \$6.2 million.

On March 8, 2023 (the "Amendment Closing Date"), the Company entered into a Second Amendment (the "Second Amendment") to the Credit Agreement.

The Second Amendment amended the Credit Agreement to, among other things, (i) provide for a new incremental delayed draw term loan B facility in an aggregate principal amount of \$60.0 million (the "Delayed Draw Term Loan B Facility"); (ii) revise the commitment expiration date for the Company's existing \$110.0 million Delayed Draw Term Loan to forty-five days following the Amendment Closing Date; (iii) extend the commencement of amortization payments on loans under the Credit Agreement from March 31, 2024 to May 31, 2025; (iv) reduce the amount of interest that the Company may elect to capitalize from 4.00% to 3.50% beginning on the second anniversary of the execution date of the Credit Agreement, 3.00% beginning on the third anniversary of the execution date of the Credit Agreement, and 1.50% beginning on December 10, 2025; (v) increase the amount of the super-priority revolving credit facility that is permitted to be added to the Credit Agreement to \$45.0 million and provide that the entirety of such facility may be used for general corporate purposes; and (vi) amend the prepayment provisions of the Credit Agreement, including to have such provisions run as of the Amendment Closing Date.

During the years ended December 31, 2023 and 2022, the Company drew \$125.0 million and \$45.0 million of the Delayed Draw Term Loans, respectively.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

Based on the elections made by the Company, as of December 31, 2023, borrowings under the Credit Agreement bore interest of Term SOFR (calculated as the Secured Overnight Financing Rate published on the Federal Reserve Bank of New York's website, plus the applicable credit spread adjustment based on the elected interest period), plus an applicable margin rate of 9.00%. As permitted under the Credit Agreement, the Company elected to capitalize 4.00% of the interest as principal amount. As a result of this election, the cash interest component of the applicable margin increased by 0.50%.

The Credit Agreement contains certain covenants that limit, among other things, the ability of the Company and its subsidiaries to incur additional indebtedness, liens or encumbrances, to make certain investments, to enter into sale-leaseback transactions or sell certain assets, to make certain restricted payments or pay dividends, to enter into consolidations, to transact with affiliates and to amend certain agreements, subject in each case to the exceptions and other qualifications as provided in the Credit Agreement. The Credit Agreement also contains covenants that require the Company to satisfy a minimum liquidity requirement of \$50.0 million, which may be decreased to \$25.0 million if the Company achieves a certain adjusted EBITDA, and maintain a maximum total leverage ratio based on the Company's consolidated EBITDA, as defined in the Credit Agreement, with de novo losses excluded from the calculation of such ratio for up to 36 months after the opening of a de novo center, which maximum total leverage ratio was initially 8.50 to 1.00, commencing with the fiscal quarter ended September 30, 2022 and is subject to a series of step-downs. For the fiscal quarters ending September 30, 2026 and thereafter the Company must maintain a maximum total leverage ratio no greater than 5.50 to 1.00.

*Loan and Security Agreement - Related Party Debt*

In November 2022, the Company entered into a Loan and Security Agreement (the "Loan and Security Agreement"), by and among Sparta Merger Sub I Inc., a Delaware corporation and wholly-owned subsidiary of the Company, Sparta Merger Sub II Inc., a Delaware corporation and wholly-owned subsidiary of the Company, Sparta Merger Sub I LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company ("Merger LLC I"), Sparta Merger Sub II LLC, a Delaware limited liability company and wholly-owned subsidiary of the Company (together with Merger LLC I, the "Guarantors"), Steward Accountable Care Network, Inc. (n/k/a as Steward Accountable Care Network, LLC) and Steward National Care Network, Inc. (n/k/a Steward National Care Network, LLC), as borrowers (the "Borrowers"), CAJ Lending LLC ("CAJ") and Deerfield Partners L.P., as lenders (the "Lenders"), and CAJ, as administrative agent and collateral agent (in such capacity, the "Agent"). Mr. Carlos A. de Solo, a director of the Company and the Company's President and Chief Executive Officer, Mr. Alberto de Solo, the Company's Executive Vice President and Chief Operating Officer, and Mr. Joseph N. De Vera, the Company's Senior Vice President and Legal Counsel, have interests in CAJ.

Pursuant to the Loan and Security Agreement, the Lenders provided the Borrowers a term loan (the "Term Loan") in the aggregate principal amount of \$35.5 million. The Company used the proceeds of the Term Loan to fund the Financed Net Pre-Closing Medicare AR acquired in connection with the Steward Acquisition.

The Term Loan bore fixed interest at a rate of 12.0% per annum. In addition, the Borrowers paid a facility fee equal to 3.0% of the aggregate principal amount of the Term Loan, which was accounted for as a debt discount. Any additional interest (if applicable) accrued and owing during the term of the Loan and Security Agreement was paid in-kind and capitalized to principal monthly in arrears. From and after the occurrence and during the continuance of an event of default, the Term Loan bore interest at a rate equal to 4.0% above the interest rate applicable immediately prior to the occurrence of the event of default. Pursuant to the Steward Acquisition Merger Agreement, the Seller agreed to pay the costs of financing the Financed Net Pre-Closing Medicare AR and, at the Steward Closing, paid to the Borrowers \$6.8 million, representing all scheduled payments of interest and fees from the Steward Closing Date up to and including November 30, 2023, which amount was then paid in advance by the Borrowers to the Lenders.

In October 2023, the Company paid off all outstanding indebtedness of \$35.5 million due under the Loan and Security Agreement with the proceeds of the MSSP payment from the federal government, and the Loan and Security Agreement was terminated.

*Elevance Health*

In October 2022, in connection with the collaboration agreement with Elevance Health (formerly known as Anthem), which was announced in August 2021, the Company entered into a promissory note for an amount of \$1.0 million due in October 2032. This borrowing bears a fixed interest rate of 6.25% per annum.

*Finance Leases*

Refer to Note 14, *Leases*, for information about the Company's finance leases.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

As of December 31, 2023 and 2022, debt consisted of the following (*in thousands*):

|  | December 31, 2023 | December 31, 2022 |
|--|-------------------|-------------------|
| Indebtedness under the Credit Agreement  | \$ 377,340        | \$ 240,277        |
| Indebtedness under the Loan and Security Agreement - Related party debt  | —                 | 35,510            |
| Finance lease obligations, interest averaging 13.5% and maturing at various dates through 2043 as of December 31, 2023 (none as of December 31, 2022). | 19,612            | —                 |
| Other  | 2,220             | 1,657             |
| Less: Unamortized discounts and debt issuance costs  | (13,349)          | (16,188)          |
|  | 385,823           | 261,256           |
| Less: Current portion  | (364,380)         | (30,530)          |
| Long-term portion  | \$ 21,443         | \$ 230,725        |

Future maturities of the indebtedness outstanding at December 31, 2023 were as follows (*in thousands*):

| Year       | Amount     |
|------------|------------|
| 2024       | \$ 389     |
| 2025       | 3,487      |
| 2026       | 4,080      |
| 2027       | 370,721    |
| 2028       | 730        |
| Thereafter | 153        |
| Total      | \$ 379,560 |

In the table above, the future maturities are presented consistent with the contractual terms. As of December 31, 2023, we were not in compliance with a financial covenant under our Credit Agreement, but received a limited waiver from the lenders thereunder. A breach of any of the covenants under the Credit Agreement or the occurrence of other events specified in the Credit Agreement could result in an event of default under the same and give rise to the lenders' right to accelerate our debt obligations thereunder and pursue other remedial actions under such agreement and/or trigger a cross default under our other long-term leases. Accordingly, as of December 31, 2023, the full balance of the outstanding indebtedness related to the Credit Agreement was classified as a current liability in our consolidated balance sheet.

