2022 Annual Report
SEC Form 10-K and Supplemental Information

Fiscal Year End: December 31, 2022

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

☒ 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 from to

Commission File Number 001-39427

Oak Street Health, Inc.

(Exact name of Registrant as specified in its Charter)

Delaware	**84-3446686**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

30 W. Monroe Street Suite 1200
Chicago, Illinois 60603
(888) 898-6762

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, $0.001 per share par value	**OSH**	**NYSE**

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 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. ☐

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

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

The aggregate market value of voting shares held by non-affiliates of the Registrant was $1,914,987,684 as of June 30, 2022, the last business day of the Registrant's most recently completed second fiscal quarter (based on a closing price of $16.44 per share).

The number of shares of Registrant's Common Stock outstanding as of February 22, 2023 was 243,999,366.

List hereunder the following documents if incorporated by reference and the Part of the Form 10-K (e.g., Part I, Part II, etc.) into which the document is incorporated: (1) Any annual report to security holders; (2) Any proxy or information statement; and (3) Any prospectus filed pursuant to Rule 424(b) or (c) under the Securities Act of 1933. The listed documents should be clearly described for identification purposes (e.g., annual report to security holders for fiscal year ended December 24, 1980).

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the information called for by Part III of this Annual Report on Form 10-K is hereby incorporated by reference from the definitive proxy statement for the Registrant's annual meeting of stockholders, which will be filed with the Securities and Exchange Commission no later than 120 days after the Registrant's fiscal year ended December 31, 2022.

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FORWARD-LOOKING STATEMENTS

Throughout this Annual Report on Form 10-K, we make "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. These forward-looking statements include statements that do not relate solely to historical or current facts, such as statements regarding Oak Street Health's expectations, intentions or strategies regarding the future. In some cases, you can identify forward-looking statements by the following words: "may," "will," "could," "would," "should," "expect," "intend," "plan," "anticipate," "believe," "estimate," "predict," "project," "aim," "potential," "continue," "ongoing," "goal," "can," "seek," "target" or the negative of these terms or other similar expressions, although not all forward-looking statements contain these words. The forward-looking statements contained in this Annual Report on Form 10-K are generally located in the material set forth under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations" but may be found in other locations as well. These statements are based upon management's current expectations, assumptions and estimates and are not guarantees of timing, future results or performance. Therefore, you should not rely on any of these forward-looking statements as predictions of future events. Actual results may differ materially from those contemplated in these statements due to a variety of risks and uncertainties and other factors, including, among other things:

- our proposed acquisition by a subsidiary of CVS Health Corporation ("CVS Health"), including the occurrence of any event, change or other circumstance that could give rise to our right or the right of CVS Health or both of us to terminate the Merger Agreement (as defined herein), including circumstances requiring us to pay CVS Health a termination fee pursuant to the Merger Agreement;

- the risk that the acquisition may not close in the anticipated timeframe or at all due to one or more of the other closing conditions to the transaction not being satisfied or, to the extent permitted by applicable law, waived, including due to the failure to obtain applicable regulatory approval or the approval of our stockholders in a timely manner or otherwise;

- the risk that the proposed acquisition disrupts our current plans and operations;

- the risk that there may be unexpected costs, charges or expenses resulting from the proposed acquisition;

- risks related to disruption of management's time and attention from ongoing business operations due to the proposed transaction;

- continued availability of capital and financing and rating- agency actions;

- the risk that any announcements related to the proposed transaction could have adverse effects on our ability to retain and hire key personnel, to retain customers and to maintain relationships with each of their respective business partners, suppliers and customers on our operating results and business generally, including with respect to Humana Inc. and its affiliates, which lease or license to us a majority of our primary care centers;

- the risk that certain restrictions during the pendency of the proposed transaction may impact our or CVS Health's ability to pursue certain business opportunities or strategic transactions;

- the risk of litigation that could be instituted against us or CVS Health or our or their respective directors, managers or officers and/or regulatory actions related to the proposed acquisition, including the effects of any outcomes related thereto;

- our history of net losses and our ability to achieve or maintain profitability in an environment of increasing expenses;

- our financial condition and results of operations have been and, we expect, will continue to be impacted by ongoing macroeconomic challenges, including labor shortages, supply chain disruptions and inflationary pressures, and an economic downturn or recession, could further adversely impact our business;
- the impact of the Coronavirus disease 2019 ("COVID-19") or any other pandemic, epidemic or outbreak of an infectious disease in the United States or worldwide on our business, financial condition and results of operations;
- the effect of our relatively limited operating history on investors' ability to evaluate our current business and future prospects;
- the viability of our growth strategy and our ability to realize expected results;
- our ability to manage our growth effectively, execute our business plan, maintain high levels of service and patient satisfaction and adequately address competitive challenges;
- our ability to attract new patients;
- the dependence of our revenues and operations on a limited number of key payors;
- the potential adverse impact of legal proceedings and litigation;
- the risk of termination or non-renewal of the Medicare Advantage contracts held by the health plans with which we contract, or the termination or non-renewal of our contracts with those plans;
- the impact on our business from changes in the payor mix of our patients and potential decreases in our reimbursement rates;
- our ability to compete in the healthcare industry;
- our ability to timely enroll new physicians and other providers in governmental healthcare programs before we can receive reimbursement for their services;
- the impact on our business of reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program;
- our dependence on reimbursements by third-party payors and payments by individuals;
- our assumption under most of our agreements with health plans of some or all of the risk that the cost of providing services will exceed our compensation;
- the impact on our business of renegotiation, non-renewal or termination of capitation agreements with health plans;
- the impact on our results from operations from Medicare's risk adjustment payment system;
- the impact on our business of security breaches, loss of data or other disruptions causing the compromise of sensitive information or preventing us from accessing critical information;

- the impact on our business of disruptions in our disaster recovery systems or management continuity planning;
- the impact of reductions in the quality ratings of the health plans we serve;
- the risk of our agreements with the physician equity holder of our practices being deemed invalid;
- our ability to maintain and enhance our reputation and brand recognition;
- our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems;
- our ability to obtain, maintain and enforce intellectual property protection for our technology;
- the potential adverse impact of claims by third parties that we are infringing on or otherwise violating their intellectual property rights;
- risks associated with existing litigation;
- our ability to protect the confidentiality of our trade secrets, know-how and other internally developed information;
- the impact of any restrictions on our use of or ability to license data or our failure to license data and integrate third-party technologies;
- risks associated with our use of "open-source" software;
- our dependence on our senior management team and other key employees;
- the concentration of our primary care centers in Illinois, Michigan, Ohio, Pennsylvania and Texas;
- the impact on our business as a result of an economic downturn;
- our ability to attract and retain highly qualified personnel;
- our management team's limited experience managing a public company;
- the impact on our business of the termination of our leases, increases in rent or inability to renew or extend leases;
- the impact of failures by our suppliers, material price increases on supplies, lack of reimbursement for drugs we purchase or limitations on our ability to access new technology or products;
- our ability to maintain our corporate culture;
- the impact of competition for physicians and nurses, shortages of qualified personnel and related increases in our labor costs;

- our ability to attract and retain the services of key primary care physicians;
- the risk that our submissions to health plans may contain inaccurate or unsupportable information regarding risk adjustment scores of members;
- our ability to accurately estimate incurred but not reported medical expense;
- the impact of negative publicity regarding the managed healthcare industry;
- the impact of state and federal efforts to reduce Medicaid spending;
- the impact on our centers of adverse weather conditions and other factors beyond our control;
- our ability to develop and maintain proper and effective internal control over financial reporting; and
- other factors disclosed in the section entitled "Risk Factors" and elsewhere in this Annual Report on Form 10-K.

We derive many of our forward-looking statements from our operating budgets and forecasts, which are based on many detailed assumptions. While we believe that our assumptions are reasonable, we caution that it is very difficult to predict the impact of known factors, and it is impossible for us to anticipate all factors that could affect our actual results. Important factors that could cause actual results to differ materially from our expectations, or cautionary statements, are disclosed under the sections entitled "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in this Annual Report on Form 10-K. All written and oral forward-looking statements attributable to us, or persons acting on our behalf, are expressly qualified in their entirety by these cautionary statements as well as other cautionary statements that are made from time to time in our other SEC filings and public communications. You should evaluate all forward-looking statements made in this Annual Report on Form 10-K in the context of these risks and uncertainties.

We caution you that the important factors referenced above may not contain all of the factors that are important to you. In addition, we cannot assure you that we will realize the results or developments we expect or anticipate or, even if substantially realized, that they will result in the consequences or affect us or our operations in the way we expect. The forward-looking statements included in this Annual Report on Form 10-K are made only as of the date hereof. We undertake no obligation to update or revise any forward-looking statement as a result of new information, future events or otherwise, except as otherwise required by law.

PART I

Item 1. Business

Overview

Oak Street Health, Inc. (collectively with its subsidiaries is referred to as "Oak Street Health," "OSH," "we," "us," "our," or the "Company") was formed as a Delaware corporation on October 22, 2019 for the purpose of completing a public offering and related restructuring transactions (collectively referred to as the "IPO") in order to carry on the business of Oak Street Health, LLC ("OSH LLC") and its affiliates. As the managing member of OSH LLC, Oak Street Health, Inc. operates and controls all of the business affairs of OSH LLC and its affiliates. Following the IPO, Oak Street Health, Inc. consolidates the financial results of OSH LLC. Our common stock trades on the New York Stock Exchange ("NYSE") under the ticker symbol "OSH."

As further described below, the Company entered into a definitive merger agreement under which a subsidiary of CVS Health will acquire all of the outstanding shares of the Company's common stock for cash. See "Management's Discussion and Analysis of Financial Conditions and Results of Operations-Proposed Transaction with CVS Health" for more information.

The Company operates primary care centers within the United States serving Medicare eligible patients. The Company, through its centers and management services organization, combines an innovative care model with superior patient experience. The Company invests resources into primary care to prevent unnecessary acute events and manage chronic illnesses. The Company engages its patients through the use of an innovative community outreach approach. Once patients are engaged, the Company integrates population health analytics, social support services and primary care into the care model to drive improved outcomes. The Company contracts with health plans and the Center for Medicare & Medicaid Services ("CMS") to generate medical costs savings and realize a return on its investment in primary care. As of December 31, 2022, the Company operated 169 centers across 21 states, which provided care for approximately 224,000 patients. We, together with our affiliated physician practice organizations, employed approximately 6,000 team members, including approximately 600 primary care providers as of December 31, 2022. Our operations are organized and reported under one segment.

Mission

Since our founding in 2012, our mission has been to build a care delivery platform, built on a chassis of primary care that directly addresses rising costs and poor outcomes, two of the most pressing challenges facing the United States healthcare system. Our approach shifts the allocation of healthcare resource delivery from traditional acute and specialist care into an enhanced, patient-centered care delivery platform which is designed to meaningfully improve the quality of care and outcomes for the most at-risk populations. We represent the frontline implementation of the solutions addressing the most powerful trends in healthcare, mainly the shift towards value-based care and increasing patient consumerism. Our approach disrupts the current state of care delivery for Medicare-eligible patients and aligns the incentives of our patients, our providers and our payors by simultaneously improving health outcomes and care quality, lowering medical costs and improving the patient experience.

To pursue our mission, we created a *technology-enabled*, *integrated* platform, which we refer to as the Oak Street Platform, to deliver *value-based* care *focused* exclusively on Medicare patients. The key attributes that differentiate the Oak Street Platform include:

- ***Our patient focus.*** We are focused on the Medicare-eligible population, which generally has consistent, clinically cohesive needs and which we believe represents the greatest potential for cost savings, while still benefiting patient health outcomes, in our current healthcare system.

- ***Our technology-enabled model.*** We leverage technology that compiles and analyzes comprehensive patient data and provides actionable health insights through applications that are embedded in care delivery workflows, including at the point of patient-provider interaction.

- ***Our integrated approach to care delivery.*** We integrate a personalized approach to primary care, proactive management of our patients' health needs and expanded preventive services to keep our patient population healthy, reducing the number of hospitalizations and other expensive and unnecessary utilization of the healthcare system. As such, we focus on delivering what we believe to be the right care in the right setting, encouraging our patients to visit us in our centers, while also offering robust virtual and digital engagement options.

- ***Our value-based relationships.*** Our value-based capitation contracts reward us for providing high- quality care rather than driving a high volume of services.

Organization

- We operate through our direct and indirect subsidiaries, primarily, Oak Street Health MSO, LLC ("OSH MSO"). OSH MSO operates as a management services organization and is in the business of providing management and other administrative services to our affiliated physician practice organizations under long-term management and/or administrative services agreements ("MSAs"), pursuant to which OSH MSO manages certain non-medical services for the physician practice organizations and has authority over all non-medical decision making related to ongoing business operations.

- Some states have laws that prohibit business entities with non-physician owners from practicing medicine, which are generally referred to as the corporate practice of medicine. States that have corporate practice of medicine laws require only physicians to practice medicine, exercise control over medical decisions or engage in certain arrangements with other physicians, such as fee-splitting.

- Therefore, in addition to our subsidiaries, we mainly operate by maintaining long-term management services agreements with our affiliated physician practice organizations, which are owned, directly or indirectly, and operated by certain licensed physicians who hold shares, and which employ or contract with additional physicians to provide medical services. Under such agreements, we provide and perform non-medical management and administrative services, including financial management, information systems, marketing, risk management and administrative support.

- We have entered into MSAs with affiliated physician practice organizations (each, a "PC"). These affiliated PCs contract with various managed care organizations or licensed health care service plans, each of which pays a fixed capitation payment to that particular PC. In return, that PC provides health care services by employing physicians and other providers of primary care services. The applicable PC assumes the financial risk of the cost of delivering health care services in excess of the fixed amounts received. The risk is subject to stop-loss provisions. The physicians employed by the PC are exclusively in control of, and responsible for, all aspects of the practice of medicine for their patients. In accordance with relevant accounting guidance, each of these PCs is determined to be a variable interest entity ("VIE") of Oak Street Health as Oak Street Health has the ability, through the MSA, to direct the activities (excluding clinical decisions) that most significantly affect the PC's economic performance. Therefore, all PCs are consolidated in the accompanying financial statements.

- On October 20, 2021, we acquired RubiconMD Holdings, Inc. ("Rubicon" or "RMD"), a leading technology platform in New York providing access to specialist expertise. The

acquisition enables Oak Street Health to integrate virtual specialty care into its existing care model, which is expected to significantly streamline the referral process and better manage costs, enhance patient experience and provide comprehensive care far beyond traditional primary care.

- Lastly, we are the majority interest owner in two joint ventures: OSH-PCJ Joliet LLC and OSH-RI, LLC, which are consolidated in the accompanying financial statements.

Proposed Transaction with CVS Health

On February 7, 2023, the Company entered into an Agreement and Plan of Merger (the "Merger Agreement") with a subsidiary of CVS Health, pursuant to which (and subject to the terms and conditions in the Merger Agreement) such subsidiary of CVS Health will acquire all of the outstanding shares of the Company's common stock in a transaction structured as a merger of an indirect wholly-owned subsidiary of CVS Health ("Merger Sub") with and into the Company, with the Company as the surviving corporation (the "Merger"). Under the terms of the Merger Agreement, at the effective time of the Merger (the "Effective Time"), each share of the Company's common stock that is issued and outstanding as of immediately prior to the Effective Time (other than shares of common stock (i) held by the Company as treasury stock as of immediately prior to the Effective Time, (ii) owned by such subsidiary of CVS Health or any of its subsidiaries (including Merger Sub) as of immediately prior to the Effective Time, (iii) owned by stockholders who have properly exercised appraisal rights under Delaware law and (iv) subject to outstanding Company restricted stock awards) will be automatically cancelled and converted into the right to receive $39.00 per share in cash, without interest thereon.

As a result of the Merger, the Company will become an indirect wholly-owned subsidiary of CVS Health. The completion of the Merger is subject to certain customary closing conditions, including, among others, the adoption of the Merger Agreement by the Company's stockholders and the expiration or termination of the applicable waiting period under the United States Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended ("HSR Act").

The Merger Agreement contains certain customary termination rights for the Company and such subsidiary of CVS Health. If the Merger Agreement is terminated under certain specified circumstances and receipt of regulatory approval has not been obtained by such time, such subsidiary of CVS Health will be required to pay the Company a termination fee of $500 million. If the Merger Agreement is terminated under other certain specified circumstances, including due to the Company accepting a superior proposal, the Company will be required to pay such subsidiary of CVS Health a termination fee of $300 million.

Industry Overview, Challenges and our Opportunity

According to the Centers for Medicare & Medicaid Services ("CMS"), healthcare spending in the United States reached nearly $4.3 trillion, and Medicare accounted for approximately $900.8 billion of spending in 2021. As of 2021, there were approximately 63.9 million Medicare beneficiaries in the United States, with additional individuals reaching the age of eligibility every day. We believe the core addressable market for the Oak Street Platform is approximately 27 million Medicare eligible patients in our target demographic, which we believe represents an approximate $356.4 billion annual industry revenue opportunity. We determine the core addressable market by multiplying an estimate of average annual revenue of $13,200 per member as of 2019, which is derived from our experience and industry knowledge and which we believe represents a reasonable national assumption, by the number of Medicare eligibles in our target markets. Average spending on Medicare is projected by CMS to grow approximately 7.2% annually, driven by the aging United States population as well as the high prevalence of chronic conditions and the associated cost of care for these conditions among the Medicare eligible population.

We reimagined the approach to caring for a patient population with a high prevalence of chronic conditions and purpose-built the Oak Street Platform to improve health outcomes and combat wasteful spending. The Oak Street Platform consists of (i) Our Centers, (ii) Our Interdisciplinary Care Teams, (iii) Canopy: Our Purpose-Built, End-to-End Technology and (iv) Our Care Delivery Approach (further discussed below).

Although we have incurred net losses since inception, we believe that the Oak Street Platform has enabled us to create a healthcare model where all constituencies involved have the ability to "Win." Our patients, payors and providers are incentivized to adopt the Oak Street Platform, and each has the potential to benefit in a meaningful way.

- ***Patients***. We leverage our differentiated care delivery model to improve the health of our patients, effectively manage their chronic conditions and avoid unnecessary hospitalizations while greatly improving their patient experience.

- ***Payors***. We enter into arrangements with Medicare Advantage ("MA") plans and CMS to manage the care of our patients, allowing us to control the plans' medical costs, increase the plans' Medicare quality scoring, improve the plans' profit margin and help the plans grow membership.

- ***Providers***. We enable our providers to focus on improving the lives of their patients and improve their job satisfaction by providing them with meaningful clinical support and customized technology resources.

We believe we can translate these "Wins" into economic benefits. Since 2016, our performance has been driven by our multi-year, contractual arrangements with payors on a per patient, per month ("PPPM") basis, which create recurring revenue streams and provide significant visibility into our financial growth trajectory. By focusing on interventions that keep our patients healthy, we can capture the cost savings the Oak Street Platform creates and reinvest them in our care model. We believe these investments lead to better outcomes and improved patient experiences, which will drive further cost savings, power patient retention and enable us to attract new patients. We believe increasing cost savings over a growing patient population will deliver an even greater surplus to the organization, enabling us to reinvest to scale and fund new centers, progress our care model and enhance our technology.

We have demonstrated an ability to rapidly scale, expanding our model to a network of 169 centers across 21 states, which provided care for approximately 224,000 patients as of December 31, 2022, of which approximately 71% are under capitation arrangements (which we refer to as "at-risk patients") and approximately 29% are fee-for-service, although fee-for-service accounted for less than 1% of our revenues for the year ended December 31, 2022. As of December 31, 2022, we, together with our affiliated physician practice organizations, employed approximately 6,000 team members, including approximately 600 primary care providers. For the years ended December 31, 2022 and 2021, our total revenues were $2,160.9 million and $1,432.6 million, respectively, representing a year-over-year growth rate of 51%.

The U.S. healthcare system is at a transition point in its evolution

Unsustainable and rising healthcare costs

Healthcare spending in the United States reached nearly $4.3 trillion in 2021 according to CMS, representing approximately 18.3% of U.S. Gross Domestic Product ("GDP"). The United States spent approximately $12,914 per person on healthcare in 2021, more than any other country in the world and twice the Organization for Economic Co-operation and Development ("OECD") average. Healthcare expenditures are particularly concentrated in the Medicare-eligible population due to the high rate of chronic conditions. While representing only approximately 15% of the United States population, the 65 and older age group accounted for 35% of all personal healthcare spending in 2014, with an average spend of $19,098 per person. Additionally, two-thirds of the Medicare population lives with two or more chronic health conditions, and treatment of these conditions represents 96% of Medicare spending.

Prevalence of wasteful spending and sub-optimal outcomes

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

In 2017, hospital care accounted for the largest portion of healthcare spending in the United States, representing 33% of the total. In 2018, over 60% of Medicare expenditures (including both Medicare Part A spend and Medicare Part B institutional spend), or approximately $455 billion, were dedicated to hospitalization, compared to only approximately 3% dedicated to primary care. Proper management of chronic conditions can significantly reduce the incidence of acute episodes, which are the main drivers of trips to the emergency room and hospitalization, particularly among the elderly.

Despite high levels of spending, the United States healthcare system struggles to produce better health outcomes and to keep doctors and patients satisfied. Life expectancy in the United States was 76.1 years in 2021, compared to 82.4 years in comparable developed countries, and patient satisfaction with the healthcare system is low, as evidenced by a Net Promoter Score of -1.2 for the average provider, as shown in a 2019 Advisory Board survey.

New payment structures have begun to address the problem

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

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

- ***Value-based payments.*** In response to rising healthcare spending in the United States, commercial, government and other payors are shifting away from fee-for-service payment models towards value-based models, including risk-based payment models that tie financial incentives to quality, efficiency and coordination of care. Value-based refers to the goal of incentivizing healthcare providers to simultaneously increase quality while lowering the cost of care. While not a policy-setting body, the Health Care Payment Learning & Action Network, an active group of public and private healthcare leaders, indicated in October of 2019 its desire to move 100% of Medicare payments to being tied to value-based care by 2025. Additionally, the Center for Medicare and Medicaid Innovation ("CMMI") launched the Global and Professional Direct Contracting ("GPDC") Model (the "Direct Contracting Model") as of April 2021 to create value-based payment arrangements directly with provider groups for their current Medicare fee-for-service patients similar to the value-based contracts that we enter into with our MA partners. On February 24, 2022, CMMI announced that the Direct Contracting Model would continue through the end of 2022. Beginning in 2023, the GPDC Model was transformed into the new Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model (the "ACO REACH Model"). The stated goals of the ACO REACH model are to advance health equity to bring benefits of accountable care to underserved communities, promote provider leadership and governance, and protect beneficiaries and the model with more participant vetting, monitoring and greater transparency. We believe that patient-centered, outcome-driven reimbursement models will continue to grow in prominence.

We already receive substantial value-based payments, and as valued-based payment systems continue to increase in prominence, it is our view that our strong clinical outcomes will be increasingly rewarded.

Legacy healthcare delivery infrastructure has been unable to transition from reactive and episodic care to proactive and comprehensive care models

In order for shifts to value-based payment models to drive meaningful results, there must be a corresponding shift in care delivery models. To date, such care delivery models have been slow to develop. While there has been significant investment by providers, payors and technology companies in developing solutions to drive higher quality and lower cost of care, these investments have not resulted in meaningful change within a healthcare delivery infrastructure that remains optimized for the fee-for-service model. As publicly reported by the University of Chicago in 2022, a recent study undertaken by University of Chicago, Johns Hopkins University and Imperial College London University found that a primary care physician seeing an average patient panel would need 26.7 hours/day to follow national guidelines for care.

Advances in technology have disrupted multiple industries when the technology was thoughtfully applied and integrated. These new business models, systems and approaches have replaced legacy offerings and driven significant changes in consumer behavior. We believe that an integrated, value-based care platform enabled by data and technology has the potential to similarly revolutionize the healthcare industry.

Our Market Opportunity

The Oak Street Platform is Re-Defining Primary Care

We reimagined the approach to caring for a patient population with a high prevalence of chronic conditions and purpose-built the Oak Street Platform to improve our patients' health outcomes and combat wasteful spending, providing a higher-quality alternative to the status quo. Our Oak Street Platform consists of (i) *Our Centers*, (ii) *Our Interdisciplinary Care Teams*, (iii) *Canopy: Our Purpose-Built, End-to-End Technology* and (iv) *Our Care Delivery Approach*.

Our Centers

Our novel approach starts with retail-like, community-based centers that implement a branded and consumer-focused design to create a welcoming environment that engages our patients. These centers are leased or licensed by OSH MSO or an affiliated entity and, pursuant to the terms of certain contractual relationships between OSH MSO and our affiliated physician practice organizations, made available for use by the medical practices in the provision of primary care services. While traditional healthcare facilities are often located in medical office buildings that are removed from where patients spend a majority of their time, we target locations in highly accessible, convenient locations close to where our patients live. Each of our centers has a consistent look and feel, which we believe differentiates Oak Street and contributes to our success in acquiring patients.

Our Interdisciplinary Care Teams

We utilize a team-based approach in our patient-focused primary care delivery model and staff interdisciplinary care teams ("Care Team") to execute our model. Each Care Team is led by a Primary Care Physician or Nurse Practitioner who is partnered with a Registered Nurse, a Medical Assistant and a Scribe to deliver value-based, coordinated care. As a center grows, we increase the number of Care Teams serving that center in order to keep the average number of patients per Care Team low to ensure optimal care quality and patient experience.

Our Care Teams are trained in preventive and comprehensive care designed to address the whole person, across medical, social and behavioral attributes, in a welcoming and friendly manner. Our Care Teams meet daily to discuss their approach for each patient they will see that day and have weekly and monthly planning and review

sessions for their sickest patients to assess their progress and determine the next steps in improving their health. Care is provided in several different ways, including face-to-face visits, telehealth visits, remote patient monitoring and in-home care.

Canopy: Our Purpose-Built, End-to-End Technology

Canopy is a key driver of the success of our care model and underlies every aspect of our day-to-day patient engagement and workflows. Canopy is comprised of internally developed software that connects a suite of population health analytics and technology applications designed to fit seamlessly into our care delivery model and Care Team virtual and in-person workflows.

Our position in the healthcare ecosystem allows Canopy to access and capture an immense amount of data about our patients from a broad set of sources, including payor claims data, pharmacy data and medical records from hospitals and specialists. Canopy enhances our ability to quickly structure and sort these disparate data sets to develop a comprehensive view of our patients across medical, behavioral and social health attributes. We leverage artificial intelligence and machine learning capabilities to create and refine our clinical rules engine (predictive models and prescriptive algorithms) that informs care delivery and addresses hospital admissions and readmissions, medical costs and patient retention. Our algorithms are internally developed and optimized for the primary care setting, undergo rapid iteration cycles and benefit from clinician partnership and input.

When paired with our operational expertise, we believe Canopy is a key driver in our ability to scale our platform quickly and consistently, while delivering evidence-based care in a value-based model.

Our Care Delivery Approach

Our care delivery approach consists of three core components:

- ***Personalized Primary Care***. We provide preventative care addressing the needs of the whole person— medical, social and behavioral. Upon joining Oak Street Health, our patients undergo a structured geriatric assessment to understand their care needs. We input these assessments, along with other available data, into Canopy, which analyzes multiple patient risk factors using our internally developed algorithms to stratify patients by their risk of experiencing an acute event. Based on this analysis, we create a tailored, individualized care plan that determines the ideal frequency of primary care visits and use of disease-specific programs. Our patients experience the results of this differentiated approach through approximately eight physician visits per year, significantly more visits than a patient can expect with a typical primary care physician, with our sickest patients being seen even more frequently. In addition, we manage the total number of patients assigned to a Care Team at each center to allow each Care Team to spend more time with their patients and reduce wait times.

- ***Proactive Patient Health Management***. In addition to spending more time with our patients, our smaller ratio of patients to Care Teams allows our physicians to reserve time daily to review their patients' care plans and each week conduct a deeper dive on high-risk patients. The Oak Street Platform leverages Canopy's robust data and analytics to generate insights, which are fed into our custom-built workflow applications in order to identify additional actions to take, gaps to close and interventions to perform on our patients. This systematic review of each of our patients is designed to ensure that once a Medicare member becomes an Oak Street patient, they stay current with their recommended health management plan, do not fall through the cracks of the healthcare systems and therefore remain on the path to better health.

- ***Enhanced Clinical Services***. Using Canopy's internally developed algorithms, we identify high-risk patients with specific needs outside of primary care and provide multi-disciplinary interventions to improve outcomes and reduce cost. We offer a number of programs that are integrated into our care model and that would not typically be available to patients under legacy

fee-for-service models, including behavioral health, home-based primary care by dedicated provider teams, virtual digital offerings, medication management, social determinant support, 24x7 live phone support by our clinical call center and transitional care support to help our patients navigate the care journey outside of our centers.

Our care delivery model is the result of years of research, observation, iteration and enhancement, and we continue to invest in improving our approach.

Our Value Proposition

We believe that, despite a history of net losses, our healthcare ecosystem provides all constituencies involved in our care delivery model with the opportunity to "Win." The Oak Street Platform incentivizes our patients, our payors and our providers to adopt our vision and rewards them each in a meaningful way.

Our Patients "Win" due to Measurably Better Health Outcomes and Patient Experience

Our patients have complex health needs. As of December 31, 2022, the average income of our patient base, as self- reported to us, was less than $17,500, and the average age was 68 years old. More than 58% identify as African American, Latino or Indigenous. Approximately 42% of our patients are dual eligible for both Medicare and Medicaid as of the year ended December 31, 2022. Approximately 45% struggle with one or more social risk factors like isolation and lack of access to housing and food that are considered social determinants of health. Approximately 88% of our at-risk patients have one or more chronic conditions, with the average at-risk patient having three or more chronic conditions. We currently provide care to this population in at least 25 different languages. The Oak Street Platform is designed to address their needs and drive top-rated quality performance, outstanding health outcomes and an experience our patients love.

In 2021, the Company formed a Diversity, Equity and Inclusion ("DE&I") Committee working group to stop the use of race-based estimated glomerular filtration rate (eGFR) for Black/African American patients for Chronic Kidney Disease (CKD) testing. This is a step towards reducing health disparities by eliminating potential sources of bias in our clinical protocols and will give our Black/African American patients increased access to appropriate kidney care.

Our Payors "Win" as Medical Costs Decline, Membership Volumes Increase, and Medicare Quality Metrics Improve

Although we have limited experience managing contracts with full risk, since entering into our first fully capitated contracts in 2016 we have worked closely with key payors to improve outcomes for patients. Our demonstrated track record of improving patient outcomes enables payors to become net beneficiaries when we open centers in locations where they have insured Medicare members or desire to grow. Payors dedicate a large share of their efforts to reducing medical costs and they have a strong desire to engage with solutions proven to achieve that goal. We believe that our ability to remove unnecessary costs through a comprehensive approach to patient care makes us a partner of choice for payors and allows payors to lock in improved medical cost performance. Also, our strong performance in Medicare quality metrics, as demonstrated by our achievements in addressing Healthcare Effectiveness Data and Information Set ("HEDIS") gaps and adherence to evidence-based care guidelines, supports improvements in payors' quality score, which increases their revenues. On the whole, we believe we represent an attractive opportunity for payors to meaningfully improve their financial results.

As of December 31, 2022, we had contractual relationships with over 30 payor partners, including all of the top five national MA payors. A significant portion of our revenues are concentrated with the following three large payors: Humana, WellCare/Meridian and Cigna HealthSpring, which together comprised approximately 55% of our capitated revenue for the year ended December 31, 2022, with 32% from Humana, 17% from WellCare/Meridian and 6% from Cigna HealthSpring.

Our Providers "Win" because the Oak Street Platform Allows Them to Focus on Improving the Lives of Their Patients

Our providers are supported by integrated Care Teams that partner together to take care of patients and allow providers to spend more time with patients. Additionally, the Oak Street Platform is enabled by technology that our providers leverage to ensure they are aware of each patient's health history and potential risks, helping to inform proper diagnoses. The Oak Street Platform is designed to reward quality, not quantity, of care. Provider compensation is determined by quality measures across the population of patients for which they are responsible and is not linked to visit volume. This dynamic is valued by providers because it reduces the potential for burnout and rewards them for making decisions in the best interest of their patients.

The net result of our model is that our providers have a smaller number of patients to care for, more time with patients, more support from our Care Teams and better technology to help them care for patients.

We "Win" through a Virtuous Cycle that Promotes Growth across All Facets of Our Business and Drives Our Financial Results

The Oak Street Platform generates a positive feedback loop that can drive our expansion and can perpetuate growth, unlocking the embedded economics of our business as we add centers and those centers mature. We built Oak Street Health to serve patients and provide measurably better health in all communities we serve. By reducing overall cost and by increasing the investment in primary and preventive care, we put the dollars where they better serve our patients and increase their overall well-being. We have created a model that incentivizes all constituencies to work together because everyone "Wins." When all constituencies benefit, we can share in the value. By structuring the majority of our contracts with MA plans and CMS as fully capitated arrangements for managing their members, we capture the meaningful value we create by increasing care quality, improving health outcomes and saving the healthcare system money. This potential surplus can then be reinvested in the business to expand and improve our care model which leads to more savings, powering a self-driven cycle of investment and growth that we believe allows us to scale nationally and rebuild healthcare as it should be.

Our Competitive Advantages

We Purpose-Built the Oak Street Platform from the Ground Up

The Oak Street Platform was designed to manage Medicare-eligible patients' total cost of care through capitated, value-based payments. We designed a brand-new model because the existing primary care infrastructure was not built to be able to provide the type of care necessary to drive the massive improvements in cost and quality the health system needs. We decided to focus on the Medicare market due to its size, growth tailwinds and largely clinically cohesive population. We designed the Oak Street Platform to take risk in managing patients' health below an agreed-upon baseline cost because we believed there was a meaningful opportunity to generate system-wide cost savings and we saw an opportunity to capture the value we created by delivering those results. The purposeful design of the Oak Street Platform against a specific population with similar clinical needs differentiates it from the majority of other players in the healthcare delivery system.

Positive Feedback Loop Accelerates Our Business

We have created an environment in which our strong performance in one dimension accelerates performance in another, which, in turn, leads to growth in yet another aspect of our business.

Custom-Designed, Integrated End-to-End Technology

Canopy is designed to fit seamlessly into our care delivery model and Care Team workflows. As we scale, so does our technology. With the benefit of larger data pools as our business grows, Canopy will be able to produce increasingly powerful data insights that will equip us with more tools to improve the health of our

patients. We believe that we have only begun to unlock the value of our data assets, which are growing rapidly as we open new centers and add more patients.

Multichannel, Community-Based Marketing and Patient Recruitment

We employ a multichannel marketing strategy that goes directly to our target customer. We fundamentally control our own destiny and can scale the number of centers on our platform rapidly and fill them with any interested patients we attract.

Highly Recurring Customer Base Creates Subscription-Like Revenue Model

Our patients benefit from our offering, and they rarely leave. Because we generate the majority of our revenue on a PPPM basis and we are able to consistently retain patients, we have significant visibility into our future financial performance. This provides us the flexibility to quickly adapt to changing circumstances and deliver what we believe to be the right care in the right setting, as we did with telehealth in the period from March to June 2020, without having an immediate adverse impact to our revenue.

A Flexible Model Able to Match Patient Needs and Preferences

The COVID-19 pandemic created difficulties for traditional fee-for-service model providers to provide care while causing changes to patient's preferred means of engagement. The changes in preference are not uniform, with some patients preferring traditional in-person visits while others would prefer leveraging telehealth.

We believe we have been able to effectively complement in-person care with telehealth visits and can continue to do so. For reasons of both patient preference and clinical need, we believe our model's adaptability and our ability to effectively engage our patients in numerous ways without negatively impacting our capitated revenue will be an advantage for Oak Street Health.

Mission-Driven Team with Unique "Oaky" Culture

Our team has a steadfast commitment to executing on the mission and vision of our business. To achieve our goals, we have developed an "Oaky" culture centered around creating an unmatched patient experience, driving clinical excellence, taking ownership, fostering innovation and radiating positive energy.

Our Growth Strategy

The key elements of our growth strategy include:

- increase patient enrollment within existing centers;
- add additional centers in existing markets;
- expand into new markets;
- movement of current patients from fee-for-service to value-based arrangements; and
- continue to optimize the Oak Street Platform.

We Are Engineered to be Scalable

We have proven our ability to execute our model, evidenced by the consistency of our performance as we have grown to date. Our performance has improved each year across all markets as our centers mature.

We believe that we have created a repeatable, data-driven playbook to expand our brand and presence across the United States and we have made substantial investments to support each key component of our approach. The fundamental aspects of our playbook include a data-driven approach to site selection based on our key criteria, a focused approach to recruiting and developing talent (including physicians, nurse practitioners, Care Team members and regional leaders) and an efficient go-to-market model with grassroots community outreach to engage and attract patients.

Intellectual Property and Licenses

This filing includes our trademarks and service marks, such as "Oak Street Health" and "RubiconMD", which are protected under applicable intellectual property laws and are the property of us or our subsidiaries. This filing also contains trademarks, service marks, trade names and copyrights of other companies, such as "Humana," "Meridian/WellCare," and "Cigna HealthSpring," which are the property of their respective owners. Solely for convenience, trademarks and trade names referred to in this filing may appear without the ® or ™ symbols, but such references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or the rights of the applicable licensor to these trademarks and trade names.

Our continued growth and success depend, in part, on our ability to protect our intellectual property and internally developed technology, including Canopy. We primarily protect our intellectual property through a combination of copyrights, trademarks and trade secrets, intellectual property licenses and other contractual rights (including confidentiality and non-disclosure with our employees, independent contractors, consultants and companies with which we conduct business). Based upon our experience providing care in 169 centers across 21 states as of December 31, 2022, we continuously evaluate the needs of our providers and the tools that Canopy can provide and make improvements and add new features based on those needs. Although we do not currently hold a patent for Canopy, we continually assess the most appropriate methods of protecting our intellectual property and may decide to pursue available protections in the future.

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

Seasonal Variations in Business

Our business experiences some variability depending upon the time of year. We experience a significant portion of our at-risk patient growth during the first quarter, when plan enrollment selections made during the prior Annual Enrollment Period ("AEP") take effect. In addition, in January of each year, CMS revises the risk adjustment factor for each patient based upon health conditions documented in the prior year, leading to an overall increase in per-patient revenue. As the year progresses, our per-patient revenue declines as new patients join us typically with less complete or accurate documentation (and therefore lower risk-adjustment scores) and patient attrition (for example, due to mortality) disproportionately impacts our higher-risk (and therefore greater revenue) patients.

Medical costs will vary seasonally depending on a number of factors but most significantly the weather and business days. Certain illnesses, such as the influenza virus, are far more prevalent during colder months of the year, which will result in an increase in medical expenses during these time periods. We would therefore expect to see higher levels of per-patient medical costs in the fourth quarter. See the summary of quarterly results

(unaudited) in Note 18, Quarterly Financial Information, to the Consolidated Financial Statements included in Part IV, Item 15 below.

Working Capital Practices

The Company uses various techniques to maintain working capital. The Company has historically financed its operations through private placements of our equity securities, payments received from various payors, issuance of convertible notes and term loans and our IPO. For additional information, see Liquidity and Capital Resources section in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7, below.

Competitive Conditions

The U.S. healthcare industry is highly competitive. We compete with large and medium-sized local and national providers of primary care services, such as ChenMed, Cano Health, Centerwell and health system affiliated practices, for, among other things, contracts with payors, recruitment of physicians and other medical and non-medical personnel and individual patients. Our principal competitors for patients and payor contracts vary considerably in type and identity by market. Because of the low barriers of entry into the primary care business and the ability of physicians to own primary care centers and/or also be medical directors for their own centers, competition for growth in existing and expanding markets is not limited to large competitors with substantial financial resources. There have also been increasing indications of interest from non-traditional providers and others to enter the primary care space and/or develop innovative technologies or business activities that could be disruptive to the industry. For example, payors have and may continue to acquire primary care and other provider assets. Our growth strategy and business could be adversely affected if we are not able to continue to penetrate existing markets, successfully expand into new markets, maintain or establish new relationships with payors, recruit qualified physicians or if we experience significant patient attrition to our competitors. See "Risk Factors—Risks Related to Our Business—The healthcare industry is highly competitive."

We believe the principal competitive factors for serving the healthcare market for adults on Medicare include: patient experience, quality of care, health outcomes, total cost of care, brand identity, insurance coverage and/or trust in that brand. We believe we compete favorably on these factors.

Government Regulations

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

- suspension or termination of our participation in government and/or private payment programs;
- refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- loss of our licenses required to operate healthcare facilities or administer pharmaceuticals in the states in which we operate;
- criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Civil Monetary Penalties Law of

the Social Security Act, Stark Law, the FCA and/or state analogs to these federal enforcement authorities, or other regulatory requirements;

- enforcement actions by governmental agencies and/or state law claims for monetary damages by patients who believe their health information has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including the regulations implementing HIPAA and the Privacy Act;

- mandated changes to our practices or procedures that significantly increase operating expenses or decrease our revenue;

- imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines, among other things;

- termination of various relationships and/or contracts related to our business, including joint venture arrangements, contracts with payors, real estate leases and provider employment arrangements;

- changes in and reinterpretation of rules and laws by a regulatory agency or court, such as state corporate practice of medicine laws, that could affect the structure and management of our business and its affiliated physician practice corporations;

- negative adjustments to government payment models including, but not limited to, Medicare Parts A, B and C and Medicaid; and

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

We expect that our industry will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. Our activities could be subject to investigations, audits and inquiries by various government and regulatory agencies and private payors with whom we contract at any time in the future. Adverse findings from such investigations and audits could bring severe consequences that could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price. In addition, private payors could require pre-payment audits of claims, which can negatively affect cash flow, or terminate contracts for repeated deficiencies.

There is no requirement in the states in which we operate for a risk-bearing provider to register as an insurance company, and we have not registered as such in any of the states in which we operate.

Federal Anti-Kickback Statute

The federal Anti-Kickback Statute 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.

Federal criminal penalties for the violation of the federal Anti-Kickback Statute include imprisonment, fines and exclusion of the provider from future participation in the federal healthcare programs, including Medicare and Medicaid. Violations of the federal Anti-Kickback Statute are punishable by imprisonment for up to ten years, fines of up to $100,000 per kickback or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities

convicted of violating the federal Anti-Kickback Statute are subject to mandatory exclusion from participation in Medicare, Medicaid and other federal healthcare programs for a minimum of five years. Civil penalties for violation of the Anti-Kickback Statute include up to $100,000 in monetary penalties per violation, repayments of up to three times the total payments between the parties to the arrangement and suspension from future participation in Medicare and Medicaid. Court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals. The ACA amended the federal Anti-Kickback Statute to clarify the intent that is required to prove a violation. Under the statute as amended, the defendant does not need to have actual knowledge of the federal Anti-Kickback Statute or have the specific intent to violate it. In addition, the ACA amended the federal Anti-Kickback Statute to provide that any claims for items or services resulting from a violation of the federal Anti-Kickback Statute are considered false or fraudulent for purposes of the FCA.

