

Sector Spotlight

Radiology

What the labor shortage, AI and M&A market mean for the value of your radiology group



Three Forces Are Reshaping the M&A Market for Radiology Groups

HARD-TO-STAFF COVERAGE CREATES LEVERAGE

\$100-300K

in annual hospital support per radiologist in stressed coverage contracts

Radiologist supply is growing, but attrition, subspecialty gaps, hard-to-staff geographies, and onsite and call requirements leave many practices and health systems short. Groups that reliably deliver scarce coverage hold leverage.

Pages 3 and 4

AI: WHO CAPTURES THE GAINS WHEN THEY COME?

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today, FDA-authorized systems that issue a final diagnostic-radiology report without clinician review

Drafting, triage, measurements and worklist tools are advancing under radiologist supervision. Adoption depends on evidence, integration, payment and liability, and regulatory approval, not capability alone.

Pages 5 to 8

DEAL FLOW HAS RETURNED, BUT FEW ACTIVE PRACTICE BUYERS

4 of 37

Four of 37 deals in the last 12 months involved standalone radiologist groups. Three were one buyer: Premier.

Deal volume has rebounded, but capital now buys imaging centers, technology and teleradiology capacity. The number of buyers is much smaller than 2018-2022, and concentrated in three acquirers. For a seller, buyer fit matters. Premier is active in teleradiology. A full-service group may need to anchor a new platform to create real competition.

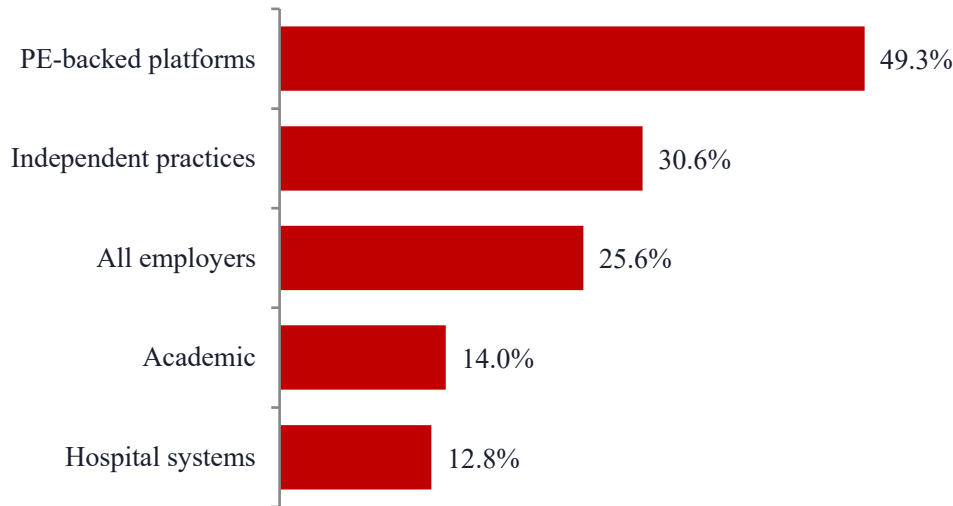
Pages 9 to 17

The pages that follow cover each force, the buyers behind it, and what each means for practice value and sale options.

Our view: groups that reliably solve hard-to-staff hospital coverage and retain the radiologists to sustain it are in an unusually strong negotiating position today. Long-term contracts and hospital support make that position durable, whether the group grows or sells. Radiology M&A is growing again, but with limited buyers. AI leaves the central question open: who captures the gains when they come?

Health Systems Are Struggling to Staff Coverage. That Gap is an Opening.

SHARE OF JOB POSTINGS OFFERING REMOTE WORK, BY EMPLOYER TYPE



Hospital systems offer remote work on one of every eight job postings. PE-backed platforms recruit remote-friendly telerad roles, which are easier to fill, and fill them fast. The rest goes unstaffed: onsite coverage and procedures stay with whoever can provide them.

Platforms are focused on remote capacity. Onsite coverage, procedures, call and certain geographies are still unsolved, and hospitals pay to solve them. Hybrid groups that staff both sides often have considerable leverage.

IN-PERSON HOSPITAL ROLES SIT OPEN FOR MONTHS

84% of postings from a hospital-based private-practice composite, mostly in-person roles, sat **open past 60 days**, vs. **1% for the largest PE-backed platform**. One academic system reposted the same radiologist opening 28 times in 78 days.

WHEN COVERAGE BREAKS

Chattanooga, July 2026: a multistate health system replaced the local radiology group it had used for decades with an offshore teleradiology provider. Within weeks, physicians there reported multi-week report delays, imaging diverted to outside facilities, nonradiologists providing preliminary reads, and a pause in outpatient imaging.

SO HOSPITALS PAY

\$100-300K per radiologist in annual support (advisory estimate), and groups are hiring advisors to negotiate subsidies and per-RVU guarantees. When a group fails, replacement teleradiology coverage runs \$80+ per wRVU (practitioner-reported), often more than keeping the group would have cost.

Behind the Deals: There Is Not One Radiologist Market. There Are Two.

ONE RADIOLOGIST JOB MARKET CLEARS FAST

1 in 4

radiology job postings closes within a week

80% vs 30%

80% of pediatric and emergency postings close within two weeks, vs. about 30% for body and MSK

THE OTHER MARKET IS STUCK

1 in 5

active openings sat open for more than 60 days

\$550K

top-of-range pay in the most stuck states vs. \$725K in fast-cycling states. The stuck jobs pay less, not more

Remote-friendly roles, certain subspecialties and outpatient reading clear faster.

Onsite presence, call and hard-to-staff geographies stay open for months. Low-population states run stuck rates 40% higher than large ones.

What separates the two markets is the work, not the pay. Onsite and call jobs sit open for months, while fully remote telerad roles clear fast. Much of the fast market is contractor work, often read for two or three companies at once. The bench is thinning: attrition doubled by 2022, subspecialists leave at higher rates, and 79% of surveyed practices are short in breast imaging. For owners: the unfilled work is often where the extra pay is. Hospitals pay support dollars and premium rates for coverage they cannot staff and for one group that can cover it all.

Two ways to win. In teleradiology, scale wins: a deep radiologist bench and high study volume allow large platforms to route reads efficiently, maintain turnaround times, and pay radiologists competitively. In harder-to-staff markets, the winner is the group that can cover the jobs others cannot. Reliable coverage can earn hospital support payments and multi-year contracts. Both models depend on recruiting and retaining radiologists.

