UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

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

For the fiscal year ended December 31, 2022

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 001-41346

NUTEX HEALTH INC.

Delaware	**11-3363609**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

6030 S. Rice Ave, Suite C,
Houston, Texas 77081
Telephone Number (713) 660-0557

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

Title of each class	Trading Symbol	Name of each exchange on which registered
Common Stock, $0.001 par value	**NUTX**	**NASDAQ Capital Market**

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, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

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

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

Indicate by check mark whether the registrant 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. o

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). o

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 voting common stock held by non-affiliates at June 30, 2022 was approximately $1.034 billion. At March 2, 2023, there were 650,926,125 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for its 2023 Annual Meeting of Shareholders (the "Proxy Statement") are incorporated by reference into Part III of this Annual Report on Form 10-K and will be filed within 120 days of the registrant's fiscal year end.

INTRODUCTORY NOTE

Unless the context dictates otherwise, references in this Annual Report on Form 10-K to the "Company," "we," "us," "our," and similar words are references to Nutex Health Inc. (formerly known as Clinigence Holdings, Inc.), a Delaware corporation, and its consolidated subsidiaries and affiliated entities, as appropriate, including its consolidated variable interest entities ("VIEs") and "Nutex" refers to Nutex Health Inc.

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995 and include this statement for purposes of complying with these safe harbor provisions.

This document contains certain forward-looking statements with respect to our financial condition, results of operations and business, plans, objectives and strategies. These forward-looking statements can be identified by the fact that they do not relate only to historical or current facts. Forward-looking statements often use words such as "estimate," "project," "predict," "will," "would," "should," "could," "may," "might," "anticipate," "plan," "intend," "believe," "expect," "aim," "goal," "target," "objective," "commit," "advance," "likely" or similar expressions that convey the prospective nature of events or outcomes. There are several factors which could cause actual plans and results to differ materially from those expressed or implied in forward-looking statements. Such factors include, but are not limited to:

- our ability to successfully execute our growth strategy, including identifying and developing successful new geographies, physician partners and patients;
- changes in applicable laws or regulations, including changes in the laws and regulations related to reimbursements;
- uncertainties in the amounts, timing and process of reimbursements by third-party payors and individuals;
- we may be adversely affected by other economic, business, and/or competitive factors;
- the difficulty in evaluating our future prospects, as well as risks and challenges, due to the new and rapidly evolving business and market;
- we may need to raise additional capital to fund our existing operations, develop and commercialize new services or expand our operations;
- possible difficulty managing growth and expanding operations;
- the continuing impact of the COVID-19 pandemic on operations, which may materially and adversely affect our business and financial results;
- our ability to retain qualified personnel;
- the effectiveness and efficiency of our marketing efforts;
- spending changes in the healthcare industry;
- we, our affiliated professional entities and other physician partners may become subject to medical liability claims;
- a failure in our information technology systems,
- security breaches, loss of data or other disruptions could compromise sensitive information related to our business or prevent us from accessing critical information, expose us to liability and our reputation may be harmed and we could lose sales, clients and members;

- any future litigation against us could be costly and time-consuming to defend;
- failure to adhere to all of the complex government laws and regulations that apply our business could result in fines or penalties, being required to make changes to its operations or experiencing adverse publicity;
- our arrangements with affiliated professional entities and other physician partners may be found to constitute improper rendering of medical services or fee splitting under applicable state laws;
- we may face inspections, reviews, audits and investigations under federal and state government programs and contracts and adverse findings may have an adverse effect on our business;
- recent healthcare legislation and other changes in the healthcare industry and in healthcare spending has and may in the future adversely affect our revenues and may cause material adverse effects on our financial results;
- the transition from volume to value-based reimbursement models may have a material adverse effect on our operations; and
- other factors disclosed in the section entitled "Risk Factors" and elsewhere in this Annual Report on Form 10-K.

These forward-looking statements reflect our current views with respect to future events and are based on numerous assumptions and assessments made by us in light of our experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors we believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties because they relate to events and depend on circumstances that will occur in the future. The factors described in the context of such forward-looking statements in this document could cause our plans, actual results, performance or achievements, industry results and developments to differ materially from those expressed in or implied by such forward-looking statements. Although we believe that the expectations reflected in such forward-looking statements are reasonable, we cannot assure you that such expectations will prove to have been correct and persons reading this document are therefore cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date of this Annual Report. We do not assume any obligation to update the information contained in this document (whether as a result of new information, future events or otherwise), except as required by applicable law.

NUTEX HEALTH INC.

FORM 10-K FOR THE YEAR ENDED DECEMBER 31, 2022

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PART I

Item 1. Business

Nutex Health Inc. ("Nutex Health" or the "Company") is a physician-led, healthcare services and operations company with 19 hospital facilities in eight states (hospital division), and a primary care-centric, risk-bearing population health management division. Our hospital division implements and operates innovative health care models, including micro-hospitals, specialty hospitals and hospital outpatient departments ("HOPDs"). The population health management division owns and operates provider networks such as independent physician associations ("IPAs") and offers a cloud-based proprietary technology platform to IPAs which aggregates clinical and claims data across multiple settings, information systems and sources to create a holistic view of patients and providers.

We employ 1,150 full- and part-time employees and partner with over 800 physicians. Our corporate headquarters is based in Houston, Texas. We were incorporated on April 13, 2000 in the state of Delaware.

Merger of Nutex Health Holdco LLC and Clinigence Holdings, Inc. On April 1, 2022, the merger (the "Merger") of Nutex Health Holdco LLC and Clinigence Holdings, Inc. ("Clinigence") was completed pursuant to the Agreement and Plan of Merger (the "Merger Agreement") entered on November 23, 2021 between Clinigence, Nutex Acquisition LLC, a Delaware limited liability company and wholly-owned subsidiary of Clinigence, Nutex, Micro Hospital Holding LLC (solely for the purposes of certain sections of the Merger Agreement), Nutex Health Holdco LLC and Thomas Vo, M.D., solely in his capacity as the representative of the equity holders of Nutex Health Holdco LLC.

In connection with the Merger Agreement, Nutex Health Holdco LLC entered into certain Contribution Agreements with holders of equity interests ("Nutex Owners") of subsidiaries and affiliates (the "Nutex Subsidiaries") pursuant to which such Nutex Owners agreed to contribute certain equity interests in the Nutex Subsidiaries to Nutex Health Holdco LLC in exchange for specified equity interests in Nutex Health Holdco LLC (collectively, the "Contribution Transaction"). Nutex owners having ownership interests representing approximately 84% of the agreed upon aggregate equity value of the Nutex Subsidiaries agreed to contribute all or a portion of their equity interests, as applicable.

Pursuant to the Merger Agreement, each unit representing an equity interest in Nutex Health Holdco LLC issued and outstanding immediately prior to the effective time of the Merger but after the Contribution Transaction (collectively, the "Nutex Membership Interests") was converted into the right to receive 3.571428575 shares of common stock of Clinigence, or an aggregate of 592,791,712 shares of common stock of Clinigence.

Potential Future Stock Issuances. Under the terms of the Contribution Agreements, contributing owners of the under construction hospitals and ramping hospitals are eligible to receive a one-time additional issuance of Company common stock.

- With respect to ramping hospitals, 24 months after the opening date (the "Determination Date") of the applicable ramping hospital, such owner is eligible to receive such owner's pro rata share of a number of shares of Company Common Stock equal to (a)(i) the trailing twelve months earnings before interest, taxes, depreciation and amortization on the respective Determination Date, multiplied by (ii) 10, (iii) minus the initial equity value received at the Closing of the Merger, and (iv) minus such owner's pro rata share of the aggregate debt of the applicable ramping hospital outstanding as of the closing of the Merger. The number of additional shares to be issued will be determined based on the greater of (a) the price of the Company's common stock at the time of determination or (b) $2.80.

- With respect to under construction hospitals, contributing owners of under construction hospitals will be eligible to receive, on the Determination Date, such owner's pro rata share of a number of shares of Company common stock equal to (a)(i) the trailing twelve months earnings before interest, taxes, depreciation and amortization as of the Determination Date multiplied by (ii) 10, minus (iii) the aggregate amount of such owner's capital contribution to the under construction hospital, minus (iv) such owner's pro rata share of the aggregate debt of the applicable under construction hospital outstanding as of the Closing of the Merger, divided by (b) the greater of (i) the price of the Company common stock at the time of determination or (ii) $2.80.

After completing the merger, Clinigence was renamed Nutex Health Inc.

Lock-up agreements. Also on April 1, 2022, each member of Nutex Health Holdco LLC entered into a Lock-up agreement agreeing not to, without the prior written consent of the Company and except in limited circumstances (i) offer, pledge, sell, contract to sell, sell

any option or contract purchase, purchase any option or contract to sell, grant any option, right or warrant to purchase or otherwise transfer or dispose of their shares of Company common stock received in the merger or (ii) enter into any swap or other agreement that transfers, in whole or in part, any of the economic consequences of ownership of such shares.

The lock-up restrictions terminated with respect to one-third of the shares of Company Common Stock on October 1, 2022. The lock-up restrictions terminate for the remaining shares on April 1, 2023 (one-third) and October 1, 2023 (final one-third).

Registration rights agreement. In September 2022, we filed a registration statement pursuant to a registration rights agreement dated as of April 1, 2022 and amended effective as of July 1, 2022, to register for resale one-third of the shares of Company common stock issued in the merger that were released from lockup restrictions on October 1, 2022. The registration rights agreement terminates on the earlier of (i) when the shares may be sold under Rule 144 without any restrictions or (ii) the dissolution or liquidation of the Company.

Operating Segments

We report the results of our operations as three segments: (i) the hospital division, (ii) the population health management (PHM) division and (ii) the real estate division.

Hospital Division. Our hospital division develops and operates a network of micro-hospitals, specialty hospitals and hospital outpatient departments (HOPDs) providing comprehensive and high-quality 24/7 care. Our full-service care delivery model provides concierge-level care traditionally offered by larger hospitals in a patient-friendly and cost-effective setting. We provide a full spectrum of healthcare services, including emergency room care, inpatient care, and behavioral health, and offer a complementary suite of ancillary services, including onsite imaging (CT scan, X-ray, MRI, ultrasound, etc.), certified and accredited laboratories, and onsite inpatient pharmacies. We own and operate 19 healthcare facilities across eight states and have an additional 17 de novo micro-hospitals under development.

Our micro-hospitals generate revenue from both emergency services and in-patient services, providing operating leverage and high earning potential of each facility. We believe that wait times are significantly lower than traditional ER settings and patients are welcomed by a friendly, attentive staff and physician team. Our hospital division generally operates as an out-of-network provider and, as such, does not have negotiated reimbursement rates with insurance companies. In the fourth quarter of 2022, we signed in-network provider contracts with the Provider Network of America (PNA). These contracts provide for payment to us of claims at 300% of the Medicare allowable rates for our services provided to PNA members.

When developing new hospitals, we provide a turn-key process from location selection, real estate design, and development of the facility to staffing, training and operations. Our management and administrative teams provide a comprehensive suite of operational and managerial services to hospitals, including management, billing, collections, recruiting and marketing. Our licensed micro-hospitals average approximately 13 thousand feet and include seven to eight emergency treatment rooms, two to ten in-patient beds for short-term stays and advanced imaging equipment. Our staffing at each facility includes four to ten physicians and hospitalists depending on the community's needs.

Most of our hospitals have contractual relationships with separately owned professional entities (the "Physician LLCs") and real estate entities (the "Real Estate Entities"). The Physician LLCs employ the doctors who work in our hospitals. The Real Estate Entities own the land and hospital buildings in which the hospitals operate and lease the buildings to the hospitals. We have no ownership interests in either the Physician LLCs or Real Estate Entities, but provide back office accounting for each. Many of these entities are owned in part, and in some cases, controlled by related parties including members of our executive management team.

The Physician LLCs are consolidated by the Company as variable interest entities (VIEs) because they do not have significant equity at risk, and we have historically provided support to the Physician LLCs in the event of cash shortages and received the benefit of their cash surpluses.

Population Health Division. Our population health management division establishes and operates independent physician associations (IPAs) and offers a cloud-based platform for healthcare organizations to provide value-based care and population health management.

An IPA is a business entity organized and owned by a network of independent physician practices. Once established, the IPA enrolls patients and negotiates managed care contracts with insurers to provide comprehensive care to their patients typically for a value-based fixed annual fee (capitation). The IPA entities are not owned by us but are managed by our management services organization

(MSO) which provides management, administrative, and other support services. Presently, we manage one IPA located in Los Angeles, California having over 22,000 patients. We have established two other IPAs, in Houston and in South Florida, and are actively contracting with primary care physicians and specialists. Once this phase is completed, we expect to contract with health insurance plans and start enrolling patients in 2023. We also anticipate forming another IPA in 2023 in Phoenix, Arizona. We consolidate the IPA entities in our financial statements as VIEs since we manage these entities.

We also provided limited services to one health maintenance organization ("HMO") and two other IPAs in Southern and Northern California.

Our cloud-based technology is offered by Clinigence Health, Inc. Our proprietary cloud-based PHM platform aggregates data across multiple groups of information, which it then uses to report clinical quality measures, gaps in care, risk-stratification of patients, predictive analytics as well as providing a scorecard and utilization dashboard on every provider. This platform provides SaaS solutions that enable connected intelligence across the care continuum by transforming massive amounts of data into actionable insights. Our solutions help healthcare organizations improve the quality and cost effectiveness of care, enhance population health management and optimize provider networks.

Real Estate Division. The Real Estate Entities own the land and hospital buildings which are leased to our hospital entities. The Real Estate Entities have mortgage loans payable to third parties which are collateralized by the land and buildings. We consolidate the Real Estate Entities as VIEs in instances where our hospital entities are guarantors or co-borrowers under their outstanding mortgage loans. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans, leaving three Real Estate Entities as current VIEs consolidated in our financial statements.

Sources of Revenue

The following table shows revenue for each of our operating segments:

	Year ended December 31,		
	2022	2021	2020
Hospital Division:			
Net patient service revenue	$ 197,254,222	$ 331,531,311	$ 274,029,061
Management fees	1,254,023	-	-
Total Hospital Division revenue	198,508,245	331,531,311	274,029,061
Population Health Management Division:			
Capitation revenue, net	15,493,432	-	-
Management fees	4,346,763	-	-
SaaS revenue	945,866	-	-
Total Population Health Management Division revenue	20,786,061	-	-
Total revenue	$ 219,294,306	$ 331,531,311	$ 274,029,061

Our hospital division receives payment for facility services rendered by us from federal agencies, private insurance carriers, and patients. The Physician LLCs receive payment for doctor services from these same sources. On average, greater than 90% of our net patient service revenue is paid by insurers, federal agencies, and other non-patient third parties. The remaining revenues are paid by our patients in the form of copays, deductibles, and self-payment. As noted, we generally operate as an out-of-network provider and, as such, do not have negotiated reimbursement rates with insurance companies. In the fourth quarter of 2022, we signed in-network provider contracts with the Provider Network of America (PNA). These contracts provide for payment to us of claims at 300% of the Medicare allowable rates for our services provided to PNA members.

The population health management division recognizes revenue for capitation and management fees for services to IPAs and physician groups and for the licensing, training, and consulting related to our cloud-based proprietary technology. Capitation revenue consists primarily of capitated fees for medical services provided by physician-owned entities we consolidate as VIEs. Capitated arrangements are made directly with various managed care providers including HMOs. Capitation revenues are typically prepaid monthly to us based on the number of enrollees selecting us as their healthcare provider. Capitation is a fixed payment amount per patient per unit of time paid in advance for the delivery of health care services, whereby the service providers are generally liable for excess medical costs. We receive management fees that are based on gross capitation revenues of the IPAs or physician groups we manage.

Our Strategy

Our mission is to make exceptional concierge-level healthcare more accessible to communities. Our business strategy is to increase stockholder value through sustained earnings growth and cash flow generation by:

- *Developing and operating innovative micro-hospitals* – We currently operate 19 micro-hospital facilities in eight states and one IPA. We plan to grow our operations by expanding our innovative micro-hospital model into several more states and developing IPAs which leverage our presence and physician relationships in each community we serve.

- *Providing a patient-centric care model* – We fulfill an underserved healthcare segment needing immediate and convenient access to primary and emergency care. Producing a compelling work environment for physicians and hospitalists helps us deliver superior patient experiences and clinical outcomes.

- *Offering a differentiated provider engagement and partnership strategy* – Having high satisfaction and retention rates of physicians helps us in delivering superior patient experiences. Financially, we are aligned with our physician partners who are co-investors with us in their community's micro-hospitals or IPAs and, in many instances, are shareholders of Nutex. Our relationships with physician partners are critical to our success.

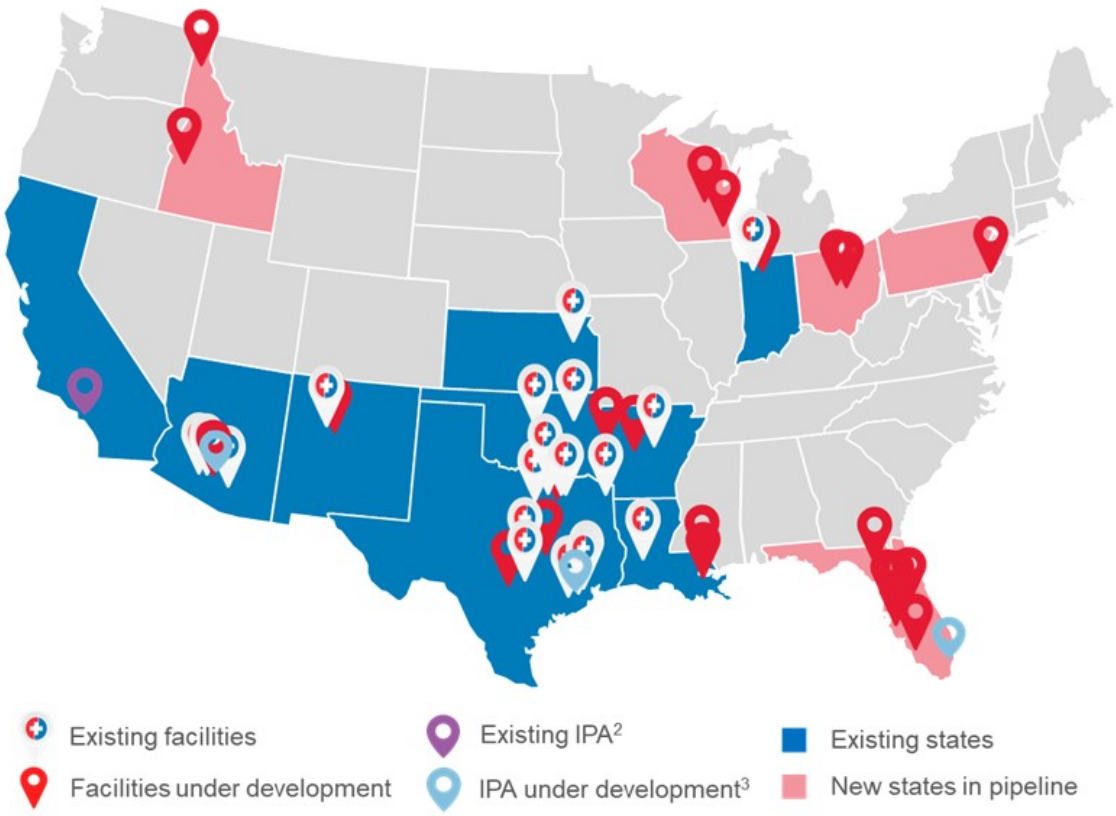
- *Having a scalable go-to-market strategy* – Robust administrative support where key support functions including billing and collection, purchasing, marketing, human resources and financial operations are centralized allowing our physicians and hospitalists to focus on patient care. Building out IPA networks in the same communities as our micro-hospitals will drive patient volume and result in greater revenue from increased capitation and full-risk contracts. To complement our organic growth plans, we may, in the normal course of business, consider and review opportunistic acquisitions.

Our Growth Strategy

We are focused on expanding patient access to quality healthcare by opening or acquiring new micro-hospital facilities in underserved areas of the United States. We are also establishing IPAs in many of the locales where we operate micro-hospitals in order to leverage our community presence and relationships with in-market physicians.

We expect to open 15 to 20 new hospital facilities by the middle of the year 2025. These facilities are either under construction or in advanced planning stages and will result in our expansion into four new states: Florida, Wisconsin, Ohio and Idaho. We anticipate launching one-to-three additional IPAs per year principally in geographic areas around our existing micro-hospitals.

The following map shows our existing and planned presence across the United States:



Our process for opening a new micro-hospital begins with identifying underserved markets. Generally, we place our micro-hospitals in larger suburban or rural locations. Before entering a new state, we investigate the regulation and licensing requirements for our business and the construction design and permitting requirements of the targeted community. We next identify and contract with in-market physicians who will co-invest with us and become the on-site management of the new facility.

For each new hospital location, three entities are usually created:

- Real estate entity – our hospital facilities are designed and constructed to meet our specific needs and governmental regulations for micro-hospitals. Construction of new facilities or major renovation of existing buildings to meet our specifications requires significant financial resources. In most cases, these financial resources are provided by a newly established real estate entity that is independently owned by the in-market physicians and other partners, including in many cases, members of our executive management team. The real estate entities often enter into mortgage loans to finance the facilities. In some instances, Nutex may participate as a co-borrower or guarantee of this indebtedness. Nutex does not own any of the real estate entities but enters into a long-term market rate lease of the facility for its operations with the real estate entity. Nutex also contracts with this entity to provide administrative services including financial accounting and other responsibilities.

- Physician LLC entity – the in-market physicians create and independently own the physician entity. In certain states, state laws and regulations prohibit non-physician ownership of physician practices. The physician entity employs or contracts with

physicians who will staff the new location. We contract with the physician entities to provide administrative services including claims billing and collections, financial accounting and other responsibilities.

- Hospital facility entity – Nutex typically has 70% or more equity ownership of new hospital facilities and in-market physicians usually own much of the remaining equity. The participation by in-market physicians in owning the hospital facility is a key factor in our success. The hospital facility contracts with the physician entity to provide physician staffing and enters into a lease of the physical facility with the associated real estate entity. The hospital facility provides the operating equipment and supplies and employs nursing and other staffing for local operations.

Our relationships with physician partners are critical to our success. The physician partners' financial participation through ownership in whole, or in part, of the above entities aligns our interests towards achieving common business goals and helps us have a high satisfaction and retention rate of physicians.

Having good physician relationships is also fundamental to our success in developing and operating IPAs. We begin development of new IPAs by identifying underserved markets. As noted previously, we are focused on launching IPAs in markets around our micro-hospitals. Doing so will leverage our existing physician relationships and increase visibility of our micro-hospitals in the marketplace. Once the physician provider network is secured, we work to contract with health insurance plans and begin enrolling patients in the new IPA.

We may achieve our growth strategy in part by acquiring or contracting existing healthcare facilities and IPAs.

There can be no assurance that we will be successful in executing our growth strategy. In addition to establishing and maintaining strong physician relationships, our growth strategy requires significant financial resources to equip and staff new locations, fund cash needs until the location becomes profitable and provide for working capital needs. If we are not able to successfully execute upon our growth strategies, there may be a material adverse effect on our business, financial condition, cash flows and results of operations.

Competition

The healthcare industry is highly competitive and highly fragmented. We face competition in every aspect of our business, including in offering a favorable reimbursement structure for existing physician partners and attracting physician partners who are not contracted with us, from a range of large and medium-sized local and national companies that provide care under a variety of models that could attract patients, providers, and payors. Our primary competitors are free-standing emergency departments and traditional large local hospital systems that are developing micro hospitals to increase their footprint in their local communities. Our competitors typically vary by geography, and we may also encounter competition in the future from other new entrants.

Since there are virtually no substantial capital expenditures required for providing healthcare services, there are few financial barriers to entry in the healthcare industry. Other companies or hospital groups could enter the micro hospital market in the future and divert some, or all, of our business. Our ability to compete successfully varies from location to location and depends on a number of factors that include, but are not limited to: the number of competing facilities in the local market and the types of services available at those facilities, our local reputation for quality care of members, 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.

Our growth strategy and our business could be adversely affected if we are not able to continue to access existing geographies, successfully expand into new geographies or maintain or establish new relationships with physician partners. See "Risk Factors."

The principal competitive factors in our business include the nature and caliber of relationships with physicians; patient healthcare quality, outcomes, and cost; the strength of relationships with payors; the quality of the physician experience; local geography leadership position; and the strength of the underlying economic model. We believe our business, partnership and operations model enables us to compete favorably.

The Healthcare Industry

According to the Centers for Medicare & Medicaid Services, or CMS, national healthcare expenditures grew 9.7% in 2020 to $4.1 trillion. Federal expenditures for healthcare increased by 36% largely in response to the COVID-19 pandemic while private health

insurance spending decreased 1%. CMS anticipates that total U.S. healthcare annual expenditures will reach nearly $6.2 trillion by 2028, accounting for approximately 19.7% of the total U.S. gross domestic product.

Hospital services, the market within the healthcare industry in which we primarily operate, is the largest single category of healthcare expenditures. In 2020, hospital care expenditures increased 6.4%, slightly faster than the growth rate of 6.3% in 2019, and totaled nearly $1.3 trillion. This growth reflected a substantial amount of funding from federal programs (including COVID-19 relief) and larger increases in Medicaid spending compared to prior years. CMS projects that the hospital services category will grow at an average of 6.0% annually from 2022 through 2028, reaching nearly $2.1 trillion by 2028.

The U.S. hospital industry includes acute care, rehabilitation and psychiatric facilities that are either public (government owned and operated), not-for-profit private (religious or secular), or for-profit institutions (investor owned). According to the American Hospital Association, there are approximately 5,139 community hospitals in the U.S., which are not-for-profit owned, investor owned, or state or local government owned. Of these hospitals, approximately 35% are located in non-urban communities. Hospital facilities offer a broad range of healthcare services, including internal medicine, general surgery, cardiology, oncology, orthopedics, OB/GYN and emergency services. In addition, hospitals offer other ancillary services, including psychiatric, diagnostic, rehabilitation, home care and outpatient surgery services.

Patients needing the most complex care are more often served by the larger and/or more specialized urban hospitals. We believe opportunities exist in selected markets to create micro-hospitals serving the community's emergency needs which expand the reach of healthcare services and have less wait times for care often seen in larger hospital emergency departments.

Physician and clinical services expenditures grew 5.4% to $809.5 billion in 2020, faster growth than the 4.2% in 2019. Relative spending for primary care in the U.S. is lower than that of many other developed nations. Preventative primary care is an important focus of U.S. healthcare education to consumers with the goal of improving patient care outcomes through early detection and treatment of illnesses. It also has the added benefit of reducing healthcare costs as extended hospital stays and more costly treatments may be avoided.

Consumers desire affordable primary care with access to specialists as needed. We believe this need may be met by offering IPAs. Our IPAs offer a trusted network of primary care physicians and specialists fostering closer patient-physician relationships.

COVID-19 Pandemic

A novel strain of coronavirus causing the disease known as COVID-19 was first identified in December 2019 and spread throughout the world. While vaccines and booster shots for the COVID-19 virus became widely available in the United States during 2021, COVID-19 continued to result in a significant number of hospitalizations.

As a provider of healthcare services, we were significantly affected by the public health and economic effects of the COVID-19 pandemic. Our hospitals, medical personnel, and employees have been actively caring for COVID-19 patients. We implemented considerable safety measures for treatment of COVID-19 patients and have incurred, and may continue to incur, certain increased expenses arising from the COVID-19 pandemic, including additional labor, supply chain, capital and other expenditures. Moreover, in recent months, the COVID-19 pandemic resulted in general inflationary pressures and significant disruptions to global supply networks. In this regard, we have experienced disruptions in connection with the provision of equipment, construction services, as well as inflationary pressures in connection with labor, supply chain, capital and other expenditures. We also experienced a delay in billing and collection of patient claims during this period.

The COVID-19 pandemic affected, and may continue to affect, our service mix, revenue mix, payor mix and/or patient volumes, as well as our ability to collect outstanding receivables. Pandemic-related factors may continue to adversely affect demand for our services, as well as the ability of patients and other payors to pay for services rendered.

While we are not able to fully quantify the impact that the COVID-19 pandemic will have on our future financial results, we expect developments related to COVID-19 to continue to affect our financial performance. Moreover, the COVID-19 pandemic may otherwise have material adverse effects on our results of operations, financial position, and/or our cash flows if economic and/or public health conditions in the United States deteriorate.

Governmental Regulation

The healthcare industry is heavily regulated and closely scrutinized by federal, state and local governments. Comprehensive statutes and regulations govern the manner in which we provide and bill for services and collect reimbursement from governmental programs and private payors, our contractual relationships with our providers, vendors and clients, our marketing activities and other aspects of our operations. Of particular importance are:

- No Surprises Act;
- the federal physician self-referral law, commonly referred to as the Stark Law;
- the federal Anti-Kickback Act;
- the criminal healthcare fraud provisions of HIPAA;
- the federal False Claims Act;
- reassignment of payment rules that prohibit certain types of billing and collection;
- similar state law provisions pertaining to anti-kickback, self-referral and false claims issues;
- state laws that prohibit general business corporations, such as us, from practicing medicine;
- laws that regulate debt collection practices as applied to our debt collection practices;

No Surprises Act. The No Surprises Act ("NSA") is a federal law that took effect January 1, 2022, to protect consumers from most instances of "surprise" balance billing. The legislation was included in the Consolidated Appropriations Act, 2021, which was passed by Congress and signed into law by President Trump on December 27, 2020. With respect to the Company, the NSA limits the amount an insured patient will pay for emergency services furnished by an out-of-network provider. The NSA addresses the payment of these out-of-network providers by group health plans or health insurance issuers (collectively, "insurers"). In particular, the NSA requires insurers to reimburse out-of-network providers at a statutorily calculated "out-of-network rate." In states without an all-payor model agreement or specified state law, the out-of-network rate is either the amount agreed to by the insurer and the out-of-network provider or an amount determined through an independent dispute resolution ("IDR") process.

Under the NSA, insurers must issue an initial payment or notice of denial of payment to a provider within thirty days after the provider submits a bill for an out-of-network service. If the provider disagrees with the insurer's determination, the provider may initiate a thirty-day period of open negotiation with the insurer over the claim. If the parties cannot resolve the dispute through negotiation, the parties may then proceed to IDR arbitration.

Independent Dispute Resolution. The provider and insurer each submits a proposed payment amount and explanation to the arbitrator. The arbitrator must select one of the two proposed payment amounts taking into account the "qualifying payment amount" and additional circumstances including among other things the level of training, outcomes measurements of the facility, the acuity of the individual treated, and the case mix and scope of services of the facility providing the service. The NSA prohibits the arbitrator from considering the provider's usual and customary charges for an item or service, or the amount the provider would have billed for the item or service in the absence of the NSA.

Qualifying Payment Amount. The "qualifying payment amount" (QPA) is generally the median of the contracted rates recognized by the plan or issuer under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the items or service is furnished, with annual increases based on the consumer price index. In other words, the qualifying payment amount is typically the median rate the insurer would have paid for the service if provided by an in-network provider or facility.

Since the NSA became effective January 1, 2022, our average payment by insurers of patient claims for emergency services has declined by approximately 30% including as much as a 37% reduction for physician services. In our experience, insurers often initially pay amounts lower than the QPA without regard for other information relevant to the claim. This requires us to make appeals using the IDR process. We submitted almost 28 thousand cases for IDR in 2022, most in the fourth quarter. The IDR process and subsequent appeals, should we pursue them, require extensive administrative time and delays in collections.

Our experience is similar to that of other healthcare providers. In February 2023, the Emergency Department Physician Management Association reported survey results of its membership. The survey found that in more than 90% of claims surveyed, insurance companies did comply with the NSA's statutory and regulatory requirements for QPA disclosure and that the average claim payment declined 32% per ER Visit post-NSA.

While we are working within the established processes for IDR, we have had varying successes at achieving collections at or higher than the established QPA. We have undertaken several strategic actions designed to improve our collections results. These include:

- maximizing our claims coding efficiency,
- increasing efforts to collect co-pays and co-insurance,
- adding additional administrative staff to handle the increased administrative IDR burden,
- having a dedicated IDR team to accelerate resubmission of claims under the IDR process,
- making appeals for additional payment of claims for periods before and after the NSA final rule was adopted through the IDR process,
- making efforts to sign favorable contracts with new insurers,
- working to sign more favorable contracted rates with existing contracted providers,
- working with both local and national legislatures to enforce the NSA rules and guidelines for Insurers, and
- focusing on the value-base IPA side of our business, which is less affected by the NSA.

HHS Final Rule. As required by the NSA, the United States Department of Health and Human Services ("HHS") has established an IDR process under which a certified IDR entity determines the ultimate amount of payment. The HHS' final rule became effective October 25, 2022.

The final rule is already the subject of legal challenges. The Texas Medical Association (TMA) in September of 2022 filed motions for summary judgment in the U.S. Eastern District of Texas, Tyler Division, seeking to invalidate the IDR related provisions of the final rule, arguing that the QPA does not represent the fair value of the services rendered by the physicians and providers and that the final rule illegally favors the QPA over the fair value of the provider services in contravention of the statutory language of the NSA.

On October 19, 2022, and in addition to amicus briefs by several other national medical associations, the American Society of Anesthesiologists, the American College of Emergency Physicians, and the American College of Radiology, professional associations representing an aggregate of approximately 136,000 physicians, filed an Amicus brief supporting the TMA Motion.