Refer to Note 1, *Description of Business and Going Concern*, for going concern considerations and refer to Note 18, *Subsequent Events*, for details related to the limited waiver of certain breaches of covenants contained in the Credit Agreement obtained subsequent to December 31, 2023.

**NOTE 9. STOCKHOLDERS' EQUITY**

Share amounts below have been restated to reflect the Reverse Split described in Note 1, *Description of Business and Going Concern*.

**Related Advisory Agreement**

On July 13, 2021, the Company entered into an exclusive real estate advisory agreement (the "Advisory Agreement") with Related CM Advisor, LLC (the "Advisor"), a Delaware limited liability company and a subsidiary of The Related Companies, L.P. ("Related") (the "Advisory Agreement"), pursuant to which the Advisor has agreed to provide certain real estate advisory services to the Company on an exclusive basis. The services include identifying locations for new centers nationwide as part of the Company's de novo growth strategy, including, but not limited to, locations within and proximate to affordable housing communities that may be owned by Related.

In connection with the Advisory Agreement, the Company and Advisor entered into a subscription agreement (the "Subscription Agreement"), whereby the Advisor purchased 16,666 shares (the "Initial Shares") of the Company's Class A Common Stock for an aggregate purchase price of \$5.0 million and the Company issued to the Advisor (i) a warrant (the "Series A Warrant") to purchase 66,666 shares of Class A Common Stock (the "Series A Warrant Shares"), which vested immediately upon issuance, is exercisable for a period of five years and is not redeemable by the Company and (ii) a warrant (the "Series B Warrant" and together with the Series A Warrant, the "Warrants") to purchase up to 200,000 shares of Class A Common Stock (the "Series B Warrant Shares" and, together with the Series A Warrant Shares, the "Warrant Shares"), pursuant to which 16,666 Series B Warrant Shares will vest and become exercisable from time to time upon the opening of each center under the Advisory Agreement for which the Advisor provides services, other than two initial centers.

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

The Company assessed the substance of the Subscription Agreement and determined that all instruments referenced in the Subscription Agreement should be assessed under the guidance of ASC 718 as non-employee awards issued to Related in exchange for real estate advisory services to be rendered per the Advisory Agreement. As a result, the Company recorded the Series A Warrants as a component of additional paid-in-capital using the fair value as of July 13, 2021.

The Series B Warrant is exercisable, to the extent vested, until the later of five years from the date of issuance or one year from vesting of the applicable Series B Warrant Shares and is redeemable with respect to vested Warrant Shares at a price of \$0.3 per Warrant Share if the price of the Class A Common Stock equals or exceeds \$540.00 per share, or \$3.00 per Warrant Share if the price of the Class A Common Stock equals or exceeds \$300.00 per share, in each case when such price conditions are satisfied for any 20 trading days within a 30-trading day period and subject to certain adjustments and conditions as described in the Series B Warrant. In the event that the Series B Warrant is called for redemption by the Company, the Advisor may pay the exercise price for the Series B Warrant Shares for six months following the notice of redemption by the Company.

Series B Warrants are recognized at their grant date fair value once vesting becomes probable. No warrants vested during the year ended December 31, 2023. During the year ended December 31, 2022, the Company recorded \$7.6 million, in other current assets, to reflect vesting of 50,000 Series B Warrant Shares. Upon adoption of ASC 842 and commencement of the related leases, the balances were reclassified to right-of-use assets. Refer to Note 13, *Related Party Transactions*, for additional information.

Balances associated with the Warrant Shares are recorded in the right-of-use assets for commenced leases, and other assets for leases that have not yet commenced except for the portion that represents amortization expected to be recognized over the next 12 months, which is recorded in other current assets. The portion of the Warrant Shares recorded in other current assets as of December 31, 2023, and 2022 was \$0.4 million and \$0.6 million, respectively.

**Redeemable Warrants - Public Warrants**

In July 2020, in connection with the IPO, DFHT sold 95,834 Public Warrants. Each whole Public Warrant entitles the registered holder to purchase one thirtieth (1/30th) of one share of Class A Common Stock at a price of \$345.00 per whole share, subject to adjustment, at any time commencing on the later of 12 months from the closing of the IPO and 30 days after the completion of the Business Combination, provided in each case that the Company has an effective registration statement under the Securities Act covering the shares of Class A Common Stock issuable upon exercise of the Public Warrants and a current prospectus relating to them is available (or the Company permits holders to exercise their Public Warrants on a cashless basis under the circumstances specified in the warrant agreement) and such shares are registered, qualified or exempt from registration under the securities, or blue sky, laws of the state of residence of the holder. Pursuant to the warrant agreements entered into at the time of the IPO, a warrant holder may exercise its Public Warrants only for a whole number of shares of Class A Common Stock. This means only a whole Public Warrant may be exercised at a given time by a warrant holder. No fractional warrants were issued upon separation of the units issued in connection with the IPO and only whole Public Warrants will trade. The Company may redeem the Public Warrants when the price per share of Class A Common Stock equals or exceeds certain threshold prices.

**Redeemable Warrants - Private Placement Warrants**

Also in connection with the IPO, DFHT issued the 97,223 Private Placement Warrants at a purchase price of \$45.00 per warrant. The Private Placement Warrants (including the Class A Common Stock issuable upon exercise of the Private Placement Warrants) are not transferable, assignable or salable until 30 days after the completion of the Business Combination (except, among other limited exceptions to DFHT's officers and directors and other persons or entities affiliated with the initial purchasers of the Private Placement Warrants) and they will not be redeemable by CareMax for cash so long as they are held by the initial stockholders or their permitted transferees. With some exceptions, the Private Placement Warrants have terms and provisions that are identical to those of the Public Warrants. If the Private Placement Warrants are held by holders other than the initial purchasers or their permitted transferees, the Private Placement Warrants will be redeemable by the Company and exercisable by the holders on the same basis as the Public Warrants.

**Contingent Consideration - Business Combination**

Pursuant to the Business Combination Agreement, the CMG Sellers and IMC Parent, who received Class A Common Stock in connection with the Business Combination, became entitled to receive contingent consideration to be paid out in the form of Class A Common Stock. The Business Combination Agreement provided that up to an additional 116,667 and 96,667 shares of Class A Common Stock (the "Earnout Shares") would have become payable to the CMG Sellers and IMC Parent, respectively, after the Closing: (i) if within the first year after the Closing, the volume weighted average trading price of Class A Common Stock equaled or exceeded \$375.00 on any 20 trading days in any 30-day trading period (the "First Share Price Trigger"), then 58,333 and 48,333 Earnout Shares

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

would have become issuable to the CMG Sellers and IMC Parent, respectively, and (ii) if within the two years after the Closing (the “Second Earnout Period”), the volume weighted average trading price of Class A Common Stock equals or exceeds \$450.00 on any 20 trading days in any 30-day trading period (the “Second Share Price Trigger” and together with the First Share Price Trigger, the “Share Price Triggers”), then 58,333 and 48,333 Earnout Shares would have become issued and paid to the former owners of CMG and IMC, respectively. If prior to (i) the satisfaction of the Share Price Triggers, and (ii) the end of the Second Earnout Period, the Company entered into a change in control transaction as described in the Business Combination Agreement, and the price per share of the Company’s Class A Common Stock payable to the stockholders of the Company in such change in control transaction was greater than the Share Price Triggers that have not been satisfied during the Earnout Period, then at the closing of such change in control transaction, the Share Price Triggers would have been deemed to have been satisfied and the Company would have issued, as of such closing, all of the Earnout Shares. The contingent consideration was classified as a liability for the period ended June 30, 2021. On July 9, 2021, the volume weighted average trading price of Class A Common Stock exceeded \$375.00 on 20 or more days resulting in the satisfaction of the First Share Price Trigger. After the First Share Price Trigger was achieved on July 9, 2021, the estimated fair value of the Earnout Shares was recorded as an equity-classified instrument as a component of stockholders' equity, with the change in fair value from the prior reporting period recorded in earnings. Accordingly, 58,333 and 48,333 Earnout Shares were issued and paid to the CMG Sellers and IMC Parent, respectively. The Second Earnout Period expired on June 9, 2023 and the Second Share Price Trigger was not achieved.