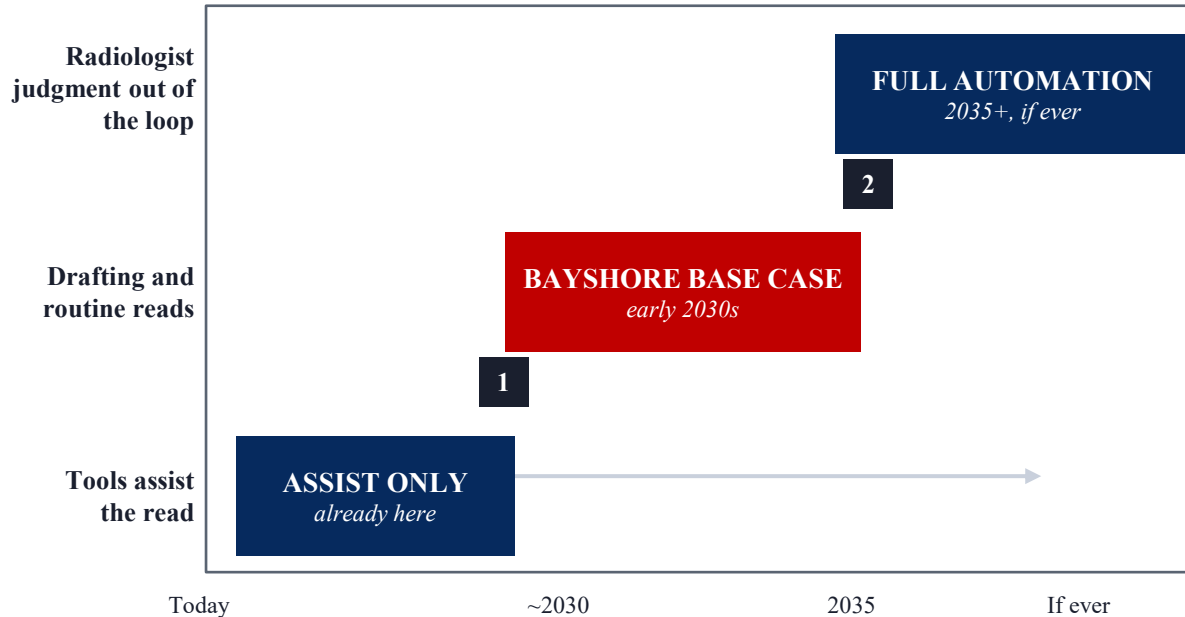
AI: The Tools Are Real, the Gains Are Narrow Today, and Replacement Is Far Off

WHAT THE CLEARED TOOLS DO		WHO ACTUALLY USES THEM		OUR ASSESSMENT	
Triage	Most cleared tools flag one finding: a bleed, a clot, a nodule. The best evidence is in stroke and pulmonary embolism triage	1,100+	Radiology-panel AI authorizations, mostly flagging one finding on one modality. Groups that adopt run a few tools, not a thousand.	Advancing	The technology is improving quickly, and drafting will become a standard part of the job this decade
Measure	Automated measurements may save seconds or minutes on a read. They do not change who reads or who is responsible for findings.	1 in 3	1 in 3 radiologists use AI in practice, and hospitals that buy it run about three tools on average. Most radiologists still work without it.	Blocked	The FDA clears tools one at a time and denied even a partial exemption in 2026. No CMS code pays for autonomous reads. No med-mal carrier has priced the liability.
Draft	Impressions draft themselves today. Full drafts work on chest X-rays first (RP, research use); all X-ray types and CT are next	~1 hr/day	Users describe editing drafts and saving up to an hour a day.	Our call	Assistive AI everywhere; autonomous reading narrow and slow. Europe cleared normal chest X-rays in 2022; four years later, still in pilots. Radiologists still sign and own the findings.

Our view: The radiologist shortage drives the market today, but buyers with long investment horizons must underwrite AI's impact. They will favor groups that adopt proven tools to realize efficiency gains while protecting quality control and data rights.

How Much of the Radiologist's Work Moves to AI, and When: Our Three Cases

HOW MUCH OF THE RADIOLOGIST'S WORK MOVES TO AI



FDA AND LIABILITY SET THE PACE

1 FDA. Each tool and each indication needs its own FDA clearance (the 2026 exemption denial kept it that way). Slows the climb; does not stop it.

2 Liability. Someone other than the signing radiologist must own errors. Med-mal, payment and the courts all say the radiologist and the group keep the risk today.

The AutoCAD analogue. When a design fails, the firm whose licensed engineer stamped the drawings is liable, not Autodesk. Software and drafting support may do much of the work, **but the engineer reviews and signs it**. Our base case for radiology is similar: vendors sell the tools, radiologists sign the studies, and groups retain the risk and final sign-off.

ASSIST ONLY. Radiologist shortage persists, pay keeps rising. AI adopters gain at the margin.

BASE CASE. Output per radiologist climbs; commodity read rates fall. Durable contracts provide near-term protection. Risk: hospitals take reading in-house, or platforms use AI economics to underbid for the contract.

FULL AUTOMATION. Demand falls toward surplus. Cannot happen unless the FDA opens a pathway and liability moves off the radiologist. Could also lift imaging volume sharply. Watch: a CMS pay code, a carrier providing insurance for AI reads.

The AI productivity gains are likely; who captures them is not. Our base case: radiologists stay in the loop and read far more, with imaging volume absorbing part of the added capacity. The big gains will take time: better tools, FDA clearances and liability coverage all have to arrive first.

Radiology AI: A Crowded Vendor Market Benefits Radiology Groups and Health Systems

WHY NO SINGLE VENDOR IS LIKELY TO DOMINATE

400+

radiology AI products already on the market, with many more in development

300+ / 100+

applications from 100+ vendors on one enterprise imaging AI marketplace

\$5.6B+

raised by medical imaging AI companies since 2015

1,163

FDA radiology-panel AI authorizations; 68 added in Q1 2026 alone

Many category winners, not one dominant vendor. Multiple developers already target the same workflow steps. In draft reporting alone, the field includes Aidoc First Read, Rad AI, HOPPR and Harrison, plus tools owned by Radiology Partners (Cognita) and RadNet (DeepHealth). As products overlap, vendors must compete for radiology groups' and health systems' business on price, performance, integration and service.

TWO WAYS TO ACCESS AI

OWN THE TOOLS

Radiology Partners paid about \$80 million for Cognita.

Ownership brings control, but also requires continued investment and leaves the owner exposed if competing tools improve faster.