On February 6, 2023, the U.S. District Court ruled in favor of the TMA by granting its motion for summary judgment against the HHS and stating that the revised IDR process in the final rule "continues to place a thumb on the scale" in favor of insurers and conflicts with the statutory provisions of the NSA, is unlawful and must be set aside. The Courts decision vacated all of the revised regulations challenged by the TMA, including HHS' rule that arbiters must primarily consider the QPA in the IDR process. The court stated that the final rules wrongly require arbitrators to presume the correctness of the QPA and then impose a heightened burden on the remaining statutory factors to overcome that presumption. In addition, the TMA on January 1, 2023, also in the U.S. Eastern District, filed a lawsuit seeking declaratory and injunctive relief to invalidate a recent 600% percent increase in the administrative fees payable in the IDR process.

We are supportive of industry efforts challenging NSA. Our experience, like that of many other healthcare providers, is that the final rule continues to unfairly favor insurers in the determination of the QPA we receive for our healthcare services. It is difficult to predict the ultimate outcome of efforts to challenge or amend the final rule. As well, there can be no assurance that third-party payors will not attempt to further reduce the rates they pay for our services or that additional rules issued under the NSA will not have adverse consequences to our business.

Regulatory Licensing and Certification. Many states, including Arizona, Arkansas, Florida, Indiana, Kansas, Louisiana, New Mexico, Ohio, Oklahoma, Texas, and Wisconsin, require regulatory approval, including licensure and certification, before establishing certain types of clinics offering certain professional and ancillary services, including the services Nutex offers. The operations of the Nutex owned and managed hospitals are subject to extensive federal, state, and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, and proof of financial ability to operate. Our ability to operate profitably depends in part on the ability of Nutex owned and managed facilities and its providers to obtain and maintain all necessary licenses and other approvals, and maintain updates to their enrollment in the Medicare and Medicaid programs, including the addition of new hospital locations, providers and other enrollment information. In addition, certain ancillary services such as the provision of diagnostic laboratory testing require additional state and federal licensure and regulatory oversight, including oversight by CMS, under Clinical Laboratory Improvement Amendments of 1988, or CLIA, which requires all clinical laboratories to meet certain quality assurance, quality control and personnel standards, and comparable state laboratory licensing authorities. Standards for testing under CLIA are based on the complexity of the tests performed by the laboratory, with tests classified as "high complexity," "moderate complexity," or "waived." Nutex owned and managed facilities hold CLIA Certificates of Waiver and perform certain CLIA-waived tests, which subjects such clinics to certain CLIA requirements. Sanctions for failure to comply with

applicable state and federal licensing, certification and other regulatory requirements include suspension, revocation or limitation of the applicable authorization, significant fines and penalties and/or an inability to receive reimbursement from government healthcare programs and other third-party payors.

Nutex' providers must meet minimum requirements to apply for participation or continued participation with Nutex through a credentialing process, including, without limitation, having a valid, current medical license and DEA registration, if required for the provider's scope of practice, the absence of any debarment, suspension, exclusion or other restriction from receiving payments from any government or other third-party payor program, and clearing National Practitioner Data Bank of any reports and/or disciplinary actions. Nutex' credentialing program is designed to meet CMS and the National Committee for Quality Assurance, or NCQA, credentialing requirements as well as applicable federal and state laws. Providers are generally recredentialed every three years or more often if necessary, which is consistent with industry guidelines. In addition, network providers are required under their participating provider agreements with Nutex to have established an ongoing quality assurance program. Moreover, Nutex' contracts may allow Nutex to withhold compensation from time to time based upon the providers meeting certain quality metrics, including HEDIS quality measures and care coordination metrics.

State Corporate Practice of Medicine and Fee-Splitting Laws. Our arrangements with our affiliated professional entities and other physician partners are subject to various state laws, commonly referred to as corporate practice of medicine and fee-splitting laws, which are intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment and prohibiting the sharing of professional service fees with non-professional or business interests. These laws vary from state to state, including those where the Company does business, and are subject to broad interpretation and enforcement by state regulators.
A determination of non-compliance against us and/or our affiliated professional entities or other physician partners based on the reinterpretation of existing laws or adoption of new laws could lead to adverse judicial or administrative action, civil or criminal penalties, receipt of cease-and-desist orders from state regulators, loss of provider licenses, and/or restructuring of these arrangements.

Healthcare Fraud and Abuse Laws. We are subject to a number of federal and state healthcare regulatory laws that restrict certain business practices in the healthcare industry. These laws include, but are not limited to, federal and state anti-kickback, false claims, self-referral and other healthcare fraud and abuse laws.

The federal Anti-Kickback Statute, or AKS, prohibits, among other things, knowingly and willfully offering, paying, soliciting, or receiving remuneration, directly or indirectly, in cash or 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. 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.

Several courts have interpreted the AKS's intent requirement to mean that if any one purpose of an arrangement involving remuneration is to induce referrals of federal healthcare covered business, the AKS has been violated.

The AKS includes statutory exceptions and regulatory safe harbors that protect certain arrangements. By way of example, the AKS safe harbor for value-based arrangements and the safe harbor for arrangements between managed care organizations and downstream contractors both require, among other things, that the arrangement does not induce a person or entity to reduce or limit medically necessary items or services furnished to any patient. Failure to meet the requirements of an applicable AKS safe harbor, however, does not render an arrangement illegal. Rather, the government may evaluate such arrangements on a case-by-case basis, taking into account all facts and circumstances, including the parties' intent and the arrangement's potential for abuse, and may be subject to greater scrutiny by enforcement agencies.

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, or DHS, from referring Medicare and Medicaid patients to such entities for the furnishing of DHS, unless an exception applies. The Stark Law also prohibits the entity from billing for any such prohibited referral. Unlike the AKS, the Stark Law is violated if the financial arrangement does not meet an applicable exception, regardless of any intent by the parties to induce or reward referrals or the reasons for the financial relationship and the referral.

The Federal False Claims Act, or FCA, prohibits a person from knowingly presenting, or caused to be presented, a false or fraudulent request for payment from the federal government, or from making a false statement or using a false record to have a claim approved. A claim includes "any request or demand" for money or property presented to the United States government. Moreover, the government may assert that a claim including items and services resulting from a violation of the AKS or the Stark Law constitutes a

false or fraudulent claim for purposes of the civil False Claims Act. Penalties for a violation of the FCA include fines for each false claim, plus up to three times the amount of damages caused by each false claim. Private individuals also have the ability to bring actions under these false claims' laws in the name of the government alleging false and fraudulent claims presented to or paid by the government (or other violations of the statutes) and to share in any amounts paid by the entity to the government in fines or settlement. Such suits, known as qui tam actions, are pervasive in the healthcare industry.

Further, the Civil Monetary Penalties Statute 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 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. Moreover, in certain cases, providers who routinely waive copayments and deductibles for Medicare and Medicaid beneficiaries can also be held liable under the AKS and civil FCA. One of the statutory exceptions to the prohibition is non-routine, unadvertised waivers of copayments or deductible amounts based on individualized determinations of financial need or exhaustion of reasonable collection efforts. The HHS' Office of Inspector General emphasizes, however, that this exception should only be used occasionally to address special financial needs of a particular patient. Although this prohibition applies only to federal healthcare program beneficiaries, the routine waivers of copayments and deductibles offered to patients covered by commercial payors may implicate applicable state laws related to, among other things, unlawful schemes to defraud, excessive fees for services, tortious interference with patient contracts and statutory or common law fraud.

HIPAA also established federal criminal statutes that prohibit, among other things, knowingly and willfully executing, or attempting to execute, a scheme to defraud any healthcare benefit program, including private third-party payors, and 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. Similar to the AKS, 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.

Several states in which we operate have also adopted similar fraud and abuse laws as described above. The scope of these laws and the interpretations of them vary from state to state and are enforced by state courts and regulatory authorities, each with broad discretion. Some state fraud and abuse laws apply to items or services reimbursed by any payor, including patients and commercial insurers, not just those reimbursed by a federally funded healthcare program.

Violation of any of these laws or any other governmental regulations that apply may result in significant penalties, including, without limitation, administrative civil and criminal penalties, damages, disgorgement, fines, additional reporting requirements and compliance oversight obligations, in the event that a corporate integrity agreement or other agreement is required to resolve allegations of noncompliance with these laws, the curtailment or restructuring of operations, exclusion from participation in governmental healthcare programs and/ or individual imprisonment.

Healthcare Reform. In the United States, there have been, and we expect there will continue to be, a number of legislative and regulatory changes to the healthcare system, many of which are intended to contain or reduce healthcare costs. By way of example, in the United States, the ACA substantially changed the way healthcare is financed by both governmental and private insurers. The ACA required, among other things, CMS to establish a Medicare shared savings program that promotes accountability and coordination of care through the creation of ACOs. The Medicare shared savings program allows for providers, physicians and other designated health care professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to give coordinated high-quality care to their Medicare patients, avoid unnecessary duplication of services and prevent medical errors. ACOs that achieve quality performance standards established by CMS are eligible to share in a portion of the Medicare program's cost savings. ACO program methodologies and participation requirements are updated by CMS for each performance year and participants are expected to comply with such program requirements and required to report on performance after the close of the year. ACOs that fail to comply with such program requirements can face penalties or even termination of their participation in the Medicare shared savings program.

Since its enactment, there have been judicial, executive, and Congressional challenges to certain aspects of the ACA. On June 17, 2021, the U.S. Supreme Court dismissed the most recent judicial challenge to the ACA without specifically ruling on the constitutionality of the ACA. Prior to the Supreme Court's decision, President Biden issued an executive order initiating a special enrollment period from February 15, 2021, through August 15, 2021 for purposes of obtaining health insurance coverage through the ACA marketplace. The executive order also instructed certain governmental agencies to review and reconsider their existing policies and rules that limit access to healthcare. It is unclear how other healthcare reform measures of the Biden administration or other efforts, if any, to challenge, repeal or replace the ACA will impact the ACA or our business.

In addition, other legislative changes have been proposed and adopted since the ACA was enacted. These changes included aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013, and, due to subsequent legislative amendments to the statute, will remain in effect through 2030, with the exception of a temporary suspension from May 1, 2020 through December 31, 2021, unless additional Congressional action is taken. In addition, on January 2, 2013, the American Taxpayer Relief Act of 2012 was signed into law, which, among other things, reduced Medicare payments to several providers, including hospitals, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years.

Additionally, the Center for Medicare and Medicaid Innovation continues to test an array of value-based alternative payment models, including the Global and Professional Direct Contracting Model to allow Direct Contracting Entities to negotiate directly with the government to manage traditional Medicare beneficiaries and share in the savings and risks generated from managing such beneficiaries. Although we currently do not participate in these pilot payment models, we may choose to do so in the future. Additional changes that may affect our business include the expansion of new programs such as Medicare payment for performance initiatives for physicians under the Medicare Access and CHIP Reauthorization Act of 2015, which first affected physician payment in 2019. At this time, it is unclear how the introduction of the Medicare quality payment program will impact overall physician reimbursement. In addition, there likely will continue to be regulatory proposals directed at containing or lowering the cost of healthcare, as government healthcare programs and other third-party payors transition from FFS to value-based reimbursement models, which can include risk-sharing, bundled payment and other innovative approaches. It is possible that the federal or state governments will implement additional reductions, increases, or changes in reimbursement in the future under government programs that may adversely affect us or increase the cost of providing our services. The implementation of cost containment measures or other healthcare reforms may prevent us from being able to generate revenue or attain growth, any of which could have a material impact on our business.

Further, healthcare providers and industry participants are also subject to a growing number of requirements intended to promote the interoperability and exchange of patient health information. For example, on April 5, 2021, healthcare providers and certain other entities became subject to information blocking restrictions pursuant to the Cures Act that prohibit practices that are likely to interfere with the access, exchange or use of electronic health information, except as required by law or specified by the HHS as a reasonable and necessary activity. Violations may result in penalties or other disincentives. 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.

Data Privacy and Security Laws. We are subject to a number of federal and state laws and regulations that govern the collection, use, disclosure, and protection of health-related and other personal information, including health information privacy and security laws, data breach notification laws, and consumer protection laws and regulations (e.g., Section 5 of the FTC Act). For example, HIPAA imposes obligations on "covered entities," including certain healthcare providers, such as the affiliated professional entities, health plans, and healthcare clearinghouses, and their respective "business associates" that create, receive, maintain or transmit individually identifiable health information for or on behalf of a covered entity, as well as their covered subcontractors with respect to safeguarding the privacy, security and transmission of individually identifiable health information. Entities that are found to be in violation of HIPAA, whether as the result of a breach of unsecured PHI, a complaint about privacy practices, or an audit by HHS, may be subject to significant civil, criminal, and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance.

In addition, certain state laws, such as the CMIA, the CCPA, and the CPRA, govern the privacy and security of personal information, including health-related information in certain circumstances, some of which are more stringent than HIPAA and many of which differ from each other in significant ways and may not have the same effect, thus complicating compliance efforts.

Failure to comply with these laws, where applicable, can result in the imposition of significant civil and/or criminal penalties and private litigation. Privacy and security laws, regulations, and other obligations are constantly evolving, may conflict with each other to complicate compliance efforts, and can result in investigations, proceedings, or actions that lead to significant civil and/or criminal penalties and restrictions on data processing.

Federal and State Insurance and Managed Care Laws. Regulation of downstream risk-sharing arrangements, including, but not limited to, at-risk and other value-based arrangements, varies significantly from state to state. Some states require downstream entities and risk-bearing entities to obtain an insurance license, a certificate of authority, or an equivalent authorization, in order to participate in downstream 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 downstream 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 downstream risk-sharing arrangement. Such oversight is accomplished via contract and may include the imposition of reserve requirements, as well as reporting obligations. Further, state regulatory stances regarding downstream risk-sharing arrangements can change rapidly and codified provisions may not keep pace with evolving risk-sharing mechanisms and other new value-based reimbursement models. Certain of the states where we currently operate or may choose to operate in the future regulate the operations and financial condition of risk bearing organizations like us and our affiliated providers.

Employees

We had 1,150 full- and part-time employees as of December 31, 2022, including our named executive officers. None of our employees are covered by collective bargaining agreements, and we have not experienced any strikes or work stoppages related to labor relation issues. We believe we have good relations with our employees.

Where You Can Find More Information

We file annual, quarterly and current reports, proxy statements and other information required by the Securities Exchange Act of 1934, as amended (the "Exchange Act"), with the Securities and Exchange Commission (the "SEC"). You may read and copy any document we file with the SEC at the SEC's public reference room located at 100 F Street, N.E., Washington, D.C. 20549, U.S.A. Please call the SEC at 1-800-SEC-0330 for further information on the public reference room. Our SEC filings are also available to the public from the SEC's internet site at http://www.sec.gov.

On our Internet website, http://www.nutexhealth.com, we post the following recent filings as soon as reasonably practicable after they are electronically filed with or furnished to the SEC: our annual reports on Form 10-K, our quarterly reports on Form 10-Q, our current reports on Form 8-K, and any amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act.

Item 1A. Risk Factors

Our business, financial condition, and operating results are affected by a number of factors, whether currently known or unknown, including risks specific to us or the healthcare industry, as well as risks that affect businesses in general. The risks disclosed in this Annual Report could materially adversely affect our business, financial condition, cash flows, or results of operations and thus our stock price. These risk factors may be important to understanding other statements in this Annual Report and should be read in conjunction with the consolidated financial statements and related notes in Part I, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Part I, Item 8, "Financial Statements and Supplementary Data" of this Annual Report on Form 10-K. Because of such risk factors, as well as other factors affecting the Company's financial condition and operating results, past financial performance should not be considered to be a reliable indicator of future performance, and investors should not use historical trends to anticipate results or trends in future periods.

Our operations and financial results are subject to various risks and uncertainties, including but not limited to those described below, which could harm our business, reputation, financial condition, and operating results.

Risks Related to Nutex Health Inc.

Sales of a substantial amount of our Common Stock by our stockholders could cause the price of our Common Stock to fall.

As of February 15, 2023, there were 650,929,125 shares of Common Stock outstanding, including 267,322,776 shares of Common Stock held by Thomas T. Vo, M.D., our Chairman and Chief Executive Officer, 41,964,832 shares of Common Stock held by Matthew S. Young, a director, and 12,008,523 shares of Common Stock held by Michael Chang, our Chief Medical Officer. An additional approximately 271,326,203 shares of Common Stock are held by former holders of member interests in Nutex Health Holdco LLC, who are non-affiliates.

Of the 592,791,712 shares issued in the merger, 395,194,476 shares are subject to lock-up as of the date hereof. On October 1, 2022, the lockup with respect to one-third, or 197,597,237 of those shares, expired. An additional 197,597,237 shares will be released from lockup on April 1, 2023 and the lockup with respect to the remaining 197,597,237 shares will expire on October 1, 2023.

Upon the expiration of the lock-up periods, large amounts of our Common Stock may be sold into the open market or in privately negotiated transactions, which could have the effect of increasing the volatility in the share price of our Common Stock or putting significant downward pressure on the price of our Common Stock.

Sales of substantial amounts of our Common Stock in the public market, or the perception that such sales will occur, could adversely affect the market price of our Common Stock and make it difficult for us to raise funds through securities offerings in the future.

We have identified material weaknesses in our internal control over financial reporting. If our internal control over financial reporting is not effective, we may not be able to accurately report our financial results or file our periodic reports in a timely manner, which may cause adverse effects on our business and may cause investors to lose confidence in our reported financial information and may lead to a decline in the price of our Common Stock.

Effective internal control over financial reporting is necessary for us to provide reliable financial reports in a timely manner. In connection with the audits of our financial statements for the years ended December 31, 2021 and 2020, we concluded that there were material weaknesses in our internal control over financial reporting. A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis. These material weaknesses related to our revenue estimation process, recordation of leases in accordance with newly adopted accounting standards and other matters caused by having inadequate accounting close processes.

The Company has started the process of designing and implementing effective internal control measures to remediate these material weaknesses. The Company's efforts include the employment of our new chief financial officer, engagement of an accounting specialist to assist in our accounting close and reporting processes, process documentation and supervisory reviews of our revenue estimate and accounting close processes. We plan to employ additional experienced personnel in our accounting and financial reporting teams as well.

While we believe that these efforts will improve our internal control over financial reporting, our remediation efforts are ongoing and will require validation and testing of the design and operating effectiveness of internal controls. The actions that we are taking are subject to ongoing senior management review, as well as audit committee oversight. We will not be able to conclude whether the steps we are taking will fully remediate the remaining material weakness in our internal control over financial reporting until we have completed our remediation efforts and subsequent evaluation of their effectiveness. We may also conclude that additional measures may be required to remediate the material weakness in our internal control over financial reporting.

If we are unable to successfully remediate the material weaknesses or identify any future significant deficiencies or material weaknesses, the accuracy and timing of our financial reporting may be adversely affected, a material misstatement in our financial statements could occur, and we may be unable to maintain compliance with securities law requirements regarding timely filing of periodic reports, which may adversely affect our business and the price of our Common Stock may decline as a result.

In addition, even if we remediate the material weaknesses, we will be required to expend significant time and resources to further improve our internal controls over financial reporting, including by further expanding our finance and accounting staff to meet the demands that placed upon us as a public company, including the requirements of the Sarbanes-Oxley Act. If we fail to adequately staff our accounting and finance function to remediate our material weaknesses or fail to maintain adequate internal control over financial reporting, any new or recurring material weaknesses could prevent our management from concluding that our internal control over financial reporting is effective and impair our ability to prevent material misstatements in our financial statements, which could cause our business to suffer.

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

We may be forced to write-down or write-off assets, restructure operations, or incur impairment or other charges that could result in losses. Even though these charges may be non-cash items and not have an immediate impact on liquidity, any report of charges of this nature could contribute to negative market perceptions about us or our securities. In addition, charges such as write-downs or impairments may make future financing difficult to obtain on favorable terms or at all. From time to time, our intangible assets are subject to impairment testing. Under current accounting standards, our goodwill, including acquired goodwill, is tested for impairment on an annual basis and may be subject to impairment losses as circumstances change (e.g., after an acquisition).

For example, in 2022, we recorded a non-cash impairment charge of $398.1 million to reduce the carrying amount of goodwill for the population health management division reporting unit acquired in the reverse business combination in connection with the Merger. The Company may have to record a significant goodwill impairment in the future, which could materially adversely affect its reported financial results and negatively impact the trading value of its Common Stock.

The laws and regulations applicable to public companies are complex and may require an increasing amount of our management's time and increase staffing and compliance costs.

We face significant challenges in managing the transition of Nutex' legacy private held operations to a publicly traded company, which is subject to significant and increasing regulatory oversight and reporting obligations under federal securities laws. Laws pertaining to public companies, including new regulations proposed by the SEC, are increasingly complex and could force management to devote increasing amounts of time to the compliance with such laws and potentially impact time available to the management of our business. The Company will be required to continue to expand its employee base and hire additional employees to support its operations as a public company, which will increase operating costs in future periods.

Our business and the markets in which we operate are new and rapidly evolving, which makes it difficult to evaluate our future prospects and the risks and challenges we may encounter.

Our business and the markets in which we operate are new and rapidly evolving which make it difficult to evaluate and assess the success of our business to date, our future prospects and the risks and challenges that we may encounter. These risks and challenges include our ability to:

- attract new partner physicians;
- retain our current physician partners;
- comply with existing and new laws and regulations applicable to our business and in our industry;

- anticipate and respond to changes in reimbursement rates and the markets in which we operate;
- react to challenges from existing and new competitors;
- maintain and continually enhance our reputation;
- effectively manage our growth and business operations, including new geographies;
- forecast our revenue, which includes reimbursements, and budget for, and manage, our expenses, including our medical expense amounts, and capital expenditures;
- hire and retain talented individuals at all levels of our organization;
- maintain and continually improve our infrastructure to adjust for the growth of the company, including our data protection, intellectual property and cybersecurity; and
- successfully execute our ambitious growth strategy.

If we fail to understand fully or adequately address these challenges that we may encounter in the future, including those challenges described here and elsewhere in this "*Risk Factors*" section, our business, financial condition and results of operations could be adversely affected. If the risks and uncertainties that we plan for when operating our business are incorrect or change, or if we fail to manage these risks successfully, our results of operations could differ materially from our expectations and our business, financial condition and results of operations could be adversely affected.

Our limited operating history as a combined company makes it difficult to evaluate our future prospects and the risks and challenges we may encounter.

We completed our merger on April 1, 2022 and we are continuing to grow our management capabilities. Consequently, predictions about our future success may not be as accurate as they could be if we had a longer combined operating history. If our growth strategy is not successful, we may not be able to continue to grow our revenue or operations. Our limited combined operating history, evolving business and anticipated rapid growth make it difficult to evaluate our future prospects and the risks and challenges we may encounter, and we may not continue to grow at or near anticipated rates.

We may need to raise additional capital to expand our operations.

We may need to spend significant amounts to expand our existing operations, including expansion into new geographies. Based upon our current operating plan, we believe that our existing cash, cash equivalents and restricted cash will be sufficient to fund our operating and capital needs for at least the next twelve months. This estimate and our expectation regarding the sufficiency of funds are based on assumptions that may prove to be incorrect, and the revenue we generate may not be sufficient to support our growth strategy. We also may finance our cash needs through a combination of equity offerings and debt financings or other sources, pending market conditions.

Our present and future funding requirements will depend on many factors, including:

- our ability to achieve revenue growth;
- our ability to effectively manage medical expense amounts;
- the cost of expanding our operations, including our geographic scope, and our offerings, including our marketing efforts;
- our rate of progress in launching, commercializing and establishing adoption of our services; and
- the effect of competing technological and market developments.

To the extent that we raise additional capital through the sale of equity or convertible debt securities, your ownership interest may be diluted, and the terms of these securities may include liquidation or other preferences that adversely affect your rights as a securityholder. In addition, debt financing and preferred equity financing, if available, may involve agreements that include covenants limiting or restricting our ability to take specific actions, such as incurring additional debt, making capital expenditures or declaring dividends. If we are unable to raise additional funds when needed, we may be required to delay, limit, reduce or terminate development efforts.

We may experience difficulties in managing our growth and expanding our operations.

We are targeting significant growth in the scope of our operations. Our ability to manage our operations and future growth will require us to continue to improve our operational, financial and management controls, compliance programs and reporting systems. We may not be able to implement improvements in an efficient or timely manner and may discover deficiencies in existing controls, programs,

systems and procedures, which could have an adverse effect on our business, reputation and financial results. Additionally, rapid growth in our business may place a strain on our human and capital resources.

Risks Related to Our Business and Industry

Reimbursement for our medical services is subject to change, and the reimbursement that we receive for emergency services could be subject to a significant and sustained decline.

Because we provide emergency medicine services, we do not have extensive relationships with large commercial payors and are generally out-of-network. Although some licensed facilities are in-network with payors, the Company's general payor contracting/government enrollment strategy is to remain out of network. Since we do not have any contractual arrangements with insurance companies, we cannot predict the timing and amount of the payments we ultimately receive for our services and estimates and assumptions, which are based on historical insurance payment amounts and timing.

In addition, as a result of the NSA becoming effective on January 1, 2022, we experienced a significant decline in collections of patient claims for emergency services and have had only limited success at achieving collections at or higher than the established qualifying payment amount, which is the median in-network contracted rate for the same insurance market. Any sustained decline in the collections we receive for our emergency services could have a material adverse effect on our operations and financial performance and may negatively affect the trading value of our Common Stock.

The estimates and assumptions we are or Nutex Health Holdco was required to make in connection with the preparation of our financial statements may prove to be inaccurate.

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period.

We apply ASC 606 – *Revenue from Contracts with Customers* in making estimates of its earned revenue and accounts receivable at each reporting date. This estimation process for variable consideration is highly subjective. The Company regularly conducts a comparative analysis of its actual results to its previously estimated results in order to evaluate whether changes to its estimation process are required. The estimation of variable consideration is particularly complex within the healthcare industry generally because of the broad range of services provided, the range of reimbursements by patient insurance companies and collectability of patient responsible amounts. In addition, our hospital division generally operates as an out-of-network provider and, as such, does not have negotiated reimbursement rates with insurance companies, adding to the complexity and potential uncertainty of the estimation process.

Our estimates with respect to the claims processing by insurance companies and our resulting cash collections may differ from previous estimated results and we may be required to make periodic adjustments to our estimation process for new facts or circumstances.

Ultimate amounts collected may differ from anticipated collections, and, as a result, may impact our ability to generate revenue at expected levels.

The continuing COVID-19 global pandemic could negatively affect our operations, business and financial condition, and our ability to generate revenue could be negatively impacted if the U.S. economy remains unstable for a significant amount of time.

The continuing COVID-19 crisis is still rapidly evolving and much of its impact remains unknown and difficult to predict. It could potentially negatively impact our financial performance in 2022 and beyond.

We experienced, and in the future could experience, supply chain disruptions, including shortages and delays, and could experience significant price increases, in equipment and medical supplies, particularly personal protective equipment or PPE. Staffing, equipment, and medical supplies shortages may also impact our ability to serve patients at our centers.

In addition, our results and financial condition may be adversely affected by future federal or state laws, regulations, orders, or other governmental or regulatory actions addressing the current COVID-19 pandemic or the U.S. health care system, which, if adopted, could result in direct or indirect restrictions to its business, financial condition, results of operations and cash flow.

Disruptions to our business as a result of the continuing COVID-19 pandemic (including the potential resurgences of COVID-19) could have a material adverse effect on our results of operations, financial condition and cash flows.

We rely on our management team and key employees and our business, financial condition, cash flows and results of operations could be harmed if we are unable to retain qualified personnel.

Our success depends largely upon the continued services of key members of senior management, including our chief executive officer. We also rely on our leadership team in the areas of operations and general and administrative functions. From time to time, there may be changes in our management team resulting from the hiring or departure of executives, which could disrupt our business. The replacement of one or more of our executive officers or other key employees would likely involve significant time and costs and may significantly delay or prevent the achievement of our business objectives. Our business would also be adversely affected if we fail to adequately plan for succession of our executives and senior management; or if we fail to effectively recruit, integrate, retain and develop key talent and/or align our talent with our business needs, in light of the current rapidly changing environment. While we have succession plans in place and we have employment arrangements with our key executives, these do not guarantee that the services of these or suitable successor executives will continue to be available to us.

Competition for qualified personnel in our field is intense due to the limited number of individuals who possess the skills and experience required by our industry. As a result, as we enter new geographies, it may be difficult for us to hire additional qualified personnel with the necessary skills to work in such geographies. If our hiring efforts in new or existing geographies are not successful, our business will be harmed. In addition, we have experienced employee turnover and expect to continue to experience employee turnover in the future. New hires require significant training and, in most cases, take significant time before they achieve full productivity. New employees may not become as productive as we expect, and we may be unable to hire or retain sufficient numbers of qualified individuals. If our retention efforts are not successful or our employee turnover rate increases in the future, our business, financial condition, cash flows and results of operations will be harmed.

In addition, in making employment decisions, job candidates often consider the value of the stock options or other equity instruments they are to receive in connection with their employment. Volatility in the price of our stock may, therefore, adversely affect our ability to attract or retain highly skilled personnel. Further, the requirement to expense stock options and other equity instruments may discourage us from granting the size or type of stock option or equity awards that job candidates require to join our company. Failure to attract new personnel or failure to retain and motivate our current personnel, could have a material adverse effect on our business, financial condition and results of operations.

Our growth depends in part on our ability to identify and develop successful new geographies, physician partners and patients. If we are not able to successfully execute upon our growth strategies, there may be a material adverse effect on our business, financial condition, cash flows and results of operations.

Our business depends on our ability to identify and develop successful geographies and relationships with physician partners and healthcare professionals, and to successfully execute upon our growth initiatives to increase the profitability of our physician partners and healthcare professionals. In order to pursue our strategy successfully, we must effectively implement our partnership model, including identifying suitable candidates and successfully building relationships with and managing integration of new physician partners. We contract with a limited number of physician partners and rely on such physicians within each geography. Our growth initiatives in our existing geographies depend, in part, on our physician partners' ability to increase their capacity and to effectively meet increased patient demand. We may encounter difficulties in recruiting additional physicians to work at our hospitals due to many factors, including significant competition in their geographies. Accordingly, the loss or dissatisfaction of any physician partners, our inability to recruit, or the failure of our hospitals to recruit additional physicians or manage and scale capacity to timely meet patient demand, could substantially harm our reputation, impact our competitiveness, and impair our ability to attract new physician partners and maintain existing physician partnerships, both in new geographies and in geographies in which we currently operate, which could have a material adverse effect on our business, financial condition, cash flows and results of operations.

Further, our growth strategy depends, in part, on securing and integrating new high-caliber physician partners and expanding into new geographies in which we have little or no operating experience. Integration and other risks can be more pronounced for larger and more complicated relationships or relationships outside of our core business space, or if we pursue multiple relationships simultaneously. New geographies into which we seek to expand may have laws and regulations that differ from those applicable to our current operations. As a rapidly growing company, we may be unfamiliar with the regulatory requirements in each geography that we

enter, and we may be forced to incur significant expenditures to ensure compliance with requirements to which we are subject. If we are unable or unwilling to incur such costs, our growth in new geographies may be less successful than in our current geographies.

Our growth to date has increased the significant demands on our management, operational and financial systems, infrastructure and other resources. We must continue to improve our existing systems for operational and financial management, including our reporting systems, procedures and controls. These improvements could require significant capital expenditures and place increasing demands on our management. We may not be successful in managing or expanding our operations or in maintaining adequate financial and operating systems and controls. If we do not successfully manage these processes, our business, financial condition, cash flows and results of operations could be harmed.

In his capacity as the co-owner of the real estate entities that lease the land and buildings to our hospital facilities, Dr. Vo, our Chairman, CEO and major stockholder, may have conflicts of interest with the Company and its public stockholders.

The majority of our hospital facilities have contractual relationships with separately owned real estate entities (the "Real Estate Entities") and each hospital has contractual relationships with separately owned professional entities (the "Physician LLCs").

The Physician LLCs, which are owned by the doctors providing services to the corresponding hospital, provide physician and provider services to the hospitals, and employ the doctors and other providers.

The Real Estate Entities, also partially owned by the doctors providing services to the corresponding hospital, own the land and/or buildings that are leased to the our hospitals. The Real Estate Entities incur debt to purchase or construct the hospital facility. Lease payments received from our hospitals are used by the Real Estate Entities to make payments on their debt. Each hospital facility's lease payments are guaranteed by the Company.

In addition to its doctor owners, each Real Estate Entity is partially owned or controlled by Dr. Vo, our Chairman, CEO and major stockholder holding approximately 41% of our outstanding Common Stock. As a result, the interests of Dr. Vo, in his capacity as part owner of the Real Estate Entities, may differ from the interests of the Company and its public shareholders, both in the re-negotiation of existing contractual relationships between the Company-owned hospital facilities and the Real Estate Entities and in the establishment of new hospital entities and their respective Real Estate Entities.

If the estimates and assumptions we use to project the size, revenue or medical expense amounts of our target geographies are inaccurate or the cost of providing services exceeds the amounts received by us, our future growth prospects may be impacted, and we may generate losses or fail to attain financial performance targets.

We often do not have access to reliable historical data regarding the size, revenue or medical expense levels of our target geographies or potential physician partners. As a result, our market opportunity estimates and financial forecasts developed as we enter into a new geography, are subject to significant uncertainty, and are based on assumptions and estimates that may not prove to be accurate. The estimates and forecasts in this prospectus relating to the size and expected growth of the market for our services and the estimates of our market opportunity may prove to be inaccurate.