**Contingent Consideration - Steward Acquisition**

Pursuant to the Merger Agreement signed in connection with Steward Acquisition, upon 100,000 Medicare lives from and/or attributable to the seller parties' Medicare network participating in risk-based, value-based care arrangements contracted through the Company with a Medical Expense Ratio of less than 85% for two consecutive calendar quarters, the Company will issue the seller, for immediate distribution to its equity holders, a number of shares of Class A Common Stock (the “Earnout Share Consideration” and together with the Initial Share Consideration, the “Share Consideration”) that, when added to the initial share consideration issued as part of the Steward Acquisition, would have represented 41% of the issued and outstanding shares of the Company’s Class A Common Stock as of November 10, 2022 (the “Steward Closing”), in each case after giving effect to issuances of Class A Common Stock between the Steward Closing and June 30, 2023 in connection with the exercise of warrants to purchase Class A Common Stock outstanding as of the Steward Closing, the potential earnout under the Company’s Business Combination and any forfeitures, surrenders or other dispositions to the Company of Class A Common Stock outstanding as of the Steward Closing. If not previously issued, the Earnout Share Consideration will also be issuable upon a Change in Control (as defined in the Merger Agreement) of the Company. Prior to June 30, 2023, the Company accounted for the Earnout Share Consideration as a liability, due to, among other terms, a variable settlement amount, based on the provisions summarized above. On June 30, 2023, the settlement amount became fixed in accordance with the terms of the Merger Agreement, and accordingly, the fair value of the Earnout Share Consideration of \$114.6 million as of June 30, 2023, was reclassified from contingent earnout liability into additional paid-in-capital.

**Preferred Stock**

The Company's third amended and restated certificate of incorporation authorizes the Company to issue up to 1,000,000 shares of preferred stock, with such designations, voting and other rights and preferences as may be determined from time to time by the Company’s board of directors (the “Board”). During the year ended December 31, 2022, the Company issued one share of Series A Preferred Stock to the seller of Steward Value-Based Care (refer to Note 4, *Acquisitions*, for information about the Steward Acquisition). This share of Series A Preferred Stock has a stated par value of \$0.0001 and has no economic rights. The holder of the outstanding share of Series A Preferred Stock is entitled to vote with holders of outstanding shares of Common Stock, voting together as a single class, with respect to the Special Matters (as defined in the Certificate of Designation of Series A Preferred Stock filed by the Company with the Secretary of State of the State of Delaware on November 10, 2022), and has no other voting rights. In any such vote, the share of Series A Preferred Stock will be entitled to 1,241,393 votes. The voting rights under the share of Series A Preferred Stock last until the earlier of (i) the two year anniversary of the Steward Closing or (ii) the issuance of the Earnout Share Consideration in connection with the Steward Acquisition.

**NOTE 10. STOCK-BASED COMPENSATION**

Share amounts below have been restated to reflect the Reverse Split described in Note 1, *Description of Business and Going Concern*.

The Company's 2021 Long-term Incentive Plan (the “2021 Plan”) permits grants of equity-based awards to officers, directors, employees and other service providers. The initial share pool of 233,333 shares of Class A Common Stock available for grants under the 2021 Plan is automatically increased on January 1st of each calendar year commencing after the Closing Date and ending on (and including) January 1, 2031, by a number of shares of Class A Common Stock equal to the lesser of (i) four percent of the aggregate number of shares of Class A Common Stock outstanding on December 31st of the immediately preceding calendar year, excluding for this purpose

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

any such outstanding shares of Class A Common Stock that were granted under the 2021 Plan and remain unvested and subject to forfeiture as of the relevant December 31st, or (ii) a lesser number of shares of Class A Common Stock as determined by the Board or the Compensation Committee of the Board prior to the relevant January 1<sup>st</sup>.

Our outstanding stock-based compensation awards consist of time-based share awards (restricted stock units, or the "RSUs"), performance-based share awards (the "PSUs") and options. Our equity awards generally vest over a three-year period, subject to continued provision of services to the Company through the applicable vesting date.

*RSUs*

The following table summarizes the RSU activity for the year ended December 31, 2023:

|                                     | Number of shares | Weighted-Average Grant Date Fair Value<br>(per share) |
|-------------------------------------|------------------|---|
| Outstanding as of December 31, 2022 | 89,107           | \$ 243.30   |
| Granted                             | 84,079           | 111.00  |
| Vested                              | (34,189)         | (242.66)  |
| Forfeited                           | (27,028)         | (173.10)  |
| Outstanding as of December 31, 2023 | 111,969          | \$ 162.60   |

As of December 31, 2023 and 2022, total unrecognized compensation expense related to unvested RSUs was \$12.8 million and \$17.4 million, respectively, expected to be recognized over a weighted-average period of 1.8 years and 2.1 years, respectively.

*PSUs*

For the PSUs, which are issued to executives, the performance-based vesting will be satisfied with respect to a percentage of the recipient's PSUs, as and when the specified price per share of Class A Common Stock is achieved through the applicable award expiration date, subject to the executive's continued employment with the Company through the applicable vesting date.

The following table summarizes the PSU activity for the year ended December 31, 2023:

|                                     | Number of shares | Weighted-Average Grant Date Fair Value<br>(per share) |
|-------------------------------------|------------------|---|
| Outstanding as of December 31, 2022 | 6,972            | \$ 171.30   |
| Granted                             | 10,267           | 111.90  |
| Vested                              | (2,188)          | (181.50)  |
| Forfeited                           | —                | —   |
| Outstanding as of December 31, 2023 | 15,050           | \$ 129.36   |

As of December 31, 2023 and 2022, total unrecognized compensation expense related to unvested PSUs was \$0.9 million and \$0.7 million, respectively, expected to be recognized over a weighted-average period of 1.4 years and 2.0 years, respectively.

The fair-value of the PSUs was determined on the respective grant dates using a Monte Carlo model with the following assumptions:

|                            | Years Ended December 31, |           |
|----------------------------|--------------------------|-----------|
|                            | 2023                     | 2022      |
| Underlying stock price     | \$ 111.60                | \$ 250.20 |
| Performance Period (years) | 2.0                      | 2.0       |
| Risk-free interest rate    | 4.5 %                    | 2.4 %     |
| Volatility                 | 70.8 %                   | 55.0 %    |
| Dividend yield             | 0.0 %                    | 0.0 %     |

The risk-free interest rate utilized is based on a term-matched zero-coupon U.S. Treasury security yield at the time of grant. Expected volatility is based on annualized standard deviation of daily continuously compounded returns of the Company's peers using the Guideline Public Companies method.

*Options*

Options provide an option to purchase a defined number of shares at a strike price of \$300.00 per share.

The following table summarizes the options activity for the year ended December 31, 2023:

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

|                                     | Number of shares | Weighted-Average Grant Date Fair Value<br>(per share) |
|-------------------------------------|------------------|---|
| Outstanding as of December 31, 2022 | 12,452           | \$ 181.80   |
| Granted                             | 17,200           | 87.90   |
| Vested                              | (4,640)          | (180.98)  |
| Forfeited                           | —                | —   |
| Outstanding as of December 31, 2023 | 25,012           | \$ 117.34   |

As of December 31, 2023 and 2022, total unrecognized compensation expense related to unvested options was \$2.0 million and \$1.7 million, respectively, expected to be recognized over a weighted-average period of 2.0 years and 2.1 years, respectively.