LICENSE THE TOOLS

Lumexa chose third-party AI. Its SEC filing says this approach is faster, requires less capital, benefits from other companies' development spending and preserves the ability to switch as the technology changes.

What competition means at the negotiating table. Overlapping products let groups compare vendors on price, performance, integration and service. The main risk is lock-in once a tool is embedded in your PACS and reporting.

Our view: most private practices are better served licensing AI than buying or developing their own. Licensing requires less capital and preserves flexibility as the many products in development improve and winners emerge.

The PACS Era through Post-COVID: Radiologists Read More, Got Paid Less per Study, but Still Earned More Overall

+63%

average radiologist pay over the past decade, \$351K to \$571K, driven by scarcity and volume (Medscape surveys)

-43%

inflation-adjusted Medicare payment per RVU (the conversion factor), 2005 to 2023. Volume, not price, drove income

+70.3%

work RVUs per FTE radiologist, 1991-92 to 2006-07; procedures per FTE +34%

-2.5%

CMS 2026 efficiency adjustment cutting payment for most non-time-based services, including imaging interpretation

5.9x

annual ED visits involving CT, 2.7M to 16.2M, 1995 to 2007

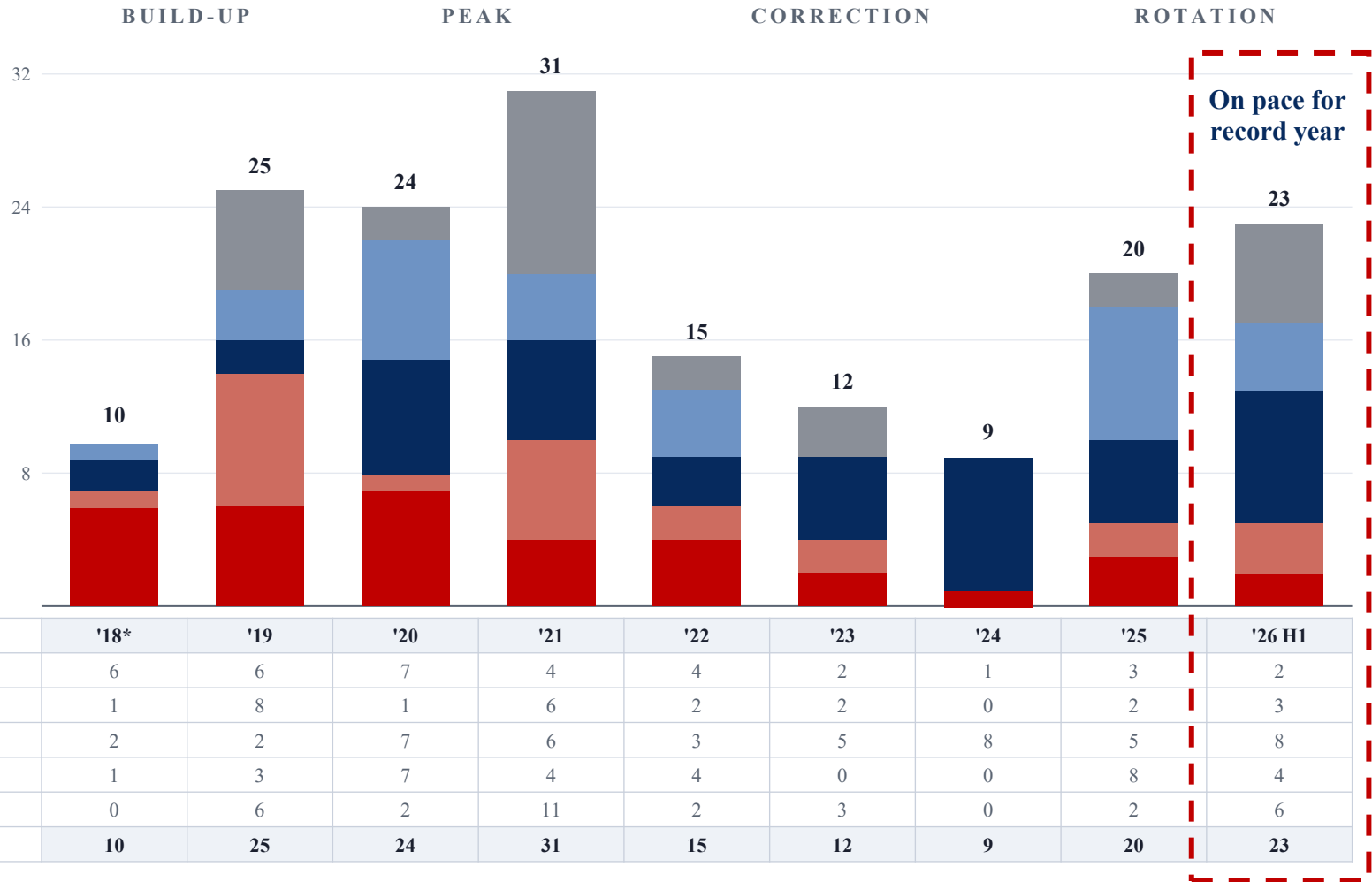
Two forces ran together. Imaging demand exploded as CT and MR became standard of care, and PACS let each radiologist read far more. Rates per study fell, volume rose faster, and incomes held. The recent surge in pay came later, from the shortage.

Adjacent fields show ownership matters: much of pathology and cardiology work moved to whoever controlled the labs and services. Value tends to follow whoever owns the work. Additional precedents are in the appendix.

PACS shows how radiology has absorbed an efficiency shock: payment per read fell, volume grew, and the gains followed the contracts. It is a precedent for the economics, not a forecast for AI, which reaches deeper into the work itself. How the AI gains are split is not settled.

Deal Flow Has Rebounded. The Mix Has Shifted to Centers, Technology and Services.