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 could have a material adverse effect on our business, results of operations, financial condition and cash flows. Additionally, the medical expenses of patients may be outside of our physician partners' control in the event that patients take certain actions that increase such expenses, such as unnecessary hospital visits. If we underestimate or do not correctly predict the cost of the care our partner physicians furnish to patients, we might be underpaid for the care that must be provided to patients, which could have a negative impact on our results of operations and financial condition.

We primarily depend on reimbursement by third-party payors, as well as payments by individuals, which could lead to delays and uncertainties in the timing and process of reimbursement, including any changes or reductions in Medicare reimbursement rates or rules.

The reimbursement process is complex and can involve lengthy delays. Although we recognize revenue when we provide services to patients, we may from time-to-time experience delays in receiving 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, 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 reduce, complicate or 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. We may not be able to collect the full amounts due with respect to these payments that are the patient's financial responsibility, or in those 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 for which we may not receive whole or partial payment. 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, which we may not be able to offset with sufficient revenue.

Our business and growth strategy depend on our ability to maintain and expand facilities staffed with qualified physicians. If we are unable to do so, future growth would be limited and our business, operating results and financial condition would be harmed.

Our success is dependent upon a continued ability to maintain an adequate staff of qualified providers to staff the facilities. If we are unable to recruit and retain physicians and other healthcare professionals, it would have a material adverse effect on its business and ability to grow and would adversely affect the results of operations. In any particular market, providers could demand higher payments or take other actions that could result in higher medical costs, less attractive service for our customers or difficulty meeting applicable regulatory or accreditation requirements. Our ability to develop and maintain satisfactory relationships with providers also may be negatively impacted by other factors not associated with us, such as changes in reimbursement levels and consolidation activity among hospitals, physician groups and healthcare providers, the continued private equity investment in physician practice management platforms and other market and operating pressures on healthcare providers. The failure to maintain or to secure new cost-effective provider contracts may result in a loss of or inability to staff existing or new facilities, higher costs, less attractive service for patients and/or difficulty in meeting applicable regulatory requirements, any of which could have a material adverse effect on our business, financial condition and results of operations.

If any of our physician partners lose their regulatory licenses, permits and/or accreditation status, or become ineligible to receive reimbursement under Medicare or Medicaid or from other third-party payors, there may be a material adverse effect on our business, financial condition, cash flows, or results of operations.

The operations of our hospitals through our physician partners are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Our hospitals and their affiliated professional entities are also subject to extensive laws and regulation relating to facility and professional licensure, conduct of operations, including financial relationships among healthcare providers, Medicare and Medicaid fraud and abuse and physician self-referrals, and maintaining updates to the hospital's affiliated professional entities' enrollment in the Medicare and Medicaid programs, including the addition of new clinic locations, providers and other enrollment information. Our hospitals and their affiliated professional entities are subject to periodic inspection by licensing authorities and accreditation organizations to assure their continued compliance with these various standards. There can be no assurance that these regulatory authorities will determine that all applicable requirements are fully met at any given time. Should any of our hospitals or their affiliated professional entities be found to be noncompliant with these requirements, we could be assessed fines and penalties, could be required to refund reimbursement amounts or could lose our licensure or Medicare and/or Medicaid certification or accreditation so that we or our hospitals are unable to receive reimbursement from third-party payors, which could materially adversely affect our business, financial condition, cash flows or results of operations.

We are dependent on our physicians and other healthcare professionals to effectively manage the quality and cost of care.

Our success depends upon our continued ability to collaborate with and expand the number of highly qualified physicians and other healthcare professionals, which are key drivers of our profitability.

We operate in a competitive industry, and if we are not able to compete effectively, our business, financial condition and results of operations will be harmed.

Our industry is competitive and we expect it to attract increased competition. We currently face competition in various aspects of our business, including from a range of companies that provide similar services, including hospitals, managed service organizations and provider networks and data analysis consultants.

Our primary competitors include numerous local provider networks, hospitals and health systems. We may face a more competitive environment and increased challenges to grow at the rates we have projected. We expect that competition will continue to increase as a result of consolidation in the healthcare industry and increased demand for its services.

Some of our competitors may have greater name recognition, particularly in local geographies, longer operating histories, superior products or services and significantly greater resources than we do. Further, our current or potential competitors may be acquired by or partner with third parties with greater resources than we have. As a result, our competitors may be able to respond more quickly and effectively than we can to new or changing opportunities, technologies, standards or customer requirements and may have the ability to initiate or withstand premium competition. In addition, current and potential competitors have established, and may in the future establish, cooperative relationships with providers of complementary services, technologies or services to increase the attractiveness of their services.

Accordingly, new competitors or alliances may emerge which could put us at a competitive disadvantage. If we are unable to successfully compete, our business, financial condition, cash flows and results of operations could be materially adversely affected.

Developments affecting spending by the healthcare industry could adversely affect our business.

The U.S. healthcare industry has changed significantly in recent years, and we expect that significant changes will continue to occur. General reductions in expenditures by healthcare industry participants could result from, among other things:

- government regulations or private initiatives that affect the manner in which healthcare providers interact with patients, payors or other healthcare industry participants, including changes in pricing or means of delivery of healthcare products and services;
- consolidation of healthcare industry participants;
- federal amendments to, lack of enforcement or development of applicable regulations for, or repeal of the ACA;
- reductions in government funding for healthcare; and
- adverse changes in business or economic conditions affecting healthcare payors or providers or other healthcare industry participants.

Any of these changes in healthcare spending could adversely affect our revenue. Even if general expenditures by industry participants remain the same or increase, developments in the healthcare industry may result in reduced spending in some or all of the specific market segments that we serve now or in the future. However, the timing and impact of developments in the healthcare industry are difficult to predict. Demand for our services may not continue at current levels and we may not have adequate technical, financial, and marketing resources to react to changes in the healthcare industry.

We and our physician partners and other healthcare professionals may become subject to medical liability claims, which could cause us to incur significant expenses and may require us to pay significant damages if the claims are not covered by insurance.

Our overall business entails the risk of medical liability claims. Although we and our partner professionals carry insurance covering medical malpractice claims in amounts that we believe are appropriate in light of the risks attendant to the services rendered, successful medical liability claims could result in substantial damage awards that exceed the limits of our and those partner professionals' insurance coverage. We carry or will carry professional liability insurance for us and each of our healthcare professionals. Professional liability insurance is expensive and insurance premiums may increase significantly in the future, particularly as we expand our services. As a result, adequate professional liability insurance may not be available to us and our partner professionals in the future at acceptable costs or at all, which may negatively impact our and our partner professionals' ability to provide services to our hospitals, and thereby adversely affect our overall business and operations.

Any claims made against us or our partner professionals that are not fully covered by insurance could be costly to defend against, result in substantial damage awards, and divert the attention of our management and our partner professional entities from our

operations, which could have a material adverse effect on our business, financial condition and results of operations. In addition, any claims may adversely affect our business or reputation.

If we or our partner physicians or other healthcare providers fail to comply with applicable data interoperability and information blocking rules, our consolidated results of operations could be adversely affected.

The 21st Century Cures Act, or the Cures Act, which was passed and signed into law in December 2016, includes provisions related to data interoperability, information blocking and patient access. In March 2020, the U.S. Department of Health and Human Services, or HHS, Office of the National Coordinator for Health Information Technology, or ONC, and CMS finalized and issued complementary rules that are intended to clarify provisions of the Cures Act regarding interoperability and information blocking, and include, among other things, requirements surrounding information blocking, changes to ONC's health IT certification program and requirements that CMS regulated payors make relevant claims/care data and provider directory information available through standardized patient access and provider directory application programming interfaces that connect to provider electronic health record systems. The companion rules will transform the way in which healthcare providers, health IT developers, health information exchanges/health information networks, or HIEs/HINs, and health plans share patient information, and create significant new requirements for healthcare industry participants. For example, the ONC rule, which went into effect on April 5, 2021, prohibits healthcare providers, health IT developers of certified health IT, and HIEs/HINs from engaging in practices that are likely to interfere with, prevent, materially discourage, or otherwise inhibit the access, exchange or use of electronic health information, or EHI, also known as "information blocking." To further support access and exchange of EHI, the ONC rule identifies eight "reasonable and necessary activities" as exceptions to information blocking activities, as long as specific conditions are met. Any failure to comply with these rules could have a material adverse effect on our business, results of operations and financial condition.

Our business and operations would suffer in the event of information technology system failures, security breaches, or other deficiencies in cybersecurity.

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 is 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.

In the ordinary course of our business, we, our partner physicians or other physician partners collect and store sensitive data, including personally identifiable information, protected health information, or PHI, intellectual property and proprietary business information owned or controlled by us or our employees, members and other parties. We manage and maintain our applications and data utilizing a combination of on-site systems and cloud-based data centers. We utilize external security and infrastructure vendors to provide and manage parts of our information technology systems, including our data centers. These applications and data encompass a wide variety of business-critical information, including research and development information, customer information, commercial information and business and financial information. We face a number of risks with respect to the protection of this information, including loss of access, inappropriate use or disclosure, unauthorized access, inappropriate modification and the risk of being unable to adequately monitor and audit and modify our controls over our critical information. This risk extends to the third-party vendors and subcontractors we use to manage this sensitive data or otherwise process it on our behalf. A breach or failure of our or our third-party vendors' or subcontractors' network, hosted service providers or vendor systems could result from a variety of circumstances and events, including third-party action, employee negligence or error, malfeasance, computer viruses, cyber-attacks by computer hackers such as denial-of-service and phishing attacks, failures during the process of upgrading or replacing software and databases, power outages, hardware failures, telecommunication failures, user errors, or catastrophic events. If these third-party vendors or subcontractors fail to protect their information technology systems and our confidential and proprietary information, we may be vulnerable to disruptions in service and unauthorized access to our confidential or proprietary information and we could incur liability and reputational damage.

The secure processing, storage, maintenance and transmission of information are vital to our operations and business strategy, and we devote significant resources to protecting such information. Although we take reasonable measures to protect sensitive data from unauthorized access, use or disclosure, our information technology and infrastructure may still be vulnerable to, and we have in the past experienced, low-threat attacks by hackers or breaches due to employee error, malfeasance or other malicious or inadvertent disruptions. Further, attacks upon information technology systems are increasing in their frequency, levels of persistence,

sophistication and intensity, and are being conducted by sophisticated and organized groups and individuals with a wide range of motives and expertise. As a result of the COVID-19 pandemic, we may also face increased cybersecurity risks due to our reliance on internet technology and the number of our employees who are working remotely, which may create additional opportunities for cybercriminals to exploit vulnerabilities. Furthermore, because the techniques used to obtain unauthorized access to, or to sabotage, systems change frequently and often are not recognized until launched against a target, we may be unable to anticipate these techniques or implement adequate preventative measures. We may also experience security breaches that may remain undetected for an extended period. Any such breach or interruption could compromise our networks and the information stored there could be accessed by unauthorized parties, publicly disclosed, lost or stolen. Our information systems must also be continually updated, patched and upgraded to protect against known vulnerabilities. The volume of new vulnerabilities has increased markedly, as has the criticality of patches and other remedial measures. In addition to remediating newly identified vulnerabilities, previously identified vulnerabilities must also be continuously addressed. Accordingly, we are at risk that cyber-attackers exploit these known vulnerabilities before they have been addressed.

Any access, breach, or other loss of information could result in legal claims or proceedings, and liability under federal or state laws that protect the privacy of personal information, and corresponding regulatory penalties. In addition, we could face criminal liability, damages for contract breach and incur significant costs for remedial measures to prevent future occurrences and mitigate past violations. Notice of breaches may be required to be made to affected individuals or other state or federal regulators, and for extensive breaches, notice may need to be made to the media or State Attorneys General. Such a notice could harm our reputation and our ability to compete. Although 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. Despite our implementation of security measures to prevent unauthorized access, our data is currently accessible through multiple channels, and there is no guarantee we can protect our data from breach. Unauthorized access, loss or dissemination could also disrupt our operations and damage our reputation, any of which could adversely affect our business.

Actual or perceived failures to comply with applicable data protection, privacy and security laws, regulations, standards and other requirements could adversely affect our business, financial condition and results of operations.

Numerous state and federal laws, regulations, standards and other legal obligations, including consumer protection laws and regulations, which govern the collection, dissemination, use, access to, confidentiality, security and processing of personal information, including health-related information, could apply to our operations or the operations of our partners. For example, the Health Insurance Portability and Accountability Act, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, and regulations implemented thereunder, or collectively HIPAA, imposes privacy, security and breach notification obligations on certain healthcare providers, health plans, and healthcare clearinghouses, known as covered entities, as well as their business associates that perform certain services that involve creating, receiving, maintaining or transmitting individually identifiable health information for or on behalf of such covered entities, and their covered subcontractors. HIPAA requires covered entities, such as physician partners, and business associates, such as us, to develop and maintain policies with respect to the protection of, use and disclosure of PHI, including the adoption of administrative, physical and technical safeguards to protect such information, and certain notification requirements in the event of a breach of unsecured PHI.

Additionally, under HIPAA, covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay, not to exceed 60 days following discovery of the breach by a covered entity or its agents. Notification also must be made to the HHS Office for Civil Rights and, in certain circumstances involving large breaches, to the media. Business associates must report breaches of unsecured PHI to covered entities within 60 days of discovery of the breach by the business associate or its agents. A non-permitted use or disclosure of PHI is presumed to be a breach under HIPAA unless the covered entity or business associate establishes that there is a low probability the information has been compromised consistent with requirements enumerated in HIPAA.

Entities that are found to be in violation of HIPAA as the result of a breach of unsecured PHI, a complaint about privacy practices or an audit by HHS may be subject to significant civil, criminal and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance. HIPAA 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.

Even when HIPAA does not apply, according to the Federal Trade Commission, or the FTC, violating consumers' privacy rights or failing to take appropriate steps to keep consumers' personal information secure may constitute unfair and/or deceptive acts or practices in violation of Section 5(a) of the Federal Trade Commission Act. The FTC expects a company's data security measures to be reasonable and appropriate in light of the sensitivity and volume of consumer information it holds, the size and complexity of its business, and the cost of available tools to improve security and reduce vulnerabilities.

Further, certain states have also adopted comparable privacy and security laws and regulations, some of which may be more stringent than HIPAA. Such laws and regulations will be subject to interpretation by various courts and other governmental authorities, thus creating potentially complex compliance issues for us and our future customers and strategic partners. For example, the state of Nevada enacted a law that went into force on October 1, 2019 and requires companies to honor consumers' requests to no longer sell their data. In addition, the California Consumer Privacy Act of 2018, or the CCPA, went into effect on January 1, 2020. The CCPA creates individual privacy rights for California consumers and increases the privacy and security obligations of entities handling certain personal information. The CCPA provides for civil penalties for violations, as well as a private right of action for data breaches that is expected to increase data breach litigation. The CCPA may increase our compliance costs and potential liability, and many similar laws have been proposed at the federal level and in other states. Further, the California Privacy Rights Act, or the CPRA, recently passed in California. The CPRA will impose additional data protection obligations on covered businesses, including additional consumer rights processes, limitations on data uses, new audit requirements for higher risk data, and opt outs for certain uses of sensitive data. It will also create a new California data protection agency authorized to issue substantive regulations and could result in increased privacy and information security enforcement. The majority of the provisions will go into effect on January 1, 2023, and additional compliance investment and potential business process changes may be required. In addition, California's Confidentiality of Medical Information Act, or the CMIA, places restrictions on the use and disclosure of health information, including PHI, and other personally identifying information, and can impose a significant compliance obligation. Violations of the CMIA can result in criminal, civil and administrative sanctions, and the CMIA also provides individuals a private right of action with respect to disclosures of their health information that violate CMIA. In the event that we are subject to these domestic privacy and data protection laws, any liability from failure to comply with the requirements of these laws could adversely affect our financial condition.

Although we work to comply with applicable laws, regulations and standards, our contractual obligations and other legal obligations, these requirements are evolving and may be modified, interpreted and applied in an inconsistent manner from one jurisdiction to another, and may conflict with one another or other legal obligations with which we must comply. Any failure or perceived failure by us or our employees, representatives, contractors, consultants, collaborators, or other third parties to comply with such requirements or adequately address privacy and security concerns, even if unfounded, could result in additional cost and liability to us, damage our reputation, and adversely affect our business and results of operations.

Any future litigation against us could be costly and time-consuming to defend.

We may become subject, from time to time, to legal proceedings, federal and state audits, government investigations, and payor audits, investigations, overpayments, and claims that arise in the ordinary course of business such as claims brought by our clients in connection with commercial disputes or employment claims made by our current or former associates. Litigation and audits may result in substantial costs and may divert management's attention and resources, which may substantially harm our business, financial condition and results of operations. Insurance may not cover such claims, may not provide sufficient payments to cover all of the costs to resolve one or more such claims and may not continue to be available on terms acceptable to us. A claim brought against us that is uninsured or underinsured could result in unanticipated costs, thereby reducing our earnings and leading analysts or potential investors to reduce their expectations of our performance, which could reduce the market price of our Common Stock.

Changes in U.S. tax laws, and the adoption of tax reform policies could adversely affect our operating results and financial condition.

We are subject to federal and state income and non-income taxes in the United States. Tax laws, regulations, and administrative practices in various jurisdictions may be subject to significant change, with or without notice, due to economic, political, and other conditions, and significant judgment is required in evaluating and estimating these taxes. Our effective tax rates could be affected by numerous factors, such as entry into new businesses and geographies, changes to our existing business and operations, acquisitions and investments and how they are financed, changes in our stock price, changes in our deferred tax assets and liabilities and their valuation, and changes in the relevant tax, accounting, and other laws, regulations, administrative practices, principles and interpretations. We are required to take positions regarding the interpretation of complex statutory and regulatory tax rules and on valuation matters that are subject to uncertainty, and tax authorities may challenge the positions that we take.

Our quarterly results may fluctuate significantly, which could adversely impact the value of our Common Stock.

Our quarterly results of operations, including our revenue, net loss and cash flows, has varied and may vary significantly in the future, and period-to-period comparisons of our results of operations may not be meaningful. Accordingly, our quarterly results should not be relied upon as an indication of future performance. Our quarterly financial results may fluctuate as a result of a variety of factors, many of which are outside of our control, including, without limitation, the following:

- the timing of recognition of revenue, including possible delays in the recognition of revenue due to sometimes unpredictable implementation timelines;
- the amount and timing of operating expenses related to the maintenance and expansion of our business, operations and infrastructure;
- our ability to respond to competitive developments;
- security or data privacy breaches and associated remediation costs; and
- the timing of expenses related to the development or acquisition of additional hospitals or businesses.

Any fluctuation in our quarterly results may not accurately reflect the underlying performance of our business and could cause a decline in the trading price of our Common Stock.

Obligations under the term loans of our Hospital Subsidiaries, and our related loan and leases guarantees could restrict our operations, particularly our ability to respond to changes in our business or to take specified actions. An event of default under the term loans could harm our business, and creditors having security interests over the hospital assets as well as the leased real estate would be able to foreclose on such assets.

Each of our Hospital Subsidiaries is a party to term loans and lines of credit guaranteed by Nutex Holdco to finance hospital equipment and related assets, for aggregate borrowings of approximately $23.3 million as of December 31, 2022.

In addition, Nutex Holdco has assumed in the Merger and subsequently entered into guarantees of finance lease obligations of each of the Hospital Subsidiaries and mortgage debt of Real Estate Entities affiliated with Dr. Vo, the Company's chairman and Chief Executive Officer.

The term loans and lease and mortgage loan guarantees require us to comply with a number of financial and other obligations, which include maintaining debt service coverage and leverage ratios and maintaining insurance coverage, and may impose significant operating and financial restrictions on us, including restrictions on our ability to take actions that may be in our interests. These obligations may limit our flexibility in our operations, and breaches of these obligations could result in defaults under the term loans or guarantees, even if we had satisfied our payment obligations. Moreover, if we defaulted on these obligations, creditors having security interests over the hospital assets or real estate assets could exercise various remedies, including foreclosing on and selling our assets or the real estate assets underlying our hospitals. Unless waived by creditors, for which no assurance can be given, defaulting on these obligations could result in a material adverse effect on our financial condition and ability to continue our operations.

The arrangements we have with our VIEs are not as secure as direct ownership of such entities.

Because of corporate practice of medicine laws, we entered into contractual arrangements to manage certain affiliated physician practice groups or independent physician associations, which allow us to consolidate those groups for financial reporting purposes. We do not have direct ownership interests in any of our VIEs and are not able to exercise rights as an equity holder to directly change the members of the boards of directors of these entities so as to affect changes at the management and operational level. Under our arrangements with our VIEs, we must rely on their equity holders to exercise our control over the entities. If our affiliated entities or their equity holders fail to perform as expected, we may have to incur substantial costs and expend additional resources to enforce such arrangements.

Any failure by our affiliated entities or their owners to perform their obligations under their agreements with us would have a material adverse effect on our business, results of operations and financial condition.

Our affiliated physician practice groups are owned by individual physicians who could die, become incapacitated, or become no longer affiliated with us. Although our Management Services Agreements (MSAs) with these affiliates provide that they will be binding on successors of current owners, as the successors are not parties to the MSAs, it is uncertain in case of the death, bankruptcy, or divorce of a current owner whether their successors would be subject to such MSAs.

If there is a change in accounting principles or the interpretation thereof affecting consolidation of VIEs, it could impact our consolidation of total revenues derived from our affiliated physician groups.

Our financial statements are consolidated and include the accounts of our majority-wholly owned AHP subsidiary, non-owned affiliated physician groups and real estate entities that each is a VIE, which consolidation is effectuated in accordance with applicable accounting rules promulgated by the Financial Accounting Standards Board ("FASB"). Such accounting rules require that, under some circumstances, the VIE consolidation model be applied when a reporting enterprise holds a variable interest (e.g., equity interests, debt obligations, certain management, and service contracts) in a legal entity. Under this model, an enterprise must assess the entity in which it holds a variable interest to determine whether it meets the criteria to be consolidated as a VIE. If the entity is a VIE, the consolidation framework next identifies the party, if one exists, that possesses a controlling financial interest in the VIE, and then requires that party to consolidate as the primary beneficiary. An enterprise's determination of whether it has a controlling financial interest in a VIE requires that a qualitative determination be made and is not solely based on voting rights. If an enterprise determines the entity in which it holds a variable interest is not subject to the VIE consolidation model, the enterprise should apply the traditional voting control model which focuses on voting rights.

In our case, the VIE consolidation model applies to our controlled, but not owned, physician-affiliated entities including our IPA and PLLCs. Our determination regarding the consolidation of our affiliates, however, could be challenged, which could have a material adverse effect on our operations. In addition, in the event of a change in accounting rules or FASB's interpretations thereof, or if there were an adverse determination by a regulatory agency or a court or a change in state or federal law relating to the ability to maintain present agreements or arrangements with our affiliated physician group, we may not be permitted to continue to consolidate the revenues of our VIE.

Risk Related to our Population Health Management Division

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New physicians and other providers must be properly enrolled in governmental healthcare programs before we can receive reimbursement for their services, and there may be delays in the enrolment process.

Each time a new physician joins us or our affiliated IPA groups, we must enroll the physician under our applicable group identification number for Medicare and Medicaid programs and for certain managed care and private insurance programs before we can receive reimbursement for services the physician renders to beneficiaries of those programs. The estimated time to receive approval for the enrollment is sometimes difficult to predict and, in recent years, the Medicare program carriers often have not issued these numbers to our affiliated physicians in a timely manner. These practices result in delayed reimbursement that may adversely affect our cash flows.

We may have difficulty collecting payments from third-party payors in a timely manner.

We derive significant revenue from third-party payors, and delays in payment or refunds to payors may adversely impact our net revenue. We assume the financial risks relating to uncollectible and delayed payments. In particular, we rely on some key governmental payors. Governmental payors typically pay on a more extended payment cycle, which could require us to incur substantial expenses prior to receiving corresponding payments. In the current healthcare environment, as payors continue to control expenditures for healthcare services, including through revising their coverage and reimbursement policies, we may continue to experience difficulties in collecting payments from payors that may seek to reduce or delay such payments. If we are not timely paid in full or if we need to refund some payments, our revenues, cash flows, and financial condition could be adversely affected.

Decreases in payor rates could adversely affect us.

Decreases in payor rates, either prospectively or retroactively, could have a significant adverse effect on our revenues, cash flows, and results of operations.

Federal and state laws may limit our ability to collect monies owed by patients.

We use third-party collection agencies whom we do not control to collect from patients any co-payments and other payments for services that our physicians provide. The federal Fair Debt Collection Practices Act of 1977 (the "FDCPA") restricts the methods that third-party collection companies may use to contact and seek payment from consumer debtors regarding past due accounts. State laws vary with respect to debt collection practices, although most state requirements are similar to those under the FDCPA. Therefore, such

agencies may not be successful in collecting payments owed to us and our affiliated physician groups. If practices of collection agencies utilized by us are inconsistent with these standards, we may be subject to actual damages and penalties. These factors and events could have a material adverse effect on our business, results of operations, and financial condition.

We have established reserves for our potential medical claim losses, which are subject to inherent uncertainties, and a deficiency in the established reserves may lead to a reduction in our assets or net incomes.

We establish reserves for estimated Insured but Not Reported (IBNR) claims. IBNR estimates are developed using actuarial methods and are based on many variables, including the utilization of healthcare services, historical payment patterns, cost trends, product mix, seasonality, changes in membership, and other factors. The estimation methods and the resulting reserves are periodically reviewed and updated.

Many of our contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such interpretations may not come to light until a substantial period of time has passed. The inherent difficulty in interpreting contracts and estimating necessary reserves could result in significant fluctuations in our estimates from period to period. Our actual losses and related expenses therefore may differ, even substantially, from the reserve estimates reflected in our financial statements. If actual claims exceed our estimated reserves, we may be required to increase reserves, which would lead to a reduction in our assets or net income.

We do not have a Knox-Keene license.

The Knox-Keene Health Care Service Plan Act of 1975 was passed by the California State Legislature to regulate California managed care plans and is currently administered by the California Department of Managed Healthcare (DMHC). A Knox-Keene Act license is required to operate a healthcare service plan, e.g., an HMO, or an organization that accepts global risk, i.e., accepts full risk for a patient population, including risk related to institutional services, e.g., hospital, and professional services. Applying for and obtaining such a license is a time consuming and detail-oriented undertaking. We currently do not hold any Knox-Keene license. If the DMHC were to determine that we have been inappropriately taking risk for institutional and professional services as a result of our various hospital and physician arrangements without having any Knox-Keene license or applicable regulatory exemption, we may be required to obtain a Knox-Keene license and could be subject to civil and criminal liability, any of which could have a material adverse effect on our business, results of operations, and financial condition.

A Knox-Keene Act license or exemption from licensure, where applicable, is required to operate a healthcare service plan, e.g., an HMO, or an organization that accepts global risk, i.e., accepts full risk for a patient population, including risk related to institutional services, e.g., hospital, and professional services.

If our affiliated physician group is not able to satisfy California financial solvency regulations, they could become subject to sanctions and their ability to do business in California could be limited or terminated.

The DMHC has instituted financial solvency regulations. The regulations are intended to provide a formal mechanism for monitoring the financial solvency of a RBO in California, including capitated physician groups. Under current DMHC regulations, our affiliated physician groups, as applicable, are required to, among other things:

- Maintain, at all times, a minimum "cash-to-claims ratio" (which means the organization's cash, marketable securities, and certain qualified receivables, divided by the organization's total unpaid claims liability) of 0.75; and
- Submit periodic reports to the DMHC containing various data and attestations regarding their performance and financial solvency, including IBNR calculations and documentation and attestations as to whether or not the organization (i) was in compliance with the "Knox-Keene Act" requirements related to claims payment timeliness, (ii) had maintained positive tangible net equity ("TNE"), and (iii) had maintained positive working capital.

In the event that a physician group is not in compliance with any of the above criteria, it would be required to describe in a report submitted to the DMHC the reasons for non-compliance and actions to be taken to bring it into compliance. Under such regulations, the DMHC can also make some of the information contained in the reports, public, including, but not limited to, whether or not a particular physician organization met each of the criteria. In the event any of our affiliated physician groups are not able to meet certain of the financial solvency requirements, and fail to meet subsequent corrective action plans, it could be subject to sanctions, or limitations on, or removal of, its ability to do business in California. There can be no assurance that our affiliated physician group, such as our IPA, will remain in compliance with DMHC requirements or be able to timely and adequately rectify non-compliance. To

the extent that we need to provide additional capital to our affiliated physician group in the future in order to comply with DMHC regulations, we would have less cash available for other parts of our operations.

Primary care physicians may seek to affiliate with our and our competitors' IPAs at the same time.

It is common in the medical services industry for primary care physicians to be affiliated with multiple IPAs. Our affiliated IPA therefore may enter into agreements with physicians who are also affiliated with our competitors. However, some of our competitors at times have agreements with physicians that require the physician to provide exclusive services. Our affiliated IPA often has no knowledge, and no way of knowing, whether a physician is subject to an exclusivity agreement without being informed by the physician. Competitors could initiate lawsuits against us alleging in part interference with such exclusivity arrangements. An adverse outcome from any such lawsuit could adversely affect our business, cash flows and financial condition.

If we inadvertently employ or contract with an excluded person, we may face government sanctions.

Individuals and entities can be excluded from participating in the Medicare and Medicaid programs for violating certain laws and regulations, or for other reasons such as the loss of a license in any state, even if the person retains other licensure. This means that the excluded person and others are prohibited from receiving payments for such person's services rendered to Medicare or Medicaid beneficiaries, and if the excluded person is a physician, all services ordered (not just provided) by such physician are also non-covered and non-payable. Entities that employ or contract with excluded individuals are prohibited from billing the Medicare or Medicaid programs for the excluded individual's services and are subject to civil penalties if it does. The U.S. Department of Health and Human Services Office of the Inspector General maintains a list of excluded persons. Although we have instituted policies and procedures to minimize such risks, there can be no assurance that we will not inadvertently hire or contract with an excluded person, or that our employees or contracts will not become excluded in the future without our knowledge. If this occurs, we may be subject to substantial repayments and civil penalties which could adversely affect our business, cash flows, and financial condition.

We could incur substantial costs in protecting or defending our intellectual property rights, and any failure to protect our intellectual property could adversely affect our business, results of operations and financial condition.

Our success depends, in part, on our ability to protect our brand and the proprietary methods and our Population Health Management Platform and other technologies that we develop under patent and other intellectual property laws of the United States and foreign jurisdictions so that we can prevent others from using our inventions and proprietary information. The particular forms of intellectual property protection that we seek, or our business decisions about when to file patent applications and trademark applications, may not be adequate to protect our business. We could be required to spend significant resources to monitor and protect our intellectual property rights. Litigation may be necessary in the future to enforce our intellectual property rights, determine the validity and scope of our proprietary rights or those of others, or defend against claims of infringement or invalidity. Such litigation could be costly, time-consuming and distracting to management, result in a diversion of significant resources, lead to the narrowing or invalidation of portions of our intellectual property and have an adverse effect on our business, results of operations and financial condition. Our efforts to enforce our intellectual property rights may be met with defenses, counterclaims and countersuits attacking the validity and enforceability of our intellectual property rights or alleging that we infringe the counterclaimant's own intellectual property. Any of our patents, patent applications, copyrights, trademarks or other intellectual property rights could be challenged by others or invalidated through administrative process or litigation.

We expect to also rely, in part, on confidentiality agreements with our business partners, employees, consultants, advisors, customers and others in our efforts to protect our proprietary technology, processes and methods. These agreements may not effectively prevent disclosure of our confidential information, and it may be possible for unauthorized parties to copy our software or other proprietary technology or information, or to develop similar software independently without our having an adequate remedy for unauthorized use or disclosure of our confidential information. In addition, others may independently discover our trade secrets and proprietary information, and in these cases, we would not be able to assert any trade secret rights against those parties. Costly and time-consuming litigation could be necessary to enforce and determine the scope of our proprietary rights, and the failure to obtain or maintain trade secret protection could adversely affect our competitive business position.

In addition, the laws of some countries do not protect intellectual property and other proprietary rights to the same extent as the laws of the United States. To the extent we expand our international activities, our exposure to unauthorized copying, transfer and use of our proprietary technology or information may increase.

Our means of protecting our intellectual property and proprietary rights may not be adequate or our competitors could independently develop similar technology. If we fail to meaningfully protect our intellectual property and proprietary rights, our business, results of operations and financial condition could be adversely affected.

Assertions by third parties of infringement or other violations by us of their intellectual property rights could result in significant costs and harm our business and operating results.

Our success depends upon our ability to refrain from infringing upon the intellectual property rights of others. Some companies, including some of our competitors, own large numbers of patents, copyrights and trademarks, which they may use to assert claims against us. As we grow and enter new markets, we will face a growing number of competitors. As the number of competitors in our industry grows and the functionality of products in different industry segments overlaps, we expect that software and other solutions in our industry may be subject to such claims by third parties. Third parties may in the future assert claims of infringement, misappropriation or other violations of intellectual property rights against us. We cannot assure you that infringement claims will not be asserted against us in the future, or that, if asserted, any infringement claim will be successfully defended. A successful claim against us could require that we pay substantial damages or ongoing royalty payments, prevent us from offering our services, or require that we comply with other unfavorable terms. We may also be obligated to indemnify our customers or business partners or pay substantial settlement costs, including royalty payments, in connection with any such claim or litigation and to obtain licenses, modify applications or refund fees, which could be costly. Even if we were to prevail in such a dispute, any litigation regarding our intellectual property could be costly and time-consuming and divert the attention of our management and key personnel from our business operations.