The fair-value of options was determined on the respective grant dates using a Black-Scholes-Merton Option Pricing model with the following assumptions:

|                            | Years Ended December 31, |           |
|----------------------------|--------------------------|-----------|
|                            | 2023                     | 2022      |
| Underlying stock price     | \$ 111.60                | \$ 250.20 |
| Performance Period (years) | 10.0                     | 10.0      |
| Risk-free interest rate    | 3.7 %                    | 2.4 %     |
| Volatility                 | 71.5 %                   | 65.5 %    |
| Dividend yield             | 0.0 %                    | 0.0 %     |

The risk-free interest rate utilized is based on a term-matched zero-coupon U.S. Treasury security yield at the time of grant. Expected volatility is based on annualized standard deviation of daily continuously compounded returns of the Company's peers using the Guideline Public Companies method.

The Company has recorded stock-based compensation expense totaling \$10.6 million and \$10.3 million for the years ended December 31, 2023 and 2022, respectively.

**NOTE 11. NET LOSS PER SHARE**

Share amounts below have been restated to reflect the Reverse Split described in Note 1, *Description of Business and Going Concern*.

The following table sets forth the calculation of basic and diluted net loss per share for the periods indicated based on the weighted-average number of common share outstanding (*in thousands, except share and per share data*):

|  | Years Ended December 31, |             |
|--|--------------------------|-------------|
|  | 2023                     | 2022        |
| Net loss attributable to CareMax, Inc. Class A common stockholders | \$ (683,348)             | \$ (37,796) |
| Weighted-average basic shares outstanding                          | 3,727,725                | 3,026,644   |
| Weighted-average diluted shares outstanding                        | 3,727,725                | 3,026,644   |
| Net loss per share   |                          |             |
| Basic  | \$ (183.31)              | \$ (12.49)  |
| Diluted  | \$ (183.31)              | \$ (12.49)  |

The following potentially dilutive outstanding securities were excluded from the computation of diluted net loss per share because their effect would have been anti-dilutive or because issuance of shares underlying such securities is contingent upon the satisfaction of certain conditions which were not satisfied by the end of the period:

|   | Years Ended December 31, |           |
|---|--------------------------|-----------|
|   | 2023                     | 2022      |
| Series A and Series B Warrants                                | 266,667                  | 266,667   |
| Public and Private Placement Warrants                         | 193,055                  | 193,055   |
| Contingent consideration                                      | 1,276,667                | 1,356,667 |
| Unvested restricted stock units                               | 120,726                  | 89,107    |
| Unvested performance stock units (assumes 100% target payout) | 13,578                   | 6,972     |
| Unvested options  | 21,872                   | 12,452    |
| Total   | 1,892,564                | 1,924,920 |

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

**NOTE 12. FAIR VALUE MEASUREMENTS**

Share amounts below have been restated to reflect the Reverse Split described in Note 1, *Description of Business and Going Concern*.

***Financial Instruments that are Measured at Fair Value on a Recurring Basis***

The following tables present information about the Company's assets and liabilities that are measured at fair value on a recurring basis and indicate the fair value hierarchy of the valuation techniques that the Company utilized to determine such fair value (*in thousands*):

| December 31, 2023 | Description   | Carrying Value | Fair Value   |   |   |
|-------------------|---|----------------|--|---|---|
|                   |   |                | Quoted Prices<br>in Active<br>Markets<br>(Level 1) | Significant other<br>Observable<br>Units<br>(Level 2) | Significant other<br>Unobservable<br>Units<br>(Level 3) |
|                   | Derivative warrant liabilities - Public Warrants            | \$ 22          | \$ 22  | \$ —  | \$ —  |
|                   | Derivative warrant liabilities - Private Placement Warrants | 1              | —  | —   | 1   |
|                   | Total liabilities measured at fair value                    | <u>\$ 22</u>   | <u>\$ 22</u>                                       | <u>\$ —</u>   | <u>\$ 1</u>   |

| December 31, 2022 | Description   | Carrying Value    | Fair Value   |   |   |
|-------------------|---|-------------------|--|---|---|
|                   |   |                   | Quoted Prices<br>in Active<br>Markets<br>(Level 1) | Significant other<br>Observable<br>Units<br>(Level 2) | Significant other<br>Unobservable<br>Units<br>(Level 3) |
|                   | Derivative warrant liabilities - Public Warrants            | \$ 1,495          | \$ 1,495   | \$ —  | \$ —  |
|                   | Derivative warrant liabilities - Private Placement Warrants | 2,479             | —  | —   | 2,479   |
|                   | Contingent earnout liability                                | 134,561           | —  | —   | 134,561   |
|                   | Total liabilities measured at fair value                    | <u>\$ 138,535</u> | <u>\$ 1,495</u>                                    | <u>\$ —</u>   | <u>\$ 137,040</u>                                       |

Fair value of Public Warrants is measured using the listed market price of such warrants.

Fair value of the Private Placement Warrants is estimated using a Monte Carlo simulation model at each measurement date. Inherent in a Monte Carlo simulation are assumptions related to expected stock price volatility, expected life, risk-free interest rate and dividend yield. The Company estimates the volatility of its common stock based on historical volatility of select peer companies that matches the expected remaining life of the warrants. The risk-free interest rate is based on the U.S. Treasury zero-coupon yield curve on the grant date for a maturity similar to the expected remaining life of the warrants. The expected life of the warrants is assumed to be equivalent to their remaining contractual term. The dividend rate is based on the historical rate, which the Company anticipates remaining at zero.

During the year ended December 31, 2023, the Company recognized a benefit resulting from a decrease in the fair value of the derivative warrant liabilities of \$4.0 million (a loss of \$4.4 million during the year ended December 31, 2022).

As of December 31, 2022, fair value of contingent earnout liability was calculated using 1.3 million shares, which will be issuable to the seller of Steward Value-Based Care upon achievement of certain performance metrics, the closing price of the Company's Class A Common Stock of \$109.5 per share, and a 99% probability of payout. On June 30, 2023, fair value of the contingent earnout consideration was reclassified from liabilities into additional paid-in-capital. Refer to Note 9, *Stockholders' Equity*, for further information.

Transfers between level 1, 2 and 3 are recognized at the end of the reporting period. There were no transfers between levels for the years ended December 31, 2023 or 2022.

Activity of the Level 3 liabilities measured at fair value was as follows (*in thousands*):

|  |             |
|--|-------------|
| Balance as of December 31, 2022  | \$ 137,040  |
| Change in fair value of derivative warrant liabilities                               | (2,479)     |
| Change in fair value of contingent earnout liability                                 | (19,916)    |
| Reclassification of contingent earnout consideration previously liability classified | (114,645)   |
| Balance as of December 31, 2023  | <u>\$ 1</u> |

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

The following table provides quantitative information regarding Level 3 fair value measurement inputs used in measurement of fair value of the Private Placement Warrants:

|   | December 31, 2023 | December 31, 2022 |
|---|-------------------|-------------------|
| Exercise price                                  | \$ 345.00         | \$ 345.00         |
| Underlying stock price                          | \$ 15.00          | \$ 109.50         |
| Volatility                                      | 58.3 %            | 69.1 %            |
| Expected life of the options to convert (years) | 2.44              | 3.44              |
| Risk-free rate                                  | 4.81 %            | 4.08 %            |
| Dividend yield                                  | 0.0 %             | 0.0 %             |