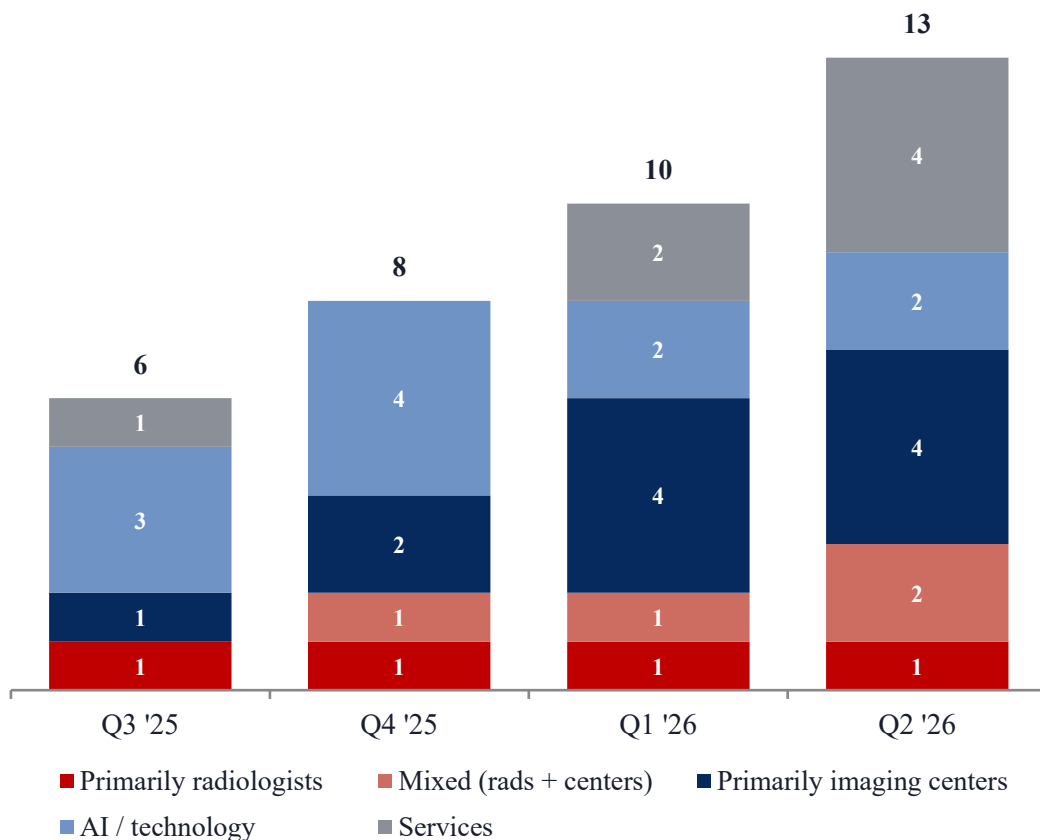
ANNOUNCED U.S. RADIOLOGY M&A TRANSACTIONS PER YEAR. COLORS SHOW WHAT WAS BOUGHT.



Deals for radiologist groups (the red shades) fell to 1 in 2024, then 5 in 2025 and 5 in the first half of 2026. Overall deal volume is on pace for its best year since at least the early 2020s, with centers, AI and services seeing the most activity

Last 12 Months: Centers and AI Led. Radiologist Deals Stayed Narrow.

ANNOUNCED RADIOLOGY TRANSACTIONS PER QUARTER,
JUL. 2025 TO JUN. 2026. COLORS SHOW WHAT WAS BOUGHT.



15

center-related deals: 11 imaging-center plus 4 mixed rads-and-centers. RadNet alone deployed \$340M+.

11

AI and technology deals. RP (Cognita) and RadNet (Gleamer) bought capabilities across the workflow.

4

radiologist-group deals. Premier made three; physician-owned Vituity made the fourth.

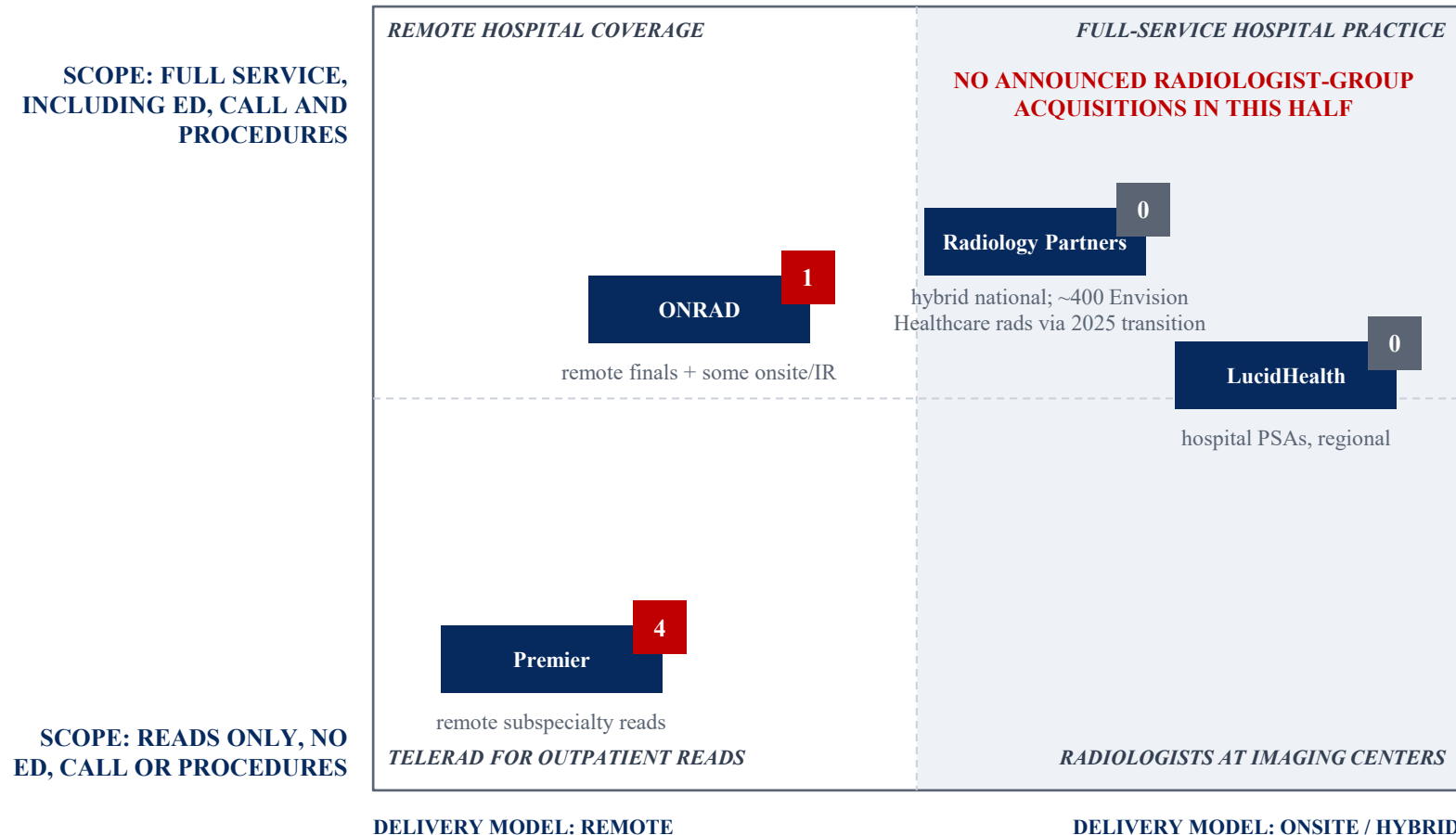
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services deals: medical physics, mobile and program companies (West Physics, Heritage Imaging, Captive Radiology).