The information that we expect to provide to our clients could be inaccurate or incomplete, which could harm our business reputation, financial condition, and results of operations.

We expect to aggregate, process, and analyze healthcare-related data and information for use by our clients. Because data in the healthcare industry is fragmented in origin, inconsistent in format, and often incomplete, the overall quality of data received or accessed in the healthcare industry is often poor, the degree or amount of data which is knowingly or unknowingly absent or omitted can be material, and we frequently discover data issues and errors during our data integrity checks. If the analytical data that we expect to provide to our clients are based on incorrect or incomplete data or if we make mistakes in the capture, input, or analysis of these data, our reputation may suffer and our ability to attract and retain clients may be materially harmed.

In addition, we expect to assist our clients with the management and submission of data to governmental entities, including CMS. These processes and submissions are governed by complex data processing and validation policies and regulations. If we fail to abide by such policies or submit incorrect or incomplete data, we may be exposed to liability to a client, court, or government agency that concludes that our storage, handling, submission, delivery, or display of health information or other data was wrongful or erroneous.

Our proprietary applications may not operate properly, which could damage our reputation, give rise to a variety of claims against us, or divert our resources from other purposes, any of which could harm our business and operating results.

Proprietary software and application development is time-consuming, expensive, and complex, and may involve unforeseen difficulties. We may encounter technical obstacles, and it is possible that we discover additional problems that prevent our proprietary applications from operating properly. If our applications and services do not function reliably or fail to achieve client expectations in terms of performance, clients could assert liability claims against us and attempt to cancel their contracts with us. Moreover, material performance problems, defects, or errors in our existing or new applications and services may arise in the future and may result from, among other things, the lack of interoperability of our applications with systems and data that we did not develop and the function of which is outside of our control or undetected in our testing. Defects or errors in our applications might discourage existing or potential clients from purchasing services from us. Correction of defects or errors could prove to be time consuming, costly, impossible, or impracticable. The existence of errors or defects in our applications and the correction of such errors could divert our resources from other matters relating to our business, damage our reputation, increase our costs, and have a material adverse effect on our business, financial condition, and results of operations.

Risks Related to Our Legal and Regulatory Environment

We conduct business in a heavily regulated industry and if we fail to adhere to all of the complex government laws and regulations that apply to our business, we could incur fines or penalties or be required to make changes to our operations or experience adverse publicity, any or all of which could have a material adverse effect on our business, results of operations, financial condition, cash flows, and reputation.

The U.S. healthcare industry is heavily regulated and closely scrutinized by federal, state and local governments. Comprehensive statutes and regulations govern the manner in which we provide and bill for services and collect reimbursement from governmental programs and private payors, our contractual relationships and arrangements with healthcare providers and vendors, our marketing activities and other aspects of our operations. Of particular importance are:

- the federal Anti-Kickback Statute, or the AKS, which prohibits the knowing and willful offer, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration for referring an individual, in return for ordering, leasing, purchasing or recommending or arranging for or to induce the referral of an individual or the ordering, purchasing or leasing of items or services covered, in whole or in part, by any federal healthcare program, such as Medicare and Medicaid. Although there are several statutory exceptions and regulatory safe harbors protecting certain common activities from prosecution, the exceptions and safe harbors are drawn narrowly. By way of example, the AKS safe harbor for value-based arrangements requires, among other things, that the arrangement does not induce a person or entity to reduce or limit medically necessary items or services furnished to any patient. Failure to meet the requirements of a safe harbor, however, does not render an arrangement illegal, although such arrangements may be subject to greater scrutiny by government authorities. Further, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;
- the federal physician self-referral law, or the Stark Law, which, subject to limited exceptions, prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of certain designated health services, or DHS, if the physician or a member of such physician's immediate family has a direct or indirect financial relationship (including an ownership interest or a compensation arrangement) with the entity, and prohibits the entity from billing Medicare or Medicaid for such DHS;
- the federal False Claims Act, or the FCA, which imposes civil and criminal liability on individuals or entities that knowingly submit false or fraudulent claims for payment to the government or knowingly make, or cause to be made, a false statement in order to have a false claim paid, including qui tam or whistleblower suits. There are many potential bases for liability under the FCA. The government has used the FCA to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, and providing care that is not medically necessary or that is substandard in quality. In addition, we could be held liable under the FCA if we are deemed to "cause" the submission of false or fraudulent claims by, for example, providing inaccurate billing, coding or risk adjustment information to our physician partners through Provider Portal and Analytic Management Tools, respectively. The government may also assert that a claim including items or services resulting from a violation of the AKS or Stark Law constitutes a false or fraudulent claim for purposes of the FCA;
- the Civil Monetary Penalties Statute, which prohibits, among other things, an individual or entity from offering remuneration to a federal healthcare program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive healthcare items or services from a particular provider;
- the criminal healthcare fraud provisions of HIPAA and related rules that prohibit knowingly and willfully executing a scheme or artifice to defraud any healthcare benefit program or falsifying, concealing or covering up a material fact or making any material false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Similar to the AKS, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;
- reassignment of payment rules that prohibit certain types of billing and collection practices in connection with claims payable by the Medicare or Medicaid programs;
- similar state law provisions pertaining to anti-kickback, self-referral and false claims issues, some of which may apply to items or services reimbursed by any payor, including patients and commercial insurers;
- laws that regulate debt collection practices;
- a provision of the Social Security Act that imposes criminal penalties on healthcare providers who fail to disclose, or refund known overpayments;
- federal and state laws that prohibit providers from billing and receiving payment from Medicare and Medicaid for services unless the services are medically necessary, adequately and accurately documented, and billed using codes that accurately reflect the type and level of services rendered; and

- federal and state laws pertaining to the provision of services by nurse practitioners and physician assistants in 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.

The laws and regulations in these areas are complex, changing and often subject to varying interpretations. As a result, there is no guarantee that a government authority will find that we or our partner physicians or other healthcare professionals are in compliance with all such laws and regulations that apply to our business. Further, because of the breadth of these laws and the narrowness of the statutory exceptions and safe harbors available, it is possible that some of the business activities undertaken by us or our partner physicians or other healthcare professionals could be subject to challenge under one or more of these laws, including, without limitation, our patient assistance programs that waive or reduce the patient's obligation to pay copayments, coinsurance or deductible amounts owed for the services we provide to them if they meet certain financial need criteria. If our operations are found to be in violation of any of such laws or any other governmental regulations that apply, we may be subject to significant penalties, including, without limitation, administrative, civil and criminal penalties, damages, fines, disgorgement, the curtailment or restructuring of operations, integrity oversight and reporting obligations, exclusion from participation in federal and state healthcare programs and imprisonment. In addition, any action against us or our partner physicians or other physician partners for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses, divert our management's attention from the operation of our business and result in adverse publicity, or otherwise experience a material adverse impact on our business, results of operations, financial condition, cash flows, reputation as a result.

If any of our hospitals lose their regulatory licenses, permits and/or registrations, as applicable, or become ineligible to receive reimbursement from third-party payors, there may be a material adverse effect on our business, financial condition, cash flows, or results of operations.

The operations of our hospitals through partner physicians and other healthcare professionals are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures and proof of financial ability to operate. Our hospitals and partner physicians and other healthcare professionals are also subject to extensive laws and regulation relating to facility and professional licensure, conduct of operations, including financial relationships among healthcare providers, Medicare, Medicaid and state fraud and abuse and physician self-referrals, and maintaining updates to our and our partner physicians' and other healthcare professionals' enrollment in the Medicare and Medicaid programs, including addition of new hospital locations, providers and other enrollment information. Our hospitals are subject to periodic inspection by licensing authorities to assure their continued compliance with these various standards. There can be no assurance that these regulatory authorities will determine that all applicable requirements are fully met at any given time. Should any of our hospitals be found to be noncompliant with these requirements, we could be assessed fines and penalties, could be required to refund reimbursement amounts or could lose our licensure or Medicare and/or Medicaid certification so that we or our partner physicians and other healthcare professionals are unable to receive reimbursement from such programs and possibly from other third-party payors, any of which could materially adversely affect our business, financial condition, cash flows or results of operations.

If our arrangements with our partner physicians and other physician partners are found to constitute the improper rendering of medical services or fee splitting under applicable state laws, our business, financial condition and our ability to operate in those states could be adversely impacted.

Our contractual relationships with our partner physicians may implicate certain state laws that generally prohibit non-professional entities from providing licensed medical services or exercising control over licensed physicians or other healthcare professionals (such activities generally referred to as the "corporate practice of medicine") or engaging in certain practices such as fee-splitting with such licensed professionals. The interpretation and enforcement of these laws vary significantly from state to state. There can be no assurance that these laws will be interpreted in a manner consistent with our practices or that other laws or regulations will not be enacted in the future that could have a material and adverse effect on our business, financial condition and results of operations. Regulatory authorities, state boards of medicine, state attorneys general and other parties may assert that, despite the agreements through which we operate, we are engaged in the provision of medical services and/or that our arrangements with our physician partners constitute unlawful fee-splitting. If a jurisdiction's prohibition on the corporate practice of medicine or fee-splitting is interpreted in a manner that is inconsistent with our practices, we would be required to restructure or terminate our arrangements with our physician partners to bring our activities into compliance with such laws. A determination of non-compliance, or the termination of or failure to successfully restructure these relationships could result in disciplinary action, penalties, damages, fines, and/or a loss of revenue, any of which could have a material and adverse effect on our business, financial condition and results of operations. State corporate practice and fee-splitting prohibitions also often impose penalties on healthcare professionals for aiding in the improper

rendering of professional services, which could discourage physicians and other healthcare professionals from providing clinical services to our hospitals.

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. Other third-party 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;
- criminal penalties;
- a corporate integrity agreement with HHS' Office of Inspector General; and
- loss of certain rights under, or termination of, our contracts with payors.

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.

The impact on us of recent healthcare legislation and other changes in the healthcare industry and in healthcare spending is currently unknown, but may adversely affect our business, financial condition and results of operations.

The impact on us of healthcare reform legislation and other changes in the healthcare industry and in healthcare spending is currently unknown, but may adversely affect our business, financial condition and results of operations. Our revenue is dependent on the healthcare industry and could be affected by changes in healthcare spending, reimbursement and policy. The healthcare industry is subject to changing political, regulatory and other influences.

On January 1, 2022, the NSA and the associated HHS interim final rule becoming effective. As a result, we experienced a significant decline in collections of patient claims for emergency services and have had only limited success at achieving collections at or higher than the established qualifying payment amount, which is the median in-network contracted rate for the same insurance market. Since we cannot predict the outcome of numerous legal challenges and whether the final rule to be adopted by HHS will make the independent dispute resolution process more favorable to us, any sustained decline in the collections we receive for our emergency services could have a material adverse effect on our operations and financial performance and may negatively affect the trading value of our Common Stock.

In addition, the ACA, which was enacted in 2010, made major changes in how healthcare is delivered and reimbursed, and it increased access to health insurance benefits to the uninsured and underinsured populations of the United States. Since its enactment, there have been judicial, executive and Congressional challenges to certain aspects of the ACA. On June 17, 2021, the U.S. Supreme Court dismissed the most recent judicial challenge to the ACA brought by several states without specifically ruling on the constitutionality of the ACA. Prior to the Supreme Court's decision, President Biden issued an executive order initiating a special enrollment period from February 15, 2021 through August 15, 2021 for purposes of obtaining health insurance coverage through the ACA marketplace. The executive order also instructed certain governmental agencies to review and reconsider their existing policies and rules that limit access to healthcare. It is unclear how other healthcare reform measures enacted by Congress or implemented by the Biden administration or other challenges to the ACA, if any, will impact the ACA or our business.

Other legislative changes have been proposed and adopted since the ACA was enacted. These changes include aggregate reductions to Medicare payments to providers of 2% per fiscal year, which began in 2013 and will remain in effect through 2030, with the exception of a temporary suspension from May 1, 2020 through December 31, 2021, unless additional Congressional action is taken. In January

2013, the American Taxpayer Relief Act of 2012 was signed into law, which, among other things, further reduced Medicare payments to several types of providers, including hospitals, imaging centers and cancer treatment centers, and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. New laws may result in additional reductions in Medicare and other healthcare funding, which may materially adversely affect consumer demand and affordability for our products and services and, accordingly, the results of our financial operations. Additional changes that may affect our business include the expansion of new programs such as Medicare payment for performance initiatives for physicians under the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, which first affected physician payment in 2019. At this time, it is unclear how the introduction of the Medicare quality payment program will impact overall physician reimbursement.

Such changes in the regulatory environment may also result in changes to our payer mix that may affect our operations and revenue. In addition, certain provisions of the ACA authorize voluntary demonstration projects, which include the development of bundling payments for acute, inpatient hospital services, physician services and post-acute services for episodes of hospital care. Further, the ACA may adversely affect payors by increasing medical costs generally, which could have an effect on the industry and potentially impact our business and revenue as payors seek to offset these increases by reducing costs in other areas.

Uncertainty regarding future amendments to the ACA as well as new legislative proposals to reform healthcare and government insurance programs, along with the trend toward managed healthcare in the United States, could result in reduced demand and prices for our services. 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 other third-party payers will pay for healthcare products and services, which could adversely affect our business, financial condition and results of operations.

Risks Related to Our Common Stock

An active, liquid trading market for the Company's Common Stock may not be sustained.

The Company may not be able to maintain an active trading market for its Common Stock on NASDAQ or any other exchange in the future. If an active market for the Common Stock is not maintained after the Merger, or if the Company fails to satisfy the continued listing standards of NASDAQ for any reason and its securities are delisted, it may be difficult for the Company's securityholders to sell their securities without depressing the market price for the securities or at all. An inactive trading market may also impair the Company's ability to both raise capital by selling shares of capital stock, attract and motivate employees through equity incentive awards and acquire other companies, products, or technologies by using shares of capital stock as consideration.

There can be no assurance that will be able to comply with the continued listing standards of Nasdaq.

If Nasdaq delists our Common Stock from trading on its exchange for failure to meet the listing standards, we could face significant material adverse consequences including:

- a limited availability of market quotations for our securities;
- reduced liquidity for our securities;
- a determination that our Common Stock is a "penny stock," which will require brokers trading in our Common Stock to adhere to more stringent rules and possibly result in a reduced level of trading activity in the secondary trading market for our securities;
- a limited amount of news and analyst coverage; and
- a decreased ability to issue additional securities or obtain additional financing in the future.

Anti-takeover provisions under Delaware law could make an acquisition of the Company, which may be beneficial to the stockholders of the Company, more difficult and may prevent attempts by the stockholders to replace or remove management.

We are subject to the anti-takeover provisions of the Delaware General Corporation Law ("DGCL"), including Section 203. Under these provisions, if anyone becomes an "interested stockholder," the Company may not enter into a "business combination" with that person for three years without special approval, which could discourage a third party from making a takeover offer and could delay or prevent a change of control. For purposes of Section 203 of the DGCL, "interested stockholder" means, generally, someone owning 15% or more of the Company's outstanding voting stock or an affiliate of the Company that owned 15% or more of the Company's outstanding voting stock during the past three years, subject to certain exceptions as described in Section 203 of the DGCL. As such, Section 203 of the DGCL could prohibit or delay mergers or a change in control and may discourage attempts by other companies to acquire the Company.

Additionally, certain provisions in our Charter, such as advance notice provisions for matters to be included in the proxy statement for annual meetings, could make it more difficult for a third party to acquire control of us, even if such change in control would be beneficial to our stockholders.

General Risk Factors

Because we have no current plans to pay cash dividends on our Common Stock for the foreseeable future, you may not receive any return on investment unless you sell your Common Stock for a price greater than that which you paid for it.

We may retain future earnings, if any, for future operations, expansion and debt repayment and have no current plans to pay any cash dividends for the foreseeable future. Any decision to declare and pay dividends will be made at the discretion of our board of directors and will depend on, among other things, our results of operations, financial condition, cash requirements, contractual restrictions and other factors that our board of directors may deem relevant. In addition, our ability to declare dividends may be limited by restrictive covenants contained in any existing or future indebtedness. As a result, you may not receive any return on an investment in our Common Stock unless you sell your Common Stock for a price greater than that which you paid for it.

The market price and trading volume of our Common Stock may be volatile and could decline significantly.

Securities markets worldwide experience significant price and volume fluctuations. This market volatility, as well as general economic, market, or political conditions, could reduce the market price of our Common Stock in spite of our operating performance, which may limit or prevent investors from readily selling their Common Stock and may otherwise negatively affect the liquidity of the Common Stock. There can be no assurance that the market price of Common Stock will not fluctuate widely or decline significantly in the future in response to a number of factors, including, among others, the following:

- 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;
- 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 health population management industry in general;
- operating and stock price performance of other companies that investors deem comparable to us;
- our ability to market new and enhanced products on a timely basis;
- changes in laws and regulations affecting our business;
- our ability to meet compliance requirements;
- commencement of, or involvement in, litigation involving us;
- changes in our capital structure, such as future issuances of securities or the incurrence of additional debt;
- the volume of shares of our Common Stock available for public sale;
- any major change in our board of directors or management;
- sales of substantial amounts of Common Stock by our directors, executive 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.

The stock market in general, and Nasdaq in particular, 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 retail stocks or the stocks of other companies which investors perceive to be similar to us could depress our stock price regardless of our business, prospects, financial condition 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.

If securities or industry analysts do not publish research or publish inaccurate or unfavorable research about our business, the price and trading volume of our securities could decline.

The trading market for our securities depends in part on the research and reports that securities or industry analysts publish about us or our business. We will not control these analysts, and the analysts who publish information about us may have relatively little experience with us or our industry, which could affect their ability to accurately forecast our results and could make it more likely that we fail to meet their estimates. If few or no securities or industry analysts cover us, the trading price for our securities would be negatively impacted. If one or more of the analysts who covers us downgrades our securities, publishes incorrect or unfavorable research about us, ceases coverage of us, or fails to publish reports on us regularly, demand for and visibility of our securities could decrease, which could cause the price or trading volumes of our securities to decline.

We will continue to incur significantly increased costs and devote substantial management time as a result of operating as a public company.

As a public company, we will continue to incur significant legal, accounting and other expenses. For example, we are subject to the reporting requirements of the Exchange Act and are required to comply with the applicable requirements of the Sarbanes-Oxley Act and the Dodd-Frank Wall Street Reform and Consumer Protection Act, as well as rules and regulations of the SEC and Nasdaq, including the establishment and maintenance of effective disclosure and financial controls, corporate governance requirements and required filings of annual, quarterly and current reports with respect to our business and results of operations. Any failure to develop or maintain effective controls or any difficulties encountered in their implementation or improvement could harm our results of operations or cause us to fail to meet our reporting obligations. We expect that continued compliance with these requirements will increase our legal and financial compliance costs and will make some activities more time-consuming and costly. In addition, we expect that our management and other personnel will need to divert attention from operational and other business matters to devote substantial time to these public company requirements. In particular, we expect to incur significant expenses and devote substantial management effort toward ensuring compliance with the requirements of Section 404 of the Sarbanes-Oxley Act, which will increase when we are no longer an emerging growth company. We are in the process of hiring additional legal and accounting personnel and may in future need to hire additional accounting and financial staff with appropriate public company experience and technical accounting knowledge and may need to establish an internal audit function.

We also expect that being a public company will make it more expensive for us to obtain director and officer liability insurance, and we may be required to accept reduced coverage or incur substantially higher costs to obtain coverage. This could also make it more difficult for us to attract and retain qualified people to serve on our board of directors, board committees or as executive officers.

We are obligated to develop and maintain proper and effective internal control over financial reporting in order to comply with Section 404 of the Sarbanes-Oxley Act. We may not complete our analysis of our internal control over financial reporting in a timely manner, or these internal controls may not be determined to be effective, which may adversely affect investor confidence in us and, as a result, adversely affect the value of our Common Stock.

We are required by Section 404 of the Sarbanes-Oxley Act to furnish a report by management on, among other things, the effectiveness of our internal control over financial reporting in our annual report. The process of designing and implementing internal control over financial reporting required to comply with this requirement will be time-consuming, costly and complicated. If during the evaluation and testing process we identify one or more other material weaknesses in our internal control over financial reporting or determine that existing material weaknesses have not been remediated, our management will be unable to assert that our internal control over financial reporting is effective. See "*—We have identified material weaknesses in our internal control over financial reporting. If our internal control over financial reporting is not effective, we may not be able to accurately report our financial results or file our periodic reports in a timely manner, which may cause adverse effects on our business and may cause investors to lose confidence in our reported financial information and may lead to a decline in the price of our Common Stock*." In addition, if we fail to achieve and maintain the adequacy of our internal controls, as such standards are modified, supplemented or amended from time to time, we may not be able to ensure that we can conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 of the Sarbanes-Oxley Act.

Even if our management concludes that our internal control over financial reporting is effective, our independent registered public accounting firm may issue a report that is qualified if it is not satisfied with the our controls or the level at which our controls are documented, designed, operated or reviewed.

We cannot be certain as to the timing of completion of our evaluation, testing and any remediation actions or the impact of the same on our operations. If we are not able to implement the requirements of Section 404 of the Sarbanes-Oxley Act in a timely manner or with adequate compliance, our independent registered public accounting firm may issue an adverse opinion due to ineffective internal controls over financial reporting, and we may be subject to sanctions or investigation by regulatory authorities, such as the SEC. As a result, there could be a negative reaction in the financial markets due to a loss of confidence in the reliability of our financial statements. In addition, we may be required to incur costs in improving our internal control system and the hiring of additional personnel. Any such action could negatively affect our results of operations and cash flows.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal executive office is located at 6030 S. Rice Ave, Suite C, Houston, Texas 77081. We also maintain corporate offices located at 2455 East Sunrise Blvd. Suite 1204 Fort Lauderdale FL, 33304. Each of these locations is leased. As of December 31, 2022, our hospital division operated 21 micro-hospitals, specialty hospitals and HOPDs in eight states in the U.S. We lease each of these locations. We consolidate three Real Estate Entities which own facilities leased to our hospital division. Our population health management division manages two IPAs and two MSOs which operate from leased locations in two states. We believe that our current facilities are in good condition and adequate to meet our operating needs for the present and immediately foreseeable future.

Item 3. Legal Proceedings

From time-to-time, the Company is involved in litigation and proceedings as part of its normal course of business. The Company is not a party to any litigation that we believe would have a material effect on our business or financial condition.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity and Related Shareholder Matters.

Our common stock is quoted on NASDAQ Capital Market under the symbol "NUTX."

Shareholders

As of the date of this report, there are approximately 953 shareholders of record of our common stock based upon our transfer agent's report. Because many of our shares of common stock are held by brokers and other nominees on behalf of stockholders, including in trust, we are unable to estimate the total number of stockholders represented by these record holders.

Dividends

We have not declared or paid any cash dividends on our common stock. To date we have utilized all available cash to finance our operations. Payment of cash dividends in the future will be at the discretion of our Board of Directors and will depend upon our earnings levels, capital requirements, any restrictive loan covenants and other factors the Board considers relevant.

Warrants

At December 31, 2022, there were 11,033,015 warrants outstanding for the purchase of Company common stock. Refer to Note 13 to the consolidated financial statements included in this annual report for additional information relating to outstanding warrants.

Equity Compensation Plans

In 2022, the Company adopted the Amended and Restated Nutex Health Inc. 2022 Equity Incentive Plan (the "2022 Plan"). The maximum aggregate number of shares that may be issued under the 2022 Plan is 5,000,000 shares, subject to increases on January 1st of each calendar year through January 1, 2027 of up to 5% annually at the discretion of the compensation committee of our Board of Directors. A total of 2,416,221 shares were available for issuance under the 2022 Plan at December 31, 2022. Awards granted under the 2022 Plan have a ten-year term and may be incentive stock options, non-statutory stock options, restricted stock, restricted stock units, stock appreciation rights, performance units or performance shares. The awards are granted at an exercise price equal to the fair market value on the date of grant and generally vest over a four-year period.

At December 31, 2022, there were 5,147,770 options outstanding for the purchase of Common Stock. Refer to Note 12 to the consolidated financial statements included in this annual report for additional information relating to outstanding options.

Recent Sales of Unregistered Securities

On November 14, 2022, the Company and Lincoln Park Capital Fund, LLC (the "Investor") entered into a purchase agreement pursuant to which we have the right, in our sole discretion, but not the obligation, to sell to the Investor up to $100 million worth of shares of Common Stock, over the 36-month term of the Agreement. We will control the timing and amount of any future sales of our Common Stock and the Investor is obligated to make purchases in accordance with the Agreement, subject to various limitations including those under the Nasdaq listing rules.

In connection with the execution of such purchase agreement, the Company issued 1,356,318 shares of Common Stock to the Investor as a commitment fee, in a private transaction exempt from registration under Section 4(a)(2) of the Securities Act of 1933, as amended.

No other shares of Common Stock have been sold under the purchase agreement with the Investor.

Purchases of Equity Securities by the Issuer and Affiliated Purchasers

In November 2022, we agreed to the rescission of the May 2022 exercise of 819,000 common stock warrants by a third-party. For accounting purposes, this was treated as a repurchase of the issued common stock for $588 thousand and modification of the warrant agreement for $561 thousand.

Item 6. Reserved

Not applicable.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion is intended to assist you in understanding our results of operations and our present financial condition and contains forward-looking statements that reflect our future plans, estimates, beliefs and expected performance. The forward-looking statements are dependent upon events, risks and uncertainties that may be outside our control. We caution you that our actual results could differ materially from those discussed in these forward-looking statements. Factors that could cause or contribute to such differences are discussed elsewhere in this Annual Report, particularly in the "Cautionary Note Regarding Forward-Looking Statements" and "Risk Factors," all of which are difficult to predict. In light of these risks, uncertainties and assumptions, the forward-looking events discussed may not occur. We do not undertake any obligation to publicly update any forward-looking statements except as otherwise required by applicable law.

Explanatory Note

On April 1, 2022 (the "Merger Date"), Nutex Health Holdco LLC and Clinigence Holdings, Inc. ("Clinigence") completed the merger (the "Merger") contemplated by the Agreement and Plan of Merger (the "Merger Agreement") dated as of November 23, 2021 between Clinigence, Nutex Acquisition LLC, a Delaware limited liability company and wholly-owned subsidiary of Clinigence, Nutex, Micro Hospital Holding LLC (solely for the purposes of certain sections of the Merger Agreement), Nutex Health Holdco LLC and Thomas Vo, M.D., solely in his capacity as the representative of the equity holders of Nutex. Immediately following the completion of the Merger, Clinigence amended its certificate of incorporation and bylaws to change its name to "Nutex Health Inc." In connection with the Merger, each outstanding equity interest of Nutex Health Holdco LLC was exchanged for 3.571428575 shares of Clinigence common stock. The Merger was accounted for as a reverse business combination under U.S. GAAP. Therefore, Nutex Health Holdco LLC was treated as the accounting acquirer in the Merger. Our financial statements presented for periods prior to the Merger Date are those of Nutex Health Holdco, LLC, as the Company's predecessor entity. Beginning with the second quarter of 2022, our financial statements are presented on a consolidated basis and include Clinigence.

Except where the context indicates otherwise, (i) references to "we," "us," "our," or the "Company" refer, for periods prior to the completion of the Merger, to Nutex Health Holdco LLC and its subsidiaries, (ii) references the "Nutex Health" for periods following the completion of the Merger, refer to Nutex Health Inc. and its subsidiaries and (ii) references to "Clinigence" refer to Clinigence Holdings, Inc. and its subsidiaries prior to the completion of the Merger.

Overview

Nutex Health Inc. is a physician-led, healthcare services and operations company with 19 hospital facilities in eight states (hospital division), and a primary care-centric, risk-bearing population health management division. Our hospital division implements and operates innovative health care models, including micro-hospitals, specialty hospitals and hospital outpatient departments ("HOPDs"). The population health management division owns and operates provider networks such as independent physician associations ("IPAs") and offers a cloud-based proprietary technology platform to IPAs which aggregates clinical and claims data across multiple settings, information systems and sources to create a holistic view of patients and providers.

We employ 1,150 full- and part-time employees and partner with over 800 physicians. Our corporate headquarters is based in Houston, Texas. We were incorporated on April 13, 2000 in the state of Delaware.

Our financial statements present the Company's consolidated financial condition and results of operations including those of majority-owned subsidiaries and variable interest entities ("VIEs") for which we are the primary beneficiary.

The hospital division includes our healthcare billing and collections organization and hospital entities. In addition, we have financial and operating relationships with multiple professional entities (the "Physician LLCs") and real estate entities (the "Real Estate Entities"). The Physician LLCs employ the doctors who work in our hospitals. These entities are consolidated by the Company as VIEs because they do not have significant equity at risk, and we have historically provided support to the Physician LLCs in the event of cash shortages and received the benefit of their cash surpluses.

The Real Estate Entities own the land and hospital buildings which are leased to our hospital entities. The Real Estate Entities have mortgage loans payable to third parties which are collateralized by the land and buildings. We consolidate the Real Estate Entities as VIEs in instances where our hospital entities are guarantors or co-borrowers under their outstanding mortgage loans. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans, leaving three Real Estate Entities as current VIEs consolidated in our financial statements.

The Company has no direct or indirect ownership interest in the Physician LLCs or Real Estate Entities, so 100% of the equity for these entities is shown as noncontrolling interest in the consolidated balance sheets and statements of operations.

The population health management division includes our management services organizations and a healthcare information technology company providing a cloud-based platform for healthcare organizations. In addition, AHISP, IPA, a physician-affiliated entity that is not owned by us—is consolidated as a VIE of our wholly-owned subsidiary AHP since we are the primary beneficiary of their operations under AHP's management services contracts with them.

Sources of revenue. Our hospital division recognizes net patient service revenue for contracts with patients and in most cases a third-party payor (commercial insurance, workers compensation insurance or, in limited cases, Medicare/Medicaid).

We receive payment for facility services rendered by us from federal agencies, private insurance carriers, and patients. The Physician LLCs receive payment for doctor services from these same sources. On average, greater than 90% of our net patient service revenue are paid by insurers, federal agencies, and other non-patient third parties. The remaining revenues are paid by our patients in the form of copays, deductibles, and self-payment. We generally operate as an out-of-network provider and, as such, do not have negotiated reimbursement rates with insurance companies. In the fourth quarter of 2022, we signed in-network provider contracts with the Provider Network of America (PNA). These contracts provide for payment to us of claims at 300% of the Medicare allowable rates for our services provided to PNA members.

The following tables present the allocation of the estimated transaction price with the patient between the primary patient classification of insurance coverage:

	Year ended December 31,		
	2022	2021	2020
Insurance	89%	96%	96%
Self pay	9%	3%	3%
Workers compensation	1%	1%	1%
Medicare/Medicaid	1%	0%	0%
Total	100%	100%	100%

The population health management division recognizes revenue for capitation and management fees for services to IPAs and physician groups and for the licensing, training, and consulting related to our cloud-based proprietary technology. Capitation revenue consists primarily of capitated fees for medical services provided by physician-owned entities we consolidate as VIEs. Capitated arrangements are made directly with various managed care providers including HMOs. Capitation revenues are typically prepaid monthly to us based on the number of enrollees selecting us as their healthcare provider. Capitation is a fixed payment amount per patient per unit of time paid in advance for the delivery of health care services, whereby the service providers are generally liable for excess medical costs. We receive management fees that are based on gross capitation revenues of the IPAs or physician groups we manage.

Our growth strategy. We plan to expand our operations by entering new market areas either through development of new hospitals, formation of new IPAs or by making acquisitions. We expect to open 15 to 20 new hospital facilities by the middle of the year 2025. These facilities are either under construction or in advanced planning stages and will result in our expansion into four new states: Florida, Wisconsin, Ohio and Idaho. We anticipate launching one-to-three additional IPAs per year principally in geographic areas around our existing micro-hospitals.

COVID-19 Pandemic

A novel strain of coronavirus causing the disease known as COVID-19 was first identified in December 2019 and spread throughout the world. While vaccines and booster shots for the COVID-19 virus became widely available in the United States during 2021, COVID-19 continued to result in a significant number of hospitalizations.

As a provider of healthcare services, we were significantly affected by the public health and economic effects of the COVID-19 pandemic. Our hospitals, medical personnel, and employees have been actively caring for COVID-19 patients. We implemented considerable safety measures for treatment of COVID-19 patients and have incurred, and may continue to incur, certain increased expenses arising from the COVID-19 pandemic, including additional labor, supply chain, capital and other expenditures. Moreover, in recent months, the COVID-19 pandemic resulted in general inflationary pressures and significant disruptions to global supply networks. In this regard, we have experienced disruptions in connection with the provision of equipment, construction services, as well as inflationary pressures in connection with labor, supply chain, capital and other expenditures. We also experienced a delay in billing and collection of patient claims during this period.

The COVID-19 pandemic affected, and may continue to affect, our service mix, revenue mix, payor mix and/or patient volumes, as well as our ability to collect outstanding receivables. Pandemic-related factors may continue to adversely affect demand for our services, as well as the ability of patients and other payors to pay for services rendered.