***Financial Instruments that are not Measured at Fair Value on a Recurring Basis***

**December 31, 2023**

|                        | Carrying Value    | Fair Value   |   |   |
|------------------------|-------------------|--|---|---|
|                        |                   | Quoted Prices<br>in Active<br>Markets<br>(Level 1) | Significant other<br>Observable<br>Units<br>(Level 2) | Significant other<br>Unobservable<br>Units<br>(Level 3) |
| <i>(in thousands)</i>  |                   |  |   |   |
| <b>Liabilities</b>     |                   |  |   |   |
| Fixed rate debt (a)    | \$ 913            | \$ —   | \$ —  | \$ 747  |
| Floating rate debt (a) | 377,340           | —  | —   | 375,240   |
| Total                  | <u>\$ 378,253</u> | <u>\$ —</u>  | <u>\$ —</u>   | <u>\$ 375,987</u>                                       |

**December 31, 2022**

|                        | Carrying Value    | Fair Value   |   |   |
|------------------------|-------------------|--|---|---|
|                        |                   | Quoted Prices<br>in Active<br>Markets<br>(Level 1) | Significant other<br>Observable<br>Units<br>(Level 2) | Significant other<br>Unobservable<br>Units<br>(Level 3) |
| <i>(in thousands)</i>  |                   |  |   |   |
| <b>Liabilities</b>     |                   |  |   |   |
| Fixed rate debt (a)    | \$ 36,498         | \$ —   | \$ —  | \$ 32,820   |
| Floating rate debt (a) | 240,277           | —  | —   | 240,280   |
| Total                  | <u>\$ 276,775</u> | <u>\$ —</u>  | <u>\$ —</u>   | <u>\$ 273,100</u>                                       |

(a) The debt amounts above do not include the impact of debt issuance costs or discounts.

**NOTE 13. RELATED PARTY TRANSACTIONS**

Share amounts below have been restated to reflect the Reverse Split described in Note 1, *Description of Business and Going Concern*.

*The Related Companies*

Refer to Note 9, *Stockholders' Equity*, for details on the transactions the Company entered into with Related.

During the years ended December 31, 2023 and 2022, the Company recognized expense related to the amortization of the Advisory Agreement Warrants Shares of \$0.4 million and \$0.5 million, respectively, in corporate, general and administrative expenses.

As of December 31, 2023, and 2022, the Company recorded \$0.4 million and \$0.6 million in other current assets, respectively, related to the Advisory Agreement Warrants Shares.

In addition, during the year ended December 31, 2022, we recorded \$0.4 million in construction in progress representing construction advisory services provided to us by Related. No construction advisory services were provided to us by Related in 2023.

On July 13, 2021, the Board appointed Mr. Bryan Cho, Executive Vice President of Related, to serve as a Class III director of the Company. The appointment of Mr. Cho was made in connection with the Advisory Agreement, which provides the Advisor with the right to designate a director to serve on the Board, subject to the continuing satisfaction of certain conditions, including that the Advisor and its affiliates maintain ownership of at least 16,667 shares of Class A Common Stock. As a director of the Company, Mr. Cho receives compensation in the same manner as the Company's other non-employee directors.

*Steward Health Care System, LLC*

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

Dr. Ralph de la Torre serves on the Board. Dr. de la Torre is also the Chairman, Chief Executive Officer and principal equity holder of Steward Health Care System, LLC. As a director of the Company, Dr. de la Torre receives compensation in the same manner as the Company's other non-employee directors.

As part of the Steward Acquisition, as described in Note 4, *Acquisitions*, the Company issued 783,333 shares of the Company's Class A Common Stock to the Seller Parties. In addition, the Company entered into a Transition Services Agreement (the "TSA") with Steward Health Care System, LLC. During the years ended December 31, 2023 and 2022, the Company incurred TSA expenses of \$1.5 million and \$1.2 million, respectively, within corporate, general and administrative expenses. As of December 31, 2023 and 2022, the Company had associated related party liabilities of \$0.2 million.

Additionally, as described in Note 4, *Acquisitions*, the Company was required to remit to the Seller Parties an amount equal to the value of the accounts receivable of Steward Value-Based Care attributable to dates of service between January 1, 2022 and the Steward Closing, partially offset for the cash already remitted of \$35.5 million at transaction close. As of December 31, 2023 and 2022, the Company had associated related party receivables, net, of \$0.0 and related party liabilities and \$0.5 million, respectively.

As further described in Note 9, *Stockholders' Equity*, as of December 31, 2023 and 2022, the Company recorded contingent earnout liability of \$0 and \$134.6 million, respectively. On June 30, 2023, the contingent consideration of \$114.6 million was reclassified from contingent earnout liability into additional paid-in-capital.

*CAJ and Deerfield*

In November 2022, the Company entered into the Loan and Security Agreement, described in Note 8, *Debt and Related Party Debt*, whereby CAJ and Deerfield are the lenders.

Mr. Carlos A. de Solo, a director of the Company and the Company's President and Chief Executive Officer, Mr. Alberto de Solo, the Company's Executive Vice President and Chief Operating Officer, and Mr. Joseph N. De Vera, the Company's Senior Vice President and Legal Counsel, have interests in CAJ.

Mr. Kevin Berg, who is on the Board, is a Senior Advisor with Deerfield. As a director of the Company, Mr. Berg receives compensation in the same manner as the Company's other non-employee directors.

Refer to Note 8, *Debt and Related Party Debt*, for updated information.

**NOTE 14. LEASES**

The Company has entered into operating and finance lease agreements for centers and office space expiring at various times through 2043, inclusive of renewal options that the Company is reasonably certain to exercise. The exercise of such lease renewal options is at our sole discretion, and to the extent we are reasonably certain we will exercise a renewal option, the years related to that option are included in our determination of the lease term for purposes of classifying and measuring a given lease.

The following table presents the location of the finance lease right-of-use assets and lease liabilities in the Company's consolidated balance sheets (*in thousands*):

|  | <u>Consolidated Balance Sheet Location</u> | <u>December 31, 2023</u> | <u>December 31, 2022</u> |
|--|--|--------------------------|--------------------------|
| Finance lease right-of-use assets, net | Property and equipment, net                | \$ 18,552                | \$ —                     |
| Current finance lease liabilities      | Current portion of third-party debt, net   | —                        | —                        |
| Long-term finance lease liabilities    | Long-term debt, net                        | 19,612                   | —                        |

Lease costs were as follows (*in thousands*):

| <i>(in thousands)</i>         | <u>Statement of Operations Location</u> | <u>Years Ended December 31,</u> |                  |
|-------------------------------|---|---------------------------------|------------------|
|                               |   | <u>2023</u>                     | <u>2022</u>      |
| Operating lease cost          | Corporate, general and administrative   | \$ 18,235                       | \$ 13,769        |
| Finance lease cost:           |   |                                 |                  |
| Amortization of lease assets  | Depreciation and amortization           | 641                             | —                |
| Interest on lease liabilities | Interest expense                        | 1,729                           | —                |
| Variable lease cost           | Corporate, general and administrative   | 3,268                           | 1,897            |
| Short-term lease cost         | Corporate, general and administrative   | 1,239                           | 1,145            |
| Total lease cost              |   | <u>\$ 25,112</u>                | <u>\$ 16,810</u> |

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

As of December 31, 2023, maturities of operating and finance lease liabilities were as follows (*in thousands*):

| Year                                 | Operating Leases  | Finance Leases   |
|--------------------------------------|-------------------|------------------|
| 2024                                 | \$ 12,217         | \$ 2,200         |
| 2025                                 | 15,702            | 2,499            |
| 2026                                 | 15,182            | 2,549            |
| 2027                                 | 14,255            | 2,625            |
| 2028                                 | 13,179            | 2,704            |
| Thereafter                           | 101,499           | 48,944           |
| Total undiscounted lease obligations | 172,034           | 61,521           |
| Less: Present value discount         | (65,923)          | (41,909)         |
| Present value of lease liabilities   | <u>\$ 106,112</u> | <u>\$ 19,612</u> |

Other information related to lease agreements was as follows:

| <i>(in thousands)</i>  | December 31, 2023 | December 31, 2022 |
|--|-------------------|-------------------|
| Weighted-average remaining lease term (years)                |                   |                   |
| Operating leases   | 11.7              | 11.0              |
| Finance leases   | 19.3              | —                 |
| Weighted-average discount rate                               |                   |                   |
| Operating leases   | 8.16 %            | 6.33 %            |
| Finance leases   | 13.46 %           | —                 |
| Cash paid for amounts included in measurement of liabilities |                   |                   |
| Operating cash flows for operating leases                    | 12,605            | —                 |
| Operating cash flows for finance leases                      | 1,310             | —                 |

At December 31, 2023, the Company was party to leases that have not yet commenced with aggregated estimated future lease payments of approximately \$56.8 million, which are not included in the above tables. These leases relate to properties that are being constructed by the future lessors. These leases are expected to commence through 2025, with initial lease terms ranging from 15 to 20 years.