Radiologist-group M&A stayed narrow and buyer-specific: exactly one deal a quarter. Centers and AI led throughout.

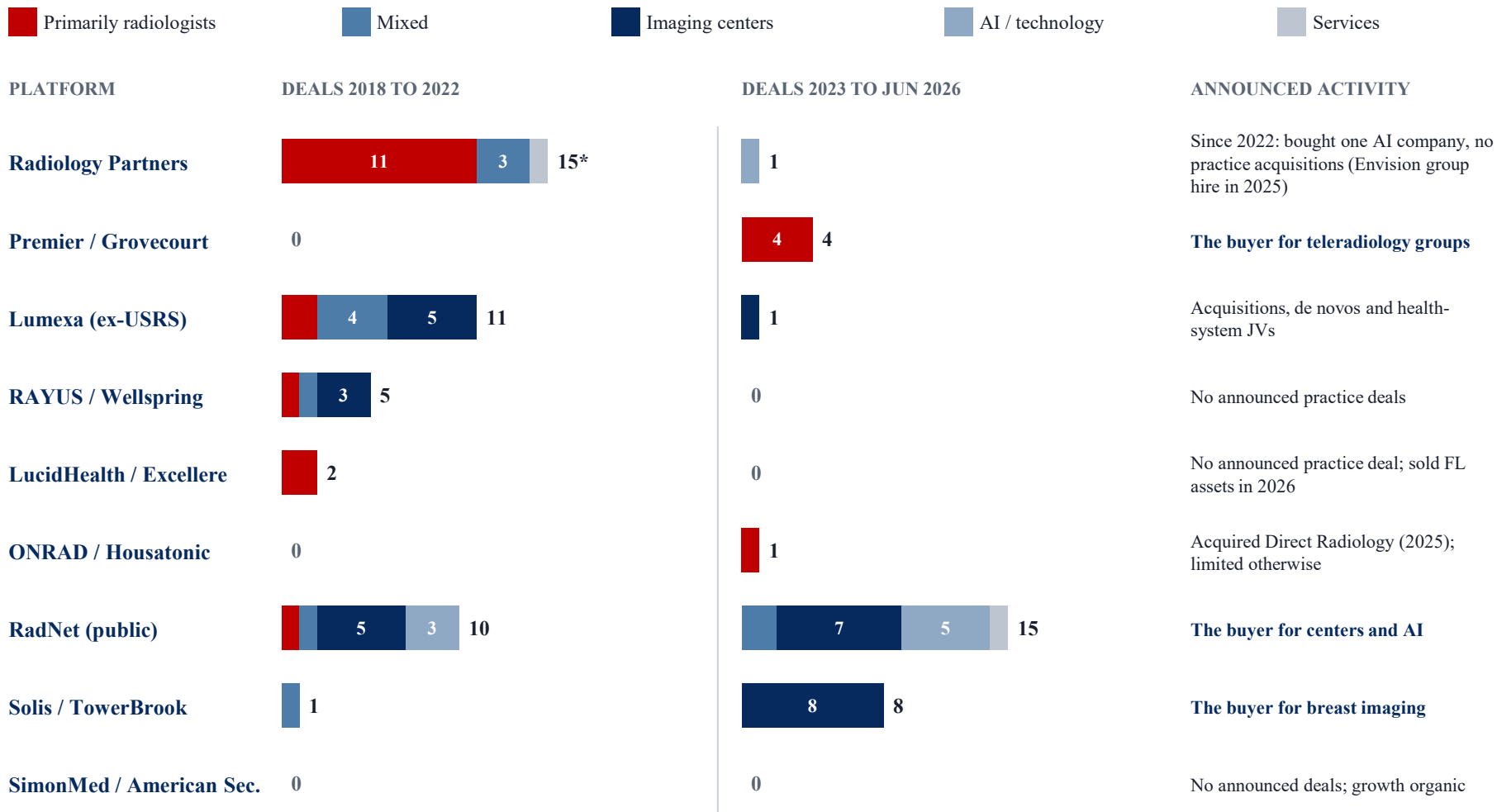
Radiologist-Group M&A Is Concentrated in Remote Teleradiology

Numbered boxes count announced acquisitions by PE-backed radiologist-group platforms, Jan. 2023 to Jun. 2026



No buyer has announced a recent radiologist-group acquisition in onsite or hybrid coverage. Radiology Partners grew this segment through contract transitions. Our view: hard-to-staff, onsite and hybrid hospital coverage is where the next platform gets built.