While we are not able to fully quantify the impact that the COVID-19 pandemic will have on our future financial results, we expect developments related to COVID-19 to continue to affect our financial performance. Moreover, the COVID-19 pandemic may otherwise have material adverse effects on our results of operations, financial position, and/or our cash flows if economic and/or public health conditions in the United States deteriorate.

Overview of Legislative Developments

The U.S. Congress and many state legislatures have introduced and passed a large number of proposals and legislation designed to make major changes in the healthcare system, including changes that have impacted access to health insurance. The most prominent of these efforts, the *Affordable Care Act*, affects how healthcare services are covered, delivered and reimbursed. The Affordable Care Act increased health insurance coverage through a combination of public program expansion and private sector health insurance reforms. There is uncertainty regarding the ongoing net effect of the Affordable Care Act due to the potential for continued changes to the law's implementation and its interpretation by government agencies and courts. There is also uncertainty regarding the potential impact of other health reform efforts at the federal and state levels.

In response to the COVID-19 pandemic, federal and state governments passed legislation, promulgated regulations, and have taken other administrative actions intended to assist healthcare providers in providing care to COVID-19 and other patients during the public health emergency and to provide financial relief. Among these, the *Coronavirus Aid, Relief, and Economic Security Act* ("CARES Act") had the most impact on our business.

The CARES Act included a waiver of insurance copayments, coinsurance, and annual deductibles for laboratory tests to diagnose COVID-19 and visits to diagnose COVID-19 at an emergency department of a hospital. These provisions of the CARES Act expired on June 30, 2021. While these provisions were effective, we experienced higher levels of revenue due to a shift of payor mix. The larger number and acuity of patient claims for COVID-19 also resulted in higher revenue.

No Surprises Act

The No Surprises Act ("NSA") is a federal law that took effect January 1, 2022, to protect consumers from most instances of "surprise" balance billing. The legislation was included in the Consolidated Appropriations Act, 2021, which was passed by Congress and signed into law by President Trump on December 27, 2020. With respect to the Company, the NSA limits the amount an insured patient will pay for emergency services furnished by an out-of-network provider. The NSA addresses the payment of these out-of-network providers by group health plans or health insurance issuers (collectively, "insurers"). In particular, the NSA requires insurers to reimburse out-of-network providers at a statutorily calculated "out-of-network rate." In states without an all-payor model agreement or specified state law, the out-of-network rate is either the amount agreed to by the insurer and the out-of-network provider or an amount determined through an independent dispute resolution ("IDR") process.

Under the NSA, insurers must issue an initial payment or notice of denial of payment to a provider within thirty days after the provider submits a bill for an out-of-network service. If the provider disagrees with the insurer's determination, the provider may initiate a thirty-day period of open negotiation with the insurer over the claim. If the parties cannot resolve the dispute through negotiation, the parties may then proceed to IDR arbitration.

Independent Dispute Resolution. The provider and insurer each submits a proposed payment amount and explanation to the arbitrator. The arbitrator must select one of the two proposed payment amounts taking into account the "qualifying payment amount" and additional circumstances including among other things the level of training, outcomes measurements of the facility, the acuity of the individual treated, and the case mix and scope of services of the facility providing the service. The NSA prohibits the arbitrator from considering the provider's usual and customary charges for an item or service, or the amount the provider would have billed for the item or service in the absence of the NSA.

Qualifying Payment Amount. The "qualifying payment amount" (QPA) is generally the median of the contracted rates recognized by the plan or issuer under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the items or service is furnished, with annual increases based on the consumer price index. In other words, the qualifying payment amount is typically the median rate the insurer would have paid for the service if provided by an in-network provider or facility.

HHS Final Rule. As required by the NSA, the United States Department of Health and Human Services ("HHS") has established an IDR process under which a certified IDR entity determines the ultimate amount of payment. The HHS' final rule became effective October 25, 2022. The final rule eliminated the rebuttable presumption that the qualified payment amount is the correct price and also abandoned the requirement that the certified IDR entity must select the offer closest to the qualifying payment amount. These key provisions were initially part of the interim rule issued in 2021 and were challenged by several court cases. Under the final rule, the certified IDR entity must instead select the offer that best reflects the value of the item or service provided, by first considering the QPA and then considering "additional information" that is relevant to the dispute.

Since the NSA became effective January 1, 2022, our average payment by insurers of patient claims for emergency services has declined by approximately 30% including as much as a 37% reduction for physician services. In our experience, insurers often initially pay amounts lower than the QPA without regard for other information relevant to the claim. This requires us to make appeals using the IDR process. We submitted almost 28 thousand cases for IDR in 2022, most in the fourth quarter. The IDR process and subsequent appeals, should we pursue them, require extensive administrative time and delays in collections.

Our experience is similar to that of other healthcare providers. In February 2023, the Emergency Department Physician Management Association reported survey results of its membership. The survey found that in more than 90% of claims surveyed, insurance companies followed the final rules implemented under the NSA for QPA disclosure and that the average claim payment declined 32% per ER Visit post-NSA.

While we are working within the established processes for IDR, we have had varying successes at achieving collections at or higher than the established QPA. We have undertaken several strategic actions designed to improve our collections results. These include:

- maximizing our claims coding efficiency,
- increasing efforts to collect co-pays and co-insurance,
- adding additional administrative staff to handle the increased administrative IDR burden,
- having a dedicated IDR team to accelerate resubmission of claims under the IDR process,
- making appeals for additional payment of claims for periods before and after the NSA final rule was adopted through the IDR process,
- making efforts to sign favorable contracts with new insurers,
- working to sign more favorable contracted rates with existing contracted providers,
- working with both local and national legislatures to enforce the NSA rules and guidelines for Insurers, and
- focusing on the value-base IPA side of our business, which is less affected by the NSA.

The final rule is already the subject of legal challenges. The Texas Medical Association (TMA) in September of 2022 filed motions for summary judgment in the U.S. Eastern District of Texas, Tyler Division, seeking to invalidate the IDR related provisions of the final rule, arguing that the QPA does not represent the fair value of the services rendered by the physicians and providers and that the final rule illegally favors the QPA over the fair value of the provider services in contravention of the statutory language of the NSA.

On October 19, 2022, and in addition to amicus briefs by several other national medical associations, the American Society of Anesthesiologists, the American College of Emergency Physicians, and the American College of Radiology, professional associations representing an aggregate of approximately 136,000 physicians, filed an Amicus brief supporting the TMA Motion.

On February 6, 2023, the U.S. District Court ruled in favor of the TMA by granting its motion for summary judgment against the HHS and stating that the revised IDR process in the final rule "continues to place a thumb on the scale" in favor of insurers and conflicts with the statutory provisions of the NSA, is unlawful and must be set aside. The Courts decision vacated all of the revised regulations challenged by the TMA, including HHS' rule that arbiters must primarily consider the QPA in the IDR process. The court stated that the final rules wrongly require arbitrators to presume the correctness of the QPA and then impose a heightened burden on the remaining statutory factors to overcome that presumption. In addition, the TMA on January 1, 2023, also in the U.S. Eastern District, filed a lawsuit seeking declaratory and injunctive relief to invalidate a recent 600% percent increase in the administrative fees payable in the IDR process.

We are supportive of industry efforts challenging NSA. Our experience, like that of many other healthcare providers, is that the final rule continues to unfairly favor insurers in the determination of the QPA we receive for our healthcare services. It is difficult to predict the ultimate outcome of efforts to challenge or amend the final rule. As well, there can be no assurance that third-party payors will not attempt to further reduce the rates they pay for our services or that additional rules issued under the NSA will not have adverse consequences to our business.

Results of Operations

We report the results of our operations as three segments in our consolidated financial statements: (i) the hospital division, (ii) the population health management division and (ii) the real estate division. Activity within our business segments is significantly impacted by demand for healthcare services we provide, competition for these services in each of the market areas we serve, and the legislative changes discussed above.

Following is our results of operations for the periods shown:

	Year ended December 31,		
	2022	2021	2020
Revenue:			
Hospital division	$ 198,508,245	$ 331,531,311	$ 274,029,061
Population health management division	20,786,061	-	-
Total revenue	219,294,306	331,531,311	274,029,061
Segment operating income:			
Hospital division	13,064,913	179,280,958	157,606,159
Population health management division	387,469	-	-
Total segment operating income	13,452,382	179,280,958	157,606,159
Corporate and other costs:			
Acquisition costs	3,885,666	3,553,716	-
Impairment of goodwill	398,135,038	-	-
General and administrative expenses	18,030,832	5,462,344	4,432,272
Total corporate and other costs	420,051,536	9,016,060	4,432,272
Interest expense	12,490,260	6,196,026	6,432,941
Other expense (income)	559,299	(5,422,144)	1,001,711
Income before taxes	(419,648,713)	169,491,016	145,739,235
Income tax expense	13,090,905	965,731	181,341
Net income (loss)	(432,739,618)	168,525,285	145,557,894
Less: net income (loss) attributable to noncontrolling interests	(7,959,172)	35,931,957	39,588,009
Net income (loss) attributable to Nutex Health Inc.	$ (424,780,446)	$ 132,593,328	$ 105,969,885
Adjusted EBITDA	$ 12,547,923	$ 145,220,199	$ 114,866,741

Year Ended December 31, 2022 Compared to Year Ended December 31, 2021

We reported a net loss attributable to Nutex Health Inc. of $424.8 million, or a loss of $0.67 per share, for 2022 as compared with net income attributable to Nutex Health Inc. of $132.6 million, or $0.22 per diluted share, for 2021. Our 2022 results were principally affected by:

- A non-cash impairment charge of $398.1 million to reduce the carrying amount of goodwill for the population health management division reporting unit acquired in the reverse business combination;
- Decrease in revenue caused by legislative changes reducing the amounts we are able to collect for patient services to median in-network rates;
- Start-up costs associated with five new facilities opened since April 2021 which are experiencing favorable market acceptance but not yet fully achieving break-even profitability;
- Higher overall costs of employees and independent contractors.

Adjusted EBITDA for 2022 was $12.5 million as compared $145.2 million for 2021. Refer to Non-GAAP Financial Measures discussed below for a definition and reconciliation of Adjusted EBITDA. The items affecting revenue and start-up costs contributed significantly to the decline in Adjusted EBITDA in the 2022 period.

A discussion of our segment results is included below.

Hospital Division. Our revenue for 2022 totaled $198.5 million as compared to $331.5 million for 2021, a decrease of 40% caused by a reduction in both collection amounts and the number of patient visits. The following table shows the number of patient visits during the periods:

	Year ended December 31,	
	2022	2021
Patient visits:		
Hospital	161,014	189,016

Total patient visits decreased 15% during 2022 as compared with 2021. Patient visits in 2021 included significant volumes of COVID-19 related cases. The average acuity or severity of patient cases in the 2022 period was slightly higher than in 2021 but only minimally offset the impact of the lower number of total patient visits.

Collections during the years 2020 and 2021 benefited from provisions of the CARES Act which waived insurance copayments, coinsurance, and annual deductibles for laboratory tests and visits at an emergency department of a hospital to diagnose COVID-19. These provisions of the CARES Act expired on June 30, 2021. While these provisions were effective, we experienced higher levels of revenue due to a shift of payor mix.

In 2022, the average payment by insurers for patient claims for emergency services declined by approximately 30% principally because of the NSA compared to prior periods. We also experienced a decrease in collection for the remaining amounts of account receivable for periods before 2022. We believe this decline was caused, in part, by insurers underpaying these claims in the same way we are experiencing lower claim payments since the NSA became effective.

The hospital division's operating income was $13.1 million during 2022, down 93% as compared $179.3 million in the same period of 2021. Our operating income for 2022 was adversely affected by the reduction in net revenue discussed above. Further, start-up costs for newer facilities contributed to reduced segment operating results. We have opened five new facilities since April 2021. Start-up costs include complete staffing for 24/7 operations, lease costs, in-market advertising and other operating expenses. These costs often exceed our revenue at these facilities until they achieve sustaining volumes of patient visits. In general, we expect new facilities to reach profitability within 12 months. In this time, we also added additional staff to manage higher volumes of medical claims billing and collection administration.

Population Health Management Division. We completed our reverse business combination with Clinigence in April 2022. Clinigence's operations are reported as the population health management division. Our total revenue for 2022 for this division was $20.8 million consisting of capitation revenue of $15.5 million, management fees of $4.3 million and SaaS revenue of $946 thousand. Capitation revenue is recognized by our consolidated VIE, AHISP. We do not have an equity interest in this VIE but consolidate it

since we are the primary beneficiary of its operations under our management services contract with them. We also earn management fees under our management services contracts with other IPAs and MSOs which are reported as revenue.

The population health management division had $387 thousand of operating income for 2022 since completion of the reverse business combination. Strategically, we are focused on the growth of this division principally through the addition of new independent physician associations and have staffed our organization to manage larger numbers of such organizations.

Real Estate Division. This division reports the operations of consolidated Real Estate Entities where we provide guarantees of their indebtedness or are co-borrowers. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans.

Revenue and operating expenses of consolidated Real Estate Entities are not significant since the extent of these entities' operations is to own facilities leased to our hospital division entities which are financed by a combination of contributed equity by related parties and third-party mortgage indebtedness. Such leases are typically on a triple net basis where our hospital division is responsible for all operating costs, repairs and taxes on the facilities. Finance lease income is recognized outside of segment operating income as other income by the Real Estate Entities. However, these amounts are largely eliminated in the consolidation of these entities into our financial statements.

At December 31, 2022, three Real Estate Entities continue to be consolidated in our financial statements. We expect that hospitals we open in the future may be leased from new Real Estate Entities which may be owned in whole or part by related parties. Third-party lenders to these entities may require that we provide a guarantee or become co-borrowers under mortgage indebtedness financings for such facilities. In such instances, we may be required to consolidate these new Real Estate Entities in our financial statements as VIEs.

Corporate and other costs. Corporate and other costs in 2022 included general and administrative expenses totaling $18.0 million, acquisition costs for the reverse business combination with Clinigence totaling $3.9 million and a non-cash impairment charge reducing goodwill totaling $398.1 million. Our corporate costs for 2021 included general and administrative costs of $5.5 million and acquisition costs of $3.6 million. General and administrative costs include our executive management, accounting, human resources, corporate technology, insurance and professional fees. We have incurred higher levels of professional fees as a public company. In 2022, we have made staffing additions commensurate with our operational growth and made key additions to our executive management team.

As a public company, we must comply with new laws, regulations and requirements, certain corporate governance provisions of the Sarbanes-Oxley Act of 2002, related regulations of the SEC and the continued listing requirements of the NASDAQ, with which we were not required to comply with as a private company. We incur additional annual expenses related to these matters and, among other things, additional directors' and officers' liability insurance, director fees, reporting requirements of the SEC, transfer agent fees, hiring additional accounting, legal and administrative personnel, increased auditing and legal fees and similar expenses.

In 2022, we recognized a non-cash impairment charge of $398.1 million, as revised, to reduce the carrying amount of goodwill for the population health management division reporting unit acquired in the reverse business combination. This impairment was determined as part of our annual test for impairment of goodwill. This test is made by comparing the estimated fair values of our reporting units to their respective carrying values. We use an income method to estimate the fair value of these assets, which is based on forecasts of the expected future cash flows attributable to the respective assets and is subject to significant estimates and assumptions. In performing this test, we determined that the estimated fair value of our population health management division reporting unit was less than its carrying value recorded in the reverse business combination. Therefore, we conducted a second step of the goodwill impairment test to determine the implied fair value of the reporting unit's goodwill. The non-cash impairment charge reduced the excess carrying amount of goodwill for the population health management division that were greater than its residual fair value. As discussed in Item 8, "Financial Statements – Note 20 – Quarterly Financial Data, we made a retrospective adjustment to reduce the amount of goodwill impairment expense from the $408.5 million previously recognized in our quarterly report on Form 10-Q for the period ended September 30, 2022 to $398.1 million.

Nonoperating items

Interest expense. Interest expense totaled $12.5 million in 2022 as compared with $6.2 million for 2021. This includes interest expense associated with the mortgage indebtedness of consolidated Real Estate Entities, interest expense on outstanding term notes and lines of credit for financing operating equipment and working capital needs, interest expense for financing leases and the accretion costs related to the conversion of notes assumed in the Clinigence transaction. Interest expense is expected to decline in future periods as a

result of the deconsolidation of 17 Real Estate Entities and their associated mortgage indebtedness during the second quarter of 2022 as well as due to the elimination of accretion costs related to the conversion of notes payable assumed in the Clinigence transaction.

Income tax expense. In periods before our merger with Clinigence, Nutex Health Holdco LLC and the Nutex Subsidiaries were pass-through entities treated as partnerships for U.S. federal income tax purposes. No provision for federal income taxes was provided for these periods as federal taxes were obligations of these companies' members. After the merger, Nutex Health Holdco LLC became a wholly-owned subsidiary of Clinigence and is included in its consolidated corporate tax filings. We recognized a non-cash charge of $21.3 million to income tax expense during 2022 for the change in tax status of Nutex Health Holdco LLC. This charge provides for the accumulated net deferred tax liabilities representing the differences between the book and tax bases of Nutex Health Holdco LLC's assets and liabilities as of the April 1, 2022 change in tax status.

At the time of our merger with Clinigence, Clinigence had a full valuation allowance against its deferred tax assets. We recorded a non-cash benefit of $2.4 million to income tax expense to remove the acquired valuation allowance after we concluded that the associated deferred tax assets would be realizable.

Each of the discrete items above, as well as the non-deductible goodwill impairment expense also recognized 2022, are one-time, non-cash items.

Year Ended December 31, 2021 Compared to Year Ended December 31, 2020

We reported net income attributable to Nutex Health Inc. of $132.6 million, or $0.22 per diluted share, for the year ended December 31, 2021 as compared with $106.0 million, or $0.18 per diluted share, for 2020. Our 2021 results benefited from higher patient volumes including COVID-19 related cases.

Adjusted EBITDA for 2021 was a $145.2 million as compared with $114.9 million for 2020. Refer to Non-GAAP Financial Measures discussed below for a definition and reconciliation of Adjusted EBITDA.

A discussion of our segment results follows.

Hospital Division. Our revenue for 2021 totaled $331.5 million as compared to $274.0 million for 2020, an increase of 21% principally caused by higher patient volumes including COVID-19 related cases. The following table shows the number of patient visits during the periods:

	Year ended December 31,	
	2021	**2020**
Patient visits:		
Hospital	189,016	168,443

Total patient visits increased 12% in 2021 as compared with 2020. Patient visits each year included significant volumes of COVID-19 related cases each year. The number and acuity of patient visits in the fall of 2021 increased significantly due to the emergence of the Omicron variant of the COVID-19 virus. These higher volumes began to subside in early-2022.

Collections during the years 2020 and 2021 benefited from provisions of the CARES Act which waived insurance copayments, coinsurance, and annual deductibles for laboratory tests and visits at an emergency department of a hospital to diagnose COVID-19. These provisions of the CARES Act expired on June 30, 2021. While these provisions were effective, we experienced higher levels of revenue due to a shift of payor mix.

The hospital division's operating income was $179.3 million during 2021, up $21.7 million or almost 14% from $157.6 million reported for 2020. Our operating income for 2021 benefited from the higher revenues discussed above.

Real Estate Division. This division reports the operations of consolidated Real Estate Entities where we provide guarantees of their indebtedness or are co-borrowers.

Revenue and operating expenses of consolidated Real Estate Entities are not significant since the extent of these entities' operations is to own facilities leased to our hospital division entities which are financed by a combination of contributed equity by related parties

and third-party mortgage indebtedness. Such leases are typically on a triple net basis where our hospital division is responsible for all operating costs, repairs and taxes on the facilities. Finance lease income is recognized outside of segment operating income as other income by the Real Estate Entities. However, these amounts are largely eliminated in the consolidation of these entities into our financial statements.

Corporate and other costs. Corporate and other costs in 2021 included general and administrative expenses totaling $5.5 million as compared with $4.4 million for 2020. Acquisition costs totaled $3.6 million in 2021. These acquisition costs and higher levels of general and administrative expenses in 2021 were incurred as we prepared for our reverse business combination with Clinigence and added corporate staffing in preparation for our public listing.

Nonoperating items

Interest expense. Interest expense totaled $6.2 million in 2021 as compared with $6.4 million for 2020. This includes interest expense associated with the mortgage indebtedness of consolidated Real Estate Entities and interest expense on outstanding term notes and lines of credit for financing operating equipment and working capital needs.

Income tax expense. As discussed above, in periods before our merger with Clinigence, Nutex Health Holdco LLC and the Nutex Subsidiaries were pass-through entities treated as partnerships for U.S. federal income tax purposes. No provision for federal income taxes was provided for these periods as federal taxes were obligations of these companies' members. Reported amounts for income tax expense in these periods were for Texas state tax obligations.

Liquidity and Capital Resources

As of December 31, 2022, we had $34.3 million of cash and equivalents, compared to $36.1 million of cash and equivalents at December 31, 2021.

Significant sources and uses of cash during 2022.

Sources of cash:

- Cash from operating activities was $50.6 million, which included $64.3 million from the primary components of our working capital (receivables, inventories, accounts payable and expenses).
- Clinigence's balance sheet at the merger date included $12.7 million of cash.
- We received net proceeds of $3.4 million from borrowings under notes payable and lines of credit.
- We received net proceeds of $4.2 million from the exercise of common stock warrants and options.
- Non-controlling members made cash capital contributions of $4.5 million.

Uses of cash:

- Capital expenditures were $14.6 million.
- We made distributions to our owners related to operations prior to the merger with Clinigence and to noncontrolling interest owners totaling $51.2 million.
- Cash associated with the 17 deconsolidated Real Estate Entities totaled $2.4 million.

Future sources and uses of cash. Our operating activities are financed with cash on hand which is generated from revenues. Most of our hospital facilities are leased from various lessors including related parties. These leases are presented in our consolidated balance sheets unless the lease is from a consolidated Real Estate Entity. Our growth plans include the development of new hospital locations. We expect that in many of these locations we will lease facilities from newly established entities partially owned by related parties.

We routinely enter into equipment lease agreements to procure new or replacement equipment and may also finance these purchases with term debt. We have smaller lines of credits available for working capital purposes and are presently working to supplement or replace these with larger financing commitments. These larger financing commitments are subject to market conditions and we may not be able to obtain such larger financing commitments at favorable economic terms or at all.

Indebtedness. The Company's indebtedness at December 31, 2022 is presented in Item 8, "Financial Statements – Note 8 – Debt" and our lease obligations are presented in Item 8, "Financial Statements—Note 9 – Leases."

We have entered into private debt arrangements with banking institutions for the purchase of equipment and to provide working capital and liquidity through cash and lines of credit. Unless otherwise delineated above, these debt arrangements are obligations of Nutex and/or its wholly-owned subsidiaries. Consolidated Real Estate Entities have entered into private debt arrangements with banking institutions for purposes of purchasing land, constructing new emergency room facilities and building out leasehold improvements which are leased to our hospital entities. Nutex is a guarantor or, in limited cases, a co-borrower on the debt arrangements of the Real Estate Entities for the periods shown. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans.

Certain outstanding debt arrangements require minimum debt service coverage ratios and other financial covenants. At December 31, 2022, we were not in compliance with the debt service coverage ratio for term loan with an outstanding balance of $1.0 million. This balance has been included in current liabilities. At December 31, 2022, we had remaining availability of $2.1 million under outstanding lines of credit.

Committed Investment Agreement with Lincoln Park Capital. On November 14, 2022, Nutex and Lincoln Park Capital Fund, LLC, an Illinois limited liability company (the "Investor"), entered into a purchase agreement pursuant to which Nutex has the right, in its sole discretion, but not the obligation, to sell to the Investor up to $100 million worth of shares of Common Stock, over the 36-month term of the purchase agreement, subject to the terms and conditions provided therein. Nutex will control the timing and amount of any future sales of its Common Stock and the Investor is obligated to make purchases in accordance with the purchase agreement, subject to various limitations including those under the Nasdaq listing rules.

Nutex intends to use the net proceeds from the future sale of its Common Stock for working capital and general corporate purposes to support its growth.

Regular Purchases: At any time after the satisfaction of certain conditions including the effectiveness of a registration statement, the Company has the right, but not the obligation, to require the Investor to purchase on any particular trading day ("Purchase Date") up to:

- 300,000 shares of Common Stock provided that the closing price is not below $0.10;
- 600,000 shares if the closing price is not below $0.75; and
- 900,000 shares if the closing price is not below $1.50.

The Investor's committed obligation under each Regular Purchase shall not exceed $3,000,000. For Regular Purchases the purchase price shall be equal to 97% of the lesser of:

- the lowest sale price of the Common Stock during the applicable Purchase Date; or
- the average of the three lowest closing sale prices of the Common Stock during the ten business days prior to the applicable Purchase Date.

Accelerated Purchases: In addition to Regular Purchases and provided that the Company has directed a Regular Purchase in full (as set forth above), the Company in its sole discretion may require the Investor on each Purchase Date to purchase on the following business day (the "Accelerated Purchase Date") up to the lesser of:

- three times the number of shares purchased pursuant to such Regular Purchase; or
- 30% of the trading volume on the Accelerated Purchase Date;

In each case, the purchase price shall be equal to 97% of the lesser of:

- the closing sale price on the Accelerated Purchase Date; or
- the Accelerated Purchase Date's volume weighted average price.

There is no upper limit to the price per share that the Investor may pay for future issuances of Common Stock under the Agreement, and the Investor has agreed not to cause or engage in any direct or indirect short selling or hedging of our Common Stock. No warrants are being issued the Investor and the Agreement does not contain any rights of first refusal, participation rights, penalties, or liquidated damages provisions in favor of any party.

In connection with the execution of the Agreement, the Company issued 1,356,318 shares of Common Stock to the Investor as a commitment fee, in a private transaction exempt from registration under Section 4(a)(2) of the Securities Act of 1933, as amended.

Under the Agreement, issuances of Common Stock may be suspended upon the occurrence of customary events, including the unavailability of the resale registration statement. The Company has the right at any time for any reason to terminate the Agreement.

Off-Balance Sheet Arrangements

As of December 31, 2022, we had no material off-balance sheet arrangements.

Non-GAAP Financial Measures

Adjusted EBITDA. Adjusted EBITDA is used as a supplemental non-GAAP financial measure by management and external users of our financial statements, such as industry analysts, investors, lenders and rating agencies. We believe Adjusted EBITDA is useful because it allows us to more effectively evaluate our operating performance.

We define Adjusted EBITDA as net income (loss) attributable to Nutex Health Inc. plus net interest expense, income taxes, depreciation and amortization, further adjusted for stock-based compensation, certain defined items of expense, any acquisition-related costs and impairments. A reconciliation of net income to Adjusted EBITDA is included below. Adjusted EBITDA is not intended to serve as an alternative to U.S. GAAP measures of performance and may not be comparable to similarly-titled measures presented by other companies.

	Year ended December 31,		
	2022	2021	2020
Reconciliation of net income (loss) attributable to Nutex Health Inc. to Adjusted EBITDA:			
Net income (loss) attributable to Nutex Health Inc.	$ (424,780,446)	$ 132,593,328	$ 105,969,885
Depreciation and amortization	13,131,374	7,662,464	5,898,361
Interest expense, net	12,490,260	6,196,026	6,432,941
Income tax expense	13,090,905	965,731	181,341
Allocation to noncontrolling interests	(4,837,514)	(5,751,066)	(3,615,787)
EBITDA	(390,905,421)	141,666,483	114,866,741
Stock-based compensation expense	189,581	-	-
Rescission of warrant exercise	1,243,059	-	-
Impairment of goodwill	398,135,038	-	-
Acquisition costs	3,885,666	3,553,716	-
Adjusted EBITDA	$ 12,547,923	$ 145,220,199	$ 114,866,741

Significant Accounting Policies

Revenue recognition.

Hospital division – Our hospital division recognizes net patient service revenue for contracts with patients and in most cases a third-party payor (commercial insurance, workers compensation insurance or, in limited cases, Medicare/Medicaid). The Company's performance obligations are to provide emergency health care services primarily on an outpatient basis. Net patient service revenues are recorded at the amount that reflects the consideration to which the Company expects to be entitled in exchange for providing patient care. These amounts are net of appropriate discounts giving recognition to differences between the Company's charges and reimbursement rates from third party payors.

Patient service net revenues earned by the Company are recognized at a point in time when the services are provided, net of adjustments and discounts. Because all the Company's performance obligations relate to contracts with a duration of less than one-year, certain disclosures are limited.

The transaction price is determined based on gross charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts and implicit e concessions provided primarily to uninsured patients in accordance with the Company's

policy. For uninsured patients, the Company recognizes revenue based on established rates, subject to certain discounts and implicit price concessions. The Company is reimbursed from third party payors under various methodologies based on the level of care provided. We are considered "out-of-network" with commercial health plans. As there are no contractual rates established with insurance entities, revenues are estimated based on the "usual and customary" charges allowed by insurance payors using historical collection experience, historical trends of refunds and payor payment adjustments (retractions). Revenue from the Medicare program is based on reimbursement rates set by governmental authorities.

Patients who have health care insurance may also have discounts applied related to their copayment or deductible. Estimates of contractual adjustments and discounts are determined by major payor classes for outpatient revenues based on historical experience. The Company estimates implicit price concessions based on its historical collection experience with these classes of patients using a portfolio approach. The portfolios consist of major payor classes for outpatient revenue. Based on historical collection trends and other analyses, the Company concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

Customer payments are due upon receipt of an explanation of benefits for insured patients or it is due upon receipt of the bill from the Company for uninsured payments. There is no financing component associated with payments due from insurers or patients.

Population health management division – The population health management division recognizes revenue for capitation and management fees for services to IPAs and physician groups and for the licensing, training, and consulting related to our cloud-based proprietary technology.

Capitation revenue consists primarily of capitated fees for medical services provided by physician-owned entities we consolidate as VIEs. Capitated arrangements are made directly with various managed care providers including HMOs. Capitation revenues are typically prepaid monthly to us based on the number of enrollees selecting us as their healthcare provider. Capitation is a fixed payment amount per patient per unit of time paid in advance for the delivery of health care services, whereby the service providers are generally liable for excess medical costs.

We receive management fees that are based on gross capitation revenues of the IPAs or physician groups we manage. Revenue is recognized and received monthly for our services. In addition, we provide consultant services that are charged as a flat fixed rate and recognized as revenue when the service is performed. Consultant services revenues represent a small portion of our total revenue.

Software licenses are provided as SaaS-based subscriptions that grants access to proprietary online databases and data management solutions. Training and consulting are project based and billable to customers on a monthly-basis or task-basis. Revenue from training and consulting are generally recognized upon delivery of training or completion of the consulting project. The duration of training and consulting projects are typically a few weeks or months and last no longer than 12 months.

SaaS-based subscriptions are generally marketed under multi-year agreements with annual, semi-annual, quarterly, or month-to-month renewals and revenue is recognized ratably over the renewal period with the unearned amounts received recorded as deferred revenue. For multiple-element arrangements accounted for in accordance with specific software accounting guidance, multiple deliverables are segregated into units of accounting which are delivered items that have value to a customer on a standalone basis.

Cash payments for SaaS-based subscriptions received in advance of the satisfaction of our performance obligations as deferred revenue and recognized as revenue over the period in which the performance obligations are satisfied. The Company completes its contractual performance obligations through providing its customers access to specified data through subscriptions for a service period, and training on consulting associated with the subscriptions. We primarily invoice our customers on a monthly basis and do not provide any refunds, rights of return, or warranties.

Construction in Progress. The Company regularly is in the process of constructing new facilities. Generally, our ER Entities are responsible for the leasehold buildout and equipment while the associated Real Estate Entity procures the land, if any, and constructs a new or remodeled facility. Costs incurred to construct assets which will ultimately be classified as fixed assets are capitalized and classified in our financial statements as construction in progress until construction is completed and the asset is available for use. Once the asset is available for use, it is reclassified as another category of fixed assets and depreciated across its useful life.

Goodwill Impairment. We test goodwill for impairment at least annually by comparing the estimated fair values of our reporting units to their respective carrying values. We use an income method to estimate the fair value of these assets, which is based on forecasts of the expected future cash flows attributable to the respective assets. Significant estimates and assumptions inherent in the valuations

reflect a consideration of other marketplace participants, and include the amount and timing of future cash flows (including expected growth rates and profitability). Estimates utilized in the projected cash flows include consideration of macroeconomic conditions, overall category growth rates, competitive activities, Company business plans and the discount rate applied to the cash flows. Unanticipated market or macroeconomic events and circumstances may occur, which could affect the accuracy or validity of the estimates and assumptions.

During the three months ended September 30, 2022, we determined that the estimated fair value of our population health management division reporting unit which was acquired in the reverse business combination with Clinigence was less than its carrying value. Therefore, we conducted a second step of the goodwill impairment test to determine the implied fair value of the reporting unit's goodwill. In this analysis, we allocated the fair value of the reporting unit to identifiable assets and liabilities of the reporting unit. The residual fair value after this allocation was compared to the goodwill balance with the excess goodwill charged to expense. Based on this analysis, we recognized a non-cash impairment charge of $398.1 million, as revised, to reduce the carrying amount of goodwill for the population health management division reporting unit. As discussed in Item 8, "Financial Statements – Note 20 – Quarterly Financial Data, we made a retrospective adjustment to reduce the amount of goodwill impairment expense from the $408.5 million previously recognized in our quarterly report on Form 10-Q for the period ended September 30, 2022 to $398.1 million.