The Company's finance leases, and one of the operating leases, contain various covenants, that require the Company, among other things, to maintain minimum consolidated stockholder's equity of \$100.0 million and minimum cash balance of \$25.0 million. In addition, these leases are subject to provisions that provide for a cross default in the event any of covenant violations under the Company's Credit Agreement. Refer to Note 18, *Subsequent Events*, for further information regarding an event of default related to such leases that happened subsequent to December 31, 2023.

**NOTE 15. INCOME TAXES**

The components of income tax benefit were as follows (*in thousands*):

|                                   | Years Ended December 31, |                    |
|-----------------------------------|--------------------------|--------------------|
|                                   | 2023                     | 2022               |
| Current income tax benefit        |                          |                    |
| Federal                           | \$ —                     | \$ —               |
| State                             | —                        | —                  |
| Total current income tax benefit  | —                        | —                  |
| Deferred income tax benefit       |                          |                    |
| Federal                           | (600)                    | (15,536)           |
| State                             | (264)                    | (4,006)            |
| Total deferred income tax benefit | (863)                    | (19,542)           |
| Total income tax benefit          | <u>\$ (863)</u>          | <u>\$ (19,542)</u> |

The reconciliation between the effective tax rate and the statutory tax rate was as follows:

|  | Years Ended December 31, |               |
|--|--------------------------|---------------|
|  | 2023                     | 2022          |
| Federal statutory rate                       | 21.0 %                   | 21.0 %        |
| State statutory rate, net of federal benefit | 2.6 %                    | 7.7 %         |
| Transaction costs                            | 0.0 %                    | (2.2 %)       |
| Earnout liability adjustments                | 0.6 %                    | 27.9 %        |
| Nondeductible amortization                   | (11.5 %)                 | (17.2 %)      |
| Other  | (0.2 %)                  | (0.2 %)       |
| Change in valuation allowance                | (12.4 %)                 | (2.9 %)       |
| Effective tax rate                           | <u>0.1 %</u>             | <u>34.1 %</u> |

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes.

The deferred tax assets and liabilities consisted of the following (*in thousands*):

|   | Years Ended December 31, |                   |
|---|--------------------------|-------------------|
|   | 2023                     | 2022              |
| <b>Deferred tax assets:</b>                   |                          |                   |
| Accrued expenses                              | \$ 4,405                 | \$ 6,738          |
| Derivative warrant liabilities                | 6                        | 1,053             |
| Goodwill and other intangibles, net           | 26,891                   | —                 |
| Federal and state net operating carryforwards | 52,875                   | 24,184            |
| Business expense limitation                   | 22,944                   | 11,682            |
| Lease liabilities                             | 33,242                   | 27,033            |
| Property and equipment                        | 620                      | 312               |
| <b>Total deferred tax assets</b>              | <b>140,982</b>           | <b>71,002</b>     |
| Less: Valuation allowances                    | (108,508)                | (25,793)          |
| <b>Total deferred tax assets, net</b>         | <b>32,474</b>            | <b>45,209</b>     |
| <b>Deferred tax liabilities:</b>              |                          |                   |
| Goodwill and other intangibles, net           | —                        | (18,524)          |
| Prepaid expenses                              | (12)                     | (7)               |
| Right of use lease assets                     | (33,789)                 | (28,868)          |
| <b>Total deferred tax liabilities</b>         | <b>(33,801)</b>          | <b>(47,399)</b>   |
| <b>Total deferred tax liability, net</b>      | <b>\$ (1,327)</b>        | <b>\$ (2,190)</b> |

The application of GAAP requires us to evaluate the recoverability of our net deferred income tax assets, including those associated with net operating loss ("NOL") carryforwards, and establish a valuation allowance, if necessary, to reduce our deferred income tax asset to an amount that is more likely than not to be realizable. Considerable judgment and the use of estimates are required in determining whether a valuation allowance is necessary, and if so, the amount of such valuation allowance. In evaluating the need for a valuation allowance, we consider many factors, including: the nature and character of the deferred income tax assets and liabilities; taxable income in prior carryback years, if any; future reversals of existing temporary differences; the length of time carryovers can be utilized; and any tax planning strategies we would employ to avoid a tax benefit from expiring unused. We determined that it was more likely than not that the net deferred income tax asset would not be realized. As of December 31, 2023 and 2022, the deferred tax assets were fully offset by the valuation allowance, except for a portion attributable to a "naked credit" deferred tax liability. For the years ended December 31, 2023 and 2022, the income tax valuation allowance increased by \$82.7 million and decreased by \$0.3 million, respectively.

As of December 31, 2023 and 2022, we had federal and state tax loss carryforwards of 199.8 million and 198.1 million, and \$91.3 million and \$90.7 million, respectively. Federal net operating losses of \$9.0 million, generated prior to December 31, 2017, will expire in 2037. Federal net operating losses generated after January 1, 2018, will have an indefinite carryforward period. We anticipate approximately \$43.9 million in losses and \$26.2 million in business expense limitation carried over from the Business Combination with IMC on June 8, 2021 will be subject to potential Section 382 limitations.

As of December 31, 2023 and 2022, we did not have any uncertain tax positions.

The Company files a federal income tax return and various state and local returns. As of December 31, 2023, all tax years from 2017 remain open to examination by Internal Revenue Service and other taxing authorities.

**NOTE 16. COMMITMENTS AND CONTINGENCIES**

**Compliance**

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with imposition of significant fines and penalties, as well as significant repayments for patient services billed. Compliance with these laws and regulations, specifically those related to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and not yet asserted at this time. Management believes that the Company is in substantial compliance with current laws and regulations.

**Litigation**

The Company is involved in various legal actions arising in the normal course of business. Management has not identified any legal actions during the years ended December 31, 2023 or 2022 that were deemed to be material.

**NOTE 17. VARIABLE INTEREST ENTITIES**

The Company has Administrative Service Agreements (the "ASAs") with Medical Care of NY, P.C., Medical Care of Tennessee, PLLC and Medical Care of Texas, PLLC (together, the "PCs"), which were established to employ healthcare providers to deliver healthcare services to patients in New York, Tennessee, and Texas, and with Care Optical, LLC ("Care Optical"), which provides optometry services in the state of Florida. The Company concluded that it has variable interest in the PCs and Care Optical on the basis of its ASAs which provide for a management fee payable to the Company from the PCs and Care Optical in exchange for providing management and administrative services which creates risk and a potential return to the Company. The PCs' and Care Optical's equity at risk, as defined by GAAP, is insufficient to finance their activities without additional support, and therefore, the PCs and Care Optical are considered to be VIEs.