The federal Anti-Kickback Statute includes statutory exceptions and regulatory safe harbors that protect certain arrangements. These exceptions and safe harbors are voluntary. Business transactions and arrangements that are structured to comply fully with an applicable safe harbor do not violate the federal Anti-Kickback Statute. However, transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the law. When an arrangement does not satisfy a safe harbor, the arrangement must be evaluated on a case-by-case basis in light of the parties' intent and the arrangement's potential for abuse. Arrangements that do not satisfy a safe harbor may be subject to greater scrutiny by enforcement agencies.

We enter into several arrangements that could potentially implicate the Anti-Kickback Statute if requisite intent was present, such as:

- Joint ventures. We operate certain of our centers under joint ventures with managed care plans or other healthcare providers. For the years ended December 31, 2022, 2021 and 2020, these joint ventures represented an immaterial portion of our total revenues. Although we do not expressly seek to enter into new joint ventures, it is possible that the payor landscape in certain markets we may attempt to enter in the future may make entering into additional joint ventures attractive. Our relationships with payors may not fully satisfy a safe harbor. Although failure to comply with a safe harbor does not render an arrangement illegal under the federal Anti-Kickback Statute, an arrangement that does not operate within a safe harbor may be subject to increased scrutiny and the Office of Inspector General (the "OIG") of HHS has warned in the past that certain joint venture relationships have a potential for abuse. Joint ventures that fall outside the safe harbors are evaluated on a case-by-case basis under the federal Anti-Kickback Statute. In this regard, we have endeavored to structure our joint ventures to satisfy as many elements of the safe harbor for investments in small entities as we believe are commercially reasonable. For example, we believe that these investments are offered and made by us on a fair market value basis and provide returns to the investors in proportion to their actual investment in the venture. However, since the arrangements may not satisfy all of the requirements of an applicable safe harbor, these arrangements could be subject to scrutiny on the ground that they are intended to induce patient referrals.

- Lease arrangements. We lease space for certain of our centers from one of our payor partners. We endeavor to structure these arrangements to comply with the federal Anti-Kickback Statute safe harbor for space rentals in all material respects.

- Discounts. Our centers sometimes acquire certain items and services at a discount that may be reimbursed by a federal healthcare program. We endeavor to structure our vendor contracts that include discount or rebate provisions to comply with the federal Anti-Kickback Statute safe harbor for discounts.

- Sales forces and patient recruitment. The OIG has expressed concern regarding the use of non-employed sales forces to recruit or facilitate the recruiting of patients or referrals, especially when the sales agent is compensated in a manner that provides rewards or incentives on a volume or value basis. Accordingly, commissions or per-patient based compensation

methodologies are closely scrutinized by federal agencies. We employ our own sales force and attempt to meet the Anti-Kickback Safe Harbor for Bona Fide Employment; however, in limited instances we use external companies to assist with certain aspects of these efforts and attempt to structure to meet the Personal Services Safe Harbor. In doing so, we believe that these arrangements do not violate the Anti-Kickback Statute or other applicable laws. Additionally, the provision of free or discounted items, services or other remuneration in connection with patient recruitment has been scrutinized by OIG. We attempt to structure any offer or actual transfer of remuneration to prospective or current patients in a manner consistent with applicable exceptions and guidance issued by OIG. On November 1, 2021, the Company received a civil investigative demand ("CID") from the United States Department of Justice. According to the CID, the Department of Justice is investigating whether the Company may have violated the False Claims Act, 31 U.S.C. §§ 3729-3722. The CID requests certain documents and information related to the Company's relationships with third-party marketing agents and related to the Company's provision of free transportation to federal health care beneficiaries and requests information and documents related to such matters. We are continuing to cooperate with the Department of Justice in response to the CID. We are currently unable to predict the outcome of this investigation or whether litigation is probable. Regardless of the outcome, this inquiry has the potential to have an adverse impact on us due to any related defense and settlement costs, diversion of management resources and other factors.

On January 10, 2022, Reginald T. Allison, individually and on behalf of all others similarly situated, filed a putative class action lawsuit against Oak Street Health, Inc., Michael Pykosz and Timothy Cook, General Atlantic LLC and General Atlantic (OSH) Interholdco, L.P., Newlight Partners LP, Newlight Harbour Point SPV and members of the Company's Board of Directors in the United States District Court for the Northern District of Illinois (Case No: 1:22-cv-00149).

On March 25, 2022, Central Pennsylvania Teamsters Pension Fund – Defined Benefit Plan, Central Pennsylvania Teamsters Pension Fund – Retirement Income Plan 1987, and Boston Retirement System's (collectively, the "Northeast Pension Funds") were appointed as the lead plaintiffs in the case. On May 25, 2022, the Northeast Pension Funds along with an additional named plaintiff, the City of Dearborn Police & Fire Revised Retirement System, filed their consolidated amended and restated complaint (the "Amended Complaint").

Plaintiffs allege that the Company and certain of its executive officers made false and/or misleading statements about patient acquisition tactics that purportedly violated the False Claims Act and federal Anti-Kickback Statute, and are purportedly the subject of the CID discussed above. The Amended Complaint includes two categories of claims: (1) claims under the Securities Exchange Act of 1934 based on allegedly misleading public statements throughout the class period of August 6, 2020 through November 8, 2021 (the "Exchange Act Claims"), and (2) claims under the Securities Act of 1933 based on allegedly misleading statements in the registration statements and prospectuses accompanying Oak Street Health, Inc.'s initial public offering and secondary public offerings (the "Securities Act Claims"). The Exchange Act claims are asserted against Oak Street Health, Inc., Michael Pykosz, our CEO and Timothy Cook, our CFO, and also against certain stockholders of as "control persons." The Securities Act Claims are asserted against the same defendants as well as the underwriters of the Company's public offerings, and the Oak Street Health, Inc. directors who signed the registration statements. The Amended Complaint seeks damages, interest, costs, attorneys' fees and other unspecified equitable relief.

On July 25, 2022, the defendants filed a consolidated motion to dismiss the Amended Complaint. On September 26, 2022, the plaintiffs' opposition to that motion to dismiss was filed, and the defendants reply to that opposition was filed on October 26, 2022. On February 10, 2023, the Court ruled on the motion to dismiss, granting the Company's motions to dismiss with respect to the plaintiffs' section 12(a)(2) claim and section 11 claim based on misrepresentations from the May 2021 secondary public offering, and denying the remainder of the motion. The Company intends to continue to defend these claims vigorously.

If any of our business transactions or arrangements, including those described above, were found to violate the federal Anti-Kickback Statute, we could face, among other things, criminal, civil or administrative sanctions, including possible exclusion from participation in Medicare, Medicaid and other state and federal healthcare programs. Any findings that we have violated these laws could have a material adverse impact on our business, results of operations, financial condition, cash flows, reputation and stock price.

Risk Bearing Provider Regulation

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 providers like us and our affiliated providers. These regulations can include capital requirements, licensing or certification, governance controls and other similar matters. While these regulations have not had a material impact on our business to date, as we continue to expand, these rules may require additional resources and capitalization and add complexity to our business.

Stark Law

The Stark Law prohibits a physician who has a financial relationship, or who has an immediate family member who has a financial relationship, with entities providing Designated Health Services ("DHS") from referring Medicare patients to such entities for the furnishing of DHS, unless an exception applies. Although uncertainty exists, federal agencies and at least one court have taken the position that the Stark Law also applies to Medicaid. DHS is defined to include clinical laboratory services, physical therapy services, occupational therapy services, radiology services including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services, radiation therapy services and supplies, durable medical equipment and supplies, parenteral and enteral nutrients, equipment, and supplies, prosthetics, orthotics and prosthetic devices and supplies, home health services, outpatient prescription drugs, inpatient and outpatient hospital services and outpatient speech-language pathology services. The types of financial arrangements between a physician and an entity providing DHS that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements. The Stark Law prohibits any entity providing DHS that has received a prohibited referral from presenting, or causing to be presented, a claim or billing for the services arising out of the prohibited referral. Similarly, the Stark Law prohibits an entity from "furnishing" a DHS to another entity in which it has a financial relationship when that entity bills for the service. The Stark Law also prohibits self-referrals within an organization by its own physicians, although broad exceptions exist that cover employed physicians and those referring DHS that are ancillary to the physician's practice to the physician group. The prohibition applies regardless of the reasons for the financial relationship and the referral. Unlike the federal Anti-Kickback Statute, the Stark Law is a strict liability violation where unlawful intent need not be demonstrated.

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

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

Fraud and Abuse under State Law

Some states in which we operate centers have laws prohibiting physicians from holding financial interests in various types of medical facilities to which they refer patients. Some of these laws could potentially be interpreted broadly as prohibiting physicians who hold shares of our publicly traded stock or are physician owners from referring patients to our centers if the centers perform services for their patients or do not otherwise satisfy an exception to the law. States also have laws similar to or stricter than the federal Anti-Kickback Statute that may affect our ability to receive referrals from physicians with whom we have financial relationships. Some state anti-kickback laws also include civil and criminal penalties. Some of these laws include exemptions that may be applicable to our physician relationships or for financial interests limited to shares of publicly traded stock. Some, however, may include no explicit exemption for certain types of agreements and/or relationships entered into with physicians. If these laws are interpreted to apply to physicians who hold equity interests in our centers or to physicians who hold our publicly traded stock, and for which no applicable exception exists, we may be required to terminate or restructure our relationships with these physicians and could be subject to criminal, civil and administrative sanctions, refund requirements and exclusions from government healthcare programs, including Medicare and Medicaid, which could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation and stock price.

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

Corporate Practice of Medicine and Fee-Splitting

The laws and regulations relating to our operations vary from state to state and many states prohibit general business corporations, such as us, from practicing medicine, controlling physicians' medical decisions or engaging in some practices such as splitting professional fees with physicians. We currently contract with affiliated physician-owned professional corporations who provide healthcare services that are required to be provided by licensed healthcare professionals. Pursuant to the MSA, we provide a comprehensive suite of administrative services to those professional corporations in exchange for the payment by such professional corporations of a management fee. While we believe that we are in substantial compliance with state laws prohibiting the corporate practice of medicine and fee-splitting, other parties may assert that, despite the way we are structured, we could be engaged in the corporate practice of medicine or unlawful fee-splitting. Were such allegations to be asserted successfully before the appropriate judicial or administrative forums, we could be subject to adverse judicial or administrative penalties, certain contracts could be determined to be unenforceable and we may be required to restructure our contractual arrangements. The laws of other states do not prohibit non-physician entities from employing physicians to practice medicine but may retain a ban on some types of fee-splitting arrangements.

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

Telehealth Regulations

During the COVID-19 pandemic, the use of telehealth services increased dramatically. There are a myriad of state and federal regulations relating to telehealth, including licensure of the professional involved,

locations of services, modality, privacy, establishment of a provider/patient relationship and recordkeeping. In response to the COVID-19 pandemic, CMS has made several changes in the manner in which Medicare will pay for telehealth visits, many of which relax previous requirements, including site requirements for both the providers and patients, telehealth modality requirements and others. State law applicable to telehealth, particularly licensure requirements, has also been relaxed in many jurisdictions as a result of the COVID-19 pandemic. These relaxed regulations allowed us to continue operating our business and delivering care to our patients predominantly through telehealth modalities during the height of the COVID-19 pandemic. It remains unclear which, if any, of these changes will remain in place permanently and which will be rolled-back as the recovery form the COVID-19 pandemic continues. Although telehealth represents a much smaller portion of our overall business today than it did during the peak of the COVID-19 pandemic because we are now able to see the majority of our patient in person, if regulations change to restrict our ability to or prohibit us from delivering care through telehealth modalities, our financial condition and results of operations may be adversely affected.

The False Claims Act

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

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

In addition, amendments to the FCA and Social Security Act impose severe penalties for the knowing and improper retention of overpayments collected from government payors. Under these provisions, within 60 days of identifying and quantifying an overpayment, a provider is required to notify CMS or the Medicare Administrative Contractor of the overpayment and the reason for it and return the overpayment. An overpayment impermissibly retained could subject us to liability under the FCA, exclusion from government healthcare programs and penalties under the federal Civil Monetary Penalty statute. As a result of these provisions, our procedures for identifying and processing overpayments may be subject to greater scrutiny.

The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On December 13, 2021, the DOJ issued a final rule announcing adjustments to FCA penalties, under which the per claim range increases to a range from $11,803 to $23,603 per claim.

The federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including but not limited to coding errors, billing for services not rendered, the submission of false cost or other reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code, billing for care that is not considered medically necessary and false reporting of risk-adjusted diagnostic codes to MA plans. The ACA provides that claims tainted by a violation of the federal Anti-Kickback Statute are false for purposes of the FCA. Some courts have held that filing claims or failing to refund amounts collected in violation of the Stark Law can form the basis for liability under the FCA. In addition

to the provisions of the FCA, which provide for civil enforcement, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government. Any allegations or findings that we have violated the FCA could have a material adverse impact on our business, results of operations and financial condition.

As discussed above, on November 1, 2021, the Company received a civil investigative demand ("CID") from the United States Department of Justice. According to the CID, the Department of Justice is investigating whether the Company may have violated the False Claims Act, 31 U.S.C. §§ 3729-3722. The CID requests certain documents and information related to the Company's relationships with third-party marketing agents and related to the Company's provision of free transportation to federal health care beneficiaries and requests information and documents related to such matters. We are continuing to cooperate with the Department of Justice in response to the CID. We are currently unable to predict the outcome of this investigation or whether litigation is probable.

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

Civil Monetary Penalties Statute

The Civil Monetary Penalties Statute, 42 U.S.C. § 1320a-7a, authorizes the imposition of civil monetary penalties, assessments and exclusion against an individual or entity based on a variety of prohibited conduct, including, but not limited to:

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

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

We could be exposed to a wide range of allegations to which the federal Civil Monetary Penalty Statute would apply. We perform monthly checks on our employees, affiliated providers and certain affiliates and vendors

using government databases to confirm that these individuals have not been excluded from federal programs. However, should an individual become excluded and we fail to detect it, a federal agency could require us to refund amounts attributable to all claims or services performed or sufficiently linked to an excluded individual. Likewise, our patient programs, which can include enhancements, incentives and additional care coordination not otherwise covered under traditional Medicare, could be alleged to be intended to influence the patient's choice in obtaining services or the amount or types of services sought. Thus, we cannot foreclose the possibility that we will face allegations subject to the Civil Monetary Penalty Statute with the potential for a material adverse impact on our business, results of operations and financial condition.

Privacy and Security

The federal regulations promulgated under the authority of HIPAA require us to provide certain protections to patients and their health information. The HIPAA privacy and security regulations extensively regulate the use and disclosure of "protected health information" ("PHI") and require covered entities, which include healthcare providers and their business associates, to implement and maintain administrative, physical and technical safeguards to protect the security of such information. Additional security requirements apply to electronic PHI. These regulations also provide patients with substantive rights with respect to their health information.

The HIPAA privacy and security regulations also require us to enter into written agreements with certain contractors, known as business associates, to whom we disclose PHI. Covered entities may be subject to penalties for, among other activities, failing to enter into a business associate agreement where required by law or as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity and acting within the scope of the agency. Business associates are also directly subject to liability under certain HIPAA privacy and security regulations. In instances where we act as a business associate to a covered entity, there is the potential for additional liability beyond our status as a covered entity.

The HHS Office for Civil Rights ("HHS OCR") also has proposed changes to the HIPAA Privacy Rule that have the potential to impact patients, covered entities, and business associates. Certain of the proposed changes are focused on the patient right of access requirements and processes, while other proposed changes would impact how covered entities may share information and would relax the requirements for providers to document how their Notice of Privacy Practices is provided to patients. It is unclear when HHS OCR will issue final regulations.

Covered entities must notify affected individuals of breaches of unsecured PHI without unreasonable delay but no later than 60 days after discovery of the breach by a covered entity or its agents. Reporting must also be made to the HHS Office for Civil Rights and, for breaches of unsecured PHI involving more than 500 residents of a state or jurisdiction, to the media. All impermissible uses or disclosures of unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the PHI has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving personal information without regard to the probability of the information being compromised. We have had no material data breaches during the years 2019- 2022.

Violations of HIPAA by providers like us, including, but not limited to, failing to implement appropriate administrative, physical and technical safeguards, have resulted in enforcement actions and in some cases triggered settlement payments or civil monetary penalties. Penalties for impermissible use or disclosure of PHI were increased by the HITECH Act by imposing tiered penalties of more than $50,000 (as adjusted) per violation and up to $1.5 million (as adjusted) per year for identical violations. In addition, HIPAA provides for criminal penalties of up to $250,000 and ten years in prison, with the severest penalties for obtaining and disclosing PHI with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Further, state attorneys general may bring civil actions seeking either injunction or damages in response to violations of the HIPAA privacy and security regulations that threaten the privacy of state residents. There can be no assurance that we will not be the subject of an investigation (arising out of a reportable breach incident, audit or otherwise) alleging non-compliance with HIPAA regulations in our maintenance of PHI.

Under the 21st Century Cures Act, Congress authorized the HHS Office of the National Coordinator for Health Information Technology ("ONC") to engage in rulemaking that would drive interoperability, prohibit information blocking, and provide timely access to health information through standardized application programming interfaces (APIs) to seamlessly coordinate care, improve outcomes and reduce the cost of care. CMS also finalized regulations under their authority to regulate Medicare and Medicaid managed care plans, qualified health plans offered on the federally facilitated Exchange, and hospitals that improve patient access to their health information and encourage provider-to-provider and payor-to-payor exchanges of health information that are designed to reduce the burden on payors and providers. In October 2020, ONC published an Interim Final Rule that extended the applicability date for the Information Blocking provisions until April 2021. The Interim Final Rule also laid out a compliance timeline that extends through December 31, 2023.

Compliance with changes in privacy and information security laws and with rapidly evolving industry standards may result in our incurring significant expense due to increased investment in technology and the development of new operational processes. Further, to the extent we fail to comply with one or more federal and/or state privacy and security requirements or if we are found to be responsible for the non-compliance of our vendors, we could be subject to substantial fines or penalties, damage to our reputation, as well as third-party claims which could have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

Healthcare reform

In March 2010, significant reforms to the United States health care system were enacted through Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act (collectively the "ACA"). Although many of the provisions of the ACA took effect immediately, and other provisions continue to be delayed and/or subsequently repealed, the reforms could continue to have an impact on our business in a number of ways. We cannot predict how employers, private payors or persons buying insurance might react to federal and state healthcare reform legislation, whether already enacted or enacted in the future, nor can we predict what form many of these regulations will take before implementation.

Other aspects of the 2010 healthcare reform laws may also affect our business, including provisions that impact the Medicare and Medicaid programs. These and other provisions of the ACA remain subject to ongoing uncertainty due to developing regulations and clarifications, including those described above, as well as continuing political and legal challenges at both the federal and state levels. Since 2016, various administrative and legislative initiatives have been implemented that have had adverse impacts on the ACA and its programs. For example, in October 2017, the federal government announced that cost-sharing reduction payments to insurers would end, effective immediately, unless Congress appropriated the funds. In December 2017, Congress passed the Tax Cuts and Jobs Act, which: (i) eliminated the penalty under the ACA's individual mandate for individuals who fail to obtain a qualifying health insurance plan; (ii) repealed the health insurance tax, which applied to most fully insured plans, beginning in 2021; and (iii) repealed the so-called Cadillac Tax, which imposed an excise tax of 40% on premiums for employer-sponsored individuals and families that exceed a certain minimum threshold. Moreover, in February 2018, Congress passed the Bipartisan Budget Act (the "BBA") which, among other things, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending by extending sequestration cuts to Medicare payments through fiscal year 2027. The Coronavirus Aid, Relief and Economic Security Act of 2020 subsequently extended Medicare sequestration cuts through the fiscal year 2030. While certain provisions of the BBA increased the scope of benefits available under MA for certain chronically ill federal health care program beneficiaries beginning in 2020, the ultimate impact of such changes cannot be predicted.

The ACA has also been the subject of continuing legal challenges. Most recently, a collection of 20 state governors and state attorneys general filed a lawsuit against the federal government in the Northern District of Texas seeking to enjoin the entire ACA following the elimination of the individual mandate penalty. In March of 2020 the United States Supreme Court granted cert in the case and heard oral arguments on November 10, 2020. On June 17, 2021, the Supreme Court held that the plaintiffs lacked standing and reversed the Fifth Circuit's

judgment in respect to standing, vacated the Fifth Circuit's judgment and remanded the case with instructions to dismiss the case.

While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. As a result, there is considerable uncertainty regarding the future with respect to the exchanges and other core aspects of the current health care marketplace. Future elections may create conditions for Congress to adopt new federal coverage programs that may disrupt our current commercial payor revenue streams. While specific changes and their timing are not yet apparent, such changes could lower our reimbursement rates or increase our expenses. Any failure to successfully implement strategic initiatives that respond to future legislative, regulatory, and executive changes could have a material adverse effect on our business, results of operations and financial condition.

CMS and state Medicaid agencies also routinely adjust the risk adjustment factor which is central to payment under MA and Managed Medicaid programs in which we participate. The monetary "coefficient" values associated with diseases that we manage in our population are subject to change by CMS and state agencies. Such changes could have a material adverse effect on our financial condition.

Other regulations

Our operations are subject to various state hazardous waste and non-hazardous medical waste disposal laws. These laws do not classify as hazardous most of the waste produced from medical services. Occupational Safety and Health Administration regulations require employers to provide workers who are occupationally subject to blood or other potentially infectious materials with prescribed protections. These regulatory requirements apply to all healthcare facilities, including primary care centers, and require employers to make a determination as to which employees may be exposed to blood or other potentially infectious materials and to have in effect a written exposure control plan. In addition, employers are required to provide or employ hepatitis B vaccinations, personal protective equipment and other safety devices, infection control training, post-exposure evaluation and follow-up, waste disposal techniques and procedures and work practice controls. Employers are also required to comply with various record-keeping requirements.

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

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

Environmental, Social, and Governance ("ESG") and Impact

At Oak Street Health, we believe the success of our business is intertwined with our impact on and relationships with our employees, customers, suppliers and the communities we serve, as well as the accountability of our leadership to shareholders and our impact on the environment. We measure our impact, in part, based on outcomes for our patients, the communities we serve and the U.S. healthcare system. Our care model has consistently demonstrated outstanding clinical results, removed costs and delivered an industry-leading patient experience. As we have expanded across the country, we have targeted working class and underserved communities whose residents need and deserve the care that Oak Street Health provides. In fact, as of December 31, 2022, approximately 42% of our patients are dual eligible, meaning they qualify for both Medicare and Medicaid.

ESG framework

The Oak Street ESG framework is structured around five pillars that underscore our mission to rebuild healthcare as it should be. We drive action through this framework to deliver on our commitment of helping older adults stay healthy and live life more fully. This overarching sense of responsibility guides us as we strive to meet the needs of our many stakeholders.

In 2022, we conducted a materiality assessment, reviewing, assessing and ranking the relative importance of ESG issues for Oak Street Health. This framework is based on that analysis, and identifies our priority issues, which are both relevant to our business and significant to our stakeholders.

Our 5 pillars are:

a. Empowering health equity: We believe quality healthcare should be available to all, regardless of income or background; our value-based care model is designed to put quality care within reach for traditionally underserved neighborhoods

b. Investing in our communities: We strive to be a pillar of our community that serves the needs of all. We seek to uplift the neighborhoods surrounding our centers, from supporting local initiatives to revitalizing areas as we invest in our community clinics

c. Building a great place to work: We are committed to diversity, equity and inclusion ("DE&I") and passionate about creating an environment where teammates feel supported, grow their careers, and make a powerful impact, as our model is only possible with a strong team member base

d. Protecting our stakeholders: We strive to promote ethical behavior, responsible measures around data and privacy, and resilient business practices across our national enterprise

e. Providing sustainable care: We believe responsible environmental stewardship can improve health for patients, communities, and teammates. We strive to identify new efficiencies and make strategic investments that reduce our environmental impact

Looking ahead, we are committed to strengthening these pillars of success, enhancing our impact and fostering healthy and productive relationships with patients and our other key stakeholders.

Health equity

We are focused on providing exceptional care to the Medicare community, with over 90% of our centers located in medically underserved census tracts. 98% of our patients are Medicare enrollees, with an average age of 68, and 42% are also Medicaid enrollees. Our patients' health needs are complex, as 88% of patients have one or more chronic conditions and approximately 50% are identified as vulnerable for activities of daily living.

Our care goes to a diverse population, with over 58% of our patients identifying as African American, Hispanic/Latino, or Indigenous Americans and speaking over 50 languages. Our care goes to those in need: the average patient income is less than $17,500, and 45% of our patients have a housing, food or isolation risk factor. We are committed to bringing high-quality care to our communities and the patients we serve.

Investing in our communities

We make a concerted effort to invest and reinvest dollars to uplift the neighborhoods surrounding our more than 160 centers, from supporting local civic engagement efforts and other initiatives to the revitalization of the areas where we build our community clinics. With each center we've built, we've invested into the built

environment of the local community, providing both jobs to community members and healthcare access and safe community spaces for seniors to gather, interact, and advance their lives. In 2022, we invested approximately $350 million in our communities and created approximately 1,500 new jobs. Ultimately, we strive to be a pillar of our community that serves the needs of all, from hosting events and activities in our community rooms (such as exercise, cooking, computer and painting classes) to serving as trusted, safe community spaces. We are particularly proud of how we've leveraged our deep community relationships to step up as a cross-sector community pillar in times of need, such as during the height of the COVID-19 pandemic, when we delivered food and medication to patients and community members in need and championed equitable testing and vaccination efforts.

Building a great place to work: Employees and Culture

As of December 31, 2022, the Company employed approximately 6,000 employees, including approximately 600 primary care providers. None of our employees are represented by labor unions or covered by collective bargaining agreements. We consider our relationship with our employees to be good. Our latest employee survey from September of 2022 had a 91% response rate and 74% engagement score. In 2022, we also received the following recognitions: Top Places to work for New Orleans, New York City, Chicago, Oklahoma City and overall US.

Our team has a steadfast commitment to executing on the mission and vision of our business. To achieve our goals, we strive to create an "Oaky" culture centered around creating an unmatched patient experience, driving clinical excellence, taking ownership, fostering innovation and radiating positive energy. Our unique combination of talent and healthcare experience across a number of professional settings, as well as our team's commitment to our "Oaky" culture, underpins our success in all that we do.

Building a great place to work: Talent Management and Engagement

Our focused approach to recruiting and developing talent helps us attract outstanding physicians, nurse practitioners, other Care Team members and regional leaders in order to continue to grow and scale our business. We believe that this approach has supported the creation of a strong pipeline of top tier talent for leadership roles within our company and provides a differentiated value proposition for our providers. In recent years, we have created multiple programs (i.e. Executive Women in Leadership and Nurse Practitioner Fellowship) to help us attract best-in-class teams and provide the necessary training to foster professional development. Additionally, we have added a variety of training and development programs, including regional leadership development, in-house provider recruitment and a medical scribe program. We believe we have demonstrated a consistent ability to attract and retain top clinical talent given our unique value proposition to physicians and nurse practitioners. Further, we reward our employees with what we believe they need to succeed, including competitive salaries, performance- based bonus plans, Employee Stock Purchase Plan with a 15% discount and a 401K with a 4% company match. Our team members also have a deep understanding of the communities in which our patients live, as we strive to hire from within the local community.

Building a great place to work: Employee Health and Well-Being

We also offer competitive benefits such as flexible health benefit options, a Health Savings Account plan, protection for the unexpected with Life and Accidental Death & Dismemberment insurance, Short- and Long- Term Disability, backup childcare days, maternity and paternity leave, tuition reimbursement, tax favored benefits through Flexible Spending Accounts and Commuter Assistance. Finally, to support our employees' overall well-being, we offer an Employee Assistance Program.

Building a great place to work: Diversity, Equality and Inclusion

We recognize the importance of having a diverse and inclusive environment as part of our mission of transforming healthcare. We embrace and encourage diversity, equality and inclusion ("DE&I") and strive to continuously improve. To rebuild healthcare as it should be, we have set the following DE&I goals: (1) Build a

diverse and empowered team at all levels of the organization; (2) Advance health equity for patients through outcomes and patient experience; and (3) Improve communities through local investment, job creation and service. We publish an annual Diversity, Equity and Inclusion at Oak Street Health report ("DE&I annual report") to further transparency and accountability on our progress towards these goals. To date, we have furthered our goals by hiring our first Director of DE&I, launching the Executive Women in Leadership program for women in senior director and above roles, providing employees with training in topics such as cultural sensitivity and sexual harassment, seeking employee input on how to make Oak Street Health a more inclusive place to work and establishing a number of People Resource Groups (PRGs) focused on fostering diversity, inclusion and belonging within Oak Street Health (with three added in 2022). In addition, we have endorsed a pledge to collect, stratify and review the race, ethnicity, language and sex data for at least 50% of our patient populations in the next three years and have implemented a Capital Expenditure Diversity Spending program with the intent of monitoring and promoting Oak Street Health's spend with diversity-owned companies in expansion-related capital expenditures.

The following data comes from the DE&I annual report, which contained data for all Oak Street Health team members as of December 31, 2022. The Oak Street Health team is racially diverse: 37% of the Oak Street team identifies as Black or African American, 22% as Hispanic/Latino, 6% as Asian, 27% as White and 3% as more than one race. This diversity is reflective of the communities we serve. Additionally, 78% of our employees identify as female, which is in-line with the healthcare workforce overall. This information is self-reported by over 5,500 employees, as of December 31, 2022. Additionally, 78% of our providers identify as female versus the United States physician workforce of 37%.

Providing Sustainable Care

Responsible and sustainable energy and waste management can reduce our impacts, improve resilience and reduce costs. As of December 31, 2022, over 90% of our centers meet California Title 24 code for water and electricity efficiency, with all new centers meeting the criteria. New centers are built with LED lighting, low-flow plumbing, and energy-efficient window films, and we will continue to review opportunities to reduce our environmental impact.

General Corporate Information

Oak Street Health, Inc. was incorporated as a Delaware corporation on October 22, 2019. Our principal executive offices are located at 30 W. Monroe Street, Suite 1200, Chicago, Illinois 60603. Our telephone number is (888) 898-6762. Our website address is www.oakstreethealth.com. The information contained on, or that can be accessed through, our website is not incorporated by reference into this filing, and you should not consider any information contained on, or that can be accessed through, our website as part of this filing. We are a holding company, and all of our business operations are conducted through our subsidiaries and affiliated medical groups.

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and, if applicable, all amendments to those reports filed or furnished pursuant to Section 13(a) of the Securities Exchange Act of 1934, as amended, are available free of charge on or through our web site, http://www.oakstreethealth.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission, or the SEC. The SEC's website, http://www.sec.gov, contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC.

Item 1A. Risk Factors

In addition to the other information in this report and our other filings with the SEC, you should carefully consider the risks and uncertainties described below, which could materially and adversely affect our business operations, financial condition and results of operations. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties that we are unaware of, or that we currently believe are not material, may also become important factors that affect us.

Summary of Risk Factors

The following is a summary of the risk factors our business faces. The list below is not exhaustive, and investors should read this "Risk Factors" section in full. Some of the risks we face include:

- risks related to our proposed transaction with a subsidiary of CVS Health, including our expectations regarding the timing and completion thereof, and general business uncertainty relating to the pending transaction;
- the risk that the proposed transaction with a subsidiary of CVS Health could lead to business uncertainties and contractual restrictions that could harm our business relationships, financial condition, operating results, cash flows, and business;
- the risk of litigation that could be instituted against the parties to the Merger Agreement or their respective directors, managers or officers and/or regulatory actions related to the proposed acquisition, including the effects of any outcomes related thereto;
- our history of net losses and our ability to achieve or maintain profitability in an environment of increasing expenses;
- our financial condition and results of operations have been and, we expect, will continue to be impacted by ongoing macroeconomic challenges, including labor shortages, supply chain disruptions and inflationary pressures, and an economic downturn or recession, could further adversely impact our business;
- the impact of COVID-19 or any other pandemic, epidemic or outbreak of an infectious disease in the United States or worldwide on our business, financial condition and results of operations;
- the effect of our relatively limited operating history on investors' ability to evaluate our current business and future prospects;
- the viability of our growth strategy and our ability to realize expected results;
- our ability to manage our growth effectively, execute our business plan, maintain high levels of service and patient satisfaction and adequately address competitive challenges;
- our ability to attract new patients;
- the dependence of our revenues and operations on a limited number of key payors;
- the potential adverse impact of legal proceedings and litigation;
- the risk of termination or non-renewal of the Medicare Advantage contracts held by the health plans with which we contract, or the termination or non-renewal of our contracts with those plans;
- the impact on our business from changes in the payor mix of our patients and potential decreases in our reimbursement rates;
- our ability to compete in the healthcare industry;
- our ability to timely enroll new physicians and other providers in governmental healthcare programs before we can receive reimbursement for their services;

- the impact on our business of reductions in Medicare reimbursement rates or changes in the rules governing the Medicare program;
- our dependence on reimbursements by third-party payors and payments by individuals;
- our assumption under most of our agreements with health plans of some or all of the risk that the cost of providing services will exceed our compensation;
- the impact on our business of renegotiation, non-renewal or termination of capitation agreements with health plans;
- the impact on our results from operations from Medicare's risk adjustment payment system;
- the impact on our business of security breaches, loss of data or other disruptions causing the compromise of sensitive information or preventing us from accessing critical information;
- the impact on our business of disruptions in our disaster recovery systems or management continuity planning;
- the impact of reductions in the quality ratings of the health plans we serve;
- the risk of our agreements with the physician equity holder of our practices being deemed invalid;
- our ability to maintain and enhance our reputation and brand recognition;
- our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems;
- our ability to obtain, maintain and enforce intellectual property protection for our technology;
- the potential adverse impact of claims by third parties that we are infringing on or otherwise violating their intellectual property rights;
- risks associated with existing litigation;
- our ability to protect the confidentiality of our trade secrets, know-how and other internally developed information;
- the impact of any restrictions on our use of or ability to license data or our failure to license data and integrate third-party technologies; and
- other risk factors listed in this "Risk Factors" section.

Risks Related to our Proposed Transaction with CVS Health

Uncertainties associated with the Merger, including the risk that the Merger may not close in the anticipated timeframe or at all due to one or more of the closing conditions to the Merger not being satisfied

or waived, may have an adverse effect on our business, financial condition, results of operations and stock price.

On February 7, 2023, we entered into the Merger Agreement with a subsidiary of CVS Health, providing for our acquisition. If the Merger is completed, we will become a privately held company, meaning that the Company's common stock will be delisted from the New York Stock Exchange and deregistered under the Exchange Act.

Completion of the Merger is subject to various closing conditions, including, among other things, approval of the adoption of the Merger Agreement by our stockholders and the expiration or termination of the applicable waiting period under the HSR Act. The regulatory agencies have broad discretion in administering the antitrust laws and could seek to impose requirements, limitations or costs or require divestitures or place restrictions on the conduct of the parties' business as a condition to the expiration or termination of the applicable waiting period under the HSR Act. Although each party is required to use reasonable best efforts to cause such expiration or termination as soon as practicable, subject to certain exceptions specified in the Merger Agreement, these requirements, limitations, costs, divestitures or restrictions (many of which have certain factors not in our control) could jeopardize or delay the consummation of the Merger. Further, if the Merger has not been consummated on or before February 7, 2024 (which date is subject to automatic extension for two additional periods, in each case under certain circumstances, up to December 23, 2024), then the Merger Agreement may be terminated by either party. There is no assurance that expiration or termination of the applicable waiting period under the HSR Act will occur, or that all of the other closing conditions will be satisfied (or waived, to the extent permitted by applicable law), or that the Merger will be completed on the terms reflected in the Merger Agreement, within the expected timeframe, or at all.

The announcement and pendency of the Merger may create disruption in and uncertainties for our business, which could have an adverse effect on our ability to retain and hire key personnel and to maintain relationships with our business partners, suppliers and customers, including with respect to Humana Inc. and its affiliates, which lease or license to us a majority of our primary care centers. These business partners (including payor partners) or suppliers could attempt to negotiate changes in existing business relationships, consider entering into business relationships with parties other than us, delay or defer decisions concerning their business with us, or terminate their existing business relationships with us during pendency of the Merger. Adverse changes in our relationships with employees, business partners, suppliers and customers may continue or intensify in the event the Merger is not consummated or is significantly delayed. As a result, there can be no assurance that our business, financial condition and results of operations will not be adversely affected, as compared to prior to the announcement of the Merger Agreement. Management's attention may also be diverted towards activities focused on completing the Merger, which could further impact these relationships and also the execution of our business plan and the quality of our services.

If the Merger is not completed, we and our stockholders may suffer other consequences. To the extent that the current market price of our stock reflects an assumption that the Merger will be completed, the price of our common stock could decrease if the Merger is not completed. Further, investor confidence in us could decline, and stockholder litigation could be brought against us. In addition, we will have incurred significant costs, expenses and fees for professional services and other transaction costs in connection with the Merger, including for activities that we would have not undertaken other than to complete the Merger. As a result, to the extent the Merger is not completed, we will receive little or no benefit from incurring these costs, and in the absence of the Merger, these costs may have been allocated elsewhere. In addition, if the Merger Agreement is terminated under certain circumstances, we may be required to pay a subsidiary of CVS Health a termination fee equal to $300 million, which could have adverse effect on our financial condition and results of operations.

Even if successfully completed, there are certain risks to our stockholders from the Merger, including: we may experience a departure of employees prior to the closing of the Merger; the amount of cash to be paid under the Merger Agreement is fixed and will not be adjusted for changes in our business, assets, liabilities, prospects, outlook, financial condition or operating results or in the event of any change in the market price of, analyst estimates of, or projections relating to, our common stock; receipt of the all-cash per share Merger

consideration under the Merger Agreement is taxable to stockholders that are treated as U.S. holders for U.S. federal income tax purposes; and if the Merger is completed, our stockholders will forego the opportunity to realize the potential long-term value of the successful execution of our current strategy as an independent company.

The Merger Agreement contains provisions that limit our ability to pursue alternatives to the Merger.

Under the Merger Agreement, we are restricted from soliciting, initiating, proposing, knowingly inducing or knowingly encouraging, facilitating or assisting alternative acquisition proposals from third parties and/or providing non-public information to third parties in response to any inquiries regarding, or the submission of any proposal or offer that constitutes, or would reasonably be expected to lead to, any Acquisition Proposal (as defined in the Merger Agreement). These provisions could discourage a third party that may have an interest in acquiring all or a significant part of our business from considering or proposing that acquisition, even if such third party were prepared to pay consideration with a higher value than the value of the consideration in the Merger.

We are subject to certain restrictions on the conduct of our business under the terms of the Merger Agreement.

Under the terms of the Merger Agreement, we have agreed to certain restrictions on the operations of our business that could harm our business relationships, financial condition, operating results, cash flows and business, including restrictions with respect to our ability to, among other things, subject to certain specified exceptions: adopt, amend, modify or terminate any employee plans (as defined in the Merger Agreement); materially increase the compensation of any director, officer or employee; hire or terminate any employee earning above a certain salary or wage (other than in the ordinary course); compromise or settle certain legal proceedings; change our methods, principles or practices of financial accounting; incur capital expenditures above specified thresholds; freely issue securities; and incur indebtedness (subject to certain exceptions). Because of these restrictions, we may be prevented from undertaking certain actions with respect to the conduct of our business that we might otherwise have taken if not for the Merger Agreement. Such restrictions could prevent us from pursuing certain business opportunities that arise prior to the effective time of the Merger and are outside the ordinary course of business, and could otherwise adversely affect our business and operations prior to completion of the Merger.

Lawsuits may arise in connection with the Merger, which could delay or prevent completion of the Merger and adversely affect our or CVS Health's business, financial condition and operating results.

Lawsuits relating to the Merger could be filed against the Company or CVS Health, including by stockholders of the Company or CVS Health. Although litigation is common in connection with acquisitions of public companies, regardless of any merits related to the underlying acquisition, the outcome of any lawsuits filed against the Company or CVS Health is uncertain and could delay or prevent completion of the Merger. While we plan to vigorously defend any such lawsuits, we may not be successful in defending against any such claims. Additionally, the costs of defense of such litigation, including costs associated with the indemnification of directors and officers, and other effects, such as negative publicity or damage to our relationships with business partners, suppliers and customers, could have an adverse effect on our business, financial condition and operating results.

Risks Related to Our Business

We have a history of net losses, we anticipate increasing expenses in the future, and we may not be able to achieve or maintain profitability.

We have incurred net losses on an annual basis since our inception. We incurred net losses of $(509.2) million,$(409.4) million and $(188.0) million, for the years ended December 31, 2022, 2021 and 2020, respectively. We expect our aggregate costs will increase substantially in the foreseeable future, and our losses will continue as we expect to invest heavily in increasing our patient base, expanding our operations, hiring

additional employees and operating as a public company. These investments may be more costly than we expect, and if we do not achieve the benefits anticipated from these investments, or if the realization of these benefits is delayed, they may not result in increased revenues or growth in our business. If our growth rate were to decline significantly or become negative, it could adversely affect our financial condition and results of operations.

The Company has historically financed its operations through private placements of our equity securities, payments received from various payors, issuance of convertible notes and term loans and our IPO. Our net cash flow from operations was negative for the years ended December 31, 2022, 2021 and 2020. We may not generate positive cash flow from operations or profitability in any given period, and our limited operating history may make it difficult for investors to evaluate our current business and our future prospects. Additionally, if we are not able to achieve or maintain positive cash flow in the long term, we may require additional financing, which may not be available on favorable terms or at all and/or which would be dilutive to our shareholders. If we are unable to successfully address these risks and challenges as we encounter them, our business, results of operations and financial condition would be adversely affected. Our failure to achieve or maintain profitability could negatively impact the value of our common stock.

Our financial condition and results of operations have been and, we expect, will continue to be impacted by ongoing macroeconomic challenges, including labor shortages, supply chain disruptions and inflationary pressures, and an economic downturn or recession, could further adversely impact our business.