We believe the estimates and assumptions utilized in our impairment testing are reasonable and are comparable to those that would be used by other marketplace participants. However, actual events and results could differ substantially from those used in our valuations. To the extent such factors result in a failure to achieve the level of projected cash flows used to estimate fair value for purposes of establishing or subsequently impairing the carrying amount of goodwill and intangible assets, we may need to record additional non-cash impairment charges in the future.

Item 7A. Quantitative and Qualitative Disclosure About Market Risk

We are exposed to market risk related to changes in interest rates, primarily as a result of the line of credit facilities which bear interest based on floating rates.

The estimated fair value of our long-term debt approximates the carrying amount at December 31, 2022 due to its relatively short maturity. To mitigate the impact of fluctuations in interest rates, we generally target our debt portfolio to be maintained at fixed rates.

Item 8. Financial Statements and Supplementary Data

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management of Nutex Health Inc. (the "Company") is responsible for establishing and maintaining adequate internal control over financial reporting and for assessing the effectiveness of internal control over financial reporting. The Company has designed its internal control over financial reporting to provide reasonable assurance on the reliability of financial reporting and the preparation of the consolidated financial statements in accordance with U.S. generally accepted accounting principles.

The Company's internal control over financial reporting includes those policies and procedures that: (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the Company's transactions and dispositions of the Company's assets; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the consolidated financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of the Company's management and directors; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

Because of inherent limitations in internal control over financial reporting, such controls may not prevent or detect misstatements. Also, projections of any evaluation of the effectiveness of internal controls 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.

In connection with the preparation of the Company's annual consolidated financial statements, management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in the *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the "COSO criteria").

Based on this assessment, the following material weaknesses have been identified:

- The Company did not design and implement logical access controls for certain financially relevant systems. Business process controls, both automated and manual, that are dependent upon the information derived from those financially relevant systems were also determined to be ineffective as a result of such deficiency;

- Business process controls across the entity's financial reporting processes were not effectively designed and implemented to properly address the risk of material misstatement, including controls without proper segregation of duties between preparer and reviewer and key management review controls; and

- Ineffective design and implementation of controls over the completeness and accuracy of information included in key spreadsheets supporting the financial statements.

Each of these material weaknesses is further described in Part II, Item 9A. Management has concluded that, based on applying the COSO criteria, as of December 31, 2022, the Company's internal control over financial reporting was not effective to provide reasonable assurance of the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles. We have made progress towards remediation and continue to implement our remediation plan. See the "Remediation of Material Weakness" caption in Part II, Item 9A for further information.

Marcum llp, the independent registered public accounting firm that audited the Company's consolidated financial statements included in this report, has issued an attestation report on the effectiveness of the Company's internal control over financial reporting, a copy of which appears on page 56-57.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Members and Board of Directors of
Nutex Health, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheet of Nutex Health, Inc (the "Company") as of December 31, 2022 and 2021, the related consolidated statements of operations, changes in equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2022 and 2021, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2022 in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the Company's internal control over financial reporting as of December 31, 2022, based on the criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in 2013 and our report dated March 1, 2023, expressed an adverse opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

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

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Our audit included performing procedures to assess the risks of material misstatement of the 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 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 financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Accounting for Identifiable Intangible Assets related to Merger with Clinigence Holdings, Inc. (Clinigence")

Description of the Matter

As discussed in Note 1 of the financial statements, the Company completed a merger with Clinigence on April 1, 2022. The merger of Nutex Health Holdco LLC and Clinigence was accounted for as a reverse business combination with the Company as the accounting acquirer in accordance with ASC 805, Business Combinations, and Clinigence as the accounting acquiree.

Auditing the Company's accounting for the acquisition of Clinigence was complex due to the significant estimates in determining the fair value of its identifiable intangible assets, which principally consisted of member relationships, management contracts and trademarks. The uncertainty of significant estimates was primarily due to the sensitivity of the underlying assumptions related to future performance of the acquired business. The significant assumptions used to estimate the fair value of the member relationships included the future operating performance and cash flows generated by the member relationships and a discount rate. The significant assumptions used to estimate the fair value of the management contracts included the future operating performance and cash flows generated by the management contracts and a discount rate. The significant assumptions used to estimate the fair value of the trademarks included the projected revenues generated by the trademarks, a royalty rate, and a discount rate. These significant assumptions are forward looking and could be affected by future economic and market conditions.

How We Addressed the Matter in Our Audit

Our audit procedures related to the accounting for the acquisition of Clinigence to address this critical audit matter included the following:

- We obtained an understanding of the Company’s method of valuing the identifiable intangible assets related to the acquisition.
- Additionally, we read the purchase agreement to identify the significant terms, and tested management’s process for estimating the fair value of member relationships, customer relationships, management contracts and trademarks including:
    - We involved our valuation specialists to assist in our evaluation of the methodologies used by the Company and the significant assumptions included in the fair value estimates, which included guideline companies, discount rates, internal rate of return, weighted average cost of capital, weighted average return on assets.
    - We evaluated the reasonableness of management’s forecasts of future cash flows by comparing projections to historical results and applying a reasonable growth rate.
    - We compared the significant assumptions to the historical results of the acquired business and performed retrospective review of the actual results compared to the projected cash flows.

Revenue Recognition – Hospital Division

Description of the Matter

Management’s accounting estimates around revenue recognition and related accounts receivable for the hospital division are based on past experiences. The hospital division revenue amounts are net of appropriate discounts giving recognition to differences between the Company’s charges and reimbursement rates from third party payors. As there are no contractual rates established with insurance entities, revenues are estimated based on the "usual and customary” charges allowed by insurance payors considering historical collection experience, historical trends of refunds and payor payment adjustments (retractions).

How We Addressed the Matter in Our Audit

Our audit procedures related to revenue recognition of hospital division to address this critical audit matter included the following:

- We obtained an understanding of the Company’s method of revenue recognition and related account receivable and evaluated the design, key factors and assumptions used in developing the management’s accounting estimate. We determined that it is reasonable in relation to the basic financial statements taken as a whole.
- We compared the Company’s past historical estimation of revenue recognition and related account receivable with actual collection experience to ensure revenue estimation is reasonable.
- We selected a sample of revenue items and evaluated revenue recognition and related account receivable.
- We compared management’s accounting estimate around revenue recognition and related accounts receivable to subsequent collections to ensure reasonableness of collectability, including a sample of account receivable items.

Impairment of Long-Lived Assets

Description of the Matter

The Company assesses the valuation of goodwill whenever events or circumstances indicate that the carrying value might not be recoverable. The Company bases its evaluation on indicators such as the nature of the assets, the future economic benefit of the assets, any historical or future profitability measurements and other external market conditions or factors that may be present. The Company recognized a non-cash impairment charge of $398.1 million in 2022 to reduce the carrying amount of goodwill for the population health management division reporting unit.

How We Addressed the Matter in Our Audit

We tested the significant assumptions used in the valuation models.

- We involved our valuation specialists to assist in our evaluation of the methodologies used by the Company and the significant assumptions included in the fair value estimates, which included guideline companies, discount rates, internal rate of return, weighted average cost of capital, weighted average return on assets.
- We evaluated the reasonableness of management's forecasts of future cash flows by comparing projections to historical results and significant assumptions.

/s/ Marcum llp

Marcum llp

We have served as the Company's auditor since 2021.

Houston, Texas
March 2, 2023

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM ON INTERNAL CONTROL OVER FINANCIAL REPORTING

To the Shareholders and Board of Directors of
Nutex Health Inc.

Adverse Opinion on Internal Control over Financial Reporting

We have audited Nutex Health Inc.'s (the "Company") internal control over financial reporting as of December 31, 2022, based on criteria established in *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, because of the effect of the material weaknesses described in the following paragraph on the achievement of the objectives of the control criteria, the Company has not maintained effective internal control over financial reporting as of December 31, 2022, based on criteria established in *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

A material weakness is a control deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the Company's annual or interim financial statements will not be prevented or detected on a timely basis. The following material weaknesses have been identified and included in "Management's Annual Report on Internal Control Over Financial Reporting":

- The Company did not design and implement logical access controls for certain financially relevant systems. Business process controls, both automated and manual, that are dependent upon the information derived from those financially relevant systems were also determined to be ineffective as a result of such deficiency.

- Business process controls across the entity's financial reporting processes were not effectively designed and implemented to properly address the risk of material misstatement, including controls without proper segregation of duties between preparer and reviewer and key management review controls.

- Ineffective design and implementation of controls over the completeness and accuracy of information included in key spreadsheets supporting the financial statements.

These material weaknesses were considered in determining the nature, timing and extent of audit tests applied in our audit of the fiscal December 31, 2022 consolidated financial statements, and this report does not affect our report dated March 2, 2023 on those financial statements.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated balance sheets as of December 31, 2022 and 2021 and the related consolidated statements of operations, changes in equity, and cash flows for each of the three years in the period ended December 31, 2022 of the Company and our report dated March 2, 2023 expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying "Management Annual Report on Internal Control Over Financial Reporting". Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the 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 audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the 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 degree of compliance with the policies or procedures may deteriorate.

/s/ Marcum llp

Marcum llp

Houston, Texas

March 2, 2023

NUTEX HEALTH INC.
CONSOLIDATED BALANCE SHEETS

	December 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 34,255,264	$ 36,118,284
Accounts receivable	57,777,386	112,766,317
Accounts receivable - related parties	538,183	1,993,117
Inventories	3,533,285	2,814,178
Prepaid expenses and other current assets	1,869,806	323,283
Total current assets	97,973,924	154,015,179
Property and equipment, net	82,094,352	151,912,500
Operating right-of-use assets	20,466,632	21,829,552
Financing right-of-use assets	192,591,624	64,614,781
Intangible assets, net	21,191,390	682,649
Goodwill, net	17,010,637	1,139,297
Other assets	423,426	456,085
Total assets	$ 431,751,985	$ 394,650,043
Liabilities and Equity		
Current liabilities:		
Accounts payable	$ 23,614,387	$ 13,582,664
Accounts payable - related parties	3,915,661	4,070,438
Lines of credit	2,623,479	72,055
Current portion of long-term debt	12,546,097	10,158,932
Operating lease liabilities, current portion	1,703,014	1,489,997
Financing lease liabilities, current portion	4,219,518	1,452,447
Accrued expenses and other current liabilities	6,240,813	6,864,426
Total current liabilities	54,862,969	37,690,959
Long-term debt, net	23,051,152	78,821,985
Operating lease liabilities, net	19,438,497	20,820,588
Financing lease liabilities, net	203,619,756	65,735,501
Deferred tax liabilities	10,452,211	-
Total liabilities	311,424,585	203,069,033
Commitments and contingencies		
Equity:		
Common stock, $0.001 par value; 900,000,000 shares authorized; 650,223,840 and 592,791,712 shares issued and outstanding as of December 31, 2022 and 2021, respectively	650,224	592,792
Additional paid-in capital	458,498,402	11,742,891
Retained earnings (accumulated deficit)	(363,285,925)	102,315,623
Nutex Health Inc. equity	95,862,701	114,651,306
Noncontrolling interests	24,464,699	76,929,704
Total equity	120,327,400	191,581,010
Total liabilities and equity	$ 431,751,985	$ 394,650,043

See accompanying notes to the consolidated financial statements.

NUTEX HEALTH INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Year ended December 31,		
	2022	2021	2020
Revenue:			
Hospital division	$ 198,508,245	$ 331,531,311	$ 274,029,061
Population health management division	20,786,061	-	-
Total revenue	219,294,306	331,531,311	274,029,061
Operating costs and expenses:			
Payroll	102,892,734	86,349,088	61,682,322
Contract services	37,567,131	17,050,957	13,447,912
Medical supplies	12,118,893	12,514,367	10,479,534
Insurance expense	9,718,723	7,643,224	5,963,845
Depreciation and amortization	13,131,374	7,662,464	5,898,361
Other	30,413,069	21,030,253	18,950,928
Total operating costs and expenses	205,841,924	152,250,353	116,422,902
Gross profit	13,452,382	179,280,958	157,606,159
Corporate and other costs:			
Acquisition costs	3,885,666	3,553,716	-
Impairment of goodwill	398,135,038	-	-
General and administrative expenses	18,030,832	5,462,344	4,432,272
Total corporate and other costs	420,051,536	9,016,060	4,432,272
Operating income (loss)	(406,599,154)	170,264,898	153,173,887
Interest expense, net	12,490,260	6,196,026	6,432,941
Other expense (income)	559,299	(5,422,144)	1,001,711
Income (loss) before taxes	(419,648,713)	169,491,016	145,739,235
Income tax expense	13,090,905	965,731	181,341
Net income (loss)	(432,739,618)	168,525,285	145,557,894
Less: net income (loss) attributable to noncontrolling interests	(7,959,172)	35,931,957	39,588,009
Net income (loss) attributable to Nutex Health Inc.	$ (424,780,446)	$ 132,593,328	$ 105,969,885
Earnings (loss) per common share			
Basic	$ (0.67)	$ 0.22	$ 0.18
Diluted	$ (0.67)	$ 0.22	$ 0.18

See accompanying notes to the consolidated financial statements.

NUTEX HEALTH INC.
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY

	Common Stock		Additional Paid-in	Retained Earnings	Noncontrolling	Total
	Shares	Amount	Capital	(Accumulated Deficit)	Interests	Equity
Balance at January 1, 2020	592,791,712	$592,792	$ 7,411,152	$ 21,075,011	$ 21,756,620	$ 50,835,575
Contributions	-	-	2,312,901	-	7,713,720	10,026,621
Distributions	-	-	-	(45,631,685)	(13,419,580)	(59,051,265)
Net income	-	-	-	105,969,885	39,588,009	145,557,894
Balance at December 31, 2020	592,791,712	592,792	$ 9,724,053	$ 81,413,211	$ 55,638,769	147,368,825
Contributions	-	-	2,018,838	-	19,734,935	21,753,773
Distributions	-	-	-	(111,690,916)	(32,647,007)	(144,337,923)
Deconsolidation of Kyle Assets, LLC	-	-	-	-	(1,728,950)	(1,728,950)
Net income	-	-	-	132,593,328	35,931,957	168,525,285
Balance at December 31, 2021	592,791,712	592,792	11,742,891	102,315,623	76,929,704	191,581,010
Reverse acquisition with Clinigence	50,961,109	50,961	436,449,305	-	194,747	436,695,013
Deconsolidation of Real Estate Entities	-	-	-	(6,466,946)	(32,336,946)	(38,803,892)
Notes payable converted to common stock	3,474,430	3,475	5,381,897	-	-	5,385,372
Common stock issued for exercise of warrants	2,147,252	2,147	4,116,994	-	-	4,119,141
Common stock issued for exercise of options	312,019	312	644,662	-	-	644,974
Rescission of warrant exercise	(819,000)	(819)	(25,572)	-	-	(26,391)
Equity financing agreement Lincoln Park Capital Fund, LLC	1,356,318	1,356	(1,356)	-	-	-
Stock-based compensation	-	-	189,581	-	-	189,581
Contributions	-	-	-	-	4,513,867	4,513,867
Distributions	-	-	-	(34,354,156)	(16,877,501)	(51,231,657)
Net loss	-	-	-	(424,780,446)	(7,959,172)	(432,739,618)
Balance at December 31, 2022	650,223,840	$650,224	$ 458,498,402	$ (363,285,925)	$ 24,464,699	$ 120,327,400

See accompanying notes to the consolidated financial statements.

NUTEX HEALTH INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year ended December 31,		
	2022	**2021**	**2020**
Cash flows from operating activities:			
Net income (loss)	$ (432,739,618)	$ 168,525,285	$ 145,557,894
Adjustment to reconcile net income (loss) to net cash from operating activities:			
Depreciation and amortization	13,131,374	7,662,464	5,898,361
Amortization of debt issuance costs	50,354	-	-
Impairment of goodwill	398,135,038	-	-
Stock-based compensation expense	189,581	-	-
Rescission of warrant exercise expense	561,651	-	-
Other income - gain on PPP loan forgiveness	-	(5,546,597)	-
Deferred tax expense	4,996,209	-	-
Debt accretion expense	1,902,475	50,273	62,405
(Gain) loss on lease termination	-	(109,494)	1,118,303
Non-cash lease expense	64,143	97,578	58,241
Changes in operating assets and liabilities:			
Accounts receivable	56,622,133	(5,392,614)	(71,234,706)
Accounts receivable - related party	1,454,934	(1,229,940)	-
Inventories	(719,107)	(1,088,489)	(825,773)
Prepaid expenses and other current assets	(1,419,139)	(233,114)	533,294
Accounts payable	10,018,100	6,365,978	3,826,271
Accounts payable - related party	(329,155)	(97,985)	2,404,307
Accrued expenses and other current liabilities	(1,311,865)	4,429,141	(726,840)
Net cash from operating activities	50,607,108	173,432,486	86,671,757
Cash flows from investing activities:			
Acquisitions of property and equipment	(14,632,414)	(36,926,591)	(61,188,768)
Acquired cash in reverse acquisition with Clinigence	12,716,228	-	-
Cash related to deconsolidation of Real Estates Entities	(2,421,212)	(48,853)	-
Net cash from investing activities	(4,337,398)	(36,975,444)	(61,188,768)
Cash flows from financing activities:			
Proceeds from lines of credit	2,623,479	-	1,000,000
Proceeds from notes payable	815,881	19,614,372	57,172,769
Repayments of lines of credit	(72,055)	(864,659)	(2,666,656)
Repayments of notes payable	(7,237,094)	(20,715,235)	(12,687,903)
Repayments of finance leases	(1,721,224)	(1,255,486)	(1,552,942)
Payment of debt issuance costs	-	(47,875)	(213,588)
Rescission of warrant exercise	(588,042)	-	-
Common stock issued for exercise of warrants	4,119,141	-	-
Common stock issued for exercise of options	644,974	-	-
Members' contributions	4,513,867	21,753,773	10,026,621
Members' distributions	(51,231,657)	(144,337,923)	(59,051,265)
Net cash from financing activities	(48,132,730)	(125,853,033)	(7,972,964)
Net change in cash and cash equivalents	(1,863,020)	10,604,009	17,510,025
Cash and cash equivalents - beginning of the year	36,118,284	25,514,275	8,004,250
Cash and cash equivalents - end of the year	$ 34,255,264	$ 36,118,284	$ 25,514,275

See accompanying notes to the consolidated financial statements.

NUTEX HEALTH INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 1 – Organization and Operations

Nutex Health Inc. ("Nutex Health" or the "Company"), is a physician-led, healthcare services and operations company with 19 hospital facilities in eight states (hospital division), and a primary care-centric, risk-bearing population health management division. Our hospital division implements and operates different innovative health care models, including micro-hospitals, specialty hospitals and hospital outpatient departments ("HOPDs"). The population health management division owns and operates provider networks such as independent physician associations ("IPAs") and offers a cloud-based proprietary technology platform to IPAs which aggregates clinical and claims data across multiple settings, information systems and sources to create a holistic view of patients and providers.

We employ 1,150 full- and part-time employees and partner with over 800 physicians. Our corporate headquarters is based in Houston, Texas. We were incorporated on April 13, 2000 in the state of Delaware.

Merger of Nutex Health Holdco LLC and Clinigence Holdings, Inc. On April 1, 2022, the merger (the "Merger") of Nutex Health Holdco LLC and Clinigence Holdings, Inc. ("Clinigence") was completed pursuant to the Agreement and Plan of Merger (the "Merger Agreement") entered on November 23, 2021 between Clinigence, Nutex Acquisition LLC, a Delaware limited liability company and wholly-owned subsidiary of Clinigence, Nutex, Micro Hospital Holding LLC (solely for the purposes of certain sections of the Merger Agreement), Nutex Health Holdco LLC and Thomas Vo, M.D., solely in his capacity as the representative of the equity holders of Nutex Health Holdco LLC.

In connection with the Merger Agreement, Nutex Health Holdco LLC entered into certain Contribution Agreements with holders of equity interests ("Nutex Owners") of subsidiaries and affiliates (the "Nutex Subsidiaries") pursuant to which such Nutex Owners agreed to contribute certain equity interests in the Nutex Subsidiaries to Nutex Health Holdco LLC in exchange for specified equity interests in Nutex Health Holdco LLC (collectively, the "Contribution Transaction"). Nutex owners having ownership interests representing approximately 84% of the agreed upon aggregate equity value of the Nutex Subsidiaries, agreed to contribute all or a portion of their equity interests, as applicable.

Pursuant to the Merger Agreement, each unit representing an equity interest in Nutex Health Holdco LLC issued and outstanding immediately prior to the effective time of the Merger but after the Contribution Transaction (collectively, the "Nutex Membership Interests") was converted into the right to receive 3.571428575 shares of common stock of Clinigence, or an aggregate of 592,791,712 shares of common stock of Clinigence.

Potential Future Stock Issuances. Under the terms of the Contribution Agreements, contributing owners of the under construction hospitals and ramping hospitals are eligible to receive a one-time additional issuance of Company common stock.

- With respect to ramping hospitals, 24 months after the opening date (the "Determination Date") of the applicable ramping hospital, such owner is eligible to receive such owner's pro rata share of a number of shares of Company Common Stock equal to (a)(i) the trailing twelve months earnings before interest, taxes, depreciation and amortization on the respective Determination Date, multiplied by (ii) 10, (iii) minus *the initial equity value received at the Closing of the Merger*, and (iv) minus such owner's pro rata share of the aggregate debt of the applicable ramping hospital outstanding as of the closing of the Merger. The number of additional shares to be issued will be determined based on the greater of (a) the price of the Company's common stock at the time of determination or (b) $2.80.

- With respect to under construction hospitals, contributing owners of under construction hospitals will be eligible to receive, on the Determination Date, such owner's pro rata share of a number of shares of Company common stock equal to (a)(i) the trailing twelve months earnings before interest, taxes, depreciation and amortization as of the Determination Date multiplied by (ii) 10, minus (iii) *the aggregate amount of such owner's capital contribution to the under construction hospital*, minus (iv) such owner's pro rata share of the aggregate debt of the applicable under construction hospital outstanding as of the Closing of the Merger, divided by (b) the greater of (i) the price of the Company common stock at the time of determination or (ii) $2.80.

After completing the merger, Clinigence was renamed Nutex Health Inc.

Lock-up agreements. Also on April 1, 2022, each member of Nutex Health Holdco LLC entered into a Lock-up agreement agreeing not to, without the prior written consent of the Company and except in limited circumstances (i) offer, pledge, sell, contract to sell, sell any option or contract purchase, purchase any option or contract to sell, grant any option, right or warrant to purchase or otherwise transfer or dispose of their shares of Company common stock received in the merger or (ii) enter into any swap or other agreement that transfers, in whole or in part, any of the economic consequences of ownership of such shares.

The lock-up restrictions terminated with respect to one-third of the shares of Company Common Stock on October 1, 2022. The lock-up restrictions terminate for the remaining shares on April 1, 2023 (one-third) and October 1, 2023 (final one-third).

Registration rights agreement. In September 2022, we filed a registration statement pursuant to a registration rights agreement dated as of April 1, 2022 and amended effective as of July 1, 2022, to register for resale one-third of the shares of Company common stock issued in the merger that were released from lockup restrictions on October 1, 2022. The registration rights agreement terminates on the earlier of (i) when the shares may be sold under Rule 144 without any restrictions or (ii) the dissolution or liquidation of the Company.

Note 2 - Summary of Significant Accounting Policies

Basis of presentation. The merger of Nutex Health Holdco LLC and Clinigence was accounted for as a reverse business combination with Nutex Health Holdco LLC as the accounting acquirer in accordance with ASC 805, *Business Combinations*, and Clinigence as the accounting acquiree. Our financial statements presented for periods prior to the merger date are those of Nutex Health Holdco, LLC, as the Company's predecessor entity. Subsequent to the merger date, our financial statements are presented on a consolidated basis including Clinigence.

The assets, including identified intangible assets, and liabilities of Clinigence were recorded at their fair values with the excess purchase price recorded as goodwill. The financial statements reflect the merger as the equivalent of the issuance of common stock for the net assets of Clinigence. The accounting for the merger did not affect the carrying values of the assets and liabilities of Nutex Health Holdco LLC.

Equity of the accounting acquirer, Nutex Health Holdco LLC, has been retroactively restated for the equivalent number of shares issued to the accounting acquirer. Similarly, shares outstanding and earnings per share have been also retroactively restated based on the equivalent number of shares issued to the accounting acquirer.

These financial statements present the Company's consolidated financial condition and results of operations including those of majority-owned subsidiaries and variable interest entities ("VIEs") for which we are the primary beneficiary.

The hospital division includes our healthcare billing and collections organization and hospital entities. In addition, we have financial and operating relationships with multiple professional entities (the "Physician LLCs") and real estate entities (the "Real Estate Entities"). The Physician LLCs employ the doctors who work in our hospitals. These entities are consolidated by the Company as VIEs because they do not have significant equity at risk, and we have historically provided support to the Physician LLCs in the event of cash shortages and received the benefit of their cash surpluses.

The Real Estate Entities own the land and hospital buildings which are leased to our hospital entities. The Real Estate Entities have mortgage loans payable to third parties which are collateralized by the land and buildings. We consolidate the Real Estate Entities as VIEs in instances where our hospital entities are guarantors or co-borrowers under their outstanding mortgage loans. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans.

The Company has no direct or indirect ownership interest in the consolidated Physician LLCs or Real Estate Entities, so 100% of the equity for these entities is shown as noncontrolling interests in the consolidated balance sheets and statements of operations. Many of the Physician LLCs and Real Estate Entities are owned in part and in some cases controlled by related parties including members of our executive management team.

The population health management division includes our management services organizations and a healthcare information technology company providing a cloud-based platform for healthcare organizations. In addition, Associated Hispanic Physicians of So. California ("AHISP"), an IPA entity that is not owned by us, but is consolidated as a VIE of our wholly-owned subsidiary AHP Health Management Services Inc. ("AHP") since AHP is the primary beneficiary of its operations and has 100% control of AHISP's operations through its management services agreement with AHISP.

All significant intercompany balances and transactions have been eliminated in consolidation.

Use of estimates. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include (i) estimates of net revenue and accounts receivable, (ii) fair value of acquired assets and liabilities in business combinations and (iii) impairment of long-lived assets and goodwill. Actual results could differ from those estimates.

Revenue recognition.

Hospital division – Our hospital division recognizes net patient service revenue for contracts with patients and in most cases a third-party payor (commercial insurance, workers compensation insurance or, in limited cases, Medicare/Medicaid). The Company's performance obligations are to provide emergency health care services primarily on an outpatient basis. Net patient service revenues are recorded at the amount that reflects the consideration to which the Company expects to be entitled in exchange for providing patient care. These amounts are net of appropriate discounts giving recognition to differences between the Company's charges and reimbursement rates from third party payors.

Patient service net revenues earned by the Company are recognized at a point in time when the services are provided, net of adjustments and discounts. Because all the Company's performance obligations relate to contracts with a duration of less than one-year, certain disclosures are limited.

The transaction price is determined based on gross charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts and implicit price concessions provided primarily to uninsured patients in accordance with the Company's policy. For uninsured patients, the Company recognizes revenue based on established rates, subject to certain discounts and implicit price concessions. The Company is reimbursed from third party payors under various methodologies based on the level of care provided. We are considered "out-of-network" with commercial health plans. As there are no contractual rates established with insurance entities, revenues are estimated based on the "usual and customary" charges allowed by insurance payors using historical collection experience, historical trends of refunds and payor payment adjustments (retractions). Revenue from the Medicare program is based on reimbursement rates set by governmental authorities.

Patients who have health care insurance may also have discounts applied related to their copayment or deductible. Estimates of contractual adjustments and discounts are determined by major payor classes for outpatient revenues based on historical experience. The Company estimates implicit price concessions based on its historical collection experience with these classes of patients using a portfolio approach. The portfolios consist of major payor classes for outpatient revenue. Based on historical collection trends and other analyses, the Company concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract-by-contract basis.

Customer payments are due upon receipt of an explanation of benefits for insured patients or it is due upon receipt of the bill from the Company for uninsured payments. There is no financing component associated with payments due from insurers or patients.

Population health management division – The population health management division recognizes revenue for capitation and management fees for services to IPAs and physician groups and for the licensing, training, and consulting related to our cloud-based proprietary technology.

Capitation revenue consists primarily of capitated fees for medical services provided by physician-owned entities we consolidate as VIEs. Capitated arrangements are made directly with various managed care providers including HMOs. Capitation revenues are typically prepaid monthly to us based on the number of enrollees selecting us as their healthcare provider. Capitation is a fixed payment amount per patient per unit of time paid in advance for the delivery of health care services, whereby the service providers are generally liable for excess medical costs.

We receive management fees that are based on gross capitation revenues of the IPAs or physician groups we manage. Revenue is recognized and received monthly for our services. In addition, we provide consultant services that are charged as a flat fixed rate and recognized as revenue when the service is performed. Consultant services revenues represent a small portion of our total revenue.

Software licenses are provided as SaaS-based subscriptions that grants access to proprietary online databases and data management solutions. Training and consulting are project based and billable to customers on a monthly-basis or task-basis. Revenue from training and consulting are generally recognized upon delivery of training or completion of the consulting project. The duration of training and consulting projects are typically a few weeks or months and last no longer than 12 months.

SaaS-based subscriptions are generally marketed under multi-year agreements with annual, semi-annual, quarterly, or month-to-month renewals and revenue is recognized ratably over the renewal period with the unearned amounts received recorded as deferred revenue. For multiple-element arrangements accounted for in accordance with specific software accounting guidance, multiple deliverables are segregated into units of accounting which are delivered items that have value to a customer on a standalone basis.

Cash payments for SaaS-based subscriptions received in advance of the satisfaction of our performance obligations are reported as deferred revenue and recognized as revenue over the period in which the performance obligations are satisfied. The Company completes its contractual performance obligations through providing its customers access to specified data through subscriptions for a service period, and training on consulting associated with the subscriptions. We primarily invoice our customers on a monthly basis and do not provide any refunds, rights of return, or warranties.

Cash and cash equivalents. The Company considers all highly liquid investments with an original maturity of three months or less to be cash and cash equivalents. The Company has cash amounts, that were at times material, held in covered banking institutions in excess of the insured amounts, but does not deem the risk of loss to be likely.

Intangible assets. Intangible assets include hospital operating licenses having indefinite lives; and acquired technology, relationships, contracts and trademark intangibles each having definite lives. Indefinite lived intangible assets are not amortized but instead are assessed for impairment at least annually, or when certain indicators of impairment exist on an interim basis. Definite lived intangible assets are amortized using the straight-line method over the estimated lives of the respective assets.

Goodwill. Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill is not amortized but instead is evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is more likely than not that impairment may exist.

Goodwill is tested for impairment at least annually by comparing the estimated fair values of our reporting units to their respective carrying values. We use an income method to estimate the fair value of these assets, which is based on forecasts of the expected future cash flows attributable to the respective assets. Significant estimates and assumptions inherent in the valuations reflect a consideration of other marketplace participants, and include the amount and timing of future cash flows (including expected growth rates and profitability). Estimates utilized in the projected cash flows include consideration of macroeconomic conditions, overall category growth rates, competitive activities, Company business plans and the discount rate applied to the cash flows. Unanticipated market or macroeconomic events and circumstances may occur, which could affect the accuracy or validity of the estimates and assumptions.

During the three months ended September 30, 2022, we determined that the estimated fair value of our population health management division reporting unit (representing the assets of Clinigence Holdings Inc. acquired in the reverse business combination) was less than its carrying value. Therefore, we conducted a second step of the goodwill impairment test to determine the implied fair value of the reporting unit's goodwill. In this analysis, we allocated the fair value of the reporting unit to identifiable assets and liabilities of the reporting unit. The residual fair value after this allocation was compared to the goodwill balance with the excess goodwill charged to expense. Based on this analysis, we recognized a non-cash impairment charge of $398.1 million, as revised, to reduce the carrying amount of goodwill for the population health management division reporting unit. As discussed in Note 20, we made a retrospective adjustment to reduce the amount of goodwill impairment expense from the $408.5 million previously recognized in our quarterly report on Form 10-Q for the period ended September 30, 2022 to $398.1 million.

We believe the estimates and assumptions utilized in our impairment testing are reasonable and are comparable to those that would be used by other marketplace participants. However, actual events and results could differ substantially from those used in our valuations. To the extent such factors result in a failure to achieve the level of projected cash flows used to estimate fair value for purposes of

establishing or subsequently impairing the carrying amount of goodwill and intangible assets, we may need to record additional non-cash impairment charges in the future.

Long-lived assets. The Company assesses the valuation of components of its property and equipment and other long-lived assets whenever events or circumstances indicate that the carrying value might not be recoverable. The Company bases its evaluation on indicators such as the nature of the assets, the future economic benefit of the assets, any historical or future profitability measurements and other external market conditions or factors that may be present. If such factors indicate that the carrying amount of an asset or asset group may not be recoverable, the Company determines whether an impairment has occurred by analyzing an estimate of undiscounted future cash flows at the lowest level for which identifiable cash flows exist. If the estimate of undiscounted cash flows during the estimated useful life of the asset is less than the carrying value of the asset, the Company recognizes a loss for the difference between the carrying value of the asset and its estimated fair value, generally measured by the present value of the estimated cash flows.

Stock-based compensation. We account for employee stock-based compensation using the fair value method. Compensation cost for equity incentive awards is based on the fair value of the equity instrument generally on the date of grant and is recognized over the requisite service period. Forfeitures are recognized as they occur.