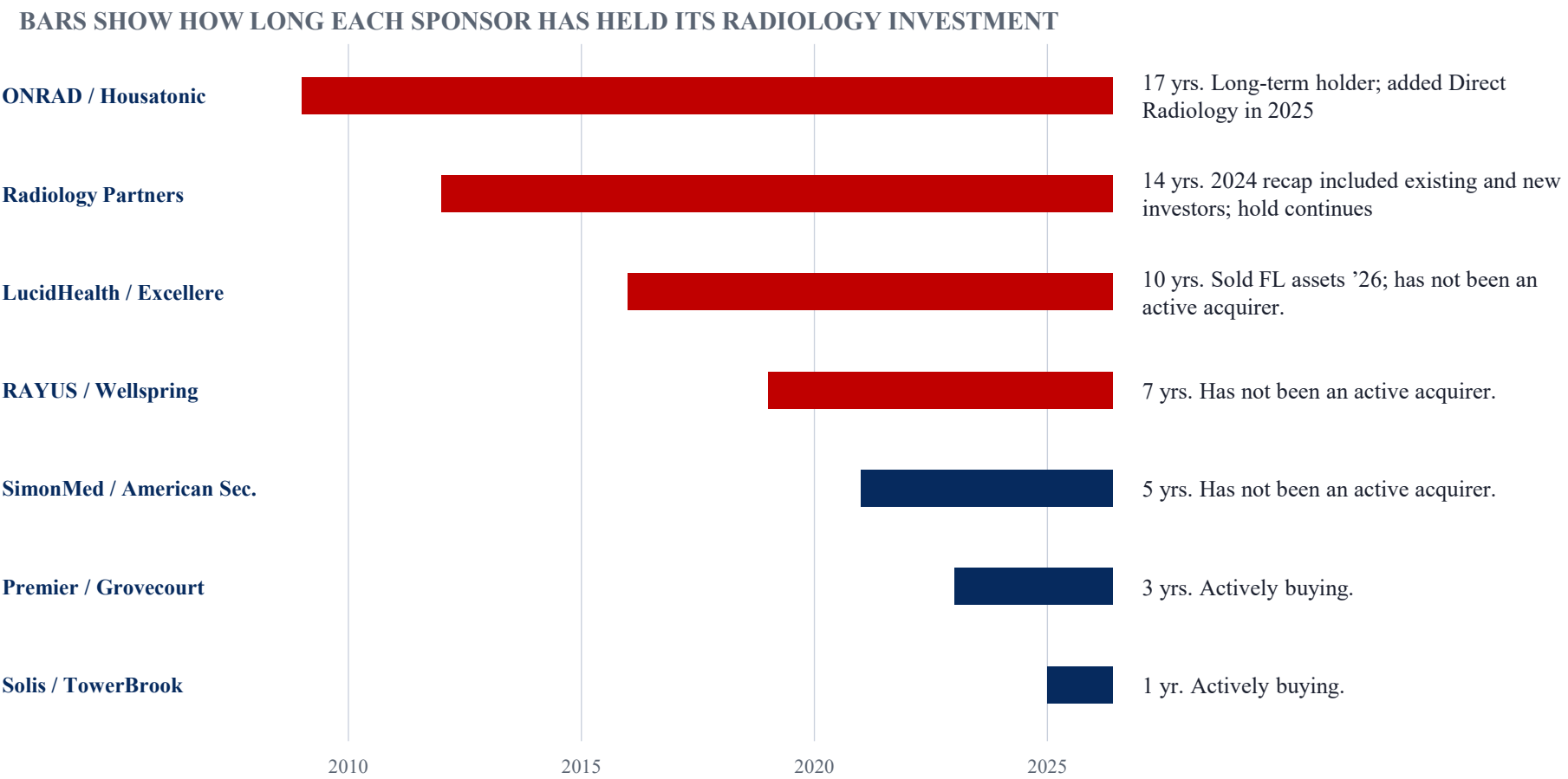
The Announced Buyer List Is Short: Roughly One per Segment



Announced transactions in Bayshore's dataset; unannounced deals may exist. *RP made pre-2018 acquisitions not shown; MEDNAX (\$885M, 2020) is included. Multi-center purchases count once. Envision Healthcare's ~400 radiologists joined RP via a 2025 contract transition, not an acquisition.

Announced activity is concentrated in a few platforms: Premier for teleradiology, Solis for breast imaging, RadNet for centers and AI. As outlined on the prior slide, Bayshore believes there is room for a new radiology platform.

PE Targets 3-to-5-Year Holds. Most Radiology Platforms Are Past That.



PE funds typically target holds of three to five years for platform investments. Platforms tend to buy fewer “add-on” acquisitions as they get later in their hold period vs. when fresh capital comes in. Buyer behavior also depends on leverage, performance, available capital and market conditions.

Exits this cycle: Lumexa, formerly US Radiology Specialists, completed its IPO in December 2025. TowerBrook acquired Solis. Jardine Matheson agreed to acquire I-MED, with closing expected later in 2026. Rezolut’s sponsor exited to employee-owned Envision Radiology (no relation to Envision Healthcare).

Premier Has Been Buying Radiologist Groups. RP's One Recent Purchase Is an AI Company.

PREMIER

The repeat buyer of radiologist groups today

Buys: four teleradiology groups since 2024 (NationalRad, MetisMD, NRAD, GLOBIS); 200+ radiologists interpreting 3M+ images a year. It values transferable client contracts, licenses, subspecialty depth and founders who stay on.

Avoids: in-person staffing and call, procedures, owning centers, building software. It licenses its platform (RamSoft) and AI (Ferrum).

Capital: Grovecourt since 2023; a typical sponsor horizon points to a sale or refinancing within a few years. Today, Premier is in acquisition mode.

For sellers: Premier buys outpatient and teleradiology groups whose client contracts transfer. It buys reading work, not onsite hospital coverage.

The same split runs through their technology: RP owns key AI and workflow tools; Premier licenses its tools and acquires telerad reading capacity and contracts. For most private practices, contracts matter more than software ownership.

RADIOLOGY PARTNERS

One purchase since 2022: Cognita, an \$80M AI company

Buys: Cognita, drafting AI, now part of its MosaicOS reporting and workflow platform.

Grows by: organic growth and group hires; when Envision Healthcare exited imaging in 2025, up to ~400 radiologists and their contracts moved to RP.

Capital: 2024 recap raised \$720M from existing and new investors; 2025 refinancing extended maturities to 2032; reported \$268M capital raise in June 2026 (PitchBook); still highly leveraged.

For sellers: RP has not announced a practice purchase since 2022. Joining means underwriting RP stock behind roughly \$2.4B of term debt, and the Mosaic thesis.

What the Few Active Buyers Are Paying For

Remote reading work	Premier: most active announced teleradiology buyer. ONRAD: major 2025 add-on.	Transferable client contracts, state licenses, subspecialty depth, physician retention and reliable turnaround.
Imaging centers and referral density	RadNet at pace; Solis in breast; Lumexa added one 2026 tuck-in; RAYUS has announced nothing since 2021; health systems and new sponsors.	Attractive markets, payer access, referral flow, modality mix, capex discipline and JV potential.
Health-system relationships and onsite capability	Few active buyers: ONRAD added one telerad group. No buyer has announced a full-service, hospital-facing platform.	Durable hospital contracts, local procedures, call coverage, service performance and recruiting depth.
A well-run operation	Every buyer. A well-run operation raises the price; a messy one kills the deal.	Durable client relationships with renewal and growth history, staffing and routing that match demand to capacity, physician retention, and measurable, consistent quality. Clean books and assignable contracts are positives.

With few buyers, fit and competitive tension drive price. We see room for a new PE-backed platform or a scaled private group to fill the full-service gap (page 17).

What We See Driving the Value of Radiology Groups

We see five drivers of radiology practice value: hard-to-replace coverage, durable contracts, recruiting strength, practical AI use and clear data rights.