Macroeconomic challenges, including labor shortages, supply chain disruptions and inflationary pressures, have impacted, and are expected to continue to impact, our business operations, as well as our suppliers' businesses. In particular, they may significantly affect our ability to hire, develop and retain our talented and diverse workforce, to maintain performance levels (especially cost and schedule), and to maintain our corporate culture. Further, if these conditions impair our ability to increase our headcount, including physicians, nurses and other specialized medical personnel, we may not be able to execute our growth plan and open new centers at the pace originally planned. It is impossible to predict how long these negative macroeconomic conditions will last, but we expect, at a minimum, that our costs will increase for labor, supplies and equipment, which could negatively impact our productivity, profitability and results of operations and cash flows. These conditions could also impact our ability to open new centers at costs originally budgeted which, in turn, could increase our capital needs during a time of rising interest rates and when conditions in the credit and capital markets are volatile. If our suppliers have increased challenges with their workforce (including as a result of illness, absenteeism, reactions to health and safety or government requirements), facility closures, timely access to necessary components, materials and other supplies at reasonable prices, access to capital, and access to fundamental support services (such as shipping and transportation), they may be unable to provide the agreed-upon goods and services in a timely, compliant and cost-effective manner. We have incurred and may in the future incur additional costs and delays in our business, including as a result of higher prices, schedule delays or the need to identify and develop alternative suppliers.

Limitations on access or disruptions to services or goods provided by or to some of our suppliers and vendors upon which our platform and business operations relies, could interrupt our ability to provide care, decrease the productivity of our workforce, and significantly harm our business operations, financial condition, and results of operations.

The effects from a broadening or protracted extension of these negative macroeconomic conditions could cause an economic slowdown or recession. During periods of recession or declining levels of income, governmental entities often experience budget deficits as a result of increased costs and lower than expected tax collections. These budget deficits at federal, state and local government entities have decreased, and may continue to decrease, spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant payor sources for our centers. Other risks we may face during periods of recession or in the case of declining levels of income include potential declines in the population covered under our capitation agreements, potential increases in the uninsured and underinsured populations and further

difficulties in our collecting patient co-payment and deductible receivables, which in turn could result in declines in our revenues and cash flows.

COVID-19, or any other pandemic, epidemic or outbreak of an infectious disease in the United States or worldwide, could adversely affect our business.

We face a wide variety of risks related to health epidemics, pandemics and similar outbreaks, especially of infectious diseases, including COVID-19 and its variants. Since first reported in late 2019, the COVID-19 pandemic has dramatically impacted the global health and economic environment, including millions of confirmed cases and deaths, business slowdowns or shutdowns, labor shortages, supply chain challenges, changes in government spending and requirements, regulatory challenges, inflationary pressures and market volatility. Although we have, to date, managed to continue our operations, we cannot predict the future course of events nor can we assure that this global pandemic, including its economic impact, will not have a material adverse impact on our business, financial position, results of operations and/or cash flows.

We expect to continue to incur additional costs as a result of the COVID-19 outbreak, including to protect the health and well-being of our employees, to respond to government requirements, and as a result of impacts on operations and performance, including staffing and schedule, which costs we may not be fully able to recover. We are and may be subject to additional regulatory requirements, enforcement actions and litigation, again with costs and liabilities that are not fully recoverable or insured.

It is not currently possible to reliably project the direct impact of COVID-19 on our revenues and expenses, particularly as new variants present unknown factors. Key factors include the duration and extent of the outbreak in our service areas as well as societal and governmental responses. Patients may continue to be reluctant to seek necessary care given the risks of the COVID-19 pandemic. This could have the effect of deferring healthcare costs that we will need to incur to later periods and may also affect the health of patients who defer treatment, which may cause our costs to increase in the future. Further, as a result of the COVID-19 pandemic, we may experience slowed growth or a decline in new patient demand. We also may experience increased internal and third-party medical costs as we provide care for patients suffering from COVID-19. This increase in costs may be particularly significant given the number of our patients who are under capitation agreements. Further, we may face increased competition due to changes to our competitors' products and services, including modifications to their terms, conditions, and pricing that could materially adversely impact our business, results of operations, and overall financial condition in future periods.

If the COVID-19 pandemic worsens, especially in regions where we have offices or centers, our business activities originating from affected areas could be adversely affected. Disruptive activities could include business closures in impacted areas, reinstating restrictions on our employees' and service providers' ability to travel, impacts to productivity if our employees or their family members experience health issues, and potential delays in hiring and onboarding of new employees. We may take further actions that alter our business operations as may be required by local, state, or federal authorities or that we determine are in the best interests of our employees. Such measures could negatively affect our sales and marketing efforts, sales cycles, employee productivity, or customer retention, any of which could harm our financial condition and business operations.

Due to the COVID-19 pandemic, we may not be able to document the health conditions of our patients as completely as we have in the past. Medicare pays capitation using a "risk adjustment model," which compensates providers based on the health status (acuity) of each individual patient. Payors with higher acuity patients receive more, and those with lower acuity patients receive less. Medicare requires that a patient's health issues be documented annually regardless of the permanence of the underlying causes. Historically, this documentation was required to be completed during an in-person visit with a patient. As part of the Coronavirus Aid, Relief and Economic Security Act, or CARES Act, Medicare is allowing documentation for conditions identified during video visits with patients. However, given the disruption caused by COVID-19, it is unclear whether we will be able to document the health conditions of our patients as comprehensively as we did during in-person patient visits prior to COVID-19, which may adversely impact our revenue in future periods.

Also, under the CARES Act, the U.S. Department of Health and Human Services distributed grants to healthcare providers to offset the impacts of the COVID-19 pandemic related expenses and lost revenues, also known as the Provider Relief Funds. Grants received are subject to the terms and conditions of the program, including that such funds may only be used to prevent, prepare for, and respond to the COVID-19 pandemic and will reimburse only for health care related expenses or lost revenues that are attributable to the COVID-19 pandemic. Recipients are not required to repay these funds, provided that they attest to and comply with certain terms and conditions, including not using the funds to reimburse expenses or losses that other sources are obligated to reimburse. As of the date of this filing, we have received $11.4 million in grants from the Provider Relief Funds. We will continue to monitor our compliance with the terms and conditions of the Provider Relief Funds, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to the COVID-19 pandemic. If we are unable to attest to or comply with current or future terms and conditions our ability to retain some or all of the distributions received may be impacted.

To the extent the COVID-19 pandemic adversely affects our business and financial results, it may also have the effect of heightening many of the other risks described in this "Risk Factors" section, including but not limited to those relating to cyber-attacks and security vulnerabilities, interruptions or delays due to third-parties, or our ability to raise additional capital or generate sufficient cash flows necessary to fulfill our obligations under our existing indebtedness or to expand our operations.

Our relatively limited operating history makes it difficult to evaluate our current business and future prospects.

Our relatively limited operating history makes it difficult to evaluate our current business and plan for our future growth. We opened our first center in Chicago in 2013, with all of our growth occurring in recent years. We entered into our first fully capitated agreements with health plans in 2016, and we have limited experience managing contracts with full risk. We have encountered and will continue to encounter significant risks and uncertainties frequently experienced by new and growing companies in rapidly changing industries, such as determining appropriate investments for our limited resources, competition from other providers, acquiring and retaining patients, hiring, integrating, training and retaining skilled personnel, determining prices for our services, unforeseen expenses and challenges in forecasting accuracy. Although we have successfully expanded our centers' footprint outside of the Midwest and intend to continue to expand into new geographical locations, we cannot provide assurance that any new centers we open or new geographical locations we enter will be successful. If we are unable to increase our patient enrollment, successfully manage our third-party medical costs or successfully expand into new patient services, our revenues and our ability to achieve and sustain profitability would be impaired. Additional risks include our ability to effectively manage growth, process, store, protect and use personal data in compliance with governmental regulation, contractual obligations and other legal obligations related to privacy and security and manage our obligations as a provider of healthcare services under Medicare and Medicaid. If our assumptions regarding these and other similar risks and uncertainties, which we use to plan our business, are incorrect or change as we gain more experience operating our business or due to changes in our industry, or if we do not address these challenges successfully, our operating and financial results could differ materially from our expectations and our business could suffer.

Our growth strategy may not prove viable, and we may not realize expected results.

Our business strategy is to grow rapidly by expanding our network of primary care centers and is significantly dependent on opening new centers in our existing markets, expanding into new geographical locations, recruiting new patients and partnering or contracting with payors, existing medical practices or other healthcare providers to provide primary care services. We seek growth opportunities both organically and through alliances with payors or other primary care providers. Our ability to grow organically depends upon a number of factors, including recruiting new patients, entering into contracts with additional payors, identifying appropriate facilities, obtaining leases, completing internal buildouts of new facilities within proposed timelines and budgets and hiring care teams and other employees. We cannot guarantee that we will be successful in pursuing our growth strategy. If we fail to evaluate and execute new business opportunities properly, we may not achieve anticipated benefits and may incur increased costs.

Our growth strategy involves a number of risks and uncertainties, including that:

- we may not be able to successfully enter into contracts with local payors on terms favorable to us or at all. In addition, we compete for payor relationships with other potential players, some of whom may have greater resources than we do. This competition may intensify due to the ongoing consolidation in the healthcare industry, which may increase our costs to pursue such opportunities;

- we may not be able to recruit or retain a sufficient number of new patients to execute our growth strategy, we may incur substantial costs to recruit new patients, and we may be unable to recruit a sufficient number of new patients to offset those costs;

- we may not be able to hire sufficient numbers of physicians and other staff and may fail to integrate our employees, particularly our medical personnel, into our care model;

- when expanding our business into new states, we may be required to comply with laws and regulations that may differ from states in which we currently operate; and

- depending upon the nature of the local market, we may not be able to implement our business model in every local market that we enter, which could negatively impact our revenues and financial condition.

There can be no assurance that we will be able to successfully capitalize on growth opportunities, which may negatively impact our business model, revenues, results of operations and financial condition.

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

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

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

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

To increase our revenues, our business strategy is to expand the number of primary care centers in our network. In order to support such growth, we must continue to recruit and retain a sufficient number of new patients. We are focused on the Medicare-eligible population and face competition from other primary healthcare providers in the recruitment of Medicare-eligible potential patients. If we are unable to convince the Medicare-eligible population of the benefits of our Oak Street Platform or if potential or existing patients prefer the care provider model of one of our competitors, we may not be able to effectively implement our growth strategy, which

depends on our ability to grow organically and attract new patients. In addition, our growth strategy is dependent on patients electing to move from fee-for-service to capitation arrangements and selecting us as their primary care provider under their MA plan. Plan enrollment selections for MA are made during an annual enrollment period from October into December of each year; therefore, our ability to grow our patient population with capitation arrangements is dependent in part on our ability to successfully recruit MA patients during the annual enrollment period and to convince MA patients to select us as their primary care provider and not subsequently change that election. Our inability to recruit new patients and retain existing patients, particularly those under capitation arrangements, would harm our ability to execute our growth strategy and may have a material adverse effect on our business operations and financial position.

Our revenues and operations are dependent upon a limited number of key payors.

Our operations are dependent on a concentrated number of payors with whom we contract to provide services to patients. We generally manage our payor contracts on a state-by-state basis, entering into a separate contract in each state with the local affiliate of the relevant payor such that no one local payor contract accounts for a majority of our revenues. When aggregating the revenues associated with each payor through its local affiliates, however, Humana, WellCare/ Meridian and Cigna HealthSpring accounted for a total of approximately 55%, 62% and 71% of our capitated revenue for the years ended December 31, 2022, 2021 and 2020, respectively, and Humana alone accounted for approximately 32%, 36% and 45% of our capitated revenue for the years ended December 31, 2022, 2021 and 2020, respectively. We believe that a majority of our revenues will continue to be derived from a limited number of key payors; they may terminate their contracts with us or our physicians credentialed by them upon the occurrence of certain events. The sudden loss of any of our payor partners or the renegotiation of any of our payor contracts could adversely affect our operating results. In the ordinary course of business, we engage in active discussions and renegotiations with payors in respect of the services we provide and the terms of our payor agreements. As the payors' businesses respond to market dynamics and financial pressures, and as payors make strategic business decisions in respect of the lines of business they pursue and programs in which they participate, a certain number of our payors may seek to renegotiate or terminate their agreements with us. These discussions could result in reductions to the fees and changes to the scope of services contemplated by our original payor contracts and consequently could negatively impact our revenues, business and prospects.

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

Although we have long-term contracts with many payors, these contracts may be terminated before their term expires for various reasons, such as changes in the regulatory landscape and poor performance by us, subject to certain conditions. Certain of our contracts are terminable immediately upon the occurrence of certain events. A certain number of our contracts may be terminated immediately by the partner if we lose applicable licenses, go bankrupt, lose our liability insurance or receive an exclusion, suspension or debarment from state or federal government authorities. Additionally, if a payor were to lose applicable licenses, go bankrupt, lose liability insurance, become insolvent, file for bankruptcy or receive an exclusion, suspension or debarment from state or federal government authorities, our contract with such payor could in effect be terminated. In addition, certain of our contracts may be terminated immediately if we become insolvent or file for bankruptcy. If any of our contracts with our payors is terminated, we may not be able to recover all fees due under the terminated contract, which may adversely affect our operating results.

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

We may be party to lawsuits and legal proceedings in the normal course of business. These matters are often expensive and disruptive to normal business operations. We may face allegations, lawsuits and regulatory inquiries, audits and investigations regarding data privacy, security, labor and employment, consumer protection and intellectual property infringement, including claims related to privacy, patents, publicity, trademarks, copyrights and other rights. We may also face allegations or litigation related to our acquisitions, securities issuances or business practices, including public disclosures about our business. Litigation and regulatory proceedings may be protracted and expensive, and the results are difficult to predict. Certain of these matters may include speculative claims for substantial or indeterminate amounts of damages and include claims for injunctive relief. Additionally, our litigation costs could be significant. Adverse outcomes with respect to litigation or any of these legal proceedings may result in significant settlement costs or judgments, penalties and fines, or require us to modify our services or require us to stop serving certain patients or geographies, all of which could negatively impact our geographical expansion and revenue growth. We may also become subject to periodic audits, which would likely increase our regulatory compliance costs and may require us to change our business practices, which could negatively impact our revenue growth. Managing legal proceedings, litigation and audits, even if we achieve favorable outcomes, is time-consuming and diverts management's attention from our business.

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

We also may be subject to lawsuits under the False Claims Act (the "FCA") and comparable state laws for submitting allegedly fraudulent or otherwise inappropriate bills for services to the Medicare and Medicaid programs. These lawsuits, which may be initiated by government authorities as well as private party relators, can involve significant monetary damages, fines, attorney fees and the award of bounties to private plaintiffs who successfully bring these suits, as well as to the government programs. In recent years, government oversight and law enforcement have become increasingly active and aggressive in investigating and taking legal action against potential fraud and abuse.

On November 1, 2021, we received a civil investigative demand ("CID") from the United States Department of Justice. According to the CID, the Department of Justice is investigating whether the Company may have violated the False Claims Act, 31 U.S.C. §§ 3729-3722. The CID requests certain documents and information related to the Company's relationships with third-party marketing agents and related to the Company's provision of free transportation to federal health care beneficiaries and requests information and documents related to such matters. We continue to cooperate with the Department of Justice in response to the CID. We are currently unable to predict the outcome of this investigation or whether qui tam or other litigation is probable. Regardless of the outcome, this inquiry has the potential to have an adverse impact on us due to any related defense and settlement costs, diversion of management resources, and other factors.

Additionally, on January 10, 2022, Reginald T. Allison, individually and on behalf of all others similarly situated, filed a putative class action lawsuit against Oak Street Health, Inc., Michael Pykosz and Timothy Cook, two of the Company's largest stockholders and members of the Company's Board of Directors in the United States District Court for the Northern District of Illinois (Case No: 1:22-cv-00149). On March 25, 2022, Central Pennsylvania Teamsters Pension Fund – Defined Benefit Plan, Central Pennsylvania Teamsters Pension Fund – Retirement Income Plan 1987, and Boston Retirement System's (collectively, the "Northeast Pension Funds") were appointed as the lead plaintiffs in the case. On May 25, 2022, the Northeast Pension Funds along with an additional named plaintiff, the City of Dearborn Police & Fire Revised Retirement System, filed their consolidated amended and restated complaint (the "Amended Complaint"). The Amended Complaint alleges that we, and such executive officers, made false and/or misleading statements and failed to disclose material adverse facts about

our business, operations and prospects related to the matters inquired about in the CID. Additionally three stockholders, Joseph Miller, the Hialeah Employees' Retirement System and the Employees Retirement System of the City of St. Louis each filed, on November 7, 2022, January 5, 2023 and February 2, 2023, respectively, derivative actions in the Delaware Court of Chancery against certain of our officers and each of the members of Oak Street's Board of Directors (collectively, "Defendants") principally alleging breach of fiduciary duties and unjust enrichment. Generally, the complaint in each derivative action concerns those Defendants' duties relating to certain outreach practices Oak Street allegedly engaged in and its patient transportation program, which are also matters that are the subject of the CID.

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

Although we maintain third-party professional liability insurance coverage, it is possible that claims against us may exceed the coverage limits of our insurance policies. Even if any professional liability loss is covered by an insurance policy, these policies typically have substantial deductibles for which we are responsible.

Professional liability claims in excess of applicable insurance coverage could have a material adverse effect on our business, financial condition and results of operations. In addition, any professional liability claim brought against us, with or without merit, could result in an increase of our professional liability insurance premiums. Insurance coverage varies in cost and can be difficult to obtain, and we cannot guarantee that we will be able to obtain insurance coverage in the future on terms acceptable to us or at all. If our costs of insurance and claims increase, then our earnings could decline.

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

In addition to contracting directly with CMS to participate in Medicare, we also contract with other health plans, often under capitated arrangements, to provide services with respect to their MA members. Our contracts with Humana to provide capitated care services for their members accounted for approximately 32%, 36% and 45% of our capitated revenue for the years ended December 31, 2022, 2021 and 2020, respectively. If a plan with which we contract for these services loses its Medicare contracts with CMS, receives reduced or insufficient government reimbursement under the Medicare program, decides to discontinue its MA plans, decides to contract with another company to provide capitated care services to its members, or decides to directly provide care, our contract with that plan could be at risk and we could lose revenue. In addition, a number of our contracts with health plans are terminable without cause. If any of these contracts were terminated, certain patients covered by such plans may choose to shift to another primary care provider within their health plan's network. Moreover, our inability to maintain our agreements with health plans, in particular with key payors such as Humana, with respect to their MA members or to negotiate favorable terms for those agreements in the future, could result in the loss of patients and could have a material adverse effect on our profitability and business.

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

The amounts we receive for services provided to patients are determined by a number of factors, including the payor mix of our patients and the reimbursement methodologies and rates utilized by our patients' plans. Reimbursement rates are generally higher for capitation agreements than they are under fee-for-service arrangements, and capitation agreements provide us with an opportunity to capture any additional surplus we create by investing in preventive care to keep a particular patient's third-party medical expenses low. Under a capitation plan such as MA, we receive a fixed fee PPPM for services. Under a fee-for-service payor arrangement,

we collect fees directly from the payor as services are provided. Fee-for-service arrangements accounted for approximately 0.6%, 0.6%, and 0.6% of our revenues for the years ended December 31, 2022, 2021 and 2020, respectively. Capitation arrangements accounted for approximately 98%, 98%, and 96% of our revenues for the years ended December 31, 2022, 2021 and 2020, respectively. A significant decrease in the number of capitation arrangements could adversely affect our revenues and results of operations.

The healthcare industry has also experienced a trend of consolidation, resulting in fewer but larger payors that have significant bargaining power, given their market share. Payments from payors are the result of negotiated rates. These rates may decline based on renegotiations, and larger payors have significant bargaining power to negotiate higher discounted fee arrangements with healthcare providers. As a result, payors increasingly are demanding discounted fee structures.

The healthcare industry is highly competitive

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

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

Each time a new physician joins us, 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. These practices result in delayed reimbursement that may adversely affect our cash flows.

With respect to Medicare, providers can retrospectively bill Medicare for services provided 30 days prior to the effective date of the enrollment. In addition, the enrollment rules provide that the effective date of the enrollment will be the later of the date on which the enrollment application was filed and approved by the Medicare contractor, or the date on which the provider began providing services. If we are unable to properly enroll physicians and other applicable healthcare professionals within the 30 days after the provider begins

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

The Affordable Care Act of 2010 (the "ACA"), as currently structured, added additional enrollment requirements for Medicare and Medicaid, which have been further enhanced through implementing regulations and increased enforcement scrutiny. Every enrolled provider must revalidate its enrollment at regular intervals and must update the Medicare contractors and many state Medicaid programs with significant changes on a timely basis. If we fail to provide sufficient documentation as required to maintain our enrollment, Medicare and Medicaid could deny continued future enrollment or revoke our enrollment and billing privileges.

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

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

We receive the majority of our revenues from Medicare, either directly or through MA plans, and revenues from Medicare accounted for 98%, 98% and 96% of our revenues for each of the years ended December 31, 2022, 2021 and 2020, respectively. In addition, many private payors base their reimbursement rates on the published Medicare rates or are themselves reimbursed by Medicare for the services we provide. As a result, our results of operations are, in part, dependent on government funding levels for Medicare programs, particularly MA programs. Any changes that limit or reduce MA or general Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past and could in the future result in substantial reductions in our revenues and operating margins. For example, due to the federal sequestration, an automatic 2% reduction in Medicare spending took effect beginning in April 2013. The CARES Act, which was signed into law on March 27, 2020, designed to provide financial support and resources to individuals and businesses affected by the COVID-19 pandemic, temporarily suspended these reductions from May 1, 2020 through March 31, 2022, reduced the reduction to 1% from April 1, 2022 through June 30, 2022, and extended the sequester by one year, through 2030.

Each year, CMS issues a final rule to establish the MA benchmark payment rates for the following calendar year. Any reduction to MA rates impacting us that is greater than the industry average rate may have a material adverse effect on our business, results of operations, financial condition and cash flows. The final impact of the MA rates can vary from any estimate we may have and may be further impacted by the relative growth of

our MA patient volumes across markets as well as by the benefit plan designs submitted. It is possible that we may underestimate the impact of the MA rates on our business, which could have a material adverse effect on our business, results of operations, financial condition and cash flows. In addition, our MA revenues may continue to be volatile in the future, which could have a material adverse impact on our business, results of operations, financial condition and cash flows.

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

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

For example, on February 1, 2023, CMS issued the Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies which proposes updates to MA payment growth rates, changes to the MA and Part D payment methodologies and changes to the risk adjustment model that CMS uses to determine the health status of Medicare patients, which, if enacted in their proposed form, could have a material adverse effect on our business, results of operations, financial condition and cash flows. Other recent legislative, judicial and executive efforts to enact further healthcare reform legislation have caused the future state of the exchanges, other reforms under the ACA, and many core aspects of the current U.S. health care system to be unclear. While specific changes and their timing are not yet apparent, enacted reforms and future legislative, regulatory, judicial, or executive changes, particularly any changes to the MA program, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Among the important statutory changes that are being implemented by CMS include provisions of the IMPACT Act. This law imposes a stringent timeline for implementing benchmark quality measures and data metrics across post-acute care providers. The enactment also mandates specific actions to design a unified payment methodology for post-acute providers. CMS is in the process of promulgating regulations to implement provisions of this enactment. Depending on the final details, the costs of implementation could be significant. The failure to meet implementation requirements could expose providers to fines and payment reductions.

Changes to the political environment may increase the likelihood of legislative or regulatory changes that would impact us, such as changes to the healthcare regulatory landscape. Examples of such potential changes also could include, among other things, legislative developments or administrative decisions such as moving to a universal health insurance or "single payor" system whereby health insurance is provided to all Americans by the government, the availability of a "public health insurance option" similar to Medicare, government programs that impact access to Medicaid expansion or impact funding provided to families to purchase plans through the health insurance exchanges or changes to the eligibility age for Medicare beneficiaries. These or similar changes could have the impact of decreasing our revenues, increasing our expenses or having other material adverse effects on our business, results of operations, financial condition and cash flows. The timing of legislative or executive action related to these potential initiatives, if any, remains uncertain, particularly in light of the ongoing COVID-19 pandemic, and as such, considerable uncertainty exists surrounding the continued development of healthcare reform measures and/or other potential changes at the federal and/or state level to laws, regulations and other requirements that govern our business.

We have made and continue to make substantial investments in value-based care and building our care capabilities, but there can be no assurances that value-based care initiatives or any other legislation or government

programs that align with our strategy and investments will be enacted or continued and will not be modified in a manner that is disadvantageous to our business model. Irrespective of whether such initiatives exist, there can be no assurances that we will be able to successfully execute on the required strategic initiatives that would allow us to provide a competitive and successful value-based care program on the broad scale, and in the desired time frame. Additionally, the ultimate longevity and terms and conditions of any such payment structures or other initiatives remain unclear. For example, as described above, on February 24, 2022, CMMI announced the transition of the Direct Contracting Model to the ACO REACH Model at the end of 2022.

There is also uncertainty regarding both MA payment rates and beneficiary enrollment, which, if reduced, would reduce our overall revenues and net income. For example, although the Congressional Budget Office ("CBO") predicted in 2010 that MA participation would drop substantially by 2020, the CBO has more recently predicted, without taking into account potential future reforms, that enrollment in MA (and other contracts covering Medicare Parts A and B) could reach 31 million by 2027. Although MA enrollment increased by approximately 5.6 million, or by 50%, between the enactment of the ACA in 2010 and 2015, there can be no assurance that this trend will continue. Further, fluctuation in MA payment rates is evidenced by CMS's annual announcement of the expected average change in revenue from the prior year: for 2022, CMS announced an average increase of 4.0%; for 2021, 1.7% and 2.5% for 2020. Uncertainty over MA enrollment and payment rates present a continuing risk to our business.

According to the Kaiser Family Foundation ("KFF"), MA enrollment continues to be highly concentrated among a few payors, both nationally and in local regions. In 2022, the KFF reported that two payors together accounted for almost half of MA enrollment and five firms accounted for approximately 77% of the lives. Consolidation among MA plans in certain regions, or the Medicare program's failure to attract additional plans to participate in the MA program, could have a material adverse effect on our business, results of operations, financial condition and cash flows.

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

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

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

In addition, certain of our patients are covered under health plans that require the patient to cover a portion of their own healthcare expenses through the payment of copayments or deductibles. 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. We have a financial assistance policy in which we assess patients for financial hardship and other criteria that are used to make a good-faith determination of financial need. If a patient is deemed to meet these criteria, we will waive or reduce that patient's obligation to pay copayments, coinsurance or deductible amounts owed for the services we provide to them. If we were to experience a substantial increase in the number of patients qualifying for such waivers or reductions or in the volume of patient receivables deemed uncollectible, our costs could increase significantly, and we may not be able to offset such additional costs with sufficient revenue.

In response to the COVID-19 pandemic, CMS made several changes in the manner in which Medicare will pay for telehealth visits, many of which relaxed previous requirements, including site requirements for both the providers and patients, telehealth modality requirements and others. State law applicable to telehealth, particularly licensure requirements, has also been relaxed in many jurisdictions as a result of the COVID-19 pandemic. These relaxed regulations helped us to continue operating our business during the height of the pandemic. It is unclear which, if any, of these changes will remain in place permanently and which will be rolled-back following the COVID-19 pandemic. Although our use of telehealth has diminished as we have been able to see patients more regularly in person, if regulations change to restrict our ability to or prohibit us from delivering care through telehealth modalities, our financial condition and results of operations may be adversely affected.

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

Approximately 98%, 98% and 96% of our revenues for the years ended December 31, 2022, 2021 and 2020, respectively, is derived from fixed fees paid by health plans under capitation agreements with us. While there are variations specific to each agreement, we generally contract with health plans to receive a fixed fee per month for professional services and assume the financial responsibility for the healthcare expenses of our patients. This type of contract is referred to as a "capitation" contract. To the extent that patients require more care than is anticipated and/or the cost of care increases, aggregate fixed compensation amounts, or capitation payments, may be insufficient to cover the costs associated with treatment. If medical costs and expenses exceed estimates, except in very limited circumstances, we will not be able to increase the fee received under these capitation agreements during their then-current terms and we could suffer losses with respect to such agreements.

Changes in our anticipated ratio of medical expenses to revenues can significantly impact our financial results.

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

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

- the health status of patients and higher levels of hospitalization;
- higher than expected utilization of new or existing healthcare services or technologies;
- an increase in the cost of healthcare services and supplies, whether as a result of inflation or otherwise;
- changes to mandated benefits or other changes in healthcare laws, regulations and practices;

- increased costs attributable to specialist physicians, hospitals and ancillary providers;
- changes in the demographics of our patients and medical trends;
- contractual or claims disputes with providers, hospitals or other service providers within and outside a health plan's network;
- the occurrence of catastrophes, major epidemics or acts of terrorism; and
- the reduction of health plan premiums.

Renegotiation, non-renewal or termination of capitation agreements with health plans could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Under most of our capitation agreements with health plans, the health plan is generally permitted to modify the benefit and risk obligations and compensation rights from time to time during the terms of the agreements. If a health plan exercises its right to amend its benefit and risk obligations and compensation rights, we are generally allowed a period of time to object to such amendment. If we so object, under some of the capitation agreements, the relevant health plan may terminate the applicable agreement upon 90 to 180 days written notice. If we enter into capitation contracts with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, we could suffer losses with respect to such contract. Since we do not negotiate with CMS or any health plan regarding the benefits to be provided under their MA plans, we often have just a few months to familiarize ourselves with each new annual package of benefits we are expected to offer. Depending on the health plan at issue and the amount of revenue associated with the health plan's capitation agreement, the renegotiated terms or termination could have a material adverse effect on our business, results of operations, financial condition and cash flows.

Medicare's risk adjustment payment system makes our revenues and profitability difficult to predict and could result in material adverse impacts to our adjustments to our results of operations.

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish appropriate compensation for covering the expected medical costs of the enrolled Medicare beneficiaries. CMS's risk adjustment model bases a portion of the total CMS reimbursement payments on various clinical and demographic factors, including hospital inpatient diagnoses, diagnosis data from hospital outpatient facilities and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and report the necessary diagnosis code information to CMS, which information is subject to review and audit for accuracy by CMS. This risk adjustment payment system has an indirect impact on the payments we received from our contracted Medicare Advantage payers. Although we, and the payers with which we contract, have auditing and monitoring processes in place to collect and provide accurate risk adjustment data to CMS for these purposes, that program may not be sufficient to ensure accuracy. If the risk adjustment data submitted by us or our payers incorrectly overstates the health risk of our patients, we might be required to return to the payer or CMS, overpayments and/or be subject to penalties or sanctions, or if the data incorrectly understates the health risk of our members, we might be underpaid for the care that we must provide to our patients, any of which could harm our reputation and have a negative impact on our results of operations and financial condition. CMS may also change the way that they measure risk and the impact on any such changes on our business are uncertain.

As a result of the COVID-19 pandemic, risk adjustment scores may also fall as a result of reduced data collection, decreased patient visits or delayed medical care and limitations on payments for certain telehealth services. As a result of the variability of factors affecting our patients' risk scores, the actual payments we receive from our payers, after all adjustments, could be materially more or less than our estimates. Consequently, our estimate of our patients' aggregate member risk scores for any period may result in favorable or unfavorable adjustments to our Medicare revenues, which may affect our profitability. Additionally, if our estimates of revenues associated with risk adjustments are materially inaccurate, it could impact the timing and the amount of

our revenue recognition or have a material adverse effect on our business, results of operations, financial condition and cash flows.

Our records and submissions to health plans and government payers may contain inaccurate or unsupportable information regarding risk adjustment scores of participants, which could cause us to overstate or understate our revenue and subject us to repayment obligations or penalties.

The claims and encounter records that we submit to health plans and government payers impact data that support the risk adjustment factor ("RAF") scores attributable to our patients. These RAF scores determine the payment we are entitled for the provision of medical care to such participants. The data submitted to CMS is based on diagnosis codes and medical charts that our providers (and other external providers treating the same patient) identify, record and prepare. Any issues with documenting such conditions could adversely impact Medicare RAF scores and our resulting revenue for future periods. CMS periodically audits risk adjustment submissions. The submission of inaccurate, incomplete or erroneous data could result in inaccurate revenue and risk adjustment payments, which may be subject to correction or retroactive adjustment in later periods. This corrected or adjusted information may be reflected in financial statements for periods subsequent to the period in which the revenue was recorded. We could be required to refund a portion of the revenue that we received, which could have a material adverse effect on our business, results of operations, financial condition and cash flows. Historically, these true-up payments typically occur between May and August, but the timing of these payments is determined by CMS, and we have neither visibility nor control over the timing of such payments. From time to time, we may experience reconciliation issues as government payors modify or adopt new systems which may be reflected as provision for bad debt in our financial statements.

If CMS seeks repayment from us for payment adjustments as a result of its audits, we could also be subject to liability for penalties for inaccurate or unsupportable RAF scores provided by us or our providers. In addition, we could be liable for penalties to the federal government under the FCA, which may include per claim penalties, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. Elements of the risk adjustment mechanism continue to be challenged, reevaluated, and revised by the U.S. Department of Justice, the OIG, and CMS. For example, on February 1, 2023 CMS published the Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Program Final Rule (Final Rule), which will take effect on April 3, 2023. The long-awaited final rule includes major updates to the RADV audit methodology used by CMS to address overpayments to MA plans based on the submission of unsupported risk-adjusting diagnosis codes, which are used to determine payments under MA. Most notably, the Final Rule: (1) allows CMS to extrapolate RADV audit findings beginning with Payment Year (PY) 2018; and (2) does not include a Fee-For-Service (FFS) adjuster in RADV audits, which was previously contemplated as a method of equalizing payment errors between FFS Medicare and Medicare Part C, and viewed as critical to ensuring actuarial equivalence between traditional and managed Medicare. CMS will not extrapolate RADV audit findings for PYs 2011 through 2017, as originally contemplated. The Final Rule has already received significant industry pushback and is expected to be a target of litigation by MA plans. There can be no assurance that claims submitted by the Company will not be randomly selected or targeted for review by CMS or that the outcome of such a review will not result in a material adjustment in our revenue and profitability, even if the information we submitted to CMS is accurate and supportable. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect our revenue.

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

In the ordinary course of our business, we collect, store, use and disclose sensitive data, including protected health information ("PHI"), and other types of personal data or personally identifiable information ("PII") relating to our employees, patients and others. We also process and store, and use third-party service providers to process and store, sensitive information, including intellectual property, confidential information and

other proprietary business information. We manage and maintain such sensitive data and information utilizing a combination of on-site systems, managed data center systems and cloud-based computing center systems.

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

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

Any such breach or interruption of our systems or those of any of our third-party service providers could compromise our networks or data security processes and sensitive information could be made inaccessible or could be accessed by unauthorized parties, publicly disclosed, lost or stolen. Any such interruption in access, improper access, disclosure or other loss of information could result in legal claims or proceedings, liability under laws and regulations that protect the privacy of member information or other personal information, such as the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), and their implementing regulations (collectively known as "HIPAA"), and regulatory penalties. Unauthorized access, loss or dissemination could also disrupt our operations, including our ability to perform our services, access patient health information, collect, process, and prepare company financial information, provide information about our current and future services and engage in other patient and clinician education and outreach efforts. Any such breach could also

result in the compromise of our trade secrets and other proprietary information, which could adversely affect our business and competitive position. While we maintain insurance covering certain security and privacy damages and claim expenses, we may not carry insurance or maintain coverage sufficient to compensate for all liability and in any event, insurance coverage would not address the reputational damage that could result from a security incident.

Additionally, our platform and the other systems or networks used in our business may experience an increase in attempted cyber-attacks, targeted intrusion, ransomware, and phishing campaigns seeking to take advantage of shifts to employees working remotely using their household or personal internet networks. The success of any of these unauthorized attempts could substantially impact our platform, the proprietary and other confidential data contained therein or otherwise stored or processed in our operations, and ultimately our business. Any actual or perceived security incident also may cause us to incur increased expenses to improve our security controls and to remediate security vulnerabilities.

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

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

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

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

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

If our agreements or arrangements with certain of our licensed physicians who hold shares in our physician entities are deemed invalid under state law, including laws against the corporate practice of medicine, or federal law, or are terminated as a result of changes in state law, or if there is a change in accounting standards by the Financial Accounting Standards Board ("FASB") or the interpretation thereof affecting consolidation of entities, it could have a material adverse effect on our consolidation of total revenues derived from such practices.

Our financial statements are consolidated in accordance with applicable accounting standards and include the accounts of our majority-owned subsidiaries and certain non-owned associated and managed practices. Such consolidation for accounting and/or tax purposes does not, is not intended to, and should not be deemed to, imply or provide us any control over the medical or clinical affairs of such practices. In the event of a change in accounting standards promulgated by FASB or in interpretation of its standards, or if there is 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 such practices, we may not be permitted to continue to consolidate the total revenues of such practices.

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

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

Additionally, our success may be impacted by the reputation of AARP due to our license arrangement with that organization. We rely on AARP to manage and maintain its brand but their reputation or goodwill may be harmed due to factors outside our control, which could be attributed to our brand and have a material adverse effect on our business, prospects, financial condition, results of operations, cash flows, as well as the trading price of our securities. Damage to our reputation or the reputations of AARP or loss of consumer confidence for any of these or other reasons could have a material adverse effect on our results of operations, financial condition and cash flows, as well as require additional resources to rebuild our reputation.

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

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

Our business is highly dependent on maintaining effective information systems as well as the integrity and timeliness of the data we use to serve our patients, support our care teams and operate our business. Because of the large amount of data that we collect and manage, it is possible that hardware failures or errors in our systems could result in data loss or corruption or cause the information that we collect to be incomplete or contain

inaccuracies that our partners regard as significant. If our data were found to be inaccurate or unreliable due to fraud or other error, or if we, or any of the third-party service providers we engage, were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our patients and care teams and hinder our ability to provide services, establish appropriate pricing for services, retain and attract patients, manage our patient risk profiles, establish reserves, report financial results timely and accurately and maintain regulatory compliance, among other things.

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

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

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

Monitoring unauthorized use of our intellectual property is difficult and costly. From time to time, we seek to analyze our competitors' services, and may in the future seek to enforce our rights against potential infringement. However, the steps we have taken to protect our intellectual property rights may not be adequate to prevent infringement or misappropriation of our intellectual property. We may not be able to detect unauthorized use of, or take appropriate steps to enforce, our intellectual property rights. Any inability to meaningfully protect

our intellectual property rights could result in harm to our ability to compete and reduce demand for our technology. Moreover, our failure to develop and properly manage new intellectual property could adversely affect our market positions and business opportunities. Also, some of our services rely on technologies and software developed by or licensed from third parties, and we may not be able to maintain our relationships with such third parties or enter into similar relationships in the future on reasonable terms or at all.

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

We are subject to litigation. If an unfavorable ruling were to occur, it could have a material adverse impact on us.

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

On January 10, 2022, Reginald T. Allison, individually and on behalf of all others similarly situated, filed a putative class action lawsuit against Oak Street Health, Inc., Michael Pykosz and Timothy Cook, two of the Company's largest stockholders and members of the Company's Board of Directors in the United States District Court for the Northern District of Illinois (Case No: 1:22-cv-00149). On March 25, 2022, Central Pennsylvania Teamsters Pension Fund – Defined Benefit Plan, Central Pennsylvania Teamsters Pension Fund – Retirement Income Plan 1987, and Boston Retirement System's (collectively, the "Northeast Pension Funds") were appointed as the lead plaintiffs in the case. On May 25, 2022, the Northeast Pension Funds along with an additional named plaintiff, the City of Dearborn Police & Fire Revised Retirement System, filed their consolidated amended and restated complaint (the "Amended Complaint"). Plaintiffs allege that the Company and certain of its executive officers made false and/or misleading statements about patient acquisition tactics that purportedly violated the False Claims Act and federal Anti-Kickback Statute, and are purportedly the subject of the CID discussed above. The Amended Complaint includes two categories of claims: (1) claims under the Securities Exchange Act of 1934 based on allegedly misleading public statements throughout the class period of August 6, 2020 through November 8, 2021 (the "Exchange Act Claims"), and (2) claims under the Securities Act of 1933 based on allegedly misleading statements in the registration statements and prospectuses accompanying Oak Street Health, Inc.'s initial public offering and secondary public offerings (the "Securities Act Claims"). The Exchange Act Claims are asserted against Oak Street Health, Inc., Michael Pykosz, our CEO and Timothy Cook, our CFO, and also against certain stockholders of as "control persons." The Securities Act Claims are asserted against the same defendants as well as the underwriters of the Company's public offerings, and the Oak Street Health, Inc. directors who signed the registration statements. The Amended Complaint seeks damages, interest, costs, attorneys' fees and other unspecified equitable relief.

On July 25, 2022, the defendants filed a consolidated motion to dismiss the Amended Complaint. On September 26, 2022, the plaintiffs' opposition to that motion to dismiss was filed, and the defendants reply to that opposition was filed on October 26, 2022. On February 10, 2023, the Court ruled on the motion to dismiss,

granting the Company's' motions to dismiss with respect to the plaintiffs' section 12(a)(2) claim and section 11 claim based on misrepresentations from the May 2021 secondary public offering, and denying the remainder of the motion. The Company intends to continue to defend these claims vigorously.

Additionally three stockholders, Joseph Miller, the Hialeah Employees' Retirement System and the Employees Retirement System of the City of St. Louis each filed, on November 7, 2022, January 5, 2023 and February 2, 2023, respectively, derivative actions in the Delaware Court of Chancery against certain of our officers and each of the members of Oak Street's Board of Directors (collectively, "Defendants") principally alleging breach of fiduciary duties and unjust enrichment. Generally, the Complaint concerns those Defendants' duties relating to certain outreach practices Oak Street allegedly engaged in and its patient transportation program, the same matters that are the subject of the CID.