The Company uses the Black-Scholes option pricing model to estimate the fair value of its stock options and warrants. The Black-Scholes option pricing model requires the input of highly subjective assumptions including the expected stock price volatility of the Company's common stock, the risk-free interest rate at the date of grant, the expected vesting term of the grant, expected dividends, and an assumption related to forfeitures of such grants. Changes in these subjective input assumptions can materially affect the fair value estimate of the Company's stock options and warrants.

Leases. Leases are capitalized on the Company's balance sheet through recognition of a liability for the discounted present value of future fixed lease payments and a corresponding right-of-use ("ROU") asset. The ROU asset recorded at commencement of the lease represents the right to use the underlying asset over the lease term in exchange for the lease payments. When readily determinable, the Company uses the interest rate implicit in a lease to determine the present value of future lease payments. For leases where the implicit rate is not readily determinable, the Company's incremental borrowing rate is utilized. The Company calculates its incremental borrowing rate on a quarterly basis using a third-party financial model that estimates the rate of interest the Company would have to pay to borrow an amount equal to the total lease payments on a collateralized basis over a term similar to the lease. The Company's lease agreements do not contain any material residual value guarantees or material restrictive covenants. Short-term leases which have an initial term of 12 months or less and do not have an option to purchase the underlying asset that is deemed reasonably certain to be exercised, are not recorded on the balance sheet. Rent expense for these short-term leases is recognized on a straight-line basis over the lease term, or when incurred if a month-to-month lease.

Convertible instruments. The Company bifurcates conversion options from their host instruments and account for them as free-standing derivative financial instruments when (a) the economic characteristics and risks of the embedded derivative instrument are not clearly and closely related to the economic characteristics and risks of the host contract, (b) the hybrid instrument that embodies both the embedded derivative instrument and the host contract is not re-measured at fair value under other GAAP with changes in fair value reported in earnings as they occur and (c) a separate instrument with the same terms as the embedded derivative instrument would be considered a derivative instrument.

The Company accounts for the conversion of convertible debt when a conversion option has been bifurcated using the general extinguishment standards. The debt and equity linked derivatives are removed at their carrying amounts and the shares issued are measured at their then-current fair value, with any difference recorded as a gain or loss on extinguishment of the two separate accounting liabilities.

Noncontrolling interests. Noncontrolling interests ("NCI") represent the portion of net assets in consolidated entities that are not owned by the Company. NCI is presented as a component of total equity in the consolidated balance sheets and the share of net income or loss attributable to noncontrolling interests is shown as a component of net income in the consolidated statements of operations.

Fair value measurements. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. We classify fair value balances based on the classification of the inputs used to calculate the fair value of a transaction. The three levels related to fair value measurements are as follows:

Level 1 — Observable inputs such as quoted prices in active markets for identical assets or liabilities.

Level 2 — Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active or other inputs that are observable or can be corroborated by observable market data.

Level 3 — Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities. This includes certain pricing models, discounted cash flow methodologies and similar techniques that use significant unobservable inputs.

The estimated fair value of accounts receivable, accounts payable, accrued expenses and notes payable approximate the carrying amount due to the relatively short maturity or time to maturity of these instruments. Accounts receivable and payable with related parties may not be arms-length transactions and therefore, may not reflect fair value.

Except for the initial valuation of intangible assets in connection with the reverse business combination with Clinigence discussed in Note 3 and the impairment of goodwill discussed above, there were no assets or liabilities that were re-measured at fair value on a non-recurring basis during the periods presented.

Advertising and marketing expense. The Company advertising and marketing expense consists of expense associated with marketing its brand and services via media outlets such as social media, billboards and publications. These costs are expensed as incurred.

Income taxes. We account for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of temporary differences by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statements of operations during the period in which the tax rate change becomes law. A valuation allowance against deferred tax assets is established if it is more likely than not that the related tax benefits will not be realized. In determining the appropriate valuation allowance, we consider the projected realization of tax benefits based on expected levels of future taxable income, available tax planning strategies and reversals of existing taxable temporary differences.

Each of the VIEs and other entities that are not wholly-owned are pass-through entities treated as partnerships for U.S. federal income tax purposes. No provision for federal income taxes is provided in the consolidated statements of operations for the noncontrolling interests associated with these entities.

We file tax returns in the U.S. and various state jurisdictions. With few exceptions, our returns for periods prior to 2017 are no longer subject to examination by tax authorities in these jurisdictions. We recognize the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. If a tax position meets the "more likely than not" recognition criteria, accounting guidance requires the tax position be measured at the largest amount of benefit greater than 50% likely of being realized upon ultimate settlement. We record income tax related interest and penalties, if any, as a component in the provision for income tax expense.

Earnings (loss) per share – Basic earnings (loss) per share amounts are calculated by dividing income available to common shareholders by the weighted average number of shares of common stock outstanding. Diluted earnings (loss) per share amounts are calculated by dividing net income by the weighted average number of shares of common stock and common stock equivalents outstanding. Common stock equivalents represent shares issuable upon the assumed conversion of outstanding convertible notes and the assumed exercise of common stock options and warrants outstanding.

Business combinations. The Company accounts for business combinations under the acquisition method of accounting. Under this method, identifiable assets acquired, the liabilities assumed, and any noncontrolling interest are recognized at their estimated fair values at the acquisition date. The excess of purchase price over the fair value amounts assigned to the assets acquired and liabilities assumed represents the goodwill amount resulting from the acquisition. Transaction costs are expensed as incurred.

Segment reporting. A public company is required to report descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. Aggregation of

similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet established criteria. The Company operates three reportable segments – the hospital division, the population health management division and the real estate division. The real estate division is comprised of the Real Estate Entities.

Variable interest entities. On an ongoing basis, as circumstances indicate the need for reconsideration, the Company evaluates each legal entity that is not wholly-owned by the Company in accordance with the consolidation guidance. The evaluation considers all of the Company's variable interests, including equity ownership, as well as management services agreements. A legal entity is determined to be a VIE if it (i) does not have sufficient equity to finance its activities without additional subordinated financial support; (ii) the entity is established with non-substantive voting rights; or (ii) the equity holders, as a group, lack the characteristics of a controlling financial interest. If an entity is determined to be a VIE, the Company evaluates whether the Company is the primary beneficiary.

The primary beneficiary analysis is a qualitative analysis based on power and economics. The Company consolidates a VIE if both power and benefits belong to the Company – that is, the Company (i) has the power to direct the activities of a VIE that most significantly influence the VIE's economic performance (power), and (ii) has the obligation to absorb losses of, or the right to receive benefits from, the VIE that could potentially be significant to the VIE (benefits). The Company consolidates VIEs whenever it is determined that the Company is the primary beneficiary.

Refer to Note 19 – "Variable Interest Entities" to the consolidated financial statements for information on the Company's consolidated VIEs. If there are variable interests in a VIE but the Company is not the primary beneficiary, the Company may account for the investment using the equity method of accounting.

Reclassifications. Financial statements presented for prior periods include reclassifications that were made to conform to the current year presentation.

Recent accounting pronouncements. There are no new accounting pronouncements that are expected to have a material impact on the consolidated financial statements.

Note 3 - Merger of Nutex Health Holdco LLC and Clinigence Holdings, Inc.

The merger of Nutex Health Holdco LLC and Clinigence was completed pursuant to the Merger Agreement on April 1, 2022. As discussed above, the merger was accounted for as a reverse business combination with Nutex Health Holdco LLC as the accounting acquirer and Clinigence as the accounting acquiree.

The fair value of purchase consideration transferred on the closing date includes the value of the shares of the combined company owned by Clinigence shareholders at closing of the merger and the fair value of Clinigence's outstanding and exercisable common stock options and warrants as determined using a Black-Scholes valuation model. The fair value per share of Clinigence's common stock was $6.40; its traded closing price on April 1, 2022. Total consideration in the merger (as revised, see Note 20) follows:

Fair value of Clinigence common shares at $6.40 per share (50,961,109 shares)	$	326,151,098
Fair value of Clinigence outstanding common stock options and warrants		110,543,915
Total consideration	$	436,695,013

The following is a revised estimate of the allocation of the total purchase consideration to acquired assets and assumed liabilities including the fair value of identified intangible assets as determined by independent valuation (a level 3 measurement):

Cash and cash equivalents	$	12,716,228
Accounts receivable, net		2,127,076
Prepaid expenses and other current assets		127,384
Property and equipment, net		14,793
Right of use asset, net		86,989
Intangible assets, net		21,668,000
Goodwill		414,006,378
Accounts payable and accrued expenses		(3,966,100)
Deferred revenue		(92,111)
Convertible notes payable, net		(3,771,858)
Term note payable		(674,526)
Lease liability		(91,238)
Deferred tax liability		(5,456,002)
Assets acquired	$	436,695,013

We made a retrospective change in the valuation of options and warrants assumed by us as part of the total consideration in the merger. This change reduced the fair value of consideration paid and goodwill by $10.3 million.

The preliminary fair values shown above are substantially complete. Additional purchase price adjustments may be recorded during the measurement period, but no later than one year from the date of the Merger. The Company reflects measurement period adjustments in the period in which the adjustments are recognized.

The intangible assets denoted above each have definite lives. These intangible assets are being amortized over their estimated useful lives of 5 to 16 years. Goodwill arising from the reverse business combination is not tax-deductible. We recognized a non-cash impairment charge of $398.1 million (as revised, see Note 20) in 2022 to reduce the carrying amount of goodwill arising in the reverse business combination.

The results of operations of Clinigence have been included in the Company's consolidated financial statements since the April 1, 2022 merger date. We expensed $3.9 million of acquisition-related costs for the merger in 2022 and $3.6 million in 2021. These costs consisted principally of legal, accounting and other professional fees for the transaction.

Supplemental Pro Forma Information – The supplemental pro forma financial information presented below is for illustrative purposes only and is not necessarily indicative of the financial position or results of operations that would have been realized if the merger with Clinigence had been completed on the date indicated, nor is it indicative of future operating results or financial position. The pro forma adjustments are based upon currently available information and certain assumptions that management believes are reasonable under the circumstances.

The supplemental pro forma financial information reflects pro forma adjustments to present the combined pro forma results of operations as if the acquisition had occurred on January 1, 2021, to give effect to certain events that management believes to be directly attributable to the acquisition. These pro forma adjustments primarily include an increase to depreciation and amortization expense that would have been recognized due to acquired tangible and intangible assets.

The supplemental pro forma financial information for the periods presented is as follows:

	Year ended December 31,		
	2022	2021	2020
Revenue	$ 225,503,481	$ 350,325,094	$ 275,615,013
Net income (loss) attributable to Nutex Health Inc.	(439,130,596)	119,763,791	98,893,032

The pro forma adjustment included in the pro forma loss above included $14.2 million of one-time stock-based compensation expense related to the merger transaction. Pro forma data does not purport to be indicative of the results that would have been obtained had these events actually occurred at the beginning of the period presented and is not intended to be a projection of future results.

Note 4 – Revenue

We disaggregate revenue from contracts with customers into types of services or products, consistent with our reportable segments, as follows:

	Year ended December 31,		
	2022	2021	2020
Hospital Division:			
Net patient service revenue	$ 197,254,222	$ 331,531,311	$ 274,029,061
Management fees	1,254,023	-	-
Total Hospital Division revenue	198,508,245	331,531,311	274,029,061
Population Health Management Division:			
Capitation revenue, net	15,493,432	-	-
Management fees	4,346,763	-	-
SaaS revenue	945,866	-	-
Total Population Health Management Division revenue	20,786,061	-	-
Total revenue	$ 219,294,306	$ 331,531,311	$ 274,029,061

Net patient service revenue. We receive payment for facility services rendered by us from federal agencies, private insurance carriers, and patients. The Physician LLCs receive payment for doctor services from these same sources. On average, greater than 90% of our net patient service revenue is paid by insurers, federal agencies, and other non-patient third parties. The remaining revenues are paid by our patients in the form of copays, deductibles, and self-payment. We generally operate as an out-of-network provider and, as such, do not have negotiated reimbursement rates with insurance companies. In the fourth quarter of 2022, we signed in-network provider contracts with the Provider Network of America (PNA).

The following tables present the allocation of the estimated transaction price with the patient between the primary patient classification of insurance coverage:

	Year ended December 31,		
	2022	2021	2020
Insurance	89%	96%	96%
Self pay	9%	3%	3%
Workers compensation	1%	1%	1%
Medicare/Medicaid	1%	0%	0%
Total	100%	100%	100%

The No Surprises Act ("NSA") is a federal law that took effect January 1, 2022, to protect consumers from most instances of "surprise" balance billing. The legislation was included in the Consolidated Appropriations Act, 2021, which was passed by Congress and signed into law by President Trump on December 27, 2020. With respect to the Company, the NSA limits the amount an insured patient will pay for emergency services furnished by an out-of-network provider. The NSA addresses the payment of these out-of-network providers by group health plans or health insurance issuers (collectively, "insurers"). In particular, the NSA requires insurers to reimburse out-of-network providers at a statutorily calculated "out-of-network rate." In states without an all-payor model agreement or specified state law, the out-of-network rate is either the amount agreed to by the insurer and the out-of-network provider or an amount determined through an independent dispute resolution ("IDR") process.

The "qualifying payment amount" (QPA) is generally the median of the contracted rates recognized by the plan or issuer under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the items or service is furnished, with annual increases based

on the consumer price index. In other words, the qualifying payment amount is typically the median rate the insurer would have paid for the service if provided by an in-network provider or facility.

Under the NSA, insurers must issue an initial payment or notice of denial of payment to a provider within thirty days after the provider submits a bill for an out-of-network service. If the provider disagrees with the insurer's determination, the provider may initiate a thirty-day period of open negotiation with the insurer over the claim. If the parties cannot resolve the dispute through negotiation, the parties may then proceed to IDR arbitration.

Since the NSA became effective January 1, 2022, our average payment by insurers of patient claims for emergency services has declined by approximately 30% including as much as a 37% reduction for physician services. In our experience, insurers often initially pay amounts lower than the QPA without regard for other information relevant to the claim. This requires us to make appeals using the IDR process. We submitted almost 28 thousand cases for IDR in 2022, most in the fourth quarter. The IDR process and subsequent appeals, should we pursue them, require extensive administrative time and delays in collections.

While we are working within the established processes for IDR, we have had varying successes at achieving collections at or higher than the established QPA.

Contract balances. Cash payments for SaaS-based subscriptions received in advance of the satisfaction of our performance obligations are reported as deferred revenue and subsequently recognized as revenue over the period in which the performance obligations are satisfied. The Company completes its contractual performance obligations through providing its customers access to specified data through subscriptions for a service period, and training on consulting associated with the subscriptions. We primarily invoice our customers on a monthly basis and do not provide any refunds, rights of return, or warranties. Deferred revenue is presented within accrued liabilities as current liabilities and totaled $99,143 as of December 31, 2022 and $0 as of December 31, 2021. We expect to recognize revenue for these amounts within the next twelve months.

Note 5 - Property and Equipment

The principal categories of property and equipment are summarized as follows:

	Useful Life (years)	December 31, 2022	December 31, 2021
Buildings and improvements	39	$ 8,521,996	$ 82,794,329
Land	-	3,721,576	18,201,804
Leasehold improvements	10-39	28,855,239	27,038,503
Construction in progress	-	19,389,329	4,299,614
Medical equipment	10	28,744,664	25,686,562
Office furniture and equipment	7	2,860,680	2,870,270
Computer hardware and software	5	1,713,434	1,288,224
Vehicles	5	135,590	161,590
Signage	10	1,163,722	1,160,195
Total cost		95,106,230	163,501,091
Less: accumulated depreciation		(13,011,878)	(11,588,591)
Total property and equipment, net		$ 82,094,352	$ 151,912,500

In the second quarter of 2022, we deconsolidated 17 Real Estate Entities. Refer to Note 19.

Depreciation and amortization of property and equipment for the years ended December 31, 2022, 2021 and 2020 totaled $4,851,849, $5,271,918, and $3,484,166 respectively.

Note 6 – Intangible Assets

The following tables provide detail of the Company's intangible assets:

Year ended December 31, 2022	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Useful Life (in years)
Amortizing intangible assets:				
Member relationships	$ 16,899,000	$ 844,950	$ 16,054,050	15
Management contracts	2,021,000	94,734	1,926,266	16
Customer contracts	914,000	45,700	868,300	15
Trademarks	1,425,000	112,525	1,312,475	7-12
PHP technology	409,000	61,350	347,650	5
Indefinite life intangible - license	682,649	-	682,649	-
Total	$ 22,350,649	$ 1,159,259	$ 21,191,390	
Year ended December 31, 2021				
Indefinite life intangible - license	$ 682,649	$ -	$ 682,649	-

Amortization of intangible assets for the years ended December 31, 2022, 2021 and 2020 totaled $1,159,259, $0 and $0, respectively.

Note 7 – Accrued Expenses and Other Current Liabilities

Accrued expenses and other current liabilities consisted of the following:

	December 31,	
	2022	2021
Accrued wages and benefits	$ 4,235,167	$ 3,088,264
Accrued taxes	1,029,790	-
Accrued other	975,856	3,776,162
Total accrued expenses and other current liabilities	$ 6,240,813	$ 6,864,426

Note 8 – Debt

The Company's outstanding debt is shown in the following table:

	Maturity Dates	Interest Rates	December 31, 2022	December 31, 2021
Term loans secured by all assets	04/2023 - 11/2030	3.25 - 6.00%	$ 11,341,934	$ 15,613,564
Term loans secured by property and equipment	01/2024 - 10/2029	4.19 - 6.90%	9,299,197	11,190,093
Line of credit secured by all assets	10/2022 - 01/2023	4.50 - 6.50%	2,623,479	72,055
Term loans of consolidated Real Estate Entities	08/2023 - 03/2037	3.59 - 4.80%	15,068,920	62,478,951
Total			38,333,530	89,354,663
Less: unamortized debt issuance costs			112,802	301,691
Less: short-term lines of credit			2,623,479	72,055
Less: current portion of long-term debt			12,546,097	10,158,932
Total long-term debt			$ 23,051,152	$ 78,821,985

Term loans and lines of credit. We have entered into private debt arrangements with banking institutions for the purchase of equipment and to provide working capital and liquidity through cash and lines of credit. Unless otherwise delineated above, these debt arrangements are obligations of Nutex and/or its wholly-owned subsidiaries. Consolidated Real Estate Entities have entered into private debt arrangements with banking institutions for purposes of purchasing land, constructing new emergency room facilities and building out leasehold improvements which are leased to our hospital entities. Nutex is a guarantor or, in limited cases, a co-borrower

on the debt arrangements of the Real Estate Entities for the periods shown. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans.

Certain outstanding debt arrangements require minimum debt service coverage ratios and other financial covenants. At December 31, 2022, we were not in compliance with the debt service coverage ratio for one term loan with an outstanding balance of $1.0 million. This balance has been included in current liabilities. At December 31, 2022, we had remaining availability of $2.1 million under outstanding lines of credit.

Convertible notes payable. We assumed $5,415,375 principal of convertible notes payable of Clinigence outstanding at the merger date. The convertible notes payable were fully converted into 3,474,430 shares of common stock at a conversion price of $1.55 per share before their maturity on July 31, 2022. Debt discount totaling $1,719,572 was accreted over four months to the maturity date of the convertible notes payable.

Scheduled Maturities. Maturities of our long-term debt are as follows:

Year ended December 31,		Amount
2023	$	15,169,576
2024		5,568,193
2025		4,082,321
2026		3,651,382
Thereafter		9,862,058
Total	$	38,333,530

Note 9 – Leases

We have entered into hospital property, office and equipment rental agreements with various lessors including related parties. The following tables disclose information about our leases of property and equipment:

	Year ended December 31,		
	2022	2021	2020
Operating lease cost	$ 2,969,789	$ 2,390,650	$ 1,223,510
Finance lease cost:			
Amortization of right-of-use assets	$ 7,120,266	$ 2,390,546	$ 2,414,195
Interest on lease liabilities	9,952,783	2,183,979	3,181,514
Total finance lease cost	$ 17,073,049	$ 4,574,525	$ 5,595,709
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows from operating leases	$ 2,778,767	$ 2,302,074	$ 1,165,269
Operating cash flows from finance leases	9,952,783	2,183,979	3,181,514
Financing cash flows from finance leases	1,721,224	1,255,486	1,712,036
Net cash paid for amounts included in the measurement of lease liabilities	$ 14,452,774	$ 5,741,539	$ 6,058,819
Right-of-use assets obtained in exchange for lease obligations:			
Operating leases	$ -	$ 13,992,943	$ 2,263,815
Finance leases	23,603,317	31,110,148	31,840,051
Total right-of-use assets obtained in exchange for lease obligations	$ 23,603,317	$ 45,103,091	$ 34,103,866
Weighted average remaining lease term (years):			
Operating leases	10	11	8.1
Finance leases	13	18	18
Weighted average discount rate:			
Operating leases	4%	4%	5%
Finance leases	3%	5%	5%

	Operating leases		Finance leases	
Minimum lease payments for the next five years:	Third-parties	Related parties	Third-parties	Related parties
2023	$ 2,386,210	$ 332,561	$ 1,767,982	$ 12,800,275
2024	2,371,152	342,538	1,433,686	13,013,737
2025	2,422,485	352,814	1,195,783	13,232,163
2026	2,334,239	363,399	1,225,678	13,455,675
2027	2,326,358	374,301	1,256,320	13,685,977
Thereafter	10,014,219	3,507,670	20,969,917	260,420,418
Total minimum lease payments	21,854,663	5,273,283	27,849,366	326,608,245
Less interest	(4,489,832)	(1,496,603)	(10,227,166)	(136,391,171)
Total lease liabilities	$ 17,364,831	$ 3,776,680	$ 17,622,200	$ 190,217,074

Note 10 – Commitments and Contingencies

Litigation. The Company, its consolidated subsidiaries or VIEs may be named in various claims and legal actions in the normal course of business. Based upon counsel and management's opinion, the outcome of such matters is not expected to have a material adverse effect on the consolidated financial statements.

Note 11 – Employee Benefit Plans

The Company's employees are eligible to participate in the 401(k) Savings Plan. There are no restrictions in eligibility to contribute to the 401(k) Savings Plan. Salary deferrals are allowed in amounts up to 100% of an eligible employee's salary, not to exceed the maximum allowed by law. Texarkana Emergency Center & Hospital, LLC ("Texarkana") is the only entity which may contribute a discretionary match up to 5% of its employees' salaries. For the years ended December 31, 2022, 2021 and 2020, Texarkana did not make significant discretionary contributions to the employee plan.

Note 12 – Stock-based Compensation

In 2022, the Company adopted the Amended and Restated Nutex Health Inc. 2022 Equity Incentive Plan (the "2022 Plan"). The maximum aggregate number of shares that may be issued under the 2022 Plan is 5,000,000 shares, subject to increases on January 1st of each calendar year through January 1, 2027 of up to 5% annually at the discretion of the compensation committee of our Board of Directors. A total of 2,416,221 shares were available for issuance under the 2022 Plan at December 31, 2022. Awards granted under the 2022 Plan have a ten-year term and may be incentive stock options, non-statutory stock options, restricted stock, restricted stock units, stock appreciation rights, performance units or performance shares. The awards are granted at an exercise price equal to the fair market value on the date of grant and generally vest over a four-year period.

Obligations for under-construction and ramping hospitals. Under the terms of the Merger Agreement, contributing owners of the under-construction hospitals and ramping hospitals are eligible to receive a one-time additional issuance of Company common stock based on their trailing twelve months earnings before interest, taxes, depreciation and amortization as determined 24 months after their respective opening, adjusted for, with respect to the ramping hospitals, the initial equity value received at the Closing of the Merger, and with respect to under-construction hospitals, the aggregate amount of such owner's capital contribution, and in each case, minus such owner's pro rata share of the aggregate debt of the applicable hospital outstanding as of the closing of the Merger. Such additional shares will be issued at the greater of (a) the price of the Company's common stock at the time of determination or (b) $2.80. We have not recognized any expense for this stock-based compensation based on our current estimates of future obligations to the contributing owners.

Restricted stock. On May 9, 2022, the Company issued 83,547 restricted common stock awards, valued at $325,000 to the board of directors to vest 1/12th per month over a 12-month period. In December 2022, the recipients of all restricted common stock awards agreed to the rescission and cancellation of all 83,547 awards. As a result, such shares are again available for grant under the 2022 Plan. We recognized stock-based compensation expense of $189,581 during 2022 for these awards.

Options. Clinigence had 6,500,010 options for the purchase of our common stock outstanding as of the merger date, all of which were fully vested and exercisable. The following table summarizes stock-based awards activity:

	Options Outstanding	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life (Years)
Options outstanding at April 1, 2022 merger date	6,500,010	$ 2.30	6.62
Options exercised	(312,019)	2.08	
Options cancelled	(1,040,221)	2.75	
Options outstanding at December 31, 2022	5,147,770	$ 2.32	7.60

Options outstanding as of December 31, 2022 consisted of:

Expiration Date	Number Outstanding	Number Exercisable	Exercise Price
March 15, 2025	157,196	157,196	$ 4.47
January 27, 2027	180,000	180,000	1.50
May 11, 2027	350,000	350,000	1.50
June 6, 2027	3,600	3,600	36.25
August 16, 2027	25,000	25,000	2.51
January 28, 2028	180,000	180,000	1.61
January 27, 2030	296,865	296,865	1.50
February 28, 2030	95,794	95,794	1.25
June 30, 2030	117,056	117,056	1.45
August 4, 2029	40,480	40,480	5.56
January 28, 2031	1,000,000	1,000,000	1.61
February 28, 2031	200,000	200,000	2.00
September 9, 2031	1,934,779	1,934,779	2.75
September 9, 2031	410,000	410,000	2.75
December 17, 2031	157,000	157,000	3.50
Total	5,147,770	5,147,770	

Note 13 – Equity

We are authorized to issue up to a total of 900,000,000 shares of common stock having a par value of $0.001 per share. Holders of our common stock are entitled to one vote for each share held of record on all matters submitted to a vote of stockholders and to receive ratably in proportion to the shares of common stock held by them any dividends declared from time to time by the board of directors. Our common stock has no preferences or rights of conversion, exchange, pre-exemption or other subscription rights.

Common Stock Issued. Following is a discussion of common stock issuances during the periods presented. All issuances referenced above were unregistered and were exempt from the registration requirements of the Securities Act of 1933, as amended, under Section 4(a)(2).

- At the time of the Merger, Clinigence had 50,961,109 common shares outstanding. These amounts are shown as issued by us in the presentation of consolidated financial statements as the accounting acquiror.
- During 2022, we issued 3,474,430 common shares for the conversion of outstanding convertible notes payable of $5,385,371.
- In the second quarter of 2022, we issued 2,147,252 common shares for the exercise of warrants for total proceeds of $4,119,141.
- In the second quarter of 2022, we issued 312,019 common shares for the exercise of options for total proceeds of $644,974.
- In November 2022, we agreed to the rescission of the May 2022 exercise of 819,000 common stock warrants by a third-party. For accounting purposes, this was treated as a repurchase of the issued common stock for $588 thousand and modification of the warrant agreement for $561 thousand. We recognized $1.2 million of expense for this modification.
- On November 14, 2022, Nutex Health and Lincoln Park Capital Fund, LLC entered into a purchase agreement and registration rights agreement (together, the "Agreement") pursuant to which Nutex Health will have the right, in its sole discretion, but not the obligation, to sell to Lincoln Park up to $100 million worth of shares of its common stock over the 36-month term of the Agreement, subject to terms and conditions as provided in the Agreement, including the filing and effectiveness of a registration statement.

In connection with the execution of such purchase agreement, the Company issued 1,356,318 shares of Common Stock to the Investor as a commitment fee. No other shares of Common Stock have been sold under the purchase agreement with the Investor.

Common Stock Warrants. Clinigence had 12,401,240 common stock warrants outstanding as of the merger date. Warrant activity follows:

	Warrants Outstanding	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life (years)
Warrants outstanding at April 1, 2022 merger date	12,401,240	$ 2.04	4.65
Warrants exercised	(2,187,225)	2.27	
Warrants cancellation of exercised	819,000	1.55	
Warrants outstanding at December 31, 2022	11,033,015	$ 1.96	3.80

Warrants outstanding as of December 31, 2022 consisted of:

Expiration Date	Number Outstanding	Number Exercisable	Exercise Price
February 5, 2023	1,500	1,500	$ 25.00
April 27, 2023	1,500	1,500	25.00
December 31, 2024	554,873	554,873	6.67
October 31, 2025	16,250	16,250	1.25
October 31, 2025	1,566,451	1,566,451	1.55
February 26, 2026	288,235	288,235	4.00
July 31, 2026	2,532,900	2,532,900	1.55
February 1, 2027	1,456,453	1,456,453	1.55
May 31, 2027	4,614,853	4,614,853	1.75
Total	11,033,015	11,033,015	

Note 14 – Income Taxes

Income tax expense consisted of the following:

	Year ended December 31,		
	2022	2021	2020
Current taxes:			
Federal	$ 6,396,753	$ -	$ -
State	1,682,682	965,731	181,341
Deferred taxes:			
Federal	4,292,445	-	-
State	719,025	-	-
Total income tax expense	$ 13,090,905	$ 965,731	$ 181,341

In periods before our merger with Clinigence, Nutex Health Holdco LLC and the Nutex Subsidiaries were pass-through entities treated as partnerships for U.S. federal income tax purposes. No provision for federal income taxes was provided for these periods as federal taxes were obligations of these companies' members. After the merger, Nutex Health Holdco LLC became a wholly-owned subsidiary of Clinigence and is included in its consolidated corporate tax filings. We recognized a non-cash charge of $21.3 million to income tax expense during 2022 for the change in tax status of Nutex Health Holdco LLC. This charge provides for the accumulated net deferred tax liabilities representing the differences between the book and tax bases of Nutex Health Holdco LLC's assets and liabilities as of the April 1, 2022 change in tax status.

At the time of our merger with Clinigence, Clinigence had a full valuation allowance against its deferred tax assets. We recorded a non-cash benefit of $2.4 million to income tax expense to remove the acquired valuation allowance after we concluded that the associated deferred tax assets would be realizable.

Each of the discrete items above, as well as the non-deductible goodwill impairment expense also recognized 2022, are one-time, non-cash items.

The items accounting for differences between income taxes computed at the federal statutory rate and the provision recorded for income taxes were as follows:

	Year ended December 31,		
	2022	2021	2020
Income taxes computed at the federal statutory rate	$ (88,126,230)	$ 35,593,113	$ 30,605,239
Effect of:			
State taxes, net of federal benefits	(17,962,513)	965,731	181,341
Income of flow-through entities	(2,185,760)	(35,593,113)	(30,605,239)
Change in tax status of Nutex Health Holdco LLC	21,312,374	-	-
Reversal of acquired Clinigence valuation allowance	(2,393,178)	-	-
Non-deductible goodwill impairment expense	100,682,261	-	-
Other, net	1,763,951	-	-
Total income tax expense	$ 13,090,905	$ 965,731	$ 181,341

Deferred tax assets and liabilities were as follows:

	December 31,	
	2022	2021
Deferred tax assets:		
Net operating loss carryforwards	$ 1,713,060	$ -
Accrued liabilities	626,730	-
Financing leases	4,090,455	-
Other	2,533,271	-
Total deferred tax assets	8,963,516	-
Deferred tax liabilities:		
Cash to accrual adjustments	(7,938,712)	-
Property and equipment	(6,018,796)	-
Intangible assets	(5,458,219)	-
Total deferred tax liabilities	(19,415,727)	-
Net deferred tax liabilities	$ (10,452,211)	$ -

Note 15 – Earnings per Share

The following is the computation of earnings (loss) per basic and diluted share:

	Year ended December 31,		
	2022	2021	2020
Amounts attributable to Nutex Health Inc.:			
Numerator-			
Net income (loss) attributable to common stockholders	$ (424,780,446)	$ 132,593,328	$ 105,969,885
Denominator:			
Weighted average shares used to compute basic and diluted EPS	634,877,629	592,791,712	592,791,712
Earnings (loss) per share:			
Basic	$ (0.67)	$ 0.22	$ 0.18
Diluted	$ (0.67)	$ 0.22	$ 0.18

The computation of diluted earnings per common share excludes the exercise of 2,335,402 common stock options and 4,212,724 warrants for the year ended December 31, 2022. The dilutive effect of the assumed exercise of outstanding options and warrants was calculated using the treasury stock method.

Note 16 - Supplemental Cash Flows Information

	Year ended December 31		
	2022	2021	2020
Cash paid for interest	$ 4,622,106	$ 4,102,167	$ 3,254,159
Cash paid for income taxes	8,233,000	335,340	181,341
Non-cash investing and financing activities:			
Financed capital expenditures	18,473,184	-	-
Acquisition of financing leases	23,603,317	31,110,148	31,840,051
Termination of financing leases	-	-	47,861,030
Modification of warrant	561,651	-	-
Reverse acquisition with Clinigence	436,695,013	-	-
Deconsolidation of Real Estate Entities	(38,803,892)	-	-
Notes payable converted to common stock	5,385,372	-	-
Rescission of warrant exercise	(26,391)	-	-

Note 17 – Segment Information

We report the results of our operations as three segments in our consolidated financial statements: (i) the hospital division, (ii) the population health management division and (ii) the real estate division. The determination of our reporting segments was made on the basis of our strategic priorities, which corresponds to the manner in which our Chief Executive Officer, as our chief operating decision maker, reviews and evaluates operating performance to make decisions about resources to be allocated. We evaluate the performance of our reportable segments based on, among other measures, operating income, which is defined as income before interest expense, other income (expense), and taxes. Corporate costs primarily include expenses for support functions and salaries and benefits for corporate employees and are excluded from segment operating results.