- 1 Hospital relationships backed by hard-to-replace coverage.** Onsite staffing where it matters, remote reads behind it and one accountable group make a contract harder to displace.
- 2 Long-term hospital contracts with durable economics.** Buyers value duration, renewal history, support dollars, repricing triggers and separate payment for IR call and medical direction.
- 3 Recruiting and retention that hold up against national platforms.** Buyers will test compensation, coverage premiums, schedule flexibility and physician turnover. Gain-sharing may matter more as AI improves; RP already splits Mosaic gains with its radiologists.
- 4 AI that fits the clinical workflow.** Buyers will test whether tools improve output without weakening quality control, final sign-off or data rights.
- 5 Clear contract and data rights.** Assignment, exclusivity, derived data, model-training rights, vendor access and termination rights.

Two models can create value: comprehensive health-system coverage or teleradiology at scale. Buyers will test whether the customer base, margins and recruiting model will hold. AI adds the unresolved question of who captures the gains.

New Capital Is Entering. A Professional Platform Still Needs an Anchor Group.

THREE MODELS FOR NEW CAPITAL

Imaging-center platforms. Anchored by imaging assets, referral density, payer access and operating capability, not necessarily a physician practice. 2026 entrant: Kain / RadX, a 26-center outpatient network.

Professional-radiology or IR platforms. Need durable client contracts, physician recruiting depth and credible clinical leadership. 2026 entrant: New Dimensions / ELMNT, building an outpatient interventional-radiology platform. None is consolidating comprehensive hybrid coverage; that platform has yet to be built.

Imaging-services platforms. Need route density, contract economics, measurable performance and scalable customer acquisition. 2026 entrant: Align / Heritage, staffed mobile and fixed-site imaging for hospitals and facilities.

Funding a new professional-radiology platform turns partly on AI. Investors must believe hospital coverage stays scarce and the platform can capture enough of the gains when they come. That remains unproven. Durable contracts, recruiting depth, quality performance and clear data rights can still make a group a credible anchor, whether it remains independent, anchors a new platform or joins an existing one.

WHAT AN INVESTOR TESTS

Clients. Contract tenure, renewal history and concentration.

Work mix. How much revenue is routine remote reading, where pricing is likely to face pressure.

Recruiting. Whether the group can hire and retain radiologists against competing companies.

AI and data. Tools in production with quality control and clear data rights. Licensing good tools is enough; owning them is optional.

The basics. Quality of earnings, defensible EBITDA, and clean legal and compliance diligence come before any of it.

Bayshore Growth Partners

25+

physician groups advised

\$1M-\$20M

EBITDA range of represented clients

\$2B+

in transaction value the team has advised on*

QoE

dedicated quality-of-earnings and accounting support

An independent healthcare M&A advisory firm; senior team leads every engagement from first meeting to close. All team members' FINRA licenses are held with NC Securities, LLC, a FINRA- and SEC-registered broker-dealer.

BAYSHORE GROWTH PARTNERS TEAM



Steven Carmen
Managing Partner

- 15+ years of M&A and business development
- Previously BNP Paribas, PwC, and GCA
- MBA, Kellogg; BS, Florida State



Andrew Adams
Managing Director

- 15+ years of M&A, operations, and strategy
- Previously Bain, Lake Capital (\$1.3B PE firm), and JP Morgan
- MBA, Wharton; BBA, Michigan



Daniel Shaw
Managing Director

- 10+ years of diligence and accounting
- Previously Alvarez & Marsal and KPMG; CPA
- BS, Louisiana Tech



Dr. Keith Friedenberg
Managing Director

- 30+ years of clinical experience
- Founder, Great Lakes Gastro and CTN
- MD, UCLA; MBA, Indiana; BA, Cornell



Alexander Dean
Vice President

- 10+ years of strategy and finance
- Previously DaVita and the U.S. Marine Corps
- MBA, Darden; BA, Seton Hall

Why Practices Choose Bayshore



Physician-practice experience

More than 25 physician groups advised on successful sale transactions.



Defensible EBITDA

Dedicated quality-of-earnings and accounting support before buyers test the numbers.



A buyer's perspective

Our team includes former PE investors who sat on investment committees. We know where buyers push on value and how to respond.



Licensed execution

FINRA-licensed bankers (through NC Securities, LLC), able to execute rollovers, earn-outs and co-investments.



Partner-led process

Partners lead strategy, buyer outreach, negotiation and closing.



Buyer knowledge

We have sold to these buyers and know who closes on LOI terms.

Selected Healthcare Transactions

Bayshore Growth Partners has served as exclusive financial advisor to 25+ physician practices, including the transactions shown below. Selected transactions:



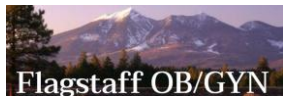
Including ASC



Including Imaging Center



Including ASC



Including Clinical Trials



**GHS Gastroenterology &
Hepatology Specialists, Inc.**

Including ASC



DESERT ROSE
OBSTETRICS & GYNECOLOGY
TERRY A. HUFF, M.D., F.A.C.O.G.
LISA ROSE HUFF, M.D., Ph.D., M.P.H.



Appendix

Supporting evidence, limitations, transaction detail and illustrative deal structures

The AI Debate: Objections and Our View

The pushback	Our view
<i>“AI will get good enough to replace radiologists. And PACS is no precedent; it never did the interpreting.”</i>	Capability alone won’t remove the accountable professional. Autonomous retinal screening was FDA-authorized in 2018; eight years later it expanded screening instead of displacing ophthalmologists. And reading is only part of the job: protocols, consults, procedures and quality work still need people.
<i>“Won't AI efficiency flip the radiologist shortage into a surplus?”</i>	That is the real question, and it is a race between capacity and volume. Imaging demand is still growing on top of a standing backlog, and cheaper, faster reads could add utilization, the way CT volume climbed once PACS made reading fast. Today's tools add capacity slowly: practitioners report up to an hour a day from drafting. A sudden surplus would take autonomous reading at scale, which needs FDA clearances that do not exist and someone other than the radiologist to be legally responsible. Until then, radiologists’ workload may shift toward complex and edge cases, but efficiency gains look unlikely to be dramatic enough to overcome today’s shortage and the expected growth in volume.
<i>“Then the only bottleneck is regulators, and that flips fast.”</i>	Four parties must all move: the FDA (tightening; it denied even a partial exemption in 2026), the courts (no case law), malpractice insurers (no actuarial base), and CMS (no payment code). Europe is the test case: it authorized autonomous reporting of normal chest X-rays in 2022, and four years later adoption is still small pilots reading only clearly normal screening studies. Even where the law allows autonomy, it crawls.
<i>“So radiologist incomes are safe?”</i>	Not exactly. The large AI gains are not here yet, and radiology's inflation-adjusted Medicare reimbursement per beneficiary fell 25% from 2005 to 2021. When the gains come, hospitals may capture them through employment or lower subsidies; payers through rate cuts; platforms through contract repricing; radiologists through gain-sharing; and practice owners through retained contracts and margins. The split will be decided over the next decade.