Furthermore, our commercial success depends on our ability to develop and commercialize our services and use our internally developed technology without infringing the intellectual property or proprietary rights of third parties. Intellectual property disputes can be costly to defend and may cause our business, operating results and financial condition to suffer. As the market for healthcare in the United States expands and more patents are issued, the risk increases that there may be patents issued to third parties that relate to our technology of which we are not aware or that we must challenge to continue our operations as currently contemplated. Whether merited or not, we may face allegations that we, our partners or parties indemnified by us have infringed or otherwise violated the patents, trademarks, copyrights or other intellectual property rights of third parties. Such claims may be made by competitors seeking to obtain a competitive advantage or by other parties. Additionally, in recent years, individuals and groups have begun purchasing intellectual property assets for the purpose of making claims of infringement and attempting to extract settlements from companies like ours. We may also face allegations that our employees have misappropriated the intellectual property or proprietary rights of their former employers or other third parties. It may be necessary for us to initiate litigation to defend ourselves in order to determine the scope, enforceability and validity of third-party intellectual property or proprietary rights, or to establish our respective rights. We may not be able to successfully settle or otherwise resolve such adversarial proceedings or litigation. If we are unable to successfully settle future claims on terms acceptable to us we may be required to engage in or to continue claims, regardless of whether such claims have merit, that can be time-consuming, divert management's attention and financial resources and can be costly to evaluate and defend. Results of any such litigation are difficult to predict and may require us to stop commercializing or using our technology, obtain licenses, modify our services and technology while we develop non-infringing substitutes or incur substantial damages, settlement costs or face a temporary or permanent injunction prohibiting us from marketing or providing the affected services. If we require a third-party license, it may not be available on reasonable terms or at all, and we may have to pay substantial royalties, upfront fees or grant cross-licenses to intellectual property rights for our services. We may also have to redesign our services so they do not infringe third-party intellectual property rights, which may not be possible or may require substantial monetary expenditures and time, during which our technology may not be available for commercialization or use. Even if we have an agreement to indemnify us against such costs, the indemnifying party may be unable to uphold its contractual obligations. If we cannot or do not obtain a third-party license to the infringed technology at all, license the technology on reasonable terms or obtain similar technology from another source, our revenue and earnings could be adversely impacted.

The outcome of litigation is necessarily uncertain, and we could be forced to expend significant resources in the defense of this and other suits, and we may not prevail. Any litigation to which we are a party may result in an onerous or unfavorable judgment that may not be reversed upon appeal, or in payments of substantial monetary damages or fines, or we may decide to settle this or other lawsuits on similarly unfavorable terms, which could adversely affect our business, financial condition, results of operations or stock price. See Item 3. "Legal Proceedings" below for additional information regarding the class action.

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

We may not be able to protect our trade secrets, know-how and other internally developed information, including in relation to the Canopy platform, adequately. Although we use reasonable efforts to protect this

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

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

We depend upon licenses from third parties for some of the technology and data used in Canopy, our technology platform, and for the platform upon which Canopy was built and operates. We expect that we may need to obtain additional licenses from third parties in the future in connection with the development of our services. In addition, we obtain a portion of the data that we use from government entities, public records and from our partners for specific partner engagements. We believe that we have all rights necessary to use the data that is incorporated into our services. We cannot, however, assure you that our licenses for information will allow us to use that information for all potential or contemplated applications. In addition, our ability to continue to offer integrated healthcare to our patients depends on maintaining Canopy, which is partially populated with data disclosed to us by our partners with their consent. If these partners revoke their consent for us to maintain, use, de-identify and share this data, consistent with applicable law, our data assets could be degraded.

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

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

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

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

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

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

Our success depends largely upon the continued services of our senior management team and other key employees. We rely on our leadership team in the areas of operations, provision of medical services, information technology and security, marketing, and general and administrative functions. From time to time, there may be changes in our executive management team resulting from the hiring or departure of executives, which could disrupt our business. Our employment agreements with our executive officers and other key personnel do not require them to continue to work for us for any specified period and, therefore, they could terminate their employment with us at any time. The loss of one or more of the members of our senior management team, or other key employees, could harm our business. In particular, the loss of the services of our co-founder and Chief Executive Officer, Mike Pykosz, could significantly delay or prevent the achievement of our strategic objectives. Changes in our executive management team may also cause disruptions in, and harm to, our business.

Our primary care centers are concentrated in Illinois, Michigan, Pennsylvania, Ohio and Texas, and we may not be able to successfully establish a presence in new geographic markets.

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

Our management team has limited experience managing a public company.

Most members of our management team have limited experience managing a publicly traded company, interacting with public company investors and complying with the increasingly complex laws pertaining to public companies. Our management team may not successfully or efficiently manage us as a public company that is subject to significant regulatory oversight and reporting obligations under the federal securities laws and the continuous scrutiny of securities analysts and investors. These new obligations and constituents require significant

attention from our senior management and could divert their attention away from the day-to-day management of our business, which could adversely affect our business, results of operations and financial condition.

We lease all of our facilities and may experience risks relating to lease termination, lease expense escalators, lease extensions and special charges.

We currently lease or license all of our centers, including slightly more than half that are leased from Humana. Our leases or licenses are typically on terms ranging from 2 to 20 years. Each of our lease or license agreements provides that the lessor may terminate the lease, subject to applicable cure provisions, for a number of reasons, including the defaults in any payment of rent, taxes or other payment obligations, the breach of any other covenant or agreement in the lease or, for centers leased from Humana, the termination of our payor contracts with Humana. Termination of certain of our lease agreements could result in a cross-default under our debt agreements or other lease agreements. If a lease agreement is terminated, there can be no assurance that we will be able to enter into a new lease agreement on similar or better terms or at all.

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

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

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

Our failure to pay the rent or otherwise comply with the provisions of any of our lease agreements could result in an "event of default" under such lease agreement and also could result in a cross default under other lease agreements and agreements for our indebtedness. Upon an event of default, remedies available to our landlords generally include, without limitation, terminating such lease agreement, repossessing and reletting the leased properties and requiring us to remain liable for all obligations under such lease agreement, including the difference between the rent under such lease agreement and the rent payable as a result of reletting the leased properties, or requiring us to pay the net present value of the rent due for the balance of the term of such lease agreement. The exercise of such remedies would have a material adverse effect on our business, financial position, results of operations and liquidity.

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

We have significant suppliers that may be the sole or primary source of products critical to the services we provide, or to which we have committed obligations to make purchases, sometimes at particular prices. If any

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

Our corporate culture has contributed to our success, and if we cannot maintain this culture as we grow, we could lose the innovation, creativity and teamwork fostered by our culture and our business may be harmed.

We believe that our culture has been and will continue to be a critical contributor to our success. We expect to continue to hire aggressively as we expand, and we believe our corporate culture has been crucial in our success and our ability to attract highly skilled personnel. If we do not continue to develop our corporate culture or maintain and preserve our core values as we grow and evolve, we may be unable to foster the innovation, curiosity, creativity, focus on execution, teamwork and the facilitation of critical knowledge transfer and knowledge sharing we believe we need to support our growth. Moreover, liquidity available to our employee securityholders could lead to disparities of wealth among our employees, which could adversely impact relations among employees and our culture in general. Our anticipated headcount growth and our transition from a private company to a public company may later result in a change to our corporate culture, which could harm our business.

Competition, labor shortages and other factors could make it more difficult to attract and retain highly qualified personnel, increase our labor costs and adversely affect our revenue, profitability and cash flows.

Our operations are dependent on the efforts, abilities and experience of our physicians and clinical personnel, and in order to execute our growth plan, we must attract and retain highly qualified personnel. If we fail to attract new personnel or fail to retain and motivate our current personnel, our business and future growth prospects could be harmed.

Competition for highly qualified personnel is intense, especially for physicians and other medical professionals who are experienced in providing care services to older adults.We compete with other healthcare providers, primarily hospitals and other facilities, in attracting physicians, nurses and medical staff to support our centers, recruiting and retaining qualified management and support personnel responsible for the daily operations of each of our centers and in contracting with payors in each of our markets. Many of the companies and healthcare providers with which we compete for experienced personnel have greater resources than we have, and these resources could be used to pursue more aggressively innovative staffing solutions as compared to the traditional market approaches of wages and benefits.

In the wake of the ongoing COVID-19 pandemic, the U.S. healthcare labor market is experiencing a shortage of clinical and non-clinical professionals. In some markets, the lack of availability of clinical personnel, such as nurses and mental health professionals, has created significant operating issues. This shortage of labor may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. These labor shortages have also led to mental health issues, lower job satisfaction and faster burnout, further exacerbating the problem. Although these issues are believed to have been caused by the COVID-19 pandemic, they are expected to continue beyond the near term and will create ongoing challenges for healthcare providers such as us to attract and retain personnel.

If our labor costs increase, we may not see that reflected in our annual rate increases from CMS nor in our contracted rates with MA plans to offset these increased costs. Because a significant percentage of our revenues consist of fixed, prospective payments, our ability to pass along increased labor costs is limited. In

particular, if labor costs rise at an annual rate greater than our net annual consumer price index basket update from Medicare, our results of operations and cash flows will likely be adversely affected.

Any union activity at our facilities that may occur in the future could contribute to increased labor costs. Certain proposed changes in federal labor laws and the National Labor Relations Board's modification of its election procedures could increase the likelihood of employee unionization attempts. Although none of our employees are currently represented by a collective bargaining agreement, to the extent a significant portion of our employee base unionizes, it is possible our labor costs could increase materially. Our failure to recruit and retain qualified management and medical personnel, or to control our labor costs, could have a material adverse effect on our business, prospects, results of operations and financial condition. We have, from time to time, experienced, and we expect to continue to experience, difficulty in hiring and retaining employees with appropriate qualifications.

Additionally, key primary care physicians with large patient enrollment could retire, become disabled, terminate their provider contracts, get lured away by a competing independent physician association or medical group, or otherwise become unable or unwilling to continue practicing medicine or continue working with our practices. As a result, patients who have been served by such physicians could choose to enroll with competitors' physician organizations or could seek medical care elsewhere, which could reduce our revenues and profits. Moreover, we may not be able to attract new physicians to replace the services of terminating physicians or to service our growing membership.

We also depend on the available labor pool of semi-skilled and unskilled workers in each of the markets in which we operate. We will need to continue to hire, train and manage additional qualified information technology, operations and marketing staff. If our new hires perform poorly, or if we are unsuccessful in hiring, training, managing and integrating these new employees, or if we are not successful in retaining our existing employees, our business may be adversely impacted.

Our revenues and profits could be diminished if we fail to retain and attract the services of key primary care physicians.

We have employment contracts with physicians and other health professionals in many states. Some of these contracts include provisions preventing these physicians and other health professionals from competing with us both during and after the term of our contract with them. The law governing non-compete agreements and other forms of restrictive covenants varies from state to state, and as of January 5, 2023, the U.S. Federal Trade Commission ("FTC") issued a notice of proposed rulemaking that would prohibit employers from using non-compete agreements. Some jurisdictions prohibit us from using non-competition covenants with our professional staff. Other states are reluctant to strictly enforce non-compete agreements and restrictive covenants applicable to physicians and other healthcare professionals. There can be no assurance that our non-compete agreements related to physicians and other health professionals will be found enforceable if challenged in certain states. Further, if enacted, the FTC's proposed rule would prohibit employers like us from implementing non-compete agreements with our physicians and other health professionals. In such event, we would be unable to prevent physicians and other health professionals formerly employed by us from competing with us, potentially resulting in the loss of some of our patients. Further, if we hire employees from competitors or other companies or healthcare providers, their former employers may attempt to assert that these employees or we have breached certain legal obligations, resulting in a diversion of our time and resources. We may also experience attrition in our primary care physicians due to our proposed transaction with a subsidiary of CVS Health.

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

The claims and encounter records that we submit to health plans may impact data that support the Medicare Risk Adjustment Factor ("RAF") scores attributable to members. These RAF scores determine, in part, the revenue to which the health plans and, in turn, we are entitled for the provision of medical care to such

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

Additionally, CMS audits MA plans for documentation to support RAF-related payments for members chosen at random. The Medicare Advantage plans ask providers to submit the underlying documentation for members that they serve. It is possible that claims associated with members with higher RAF scores could be subject to more scrutiny in a CMS or plan audit. There is a possibility that a Medicare Advantage plan may seek repayment from us should CMS make any payment adjustments to the Medicare Advantage plan as a result of its audits. The plans also may hold us liable for any penalties owed to CMS for inaccurate or unsupportable RAF scores provided by us or our affiliated physicians. In addition, we could be liable for penalties to the government under the FCA that range from $5,500 to $11,000 (adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. On December 13, 2021, the DOJ issued a final rule announcing adjustments to FCA penalties, under which the per claim range increased to a range from $11,803 to $23,607 per claim.

CMS has indicated that payment adjustments, such as Risk Adjustment Data Validation audits, will not be limited to RAF scores for the specific MA enrollees for which errors are found but may also be extrapolated to the entire MA plan subject to a particular CMS contract. CMS has described its audit process as plan-year specific and stated that it will not extrapolate audit results for plan years prior to 2011. Because CMS has not stated otherwise, there is a risk that payment adjustments made as a result of one plan year's audit would be extrapolated to prior plan years after 2011. Plans could then seek to retroactively recoup these amounts from us.

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

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

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

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

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

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

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

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

Certain of our patients are dual-eligible, meaning their coverage comes from both Medicare and Medicaid. In addition, a very small portion of our patients (under 2%) are fully covered by Medicaid. As a result, a small portion of our revenues comes from Medicaid, accounting for approximately 2%, 2% and 2% of our revenues for the years ended December 31, 2022, 2021 and 2020, respectively. Medicaid is a joint federal-state program purchasing healthcare services for the low income and indigent as well as certain higher-income individuals with significant health needs. Under broad federal criteria, states establish rules for eligibility, services and payment. Medicaid is a state-administered program financed by both state funds and matching federal funds. Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets. This, combined with slower state revenue growth, has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending.

For example, a number of states have adopted or are considering legislation designed to reduce their Medicaid expenditures, such as financial arrangements commonly referred to as provider taxes. Under provider tax arrangements, states collect taxes from healthcare providers and then use the revenues to pay the providers as a Medicaid expenditure, which allows the states to then claim additional federal matching funds on the additional reimbursements. Current federal law provides for a cap on the maximum allowable provider tax as a percentage of the provider's total revenues. There can be no assurance that federal law will continue to provide matching federal funds on state Medicaid expenditures funded through provider taxes, or that the current caps on provider taxes will not be reduced. Any discontinuance or reduction in federal matching of provider tax-related Medicaid expenditures could have a significant and adverse effect on states' Medicaid expenditures, and as a result could have an adverse effect on our business.

In addition, CMS has recently approved demonstration waivers for the Indiana Medicaid program that, among other things, imposes work or community engagement and income-based premiums on certain adult Medicaid beneficiaries, and similar waivers may be applied in other states. Also, as part of the movement to repeal, replace or modify the ACA and as a means to reduce the federal budget deficit, there are renewed congressional efforts to move Medicaid from an open-ended program with coverage and benefits set by the federal government to one in which states receive a fixed amount of federal funds, either through block grants or per capita caps, and have more flexibility to determine benefits, eligibility or provider payments. If those changes are implemented, we cannot predict whether the amount of fixed federal funding to the states will be based on current

payment amounts, or if it will be based on lower payment amounts, which would negatively impact those states that expanded their Medicaid programs in response to the ACA.

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

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

Our results of operations may be adversely impacted by adverse conditions affecting our centers, including severe weather events such as tornadoes and widespread winter storms, public health concerns such as contagious disease outbreaks, violence or threats of violence or other factors beyond our control that cause disruption of patient scheduling, displacement of our patients, employees and Care Teams, or force certain of our centers to close temporarily. Our future operating results may be adversely affected by these and other factors that disrupt the operation of our centers.

As a result of being a public company, 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. These internal controls may not be determined to be effective or our independent registered public accountants may issue an adverse opinion on these controls now that we are no longer an emerging growth company, all of which may adversely affect investor confidence in us and, as a result, the value of our common stock.

As a result of becoming a public company, we are subject to Section 404 of the Sarbanes-Oxley Act ("SOX) which requires, among other things, that companies maintain disclosure controls and procedures to ensure timely disclosure of material information, and that management review the effectiveness of those controls on a quarterly basis. The process of designing and implementing internal control over financial reporting required to comply with this requirement is 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, our management will be unable to assert that our internal control over financial reporting is effective. 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 our controls or the level at which our controls are documented, designed, operated or reviewed. Because we are no longer an "emerging growth company" as defined in the Jumpstart Our Business Startups Act of 2012 (the "JOBS Act") with our transition to large accelerated filer status as of December 31, 2021, we are also now subject to Section 404(b) of SOX, which requires that our independent registered public accounting firm provide an attestation report on the effectiveness of our internal control over financial reporting in this Annual Report on Form 10-K for the year ended December 31, 2022, among other additional requirements. Effective internal controls are necessary for us to provide reliable financial reports and to help prevent fraud, and our management and other personnel devote a substantial amount of time to these compliance requirements. These rules and regulations also increase our legal and financial compliance costs and make some activities more time-consuming and costly. Our independent registered public accounting firm may issue a report that is adverse in the event it is not satisfied with the level at which our internal control over financial reporting is documented, designed or operating. Any failure to maintain effective disclosure controls and internal control over financial reporting could materially and adversely affect our business, results of operations and financial condition and could cause a decline in the trading price of our common stock.

If we are not able to maintain the requirements of Section 404 of the Sarbanes-Oxley Act 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.

The requirements of being a public company, particularly now that we are no longer an "emerging growth company," may strain our resources and distract our management, which could make it difficult to manage our business.

As a public company, we have incurred legal, accounting and other expenses that we did not previously incur. We are subject to the reporting requirements of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and the Sarbanes-Oxley Act, the listing requirements of the NYSE and other applicable securities rules and regulations.

We anticipate that costs and compliance initiatives will increase as a result of the fact that we are no longer an "emerging growth company." In particular, we are now, or will be, subject to certain disclosure requirements that are applicable to other public companies that had not been applicable to us as an emerging growth company. These requirements include: (i) compliance with the auditor attestation requirements in the assessment of our internal control over financial reporting; (ii) compliance with any requirement that may be adopted by the Public Company Accounting Oversight Board regarding mandatory audit firm rotation or a supplement to the auditor's report providing additional information about the audit and the financial statements; (iii) full disclosure and analysis obligations regarding executive compensation; and (vi) compliance with regulatory requirements of holding a nonbinding advisory vote on executive compensation and shareholder approval of any golden parachute payments not previously approved. There can be no assurance that we will be able to comply with the applicable regulations in a timely manner, if at all.

Compliance with these rules and regulations will continue to increase our legal and financial compliance costs, make some activities more difficult, time-consuming or costly and increase demand on our systems and resources. We have made, and will continue to make, changes to our internal controls and procedures for financial reporting and accounting systems to meet our reporting obligations as a public company. However, the measures we take may not be sufficient to satisfy our obligations as a public company. In addition, these rules and regulations increase our legal and financial compliance costs and make some activities more time-consuming and costly. For example, these rules and regulations make it more difficult and more expensive for us to obtain director and officer liability insurance, and we may be required to incur substantial costs to maintain the same or similar coverage. These additional obligations could have a material adverse effect on our business, financial condition and results of operations.

Our indebtedness and liabilities could limit the cash flow available for operations, or expose us to risks that could adversely affect our business, financial condition and results of operations.

As of December 31, 2022, we had total outstanding debt of $978.6 million, which includes $905.8 million aggregate principal amount of our Convertible Senior Notes due in March 2026 and $72.8 million principal amount outstanding under our term loan facility, net of debt issuance costs. In the future, we may incur additional indebtedness to meet financing needs. Our indebtedness could have significant negative consequences for our security holders and our business, results of operations and financial condition by, among other things:

- increasing our vulnerability to adverse economic and industry conditions;
- limiting our ability to obtain additional financing;

- in the event special interest accrues on the Convertible Senior Notes, requiring the dedication of a substantial portion of our cash flow from operations to service our indebtedness, which will reduce the amount of cash available for other purposes;

- limiting our flexibility to plan for, or react to, changes in our business; and

- placing us at a possible competitive disadvantage with competitors that are less leveraged than us or have better access to capital.

Our business may not generate sufficient funds, and we may otherwise be unable to maintain sufficient cash reserves, to pay amounts due under the Convertible Senior Notes or any additional indebtedness that we may incur. In addition, any future indebtedness that we may incur may contain restrictive covenants that may limit our ability to operate our business, raise capital or make payments under our indebtedness. If we fail to comply with these covenants or to make payments under our indebtedness when due, then we would be in default under that indebtedness, which could, in turn, result in that indebtedness becoming immediately payable in full.

The conditional conversion feature of the Convertible Senior Notes, if triggered, may adversely affect our financial condition and operating results.

In the event the conditions to convert the notes are satisfied, holders will be entitled to convert their notes at any time during specified periods at their option. If one or more holders elect to convert their notes, unless we elect to satisfy our conversion obligation by delivering solely shares of our common stock (other than paying cash in lieu of delivering any fractional share), we would be required to settle a portion or all of our conversion obligation through the payment of cash, which could adversely affect our liquidity. In addition, even if holders do not elect to convert their notes, we could be required under applicable accounting rules to reclassify all or a portion of the outstanding principal of the notes as a current rather than long-term liability, which would result in a material reduction of our net working capital.

Conversion of the Convertible Senior Notes may dilute the ownership interest of our stockholders or may otherwise depress the price of our common stock.

The conversion of some or all of the notes may dilute the ownership interests of our stockholders. Upon conversion of the notes, we have the option to pay or deliver, as the case may be, cash, shares of our common stock, or a combination of cash and shares of our common stock. If we elect to settle our conversion obligation in shares of our common stock or a combination of cash and shares of our common stock, any sales in the public market of our common stock issuable upon such conversion could adversely affect prevailing market prices of our common stock. In addition, the existence of the notes may encourage short selling by market participants because the conversion of the notes could be used to satisfy short positions, or anticipated conversion of the notes into shares of our common stock could depress the price of our common stock.

The capped call transactions may affect the value of the Convertible Senior Notes and our common stock.

In connection with the pricing of the notes, we entered into capped call transactions with one or more of the purchasers or their affiliates and/or other financial institutions (the "option counterparties"). The capped call transactions are expected generally to reduce potential dilution to our common stock upon conversion of any notes and/or offset any cash payments we are required to make in excess of the principal amount of converted notes, as the case may be, with such reduction and/or offset subject to a cap. In connection with establishing their initial hedges of the capped call transactions, the option counterparties or their respective affiliates purchased shares of our common stock and/or entered into various derivative transactions with respect to our common stock. This activity could have increased (or reduced the size of any decrease in) the market price of our common stock or the notes at that time.

The option counterparties and/or their respective affiliates may modify their hedge positions by entering into or unwinding various derivatives with respect to our common stock and/or purchasing or selling our common

stock or other securities of ours in secondary market transactions prior to the maturity of the notes (and are likely to do so on each exercise date for the capped call transactions, which are expected to occur on each trading day during the 40 trading day period beginning on the 41st scheduled trading day prior to the maturity date of the notes, or following any termination of any portion of the capped call transactions in connection with any repurchase, redemption or early conversion of the notes). This activity could cause a decrease or avoid an increase in the market price of our common stock. We do not make any representation or prediction as to the direction or magnitude of any potential effect that the transactions described above may have on the price of our common stock. In addition, we do not make any representation that the option counterparties will engage in these transactions or that these transactions, once commenced, will not be discontinued without notice.

We are subject to counterparty risk with respect to the capped call transactions.

The option counterparties are financial institutions, and we will be subject to the risk that any or all of them might default under the capped call transactions. Our exposure to the credit risk of the option counterparties will not be secured by any collateral. Past global economic conditions have resulted in the actual or perceived failure or financial difficulties of many financial institutions. If an option counterparty becomes subject to insolvency proceedings, we will become an unsecured creditor in those proceedings with a claim equal to our exposure at that time under the capped call transactions with such option counterparty. Our exposure will depend on many factors but, generally, an increase in our exposure will be correlated to an increase in the market price and in the volatility of our common stock. In addition, upon a default by an option counterparty, we may suffer more dilution than we currently anticipate with respect to our common stock. We can provide no assurance as to the financial stability or viability of the option counterparties.

Certain provisions in the agreements governing our indebtedness may delay or prevent an otherwise beneficial takeover attempt of us.

Certain provisions in the agreements governing our indebtedness may make it more difficult or expensive for a third party to acquire us. For example, the indenture governing the Convertible Senior Notes will require us, subject to certain exemptions, to repurchase the notes for cash upon the occurrence of a fundamental change and, in certain circumstances, to increase the conversion rate for a holder that converts its notes in connection with a make-whole fundamental change. A takeover of us may trigger the requirement that we repurchase the notes and/or increase the conversion rate, which could make it more costly for a potential acquirer to engage in such takeover. Such additional costs may have the effect of delaying or preventing a takeover of us that would otherwise be beneficial to investors. The Loan Agreement has similar provisions and requires prepayment of all outstanding obligations thereunder upon certain change of control events including if a change in control or fundamental change occurs under the Convertible Senior Notes.

Our growth strategy is partially dependent upon our ability to identify and successfully complete acquisitions, joint ventures and other strategic partnerships and alliances.

An element of our growth strategy is to identify, pursue and successfully complete and integrate acquisitions, joint ventures and other strategic partnerships and alliances that either expand or complement our existing operations. Acquisitions and other strategic transactions involve numerous risks, including difficulties in successfully integrating the operations and personnel, navigating the necessary regulatory approval requirements, distraction of management from overseeing, and disruption of, our existing operations, difficulties in entering markets or lines of business in which we have no or limited direct prior experience, the possible loss of key employees and customers, and difficulties in achieving the synergies we anticipated. Any failure to select suitable opportunities at fair prices, conduct appropriate due diligence, acquire and successfully integrate the acquired company, including particularly when acquired businesses operate in new geographic markets or areas of business, could materially and adversely impact our growth strategies, financial condition and results of operations.

These transactions may also cause us to significantly increase our interest expense, leverage and debt service requirements if we incur additional debt to pay for an acquisition or investment, issue common stock that

would dilute our current stockholders' percentage ownership or incur asset write-offs and restructuring costs and other related expenses that could have a material adverse impact on our operating results. Acquisitions, joint ventures and strategic investments also involve numerous other risks, including potential exposure to assumed litigation and unknown environmental and other liabilities, as well as undetected internal control, regulatory or other issues, or additional costs not anticipated at the time the transaction was completed.

We may be unable to identify, purchase or integrate desirable acquisition targets, future acquisitions may be unsuccessful, and we may not realize the anticipated cost savings, revenue enhancements or other synergies from such acquisitions.

We have in the past and plan to in the future to investigate and acquire strategic businesses with the potential to be accretive to earnings, increase our market penetration, brand strength and its market position or enhancement of our existing product and service offerings. There can be no assurance that we will identify or successfully complete transactions with suitable acquisition candidates in the future. Additionally, if we were to undertake a substantial acquisition, the acquisition may need to be financed in part through additional financing through public offerings or private placements of debt or equity securities or through other arrangements. There is no assurance that the necessary acquisition financing will be available to us on acceptable terms if and when required. Acquisitions could also result in dilutive issuances of equity securities or the incurrence of debt, which could adversely affect our operating results. We may also unknowingly inherit liabilities from acquired businesses or assets that arise after the acquisition and that are not adequately covered by indemnities. In addition, if an acquired business fails to meet our expectations, its operating results, business and financial position may suffer.

We have a substantial amount of goodwill which could, in the future, become impaired and result in material non-cash charges to our results of operations.

As of December 31, 2022 we had $158.0 million of goodwill on our consolidated balance sheets. We evaluate this goodwill for impairment annually either quantitatively or qualitatively during the fourth quarter, or more frequently if an event occurs or circumstances change that could more likely than not reduce the fair value of a reporting unit or indefinite-lived intangible asset below its carrying value. As part of this impairment analysis, we estimate the fair value for each reporting unit using both the income and market approaches. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt and equity, capital expenditure levels, operating cash flows or market capitalization, whether due to COVID-19 or otherwise. There can be no assurance that impairments will not occur, and any impairment may have a material impact on our financial condition and results of operations.

Risks Related to Regulation

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

Our operations are subject to extensive federal, state and local government laws and regulations, such as:

- Medicare and Medicaid reimbursement rules and regulations;
- federal and state anti-kickback laws, 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;

- the Self-Referral Law and analogous state self-referral prohibition statutes, which, subject to limited exceptions, prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of certain "designated health services" 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 an entity, and prohibit the entity from billing Medicare or Medicaid for such "designated health services";

- the FCA and associated regulations, that imposes civil and criminal liability on individuals or entities that knowingly submit false or fraudulent claims for payment to the government or knowingly making, or causing to be made, a false statement in order to have a false claim paid, including qui tam or whistleblower suits;

- the Civil Monetary Penalty statute and associated regulations, which authorizes the government agent to impose civil money penalties, an assessment, and program exclusion for various forms of fraud and abuse involving the Medicare and Medicaid programs;

- federal and state laws regarding the collection, use and disclosure of patient health information (e.g., HIPAA) and the storage, handling, shipment, disposal and/or dispensing of pharmaceuticals and blood products and other biological materials and many other applicable state and federal laws and requirements;

- federal and state laws regarding the use of telehealth;

- state and federal statutes and regulations that govern workplace health and safety;

- federal and state laws and policies that require healthcare providers to maintain licensure, certification or accreditation to enroll and participate in the Medicare and Medicaid programs, to report certain changes in their operations to the agencies that administer these programs and, in some cases, to re-enroll in these programs when changes in direct or indirect ownership occur; and

- federal and state laws pertaining to the provision of services by nurse practitioners and physician assistants certain settings, physician supervision of those services, and reimbursement requirements that depend on the types of services provided and documented and relationships between physician supervisors and nurse practitioners and physician assistants.

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

These legal requirements are civil, criminal and administrative in nature depending on the law or requirement.

We endeavor to comply with all legal requirements. We further endeavor to structure all of our relationships with physicians and providers to comply with state and federal anti-kickback physician and Stark laws and other applicable healthcare laws. We utilize considerable resources to monitor laws and regulations and implement necessary changes. However, the laws and regulations in these areas are complex, changing and often subject to varying interpretations. As a result, there is no guarantee that we will be able to adhere to all of the laws and regulations that apply to our business, and any failure to do so could have a material adverse impact on our

business, results of operations, financial condition, cash flows and reputation. For example, if an enforcement agency were to challenge the level of compensation that we pay our medical directors or the number of medical directors whom we engage, or otherwise challenge these arrangements, we could be required to change our practices, face criminal or civil penalties, pay substantial fines or otherwise experience a material adverse impact on our business, results of operations, financial condition, cash flows and reputation as a result. Similarly, we may face penalties under the FCA, the federal Civil Monetary Penalty statute or otherwise related to failure to report and return overpayments within 60 days of when the overpayment is identified and quantified. These obligations to report and return overpayments could subject our procedures for identifying and processing overpayments to greater scrutiny. We have made investments in resources to decrease the time it takes to identify, quantify and process overpayments, and may be required to make additional investments in the future.

Additionally, the federal government has used the FCA to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare, Medicaid and other federally funded health care programs. Moreover, amendments to the federal Anti-Kickback Statute in the ACA make claims tainted by anti-kickback violations potentially subject to liability under the FCA, including qui tam or whistleblower suits. The penalties for a violation of the FCA range from $5,500 to $11,000 (adjusted for inflation) for each false claim plus three times the amount of damages caused by each such claim which generally means the amount received directly or indirectly from the government. On December 13, 2021, the DOJ issued a final rule announcing adjustments to FCA penalties, under which the per claim range increases to a range from $11,803 to $23,607 per claim. Given the high volume of claims processed by our various operating units, the potential is high for substantial penalties in connection with any alleged FCA violations.

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

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

- suspension or termination of our participation in government payment programs;
- refunds of amounts received in violation of law or applicable payment program requirements dating back to the applicable statute of limitation periods;
- loss of our required government certifications or exclusion from government payment programs;
- loss of our licenses required to operate healthcare facilities or administer pharmaceuticals in the states in which we operate;
- criminal or civil liability, fines, damages or monetary penalties for violations of healthcare fraud and abuse laws, including the federal Anti-Kickback Statute, Civil Monetary Penalties Law, Stark Law and FCA, or other failures to meet regulatory requirements;
- enforcement actions by governmental agencies and/or state law claims for monetary damages by patients who believe their PHI has been used, disclosed or not properly safeguarded in violation of federal or state patient privacy laws, including HIPAA and the Privacy Act of 1974;
- mandated changes to our practices or procedures that significantly increase operating expenses;

- imposition of and compliance with corporate integrity agreements that could subject us to ongoing audits and reporting requirements as well as increased scrutiny of our billing and business practices which could lead to potential fines, among other things;

- termination of various relationships and/or contracts related to our business, including joint venture arrangements, medical director agreements, real estate leases and consulting agreements with physicians; and

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

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

We may in the future be subject to investigations and audits by state or federal governmental agencies and/ or private civil qui tam complaints filed by relators and other lawsuits, demands, claims and legal proceedings, including investigations or other actions resulting from our obligation to self-report suspected violations of law.

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

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

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

Due to the importance of the healthcare industry in the lives of all Americans, federal, state, and local legislative bodies frequently pass legislation and promulgate regulations relating to healthcare reform or that affect the healthcare industry. As has been the trend in recent years, it is reasonable to assume that there will continue to be increased government oversight and regulation of the healthcare industry in the future. We cannot

assure our shareholders as to the ultimate content, timing or effect of any new healthcare legislation or regulations, nor is it possible at this time to estimate the impact of potential new legislation or regulations on our business. It is possible that future legislation enacted by Congress or state legislatures, or regulations promulgated by regulatory authorities at the federal or state level, could adversely affect our business or could change the operating environment of our primary care centers. It is possible that the changes to the Medicare, Medicaid or other governmental healthcare program reimbursements may serve as precedent to possible changes in other payors' reimbursement policies in a manner adverse to us. Similarly, changes in private payor reimbursements could lead to adverse changes in Medicare, Medicaid and other governmental healthcare programs, which could have a material adverse effect on our business, financial condition and results of operations.

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

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

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

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

The HHS OCR also has proposed changes to the HIPAA Privacy Rule that have the potential to impact patients, covered entities, and business associates. Certain of the proposed changes are focused on the patient right of access requirements and processes, while other proposed changes would impact how covered entities may share information and would relax the requirements for providers to document how their Notice of Privacy Practices is provided to patients. It is unclear when HHS OCR will issue final regulations.

HIPAA imposes mandatory penalties for certain violations. Penalties for violations of HIPAA and its implementing regulations start at $120 per violation and are not to exceed $60,226 per violation, subject to a cap of $1.81 million for violations of the same standard in a single calendar year. However, a single breach incident can result in violations of multiple standards. HIPAA also authorizes state attorneys general to file suit on behalf of their residents. Courts may award damages, costs and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

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

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

In addition to HIPAA, numerous other federal and state laws and regulations protect the confidentiality, privacy, availability, integrity and security of PHI and other types of PII, including the Illinois Biometric Information Privacy Act. State statutes and regulations vary from state to state, and these laws and regulations in many cases are more restrictive than, and may not be preempted by, HIPAA and its implementing rules. These laws and regulations are often uncertain, contradictory, and subject to changed or differing interpretations, and we expect new laws, rules and regulations regarding privacy, data protection, and information security to be proposed and enacted in the future. In the event that new data security laws are implemented, we may not be able to timely comply with such requirements, or such requirements may not be compatible with our current processes. Changing our processes could be time consuming and expensive, and failure to timely implement required changes could subject us to liability for non-compliance. Some states may afford private rights of action to individuals who believe their PII has been misused. This complex, dynamic legal landscape regarding privacy, data protection, and information security creates significant compliance issues for us and potentially restricts our ability to collect, use and disclose data and exposes us to additional expense, adverse publicity and liability.

Under the 21st Century Cures Act, Congress authorized the HHS Office of the National Coordinator for Health Information Technology ("ONC") to engage in rulemaking that would drive interoperability, prohibit information blocking, and provide timely access to health information through standardized application programming interfaces (APIs) to seamlessly coordinate care, improve outcomes and reduce the cost of care. CMS also finalized regulations under their authority to regulate Medicare and Medicaid managed care plans, qualified health plans offered on the federally facilitated Exchange, and hospitals that improve patient access to their health information and encourage provider-to-provider and payor-to-payor exchanges of health information that are designed to reduce the burden on payors and providers. ONC published an Interim Final Rule that extended the applicability date for the Information Blocking provisions until April 2021. The Interim Final Rule also laid out a compliance timeline that extends through December 31, 2023.

While we have implemented data privacy and security measures in an effort to comply with applicable laws and regulations relating to privacy and data protection, some PHI and other PII or confidential information is transmitted to us by third parties, who may not implement adequate security and privacy measures, and it is possible that laws, rules and regulations relating to privacy, data protection, or information security may be interpreted and applied in a manner that is inconsistent with our practices or those of third parties who transmit PHI and other PII or confidential information to us. If we or these third parties are found to have violated such laws, rules or regulations, it could result in government-imposed fines, orders requiring that we or these third parties change our or their practices, or criminal charges, which could adversely affect our business. Complying with these various laws and regulations could cause us to incur substantial costs or require us to change our business practices, systems and compliance procedures in a manner adverse to our business.

We also publish statements to our patients and partners that describe how we handle and protect PHI. If federal or state regulatory authorities or private litigants consider any portion of these statements to be untrue, we may be subject to claims of deceptive practices, which could lead to significant liabilities and consequences,

including, without limitation, costs of responding to investigations, defending against litigation, settling claims, and complying with regulatory or court orders. Any of the foregoing consequences could seriously harm our business and our financial results. Any of the foregoing consequences could have a material adverse impact on our business and our financial results.

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

Some states have laws that prohibit business entities, such as us, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians or engaging in certain arrangements, such as fee-splitting, with physicians (such activities generally referred to as the "corporate practice of medicine"). In some states these prohibitions are expressly stated in a statute or regulation, while in other states the prohibition is a matter of judicial or regulatory interpretation. All of the states in which we currently operate generally prohibit the corporate practice of medicine, and other states may as well.

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

Some of the relevant laws, regulations and agency interpretations in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretation. Moreover, state laws are subject to change. Regulatory authorities and other parties may assert that, despite the management agreements and other arrangements through which we operate, we are engaged in the prohibited corporate practice of medicine or that our arrangements constitute unlawful fee-splitting. If this were to occur, we could be subject to civil and/or criminal penalties, our agreements could be found legally invalid and unenforceable (in whole or in part) or we could be required to restructure our contractual arrangements. In markets where the corporate practice of medicine is prohibited, we have historically operated by maintaining long-term management contracts with multiple associated professional organizations which, in turn, employ or contract with physicians to provide those professional medical services required by the enrollees of the payors with which the professional organizations contract. Under these management agreements, Oak Street Health MSO, LLC performs only non-medical administrative services, does not represent that it offers medical services and does not exercise influence or control over the practice of medicine by the physicians or the associated physician groups with which it contracts. In the event of certain of our licensed physicians who hold shares in our physician groups death or disability or upon certain other triggering events, we maintain the right to direct the transfer of the ownership of the professional organizations to another licensed physician.

In addition to the above management arrangements, we have certain contractual rights relating to the orderly transfer of equity interests in our physician practices through succession agreements and other arrangements with their physician equity holders. Such equity interests cannot, however, be transferred to or held by us or by any non-professional organization. Accordingly, neither we nor our direct subsidiaries directly own any equity interests in any of our physician practices. In the event that any of the physician owners of our practices fail to comply with the management arrangement, if any management arrangement is terminated and/or we are unable to enforce our contractual rights over the orderly transfer of equity interests in any of our physician practices, such events could have a material adverse effect on our business, results of operations, financial condition and cash flows.

It is possible that a state regulatory agency or a court could determine that our agreements with physician equity holders of our practices and the way we carry out these arrangements as described above, either independently or coupled with the management services agreements with such associated physician practices, are in violation of prohibitions on the corporate practice of medicine. As a result, these arrangements could be deemed invalid, potentially resulting in a loss of revenues and an adverse effect on results of operations derived from such practices. Such a determination could force a restructuring of our management arrangements with the affected

practices, which might include revisions of the management services agreements, including a modification of the management fee and/or establishing an alternative structure that would permit us to contract with a physician network without violating prohibitions on the corporate practice of medicine. There can be no assurance that such a restructuring would be feasible, or that it could be accomplished within a reasonable time frame without a material adverse effect on our business, results of operations, financial condition and cash flows.

If our agreements or arrangements with certain of our licensed physicians who hold shares in our physician groups or our affiliated physician groups are deemed invalid under state corporate practice of medicine and similar laws or federal law, or are terminated as a result of changes in state law, it could have a material impact on our results of operations and financial condition.

There are various state laws, including in the states in which we operate, regulating the corporate practice of medicine that prohibit us from directly owning certain types of healthcare entities. These prohibitions are intended to prevent unlicensed persons from interfering with or inappropriately influencing a physician's professional judgment. Corporate practice of medicine regulations and other similar laws may also prevent fee-splitting, or the sharing of professional service income with non-professional or business interests. The interpretation and enforcement of these laws vary significantly from state to state. Although we have structured our agreements and arrangements with our affiliated physician groups to avoid breaching corporate practice of medicine regulations, such as having our nominee shareholder hold shares in the physician groups, we cannot guarantee that these agreements and arrangements will not be held to be invalid under state laws prohibiting the corporate practice of medicine. If these agreements and arrangements were deemed to be invalid, a significant portion of our revenues could be affected, which may result in a material adverse effect on our results of operations and financial condition. In addition, these agreements and arrangements may not be as effective in providing control as direct ownership. Any changes to Federal or state law that prohibited such agreements or arrangements could also have a material adverse effect upon our results of operations and financial condition.

If we lost the services of certain of our licensed physicians who hold shares in our physician groups for any reason, the contractual arrangements with our VIEs could be in jeopardy.

Because of regulations preventing the corporate practice of medicine, many of our affiliated physician practice groups are wholly owned or primarily owned by our nominee shareholders. Although we retain the right to direct the transfer of these ownership arrangements to another licensed physician, if our nominee shareholder died, was incapacitated or otherwise was no longer affiliated with us, there could be a material adverse effect on the relationship between us and each of those variable interest entities ("VIEs") and, therefore, our business as a whole could be adversely affected.

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

Because of laws prohibiting the corporate practice of medicine, we enter into contractual arrangements to manage certain of our affiliated physician practice groups, which allows us to consolidate those groups with OSH MSO for financial reporting purposes. If we were to hold such groups directly, we would be able to exercise our rights as an equity holder directly to effect changes in the boards of directors of those entities, which could effect changes at the management and operational level. In contrast, under our current contractual arrangements with our physician groups, we may not be able to directly change the members of the boards of directors of these entities and would have to rely on the entities and the entities' equity holders to perform their obligations in order to exercise our control over the entities. If any of these affiliated entities or their equity holders fail to perform their respective obligations under the contractual arrangements, we may have to incur substantial costs and expend additional resources to enforce such arrangements.

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

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

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

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

Our income tax treatment has changed as a result of the restructuring transactions undertaken immediately prior to our IPO and our future effective income tax rates could be subject to volatility.