In order to determine whether the Company has a controlling financial interest in the PCs and Care Optical, and, thus, is the PCs' and Care Optical's primary beneficiary, the Company considered whether it has (i) the power to direct the activities of PCs and Care Optical that most significantly impacts their economic performance and (ii) the obligation to absorb losses of the PCs and Care Optical or the right to receive benefits from the PCs and Care Optical that could potentially be significant to them. The Company concluded that the member and employees of the PCs and Care Optical have no individual power to direct activities of the PCs and Care Optical that most significantly impact their economic performance. Under the ASAs, the Company is responsible for providing services that impact the growth of the patient population of the PCs and Care Optical, the management of the respective population's healthcare needs, the provision of required healthcare services to those patients, and the PCs' and Care Optical's ability to receive revenue from health plans. In addition, the Company's variable interest in the PCs and Care Optical provides the Company with the right to receive benefits that could potentially be significant to them. The single members of the PCs and Care Optical are employees of the Company. Based on this analysis, the Company concluded that it is the primary beneficiary of the PCs and Care Optical and therefore consolidates the balance sheet, results of operations and cash flow of the PCs and Care Optical.

Furthermore, as a direct result of nominal initial equity contributions by the single members of the PCs and Care Optical, the financial support CareMax provides to the PCs and Care Optical (e.g. loans) and the provisions of the arrangements described above, the interest held by the single member lacks economic substance and does not provide the member with the ability to participate in the residual profits or losses generated by the PCs and Care Optical. Therefore, all income and expenses recognized by the PCs and Care Optical are allocated to CareMax.

The following tables summarize the financial position and operations of the PCs and Care Optical (*in thousands*):

|                   | Years Ended December 31, |       |      |       |
|-------------------|--------------------------|-------|------|-------|
|                   | 2023                     |       | 2022 |       |
| Total assets      | \$                       | 1,200 | \$   | 1,097 |
| Total liabilities | \$                       | 9,896 | \$   | 2,961 |

  

|                    | Years Ended December 31, |       |      |       |
|--------------------|--------------------------|-------|------|-------|
|                    | 2023                     |       | 2022 |       |
| Revenues           | \$                       | 2,254 | \$   | 1,515 |
| Operating expenses | \$                       | 7,027 | \$   | 3,551 |

**CAREMAX, INC.**  
**Notes to Consolidated Financial Statements - Continued**

**NOTE 18. SUBSEQUENT EVENTS**

On January 31, 2024, the Company completed a 1-for-30 Reverse Split further described in Note 1, *Description of Business and Going Concern*. The effects of the Reverse Split were retroactively reflected in these consolidated financial statements and notes thereto for all periods presented.

In March 2024, the Company failed to make rent payments due pursuant to certain leases on centers that it generally does not intend to operate, which constitutes an event of default under the terms of the related lease agreements. Upon an event of default, remedies available to our landlords generally include, without limitation, terminating such lease agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such lease agreement, including the difference between the rent under such lease agreement and the rent payable as a result of reletting the leased properties, or requiring us to pay the rent due for the balance of the term of such lease agreement, less proceeds from re-letting, if any.

On March 15, 2024 (the “Third Amendment Effective Date”), we entered into a Waiver and Third Amendment to Credit Agreement (the “Third Amendment”) among us, certain of our subsidiaries, as guarantors, the lenders party thereto and Jefferies Finance LLC, as administrative agent and collateral agent. The Third Amendment amended the Credit Agreement to, among other things, (i) waive certain events of default under the Credit Agreement in the limited manner set forth therein through May 15, 2024 (the “Third Amendment Specified Period”), subject to an earlier termination of the waiver upon the occurrence of certain specified events, (ii) increase the applicable margin rate by 2.00% during the Third Amendment Specified Period, which additional interest we may elect to capitalize as principal amount on the outstanding loans and (iii) modify certain covenants contained in the Credit Agreement, including, but not limited to, reducing the minimum liquidity requirement to \$10 million during the Third Amendment Specified Period and providing for additional reporting to the lenders. See Note 1, *Basis of Presentation and Significant Accounting Policies and Going Concern*, to the consolidated financial statements that appear elsewhere in this Annual Report on Form 10-K for details regarding our going concern consideration.

**Subsidiaries**

| Name of Subsidiary                 | State of Organization | Number of Omitted Subsidiaries Operating |                      |
|------------------------------------|-----------------------|--|----------------------|
|                                    |                       | In the United States                     | In Foreign Countries |
| CareMax Medical Group, L.L.C.      | Florida               | 22                                       | 1                    |
| Managed Healthcare Partners L.L.C. | Florida               | 0  | 0                    |
| Care Optimize LLC                  | Delaware              | 0  | 1                    |
| IMC Medical Group Holdings, LLC    | Florida               | 7  | 0                    |
| CareMax Holdings, LLC              | Delaware              | 7  | 0                    |

---

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statements on Form S-3 (No. 333-264654) and Form S-8 (Nos. 333-271988 and 333-260477) of CareMax, Inc. of our report dated March 18, 2024 relating to the financial statements, which appears in this Form 10-K.

/s/ PricewaterhouseCoopers LLP

Miami, Florida  
March 18, 2024

---

**CERTIFICATION OF CHIEF EXECUTIVE OFFICER  
PURSUANT TO RULE 13A-14(A) UNDER THE SECURITIES EXCHANGE ACT OF 1934,  
AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Carlos A. de Solo, certify that:

1. I have reviewed this annual report on Form 10-K of CareMax, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 18, 2024

/s/ Carlos A. de Solo

Name: Carlos A. de Solo

Title: President, Chief Executive Officer and Director  
(Principal Executive Officer)

**CERTIFICATION OF CHIEF FINANCIAL OFFICER  
PURSUANT TO RULE 13A-14(A) UNDER THE SECURITIES EXCHANGE ACT OF 1934,  
AS ADOPTED PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Kevin Wirges, certify that:

1. I have reviewed this annual report on Form 10-K of CareMax, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: March 18, 2024

/s/ Kevin Wirges

Name: Kevin Wirges

Title: Executive Vice President, Chief Financial Officer and Treasurer  
(Principal Financial Officer)

**CERTIFICATION PURSUANT TO  
18 U.S.C. SECTION 1350  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of CareMax, Inc. (the “Company”) on Form 10-K for the year ended December 31, 2023, as filed with the Securities and Exchange Commission (the “Report”), I, Carlos A. de Solo, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. §1350, as added by §906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: March 18, 2024

/s/ Carlos A. de Solo

\_\_\_\_\_  
Name: Carlos A. de Solo

Title: President and Chief Executive Officer

(Principal Executive Officer)

---

**CERTIFICATION PURSUANT TO  
18 U.S.C. SECTION 1350  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of CareMax, Inc. (the "Company") on Form 10-K for the year ended December 31, 2023, as filed with the Securities and Exchange Commission (the "Report"), I, Kevin Wirges, Executive Vice President, Treasurer and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. §1350, as added by §906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1. The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: March 18, 2024

/s/ Kevin Wirges

\_\_\_\_\_  
Name: Kevin Wirges

Title: Executive Vice President, Treasurer and Chief Financial Officer  
(Principal Financial Officer)

---

**CAREMAX, INC.**  
**POLICY ON RECOUPMENT OF INCENTIVE COMPENSATION**

**Introduction**

The Board of Directors (the “Board”) of CareMax, Inc. (the “Company”) has adopted this Policy on Recoupment of Incentive Compensation (this “Policy”), which provides for the recoupment of compensation in certain circumstances in the event of a restatement of financial results by the Company. This Policy shall be interpreted to comply with the requirements of U.S. Securities and Exchange Commission (“SEC”) rules and Nasdaq Stock Market (“Nasdaq”) listing standards implementing Section 954 of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the “Dodd-Frank Act”) and, to the extent this Policy is in any manner deemed inconsistent with such rules, this Policy shall be treated as retroactively amended to be compliant with such rules.