The Digitization Precedent, in Detail

WHAT DIGITIZATION DID

PACS and filmless workflow expanded reading capacity, while CT and MRI studies became more image-dense and complex. Compensation rose, but reimbursement per unit stayed under pressure. Hiring ran in cycles around the trend: groups froze hiring in 2010-13 fearing ACA cuts, and again when COVID crushed volumes; each freeze set up the next shortage.

+34%

procedures per FTE radiologist
(1991-92 to 2006-07)

+70.3%

work RVUs per FTE radiologist
(same period)

82 → 679

images per CT exam, 1999 to 2010;
MRI rose 164 to 570

-25%

inflation-adjusted Medicare
radiology reimbursement per
beneficiary, 2005 to 2021

Incomes rose throughout, even as inflation-adjusted Medicare radiology reimbursement fell 25% (2005 to 2021). Radiologists won on volume, not price.

WHERE THE VOLUME CAME FROM

New clinical capability. CT replaced most exploratory trauma surgery and ED protocols became standard of care: ED visits involving CT rose 5.9x, 1995 to 2007. Referrers order what the pathway dictates.

Harder work. The mix shifted from X-ray to CT and MR, raising minutes per study.

Imaging begets imaging. Follow-up recommendations doubled, from ~6% to ~12% of reports (1995 to 2008).

Demographics and screening. Imaging intensity rises with age, and lung cancer screening still reaches only about 1 in 5 eligible adults (ACS, 2025).

Selected Transactions: What Was Actually Acquired

Date	Target	Acquirer (backer)	Primary asset*	Why it matters
Jun '26	RadX (26 centers)	Kain Capital	Centers	New lower-middle-market sponsor entering imaging
May '26	Heritage Imaging	Align Capital Partners	Centers	Another new sponsor; mobile and fixed-site platform
Apr '26	GLOBIS	Premier (Grovecourt)	Radiologists	Premier's 4th telerad deal; founder and team join Premier
Mar '26	Gleamer	RadNet / DeepHealth (~€230M)	AI	Largest imaging-AI deal of the period
Feb '26	Northwest Radiology	RadNet	Centers*	Six imaging centers; continuing professional-services relationship.
Jan '26	NRAD	Premier (Grovecourt)	Radiologists	Founder and team join Premier
Jan '26	Radiology Regional + 13 FL centers	RadNet (from LucidHealth)	Rads + centers	A 10-year PE hold exits to a public strategic
Jan '26	Rezolut (42 centers)	Envision Radiology (employee-owned)	Centers*	Employee-owned company buys out a PE sponsor
Dec '25	Knoxville Breast; Women's Ctr. for Radiology	Solis (TowerBrook)	Centers	Fresh sponsor, three breast deals in months
Nov '25	Cognita Imaging	RP / Mosaic (\$80M)	AI	RP's only acquisition since 2022
Nov '25	Focus Medical Imaging	Vituity (physician-owned)	Radiologists	A physician-owned alternative to PE
Jul '25	MetisMD	Premier (Grovecourt)	Radiologists	30+ fellowship-trained radiologists

Illustrative PE Structures for Sellers: Established Platform vs. New Platform

	Joining an existing platform (an existing PE investment)	Anchoring a new platform (a new investment for the PE firm)
Valuation	Premium possible: a platform can pay more because it expects to resell at a higher multiple than it pays for add-ons	Premium possible to secure a strong anchor practice
Typical Structure	70-80% cash at close; 20-30% rollover equity	60-70% cash at close; 30-40% rollover equity
Rollover upside (illustrative)	Illustrative: 2.0x-2.5x. Platform scale and diversification, but leverage, limited governance and dilution risk.	Illustrative: 3x-4x if the platform builds well. Higher execution risk: the sponsor is new to the space.
Administration and operations	Practice shifts to the platform's systems	The operations team typically stays and runs non-clinical functions
Leadership	Platform leadership drives strategy; physicians hold medical-board seats	Physicians lead the medical board and shape strategy with the sponsor

In radiology today: RadX (imaging centers), Heritage (mobile imaging) and ELMNT (interventional radiology) were sponsors' first radiology investments in 2026.

Sources, Methods and Limitations

1. Peer-reviewed and government

Zamani et al., JACR 2026; Bhargavan et al., Radiology 2009; Larson et al., Radiology 2011; Golshani & Joseph, Cureus 2026; Taib et al., Radiology 2026; Bredella et al., JACR 2026; FDA AI-enabled device list; CMS CY2026 PFS final rule; Neiman HPI / JACR, Medicare radiology reimbursement 2005-2021.

2. Company filings and releases

Lumexa Form S-1 (2025); RadNet SEC filings and Q1 2026 earnings; Radiology Partners 2024 recapitalization and 2025 refinancing releases; PitchBook company profiles (2026).

3. Named surveys and reports

ACR/Neiman HPI (Feb. 2026); RadBoard 2026 US Radiology Job Market report (Mar. to May 2026); Medscape 2026 compensation report; ACR imaging AI practice parameter (2026); Radiology Business (Jul. 2026); benwhite.com on RP Mosaic gain-sharing (2026); practitioner reports from radiology forums (2026; sample skews toward teleradiology and contractor radiologists); Philips Future Health Index 2026.

4. Bayshore analysis and experience

Bayshore radiology deal database (169 announced transactions, 2018 to Jun. 30, 2026; curated and non-exhaustive) and Bayshore transaction experience. Bayshore interviews with radiology industry participants.

Limitations

Transaction counts come from a curated, non-exhaustive database of publicly announced events. Classifications reflect the principal asset or capability acquired and may not capture every legal entity transferred.

Limitations, continued

Workforce studies cover different samples and periods and should not be treated as a single national census. Job postings describe advertised vacancies, not the installed workforce. A posting that closes may reflect a hire, a withdrawal, an expiration or a repost, not a confirmed fill. Company-reported metrics have not been independently verified.

Methods

AI adoption and autonomy statements are scenarios, not predictions. Numerical claims are sourced in slide footnotes or this appendix. Prepared as of August 4, 2026.