Prior to the IPO, we conducted our business as Oak Street Health, LLC. Oak Street Health, LLC was classified as a partnership for U.S. federal income tax purposes and consequently did not generally pay any U.S. federal, state or local income taxes. Following the IPO, we now operate under Oak Street Health, Inc., and Oak Street Health, Inc. is classified as a corporation for U.S. federal income tax purposes. See "Organizational Transactions" within our 2020 Form 10-K filed with the SEC on March 10, 2021. As a corporation, Oak Street Health, Inc. is subject to U.S. federal, state, and local income taxes with respect to its taxable income.

Oak Street Health, Inc.'s future effective income tax rates could be subject to volatility or adversely affected by a number of factors, including:

- changes in tax laws (including statutory changes that increase the applicable U.S. federal corporate tax rate from its current 21%);
- changes in the valuation of our deferred tax assets and liabilities;
- expected timing and amount of the release of any tax valuation allowances;

- structural changes in our business;
- tax effects of equity-based compensation; or
- changes in tax regulations or other interpretations of applicable tax law.

In addition, as a corporation, Oak Street Health, Inc. is be subject to audits by U.S. federal, state and local tax authorities. Outcomes from these audits may adversely affect the operating results and financial condition of Oak Street Health, Inc.

We may incur certain tax liabilities attributable to our pre-IPO investors as a result of the restructuring transactions undertaken immediately prior to our IPO.

In connection with the IPO and related restructuring, the entities through which the investment entities affiliated with General Atlantic LLC (collectively, "General Atlantic") and Newlight Partners LP ("Newlight" and, together with General Atlantic, the "Lead Sponsors") and other institutional investors held their ownership interests in Oak Street Health engaged in a series of transactions that resulted in each of these entities becoming wholly owned subsidiaries of Oak Street Health, Inc. As the parent company to these entities, Oak Street Health, Inc. generally succeeded to and, subject to certain rights to be indemnified, is responsible for the tax liabilities of the entities prior to the restructuring and, subject to certain rights to be indemnified, be responsible for costs incurred in defending any audits or other proceedings with respect to such taxes. Any such liabilities for which Oak Street Health, Inc. is responsible could have an adverse effect on our operating results and financial condition.

We may incur certain tax liabilities attributable to the pre-IPO taxable income or taxable loss of Oak Street Health, LLC.

Prior to the IPO and restructuring, we operated under Oak Street Health, LLC, and Oak Street Health, LLC was classified as a partnership for U.S. federal income tax purposes. As a partnership, prior to the IPO and the restructuring, Oak Street Health, LLC did not directly pay any federal, state or local income taxes with respect to the taxable income shown on its tax returns. Rather, items of income, gain, loss, deduction, and credit are allocated among its partners and such persons are liable for any of the resulting income taxes.

Pursuant to certain provisions of the Internal Revenue Code of 1986, as amended (the "Code") enacted as part of the Bipartisan Budget Act of 2015 (such provisions, the "Partnership Tax Audit Rules"), partnerships (and not the partners of the partnerships) can be subject to U.S. federal income taxes (and any related interest and penalties) resulting from adjustments made pursuant to an IRS audit or judicial proceedings to the items of income, gain, loss, deduction, or credit shown on the partnership's tax return (or how such items are allocated among the partners). For example, such an adjustment could include the reduction of a loss allocated in periods prior to the IPO, which in turn increases the taxable income reportable for periods after the IPO. The Partnership Tax Audit Rules apply to Oak Street Health, LLC for each of its taxable years ending after December 31, 2017.

Under the Partnership Tax Audit Rules, a partnership's liability for taxes can be reduced or avoided in certain circumstances depending on the status or actions of its partners. For example, if partners agree to amend their tax returns and pay the resulting taxes, the partnership's liability can be reduced. Partnerships can also make elections to "push out" the tax liability resulting from the adjustment to its partners and, as a result, have the partners and not the partnerships pay the income taxes. Under current authority, partnerships that cease to exist can be considered to automatically have made this "push out" election. Whether a partnership ceases to exist is currently based on a determination by the IRS.

Following the IPO and the restructuring, Oak Street Health, Inc. pursued a series of internal reorganizations intended to simplify its entity structure (the "Internal Reorganization"). Following the Internal Reorganization, Oak Street Health, LLC remains in legal existence, but is no longer treated as a partnership for U.S. federal income tax purposes. Whether Oak Street Health, LLC has ceased to exist for purposes of the

Partnership Tax Audit Rules, and therefore whether Oak Street Health, LLC has automatically made a "push out" election following these transactions, is unclear.

If Oak Street Health, LLC is not treated as ceasing to exist for purposes of the Partnership Tax Audit Rules, it does not appear that Oak Street Health, LLC would be considered to automatically make the "push out" election. Without an automatic or elective "push out" election, if there is an adjustment under the Partnership Tax Audit Rules, the prior partners of Oak Street Health, LLC would not be obligated to file any amended returns to reduce or avoid any tax that would otherwise be imposed on Oak Street Health, LLC, and Oak Street Health, Inc. would economically incur any taxes, interest, or penalties associated with any of these adjustments (including in respect of such allocated tax losses). Any such liabilities for which Oak Street Health, Inc. is responsible could have an adverse effect on our operating results and financial condition.

If Oak Street Health, LLC is treated as ceasing to exist for purposes of Partnership Tax Audit Rules and is automatically treated as making a "push out election", or if a "push out election" is voluntarily made, Oak Street Health, Inc. would still economically incur the portion of the taxes resulting from such audit that relate to certain of the entities that were contributed to Oak Street Health, Inc. as part of the Organizational Transactions. Further, whether or not a "push out" election is made or required, Oak Street Health, Inc. would bear the costs of defending any actions to make adjustments to the income tax returns of Oak Street Health, LLC for periods prior to the IPO (including in respect of tax losses allocated prior to the IPO). Any such liabilities for which Oak Street Health, Inc. is economically responsible could have an adverse effect on our operating results and financial condition.

We will not have control of any IRS audit or related proceeding pursuant to the Partnership Tax Audit Rules.

Under the Partnership Tax Audit Rules, the partnership (including Oak Street Health, LLC) is required to appoint one person (the "partnership representative") to act on its behalf in connection with IRS audits and related proceedings. Under the Partnership Tax Audit Rules, this person does not need to be a partner of the partnership (including Oak Street Health, LLC). As described above, the partnership representative's actions, including the partnership representative's agreement to adjustments of the partnership's income in settlement of an IRS audit of the partnership, will bind all partners of the partnership, and opt-out rights available to certain partners in connection with certain actions of the tax matters partner under the Partnership Tax Audit Rules for tax years beginning before January 1, 2018 will no longer be available.

The "partnership representative" for Oak Street Health, LLC for the years prior to its ownership by Oak Street Health, Inc. was an individual that was a member of Oak Street Health, LLC prior to the Organizational Transactions and is currently an officer of Oak Street Health, Inc. As a result, Oak Street Health, Inc. may not have any control over any IRS audit or related proceeding with respect to Oak Street Health, LLC. However, as described above, depending on the actions of the person acting as "partnership representative," Oak Street Health, Inc. may still be held liable for any tax which results from an adjustment made pursuant to an IRS audit or judicial proceedings to the items of income, gain, loss, deduction, or credit shown on Oak Street Health, LLC's income tax return.

Risks Related to Our Common Stock

The Lead Sponsors own a large portion of our common stock, and their interests may conflict with ours or yours in the future.

Investment entities affiliated with General Atlantic and Newlight, collectively, beneficially own approximately 38.7% of our issued and outstanding shares of common stock. While we were previously a controlled company and no longer qualify as such, for so long as the Lead Sponsors continue to own a large portion of our common stock, the Lead Sponsors will still be able to significantly influence the composition of our Board and the approval of actions requiring shareholder approval. Accordingly, for such period of time, the Lead Sponsors will continue to have significant influence with respect to our management, business plans and

policies, including the appointment and removal of our officers, decisions on whether to raise future capital and amending our charter and bylaws, which govern the rights attached to our common stock.

In addition, we are party to the Sponsor Director Nomination Agreement (defined herein) that provides each Lead Sponsor the right to designate: (i) three of the nominees for election to our Board for so long as each beneficially owns at least 20% of our common stock then outstanding; (ii) two of the nominees for election to our Board for so long as each beneficially owns less than 20% but at least 10% of our common stock then outstanding; and (iii) one of the nominees for election to our Board for so long as each beneficially owns less than 10% but at least 5% of our common stock then outstanding. As of the date of this filing, our Lead Sponsors continue to hold more than 35% of our common stock then outstanding. The Lead Sponsors may also assign such right to their affiliates. The Sponsor Director Nomination Agreement also prohibits us from increasing or decreasing the size of our Board without the prior written consent of the Lead Sponsors.

The Lead Sponsors and their affiliates engage in a broad spectrum of activities, including investments in the healthcare industry generally. In the ordinary course of their business activities, the Lead Sponsors and their affiliates may engage in activities where their interests conflict with our interests or those of our other shareholders, such as investing in or advising businesses that directly or indirectly compete with certain portions of our business or are suppliers or customers of ours. Our certificate of incorporation provides that none of the Lead Sponsors, any of their affiliates or any director who is not employed by us (including any non-employee director who serves as one of our officers in both his director and officer capacities) or its affiliates have any duty to refrain from engaging, directly or indirectly, in the same business activities or similar business activities or lines of business in which we operate. The Lead Sponsors also may pursue acquisition opportunities that may be complementary to our business, and, as a result, those acquisition opportunities may not be available to us. In addition, the Lead Sponsors may have an interest in pursuing acquisitions, divestitures and other transactions that, in its judgment, could enhance its investment, even though such transactions might involve risks to you.

The requirements of being a public company may strain our resources and distract our management, which could make it difficult to manage our business, particularly now that we are no longer an "emerging growth company."

As a public company, we incur legal, accounting and other expenses that we did not previously incur. We are subject to the reporting requirements of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and the Sarbanes-Oxley Act, the listing requirements of the NYSE and other applicable securities rules and regulations. Compliance with these rules and regulations will continue to increase our legal and financial compliance costs, make some activities more difficult, time-consuming or costly and increase demand on our systems and resources, particularly now that we are no longer an "emerging growth company." The Exchange Act requires that we file annual, quarterly and current reports with respect to our business, financial condition and results of operations. The Sarbanes-Oxley Act requires, among other things, that we establish and maintain effective internal controls and procedures for financial reporting. Furthermore, the need to establish the corporate infrastructure demanded of a public company may divert our management's attention from implementing our growth strategy, which could prevent us from improving our business, financial condition and results of operations. We have made, and will continue to make, changes to our internal controls and procedures for financial reporting and accounting systems to meet our reporting obligations as a public company. However, the measures we take may not be sufficient to satisfy our obligations as a public company. In addition, these rules and regulations increase our legal and financial compliance costs and make some activities more time-consuming and costly. For example, these rules and regulations make it more difficult and more expensive for us to obtain director and officer liability insurance, and we may be required to incur substantial costs to maintain the same or similar coverage. These additional obligations could have a material adverse effect on our business, financial condition and results of operations.

In addition, changing laws, regulations and standards relating to corporate governance and public disclosure are creating uncertainty for public companies, increasing legal and financial compliance costs and making some activities more time consuming. These laws, regulations and standards are subject to varying interpretations, in many cases due to their lack of specificity, and, as a result, their application in practice may

evolve over time as new guidance is provided by regulatory and governing bodies. This could result in continuing uncertainty regarding compliance matters and higher costs necessitated by ongoing revisions to disclosure and governance practices. We have invested, and will continue to invest, resources to comply with evolving laws, regulations and standards, and this investment may result in increased general and administrative expenses and a diversion of our management's time and attention from revenue-generating activities to compliance activities. If our efforts to comply with new laws, regulations and standards differ from the activities intended by regulatory or governing bodies due to ambiguities related to their application and practice, regulatory authorities may initiate legal proceedings against us and there could be a material adverse effect on our business, financial condition and results of operations.

Provisions of our corporate governance documents could make an acquisition of us more difficult and may prevent attempts by our shareholders to replace or remove our current management, even if beneficial to our shareholders.

In addition to the Lead Sponsors' beneficial ownership of a combined 38.7% of our common stock, our certificate of incorporation and bylaws and the Delaware General Corporation Law (the "DGCL"), contain provisions that could make it more difficult for a third party to acquire us, even if doing so might be beneficial to our shareholders. Among other things, these provisions:

- allow us to authorize the issuance of undesignated preferred stock, the terms of which may be established and the shares of which may be issued without shareholder approval, and which may include supermajority voting, special approval, dividend, or other rights or preferences superior to the rights of shareholders;
- provide for a classified board of directors with staggered three-year terms;
- prohibit shareholder action by written consent from and after the date on which the Lead Sponsors beneficially own, in the aggregate, less than 40% of our common stock then outstanding;
- provide that any amendment, alteration, rescission or repeal of our bylaws by our shareholders will require the affirmative vote of the holders of at least 66 2/3% in voting power of all the then- outstanding shares of our stock entitled to vote thereon, voting together as a single class; and
- establish advance notice requirements for nominations for elections to our Board or for proposing matters that can be acted upon by shareholders at shareholder meetings, provided, however, that at any time when a Lead Sponsor beneficially owns, in the aggregate, at least 5% of our common stock then outstanding, such advance notice procedure will not apply to that Lead Sponsor.

Our certificate of incorporation contains a provision that provides us with protections similar to Section 203 of the DGCL, and prevents us from engaging in a business combination with a person (excluding the Lead Sponsors and any of their direct or indirect transferees and any group as to which such persons are a party) who acquires at least 15% of our common stock for a period of three years from the date such person acquired such common stock, unless board or shareholder approval is obtained prior to the acquisition. This provision could discourage, delay or prevent a transaction involving a change in control of our company. This provision could also discourage proxy contests and make it more difficult for you and other shareholders to elect directors of your choosing and cause us to take other corporate actions you desire, including actions that you may deem advantageous, or negatively affect the trading price of our common stock. In addition, because our Board is responsible for appointing the members of our management team, these provisions could in turn affect any attempt by our shareholders to replace current members of our management team.

These and other provisions in our certificate of incorporation, bylaws and Delaware law could make it more difficult for shareholders or potential acquirers to obtain control of our Board or initiate actions that are opposed by our then-current Board, including delay or impede a merger, tender offer or proxy contest involving our company. The existence of these provisions could negatively affect the price of our common stock and limit opportunities for you to realize value in a corporate transaction.

Our certificate of incorporation designates the Court of Chancery of the State of Delaware as the exclusive forum for certain litigation that may be initiated by our shareholders, which could limit our shareholders' ability to obtain a favorable judicial forum for disputes with us.

Pursuant to our certificate of incorporation, unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware is the sole and exclusive forum for (1) any derivative action or proceeding brought on our behalf, (2) any action asserting a claim of breach of a fiduciary duty owed by any of our directors, officers or other employees to us or our shareholders, (3) any action asserting a claim against us arising pursuant to any provision of the DGCL, our certificate of incorporation or our bylaws or (4) any other action asserting a claim against us that is governed by the internal affairs doctrine; provided that for the avoidance of doubt, the forum selection provision that identifies the Court of Chancery of the State of Delaware as the exclusive forum for certain litigation, including any "derivative action," will not apply to suits to enforce a duty or liability created by the Securities Act, the Exchange Act or any other claim for which the federal courts have exclusive jurisdiction. Our certificate of incorporation further provides that any person or entity purchasing or otherwise acquiring any interest in shares of our capital stock is deemed to have notice of and consented to the provisions of our certificate of incorporation described above. The forum selection clause in our certificate of incorporation may have the effect of discouraging lawsuits against us or our directors and officers and may limit our shareholders' ability to obtain a favorable judicial forum for disputes with us.

An active, liquid trading market for our common stock may not be sustained.

Although our common stock is currently listed on the NYSE under the symbol "OSH," an active trading market for our shares may not be sustained. Accordingly, if an active trading market for our common is not maintained, the liquidity of our common stock, your ability to sell your shares of our common stock when desired and the prices that you may obtain for your shares of common stock will be adversely affected.

Our operating results and stock price may be volatile.

Our quarterly operating results are likely to fluctuate in the future. In addition, securities markets worldwide have experienced, and are likely to continue to experience, significant price and volume fluctuations. This market volatility, as well as general economic, market or political conditions, could subject the market price of our shares to wide price fluctuations regardless of our operating performance. Our operating results and the trading price of our shares may fluctuate in response to various factors, including:

- the timing of, and our ability to close, the potential CVS Merger, as well as changes in factors that influence the timing or likelihood of closing the potential CVS Merger;
- market conditions in our industry or the broader stock market;
- actual or anticipated fluctuations in our quarterly financial and operating results;
- introduction of new solutions or services by us or our competitors;
- issuance of new or changed securities analysts' reports or recommendations;
- sales, or anticipated sales, of large blocks of our stock;

- additions or departures of key personnel;
- regulatory or political developments;
- litigation and governmental investigations;
- changing economic conditions;
- investors' perception of us;
- events beyond our control such as weather and war; and
- any default on our indebtedness.

These and other factors, many of which are beyond our control, may cause our operating results and the market price and demand for our shares to fluctuate substantially. Fluctuations in our quarterly operating results could limit or prevent investors from readily selling their shares and may otherwise negatively affect the market price and liquidity of our shares. In addition, in the past, when the market price of a stock has been volatile, holders of that stock have sometimes instituted securities class action litigation against the company that issued the stock. Such a lawsuit was filed against the Company in January 2022. If any of our shareholders brought a lawsuit against us, we could incur substantial costs defending the lawsuit. Such a lawsuit could also divert the time and attention of our management from our business, which could significantly harm our profitability and reputation.

Because we have no current plans to pay regular 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 do not anticipate paying any regular cash dividends on our common stock for the foreseeable future. Any decision to declare and pay dividends in the future will be made at the discretion of our Board and will depend on, among other things, our results of operations, financial condition, cash requirements, contractual restrictions and other factors that our Board may deem relevant. In addition, our ability to pay dividends is, and may be, limited by covenants of any future outstanding indebtedness we or our subsidiaries incur. Therefore, any return on investment in our common stock is solely dependent upon the appreciation of the price of our common stock on the open market, which may not occur.

If securities or industry analysts do not publish research or reports about our business, if they adversely change their recommendations regarding our shares or if our results of operations do not meet their expectations, our stock price and trading volume could decline.

The trading market for our shares is influenced by the research and reports that industry or securities analysts publish about us or our business. We do not have any control over these analysts. If one or more of these analysts cease coverage of us or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock, or if our results of operations do not meet their expectations, our stock price could decline.

We may issue shares of preferred stock in the future, which could make it difficult for another company to acquire us or could otherwise adversely affect holders of our common stock, which could depress the price of our common stock.

Our certificate of incorporation authorizes us to issue one or more series of preferred stock. Our Board has the authority to determine the preferences, limitations and relative rights of the shares of preferred stock and

to fix the number of shares constituting any series and the designation of such series, without any further vote or action by our shareholders. Our preferred stock could be issued with voting, liquidation, dividend and other rights superior to the rights of our common stock. The potential issuance of preferred stock may delay or prevent a change in control of us, discouraging bids for our common stock at a premium to the market price, and materially adversely affect the market price and the voting and other rights of the holders of our common stock.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our principal executive offices are located in Chicago, Illinois where we occupy facilities totaling approximately 35,000 square feet under subleases that expire on June 30, 2023 and October 31, 2025. We use this facility for administration, sales and marketing, technology and development and professional services. We also lease offices elsewhere in the United States, including Charlotte, North Carolina, Downers Grove and Oak Brook, Illinois.

We intend to procure additional space as we add team members and expand geographically. We believe that our facilities are adequate to meet our needs for the immediate future, and that, should it be needed, suitable additional space will be available to accommodate any such expansion of our operations.

As of December 31, 2022, we leased approximately 1,900,000 gross square feet relating to 169 open centers located in 21 states, including our corporate offices and some centers that are yet to be opened. See "Risk Factors—Risks Related to Our Business—We lease all of our facilities and may experience risks relating to lease termination, lease expense escalators, lease extensions and special charges." Our leases typically have terms of 2 to 20 years, and generally provide for renewal or extension options. Our lease obligations often include annual fixed rent escalators ranging between 2% and 3% or variable rent escalators based on a consumer price index. Generally, our leases are "net" leases, which require us to pay all of the cost of insurance, taxes, maintenance and utilities. We generally cannot cancel these leases at our option. For more information on leases, see Note 10 to the Consolidated Financial Statements included in Part IV, Item 15, of this Form 10-K.

Item 3. Legal Proceedings

On November 1, 2021, the Company received a civil investigative demand ("CID") from the United States Department of Justice. According to the CID, the Department of Justice is investigating whether the Company may have violated the False Claims Act, 31 U.S.C. §§ 3729-3722. The CID requests certain documents and information related to the Company's relationships with third-party marketing agents and related to the Company's provision of free transportation to federal health care beneficiaries and requests information and documents related to such matters. We are continuing to cooperate with the Department of Justice in response to the CID. We are currently unable to predict the outcome of this investigation detailed in our financial statements. Regardless of the outcome, this inquiry has the potential to have an adverse impact on us due to any related defense and settlement costs, diversion of management resources, and other factors.

Additionally, on January 10, 2022, Reginald T. Allison, individually and on behalf of all others similarly situated, filed a putative class action lawsuit against Oak Street Health, Inc., Michael Pykosz and Timothy Cook, two of the Company's largest stockholders and members of the Company's Board of Directors in the United States District Court for the Northern District of Illinois (Case No: 1:22-cv-00149). On March 25, 2022, Central Pennsylvania Teamsters Pension Fund – Defined Benefit Plan, Central Pennsylvania Teamsters Pension Fund – Retirement Income Plan 1987, and Boston Retirement System's (collectively, the "Northeast Pension Funds") were appointed as the lead plaintiffs in the case. On May 25, 2022, the Northeast Pension Funds along with an additional named plaintiff, the City of Dearborn Police & Fire Revised Retirement System, filed their consolidated amended and restated complaint (the "Amended Complaint").

Plaintiffs allege that the Company and certain of its executive officers made false and/or misleading statements about patient acquisition tactics that purportedly violated the False Claims Act and federal Anti-Kickback Statute, and are purportedly the subject of the CID discussed above. The Amended Complaint includes two categories of claims: (1) claims under the Securities Exchange Act of 1934 based on allegedly misleading public statements throughout the class period of August 6, 2020 through November 8, 2021 (the "Exchange Act Claims"), and (2) claims under the Securities Act of 1933 based on allegedly misleading statements in the registration statements and prospectuses accompanying Oak Street Health, Inc.'s initial public offering and secondary public offerings (the "Securities Act Claims"). The Exchange Act claims are asserted against Oak Street Health, Inc., Michael Pykosz, our CEO and Timothy Cook, our CFO, and also against certain stockholders of as "control persons." The Securities Act Claims are asserted against the same defendants as well as the underwriters of the Company's public offerings, and the Oak Street Health, Inc. directors who signed the registration statements. The Amended Complaint seeks damages, interest, costs, attorneys' fees and other unspecified equitable relief.

On July 25, 2022, the defendants filed a consolidated motion to dismiss the Amended Complaint. On September 26, 2022, the plaintiffs' opposition to that motion to dismiss was filed, and the defendants reply to that opposition was filed on October 26, 2022. On February 10, 2023, the Court ruled on the motion to dismiss, granting the Company's' motions to dismiss with respect to the plaintiffs' section 12(a)(2) claim and section 11 claim based on misrepresentations from the May 2021 secondary public offering, and denying the remainder of the motion. Additionally three stockholders, Joseph Miller, the Hialeah Employees' Retirement System and the Employees Retirement System of the City of St. Louis each filed, on November 7, 2022, January 5, 2023 and February 2, 2023, respectively, derivative actions in the Delaware Court of Chancery against certain of our officers and each of the members of Oak Street's Board of Directors (collectively, "Defendants") principally alleging breach of fiduciary duties and unjust enrichment. Generally, the complaint in each derivative action concerns those Defendants' duties relating to certain outreach practices Oak Street allegedly engaged in and its patient transportation program, which are also matters that are the subject of the CID. The Company intends to continue to defend these claims vigorously. Given the uncertainty of litigation, the preliminary stage of the case, and the legal standards that must be met for, among other things, class certification and success on the merits, the Company cannot reasonably estimate the possible loss or range of loss that may result from this action.

Further information in response to this item is included in Note 9, Commitments and Contingencies, to the Consolidated Financial Statements included in Part IV, Item 15, of this Form 10-K.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Securities Market Information

Our common stock has been listed on the NYSE under the symbol "OSH" since August 6, 2020. Prior to that, there was no public trading market for our common stock.

Holders of Record

As of February 22, 2023, there were approximately 35 stockholders of record for our common stock. The actual number of stockholders is greater than this number of record holders, and includes stockholders who are beneficial owners, but whose shares are held in street name by brokers and other nominees. This number of holders of record also does not include stockholders whose shares may be held in trust by other entities.

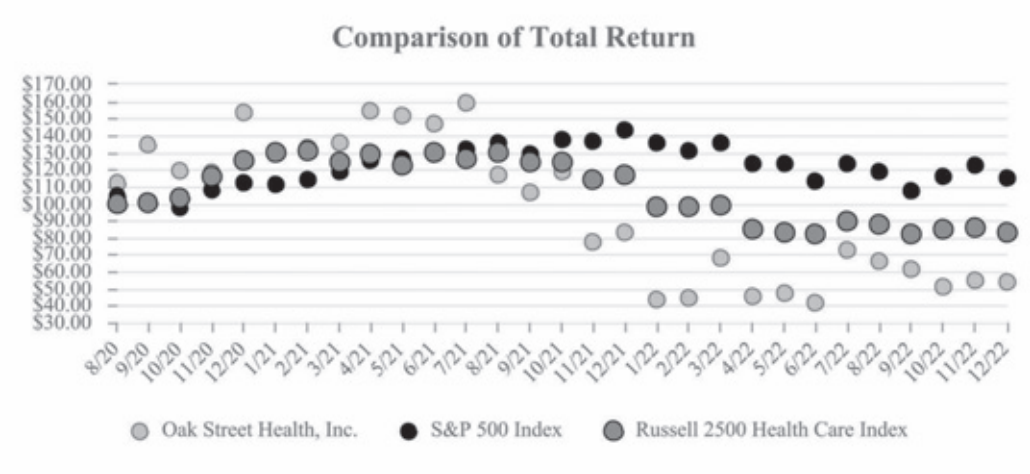
Dividend Policy

We currently intend to retain all available funds and any future earnings to fund the development and growth of our business and to repay indebtedness and, therefore, we do not anticipate paying any cash dividends in the foreseeable future. Additionally, because we are a holding company, our ability to pay dividends on our common stock may be limited by restrictions on the ability of our subsidiaries to pay dividends or make distributions to us. Any future determination to pay dividends will be at the discretion of our Board, subject to compliance with covenants in current and future agreements governing our and our subsidiaries' indebtedness, and will depend on our results of operations, financial condition, capital requirements and other factors that our Board may deem relevant.

Stock Performance Graph

The following performance graph and related information shall not be deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, or otherwise subject to the liabilities of that section or Sections 11 and 12(a)(2) of the Securities Act of 1933, as amended, and shall not be incorporated by reference into any registration statement or other document filed by us with the SEC, whether made before or after the date of this Annual Report on Form 10-K, regardless of any general incorporation language in such filing, except as shall be expressly set forth by specific reference in such filing.

The following graph and related information show a comparison of the cumulative total return for our common stock, the Russell 2500 Health Care Industry Index ("Russell 2500 Health Care Index") and the Standard & Poor 500 Index ("S&P 500 Index") between August 6, 2020 (the date our common stock commenced trading on the NYSE) through December 31, 2022. All values assume an initial investment of $100 and reinvestment of any dividends. The comparisons are based on historical data and are not indicative of, nor intended to forecast, the future performance of our common stock.



	8/6/2020	8/31/2020	9/30/2020	10/31/2020	11/30/2020	12/31/2020	1/31/2021	2/28/2021	3/31/2021
Oak Street Health, Inc.	$100.00	$111.58	$133.85	$118.98	$117.93	$152.90	$129.68	$132.58	$135.68
S&P 500 Index	$100.00	$104.51	$100.41	$97.64	$108.14	$112.15	$110.90	$113.79	$118.62
Russell 2500 Health Care Index	$100.00	$99.69	$100.60	$103.02	$115.26	$124.46	$129.53	$130.46	$124.02
	4/30/2021	**5/31/2021**	**6/30/2021**	**7/31/2021**	**8/31/2021**	**9/30/2021**	**10/31/2021**	**11/30/2021**	**12/31/2021**
Oak Street Health, Inc.	$154.08	$150.98	$146.43	$159.10	$116.83	$106.33	$118.08	$77.38	$82.85
S&P 500 Index	$124.84	$125.53	$128.32	$131.23	$135.04	$128.62	$137.51	$136.36	$142.31
Russell 2500 Health Care Index	$128.56	$122.53	$129.89	$125.66	$129.63	$123.91	$124.33	$113.68	$116.03
	1/31/2022	**2/28/2022**	**3/31/2022**	**4/30/2022**	**5/31/2022**	**6/30/2022**	**7/31/2022**	**8/31/2022**	**9/30/2022**
Oak Street Health, Inc.	$43.45	$43.78	$67.20	$45.23	$47.20	$41.10	$72.38	$65.50	$61.30
S&P 500 Index	$134.83	$130.60	$135.27	$123.37	$123.38	$113.02	$123.32	$118.09	$107.06
Russell 2500 Health Care Index	$97.55	$97.35	$98.62	$84.34	$82.28	$81.38	$88.93	$87.29	$82.02
x	**10/31/2022**	**11/30/2022**	**12/31/2022**						
Oak Street Health, Inc.	$50.58	$54.05	$53.78						
S&P 500 Index	$115.61	$121.82	$114.64						
Russell 2500 Health Care Index	$84.56	$85.72	$82.79						

Securities Authorized for Issuance Under Equity Compensation Plans

The information called for by this item regarding equity compensation plans is incorporated by reference to the information set forth in Part III, Item 12 of this Annual Report on Form 10-K.

Recent Sales of Unregistered Securities

There were no unregistered sales of equity securities during the year ended December 31, 2022, except as previously reported.

Issuer Purchases of Equity Securities

None.

Use of Proceeds from Registered Securities

None.

Item 6. Reserved

Not applicable.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations ($ in millions)

The following discussion and analysis is intended to help the reader understand our business, financial condition, results of operations, liquidity and capital resources. This discussion should be read in conjunction with our consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K and the description of the Company's Business in Item 1 above. Unless the context otherwise indicates or requires, the terms "we", "our" and "the Company" as used herein refer to Oak Street Health, Inc. and its consolidated subsidiaries, including Oak Street Health, LLC, which is Oak Street Health, Inc.'s predecessor for financial reporting purposes for periods presented prior to August 10, 2020.

In addition to historical data, the discussion contains forward-looking statements about the business, operations and financial performance of the Company based on our current expectations that involves risks, uncertainties and assumptions. Actual results could differ materially from those discussed in or implied by forward-looking statements as a result of various factors, including those discussed above in "Forward-Looking Statements," and Part I, Item 1A, "Risk Factors." The forward-looking statements contained herein do not assume the consummation of the proposed transaction with a subsidiary of CVS Health.

Overview

Oak Street Health, Inc. (collectively referred to as "Oak Street Health," "OSH," "we," "us," "our," or the "Company") was formed as a Delaware corporation on October 22, 2019 for the purpose of completing a public offering and related restructuring transactions (collectively referred to as the "IPO") in order to carry on the business of Oak Street Health, LLC ("OSH LLC") and its affiliates. As the managing member of OSH LLC, Oak Street Health, Inc. operates and controls all of the business affairs of OSH LLC and its affiliates. For further discussion related to the IPO, see Note 1 in Part IV, Item 15. Our common stock trades on the New York Stock Exchange ("NYSE") under the ticker symbol "OSH."

Oak Street Health was designed to provide and manage Medicare-eligible patients' total healthcare through capitated, value-based payments. We created a new care platform because the then existing primary care infrastructure was not built with the capacity to drive significant improvements in cost and quality the current health system needs. We decided to focus on the Medicare market due to its size, growth tailwinds and largely clinically cohesive population. We designed our platform to take risk in managing patients' health below and agreed-upon baseline cost because we believe there is a meaningful opportunity to produce system-wide cost savings by changing where and how patients' healthcare is delivered. Our platform's design has included investments in technology and patient centered, community-based care delivery to create a difference and we believe, better approach to addressing the needs of high-risk Medicare-eligible patients. As of December 31, 2022, the Company operated 169 centers across 21 states, which provided care for approximately 224,000 patients. We, together with our affiliated physician practice organizations, employed approximately 6,000 team members, including approximately 600 primary care providers as of December 31, 2022. Our operations are organized and reported under one segment.

Proposed Transaction with CVS Health

On February 7, 2023, the Company entered into the Merger Agreement with a subsidiary of CVS Health, pursuant to which (and subject to the terms and conditions in the Merger Agreement) such subsidiary of CVS Health will acquire all of the outstanding shares of the Company's common stock in a transaction structured as a merger of an indirect wholly-owned subsidiary of CVS Health with and into the Company, with the Company continuing as the surviving corporation.

Subject to the terms and conditions of the Merger Agreement, such subsidiary of CVS Health will acquire all of the outstanding shares of common stock of the Company as of immediately prior to the effective time of the Merger (subject to certain exceptions) for $39.00 per share, without interest thereon, in an all-cash transaction, representing an enterprise value of approximately $10.6 billion. As a result of the Merger, the

Company will become an indirect wholly-owned subsidiary of CVS Health. The consummation of the Merger is subject to certain customary closing conditions, including, among others, the adoption of the Merger Agreement by the Company's stockholders and the expiration or termination of the applicable waiting period under the HSR Act.

The Merger Agreement contains certain customary termination rights for the Company and such subsidiary of CVS Health. Subject to certain limitations set forth in the Merger Agreement, either party may terminate the Merger Agreement if the Merger has not been consummated on or before February 7, 2024 (which date is subject to automatic extension for two additional periods, in each case under certain circumstances, up to December 23, 2024, (as so extended, the "Termination Date")). If the Merger Agreement is terminated under certain specified circumstances and receipt of regulatory approval has not been obtained by such time, a subsidiary of CVS Health will be required to pay the Company a termination fee of $500 million. If the Merger Agreement is terminated under other certain specified circumstances, including due to the Company accepting a superior proposal, the Company will be required to pay such subsidiary of CVS Health a termination fee of $300 million.

In addition to the foregoing termination rights, and subject to certain limitations set forth in the Merger Agreement, either party may terminate the Merger Agreement if the Merger is not consummated by the applicable Termination Date, if at each such Termination Date, all of the closing conditions have not been satisfied or waived as of such date.

The exact timing of completion of the Merger, if at all, cannot be predicted.

We are subject to customary restrictions on our ability to solicit alternative acquisition proposals from third parties and to provide non-public information to, and participate in discussions and engage in negotiations with, third parties regarding alternative acquisition proposals, subject to customary exceptions, including the adoption of the Merger Agreement by stockholders representing a majority of the outstanding shares of common stock of the Company and the receipt of applicable regulatory approvals.

For further discussion about the Merger, see the section titled "Proposed Merger with CVS" in Note 1 - "Summary of Significant Accounting Policies" and "Subsequent Events" in Note 19 in the notes to the consolidated financial statements included in Part IV, Item 15 of this Annual Report on Form 10-K, our Form 8-K filed with the SEC on February 8, 2023, and our definitive proxy statement and any other documents or materials related to the Merger we may file with the SEC when they become available. See section titled, "Risk Factors- Risks Related to our Proposed Transaction with CVS Health" included under Part I, Item 1A of this Annual Report on Form 10-K for more information regarding risks associated with the Merger.

COVID-19 Update on our Business

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. The rapid spread of COVID-19 around the world and throughout the United States altered the behavior of businesses and people. Various policies were implemented by federal, state and local governments in response to the COVID-19 pandemic that caused many people to remain at home and forced the closure of or limitations on certain businesses, as well as suspended elective procedures by health care facilities. The ongoing COVID-19 global pandemic disproportionately impacts older adults, especially those with chronic illnesses, which describes many of our patients.

In response to the COVID-19 pandemic, we completed the following actions to ensure the safety of our employees and their families and to address the physical, mental and social health of our patients:

- Created a COVID-19 Response Team as of March 2020 that is supported by team members from across our organization to ensure a coordinated response to the pandemic;

- Re-opened all of our corporate offices as of summer 2021, which were temporarily closed since March 2020, with the expectation that our corporate work force will continue to work remotely at least part-time;

- Transitioned much of our center-based care to be delivered by our providers virtually through newly developed telehealth capabilities, including video and telephone from March through June 2020 but have transitioned our business back to a more normal operating cadence as of July 2020, including seeing a larger proportion of our patients via in-center visits (with a corresponding reduction in telehealth visits) while maintaining stringent safety protocols to minimize the potential transmission of COVID-19. We continue to leverage our telehealth capabilities as a means of interacting with our patients to the extent an in-person visit is not required or preferred;

- Made operational changes to the staffing and operations of our centers, which remain open as "essential" businesses, to minimize potential exposure to and transmission of COVID-19;

- Temporarily delayed planned openings of new centers from March through August 2020 but have restarted our growth efforts through patient outreach and as of August 2020, we resumed opening new centers consistent with our pre-COVID operations;

- Temporarily halted community outreach and other marketing initiatives which drive new patients to our platform from March through June 2020 but have recommenced community outreach as of the third quarter of 2020 albeit with less frequency compared to periods before March 2020;

- Acquired and deployed significantly greater amounts of personal protective equipment ("PPE") to ensure the safety of our employees and patients;

- Created a program called "COVID Care" to actively monitor our patients for suspected COVID-19 infections with the goal of managing those symptoms to keep our patients safely out of the hospital unless and until necessary due to the potential infection risks in the hospital environment;

- Temporarily redeployed our contracted and employed drivers, who typically transport patients to our centers, to deliver food from food pantries to our patients to address food supply issues or challenges;

- Provided free rapid COVID-19 tests to all members of the Chicago community;

- Launched an effort in January 2021 to vaccinate frontline healthcare workers (both employees of Oak Street Health and non-employees), our patients, and other eligible members of our communities; and

- Administered more than 200,000 total COVID-19 vaccine doses as of December 31, 2022.

The COVID-19 pandemic has impacted both our per-patient capitated revenue and medical claims expense. Throughout the pandemic, our risk scores for existing Oak Street Health patients have been consistent with our historical experience. New patients in 2021 had lower risk scores that what we would expect based on historical experience, due to a lack of availability of care in 2020 as the healthcare system was inaccessible to non-Oak Street Health patients for several months in 2020, due to local COVID-19 restrictions. As we are able to more completely and accurately document both current and new patients' health conditions, we expect that risk scores will increase to reflect the true severity of these patients' conditions. It is unknown to us at present how significantly, if at all, this new patient risk score dynamic might impact our business in 2023.

As we are financially responsible for essentially all of the healthcare costs associated with our at-risk patients whether we provide that care or a third party provides that care, we suspect that the healthcare costs of patients infected with COVID-19 will be greater than had COVID-19 not occurred as costs directly related to COVID-19 persist. It is impossible, however, to know what other healthcare issues these patients may have encountered in their pre-COVID-19 lives and whether the COVID-19 costs are or will be greater or lesser than the costs these patients would otherwise incur. Because of the COVID-19 related volatility in medical cost data in 2020 and 2021, and the first half of 2022, we do not believe that these periods can serve as a reliable basis for estimating our future performance and do not know what the impact from COVID-19 will be on medical costs in the future. Given these factors, per-patient medical costs may be greater in 2023 than the levels we experienced in our recent historical results. We do believe, however, that the impact of on per-patient revenue and medical claims related to COVID-19 that we expect to experience will not have a materially detrimental effect on our long-term financial performance.

We continue to closely monitor the COVID-19 pandemic and its lingering impact on the economy, our patients and prospective patients and our business. The ongoing efforts of the pandemic remain unresolved and could continue for an extended period of time. Even as the COVID-19 pandemic subsides, disruptions caused by the pandemic, including labor shortages, supply chain disruptions and inflationary pressure, may continue and could, in turn, have a negative impact on the Company. Further, recurring COVID-19 outbreaks could have the potential to impact the Company and its future results of operations, cash flows and financial position.

The COVID-19 pandemic had a material impact on our results from operations, cash flows and financial position for the years ended December 31, 2021 and 2022. Based upon claims paid to date, our direct costs related to COVID-19 claims were approximately $96.1 million for the period from March 1, 2020 through December 31, 2022. We expect to incur additional COVID-19 related costs given the volume of positive cases in our markets. Due to the uncertainty of COVID-19 infection and hospitalization rates, we cannot estimate any incremental COVID-19 related costs we may incur.

The full extent to which the COVID-19 pandemic will directly or indirectly impact our business, future results of operations and financial condition will depend on future factors that are highly uncertain and cannot be accurately predicted, including new information that may emerge concerning COVID-19 and the economic impact on our markets. Such factors include, but are not limited to, the scope and duration of stay-at-home practices and business closures and restrictions, government-imposed or recommended suspensions of elective procedures, and expenses required for supplies and personal protective equipment. Because of these and other uncertainties, we cannot estimate the length or severity of the impact of the pandemic on our business. Furthermore, because of our business model, the full impact of the COVID-19 pandemic may not be fully reflected in our results of operations and overall financial condition until future periods. We will continue to closely evaluate and monitor the nature and extent of these potential impacts to our business, results of operations and liquidity.

The US Department of Health and Human Services has announced that the coronavirus public health emergency will conclude on May 11, 2023. As part of the continuous coverage requirement, as part of the public health emergency, Medicaid recipients were neither disenrolled, nor required to complete the annual redetermination process that is typically necessary to verify ongoing eligibility. The Medicaid redetermination process will restart on April 1, 2023. Experts have expressed concerns that renewing redeterminations may lead to major coverage losses, including with respect to dual eligible patients who make up a substantial portion of our patients. Given reimbursement rates are greater for dual eligible patients, our revenue and profit could be materially impacted should a significant portion of our dual eligible patients fail to complete the required steps to verify their Medicaid eligibility.

For additional information on the various risks posed by the COVID-19 pandemic, please read the Risk Factors included in this Annual Report on Form 10-K.

Key Factors Affecting Our Performance

- ***Adding New Patients in Existing Centers:*** Our ability to add new patients is a key indicator of the market's recognition of the attractiveness of the Oak Street Platform, both to our patients and MA plan partners, and a key growth driver for the business. As we add patients to our existing centers, we expect these patients to contribute significant incremental economics to Oak Street Health as we leverage our fixed cost base at each center. We grow our patient base through our own internal sales and marketing efforts, which drive most of our new patient growth, as well as assignments from our MA plan partners. We grew our patient base from approximately 153,500 patients as of December 31, 2021 to approximately 224,000 patients as of December 31, 2022.