Reportable segment information, including intercompany transactions, is presented below:

	Year ended December 31,		
	2022	2021	2020
Revenue from external customers:			
Hospital division	$ 198,508,245	$ 331,531,311	$ 274,029,061
Population health management division	20,786,061	-	-
Total revenue	$ 219,294,306	$ 331,531,311	$ 274,029,061
Segment operating income (loss):			
Hospital division	$ 13,064,913	$ 179,280,958	$ 157,606,159
Population health management division	387,469	-	-
Total segment operating income (loss)	$ 13,452,382	$ 179,280,958	$ 157,606,159
Capital expenditures:			
Hospital division	$ 5,926,119	$ 13,660,343	$ 10,788,948
Real estate division	8,706,295	23,266,248	50,399,820
Total capital expenditures	$ 14,632,414	$ 36,926,591	$ 61,188,768
Revenue from inter-segment activities:			
Real estate division	$ 269,699	$ 10,471,333	$ 18,540,922
Depreciation and amortization:			
Hospital division	$ 11,967,649	$ 7,624,816	$ 5,829,912
Population health management division	1,162,864	-	-
Real estate division	861	37,648	68,449
Total depreciation and amortization	$ 13,131,374	$ 7,662,464	$ 5,898,361

	December 31,	
	2022	2021
Assets:		
Hospital division	$ 314,085,287	$ 222,637,352
Population health management division	77,825,753	-
Real estate division	39,840,945	172,012,691
Total Assets	$ 431,751,985	$ 394,650,043

Note 18 – Related Party Transactions

Related party transactions included the following:

- The Physician LLCs employ the doctors who work in our hospitals. We have no direct ownership interest in these entities but they are owned and, in some instances, controlled by related parties including our CEO, Dr. Thomas Vo. The Physician LLCs are consolidated by the Company as VIEs because they do not have significant equity at risk, and we have historically provided support to them in the event of cash shortages and received the benefit of their cash surpluses. Amounts due from Physician LLCs totaled $0 at December 31, 2022 and $1,891,147 at December 31, 2021. These amounts are eliminated in the consolidation of these VIEs except as noted below.

- In connection with the merger with Clinigence, we forgave certain amounts due from Physician LLCs for past advances made by us in support of their operations. We recognized net expense of $1,506,650 in the three months ended March 31, 2022 as general and administrative expense in the consolidated statements of operations. No such expense was recognized subsequently.

- The Physician LLCs had outstanding obligations to their member owners, who are also Company stockholders, totaling $2,058,701 at December 31, 2022 and $2,675,195 at December 31, 2021 are reported within accounts payable – related party in our consolidated balance sheets.

- Most of our hospital division facilities are leased from real estate entities which are owned by related parties. These leases are typically on a triple net basis where our hospital division is responsible for all operating costs, repairs and taxes on the facilities. Our obligations under these leases are presented in Note 9. During the years ended December 31, 2022, 2021 and 2020, we made cash payments for these lease obligations totaling $13,016,727, $10,736,652 and $5,492,007, respectively.

  We received $1,245,000 of cash in the three months ended June 30, 2022 as a lease incentive from an affiliated Real Estate Entity not consolidated by us. This incentive was included in the determination of our financing lease obligations to this entity.

- We consolidate Real Estate Entities as VIEs when they do not have sufficient equity at risk and our hospital entities are guarantors or co-borrowers under their outstanding mortgage loans. The consolidated Real Estate Entities have mortgage loans payable to third parties which are collateralized by the land and buildings. We have no direct ownership interest in these entities but they are owned and, in some instances, controlled by related parties including our CEO. During the second quarter of 2022, we deconsolidated 17 Real Estate Entities after the third-party lenders released our guarantees of associated mortgage loans. At December 31, 2022, three Real Estate Entities continue to be consolidated in our financial statements.

- In connection with the merger with Clinigence, we forgave certain amounts due from Real Estate Entities for past advances made by us. We recognized net expense totaling $553,259 in the three months ended March 31, 2022 as other expense in the consolidated statements of operations. No such expense was recognized subsequently.

- We made advances to unconsolidated entities owned by related parties that we lease facilities from. These advances totaled $0 at December 31, 2022 and $1,288,354 at December 31, 2021 and are reported as accounts receivable – related party in our consolidated balance sheets. These amounts are due on demand and bear no interest.

- Accounts receivable – related party included $538,184 at December 31, 2022 and $600,044 at December 31, 2021 due from noncontrolling interest owners of consolidated ER Entities.

- Micro Hospital Holding LLC, an affiliate controlled by our CEO, made advances to one of our hospital facilities, SE Texas ER. These advances totaled $1,424,948 at December 31, 2022 and December 31, 2021 and are reported as accounts payable – related party in our consolidated balance sheets. The advances have no stated maturity and bear no interest.

- Accounts payable – related party in our consolidated balance sheets included $2,500 at December 31, 2022 and $0 at December 31, 2021 for reimbursement of expenses incurred on our behalf.

- We provide managerial services to emergency centers owned and, in some instances, controlled by related parties including an entity controlled by our CEO. We recognized $1,151,284, $1,841,399 and $1,227,918 of managerial fees within the hospital division in the years ended December 31, 2022, 2021 and 2020, respectively, for these services.

- Two of our ER Entities are obligated under managerial services agreements with related parties commencing in 2022. Payments under these agreements totaled $1,671,855 for the year ended December 31, 2022.

Note 19 – Variable Interest Entities

The following tables provide the balance sheet amounts for consolidated VIEs:

	December 31, 2022		
	Real Estate Entities	Physician LLCs	AHP IPA
Current assets	$ 23,089,459	$ 6,915,710	$ 6,641,448
Property and equipment, net	16,726,986	3,668	-
Other long-term assets	24,500	-	16,553,040
Total assets	$ 39,840,945	$ 6,919,378	$ 23,194,488
Current liabilities	2,326,335	4,831,617	23,163,808
Long-term liabilities	15,019,633	-	30,680
Total liabilities	17,345,968	4,831,617	23,194,488
Equity	22,494,977	2,087,761	-
Total liabilities and equity	$ 39,840,945	$ 6,919,378	$ 23,194,488

	December 31, 2021	
	Real Estate Entities	Physician LLCs
Current assets	$ 10,959,090	$ 22,035,457
Property and equipment, net	32,182,902	-
Long-term assets	128,870,699	4,279
Total assets	$ 172,012,691	$ 22,039,736
Current liabilities	6,666,690	5,070,706
Long-term liabilities	68,850,689	930,000
Total liabilities	75,517,379	6,000,706
Equity	96,495,312	16,039,030
Total liabilities and equity	$ 172,012,691	$ 22,039,736

The assets of each of the ER Entities may only be used to settle the liabilities of that entity or its consolidated VIEs and may not be required to be used to settle the liabilities of any of the other ER Entities, other VIEs, or corporate entity. Additionally, the assets of corporate entities cannot be used to settle the liabilities of VIEs. The Company has aggregated all of the Physician LLCs and Real
for each VIE would not add more useful information.

Real Estate Entities are consolidated by the Company as VIEs because they do not have sufficient equity at risk and our hospital entities are guarantors of their outstanding mortgage loans. We have been working with the third-party lenders to remove our guarantees of their outstanding mortgage loans. As these guarantees are released, the associated Real Estate Entity no longer qualifies as a VIE and is deconsolidated. In the second quarter of 2022, we deconsolidated 17 Real Estate Entities. There was no gain or loss on the deconsolidation of these entities.

At the date we deconsolidated these Real Estate Entities, they had $2,421,212 of cash, $98,086,690 of fixed assets (principally land and building), $533,874 of other assets, $69,638,778 of liabilities (principally mortgage indebtedness) and $31,402,998 of equity reported as noncontrolling interests.

Note 20 – Quarterly Financial Data (Unaudited)

The following table presents statements of operations financial data for third quarter ended September 30, 2022, which was retrospectively changed, and for the fourth quarter ended December 31, 2022:

	Year ended December 31, 2022	
	Q3 [1]	Q4
Total revenue	$ 28,395,058	$ 53,724,073
Total operating costs and expenses	54,863,504	53,193,749
Gross profit (loss)	(26,468,446)	530,324
Corporate and other costs:		
Impairment of goodwill	398,135,038	-
General and administrative expenses	4,077,255	6,309,235
Total corporate and other costs	402,212,293	6,309,235
Operating loss	(428,680,739)	(5,778,911)
Interest expense, net	3,402,606	2,862,071
Other expense (income)	(630,450)	212,426
Income (loss) before taxes	(431,452,895)	(8,853,408)
Income tax expense	(8,543,880)	1,805,176
Net loss	(422,909,015)	(10,658,584)
Less: net income (loss) attributable to noncontrolling interests	(10,722,749)	4,093,593
Net loss attributable to Nutex Health Inc.	$ (412,186,266)	$ (14,752,177)
Earnings (loss) per common share		
Basic	$ (0.63)	$ (0.02)
Diluted	$ (0.63)	$ (0.02)

(1) As discussed in Note 3, we made a retrospective change in the valuation of options and warrants assumed by us as part of the total consideration in the merger with Clinigence. This change reduced the fair value of consideration paid and goodwill arising from the reverse business combination by $10.3 million.

In our quarterly report on Form 10-Q for the period ended September 30, 2022, we reported a non-cash impairment charge of $408.5 million to reduce the carrying amount of goodwill for the population health management division reporting unit. This amount was retrospectively lowered by $10.3 million because of the changes made to the fair value of consideration paid and goodwill arising from the reverse business combination.

Note 21 - Subsequent Events

The Company has evaluated subsequent events through the filing of this report and determined that there have been no events that have occurred that would require adjustments to our disclosures in the consolidated financial statements except for the transaction described below:

In February 2023, we closed one micro-hospital and two hospital outpatient department locations in our hospital division. The estimated closing costs include employee severance totaling approximately $162 thousand and non-cash lease right-of-use asset impairment expense totaling approximately $20.5 million.

In February 2023, the Company opened a new micro-hospital in Fort Smith, Arkansas.

On January 18, 2023, we issued 702,285 shares in a cashless exercise of warrants in a transaction exempt from registration.

* * * * *

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 as that term is defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act that are designed to ensure that information required to be disclosed by the Company in reports that it files or submits 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 ("CEO") and our Chief Financial Officer ("CFO"), as appropriate, to allow timely decisions regarding required disclosures. Any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives. In accordance with Rule 13a-15(b) of the Exchange Act, we have evaluated, under the supervision of our CEO and our CFO, the effectiveness of disclosure controls and procedures as of December 31, 2022. Based on this evaluation, the Company concluded that our disclosure controls and procedures were ineffective as of December 31, 2022 due to the material weakness identified as described below.

Material Weaknesses. In connection with the preparation of the Company's annual consolidated financial statements, management assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in the *Internal Control-Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the "COSO criteria").

Based on this assessment, the following material weaknesses have been identified:

- The Company did not design and implement logical access controls for certain financially relevant systems. Business process controls, both automated and manual, that are dependent upon the information derived from those financially relevant systems were also determined to be ineffective as a result of such deficiency;

- Business process controls across the entity's financial reporting processes were not effectively designed and implemented to properly address the risk of material misstatement, including controls without proper segregation of duties between preparer and reviewer and key management review controls; and

- Ineffective design and implementation of controls over the completeness and accuracy of information included in key spreadsheets supporting the financial statements.

Each of these material weaknesses is further described in Part II, Item 9A. Management has concluded that, based on applying the COSO criteria, as of December 31, 2022, the Company's internal control over financial reporting was not effective to provide reasonable assurance of the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

Remediation Plans. These material weaknesses did not result in a material misstatement of the Company's consolidated financial statements for the periods presented. The Company has started the process of designing and implementing effective internal control measures to remediate the reported material weaknesses. The Company's efforts include implementing a new enterprise-wide system that will help us in reducing reliance on manual processes and spreadsheets supporting the financial statements. We expect to complete this implementation in 2023. Additionally, the Company plans to engage a firm to assist in the proper design, implementation and testing of internal controls over financial reporting. We expect to add key senior management positions including a Chief Operating Officer and a SEC financial reporting manager as well in the near term. We have also already made some additions to our accounting and financial reporting teams in early-2023.

While we believe that these efforts will improve our internal control over financial reporting, our remediation efforts are ongoing and will require validation and testing of the design and operating effectiveness of internal controls. The actions that we are taking are subject to ongoing senior management review, as well as audit committee oversight. We will not be able to conclude whether the steps we are taking will fully remediate the remaining material weakness in our internal control over financial reporting until we have completed our remediation efforts and subsequent evaluation of their effectiveness. We may also conclude that additional measures may be required to remediate the material weakness in our internal control over financial reporting.

Changes in Internal Control Over Financial Reporting. We are taking actions to remediate the material weakness relating to our internal control over financial reporting, as described above. Except as otherwise described herein, there were no changes in our internal control over financial reporting (as defined in Rule 13a-15(f) under the Exchange Act) that occurred during the period covered by this Quarterly Report that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Disclosure Controls and Procedures. Our senior members of management do not expect that our disclosure controls and procedures or our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. 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.

Item 9B. Other Information

None.

Item 9C. Disclosures Regarding Foreign Jurisdiction that Prevent Inspections

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item is incorporated herein by reference to our Proxy Statement for the 2023 Annual Meeting of Stockholders, which is expected to be filed with the SEC within 120 days after the close of our fiscal year.

Item 11. Executive Compensation

The information required by this Item is incorporated herein by reference to our Proxy Statement for the 2023 Annual Meeting of Stockholders, which is expected to be filed with the SEC within 120 days after the close of our fiscal year.

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 our Proxy Statement for the 2023 Annual Meeting of Stockholders, which is expected to be filed with the SEC within 120 days after the close of our fiscal year.

Item 13. Certain Relationships and Related Persons Transactions

The information required by this Item is incorporated herein by reference to our Proxy Statement for the 2023 Annual Meeting of Stockholders, which is expected to be filed with the SEC within 120 days after the close of our fiscal year.

Item 14. Principal Accountant Fees and Services

The information required by this Item is incorporated herein by reference to our Proxy Statement for the 2023 Annual Meeting of Stockholders, which is expected to be filed with the SEC within 120 days after the close of our fiscal year.

Item 15. Exhibits and Financial Statement Schedules

(a) *The following documents are filed as part of this Report:*

	Management Report on Internal Control Over Financial Reporting
(1)	Reports of Independent Registered Public Accounting Firm (PCAOB ID Number 688)
	Consolidated Balance Sheets as of December 31, 2022 and 2021
	Consolidated Statements of Operations for the Years Ended December 31, 2022, 2021 and 2020
	Consolidated Statements of Equity (Deficit) for the Years Ended December 31, 2022, 2021 and 2020
	Consolidated Statements of Cash Flows for the Years Ended December 31, 2022, 2021 and 2020
	Notes to Consolidated Financial Statements

(b) *Exhibits:*

Exhibit No	Description	Incorporated by Reference (File No. 000-53862) Form	Exhibit	File Date
2.1	Agreement and Plan of Merger, dated as of February 25, 2021 by and among the Registrant, AHP, Merger Sub, and the Signing Stockholder	8- K	2.1	Mar. 2, 2021
2.2	Agreement and Plan of Merger, dated as of February 25, 2021 by and among the Registrant, AHA, and Merger Sub	8-K	2.3	Mar. 2, 2021
2.3	Agreement and Plan of Merger dated as of November 23, 2021 among Clinigence Holdings, Inc., Nutex Acquisition LLC, Nutex Health Holdco LLC, Micro Hospital Holding LLC (solely for the purposes of certain Sections), Nutex Health LLC (solely for the purposes of certain Sections) and Thomas T. Vo in his capacity as the Nutex Representative	8-K	99.1	Nov. 24, 2021
2.4	Agreement and Plan of Merger dated effective as of October 21, 2021, by and between Clinigence Holdings, Inc., Clinigence Procare Health, Inc., Procare Health, Inc. Anh Nguyen and Tram Nguyen	8-K	2.1	Oct. 21, 2021
2.5	Form of Contribution Agreement (Under Construction Hospitals) as of November 23, 2021 by and among Nutex Health Holdco LLC and the owners listed on the signature pages thereto	10-Q	2.5	Aug. 22, 2022
2.6	Form of Contribution Agreement (Ramping Hospitals) as of November 23, 2021 by and among Nutex Health Holdco LLC and the owners listed on the signature pages thereto	10-Q	2.6	Aug. 22, 2022
2.7	Form of Contribution Agreement (Mature Hospitals) as of November 23, 2021 by and among Nutex Health Holdco LLC and the owners listed on the signature pages thereto	10-Q	2.7	Aug. 22, 2022
3.1	Amended and Restated Certificate of Incorporation of Clinigence Holdings, Inc. filed April 1, 2022	10-Q	3.1	Aug. 22, 2022
3.2	Second Amended and Restated Bylaws	8-K	3.2	Apr. 4, 2022
4.1	Note Purchase Agreement dated May 15, 2019.	10-K	4.1	May 14, 2020
4.2	Form of Convertible Promissory Note November 18, 2019	8-K	10.2	Nov. 22. 2019
4.3	Form of Warrant November 18, 2019	8-K	10.3	Nov. 22. 2019
4.4	2019 Omnibus Equity Incentive Plan	S-8 (333-267710)	10.2	Sep. 30, 2022
4.5	Amended and Restated Nutex Health Inc. 2022 Equity Incentive Plan	S-8 (333-267710)	10.1	Sep. 30, 2022
4.6	Description of Common Stock	10-Q	4.6	Aug. 22, 2022
4.7	Registration Rights Agreement dated as of September 21, 2021 by and among Clinigence Holdings, Inc. and Apollo Medical Holdings, Inc.	10-Q	4.7	Aug. 22, 2022
4.8	Registration Rights Agreement dated as of April 1, 2022 by and among Nutex Health Inc. and the stockholders of Nutex Health Holdco LLC set forth on Schedule A thereto	S-3 (333-267686)	4.4	Apr. 11, 2022
4.9	Amendment No. 1 dated as of July 1, 2022 to Registration Rights Agreement dated as of April 1, 2022	10-Q	4.9	Aug. 22, 2022
4.10	Registration Rights Agreement dated as of November 14, 2022 between Nutex Health Inc. and Lincoln Park Capital Fund, LLC	8-K	10.2	Nov. 18, 2022

10.1	Master Services Agreement dated as of February 25, 2021 by and between AHA Management, Inc. and AHPIPA	8-K	2.2	Mar. 2, 2021
10.2	Intellectual Property Asset Purchase Agreement, dated as of May 27, 2020 by and among the Registrant, Clinigence Health, AHA, and AHA Analytics	8-K	2.1	Jun. 3, 2020
10.3	Intellectual Property License Agreement, dated as of May 27, 2020 by and between Clinigence Health and AHA Analytics	8-K	2.2	Jun. 3, 2020
10.4	Managed Services Agreement, dated as of May 27, 2020 by and between Clinigence Health and AHA Analytics	8-K	2.3	Jun. 3, 2020
10.5	Securities Purchase Agreement between Clinigence Holdings, Inc. and Apollo Medical Holdings, Inc. dated as of September 21, 2021	8-K	3.02	Oct. 1, 2021
10.6	Form of Board of Directors Agreement	8-K	10.1	Apr. 26, 2022
10.7	Employment Agreement between Thomas T. Vo and Clinigence Holdings, Inc. (to be renamed Nutex Health Inc.) dated as of April 1, 2022	8-K	10.1	Apr. 4, 2022
10.8	Employment Agreement between Warren Hosseinion and Clinigence Health Holdings, Inc. (to be renamed Nutex Health Inc.) dated April 1, 2022	8-K	10.2	Apr. 4, 2022
10.9	Employment Agreement, dated as of June 8, 2022, between the Company and Jon Bates.	8-K	10.2	Jun. 10, 2022
10.10	Employment and Transition Agreement, dated as of June 8, 2022, between the Company and Michael Bowen	8-K	10.1	Jun. 10, 2022
10.11	Form of Commercial Lease Agreement (Hospital Entities) including Parent Guarantee (Nutex Health Inc.)	10-Q	10.11	Aug. 22, 2022
10.12	Form of Construction Loan Agreement (Hospital Entities) including Personal Guarantee (Related Parties)	10-Q	10.11	Aug. 22, 2022
10.13	Purchase Agreement dated as of November 14, 2022 between Nutex Health Inc. and Lincoln Park Capital Fund, LLC	8-K	10.1	Nov. 18, 2022
10.14*	Form of Restricted Stock Award Rescission Agreement			
10.15	Partial Option Cancellation Agreement	8-K	10.1	Jan. 4, 2023
21.1*	List of Subsidiaries			
23.1	Consent of Marcum LLP			
31.1*	Certification of the Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.			
31.2*	Certification of the Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.			
32.1**	Certification of the Chief Executive Officer Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.			
32.2**	Certification of the Chief Financial Officer Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.			
101.INS*	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.			
101.SCH*	XBRL Taxonomy Extension Schema Document.			
101.CAL*	XBRL Taxonomy Extension Calculation Linkbase Document.			
101.DEF*	XBRL Taxonomy Extension Definition Linkbase Document.			
101.LAB*	XBRL Taxonomy Extension Label Linkbase Document.			
101.PRE*	XBRL Taxonomy Extension Presentation Linkbase Document.			
104	Cover Page Interactive Data File - The cover page interactive data file does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.			

* Filed herewith

** Furnished herewith. This exhibit shall not be deemed "filed" for the purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to the liability of that section. Further, this exhibit shall not be deemed to be incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended.

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.

March 2, 2023	/s/ Thomas T. Vo
	Thomas T. Vo, M.D. Chief Executive Officer and Chairman of the Board (principal 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 dates indicated.

March 2, 2023	/s/ Thomas T. Vo
	Thomas T. Vo, M.D. Chief Executive Officer and Chairman of the Board (principal executive officer)
March 2, 2023	/s/ Jon C. Bates
	Jon C. Bates Chief Financial Officer (principal financial officer and principal accounting officer)
March 2, 2023	/s/ Warren Hosseinion
	Warren Hosseinion President and Director
March 2, 2023	/s/ Matthew S. Young
	Matthew S. Young, M.D. Director
March 2, 2023	/s/ John Waters
	John Waters, CPA Director
March 2, 2023	/s/ Cheryl Grenas
	Cheryl Grenas, R.N., M.S.N. Director
March 2, 2023	/s/ Michael L. Reed
	Michael L. Reed Director
March 2, 2023	/s/ Mitchell Creem
	Michell Creem Director

NUTEX HEALTH INC.

RESTRICTED STOCK AWARD RESCISSION AGREEMENT

This Restricted Stock Award Rescission Agreement (this "Rescission Agreement") is entered into as of December [•], 2022 (the "Rescission Date"), by and between [NAME] (the "Director") and Nutex Health Inc. (the "Company"), (each, a "Party" and collectively, the "Parties").

RECITALS

WHEREAS, the Director and the Company are parties to that certain Restricted Stock Award Agreement (the "Award Agreement") dated as of May 9, 2022 (the "Grant Date"), a copy of which is attached as Exhibit A hereto;

WHEREAS, under the Award Agreement, the Director was granted [NUMBER] shares of common stock, par value $0.001 per share, of the Company ("Common Stock"), subject to vesting (see below) under the Amended and Restated Nutex Health Inc. 2022 Equity Incentive Plan dated as of April 1, 2022 (the "Award");

WHEREAS, under the terms of the Award Agreement the Award is scheduled to vest in equal 12 monthly increments with the last vesting date on March 31, 2023;

WHEREAS, under the Board of Directors Agreement dated as of April 20, 2022, the Director is entitled to an annual retainer ("Annual Retainer") of $150,000 which may be payable, in the discretion of the Compensation Committee, 50% in cash and 50% as equity consideration;

WHEREAS, it was the intent of the Compensation Committee for the Award to represent the 50% of the equity consideration portion of the Annual Retainer;

WHEREAS, subsequent to the Grant Date, due to the significant decline in the Company's stock price, the Parties discovered that any tax liability as a result of the Award may exceed the current value of the Award and accordingly, the Board has determined that any equity based awards with respect to the current fiscal year should be granted under the Company's 2023 compensation policy, especially in light of the volatility of the Company's stock price after the reverse merger;

WHEREAS, each Party hereto has determined that it is in the best interest of the Parties to rescind the Award *ab initio* in accordance with Revenue Ruling 80-58, 1980-1 C.B. 181, and to revoke the terms and conditions set forth in the Award Agreement; and

WHEREAS, no consideration has been paid or promised to either Party in order to induce assent to the rescission of the Award.

NOW, THEREFORE, the Parties hereto do hereby agree as follows:

1. Rescission of the Award. The Award is hereby unconditionally and irrevocably rescinded *ab initio*, and is neither valid nor effective in any manner whatsoever. Each Party hereby acknowledges that he or it has been restored to the position such Party was in immediately before the Award was granted and the Award Agreement was executed. In connection with the rescission of the Award, the Parties agree as follows:

    a. The Parties hereto individually and jointly agree that all terms, conditions, covenants, representations and warranties in the Award Agreement are null and void *ab initio* and of no further force or effect.

b. The Parties agree that any and all assets, property, securities or items of value that may have been assigned or transferred pursuant to the terms of the Award are hereby transferred and re-conveyed to the respective Party that assigned and/or transferred such items under the terms of the Award.

c. The Parties shall treat the Award and Award Agreement as rescinded for all purposes and shall take no action inconsistent with such treatment.

d. This Rescission Agreement and the rescission of the Award are binding upon each of the Parties and their respective legal representatives, successors and assigns and shall become effective automatically without further act on the part of any Party upon execution of this Rescission Agreement.

e. The Parties acknowledge and agree that no consideration has been paid or promised to any Party to enter into this Rescission Agreement.

f. It is intended that the rescission of the Award meet the requirements of Revenue Ruling 80-58, 1980-1 C.B. 181 and that this Rescission Agreement shall be construed and interpreted in accordance with such intent.

g. Any election under Section 83(b) filed subsequent to the Grant Date shall, as a result of the rescission, have no effect since the rescission of the award eliminated the underlying compensation event to which the Section 83(b) election applies.

h. Any shares of Common Stock issued as a result of the Award will be treated as if they had not been issued under the Plan and will be available for future issuance under the Plan.

2. Mutual Release of Liabilities. Effective as of the Rescission Date, each Party, for itself and each of its respective successors and assigns, hereby fully and unconditionally releases and forever discharges the other Party, and their successors and assigns, of and from any and all actions, causes of action, suits, debts, obligations, claims, liabilities, and demands whatsoever that such Party has or may have in connection with or under the terms of the Award and the Award Agreement. Each Party hereby covenants to the other Party that with respect to any claim or obligation released by this Rescission Agreement, it will not directly or indirectly encourage, solicit, or voluntarily assist or participate in any way in the filing, reporting, or prosecution by itself or any third party of a suit, arbitration, mediation, or claim (including a third-party or derivative claim) against the other Party relating to any such released claim or obligation.

3. Miscellaneous. This Rescission Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. For purposes of this Rescission Agreement, use of a facsimile, e-mail, or other electronic medium shall have the same force and effect as an original signature. This Rescission Agreement constitutes the final, complete, and exclusive statement of the agreement of the Parties with respect to the subject matter hereof, and supersedes any and all other prior and contemporaneous agreements and understandings, both written and oral, between the Parties. If any provision of this Rescission Agreement is held invalid or unenforceable by any court of competent jurisdiction, the other provisions of this Rescission Agreement will remain in full force and effect. Any provision of this Rescission Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable. This Rescission Agreement shall be governed by and construed in accordance with the laws of the State of Texas without regard to conflicts of laws principles.

[*signature page follows*]

IN WITNESS WHEREOF, the Parties hereto have executed this Rescission as of the date first above written.

DIRECTOR

_____
Name:

NUTEX HEALTH INC.

By: _____
Name: Elisa V. Luqman
Title: Chief Legal Officer

NUTEX HEALTH INC.

SUBSIDIARIES

Company	Jurisdiction of Organization
Nutex Health Holdco LLC	Delaware
Tyvan LLC	Texas
Nutex Health LLC	Texas
Clinigence Health, Inc.	Delaware
AHP Health Management Services, Inc.	Delaware
Procare Health Inc.	California
Accountable Healthcare America, Inc.	Delaware
South Florida Physicians IPA, Inc. (100% Owned Subsidiary of Accountable Healthcare America, Inc.)	Florida

Listed below are the subsidiaries of Nutex Health Holdco LLC, their jurisdictions of incorporation and the respective ownership percentages held by Nutex Health Holdco LLC in such subsidiaries:

Subsidiary of Nutex Health Holdco LLC	Nutex Health Holdco LLC Ownership %	Jurisdiction of Incorporation
ABQ Hospital, LLC	100.00%	New Mexico
Albuquerque ER LLC	100.00%	New Mexico
Alexandria Hospital LLC	99.50%	Louisiana
Columbus ER Hospital, LLC	100.00%	Ohio
Covington Hospital, LLC	64.36%	Louisiana
East Valley Hospital, LLC	100.00%	Arizona
Everest Real Estate Investments, LLP	100.00%	Texas
Fort Myers Hospital, LLC	100.00%	Florida
Fort Smith Emergency Hospital LLC	83.00%	Arkansas
Gahanna Hospital, LLC	100.00%	Ohio
Breen Bay Hospital, LLC	75.00%	Wisconsin
Healthcare HL Emergency Services LLC	64.17%	Texas
Jacksonville ER & Hospital LLC	60.00%	Florida
Kyle ER LLC	46.32%	Texas
Little Rock Hospital 1, LLC	81.99%	Arkansas
Maricopa Hospital, LLC	100.00%	Arizona
Miami ER & Hospital, LLC	67.00%	Florida
Milwaukee Hospital, LLC	80.00%	Wisconsin
NB Hospital, LLC	61.00%	Texas
Northwest Indiana Hospital LLC	74.90%	Indiana
Oklahoma ER Hospital, LLC	68.70%	Oklahoma
Phoenix ER and Medical Hospital, L.L.C.	100.00%	Arizona
Royse City ER, LLC	89.50%	Texas
Starkey Hospital LLC	62.00%	Florida
Texarkana ER LLC	100.00%	Texas
Texoma ER LLC	100.00%	Texas
Topeka ER Hospital LLC	100.00%	Kansas
Tucson Hospital LLC	100.00%	Arizona
Tulsa ER & Hospital LLC	79.62%	Oklahoma
Vance Jackson Hospital, LLC	61.00%	Texas
Wylie ER, LLC	80.17%	Texas

Exhibit 23.1

INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM'S CONSENT

We consent to the incorporation by reference in the Registration Statements of Nutex Health, Inc. on Form S-3 (File No. 333-267686) Form S-8 (File No. 333-267710) and Form S-3 (File No. 333.269191) of our report dated March 2, 2023, with respect to our audits of the consolidated financial statements of Nutex Health, Inc. as of December 31, 2022 and 2021 and for each of the three the years in the period ended December 31, 2022, and our report dated March 2, 2023 with respect to our audit of internal control over financial reporting of Nutex Health, Inc. as of December 31, 2022,which reports are included in this Annual Report on Form 10-K of Nutex Health, Inc. for the year ended December 31, 2022.

Our report on the effectiveness of internal control over financial reporting expressed an adverse opinion because of the existence of material weaknesses.

/s/ Marcum llp

Marcum llp

Houston, Texas
March 2, 2023

Exhibit 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO RULE 13A-14(A) AND RULE 15D-14(A)
OF THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED

I, Thomas Vo, certify that:

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

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

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

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

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

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

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

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

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

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

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

March 2, 2023

/s/ Thomas Vo
Chief Executive Officer

Exhibit 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO RULE 13A-14(A) AND RULE 15D-14(A)
OF THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED

I, Jon Bates, certify that:

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

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

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

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

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

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

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

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

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

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

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

March 2, 2023

/s/ Jon Bates
Chief Financial Officer

Exhibit 32.1

CERTIFICATION OF
CHIEF EXECUTIVE OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350 AS ADOPTED PURSUANT TO SECTION 906 OF THE
SARBANES OXLEY ACT OF 2002

Solely for the purposes of complying with 18 U.S.C. s.1350 as adopted pursuant to section 906 of the Sarbanes-Oxley act of 2002, I, the undersigned Chief Executive Officer of Nutex Health Inc. (the "Company"), hereby certify, based on my knowledge, that the Annual Report on Form 10-K of the Company for the year ended December 31, 2022, (the "Report") fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934 and that information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

March 2, 2023

/s/ Thomas Vo
Chief Executive Officer

Exhibit 32.2

CERTIFICATION OF
CHIEF FINANCIAL OFFICER
PURSUANT TO 18 U.S.C. SECTION 1350 AS ADOPTED PURSUANT TO SECTION 906 OF THE
SARBANES OXLEY ACT OF 2002

Solely for the purposes of complying with 18 U.S.C. s.1350 as adopted pursuant to section 906 of the Sarbanes-Oxley act of 2002, I, the undersigned Chief Financial Officer of Nutex Health Inc. (the "Company"), hereby certify, based on my knowledge, that the Annual Report on Form 10-K of the Company for the year ended December 31, 2022, (the "Report") fully complies with the requirements of Section 13(a) of the Securities Exchange Act of 1934 and that information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

March 2, 2023

/s/ Jon Bates
Chief Financial Officer