**Administration**

This Policy shall be administered by the Compensation Committee (the “Compensation Committee”) of the Board. Any determinations made by the Compensation Committee shall be final and binding on all affected individuals. The Compensation Committee is authorized to interpret and construe this Policy and to make all determinations necessary, appropriate or advisable for the administration of this Policy, in all cases consistent with the Dodd-Frank Act. The Board or Compensation Committee may amend this Policy from time to time in its discretion.

**Covered Executives**

This Policy applies to any current or former “executive officer,” within the meaning of Rule 10D-1 under the Securities Exchange Act of 1934, as amended, of the Company or a subsidiary of the Company (each such individual, an “Executive”). This Policy shall be binding and enforceable against all Executives and their beneficiaries, executors, administrators, and other legal representatives.

**Recoupment Upon Financial Restatement**

If the Company is required to prepare an accounting restatement due to the material noncompliance of the Company with any financial reporting requirement under the securities laws, including any required accounting restatement to correct an error in previously issued financial statements that is material to the previously issued financial statements, or that would result in a material misstatement if the error were corrected in the current period or left uncorrected in the current period (a “Financial Restatement”), the Compensation Committee shall cause the Company to recoup from each Executive, as promptly as reasonably possible, any erroneously awarded Incentive-Based Compensation, as defined below.

**No-Fault Recovery**

Recoupment under this Policy shall be required regardless of whether the Executive or any other person was at fault or responsible for accounting errors that contributed to the need for the Financial Restatement or engaged in any misconduct.

**Compensation Subject to Recovery; Enforcement**

This Policy applies to all compensation granted, earned or vested based wholly or in part upon the attainment of any financial reporting measure determined and presented in accordance with the accounting principles used in preparing the Company’s financial statements, and any measure that is derived wholly or in part from such measures, whether or not presented within the Company’s financial statements or included in a filing with the SEC, including stock price and total shareholder return (“TSR”), including but not limited to performance-based cash, stock, options or other equity-based awards paid or granted to the Executive (“Incentive-Based Compensation”). Compensation that is granted, vests or is earned based solely upon the occurrence of non-financial events, such as base salary, restricted stock or options with time-based vesting, or a bonus awarded solely at the discretion of the Board or Compensation Committee and not based on the attainment of any financial measure, is not subject to this Policy.

In the event of a Financial Restatement, the amount to be recovered will be the excess of (i) the Incentive-Based Compensation received by the Executive during the Recovery Period (as defined below) based on the erroneous data and calculated without regard to any taxes paid or withheld, over (ii) the Incentive-Based Compensation that would have been received by the Executive had it been calculated based on the restated financial information, as determined by the Compensation Committee. For purposes of this Policy, “Recovery Period” means the three completed fiscal years immediately preceding the date on which the Company is required to prepare the Financial Restatement, as determined in accordance with the last sentence of this paragraph, or any transition period that results from a change in the Company’s fiscal year (as set forth in Section 5608(b)(i)(D) of the Nasdaq Listing Rules). The date on which the Company is required to prepare a Financial Restatement is the earlier to occur of (A) the date the Board or a Board committee (or authorized officers of the Company if Board action is not required) concludes, or reasonably should have concluded, that the Company is required

---

to prepare a Financial Restatement or (B) the date a court, regulator, or other legally authorized body directs the Company to prepare a Financial Restatement. For Incentive-Based Compensation based on stock price or TSR, where the amount of erroneously awarded compensation is not subject to mathematical recalculation directly from the information in the Financial Restatement, then the Compensation Committee shall determine the amount to be recovered based on a reasonable estimate of the effect of the Financial Restatement on the stock price or TSR upon which the Incentive-Based Compensation was received and the Company shall document the determination of that estimate and provide it to Nasdaq.

Incentive-Based Compensation is considered to have been received by an Executive in the fiscal year during which the applicable financial reporting measure was attained or purportedly attained, even if the payment or grant of such Incentive-Based Compensation occurs after the end of that period.

The Company may use any legal or equitable remedies that are available to the Company to recoup any erroneously awarded Incentive-Based Compensation, including but not limited to by collecting from the Executive cash payments or shares of Company common stock from or by forfeiting any amounts that the Company owes to the Executive. Executives shall be solely responsible for any tax consequences to them that result from the recoupment or recovery of any amount pursuant to this Policy, and the Company shall have no obligation to administer the Policy in a manner that avoids or minimizes any such tax consequences.

#### **No Indemnification**

The Company shall not indemnify any Executive or pay or reimburse the premium for any insurance policy to cover any losses incurred by such Executive under this Policy or any claims relating to the Company's enforcement of rights under this Policy.

#### **Exceptions**

The compensation recouped under this Policy shall not include Incentive-Based Compensation received by an Executive (i) prior to beginning service as an Executive or (ii) if he or she did not serve as an Executive at any time during the performance period applicable to the Incentive-Based Compensation in question. The Compensation Committee (or a majority of independent directors serving on the Board) may determine not to seek recovery from an Executive in whole or part to the extent it determines in its sole discretion that such recovery would be impracticable because (A) the direct expense paid to a third party to assist in enforcing recovery would exceed the recoverable amount (after having made a reasonable attempt to recover the erroneously awarded Incentive-Based Compensation and providing corresponding documentation of such attempt to Nasdaq), (B) recovery would violate the home country law that was adopted prior to November 28, 2022, as determined by an opinion of counsel licensed in the applicable jurisdiction that is acceptable to and provided to Nasdaq, or (C) recovery would likely cause the Company's 401(k) plan or any other tax-qualified retirement plan to fail to meet the requirements of Section 401(a)(13) or Section 411(a) of the Internal Revenue Code of 1986, as amended, and the regulations thereunder.

#### **Other Remedies Not Precluded**

The exercise by the Compensation Committee of any rights pursuant to this Policy shall be without prejudice to any other rights or remedies that the Company, the Board or the Compensation Committee may have with respect to any Executive subject to this Policy, whether arising under applicable law (including pursuant to Section 304 of the Sarbanes-Oxley Act of 2002), regulation or pursuant to the terms of any other policy of the Company, employment agreement, equity award, cash incentive award or other agreement applicable to an Executive. Notwithstanding the foregoing, there shall be no duplication of recovery of the same Incentive-Based Compensation under this Policy and any other such rights or remedies.

#### **Acknowledgment**

To the extent required by the Compensation Committee, each Executive shall be required to sign and return to the Company the acknowledgement form attached hereto as Exhibit A pursuant to which such Executive will agree to be bound by the terms of, and comply with, this Policy. For the avoidance of doubt, each Executive shall be fully bound by, and must comply with, the Policy, whether or not such Executive has executed and returned such acknowledgment form to the Company.

#### **Effective Date and Applicability**

This Policy has been adopted by the Board on November 28, 2023, and shall apply to any Incentive-Based Compensation that is received by an Executive on or after October 2, 2023.

---

**EXHIBIT A**

**DODD-FRANK COMPENSATION CLAWBACK POLICY**

**ACKNOWLEDGEMENT FORM**

Capitalized terms used but not otherwise defined in this Acknowledgement Form (this “*Acknowledgement Form*”) shall have the meanings ascribed to such terms in the Policy.

By signing this Acknowledgement Form, the undersigned acknowledges, confirms and agrees that the undersigned: (i) has received and reviewed a copy of the Policy; (ii) is and will continue to be subject to the Policy and that the Policy will apply both during and after the undersigned’s employment with the Company; and (iii) will abide by the terms of the Policy, including, without limitation, by reasonably promptly returning any recoverable compensation to the Company as required by the Policy, as determined by the Compensation Committee in its sole discretion.

Sign: \_\_\_\_\_  
Name: [Employee]

Date: \_\_\_\_\_

---