- ***Expand our Center Base within Existing and New Markets:*** We believe our core market consists of approximately 27 million patients, and we served approximately 224,000 patients as of December 31, 2022. As a result, we believe there is significant opportunity to expand in our existing markets through the acquisition of new patients to existing centers and addition of new centers. For the long term, these strategically developed new sites allow us to access additional neighborhoods while leveraging our established brand and infrastructure in a market. Our existing markets today represent a small fraction of the overall market opportunity. Based upon our experience to date, we believe our care model can scale nationally, and we therefore expect to selectively and strategically expand into new geographies. Additionally, we began participating in the Global and Direct Contracting Model as of April 1, 2021, which we are hopeful will allow us to manage existing fee-for-service ("FFS") patients on an at-risk basis. The Direct Contracting Model and the ACO REACH Model, as its successor, create new opportunities for CMS to test an array of financial risk-sharing arrangements in the traditional Medicare fee-for-service population, and it will enable us to assume financial risk for the cost of care for patients covered by traditional Medicare. Through this model, CMS aims to transform risk-sharing arrangements in Medicare FFS, empower and engage beneficiaries (or patients or members) in their own care delivery, broaden participation in CMS Innovation Center models, reduce provider burden and shift providers from FFS to value-based payments in primary care. The stated goals of the ACO REACH Model are to advance health equity to bring benefits of accountable care to underserved communities, promote provider leadership and governance and protect beneficiaries and the model with more participant vetting, monitoring and greater transparency. There can be no assurances, however, that these or any other payment models that align with our strategy and investments will be continued or not changed in ways that could be disadvantageous to our business.

- ***Contract with Payors:*** Our economic model relies on our capitated partnerships with payors and CMS which manage and market MA plans across the United States. In our short history, we have been able to establish strategic value-based relationships with over 30 different payors as of December 31, 2022, including each of the top 5 national payors by number of MA patients. These existing contracts and relationships and our partners' understanding of the value of our model reduces the risk of entering into new markets as we typically have payor contracts before entering a new market. Maintaining, supporting, and growing these relationships, particularly as we enter new geographies, is critical to our long-term success.

- ***Effectively Manage the Cost of Care for Our Patients:*** The capitated nature of our contracting with payors requires us to prudently manage the medical expense of our patients. Our care model focuses on leveraging the primary care setting as a means of avoiding costly downstream healthcare costs, such as acute hospital admissions. Our patients, however, retain the freedom to seek care at emergency rooms or hospitals; we do not restrict their access to care beyond the limits of their MA plan. Therefore, we are liable for potentially large medical claims should we not effectively manage our patients' health.

- ***Center-Level Contribution Margin:*** We endeavor to expand our number of centers and number of patients at each center over time. Due to the significant fixed costs associated with operating and managing our centers and the increases we experience in patient contribution on a per-patient basis the longer a patient is part of the Oak Street Platform, we generate significantly better center-level contribution margins (defined as (i) total revenues generated within our centers, excluding Medicare Part D revenue minus (ii) the sum of (a) medical claims expense, excluding Medicare Part D related expenses, and (b) cost of care, excluding depreciation and amortization) as the patient base within our centers increases and matures and our costs decrease as a percent of revenue. As a result, the value of a center to our business increases over time. As we add patients and document their health conditions, we are able to more accurately assess risk scores. We expect close monitoring will result in higher risk scores, which will yield higher revenue from increased capitated payments.

- ***Seasonality to our Business:*** Our operational and financial results, including at-risk patient growth, per-patient revenue and medical costs, will experience some variability depending upon the time of year in which they are measured. We typically experience a significant portion of our at-risk patient growth during the first quarter, when plan enrollment selections made during the prior Annual Enrollment Period ("AEP") from October 15th through December 7th of the prior year take effect. Our per-patient revenue will generally decline over the course of the year. As the year progresses, our per-patient revenue declines as new patients join us typically with less complete or accurate documentation (and therefore lower risk-adjustment scores), and our patient attrition skews towards our higher-risk (and therefore greater revenue) patients. Finally, medical costs will vary seasonally depending on a number of factors, including the weather which can be a driver of certain illnesses, such as the influenza virus. We would therefore expect to see higher levels of per-patient medical costs in the fourth quarter. Medical costs also depend upon the number of business days in a period as periods with fewer business days will have lower medical costs all else equal.

- ***Investments in Growth:*** We expect to continue to focus on long-term growth through investments in our centers, care model and sales and marketing. In addition, we expect our corporate, general and administrative expenses to increase in absolute dollars for the foreseeable future to support our growth and because of additional costs of being a public company.

Executive Summary

The following table presents key financial statistics for the Company for the years ended December 31, 2022, 2021 and 2020:

	For the Years Ended		
(dollars in millions)	December 31, 2022	December 31, 2021	December 31, 2020
Centers	169	129	79
Total patients	224,000	153,500	97,000
At-risk	*159,000*	*114,500*	*64,500*
Fee-for-service	*65,000*	*39,000*	*32,500*
Total revenues	$ 2,160.9	$ 1,432.6	$ 882.8
Loss from operations[1]	$ (466.2)	$ (414.0)	$ (183.5)
Net loss[1]	$ (509.7)	$ (414.6)	$ (192.1)
Patient contribution (Non-GAAP)[2]	$ 480.9	$ 288.0	$ 233.5
Platform contribution (Non-GAAP)[2]	$ 81.9	$ 31.5	$ 77.5
Adjusted EBITDA (Non-GAAP)[2]	$ (286.3)	$ (228.9)	$ (92.6)

1 Includes stock and unit-based compensation as shown in the table in the Results of Operations section below

2 See "—Non-GAAP Reconciliations" below for reconciliations to the most directly comparable financial measures calculated in accordance with GAAP and related disclosures

Centers

We define our centers as those primary care centers open for business and attending to patients at the end of a particular period. Our centers are leased or licensed by OSH MSO or an affiliated entity and, pursuant to the terms of certain contractual relationships between OSH MSO and our affiliated medical practices, made available for use by the medical practices in the provision of primary care services.

Total Patients

Total patients includes both at-risk Medicare Advantage and Direct Contracting Model patients (those patients for whom we are financially responsible for their total healthcare costs) as well as fee-for-service Medicare patients (those patients for whom our affiliated medical groups submit claims to the federal government for direct reimbursement under the Medicare program or to MA plans which we do not have value-based arrangements). We define our total at-risk patients as at-risk patients who have selected one of our affiliated medical groups as their provider of primary care medical services or have been aligned under the Direct Contracting Model as of the end of a particular period. We define our total fee-for-service Medicare patients as fee-for-service Medicare patients who come to one of our centers for medical care at least once per year. A fee-for-service patient continues to be included in our patient count until the earlier to occur of (a) more than one year since the patient's last visit, (b) the patient communicates a desire to stop receiving care from us or (c) the patient passes away.

Non-GAAP Financial Measures

We utilize certain financial measures that are not calculated based on GAAP. Certain of these financial measures are considered "non-GAAP" financial measures within the meaning of Item 10 of Regulation S-K promulgated by the SEC. We believe that non-GAAP financial measures provide an additional way of viewing aspects of our operations that, when viewed with the GAAP results, provide a more complete understanding of our results of operations and the factors and trends affecting our business. These non-GAAP financial measures are also used by our management to evaluate financial results and to plan and forecast future periods. However, non-GAAP financial measures should be considered as a supplement to, and not as a substitute for, or superior to, the corresponding measures calculated in accordance with GAAP. Non-GAAP financial measures used by us may differ from the non-GAAP measures used by other companies, including our competitors.

To supplement our consolidated financial statements presented on a GAAP basis, we disclose the following Non-GAAP measures: platform contribution, patient contribution and adjusted EBITDA as these are performance measures that our management uses to assess our operating performance. Because platform contribution, patient contribution and adjusted EBITDA facilitate internal comparisons of our historical operating performance on a more consistent basis, we use these measures for business planning purposes and in evaluating acquisition opportunities.

Platform and patient contributions are reconciled to gross profit as the most directly comparable GAAP measure as set forth in the below tables under "Non-GAAP Reconciliations." Gross profit is defined as total revenues less medical claims expense. Adjusted EBITDA is reconciled to net loss as the most directly comparable GAAP measure as set forth in the below table under "Non-GAAP Reconciliations."

Our definitions of platform contribution, patient contribution and adjusted EBITDA may differ from the definition used by other companies and therefore comparability may be limited. In addition, other companies may not publish this or similar metrics. Thus, our non-GAAP financial measures should be considered in addition to,

not as a substitute for, or in isolation from, measures prepared in accordance with GAAP, such as gross profit and net loss.

We provide investors and other users of our financial information with reconciliations of platform contribution, patient contribution and adjusted EBITDA to gross profit and net loss, respectively. We encourage investors and others to review our financial information in its entirety, not to rely on any single financial measure and to view platform contribution, patient contribution and adjusted EBITDA in conjunction with gross profit and net loss, respectively.

Patient Contribution

We define patient contribution as capitated revenue less medical claims expense. Patient contribution is intended to isolate the profitability of the Company's capitated arrangements with our health plan payors and/or CMS for which the Company provides and/or manages healthcare services for its at-risk patients. We expect that patient contribution will grow year-over-year in absolute dollars as our at-risk patient base continues to grow. We would also expect that our patient contribution per-patient-per-month economics on our at-risk patients will continue to improve the longer our patients are part of the Oak Street Platform as we better understand their health conditions, assess their risk scores, and the patients better engage with our care model. We would expect, however, that our aggregate patient contribution per-patient-per-month economics on our at-risk patients may decrease at an aggregate level to the extent our patient growth skews our mix of patients towards patients newer to the Oak Street Platform. We would also expect to experience seasonality in patient contribution per-patient-per-month with the first quarter generally generating the greatest patient contribution per-patient-per-month, decreasing for the rest of the year. This seasonality is primarily driven by our adding new patients to the Oak Street Platform throughout the year, who generally have lower per-patient capitated revenue compared to our existing patient base.

Platform Contribution

We define platform contribution as total revenues less the sum of medical claims expense and cost of care, excluding depreciation and amortization and equity-based compensation. We believe this metric best reflects the economics of our care model as it includes all medical claims expense associated with our patients' care as well as the costs we incur to care for our patients via the Oak Street Platform. As a center matures, we expect the platform contribution from that center to increase both in terms of absolute dollars as well as a percent of capitated revenue. This increase will be driven by improving patient contribution economics over time as well as our ability to generate operating leverage on the costs of our centers. Our aggregate platform contribution may not increase despite improving economics at our existing centers should we open new centers at a pace that skews our mix of centers towards newer centers. We would also expect to experience seasonality in platform contribution due to seasonality in our patient contribution.

Adjusted EBITDA

We define adjusted EBITDA as net loss excluding interest expense; net, other income/ expense; income taxes; fair value adjustments related to assets and liabilities recorded in purchase accounting, such as earn-out liabilities and equity-method investments' activity, including any impairment of such investments; depreciation and amortization; transaction/ offering related costs; one-time in nature litigation costs and stock and equity-based compensation. We include adjusted EBITDA in this Annual Report because it is an important measure upon which our management assesses and believes investors should assess our operating performance. We also consider adjusted EBITDA to be an important measure because it helps illustrate underlying trends in our business and our historical operating performance on a more consistent basis.

Results of Operations

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

(dollars in millions)	For the Years Ended December 31, 2022	December 31, 2021	December 31, 2020
Revenues:			
Capitated revenue	$ 2,125.9	$ 1,397.0	$ 851.3
Other revenue	35.0	35.6	31.5
Total revenues	2,160.9	1,432.6	882.8
Operating expenses:			
Medical claims expense	1,645.0	1,109.0	617.8
Cost of care, excluding depreciation and amortization (1)	437.8	293.7	187.5
Sales and marketing (2)	164.3	119.4	64.2
Corporate, general and administrative (3)	344.8	306.7	185.6
Depreciation and amortization	35.2	17.8	11.2
Total operating expenses	2,627.1	1,846.6	1,066.3
Loss from operations	$ (466.2)	$ (414.0)	$ (183.5)
Other (expense)/income:			
Interest expense, net	(2.5)	(2.5)	(8.7)
Other	(40.8)	—	0.1
Total other expense	(43.3)	(2.5)	(8.6)
Loss before income taxes and non-controlling interests	$ (509.5)	$ (416.5)	$ (192.1)
Provision for income taxes	0.2	(1.9)	—
Net loss	$ (509.7)	$ (414.6)	$ (192.1)
Net loss attributable to non-controlling interests	(0.5)	(5.2)	(4.1)
Net loss attributable to the Company	$ (509.2)	$ (409.4)	$ (188.0)
(1) Includes stock/unit-based compensation, as follows:	$ 3.8	$ 1.6	$ —
(2) Includes stock/unit-based compensation, as follows:	4.1	3.4	1.3
(3) Includes stock/unit-based compensation, as follows:	$ 131.0	$ 156.4	$ 77.3

The following table sets forth our results of operations for the periods presented as a percentage of our total revenues for those periods.

	For the Years Ended		
	December 31, 2021	December 31, 2021	December 31, 2020
Revenues:			
Capitated revenue	98%	98%	96%
Other revenue	2%	2%	4%
Total revenues	100%	100%	100%
Operating expenses:			
Medical claims expense	77%	77%	70%
Cost of care, excluding depreciation and amortization	21%	21%	21%
Sales and marketing	8%	8%	7%
Corporate, general and administrative	16%	21%	21%
Depreciation and amortization	2%	1%	1%
Total operating expenses	124%	129%	121%
Loss from operations	(24)%	(29)%	(21)%
Other (expense)/income:			
Interest expense, net	0%	0%	(1)%
Other	(2)%	0%	0%
Total other expense	(2)%	0%	(1)%
Income before income taxes and non-controlling interests	(26)%	(29)%	(22)%
Provision for income taxes	0%	0%	0%
Net loss	(26)%	(29)%	(22)%
Net income/(loss) attributable to non-controlling interests	0%	0%	0%
Net loss attributable to the Company	(26)%	(29)%	(22)%

Comparison of the Years Ended December 31, 2022 and 2021

Total revenues

	For the Years Ended		Change	
(dollars in millions)	December 31, 2022	December 31, 2021	$	%
Revenues:				
Capitated revenue	$ 2,125.9	$ 1,397.0	$ 728.9	52%
Other revenue	35.0	35.6	(0.6)	(2)%
Total revenues	$ 2,160.9	$ 1,432.6	$ 728.3	51%

Capitated revenue was $2,125.9 million for the year ended December 31, 2022, an increase of $728.9 million, or 52%, compared to $1,397.0 million for the year ended December 31, 2021. This increase was driven primarily by a 39% increase in total patients under capitated arrangements (including Direct Contracting, which started as of April 2021) and an increase in capitated revenue rates of 10%. Immaterial prior period capitated revenue was included in the year ended December 31, 2022 compared to $20.8 million of capitated revenue that was primarily earned in 2020 but recorded in the year ended December 31, 2021. This prior period amount in 2021 was primarily due to patient retroactivity and rate increases due to final risk score adjustments.

Operating Expenses

	For the Years Ended		Change	
(dollars in millions)	December 31, 2022	December 31, 2021	$	%
Medical claims expense	$ 1,645.0	$ 1,109.0	$ 536.0	48%
Cost of care, excluding depreciation and amortization	437.8	293.7	144.1	49%
Sales and marketing	164.3	119.4	44.9	38%
Corporate, general and administrative	344.8	306.7	38.1	12%
Depreciation and amortization	35.2	17.8	17.4	98%
Total operating expenses	$ 2,627.1	$ 1,846.6	$ 780.5	42%

Medical claims expense was $1,645.0 million or 77% of total revenues for the year ended December 31, 2022, an increase of $536.0 million, or 48%, compared to $1,109.0 million or 77% of total revenues for the year ended December 31, 2021. The increase was primarily driven by a 39% increase in total patients under capitated arrangements (including an increase in Direct Contracting which started as of April 2021) as well as an increase in medical costs per patient of 7%.

Cost of care, excluding depreciation and amortization was $437.8 million or 21% of total revenues for the year ended December 31, 2022, an increase of $144.1 million, or 49%, compared to $293.7 million or 21% of total revenues for the year ended December 31, 2021. The increase was primarily driven by increases in salaries and benefits of $94.1 million, clinical and transportation costs of $20.5 million, and occupancy costs of $23.6 million, due to the growth in both the number of centers we operate and the number of team members supporting our larger patient base.

Sales and marketing expense was $164.3 million or 8% of total revenues for the year ended December 31, 2022, an increase of $44.9 million, or 38%, compared to $119.4 million or 8% of total revenues for the year ended December 31, 2021. The increase was driven by growth in our center based outreach teams for new centers, resulting in net headcount growth of $37.9 million.

Corporate, general and administrative expense was $344.8 million or 16% of total revenues for the year ended December 31, 2022, an increase of $38.1 million, or 12%, compared to $306.7 million or 21% of total revenues for the year ended December 31, 2021. The increase was primarily driven by greater salaries and benefits of $25.0 million due to a higher headcount year over year. We note that the increase to salaries and wages was reduced by a year over year decrease to stock compensation expense of $25.4 million. This reduction is due to the large amount of pre-IPO equity awards that fully vested during the second quarter of 2022. This significantly reduced the stock compensation expense for the second half of the year relative to 2021.

Depreciation and amortization expense was 35.2 million or 2% of total revenues for the year ended December 31, 2022, an increase of $17.4 million, or 98%, compared to 17.8 million or 1% of total revenues for the year ended December 31, 2021. The increase was primarily due to higher capital expenditures purchased to support the continued growth of our business as more centers are opened.

Other Income (Expense)

	For the Years Ended		Change	
(dollars in millions)	December 31, 2022	December 31, 2021	$	%
Interest expense, net	$ (2.5)	$ (2.5)	$ —	—%
Other	(40.8)	—	(40.8)	—%
Total other expense	$ (43.3)	$ (2.5)	$ (40.8)	—%

Other expense was $(40.8) million for the year ended December 31, 2022, an increase of $40.8 million compared to zero for the year ended December 31, 2021. The expense primarily related to a $38.3 million fair value adjustment to the contingent consideration related to the acquisition of Rubicon in October 2021. This adjustment was to record the maximum earn-out achieved by RMD during the second quarter of 2022.

Comparison of the Years Ended December 31, 2021 and 2020

For discussion related to changes in financial condition and the results of operations for fiscal year 2021 compared to fiscal year 2020, refer to Part II - Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations included in our Annual Report on Form 10-K for the fiscal year ended December 31, 2021, which was filed with the SEC on February 28, 2022.

Non-GAAP Reconciliations

The following table provides a reconciliation of gross profit, the most closely comparable GAAP financial measure, to patient contribution.

	For the Years Ended		
(dollars in millions)	December 31, 2022	December 31, 2021	December 31, 2020
Gross profit	$ 515.9	$ 232.6	$ 265.0
Other revenue	(35.0)	(35.6)	(31.5)
Patient contribution	$ 480.9	$ 288.0	$ 233.5

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

	For the Years Ended		
(dollars in millions)	December 31, 2022	December 31, 2021	December 31, 2020
Gross profit	$ 515.9	$ 323.6	$ 265.0
Cost of care, excluding depreciation and amortization	(437.8)	(293.7)	(187.5)
Stock/unit-based compensation	3.8	1.6	—
Platform contribution	$ 81.9	$ 31.5	$ 77.5

The following table provides a reconciliation of net loss, the most closely comparable GAAP financial measure, to Adjusted EBITDA:

	For the Years Ended		
(dollars in millions)	December 31, 2022	December 31, 2021	December 31, 2020
Net loss	$ (509.7)	$ (414.6)	$ (192.1)
Interest expense, net	2.5	2.5	8.7
Fair value adjustments	40.3	—	—
Depreciation and amortization	35.2	17.8	11.2
Stock/unit-based compensation	138.9	161.4	78.6
Litigation costs[1]	3.5	0.3	—
Transaction/offering related costs	2.3	5.6	1.1
Other expense/(income)	0.5	—	(0.1)
Provision for income taxes	0.2	(1.9)	—
Adjusted EBITDA	(286.3)	(228.9)	(92.6)

Transaction/ offering related costs deducted in our Adjusted EBITDA calculation include one-time costs incurred related to private, public offerings and due diligence costs associated with our acquisitions. These expenses are included within corporate, general and administrative expenses in the consolidated statements of operations.

Liquidity and Capital Resources

Overview

The Company's long-term capital policy is to: maintain a strong balance sheet and financial flexibility; reinvest in its care model; and invest in strategic opportunities that reinforce its care model and meet return requirements. We use various techniques to maintain working capital. We have historically financed our

[1] Litigation costs included in the calculation of Adjusted EBITDA include only those costs which are considered one-time in nature and outside of the ordinary course of business based on the following considerations which we assess regularly: (i) the frequency of similar cases that have been brought to date, or are expected to be brought within two years; (ii) the complexity of the case; (iii) the nature of the remedy(ies) sought, including the size of any monetary damages sought; (iv) the counterparty involved; and (v) our overall litigation strategy, such as litigation costs related to the DOJ matter and class-action lawsuit (refer to Note 9 in the Form 10-K herein).

operations through private placements of our equity securities, payments received from various payors, issuance of convertible notes and term loans and our IPO. We believe that our access to capital markets will provide adequate resources to fund our short-term and long-term operating and financing needs. As of December 31, 2022, we had cash, restricted cash and cash equivalents of $158.5 million. Our cash and cash equivalents primarily consist of highly liquid investments in money market funds and cash. Since our inception and through December 31, 2022, we have generated significant operating losses from our operations as reflected in our accumulated deficit and negative cash flows from operations.

We expect to continue to incur operating losses and generate negative cash flows from operations for the foreseeable future due to the investments we intend to continue to make in expanding our operations and sales and marketing and due to additional general and administrative costs we expect to incur in connection with supporting our growth and operating as a public company. As a result, we may require additional capital resources to execute strategic initiatives to grow our business.

We believe that the proceeds from the Term Loan Facility in September 2022 and convertible debt offering in 2021 are sufficient to satisfy our anticipated cash requirements, which consist of capital expenditures, working capital, and potential acquisition and strategic transactions, for the next twelve months, even with the uncertainty arising from the macroeconomic trends of rising inflation and interest rates, along with the COVID-19 pandemic. Under that certain Loan and Security Agreement, dated as of September 30, 2022 (the "Loan Agreement,"), by and among the Company and certain of its subsidiaries and Hercules Capital, Inc., a Maryland corporation, Silicon Valley Bank, a California corporation and the several banks and other financial institutions from time to time party thereto and Hercules Capital, Inc., in its capacity as administrative agent and collateral agent for itself and the lenders party thereto, as of December 31, 2022, we have drawn down $72.8 million, net of debt issuance costs, and have the ability to draw down up to $300 million over the life of the loan pursuant to separate tranches that are available at specified time periods. See Note 8, "Long-Term Debt." Our assessment of the period of time through which our financial resources will be adequate to support our operations is a forward-looking statement and involves risks and uncertainties. Our actual results and our future capital requirements could vary because of many factors, including our growth rate, the timing and extent of spending to open new centers and expand into new markets and the expansion of sales and marketing activities.

We may in the future enter into arrangements to acquire or invest in complementary businesses, services and technologies, including intellectual property rights. We have based this estimate on assumptions that may prove to be wrong, and we could use our available capital resources sooner than we currently expect. We may be required to seek additional equity or debt financing. In the event that additional financing is required from outside sources, we may not be able to raise it on terms acceptable to us or at all. If we are unable to raise additional capital when desired, or if we cannot expand our operations or otherwise capitalize on our business opportunities because we lack sufficient capital, our business, results of operations and financial condition would be adversely affected.

Term Loan

On September 30, 2022, the Company and certain of its subsidiaries entered into the Loan Agreement with Hercules Capital, Inc., as administrative and collateral agent and a lender, Silicon Valley Bank and other lenders from time to time party thereto. The Loan Agreement provides the Company with a Term Loan Facility of up to $300.0 million to be funded in five committed tranches available to be drawn at the Company's option during the specified time period. Under Tranche A (available from September 30, 2022 ("Closing") until March 31, 2023), the Company was required to draw down $75.0 million upon Closing and may draw up to an additional $25.0 million. Under Tranche B (available from Closing until December 15, 2023), the Company may borrow up to $50.0 million in $25.0 million increments. Under Tranche C (available from January 1, 2024 until June 30, 2024), the Company may borrow up to $50.0 million in $25.0 million increments. Under Tranche D (available from the earlier of (a) the date on which Tranche C is fully drawn, (b) July 1, 2024 and (c) subject to approval by the lenders' investment committee(s) in their sole and unfettered discretion, any date prior thereto until December 15, 2024), the Company may borrow up to $75.0 million in $25.0 million increments. Under Tranche E (available from Closing until June 1, 2025), the Company may borrow up to $25.0 million subject to the approval of the

individual lenders' investment committee(s) in their sole and unfettered discretion. If the Company does not elect to draw the entire principal amount available under the Tranche B, C or D during the applicable drawdown period, then any such undrawn portion will be added to the aggregate principal amount available under Tranche E. The obligations under the Term Loan Facility are secured by a first priority perfected security interest in substantially all of the assets of the Company, subject to certain limitations and exceptions. The Term Loan Facility is scheduled to mature on October 1, 2027, subject to a springing maturity date of September 1, 2025 if, prior to June 1, 2025, the Company's Convertible Senior Notes have not been (i) converted into equity interests of the Company, (ii) amended such that the scheduled maturity date of the Convertible Senior Notes is at least 180 days after the initial maturity date of the tranches of the Term Loans then in effect, or (iii) fully redeemed and extinguished.

As required under the Loan Agreement, at the Closing, the Company borrowed $75.0 million under Tranche A of the Term Loan Facility. The Company intends to use the proceeds from the initial borrowing of the Term Loan for related fees and expenses in connection with the Loan Agreement and for working capital and general corporate purposes. The Loan Agreement contains customary affirmative and negative covenants. In addition, beginning on the earlier of (i) the reporting deadline of the Company's fourth quarter 2023 financial statements under the Loan Agreement and (ii) the date at which more than $100.0 million in aggregate principal (excluding any paid-in-kind interest) is outstanding under the Term Loan Facility, the Company is required to maintain a specified trailing twelve-month platform contribution, with the applicable platform contribution increasing over time and as the Company's borrowings under the Term Loan Facility increase. At December 31, 2022, the financial covenant is not yet in effect. Refer to Note 8, "Long-Term Debt," of the notes to consolidated financial statements included in this Annual Report on Form 10-K.

Convertible Senior Notes, Capped Call Transactions and Marketable Debt Securities

In March 2021, we issued $920.0 million aggregate principal amount of Convertible Senior Notes. Concurrently with the pricing of the Convertible Senior Notes, we entered into capped call transaction to mitigate the impact of potential economic dilution to our common stock upon conversion of the Convertible Senior Notes. The Convertible Senior Notes are governed by an Indenture, are general senior, unsecured obligations of the Company and will mature on March 15, 2026, unless earlier redeemed, repurchased or converted. Refer to Note 8, "Long-Term Debt," of the notes to consolidated financial statements included in this Annual Report on Form 10-K.

Total proceeds realized from the sale of the Convertible Senior Notes, net of debt issuance and offering costs of $22.1 million, were $879.9 million. We used approximately $123.6 million of the net proceeds to pay the cost of the capped call transactions, We intend to use the remainder of the net proceeds for general corporate purposes, which may include working capital, capital expenditures, and potential acquisitions and strategic transactions.

The Indenture contains customary covenants related to timely filings and reporting, and customary events of default. As of December 31, 2022, we were in compliance with all covenants under the Indenture.

Proposed Transaction with CVS Health

On February 7, 2023, the Company entered into a Merger Agreement with a subsidiary of CVS Health. Under the terms of the Merger Agreement, we have agreed to certain customary restrictions regarding the operation of the business of the Company prior to the effective date of the Merger. Subject to certain specified exceptions, we may not agree, resolve or commit to take certain actions without the consent of such subsidiary of CVS Health, including, among other things:

- acquiring businesses and disposing of significant assets above specified thresholds;
- incurring capital expenditures above specified thresholds;

- entering into, amending or terminating material contracts (other than in the ordinary course of business consistent with past practice);

- issuing equity or debt securities, or

- incurring indebtedness above specified thresholds.

We do not believe these restrictions will prevent us from meeting our ongoing costs of operations, working capital needs or capital expenditure requirements.

Cash Flows

The following table presents a summary of our consolidated cash flows from operating, investing and financing activities for the periods indicated:

	For the Years Ended			
(dollars in millions)	December 31, 2022	December 31, 2021	$ Change	% Change
Net cash used in operating activities	$ (309.4)	$ (197.2)	$ (112.2)	57%
Net cash provided by (used in) investing activities	281.1	(887.4)	1,168.5	(132)%
Net cash provided by financing activities	66.4	785.3	(718.9)	(92)%
Net change in cash	$ 38.1	$ (299.3)	$ 337.4	(113)%

Operating Activities

For the year ended December 31, 2022, net cash used in operating activities was $(309.4) million, an increase of $(112.2) million compared to net cash used in operating activities of $(197.2) million for the year ended December 31, 2021. The principal contributors to the year-over-year change in the operating cash flows were as follows:

- A net change of $(37.9) million in net loss and non-cash charges and credits, primarily due to an increase in net loss for the business and decreased stock and equity-based compensation expense, as noted above under "Results of Operations" offset by higher fair value adjustments to contingent consideration, depreciation and amortization and non-cash operating lease charges; and

- A net increase of $74.3 million in cash outflows related to operating assets and liabilities resulting from changes in accounts receivable due to the timing of collections and the growth in the number of at-risk patients and changes in operating lease costs and other liabilities due to the growth in the number of operating centers.

Investing Activities

For the year ended December 31, 2022, net cash provided by investing activities was $281.1 million, an increase of $1,168.5 million compared to net cash used in investing activities of $(887.4) million for the year ended December 31, 2021. The increase was primarily due to net increase in cash inflows of $1,054.5 million related to the sales, maturities and purchases of marketable debt securities. Additionally, the prior year included the acquisition of Rubicon as of October 2021, resulting in an outflow of $124.0 million as of the year ended December 31, 2021.

Financing Activities

Cash provided by financing activities for the year ended December 31, 2022 was $66.4 million primarily due to the proceeds received of $72.3 million from the Company's borrowings under its Term Loan Facility

executed September 30, 2022 and the proceeds of $14.8 million from exercises of options, partially offset by the $21.7 million payment of contingent consideration. Cash provided by financing activities for the year ended December 31, 2021 was $785.3 million, which was primarily due to the issuance of the Convertible Senior Notes of $897.9 million, partially offset by cash outflows of $123.6 million related to the capped call transactions completed in March 2021.

Contractual Obligations and Commitments

The Company's contractual obligations as of December 31, 2022 were as follows:

(dollars in millions)	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Convertible senior notes (1)	$ 920.0	$ —	$ —	$ 920.0	$ —
Term loan (2)	75.0	—	—	75.0	—
Operating lease obligations (3)	486.4	49.6	111.2	109.2	216.4
Total	$ 1,481.4	$ 49.6	$ 111.2	$ 1,104.2	$ 216.4

(1) We hold borrowings under our Convertible Senior Notes, which have a 0% interest rate. The Convertible Senior Notes are governed by an indenture ("Indenture"), dated as of March 16, 2021, between the Company and U.S. Bank National Association, as trustee. Under the Indenture, the Convertible Senior Notes are general senior, unsecured obligations of the Company and will mature on March 15, 2026, unless earlier redeemed, repurchased or converted.

(2) On September 30, 2022, the Company entered into the Loan Agreement, which provides the Company with the Term Loan Facility. Under the Term Loan Facility, the Company may borrow up to $300.0 million in five committed tranches. At December 31, 2022, the outstanding balance under the Term Loan was $72.8 million, which is net of debt issuance costs with an additional availability up to $225 million. The Term Loan Facility is scheduled to mature on October 1, 2027.

(3) The Company leases offices, operating facilities, vehicles and IT equipment, which are accounted for as operating leases. These leases have remaining lease terms of up to 30 years, inclusive of renewal or termination options that the Company is reasonably certain to exercise.

Critical Accounting Policies and Estimates

Management prepared the consolidated financial statements of the Company under accounting principles generally accepted in the United States. The application of these principles requires the use of estimates, judgments and assumptions that affect the reported amounts of assets and liabilities, revenue and expenses and related disclosures of contingent assets and liabilities. We believe that our estimates, judgments and assumptions are reasonable based upon available information and our past experience; we evaluate our estimates on an ongoing basis. Accordingly, actual results could materially differ from these estimates under different assumptions or conditions, impacting our reported results of operations and financial condition. We refer to accounting estimates of this type as critical accounting policies, which we further discuss below.

Please see Note 2, "Summary of Significant Accounting Policies" in the Notes to Consolidated Financial Statements (Part IV, Item 15) for a summary of our significant accounting policies. Some of the more critical policies and estimates include capitated revenue, medical claims expense, business combinations, goodwill and intangible assets and impairment of long-lived assets.

Below is a discussion of our critical accounting policies, which are those that are most important to our financial condition and results of operation, and require management to make subjective and complex judgments in the preparation of our financial statements.

Capitated Revenue

The transaction price for our capitated payor contracts is variable as it primarily includes per patient, per month ("PPPM") fees associated with unspecified membership. PPPM fees can fluctuate throughout the contract based on the health status (acuity) of each individual patient. In certain contracts, PPPM fees also include "risk adjustments" for items such as performance incentives, performance guarantees and risk shares. The capitated revenues are recognized based on the estimated PPPM earned net of projected performance incentives, performance guarantees, risk shares and rebates because we are able to reasonably estimate the ultimate PPPM payment of these contracts. We recognize revenue in the month in which eligible patients are entitled to receive healthcare benefits. Subsequent changes in PPPM fees and the amount of revenue to be recognized are reflected through subsequent period adjustments to properly recognize the ultimate capitation amount. We also assess the profitability of our capitation arrangements to identify contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future revenues, a premium deficiency reserve is recognized.

Certain third-party payor contracts include a Medicare Part D payment related to pharmacy claims, which is subject to risk sharing through accepted risk corridor provisions. Under certain agreements the fund risk allocation is established whereby we, as the contracted provider, receive only a portion of the risk and the associated surplus or deficit. We estimate and recognize an adjustment to Part D capitated revenues related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual risk contract were to terminate at the end of the reporting period.

For our capitated revenue arrangements, we evaluate whether we are the principal, and report revenues on a gross basis, or an agent, and report revenues on a net basis. In this assessment, we consider if we obtain control of the specified services before they are transferred to our customers, as well as other indicators such as the party primarily responsible for fulfillment.

We review our assumptions and adjust these estimates accordingly on a quarterly basis. Our consolidated financial statements could be materially impacted if actual risk scores are different from the estimated risk scores. If our accrual estimates for risk scores at December 31, 2022 were to differ by +/- 5%, the impact on revenues would be approximately $3.4 million.

Medical Claims Expense

Medical claims expenses are costs for third party healthcare service providers that provide medical care to our patients for which we are contractually obligated to pay through our full-risk capitation arrangements. The estimated reserve for our liability for incurred and not reported claims is included in the liability for unpaid claims in the consolidated balance sheets. Actual claims expense will differ from the estimated liability due to factors in estimated and actual member utilization of health care services, the amount of charges and other factors. We assess our estimates with an independent actuarial expert to ensure our estimates represent the best, most reasonable estimate given the data available to us at the time the estimates are made. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies and benefit plan changes.

We review our assumptions and adjust these estimates accordingly on a quarterly basis. Our consolidated financial statements could be materially impacted if actual claims expense is different from our estimates. If our liability for incurred and not reported claims at December 31, 2022 were to differ by +/- 5%, the impact on medical claims expense would be approximately $21.3 million.

Business Combinations, Goodwill and Intangible Assets

The Company accounts for business combinations using the acquisition method of accounting, which requires that once control is obtained, all the assets acquired and liabilities assumed be recorded at their respective

fair values at the date of acquisition. The determination of fair values of assets and liabilities acquired requires estimates. The determination of fair values of assets and liabilities acquired requires estimates and the use of valuation techniques when market value is not readily available.

For intangible assets, the Company generally uses the income approach to determine fair value. The income approach requires management to make significant estimates and assumptions. These estimates and assumptions primarily include, but are not limited to: discount rates, terminal growth rates, royalty rates, forecasts of revenue, operating income, depreciation, amortization and capital expenditures. The discount rates applied to the projections reflect the risk factors associated with those projections.

Our acquisitions may also include contingent consideration, or earn-out provisions, which provide for additional consideration to be paid to the seller if certain future conditions are met. These earn-out provisions are estimated at fair value at the acquisition date based on certain internal volumes in the year following the acquisition.

Although the Company believes its estimates of fair value are reasonable, actual financial results could differ from those estimates due to the inherent uncertainty involved in making such estimates. Changes in assumptions concerning future financial results or other underlying assumptions could have a significant impact on the determination of the fair value of the intangible assets acquired.

Judgment is also required in determining the intangible asset's useful life.

Goodwill represents the excess of consideration paid over the fair value of net assets acquired through business acquisitions. Goodwill is not amortized but is tested for impairment at least annually. We test goodwill for impairment annually on October 1st or more frequently if triggering events occur or other impairment indicators arise which might impair recoverability. These events or circumstances would include a significant change in the business climate, legal factors, operating performance indicators, competition, sale, disposition of a significant portion of the business or other factors.

Impairment of Long-Lived Assets

The Company evaluates the recoverability of long-lived assets whenever events or changes in circumstances indicate that the carrying value of such an asset may not be recoverable. The evaluation of long-lived assets is performed at the lowest level of identifiable cash flows. Long-lived assets related to the Company's centers include property, plant and equipment, definite-lived intangibles, right of use assets as well as operating lease liabilities. If the asset group fails the recoverability test, then an impairment charge is determined based on the difference between the fair value of the asset group compared to its carrying value. Fair value of the asset group is generally determined using an income approach based on cash flows expected from the use and eventual disposal of the asset group.

The determination of the fair value of the asset group requires management to estimate a number of factors including anticipated future cash flows and discount rates. Although we believe these estimates are reasonable, actual results could differ from those estimates due to the inherent uncertainty involved in making such estimates.

Recent Accounting Pronouncements

See Note 2 to our consolidated financial statements "Summary of Significant Accounting Policies—Recently Adopted Accounting Pronouncements" in Part IV, Item 15 of our consolidated financial statements for more information.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Market risk represents the risk of loss that may impact our financial position due to adverse changes in financial market prices and rates. Our market risk exposure is primarily a result of exposure due to potential changes in inflation or interest rates. We do not hold financial instruments for trading purposes.

Interest Rate Risk

As of December 31, 2022, we had cash, cash equivalents and restricted cash of $158.5 million, compared to $120.4 million as of December 31, 2021, held primarily in cash deposits for working capital purposes. We had marketable debt securities of $287.7 million as of December 31, 2022, compared to $671.1 million as of December 31, 2021, consisting of U.S. Treasury obligations, corporate bonds, available-for-sale securities and others. Our investments are made for capital preservation purposes. We do not enter into investments for trading or speculative purposes. All our investments are denominated in U.S. dollars.

As of December 31, 2022, we had outstanding debt of $920.0 million in convertible notes which has a 0% interest rate, and $75.0 million under our Term Loan which has a variable market-based interest rate.

Our cash and cash equivalents, marketable debt securities and debt are subject to market risk due to changes in interest rates. Fixed rate securities may have their market value negatively impacted due to a rise in interest rates, while floating rate securities may produce less income than expected if interest rates fall. Due in part to these factors, our future investment income may fall short of expectation due to changes in interest rates or we may suffer losses in principal if we are forced to sell securities that decline in market value due to changes in interest rates.

We do not believe that an increase or decrease in interest rates of 100 basis points would have a material effect on our business, financial condition or results of operations.

Item 8. Financial Statements and Supplementary Data

All information required by this item is included in Part IV, Item 15 of this Annual Report on Form 10-K and is incorporated in this item by reference.

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

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report. Based on their evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures were effective as of December 31, 2022.

Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rules 13a-15(f) and 15d-15(f) of the Exchange Act. 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 reporting purposes in accordance with generally accepted

accounting principles. Our management, including our Chief Executive Officer and Chief Financial Officer, conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2022 based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission in 2013. Based on the results of this evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2022. The effectiveness of our internal control over financial reporting as of December 31, 2022 has been audited by our independent registered public accounting firm, as stated in their attestation report, which is below.

Attestation Report of the Independent Registered Public Accounting Firm

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Oak Street Health, Inc.

Opinion on Internal Control Over Financial Reporting

We have audited Oak Street Health, Inc's internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Oak Street Health, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2022, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2022 and 2021, and the related consolidated statements of operations, comprehensive loss, changes in redeemable investor units and stockholders' equity/members' deficit and cash flows for each of the three years in the period ended December 31, 2022, and the related notes and our report dated February 28, 2023 expressed an unqualified opinion thereon.

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 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 included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and 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 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.

/s/ Ernst & Young LLP
Chicago, IL
February 28, 2023

Changes to our Internal Controls over Financial Reporting

There were no material changes in our internal control over financial reporting during the year ended December 31, 2022 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitation on the Effectiveness of Internal Control

The effectiveness of any system of internal control over financial reporting, including ours, is subject to inherent limitations, including the exercise of judgment in designing, implementing, operating, and evaluating the controls and procedures, and the inability to eliminate misconduct completely. Accordingly, in designing and evaluating the disclosure controls and procedures, management recognizes that any system of internal control over financial reporting, including ours, no matter how well designed and operated, can only provide reasonable, not absolute assurance of achieving the desired control objectives. In addition, the design of disclosure controls and procedures must reflect the fact that there are resource constraints and that management is required to apply its judgment in evaluating the benefits of possible controls and procedures relative to their costs. Moreover, 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. We intend to continue to monitor and upgrade our internal controls as necessary or appropriate for our business but cannot assure you that such improvements will be sufficient to provide us with effective internal control over financial reporting.

Item 9B. Other Information

None.

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections

Not applicable.

PART III

The Company intends to file with the SEC a definitive proxy statement for its next Annual Meeting of Stockholders (the "Proxy Statement") pursuant to SEC Regulation 14A no later than 120 days after December 31, 2022. The information required by Part III (Items 10, 11, 12, 13 and 14) is incorporated by reference to the disclosure in that Proxy Statement. The Company's next Annual Meeting of Stockholders is scheduled to be held on April 27, 2023 and involves the election of directors.

Item 10. Directors, Executive Officers and Corporate Governance

We adopted a written code of ethics and business conduct that applies to our directors, executive officers and employees, including our Chief Executive Officer, Chief Financial Officer, principal accounting officer, the controller and all persons performing similar functions. A current copy of the code is posted under "Governance" on the Investor Relations section of our website, www.oakstreethealth.com. Any waiver from the Code of Ethics and any amendments to the Code of Ethics will be disclosed on such page of the Company's web site.

All other information in response to this item is incorporated by reference from the Proxy Statement sections entitled "Board of Directors and Corporate Governance," "Election of Directors," "Board Meetings and Committees," "Executive Officers," and "Delinquent Section 16(a) Reports."

Item 11. Executive Compensation

The information in response to this item is incorporated by reference from the Proxy Statement sections entitled "Executive and Director Compensation," "Executive Compensation – Compensation Committee Interlocks and Insider Participation" and "Compensation Committee Report."

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

The information in response to this item is incorporated by reference from the Proxy Statement section entitled "Security Ownership of Certain Beneficial Owners and Management."

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

The information in response to this item is incorporated by reference from the Proxy Statement sections entitled "Certain Relationships and Related Party Transactions," "Board of Directors and Corporate Governance" "Election of Directors," and "Board Meetings and Committees."

Item 14. Principal Accounting Fees and Services.

The information in response to this item is incorporated by reference from the Proxy Statement section entitled "Fees and Services."

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) The following documents are filed as part of this Annual Report on Form 10-K:

1. *Financial Statements.*

   The accompanying Index to Consolidated Financial Statements on page F-1 of this annual report on Form 10-K is provided in response to this item.

2. *List of Financial Statement Schedules.*

   All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

(b) The exhibits listed in the following "Exhibit Index" are filed, furnished or incorporated by reference as part of this Annual Report.

Exhibit Index

Exhibit Number	Description
2.1§	Agreement and Plan of Merger, dated as of February 7, 2023, by and among CVS Pharmacy, Inc., Halo Merger Sub Corp., Oak Street Health, Inc. and, for the limited purposes set forth therein, CVS Health Corporation (incorporated by reference to Exhibit 2.1 to the Company's Form 8-K filed on February 8, 2023).
3.1	Amended and Restated Certificate of Incorporation of Oak Street Health, Inc., dated August 10, 2020 (incorporated by reference to Exhibit 3.1 to the Company's Form 8-K filed on August 11, 2020).
3.2	Amended and Restated Bylaws of Oak Street Health, Inc., dated August 10, 2020 (incorporated by reference to Exhibit 3.2 to the Company's Form 8-K filed on August 11, 2020).
4.1	Registration Rights Agreement, dated August 10, 2020, by and among the Company and the other signatories party thereto (incorporated by reference to Exhibit 4.1 to the Company's Form 8-K filed on August 11, 2020).
4.2	Description of capital stock (incorporated by reference to Exhibit 4.2 to the Company's Form 10-K filed on March 10, 2021).
4.3	Indenture, dated March 16, 2021, between Oak Street Health, Inc. and U.S. Bank National Association (incorporated by reference to Exhibit 4.1 to the Current Report filed with the SEC on March 16, 2021).
4.4	Form 0% Convertible Senior Notes due 2026 (incorporated by reference to Exhibit 4.2 to the Current Report filed with the SEC on March 16, 2021).
4.5	Security and Loan Agreement, dated as of September 30, 2022, by and among the Company and certain of its subsidiaries named thereto, as borrowers, Hercules Capital, Inc. as agent and lender, Silicon Valley Bank and the several banks and other financial institutions or entities from time to time parties thereto as lenders (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on October 3, 2022).
10.1	Sponsor Director Nomination Agreement, dated as of August 10, 2020, by and among the Company and the other signatories party thereto (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on August 11, 2020).
10.2	Humana Director Nomination Agreement, dated as of August 10, 2020, by and among the Company and the other signatories party thereto (incorporated by reference to Exhibit 10.2 to the Company's Form 8-K filed on August 11, 2020).
10.7	Tax Matters Agreement, dated as of August 10, 2020, by and among the Company and the other signatories party thereto (incorporated by reference to Exhibit 10.7 to the Company's Form 8-K filed on August 11, 2020).
10.8+	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.5 to the Company's Form S-1 filed on July 10, 2020).
10.9+	Oak Street Health, Inc. Omnibus Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Form S-8 filed on August 10, 2020).

Exhibit Number	Description
10.10+	Oak Street Health, Inc. 2020 Employee Stock Purchase Plan (incorporated by reference to Exhibit 10.6 to the Company's Form S-8 filed on August 10, 2020).
10.11+	Restricted Stock Unit Award Agreement with Kim Keck dated October 1, 2020 (incorporated by reference to Exhibit 10.1 on the Company's Form 8-K filed on October 2, 2020).
21.1	List of subsidiaries of Oak Street Health, Inc.
23.1	Consent of Ernst & Young LLP.
31.1	Certification of the Chief Executive Officer pursuant to Exchange Act Rules Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2020, filed herewith.
31.2	Certification of the Chief Financial Officer pursuant to Exchange Act Rules Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2020, filed herewith.
32.1*	Certification of the Chief Executive Officer pursuant to 18 U.S.C. Section 1350, filed herewith.
32.2*	Certification of the Chief Financial Officer pursuant to 18 U.S.C. Section 1350, filed herewith.
101.INS	Inline XBRL Instance Document
101.SCH	Inline XBRL Taxonomy Extension Schema Document
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	Cover Page Interactive Data File (embedded within the Inline XBRL document)

+ Indicates a management contract or compensatory plan or agreement.

§ Certain of the exhibits and schedules to this exhibit have been omitted in accordance with Regulation S-K Item 601(b)(2). The Registrant agrees to furnish supplementally a copy of all omitted exhibits and schedules to the SEC upon its request. The Company request confidential treatment pursuant to Rule 24b-2 of the Securities Act of 1934, as amended of any schedule or exhibit to furnished.

* The certifications furnished in Exhibit 32.1 and Exhibit 32.2 hereto are deemed to accompany this Annual Report on Form 10-K and will not be deemed "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, as amended, except to the extent that the registrant specifically incorporates it by reference.

Item 16. Form 10-K Summary

None.

SIGNATURES

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

Oak Street Health, Inc.

Date: February 28, 2023

By: /s/ Michael Pykosz
Michael Pykosz
Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Report has been signed below by the following persons on behalf of the Registrant in the capacities and on the dates indicated.

Name	Title	Date
/s/ Mike Pykosz Mike Pykosz	Chief Executive Officer and Director (Principal Executive Officer)	February 28, 2023
/s/ Tim Cook Tim Cook	Chief Financial Officer (Principal Financial and Accounting Officer)	February 28, 2023
/s/ Geoff Price Geoff Price	Chief Innovation Officer and Director	February 28, 2023
/s/ Griffin Myers Griffin Myers	Chief Medical Officer and Director	February 28, 2023
/s/ Regina Benjamin Regina Benjamin	Director	February 28, 2023
/s/ Cheryl Dorsey Cheryl Dorsey	Director	February 28, 2023
/s/ Mohit Kaushal Mohit Kaushal	Director	February 28, 2023
/s/ Kim Keck Kim Keck	Director	February 28, 2023
/s/ Julie Klapstein Julie Klapstein	Director	February 28, 2023
/s/ Paul Kusserow Paul Kusserow	Director	February 28, 2023
/s/ Robert Vorhoff Robert Vorhoff	Director	February 28, 2023
/s/ Srdjan Vukovic Srdjan Vukovic	Director	February 28, 2023

INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of Oak Street Health, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Oak Street Health, Inc. (the Company) as of December 31, 2022 and 2021, the related consolidated statements of operations, comprehensive loss, changes in redeemable investor units and stockholders' equity/members' deficit 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 "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at 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 U.S. generally accepted accounting principles.

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 criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 28, 2023 expressed an unqualified opinion thereon.

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 audits. 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 audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits 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 consolidated 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 Capitated Revenue and Accounts Receivable

Description of the Matter	As described in Note 3 to the consolidated financial statements, for the year ended and at December 31, 2022, the Company had $2,125.9 million and $894.0 million in capitated revenue and accounts receivable, respectively, which comprises the most significant portion of total revenue for the

Company. Capitated revenue and accounts receivable are generated from risk contracting agreements made with various Medicare Advantage managed care payors and the centers for Medicare and Medicaid Services ("CMS") whereby the Company receives a fixed payment per patient per month ("PPPM") for a defined patient population. Capitated revenues are recognized based on the estimated PPPM net of projected acuity adjustments and performance incentives/penalties that the Company expects to be entitled to receive from Medicare Advantage managed care payors and CMS.

Auditing the Company's accounting for capitated revenue and accounts receivable was complex and required significant auditor judgment due to the significant estimation required to determine the revenue and accounts receivable for periods which have not been paid and or settled by the Medicare Advantage managed care payors and CMS, inclusive of projected acuity adjustments and performance incentives/penalties, and is estimated using a combination of either partially received data, most recently available data or assumptions based on similar types of health plans and Company experience.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's capitated revenue and accounts receivable process, including management's assessment of the assumptions and data used in supporting the recognition and measurement of capitated revenue and accounts receivable.

To test the capitated revenue and accounts receivable balance which has not been paid and or settled as of the balance sheet date, our audit procedures included understanding and evaluating the methodology and the assumptions used in management's calculations. We reviewed management's methodology to ensure that it was reasonably applied to each managed care payor's estimated capitated revenue and accounts receivable based on the available data for that respective managed care payor. Our testing of assumptions included confirming certain inputs directly with the Medicare Advantage managed care payors, obtaining subsequent statements of accounts, and performing a retrospective analysis. We also performed various analytical procedures to support the reasonableness of the underlying assumptions used by the Company. Additionally, on a test basis, we agreed the cash received by the Company to the statements of accounts and agreed it to bank statements.

Accounting for Liability for Unpaid Claims

Description of the Matter

As described in Note 6 to the consolidated financial statements, at December 31, 2022, the Company had $850.3 million in liabilities for unpaid claims for medical care services provided to its insured consumers by third parties, but for which claims have either not yet been received, processed or paid. The Company develops its estimate for medical care services incurred but not reported ("IBNR"), which includes estimates for claims that have not been received or fully processed, by utilizing actuarial models that consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume

and demographics, the introduction of new technologies and benefit plan changes.

Auditing management's estimate of the liability for unpaid claims involved auditor judgment because the liability requires the Company to estimate medical care services incurred but not reported and required the involvement of specialists due to the highly judgmental nature of the assumptions used in the estimation process. These assumptions have a significant effect on the estimate for the liability for unpaid claims.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design and tested the operating effectiveness of controls over the Company's process over liabilities for unpaid claims, including management's assessment of the assumptions and data used in supporting the measurement of liabilities for unpaid claims.

To test the Company's liability for unpaid claims our audit procedures included, among others, testing on a sample basis the completeness and accuracy of the underlying claims data by confirming the claims paid detail directly with the Medicare Advantage managed care payors, agreed a sample of incurred and paid claims from the confirmed detail to that used by the Company, and obtaining subsequent statement of accounts and benchmarking certain inputs used in the calculation to overall Company experience. In addition, we involved our actuarial specialists to assist in evaluating the key assumptions and methodologies used in the calculation and to independently calculate a range of medical care services incurred but not reported to what was recorded by the Company. We also performed various analytical procedures to support the reasonableness of the amount recorded by the Company.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2019.

Chicago, IL
February 28, 2023

OAK STREET HEALTH, INC.
CONSOLIDATED BALANCE SHEETS
($ in millions, except shares/ units and per share data)

	December 31, 2022	December 31, 2021
Assets		
Current assets:		
Cash and cash equivalents	$ 137.9	$ 104.7
Restricted cash	20.6	15.7
Other receivables, net (Humana comprised $0.2 as of December 31, 2021)	2.5	3.1
Capitated accounts receivable (Humana comprised $105.0 as of December 31, 2021)	894.0	559.4
Marketable debt securities	287.7	671.1
Prepaid expenses and toher current assets	15.9	14.0
Total current assets	1,358.6	1,368.0
Long-term assets:		
Property, plant and equipment, net	204.1	144.8
Operating lease right-of-use assets (Humana comprised $70.9 as of December 31, 2021)	317.6	157.7
Goodwill	158.0	152.9
Intangible assets, net	9.1	10.8
Other long-term assets	7.3	6.9
Total assets	$ 2,054.7	$ 1,841.1
Liabilities and stockholders' (deficit) equity		
Current liabilities:		
Accounts payable	$ 17.1	$ 22.1
Accrued compensation and benefits	52.7	41.7
Liability for unpaid claims (Humana comprised $99.1 as of December 31, 2021)	850.3	556.3
Other liabilities (Humana comprised $19.3 as of December 31, 2021)	43.0	44.0
Total current liabilities	963.1	664.1
Long-term operating lease liabilities (Humana comprised $66.0 as of December 31, 2021)	349.3	164.2
Other long-term liabilities (Humana comprised $43.1 as of December 31, 2021)	31.0	55.4
Long-term debt	978.6	901.4
Total liabilities	$ 2,322.0	$ 1.785.1
Commitments and contingencies (See Note 9)		
Stockholders' (deficit) equity:		
Preferred stock, par value $0.001; 50,000,000 shares authorized as of December 31, 2022 and December 31, 2021; no shares issued and outstanding as of December 31, 2022 and December 31, 2021	—	—
Common stock, par value $0.001; 500,000,000 shares authorized as of December 31, 2022 and December 31, 2021; 242,873,706 and 240,937,465 shares issued and outstanding as of December 31, 2022 and December 31, 2021, respectively	0.2	0.2
Additional paid-in capital (Humana comprised $50.0 as of December 31, 2021)	1,205.4	1,017.9
Accumulated other comprehensive loss	(2.2)	(1.4)
Accumulated deficit	(1,474.5)	(965.3)
Total stockholders' (deficit) equity allocated to Oak Street Health, Inc.	(271.1)	51.4
Non-controlling interests	3.8	4.6
Total stockholders' (deficit) equity	(267.3)	56.0
Total liabilities and stockholders' (deficit) equity	$ 2,054.7	$ 1,841.1

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

OAK STREET HEALTH, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
($ in millions, except shares/units and per share data)

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Revenues:			
Capitated revenue (Humana comprised $506.7 and $385.7 for the year ended December 31, 2021 and 2020, respectively)	$ 2,125.9	$ 1,397.0	$ 851.3
Other revenue (Humana comprised $6.5 and $3.6 for the year ended December 31, 2021 and 2020, respectively)	35.0	35.6	31.5
Total revenues	2,160.9	1,432.6	882.8
Operating expenses:			
Medical claims expense (Humana comprised $380.5 and $254.9 for the year ended December 31, 2021 and 2020, respectively	1,645.0	1,109.0	617.8
Cost of care, excluding depreciation and amortization (Humana comprised $10.5 and $5.6 for the year ended December 31, 2021 and 2020, respectively(	437.8	293.7	187.5
Sales and marketing	164.3	119.4	64.2
Corporate, general and administrative	344.8	306.7	185.6
Depreciation and amortization	35.2	17.8	11.2
Total operating expenses	2,627.1	1,846.6	1,066.3
Loss from operations			
Other (expense)/income:			
Interest expense, net	(2.5)	(2.5)	(8.7)
Other	(40.8)	—	0.1
Total other (expense)	(43.3)	(2.5)	(8.6)
Loss before income taxes and non-controlling interests	(509.5)	(416.5)	(192.1)
Provision (benefit) for income taxes	0.2	(1.9)	—
Net loss	(509.7)	(414.6)	(192.1)
Net loss attributable to non-controlling interests	(0.5)	(5.2)	(4.1)
Net loss attributable to Oak Street Health, Inc.	$ (509.2)	$ (409.4)	$ (188.0)
Undeclared and deemed dividends	$ —	$ —	$ (27.2)
Net loss attributable to common stock/unitholders	$ (509.2)	$ (409.4)	$ (215.2)
Weighted average common stock outstanding - basic and diluted [1]	230,132,551	222,553,237	218,825,324
Net loss per share - basic and diluted	$ (2.21)	$ (1.84)	$ (0.55)

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

OAK STREET HEALTH, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE LOSS
($ in millions, except shares/units and per share data)

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Net loss	$ (509.7)	$ (414.6)	$ (192.1)
Other comprehensive loss:			
Net unrealized loss on marketable debt securities, net of tax	(0.8)	(1.4)	—
Comprehensive loss	(510.5)	(416.0)	(192.1)
Less: Comprehensive loss attributable to non-controlling interests	(0.5)	(5.2)	(4.1)
Comprehensive loss attributable to Oak Street Health, Inc.	$ (510.0)	$ (410.8)	$ (188.0)

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

OAK STREET HEALTH, INC.
CONSOLIDATED STATEMENTS OF CHANGES IN
REDEEMABLE INVESTOR UNITS AND STOCKHOLDERS' EQUITY/MEMBERS' (DEFICIT)
($ in millions, except shares/units and per share data)

	Redeemable Investor Units		Members' Capital		Common Stock						
	Shares Issued	Amount	Shares Issued	Amount	Shares Issued	Amount	Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Non-controlling Interest	Total Equity / (Deficit)
Balances January 1, 2020	11,000,619	$ 320.6	2,530,864	$ 4.2	—	$ —	$ —	$ (354.4)	$ —	$ 5.4	$ (344.8)
Issuance of Series I, II and III and Investor Units	1,471,623	224.4	—	—	—	—	—	—	—	—	—
Conversion of redeemable preferred stock into common stock upon closing of initial public offering	(12,472,242)	(545.0)	—	—	184,787,783	0.2	544.8	—	—	—	545.0
Conversion of members' capital into common stock upon closing of initial public offering	—	—	(1,117,312)	(7.0)	15,498,529	—	7.0	—	—	—	—
Conversion of members' capital into restricted stock upon closing of initial public offering	—	—	(2,339,322)	—	22,612,472	—	—	—	—	—	—
Issiance of common stock upon closing of initial public offering, net	—	—	—	—	17,968,750	—	351.2	—	—	—	351.2
Issuance of Common Units	—	—	1,095,067	—	—	—	—	—	—	—	—
Tender Offer - Investor Units, Founder's Units, Incentive Units	—	—	(131,151)	(5.9)	—	—	—	(13.5)	—	—	(19.4)
Exercise of options	—	—	—	—	6,607	—	0.1	—	—	—	0.1
Shares withheld related to net share settlement of stock based awards	—	—	—	—	(1,628)	—	—	—	—	—	—
Repurchases - Profits Interests	—	—	(5,856)	—	—	—	—	—	—	—	—
Forfeitures	—	—	(32,290)	(0.2)	(115,799)	—	(0.1)	—	—	—	(0.3)
Stock and unit-based compensation	—	—	—	8.9	—	—	68.8	—	—	—	77.7
Payments from non-controlling Interest	—	—	—	—	—	—	—	—	—	5.9	5.9

	Redeemable Investor Units		Members' Capital		Common Stock						
	Shares Issued	Amount	Shares Issued	Amount	Shares Issued	Amount	Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Non-controlling Interest	Total Equity / (Deficit)
Payments to non-controlling Interest	—	—	—	—	—	—	—	—	—	(0.1)	(0.1)
Net loss	—	—	—	—	—	—	—	(188.0)	—	(4.1)	(192.1)
Balances December 31, 2020	—	$ —	—	$ —	240,756,714	$ 0.2	$ 971.8	$ (555.9)	$ —	$ 7.1	$ 423.1
Purchase of capped calls	—	—	—	—	—	—	(123.6)	—	—	—	(123.6)
Issuance of common stock upon vesting exercise of restricted stock units	—	—	—	—	65,432	—	—	—	—	—	—
Issuance of common stock upon exercise of options	—	—	—	—	259,579	—	5.3	—	—	—	5.3
Shares withheld related to net settlement of stock based awards	—	—	—	—	(3.331)	—	—	—	—	—	—
Issuance of common stock under the employee purchase plan	—	—	—	—	62,575	—	3.0	—	—	—	3.0
Forfeitures	—	—	—	—	(203,504)	—	(1.3)	—	—	—	(1.3)
Stock-based compensation	—	—	—	—	—	—	162.7	—	—	—	162.7
Payments from non-controlling interest	—	—	—	—	—	—	—	—	—	4.2	4.2
Payments to non-controlling interest	—	—	—	—	—	—	—	—	—	(1.5)	(1.5)
Net unrealized loss on marketable debt securities	—	—	—	—	—	—	—	—	(1.4)	—	(1.4)
Net loss	—	—	—	—	—	—	—	(409.4)	—	(5.2)	(414.6)
Balances December 31, 2021	—	$ —	—	$ —	240,937,465	$ 0.2	$ 1,017.9	$ (965.3)	$ (1.4)	$ 4.6	$ 56.0
Issuance of common stock upon exercise of options	—	—	—	—	745,982	—	15.1	—	—	—	15.1
Shares withheld related to net share settlement of stock based awards	—	—	—	—	(29,682)	—	(0.3)	—	—	—	(0.3)
Issuance of common stock under the employee purchase plan	—	—	—	—	224,473	—	4.0	—	—	—	4.0
Issuance of common stock under RMD earnout	—	—	—	—	1,225,122	—	32.5	—	—	—	32.5

	Redeemable Investor Units		Members' Capital		Common Stock						
	Shares Issued	Amount	Shares Issued	Amount	Shares Issued	Amount	Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Non-controlling Interest	Total Equity / (Deficit)
Issuance of common stock upon vesting of restricted stock units	—	—	—	—	157,782	—	—	—	—	—	—
Forfeitures	—	—	—	—	(387,436)	—	(9.3)	—	—	—	(9.3)
Stock-based compensation	—	—	—	—	—	—	148.2	—	—	—	148.2
Payments from non-controlling interest	—	—	—	—	—	—	—	—	—	0.4	0.4
Payments to non-controlling interest	—	—	—	—	—	—	—	—	—	(1.3)	(1.3)
Dissolution of joint venture	—	—	—	—	—	—	(2.7)	—	—	0.6	(2.1)
Net unrealized loss on short-term marketable securities	—	—	—	—	—	—	—	—	(0.8)	—	(0.8)
Net loss	—	—	—	—	—	—	—	(509.2)	—	(0.5)	(509.7)
Balances December 31, 2022	—	$ —	—	$ —	242,873,706	$ 0.2	$ 1,205.4	$ (1,474.5)	$ (2.2)	$ 3.8	$ (267.3)

OAK STREET HEALTH, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
($ in millions)

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Cash flows from operating activities:			
Net loss	$ (509.7)	$ (414.6)	$ (192.1)
Adjustments to reconcile net loss to net cash used in operating activities:			
Income tax expense (benefit)	0.2	(1.9)	—
Amortization of discount on debt and related issuance costs	4.9	3.5	4.4
Accretion of discounts and amortization of premiums on short-term marketable securities, net	5.2	4.6	—
Fair value adjustment to contingent consideration	38.3	—	—
Depreciation and amortization	35.2	17.8	11.2
Non-cash operating lease costs	35.4	15.5	—
Stock and unit-based compensation, net of forfeitures	138.9	161.4	77.4
Change in fair value of bifurcated derivative	—	—	0.2
Change in operating assets and liabilities, net of impact of acquisitions:			
Accounts receivable	(334.0)	(304.7)	(88.3)
Other assets	(1.3)	(3.0)	(1.6)
Amounts payable and accrued compensation and benefits	6.7	15.4	0.1
Liability for unpaid claims	294.0	294.2	91.5
Operating lease liabilities	(22.4)	(12.2)	—
Other liabilities	(0.8)	26.8	19.4
Other	—	—	0.6
Net cash used in operating activities	(309.4)	(197.2)	(77.2)
Cash flows from investing activities:			
Proceeds from sales and maturities of marketable debt securities	830.3	193.6	—
Purchases of marketable debt securities	(452.9)	(870.7)	—
Purchase of promissory note	—	—	(0.8)
Investment in business	(1.0)	(5.0)	—
Purchase of business, net of cash acquired	(6.1)	(124.0)	—
Purchases of proeprty and equipment	(89.2)	(81.3)	(20.9)
Net cash provided by (used in) investing activities	281.1	(887.4)	(21.7)
Cash flows from financing activities:			
Proceeds from borrowings on term loan, net	72.3	—	—
Proceeds from initial public offering	—	—	377.3
Payments of underwriting fees, net of discounts and offering costs	—	—	(26.1)
Principal payments on long-term debt	—	—	(80.0)
End of term charge and prepayments for debt paydown	—	—	(5.8)
Proceeds from borrowings on convertible senior notes, net	—	897.9	—
Purchase of capped calls	—	(123.6)	—
Proceeds from issuance fo redeemable investor units	—	—	224.4
Capital contributions from non-controlling interests	0.4	4.2	5.9
Settlement of contingent earnout liability	(21.7)	—	—
Capital distributions to non-controlling interests	(1.3)	(1.5)	(0.1)
Purchase of joint venture minority interest	(2.1)	—	—
Tender Offer - common units	—	—	(19.4)
Proceeds from exercise of options, net	14.8	5.3	0.1
Proceeds from issuance of common stock under the employee purchas plan	4.0	3.0	—
Net cash provided by financing activities	66.4	785.3	476.3
Net change in cash, cash equivalents and restricted cash	38.1	(299.3)	377.4
Cash, cash equivalents and restricted cash, beginning of period	120.4	419.7	42.3
Cash, cash equivalents and restricted cash, end of period	$ 158.5	$ 120.4	$ 419.7

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Supplemental disclosures			
Cash paid for interest	—	—	5.5
Additions to construction in process funded through accounts payable	4.3	1.6	1.3
Contingent consideration in connection with purchases of business	0.2	21.7	—

NOTE 1. ORGANIZATION AND NATURE OF BUSINESS

Description of Business

Oak Street Health, Inc. (collectively with its subsidiaries is referred to as "Oak Street Health," "OSH," "we," "us," "our," or the "Company") was formed as a Delaware corporation on October 22, 2019 for the purpose of completing a public offering and related restructuring transactions (collectively referred to as the "IPO") in order to carry on the business of Oak Street Health, LLC ("OSH LLC") and its affiliates. On August 10, 2020, the Company completed its IPO of its Class A common stock, par value $0.001 per share. We issued and sold 17,968,750 shares of common stock at an offering price of $21.00 per share. The share amount includes the exercise in full of the underwriters' options to purchase 2,343,750 additional shares of common stock. We received net proceeds of $351.2 million, after deducting underwriting discounts and commissions of $22.6 million and deferred offering costs of $3.5 million. Upon completion of the IPO, these deferred offering costs were reclassified from current assets to stockholders' equity and recorded against the net proceeds from the offering.

The Company operates primary care centers serving Medicare beneficiaries. The Company, through its centers and management services organization, combines an innovative care model with superior patient experience. The Company invests resources into primary care to prevent unnecessary acute events and manage chronic illnesses. The Company engages Medicare eligible patients through the use of an innovative community outreach approach. Once patients are engaged, the Company integrates population health analytics, social support services and primary care into the care model to drive improved outcomes. The Company contracts with health plans to generate medical costs savings and realize a return on its investment in primary care. As of December 31, 2022, the Company operated 169 centers across the United States.

Proposed Transaction with CVS Health

As more fully described in Note 19, on February 7, 2023, the Company entered into an Agreement and Plan of Merger (the "Merger Agreement") with a subsidiary of CVS Health, pursuant to which (and subject to the terms and conditions in the Merger Agreement) such subsidiary of CVS Health will acquire all of the outstanding shares of the Company's common stock in a transaction structured as a merger of an indirect wholly-owned subsidiary of CVS Health with and into the Company, with the Company continuing as the surviving corporation.

COVID-19

Even as the COVID-19 pandemic subsides, disruptions caused by the pandemic, including labor shortages and inflationary pressures, may continue and could, in turn, have a negative impact on the Company. Further, recurring COVID-19 outbreaks could have the potential to impact the Company and its future results of operations, cash flows and financial position.

On March 27, 2020, the United States President signed into law the Coronavirus Aid, Relief and Economic Securities Act ("CARES Act") which provides economic assistance to a wide array of industries, including healthcare. This legislation did not have a material impact on our financial statements as of and for the year ended December 31, 2022. The impact of this legislation for the prior periods presented is as follows:

- *Provider Relief Funds.* The U.S. Department of Health and Human Services ("HHS") distributed grants to healthcare providers to offset the impacts of COVID-19 pandemic related expenses and lost revenues through the Public Health and Social Services Emergency Fund. Grants received are subject to the terms and conditions of the program, including that such funds may only be used to prevent, prepare for, and respond to COVID-19 and will reimburse

only for health care related expenses, general and administrative expenses or lost revenues that are attributable to the COVID-19 pandemic as defined by the HHS. Payments from this fund are not loans and, therefore, they are not subject to repayment. Given the lack of definitive authoritative guidance under GAAP for accounting for government grants, the Company analogizes to accounting guidance under International Accounting Standard No. 20, "Accounting for Government Grants and Disclosure of Government Assistance" and recognizes grant payments as income when there is reasonable assurance that we have complied with conditions associated with the grant. During the years ended December 31, 2021 and 2020, the Company received $2.8 million and $8.4 million, respectively, related to these grants and recognized $3.6 million and $7.6 million, respectively, as income to offset COVID-19 pandemic related expenses incurred and lost revenues. For the year ended December 31, 2021, $3.6 million was recognized as an offset to the costs incurred in cost of care, excluding depreciation and amortization on the consolidated statement of operations. For the year ended December 31, 2020, $5.4 million was recognized as an offset to cost of care, excluding depreciation and amortization and $2.2 million was recognized in other income to offset lost other revenues on the consolidated statement of operations. There were no unrecognized grants on the consolidated balance sheets as of December 31, 2022 and 2021.

- *Payroll Tax Deferral.* Under the CARES Act, the Company elected to defer payment on its portion of Social Security taxes, on an interest free basis, incurred from March 27, 2020 to December 31, 2020. One-half of such deferral amount was due on December 31, 2021, and the remainder became due on December 31, 2022. We paid the balance due on December 31, 2021 of $4.0 million. We paid the remaining balance due on December 31, 2022 of $3.0 million, which was classified in accrued compensation and benefits on the consolidated balance sheet as of December 31, 2021.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The consolidated financial statements and accompanying notes are prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP") and the rules and regulations of the Securities and Exchange Commission ("SEC"). The consolidated financial statements of Oak Street Health include the financial statements of all wholly-owned subsidiaries and majority-owned or controlled entities. For those consolidated subsidiaries where our ownership is less than 100%, the portion of the net income or loss allocable to the non-controlling interests is reported as "Net loss in attributable to non-controlling interests" in the consolidated statements of operations. The Company records a non-controlling interest for the portion attributable to its minority partners for all of its joint ventures. Intercompany balances and transactions have been eliminated in consolidation. Business combinations accounted for as purchases have been included from their respective dates of acquisition.

Upon completion of the IPO, our sole material asset is our interest in OSH LLC and its affiliates. In accordance with the master structuring agreement dated August 10, 2020, by and among Oak Street Health, Inc. and the other signatories party thereto (the "Master Structuring Agreement"), we have all management powers over the business and affairs of OSH LLC and to conduct, direct and exercise full control over the activities of OSH LLC. Due to our power to control the activities most directly affecting the results of OSH LLC, we are considered the primary beneficiary of the variable interest entity ("VIE"). Accordingly, following the effective date of the IPO, we consolidate the financial results of OSH LLC and its affiliates and the financial statements for the periods prior to the IPO have been adjusted to combine the previously separate entities for presentation purposes.

Variable Interest Entities

The Company evaluates its ownership, contractual and other interests in entities to determine if it has any variable interest in a VIEs. These evaluations are complex, involve judgment and the use of estimates and assumptions based on available historical information, among other factors. The Company considers itself to control an entity if it is the majority owner of or has voting control over such entity. The Company also assesses control through means other than voting rights ("variable interest entities" or "VIEs") and determines which business entity is the primary beneficiary of the VIE. The Company consolidates VIEs when it is determined that the Company is the primary beneficiary of the VIE. Management performs ongoing reassessments of whether changes in the facts and circumstances regarding the Company's involvement with a VIE will cause the consolidation conclusion to change. Changes in consolidation status are applied prospectively (see Note 15).

In addition to the consolidated VIEs, Oak Street Health is the majority interest owner in two joint ventures: OSH-PCJ Joliet, LLC (50.1% ownership) and OSH-RI, LLC (50.1% ownership), which are consolidated in the Company's financial statements. In the first quarter of 2022, the Company paid a former joint venture partner, Evangelical Services Corporation, $2.1 million to acquire its 49.9% ownership interest in OSH-ESC Joint Venture, LLC. As such, OSH now owns 100% of this entity as of the year ended December 31, 2022, and the joint venture was effectively dissolved. The following table illustrates the contributions and distributions made to and from the joint venture and Oak Street Health MSO, LLC for the periods then ended ($ in millions):

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
OSH-PCJ Joliet, LLC			
Contributions	$ —	$ —	$ —
Distributions	1.3	1.5	0.1
OSH-RI, LLC			
Contributions	—	4.1	5.9
Distributions	—	—	—
OSH-ESC Joint Venture, LLC			
Contributions	—	0.1	—
Distributions	—	—	—

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The Company bases its estimates on the information available at the time, its experiences and various other assumptions believed to be reasonable under the circumstances including estimates of the impact of COVID-19. The areas where significant estimates are used in the accompanying financial statements include revenue recognition, the liability for unpaid claims, valuation and related impairment recognition of long-lived assets, including intangible assets and goodwill and the valuation of stock options. Actual results could differ from those estimates.

Cash, Cash Equivalents and Restricted Cash

Cash and cash equivalents consist of currency on hand with banks and financial institutions and investments in money market funds. The Company considers all short-term, highly liquid investments with an original maturity of three months or less at the date of purchase to be cash equivalents. Restricted cash are funds held in Company bank accounts as collateral for bank issued letters of credit and are not available for operational use. The underlying letters of credit are contractually required by payor contracts and facility lease agreements.

Marketable Debt Securities

The Company's investments in marketable debt securities are classified as available-for-sale and are carried at fair value, with the unrealized gains and losses reported as a component of accumulated other

comprehensive income (loss) in total stockholders' equity (deficit). The Company determines the appropriate classification of these investments at the time of purchase and reevaluates such designation at each balance sheet date. The Company classifies the available-for-sale investments as current assets under the caption marketable debt securities on the consolidated balance sheets as these investments generally consist of highly marketable securities that are identified to be available to meet near-term cash requirements and fund current operations. Realized gains and losses and declines in value related to credit losses are included as a component of other (expense) income in the consolidated statements of operations.

The Company periodically evaluates its investments in marketable debt securities for impairment. When assessing short-term marketable security investments for declines in value, the Company considers such factors as, among other things, how significant the decline in value is as a percentage of the original cost, the Company's ability and intent to retain the short-term marketable security investment for a period of time sufficient to allow for any anticipated recovery in fair value, market conditions in general and whether the decline in value is due to a credit loss. If any adjustment to fair value reflects a decline in the value of the marketable security that the Company considers to be for non-credit related factors, the Company reduces the marketable debt securities through a charge to other comprehensive income. If a decline in value is determined to be related to a credit loss, we record an allowance not greater than the difference between the carrying amount and fair value of the investment. No such adjustments were necessary during the periods presented.

Concentration of Credit Risk and Significant Customers

Financial instruments that potentially subject the Company to concentration of credit risk consist primarily of capitated accounts receivable. The Company's concentration of credit risk is limited by the diversity, geography and number of patients and payers. As of December 31, 2022 and 2021, the Company had payers that individually represented 10% or more of the Company's capitated accounts receivable.

The capitated accounts receivables by payor source consisted of the following as of:

	For the Years Ended	
	December 31, 2022	**December 31, 2021**
Aetna	13%	10%
Anthem	10%	8%
Humana	14%	19%
Medicare	18%	17%
Wellcare / Meridian	16%	19%
United Healthcare	14%	12%
Other	15%	15%

Property and Equipment

The Company records property and equipment ("PPE") at cost and depreciates them using the straight-line method at rates designed to distribute the cost of PPE over estimated service lives ranging from three to fifteen years. Routine maintenance and repairs are expensed as incurred. Expenditures that increase values, change capacities or extend useful lives are capitalized. When assets are sold or retired, the cost and related accumulated depreciation are removed from the accounts, with any resulting gain or loss recorded in corporate, general and administrative expenses in the consolidated statements of operations.

Leasehold improvements	15 years or term of lease
Furniture and fixtures	8 years
Computer equipment	3 - 5 years
Internal use software	5 years
Office equipment	5 - 8 years

Internal Use Software

The Company accounts for costs incurred to develop computer software for internal use in accordance with Accounting Standards Codification ("ASC") 350-40, *Internal-Use Software* ("ASC 350-40"). The Company capitalizes the costs incurred during the application development stage, which generally include personnel and related costs to design the software configuration and interfaces, coding, installation and testing. The Company begins capitalization of qualifying costs when both the preliminary project stage is completed, and management has authorized further funding for the completion of the project. Costs incurred during the preliminary project stage along with post implementation stages of internal-use computer software are expensed as incurred. The Company also capitalizes costs related to specific upgrades and enhancements when it is probable the expenditures will result in additional functionality. Capitalized development costs are classified as property and equipment, net in the consolidated balance sheets and are amortized over the estimated useful life of the software, which is five years.

Impairment of Long-Lived Assets

The Company reviews its long-lived assets for possible impairment in accordance with ASC 360, *Property, Plant, and* Equipment ("ASC 360"), whenever events and circumstances indicate that the carrying value of an asset may not be recoverable. If the sum of the estimated undiscounted cash flows is less than the carrying amount of the assets, an impairment loss is recorded. The impairment loss is measured by comparing the fair value of the assets with their carrying amounts. Fair value is determined based on discounted cash flows or appraised values, as appropriate. There was no impairment of long-lived assets for the years ended December 31, 2022, 2021 and 2020.

Equity method investments

The Company's investments primarily include equity securities that are being accounted for by the equity method of accounting under which the Company's share of net income or loss is recognized as income or loss in the Company's statements of operations and added or deducted to the investment account. Distributions or dividends received from the investments are treated as a reduction of the investment account. The Company consistently follows the practice of recognizing the net income (loss) from equity method investments based on the most recent reliable data.

The carrying value of the Company's investments in securities was $5.4 million and $5.0 million as of December 31, 2022 and 2021, respectively, which is recorded in other long-term assets on the consolidated balance sheets. The Company did not identify any material observable price changes for the years ended December 31, 2022, 2021 and 2020.

Debt

The Company evaluates all conversion, repurchase and redemption features contained in a debt instrument to determine if there are any embedded features that require bifurcation as a derivative. In accounting for the issuance of the 0% Convertible Senior Notes due 2026 issued in March 2021 (the "Convertible Senior Notes"), the Company recorded a long-term debt liability equal to the proceeds received from issuance, including the embedded conversion feature, net of the debt issuance and offering costs on the Company's consolidated balance sheets. The conversion feature is not required to be accounted for separately as an embedded derivative.

In accounting for the Term Loan Facility entered into as of September 30, 2022, the Company recorded a long-term debt liability equal to the proceeds received related to the Company's borrowings, net of debt issuance costs on the Company's consolidated balance sheets. The Company amortizes debt issuance and offering costs over the respective terms of the Convertible Senior Notes and Term Loan Facility as interest expense utilizing the effective interest method on the Company's consolidated statements of operations. For more information on the Convertible Senior Notes and Term Loan Facility, see Note 8, "Long-term Debt."

Capped Call Transactions

In connection with the issuance of the Convertible Senior Notes, the Company entered into capped call transactions. The capped call transactions are expected generally to reduce the potential dilution to the holders of the Company's common stock upon any conversion of the Convertible Senior Notes. The capped call transactions are purchased call options on the issuer's stock that settle by reference to the Company's stock with no forced cash payment. The terms of the capped call transactions allow the purchased call options to be classified as an equity instrument and will not be subsequently remeasured as long as the conditions for equity classification continue to be met. The Company recorded the cash used to purchase the capped call transactions as a reduction to additional paid-in capital within the Company's consolidated statements of changes in redeemable investor units and stockholders' equity/members' (deficit).

Leases

The Company leases offices, operating facilities or centers, vehicles and IT equipment, which are accounted for as operating leases. These leases have remaining lease terms of up to 30 years, inclusive of renewal or termination options that the Company is reasonably certain to exercise. The Company determines if an arrangement is a lease at inception and evaluates the lease classification (i.e., operating lease or financing lease) at that time. Lease arrangements with an initial term of 12 months or less are considered short-term leases and are not recorded on the balance sheet. The Company recognizes lease expense for these leases on a straight-line basis over the term of the lease.

Operating leases are included in operating lease right-of-use assets, current portion (recorded within other current liabilities) and long-term operating lease liabilities on the Company's consolidated balance sheets. Operating lease right-of-use assets represent our right to use an underlying asset for the lease term, and lease liabilities represent our obligation to make lease payments arising from the lease. Operating lease right-of-use assets and liabilities are recognized at the commencement date based on the present value of lease payments over the lease term. The Company has no financing leases.

The Company uses its incremental borrowing rate on the commencement date for determining the present value of lease payments. The Company considers the likelihood of exercising options to extend or terminate the lease when determining the lease term.

The Company has lease agreements with lease and non-lease components. The Company elected the practical expedient to account for the lease and non-lease components as a single lease component for all leases.

Fair Value of Financial Instruments

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The carrying amounts of financial instruments including cash, accounts receivable, accounts payable and accrued liabilities approximate fair value due to the short maturities of such instruments. Our financial assets and liabilities that require recognition and fair value measurement under the accounting guidance generally include our marketable debt securities, contingent consideration and debt (see Note 7).

Income Taxes

Prior to the IPO and related restructuring transactions, the Company was a limited liability company. Accordingly, pursuant to its election under Section 701 of the Internal Revenue Code, each item of income, gain, loss, deduction or credit of the Company was ultimately reportable by its members in their individual tax returns, except in certain states and local jurisdictions where the Company was subject to income taxes. As such, the Company did not record a provision for federal income taxes or for taxes in states and local jurisdictions that did not assess taxes at the entity level. After the IPO and related restructuring transactions, the Company is a C Corporation and each item of income, gain, loss, deduction or credit of the Company is reportable by the

Company. As such, the Company has recorded a provision for federal, state and local income taxes at the entity level in continuing operations for all deferred taxes net of the valuation allowance and activity post IPO.

We account for income taxes under the liability method; under this method, deferred tax assets and liabilities are determined based on differences between financial reporting and tax reporting bases of assets and liabilities and are measured using enacted tax rates and laws that are expected to be in effect when the differences are expected to reverse. Realization of deferred tax assets is dependent upon future earnings, the timing and amount of which are uncertain.

A tax position is recognized as a benefit only if it is more likely than not that the tax position would be sustained in a tax examination, with a tax examination being presumed to occur. The amount recognized is the largest amount of tax benefit that is greater than 50% likely of being realized on examination. For tax positions not meeting the more-likely-than-not test, no tax benefit is recorded. The Company's tax filings are generally subject to examination for a period of three years from the filing date. Management has not identified any material tax position taken that requires income tax reserves to be established. The Company does not expect the total amount of unrecognized tax benefits to significantly change in the next twelve months.

The Company reduces its deferred tax assets by a valuation allowance if it is more likely than not that some portion or all of a deferred tax asset will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences are deductible. In making this determination, the Company considers all available positive and negative evidence affecting specific deferred tax assets, including past and anticipated future performance, the reversal of deferred tax liabilities, the length of carry-back and carry-forward periods and the implementation of tax planning strategies.

Objective positive evidence is necessary to support a conclusion that a valuation allowance is not needed for all or a portion of deferred tax assets when significant negative evidence exists. Cumulative tax losses in recent years are the most compelling form of negative evidence considered by management in this determination. Management determined that based on all available evidence, a full valuation allowance was required for all U.S. state and local deferred tax assets due to losses incurred for the past several years.

Segment Reporting

The Company determined in accordance with ASC 280, *Segment Reporting* ("ASC 280"), that the Company's operations are organized under one operating and reportable segment – Oak Street Health, Inc. The Company's chief operating decision makers ("CODMs") regularly review financial operating results on a consolidated basis for purposes of allocating resources and evaluating financial performance. Our CODM has been identified as, collectively, the Chief Executive Officer, Chief Financial Officer and Chief Operating Officer. Although the Company derives its revenues from several different geographic regions, the Company neither allocates resources based on the operating results from the individual regions nor manages each individual region as a separate business unit. The Company's CODMs manage the operations on a consolidated basis to make decisions about overall corporate resource allocation and to assess overall corporate profitability based on consolidated revenues, net income and adjusted EBITDA. For the periods presented, all of the Company's long-lived assets were located in the United States, and all revenues were earned in the United States. As such, we have identified a single operating segment and reportable segment.

Business Combinations, Goodwill and Other Intangible Assets

The Company accounts for business combinations using the acquisition method of accounting. This method requires that the purchase price, including the fair value of contingent consideration, of the acquisition be allocated to the assets acquired and liabilities assumed using the fair values determined by management as of the acquisition date. Goodwill represents the excess of consideration paid over the fair value of net assets acquired through business acquisitions

The Company performs a qualitative goodwill impairment analysis annually on October 1st or more frequently if triggering events occur or other impairment indicators arise which might impair recoverability. If we determine based on the qualitative analysis that it is more likely than not that the reporting unit has a fair value below its carrying value, we perform a quantitative analysis by comparing the fair value of the reporting unit to the carrying value. If the fair value is below the carrying value, the excess carrying value is recognized as an impairment loss. As of December 31, 2022 and 2021, all goodwill recorded in the consolidated balance sheets is assigned to the Oak Street Health, Inc. reporting unit, which has a negative carrying value as of December 31, 2022. Based on our qualitative analyses performed, there were no goodwill impairment losses recorded during the years ended December 31, 2022, 2021 and 2020.

Identified intangibles are recorded at their acquisition date fair value and are amortized on a straight-line basis over their useful lives. Intangible assets are reviewed for impairment in conjunction with long-lived assets. There were no intangible asset impairments recorded during the years ended December 31, 2022, 2021 and 2020.

Acquisition related transaction costs, such as banking, legal, accounting, and other costs incurred in connection with an acquisition are expensed as incurred in corporate, general and administrative expenses in the consolidated statements of operations. Acquisition related consideration accounted for as compensation expense, such as retention bonuses, incurred in connection with an acquisition are included in corporate, general and administrative expenses in the consolidated statements of operations.

See Note 5, "Business Combinations, Goodwill and Other Intangibles," for additional information.

Medical Claims Expense

Medical claims expense and the liability for unpaid claims include estimates of the Company's obligations for medical care services that have been rendered by third parties on behalf of insured consumers for which the Company is contractually obligated to pay, but for which claims have either not yet been received, processed or paid. The Company develops estimates for medical care services incurred but not reported ("IBNR"), which includes estimates for claims that have not been received or fully processed, using a process that is consistently applied, centrally controlled and automated. This process includes utilizing actuarial models when a sufficient amount of medical claims history is available from the third-party healthcare service providers. The actuarial models consider factors such as time from date of service to claim processing, seasonal variances in medical care consumption, health care professional contract rate changes, medical care utilization and other medical cost trends, membership volume and demographics, the introduction of new technologies and benefit plan changes. In developing its unpaid claims liability estimates, the Company applies different estimation methods depending on which incurred claims are being estimated. We assess our estimates with an independent actuarial expert to ensure our estimates represent the best, most reasonable estimate given the data available to us at the time the estimates are made.

Medical claims expense also includes supplemental external costs of providing medical care such as administrative health plan fees, fees to perform payor delegated activities and provider excess insurance costs. The Company purchases provider excess insurance to protect against significant, catastrophic claims expenses incurred on behalf of its patients. The total amount of provider excess insurance premium was $4.0 million, $4.6 million and $3.6 million, and total reimbursements were $2.8 million, $4.7 million and $3.1 million for the years ended December 31, 2022, 2021 and 2020, respectively. The provider excess insurance premiums less reimbursements are reported in medical claims expense in the consolidated statements of operations. Provider excess recoverables due are reported in other current assets in the consolidated balance sheets. As of December 31, 2022 and 2021, the Company's provider excess insurance deductible was $0.4 million and $0.3 million per member, respectively, and covered up to a maximum of $5.0 million per member per calendar year.

Cost of Care, Excluding Depreciation and Amortization

Cost of care, excluding depreciation and amortization includes the costs we incur to operate our centers and care model, including care team and patient support employee-related costs (including stock-based

compensation), occupancy costs, patient transportation, medical supplies, insurance, fees paid to specialists and other operating costs. These costs exclude any expenses associated with sales and marketing activities incurred at the local level to support our patient growth strategies, and excludes any allocation of our corporate, general and administrative expenses. Care team employees include medical doctors, nurse practitioners, physician assistants, registered nurses, scribes, medical assistants and phlebotomists. Patient support employees include practice managers, welcome coordinators and patient relationship managers.

Sales and Marketing

Sales and marketing expenses consist of employee-related expenses, including salaries, commissions, stock-based compensation and employee benefits costs, for all of our employees engaged in marketing, sales, community outreach and sales support. These employee-related expenses capture all costs for both our field-based and corporate sales and marketing teams. Sales and marketing expenses also includes central and community-based advertising to generate greater awareness, engagement, and retention among our current and prospective patients as well as the infrastructure required to support all our marketing efforts. Advertising and promotion costs are expensed as incurred and were $77.2 million, $54.4 million and $29.3 million, for the years ended December 31, 2022, 2021 and 2020, respectively, and are included in sales and marketing expenses in the consolidated statements of operations.

Corporate, General and Administrative

Corporate, general and administrative expenses include employee-related expenses, including salaries and related costs and stock/unit-based compensation for our executives, technology infrastructure, operations, clinical and quality support, finance, legal, human resources and development departments. In addition, general and administrative expenses include all corporate technology and occupancy costs.

Transaction Costs

The Company incurred costs related to private/public offerings and acquisitions. Total one-time costs expensed were $2.3 million, $5.9 million and $1.1 million for the years ended December 31, 2022, 2021 and 2020, respectively, and are included in corporate, general, and administrative expenses in the consolidated statements of operations.

Retirement Plan

The Company maintains a profit sharing and retirement savings 401(k) plan (the "401(k) Plan") for full-time employees. Participants may elect to contribute to the 401(k) Plan, through payroll deductions, subject to Internal Revenue Service limitations. At its discretion, the Company makes 4% matching and/or profit-sharing contributions to the 401(k) Plan. The Company recorded expense of $10.3 million, $7.1 million, and $4.7 million in salaries and employee benefits in the accompanying consolidated statements of operations for the years ended December 31, 2022, 2021 and 2020, respectively, for discretionary matching and profit-sharing contributions to the 401(k) Plan.

Professional Liability

The physicians employed by the Physician Groups (or PC entities) were insured for professional liability exposure on a claims-made basis with a master insurance policy. The master policy renews in August of each year and newly employed physicians and terminating physicians are added to or removed from the coverage by endorsement, with premiums prorated to the next year's expiration date. The limits of the coverage are $1.0 million each claim and $3.0 million in aggregate. Additional insureds on the policy include the PC entities, the physician employees and OSH MSO.

Stock & Unit-Based Compensation Expense

Post-IPO

Following the IPO, we account for stock-based compensation awards approved by our Board of Directors, including stock options and restricted stock units ("RSUs"), based on their estimated grant date fair value in accordance with ASC 718, *Compensation—Stock Compensation*. We estimate the fair value of our stock options using the Black-Scholes option-pricing model. We estimate the fair value of our RSUs based on the fair value of the underlying common stock.

We recognize the fair value of stock options at the grant date, which vest based on continued service at a rate of 25% each year, over the requisite service period, which is generally four years. Options generally expire ten years from the date of the grant. We recognize the fair value of the RSUs at the grant date on a straight-line basis over the requisite period, which is generally four years. The related compensation expense is recorded straight line over the service period and reflects actual forfeitures as they occur. For stock options and restricted stock units that have both service and performance conditions, the related compensation expense also includes estimates regarding the probability of achieving the performance metrics. Compensation expense related to these awards are recorded over the requisite service period as achievement of the performance objective becomes probable. The Company reassesses the probability of vesting at each reporting period and adjusts compensation expense based on the probability assessment.

Pre-IPO

Prior to the IPO, the Company's unit-based incentive plan rewarded employees with various types of awards, including but not limited to, profits interests on a service-based or performance-based schedule. These awards also contained market conditions. The Company had elected to account for forfeitures as they occur. The Company used a combination of the income and market approaches to estimate the fair value of each award as of the grant date.

For performance-vesting units pre-IPO, the Company recognized unit-based compensation expense when it was probable that the performance condition would be achieved. The Company analyzed if a performance condition was probable for each reporting period through the settlement date for awards subject to performance vesting. For service-vesting units, the Company recognized unit-based compensation expense over the requisite service period for each separately vesting portion of the profits interest as if the award was, in-substance, multiple awards.

Net Loss Per Share

Prior to the IPO, the OSH LLC membership structure included pre-IPO units, some of which were investor units and profits interests. As part of the IPO and related restructuring transactions, all existing unitholders exchanged their membership interests in the limited liability company for common stock of Oak Street Health, Inc (see further discussion of the conversion in Notes 11 & 12).

The Company analyzed the calculation of earnings per unit for periods prior to the IPO and determined that it resulted in values that would not be meaningful to the users of these consolidated financial statements. Therefore, the basic and diluted earnings per share for the year ended December 31, 2020 is applicable only for the period from August 10, 2020 to December 31, 2020, which is the period following the IPO and presents the period that the Company had outstanding common stock.

Basic net loss per share attributable to common shareholders is calculated by dividing the net loss by the weighted-average number of common shares outstanding during the period, without consideration for common share equivalents. Diluted net loss per share attributable to common shareholders is computed by dividing the diluted net loss attributable to common shareholders by the weighted-average number of shares of common shares

outstanding for the period, including potential dilutive common shares assuming the dilutive effect of common shares equivalents.

In periods in which the Company reports a net loss attributable to common shareholders, the diluted net loss per share attributable to common stockholders is computed by giving effect to all potential dilutive common stock equivalents outstanding for the period determined using the treasury stock method or the if-converted method, as appropriate. For purposes of this calculation, stock options, restricted stock units, restricted stock awards and contingently issuable shares under our Convertible Senior Notes are considered common stock equivalents but have been excluded from the calculation of diluted net loss per share attributable to common stockholders as their effect is anti-dilutive.

Correction of immaterial error in previously issued financial statements

The Company has arrangements with Humana, that include a license fee payable by the Company to Humana for the Company's provision of health care services in certain centers owned or leased by Humana. The license fee is a reimbursement to Humana for its costs of owning or leasing and maintaining the centers, including rental payments, center maintenance or repair expenses, equipment expenses, special assessments, cost of upgrades, taxes, leasehold improvements and other expenses identified by Humana. During the second quarter of 2022, the Company reassessed the nature of its license fee arrangements and determined that the reimbursement for leasehold improvements included in the license fee payments should be included as a lease component and accounted for under ASC 842, *Leases* ("ASC 842"). As previously disclosed in the Company's 2021 Form 10-K, the Company adopted ASC 842 effective January 1, 2021 under the modified retrospective transition method.

The Company considered the guidance in Accounting Standards Codification 250, *Accounting Changes and Error Corrections* as well as the guidance in SEC Staff Bulletin 99, *Materiality* and concluded that the error was immaterial to the Company's previously issued interim and annual consolidated financial statements. The Company has corrected the cumulative impact of the error. The table below summarizes the prior period impact recorded to the consolidated balance sheet as of December 31, 2022:

	Adjustments
Operating lease right-of-use assets	95.8
Total assets	$ **95.8**
Other liabilities	1.5
Total current liabilities	$ **(1.5)**
Other long-term liabilities	(15.4)
Long-Term operating lease liabilities	110.5
Total liabilities	$ **93.6**

We recorded a decrease to cost of care, excluding depreciation and amortization, within the consolidated statements of operations of $2.2 million and impact of $0.01 to our net loss per share-basic and diluted for the year ended December 31, 2022. There was no impact to the consolidated statement of cash flows or the consolidated statements of equity/(deficit).

Recently Adopted Accounting Pronouncements

In October 2021, the FASB issued Accounting Standard Update ("ASU") 2021-08, *Business Combinations (Topic 805): Accounting for Contract Assets and Contract Liabilities from Contracts with Customers*. The new guidance requires contract assets and liabilities acquired in a business combination to be recognized and measured by the acquirer on the acquisition date in accordance with ASC 606, *Revenue from Contracts with Customers*, as if it had originated the contracts. Under the current business combinations guidance, such assets and liabilities are recognized by the acquirer at fair value on the acquisition date. The new standard is effective for fiscal years beginning after December 15, 2022. Early adoption is permitted. The standard will not

impact acquired contract assets or liabilities from business combinations occurring prior to the effective date of adoption. We elected to adopt this guidance early effective as of the year ended December 31, 2022 in connection with the Company's acquisition of substantially all of the assets of CHW Cares Inc. ("CHW"), which was completed in the year ended 2022. The guidance was not applicable to the CHW acquisition as contract assets and liabilities were not acquired, and as such, the adoption did not have a material effect on our consolidated financial statements or notes to the consolidated financial statements. For more information about the CHW acquisition, see Note 5, "Business Combinations, Goodwill and Intangible Assets."

In November 2021, the FASB issued ASU 2021-10, *Government Assistance (Topic 832): Disclosures by Business Entities about Government Assistance*. This update requires annual disclosures about transactions with a government that are accounted for by applying a grant or contribution accounting model by analogy. This standard is effective for fiscal years beginning after December 15, 2021 and should be applied prospectively or retrospectively. We have adopted ASU 2021-10 as of January 1, 2022 using the prospective method. This adoption did not have a material impact on our consolidated financial statements or notes to the consolidated financial statements.

Recent Accounting Pronouncements Not Yet Adopted

In June 2022, the FASB issued ASU 2022-03, *Fair Value Measurement (Topic 820) of Equity Securities Subject to Contractual Sale Restrictions*. The new guidance clarifies that a contractual restriction on the sale of an equity security is not considered part of the unit of account of the equity security and, therefore, is not considered in measuring fair value. The amendments also clarify that an entity cannot, as a separate unit of account, recognize and measure a contractual sale restriction. The guidance is required to be adopted by public companies by January 1, 2024. The guidance is to be applied prospectively with adjustments resulting from the initial adoption recognized in earnings and disclosed. We do not anticipate this standard update will have a material impact on our consolidated financial statements or notes to the consolidated financial statements.

NOTE 3. REVENUE RECOGNITION

The Company earns revenue from our capitated arrangements and other revenue arrangements. Other revenue is comprised of care coordination and management arrangements, subscription license arrangements, fee for services and other arrangements. We disaggregate revenue from contracts with customers by service type within our consolidated statements of operations.

Capitated Revenue and Accounts Receivable

Capitated revenue consists primarily of capitated fees for medical services provided by us under capitated arrangements directly made with various Medicare Advantage managed care payors or the Centers for Medicare and Medicaid Services ("CMS"). The Company receives a fixed fee per patient under what is typically known as a "risk contract." Risk contracting, or full risk capitation, refers to a model in which the Company receives from the third-party payor a fixed payment per patient per month ("PPPM" payment) for a defined patient population, and the Company is then responsible for providing healthcare services required by that patient population. The Company is responsible for incurring or paying for the cost of healthcare services required by that patient population in addition to those provided by the Company. Fees are recorded gross in revenues because the Company is acting as a principal in arranging, providing and controlling the managed healthcare services provided to the eligible enrolled members. Neither the Company nor any of its affiliates is a registered insurance company because state law in the states in which it operates does not require such registration for risk-bearing providers.

The Company's payor contracts generally have a term of one year or longer, but the contracts between the enrolled members (our customers) and the payor are one calendar year or less. In general, the Company considers all contracts with customers (enrolled members) as a single performance obligation to stand ready to provide healthcare services. The Company identified that contracts with customers for capitation arrangements

have similar performance obligations and therefore groups them into one portfolio. This performance obligation is satisfied over time as the Company stands ready to fulfill its obligation to enrolled members.

Our revenues are based upon the estimated PPPM amounts we expect to be entitled to receive from Medicare Advantage managed care payors and CMS. Under our managed care contracts, the PPPM rates are determined as a percent of the premium the Medicare Advantage plan receives from CMS for our at-risk members. Those premiums are determined via a competitive bidding process with CMS and are based upon the cost of care in a local market and the average utilization of services by the patients enrolled. Under our contract with CMS, the PPPM rates are determined as a percentage of the premium, also adjusted for the cost of care in a local market and the average utilization of services, for our at-risk members.

CMS pays capitation using a "risk adjustment model," which compensates providers based on the health status (acuity) of each individual patient. Payors with higher acuity patients receive more, and those with lower acuity patients receive less. Under the risk adjustment model, capitation is paid on an interim basis based on enrollee data submitted for the preceding year and is adjusted in subsequent periods after the final data is compiled. As premiums are adjusted via this risk adjustment model, our PPPM payments will change in unison with how our payor partners' premiums change with CMS. The Company determined the transaction price for these contracts is variable as it primarily includes PPPM fees which can fluctuate throughout the contract based on the acuity of each individual enrollee. Our capitated accounts receivable balances are carried at amounts the Company deems collectible. Accordingly, an allowance is provided based on credit losses expected over the contractual term. Accounts receivable are written off when they are deemed uncollectible. As of December 31, 2022 and December 31, 2021, no allowances were deemed necessary. The ultimate collectability of accounts receivable may differ from amounts estimated.

For the years ended December 31, 2022 and 2021, respectively, we estimate that we will receive an additional $67.1 million and $54.0 million for acuity-related adjustments in subsequent periods. In certain contracts, PPPM fees also include adjustments for items such as performance incentives or penalties based on the achievement of certain clinical quality metrics as contracted with payors. There were no material PPPM adjustments related to performance incentives or penalties for quality-related metrics for the years ended December 31, 2022, 2021, and 2020.

The capitated revenues are recognized based on the estimated PPPM transaction price to transfer the service for a distinct increment of the series (i.e. month) and is recognized net of projected acuity adjustments and performance incentives/penalties because the Company is able to reasonably estimate the ultimate PPPM payment of these contracts. We recognize revenue in the month in which eligible members are entitled to receive healthcare benefits during the contract term. Subsequent changes in PPPM fees and the amount of revenue to be recognized by the Company are reflected through subsequent period adjustments to properly recognize the ultimate capitation amount. As the period between the time of service and time of payment is typically one year or less, the Company elected the practical expedient under ASC 606-10-32-18 and did not adjust for the effects of a significant financing component.

Certain third-party payor contracts include a Medicare Part D payment related to pharmacy claims, which is subject to risk sharing through accepted risk corridor provisions. Under certain agreements the fund risk allocation is established where the Company, as the contracted provider, receives only a portion of the risk and the associated surplus or deficit. The Company estimates and recognizes an adjustment to Part D capitated revenues related to these risk corridor provisions, based upon pharmacy claims experience to date, as if the annual risk contract were to terminate at the end of the reporting period. Medicare Part D comprised 2%, 2% and 2% of capitated revenues for the years ended December 31, 2022, 2021 and 2020, respectively. Medicare Part D comprised 3%, 2% and 3% of medical claims expense for the years ended December 31, 2022, 2021 and 2020, respectively.

The Company had agreements in place with the payors listed below, and payor sources of capitated revenue for each period were as follows:

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Humana	32%	36%	45%
Wellcare / Meridian	17%	17%	15%
Cigna-HealthSpring	6%	9%	11%
Other	45%	38%	29%

Other Revenue, Accounts Receivable and Contract Liabilities

Other revenue is comprised of ancillary fees earned under contracts with certain managed care organizations for the provision of certain care coordination service and management services, fee-for-service revenue, license subscriptions and fees and CARES Act grant income. The composition of other revenue for each period was as follows ($ in millions):

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Care coordination and care management services	$ 12.2	$ 24.7	$ 24.3
License subscription and other fees	9.7	1.9	—
CARES Act grant income	—	—	2.2
Fee for service	13.1	9.0	5.0
Total other revenue	$ 35.0	$ 35.6	$ 31.5

The Company has entered into multi-year agreements with Humana and its affiliates to provide services at certain centers to members covered by Humana. The agreements contain an administrative payment from Humana in exchange for the Company providing certain care coordination services during the term of the contract ("Care Coordination payment"). The Care Coordination payments are recognized in other revenue ratably over the length of the terms stated in the contracts and are refundable to Humana on a pro-rata basis if the Company ceases to provide services at the centers within the length of the term specified in the contracts. We have identified a single performance obligation to stand ready to provide care coordination services to our patients, which constitutes a series of distinct service increments. As of December 31, 2022 and 2021, the Company's contract liabilities related to these payments totaled $37.6 million and $33.9 million, respectively. The short-term portion is recorded in other liabilities and the long-term portion is included in other long-term liabilities in the consolidated balance sheets.

Care management services are provided to enrolled members of certain contracted managed care organizations regardless of whether those members are Oak Street Health patients. Similar to the other care management services provided to the Company's centers, the Company provides delegated services and other administrative services to plans in order to assist with the management of its Medicare population, therefore, we have identified a single performance obligation to stand ready to provide care management services, which constitutes a series of distinct service increments.

Also included in the year ended December 31, 2021 care coordination and care management total above are revenues recognized related to the Accountable Care Organization ("ACO") Medicare Shared Savings Program ("Shared Savings Program"). The Shared Savings Program offers providers an opportunity to create an ACO. An ACO agrees to be held accountable for the quality, cost and experience of care of an assigned Medicare fee-for-service beneficiary population. Within the Shared Savings Program, CMS enters into agreements with ACOs. ACOs may share savings with CMS when they lower growth in Medicare Parts A and B fee-for-service expenditures relative to their unique targets (i.e., benchmarks) while meeting quality of care performance standards, or in certain instances, owe losses to CMS when they have higher growth in Medicare Parts A and B fee-for-service expenditures relative to their benchmark. The Company received $4.9 million from CMS related to the Shared Savings Program for the year ended December 31, 2021.

The Company acquired RubiconMD Holdings, Inc. ("RMD") on October 20, 2021 (see Note 5). RMD is a healthcare technology firm specializing in an online eConsult platform which enables primary care providers to easily access same-day insights from top specialists in order to provide better care for the patients. RMD

primarily generates revenue through subscription licenses for its customers to access its eConsult platform. We have identified the performance obligation to be standing ready to provide access to our customers to the eConsult platform. Subscription license revenue is recognized when the performance obligation is met over time by either the straight-line method or when services are performed over the terms of the applicable contract. Other receivables include amounts due to us from our customers to utilize the e-Consult platform. The receivable balances are carried at amounts the Company deems collectible. Accordingly, an allowance is provided based on credit losses expected. Accounts receivable are written off when they are deemed uncollectible. As of December 31, 2022 and 2021, the Company has recorded immaterial allowances.

Fee-for-service revenue is primarily derived from healthcare services rendered to patients. The services provided by the Company have no fixed duration and can be terminated by the patient or the Company at any time, therefore each treatment is its own standalone contract. Services ordered by a healthcare provider during an office visit are not separately identifiable, and therefore have been combined into a single performance obligation for each contract. The Company recognizes revenue as its performance obligation is completed on the date of service. Fee-for-service revenue is recognized in the period in which services are provided at estimated net realizable amounts from patients, third-party payors and others. Other receivables include amounts due to us from Medicare plans for fee-for-service patients. The receivable balances are carried at amounts the Company deems collectible. Accordingly, an allowance is provided based on credit losses expected. Accounts receivable are written off when they are deemed uncollectible. As of December 31, 2022 and 2021, the Company has recorded immaterial allowances.

Remaining Performance Obligations

As our material performance obligations relate to contracts with a duration of one year or less, the Company elected the optional exemption in ASC 606-10-50-14(a). Therefore, the Company is not required to disclose the transaction price for the remaining performance obligations at the end of the reporting period or when the Company expects to recognize revenue. The Company had no material unsatisfied performance obligations at the end of the reporting periods as our patients typically are under no obligation to continue receiving services at our facilities.

NOTE 4. PROPERTY AND EQUIPMENT

Property and equipment consisted of the following as of ($ in millions):

	December 31, 2022	December 31, 2021
Leasehold improvements	$ 136.7	$ 88.1
Furniture and fixtures	9.3	5.7
Computer equipment	65.3	49.3
Internal use software	32.7	14.9
Office equipment	16.2	12.7
Construction in process	22.0	18.6
Total, at cost	282.2	189.3
Less accumulated depreciation	(78.1)	(44.5)
Property and equipment, net	$ 204.1	$ 144.8

The Company recorded depreciation expense of $33.5 million, $17.0 million and $10.8 million for the years ended December 31, 2022, 2021 and 2020, respectively. Included within depreciation expense, the Company recorded $4.0 million, $1.6 million and $0.4 million of internal use software costs for the years ended December 31, 2022, 2021 and 2020, respectively.

NOTE 5. BUSINESS COMBINATIONS, GOODWILL AND OTHER INTANGIBLE ASSETS

Acquisition of RubiconMD Holdings, Inc. ("Rubicon" or "RMD")

On October 20, 2021, the Company acquired RubiconMD Holdings, Inc (RMD). RMD is a leading technology platform providing access to specialist expertise. The deal enables Oak Street Health to integrate virtual specialty care into our existing care model, which we expect to significantly streamline the referral process and better manage costs, enhance patient experience and provide comprehensive care far beyond traditional primary care.

The purchase price for the RMD acquisition consisted of (i) $134.7 million in cash after a final working capital adjustment of $0.2 million and (ii) $21.7 million fair value for contingent consideration (related to the $60.0 million maximum earn-out that the Company was obligated to pay during the fiscal year 2022 or 2023 should the acquired company achieve certain internal volumes in the year(s) following the acquisition). The Company estimated the fair value of the earn-out on the acquisition date and recorded a contingent consideration liability measured at the present value of the probability weighted consideration expected to be transferred. As of December 31, 2021, the Company recorded $9.3 million of the contingent consideration within other liabilities and $12.4 million within other long term liabilities on the consolidated balance sheets. The purchase price was allocated to $12.7 million of cash, $1.8 million of other assets, $8.6 million of identified intangible assets, $8.1 million of liabilities assumed with the remainder of the purchase price being recorded to goodwill of $141.6 million, after the PPA adjustment. The goodwill relating to this acquisition is primarily attributable to synergies related to medical costs and assembled workforce and is non-deductible for tax purposes. As of December 31, 2022, the purchase price allocation is considered final.

During the year ended December 31, 2022, RMD achieved the certain internal volumes required to earn the maximum earn-out consideration of $60.0 million, and the change in fair value of the contingent consideration liability was recorded in other income (expense) on the consolidated statement of operations. For the year ended December 31, 2022, the Company recorded $38.3 million within our other expenses as a result of RMD achieving the maximum earn-out consideration. For the total earn-out earned, the Company paid out $27.5 million in cash and issued $32.5 million of Oak Street Health common stock during the year ended December 31, 2022. Of the total cash paid of $27.5 million, $21.7 million had been recorded as a liability at the date of acquisition and presented as cash used in financing activities in the consolidated statement of cash flows for the year ended December 31, 2022 with remaining amount reflected as cash used in operating activities.

Acquisition of medical practices

On September 23, 2022, OSH acquired substantially all of the assets of *CHW Cares Inc.* ("*CHW*") for a total purchase price of $6.2 million, including contingent consideration with an estimated fair value of $0.2 million. The estimated fair value of the contingent consideration is recorded within other long-term liabilities. The maximum potential earn-out is $5.5 million dependent on internal metrics. As part of the CHW acquisition, the Company recorded $5.3 million of goodwill and is deductible for tax purposes. As of December 31, 2022, the purchase price allocation is considered final.

The Company additionally acquired two medical practices during the year ended December 31, 2021 for total consideration of $2.9 million.

Goodwill & Other Intangibles

The following table details the annual movements in goodwill:

	(in millions)
Balance as of December 31, 2020	$ 9.6
Acquisitions and acquisition adjustments	143.3
Balance as of December 31, 2021	$ 152.9
Acquisitions and acquisition adjustments	5.1
Balance as of December 31, 2022	$ 158.0

Intangible assets with a finite useful life continue to be amortized over their useful lives. Gross intangible assets amounted to $12.5 million and $12.5 million at December 31, 2022 and 2021, respectively. Accumulated amortization related to intangible assets amount to $3.4 million and $1.7 million at December 31, 2022 and 2021, respectively. The Company recorded amortization expense of $1.7 million and $0.8 million for the years ended December 31, 2022 and 2021, respectively.

The remaining weighted average amortization period of finite-lived identifiable intangible assets is 5.5 years. The remaining estimated future amortization expense by year, as of December 31, 2022, is presented in the following table:

	(in millions)
2023	$ 1.7
2024	1.7
2025	1.7
2026	1.7
2027	1.7
Thereafter	0.6
Estimated aggregate future intangible asset amortization	$ 9.1

NOTE 6. LIABILITY FOR UNPAID CLAIMS

The Company's liabilities for unpaid claims were as follows ($ in millions):

	December 31, 2022	December 31, 2021
Balance, beginning of period	$ 556.3	$ 262.1
Incurred health care costs:		
Current year	1,645.1	1,098.9
Prior years	(2.9)	8.6
Total claims incurred	$ 1,642.2	$ 1,107.5
Claims paid:		
Current year	(827.5)	(552.5)
Prior years	(521.6)	(263.4)
Total claims paid	$ (1,349.1)	$ (815.9)
Adjustments to other claims-related liabilities	0.9	2.6
Balance, end of period	$ 850.3	$ 556.3

We assess the profitability of our managed care capitation arrangement to identify contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future revenues, a premium deficiency reserve is recognized. No material premium deficiency reserves were recorded for the years ended December 31, 2022, 2021 and 2020.

The following tables provide information about incurred and paid claims development as of December 31, 2022 ($ in millions):

	Incurred Claims For the Years Ended			
Claim Incurred Year	December 31, 2019	December 31, 2020	December 31, 2021	December 31, 2022
2019	$ 383.2	$ 394.9	$ 394.6	$ 394.5
2020		604.9	613.7	616.6
2021			1,098.9	1,093.2
2022				1,645.1
Total				$ 3,749.4

	Cumulative Paid Claims For the Years Ended			
Claim Incurred Year	December 31, 2019	December 31, 2020	December 31, 2021	December 31, 2022
2019	$ 226.6	383.2	394.6	394.5
2020		356.5	608.5	614.9
2021			552.5	1,067.8
2022				827.5
Total				$ 2,904.7
Other claims-related liabilities				5.6
Liability for unpaid claims				$ 850.3

NOTE 7. FAIR VALUE MEASUREMENTS AND INVESTMENTS

Fair Value Measurements

In determining the fair value of financial assets and liabilities, the Company utilizes market data or other assumptions that it believes market participants would use in pricing the asset or liability in the principal or most advantageous market and adjusts for non-performance and/or other risks associated with the Company as well as counterparties, as appropriate. Assets and liabilities measured at fair value are classified using the following hierarchy, which is based upon the transparency of inputs to the valuation as of the measurement date:

Level 1 – Valuations based on unadjusted quoted prices which are available in active markets for identical assets or liabilities accessible at the measurement date.

Level 2 – Valuations with inputs other than quoted prices included in Level 1 inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.

Level 3 – Valuations with unobservable inputs for the asset or liability used to measure fair value to the extent that observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date.

The following tables present information about the Company's financial assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Fair Value Measurements as of December 31, 2022 using:			Fair Value Measurements as of December 31, 2021 using:		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Marketable debt securities:						
Commercial paper	$ 88.4	$ —	$ —	$ 120.8	$ —	$ —
U.S. Treasury obligations	—	4.9	—	—	26.0	—
Corporate bonds	—	158.1	—	—	412.3	—
Asst-backed securities	—	14.3	—	—	99.2	—

	Fair Value Measurements as of December 31, 2022 using:			Fair Value Measurements as of December 31, 2021 using:		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Other	—	22.0	—	—	12.8	—
Total financial assets	$ 88.4	$ 199.3	$ —	$ 120.8	$ 550.3	$ —
Liabilities:						
Contingent consideration [1]	—	—	0.2	—	—	21.7
Total liabilities	$ —	$ —	$ 0.2	$ —	$ —	$ 21.7

[1] During the quarter-ended June 30, 2022, RMD achieved both earn-out hurdles. As such, the Company no longer measured the fair value of the contingent consideration and instead recorded the maximum earn-out as an amount payable to RMD as of June 30, 2022. See Footnote 5 for further detail.

The Company measures the fair value of its corporate bonds, U.S. treasury obligations and asset-backed securities by taking into consideration valuations obtained from third-party pricing services. The pricing services utilize industry standard valuation models, including both income and market-based approaches, for which all significant inputs are observable, either directly or indirectly, to estimate fair value.

The fair value of the Company's Convertible Senior Notes was $702.0 million and $752.7 million as of December 31, 2022 and 2021, respectively, and classified within Level 2 of the fair value hierarchy as the valuation inputs are based on quoted prices in an inactive market on the last day in the reporting period. The carrying value of the Convertible Senior Notes was $905.8 million and $901.4 million as of December 31, 2022 and 2021, respectively, which is net of unamortized debt issuance and offering costs.

As of December 31, 2022, the carrying value of the Company's Term Loan is $72.8 million, net of debt issuance costs, which approximates fair value as the variable interest rate re-prices frequently. The fair value of the Term Loan is classified within Level 2 of the fair value hierarchy. For more information about the Term Loan, see Note 8, "Long-Term Debt."

During the years ended December 31, 2022 and 2021, there were no transfers between Levels 1, 2 and 3.

Investments

On December 31, 2022 and 2021, the Company's marketable debt securities classified as available-for-sale were as follows ($ in millions):

	December 31, 2022			December 31, 2021		
	Amortized cost	Gross unrealized gains (losses)	Fair value	Amortized cost	Gross unrealized gains (losses)	Fair value
Marketable debt						
Commercial paper	$ 88.5	$ (0.1)	$ 88.4	$ 120.9	$ (0.1)	$ 120.8
U.S. Treasury obligations	4.9	0.0	4.9	26.0	—	26.0
Corporate bonds	160.0	(1.9)	158.1	413.4	(1.1)	412.3
Asset-backed securities	14.4	(0.1)	14.3	99.4	(0.2)	99.2
Other	22.1	(0.1)	22.0	12.8	—	12.8
Total marketable debt securities	$ 289.9	$ (2.2)	$ 287.7	$ 672.5	$ (1.4)	$ 671.1

These investments in marketable debt securities carry maturity dates between less than one year and five years from date of purchase. The net realized gains and losses were immaterial during the years ended December 31, 2022 and 2021. We do not intend to sell these investments, and it is not more likely than not that we will be required to sell the investments before recovery of their amortized cost basis. We did not record an allowance for credit losses as of December 31, 2022 and 2021 as no losses were determined to be caused by credit losses.

NOTE 8. LONG-TERM DEBT

The following table is a summary of the Company's borrowings as of December 31, 2022 and 2021 ($ in millions):

	December 31, 2022	December 31, 2021
Liability component:		
Convertible Notes Principal	$ 920.0	$ 920.0
Term Loan Principal	75.0	—
Total Principal	995.0	920.0
Less: Convertible Notes debt issuance costs, net of amortization	$ (14.2)	$ (18.6)
Less: Term Loan debt issuance costs, net of amortization	$ (2.2)	$ —
Total debt issuance costs, net of amortization	$ (16.4)	$ (18.6)
Net carrying amount	$ 978.6	$ 901.4
Equity component recorded at issuance:		
Capped call transactions	$ 123.6	$ 123.6

Term Loan

On September 30, 2022, the Company and certain of its subsidiaries entered into the Loan Agreement with Hercules Capital, Inc., as administrative and collateral agent and a lender, Silicon Valley Bank and other lenders from time to time party thereto. The Loan Agreement provides the Company with a Term Loan Facility of up to $300.0 million to be funded in five committed tranches available to be drawn at the Company's option during the specified time period. Under Tranche A (available from September 30, 2022 ("Closing") until March 31, 2023), the Company was required to draw down $75.0 million upon Closing and may draw up to an additional $25.0 million. Under Tranche B (available from Closing until December 15, 2023), the Company may borrow up to $50.0 million in $25.0 million increments. Under Tranche C (available from January 1, 2024 until June 30, 2024), the Company may borrow up to $50.0 million in $25.0 million increments. Under Tranche D (available from the earlier of (a) the date on which Tranche C is fully drawn, (b) July 1, 2024 and (c) subject to the approval by the lenders' investment committee(s) in their sole and unfettered discretion, any date prior thereto until December 15, 2024), the Company may borrow up to $75.0 million in $25.0 million increments. Under Tranche E (available from Closing until June 1, 2025), the Company may borrow up to $25.0 million subject to the approval of the individual lenders' investment committee(s) in their sole and unfettered discretion. If the Company does not elect to draw the entire principal amount available under the Tranche B, C or D during the applicable drawdown period, then any such undrawn portion will be added to the aggregate principal amount available under Tranche E. The obligations under the Term Loan Facility are secured by a first priority perfected security interest in substantially all of the assets of the Company, subject to certain limitations and exceptions. The Term Loan Facility is scheduled to mature on October 1, 2027, subject to a springing maturity date of September 1, 2025 if, prior to June 1, 2025, the Company's Convertible Senior Notes have not been (i) converted into equity interests of the Company, (ii) amended such that the scheduled maturity date of the Convertible Senior Notes is at least 180 days after the initial maturity date of the tranches of the Term Loans then in effect, or (iii) fully redeemed and extinguished.

The Term Loan interest rate will float and adjust as the prime rate changes from time to time. The Term Loan cash interest rate is equal to the greater of either 7.95%% or the prime rate plus 2.45%%. In addition, the principal balance of the Term Loans will bear "payment-in-kind" interest at the rate of 1.00% ("PIK Interest"), which PIK Interest will be added to the outstanding principal balance of the Term Loans and increase the outstanding principal balance of the Term Loans on each payment date. In addition, an end-of-term charge equal to 4.95% of the aggregate original principal amount of the Term Loans, due on the earlier of the maturity date of the Term Loans or the repayment of the Term Loans, is payable by the Company. Interest payments on the loan are due on the first day of each month.

Borrowings under the Term Loan Facility may be voluntarily prepaid in minimum increments of $25.0 million, subject to a prepayment fee equal to (i) 2.00% of the amount prepaid, if the prepayment occurs during the first year following the closing, (ii) 1.00% of the amount prepaid, if the prepayment occurs during the second year following the closing, and (iii) 0.50% of the amount prepaid, if the prepayment occurs during the third year following the closing. There is no prepayment fee, penalty or premium applicable to voluntary prepayments made by the Company on or after the fourth year following the closing.

Beginning on the earlier of (i) the reporting deadline of the Company's fourth quarter 2023 financial statements under the Loan Agreement and (ii) the date at which more than $100.0 million in aggregate principal (excluding any paid-in-kind interest) is outstanding under the Term Loan Facility, the Company is required to maintain a specified trailing twelve-month platform contribution (as defined in the Loan Agreement), with the applicable platform contribution increasing over time and as the Company's borrowings under the Term Loan Facility increase. On December 31, 2022, the financial covenant was not yet in effect.

Convertible Senior Notes

On March 16, 2021, the Company issued, at par value, $920.0 million aggregate principal amount of 0% Convertible Senior Notes in a private offering exempt from registration under the Securities Act of 1933, including $120.0 million in aggregate principal amount pursuant to the option we granted to the initial purchasers to purchase additional convertible senior notes, which was exercised in full in March 2021 (collectively, the "Convertible Senior Notes"). Total proceeds received by the Company from the sale of the Convertible Senior Notes, net of debt issuance and offering costs of $22.1 million, were $897.9 million. The Company used $123.6 million of the net proceeds to pay for the cost of the capped call transactions (see discussion on capped call transactions further below).

The Convertible Senior Notes are governed by an indenture ("Indenture"), dated as of March 16, 2021, between the Company and U.S. Bank National Association, as trustee. Under the Indenture, the Convertible Senior Notes are general senior, unsecured obligations of the Company and will mature on March 15, 2026, unless earlier redeemed, repurchased or converted. The Convertible Senior Notes are equal in right of payment with the Company's future senior, unsecured indebtedness and structurally subordinated to all indebtedness and liabilities of the Company's subsidiaries.

The Convertible Senior Notes are convertible, subject to certain conditions described below, into shares of our common stock at an initial conversion rate of 12.6328 shares per $1,000 principal amount of the Convertible Senior Notes, which represents an initial conversion price of approximately $79.16 per share, subject to adjustments upon occurrence of certain events set forth in the Indenture. Upon conversion, we will pay or deliver, cash, shares of our common stock or a combination thereof at our election. The maximum number of shares issuable should there be an increase in the conversion rate is 16,561,656 shares of the Company's common stock.

The Convertible Senior Notes are convertible at the option of the holders at any time prior to the close of business on the business day immediately preceding December 15, 2025, only under the following circumstances:

- during any calendar quarter ending after September 30, 2021, if our closing stock price is greater than or equal to 130% of the conversion price on each of at least 20 trading days (whether or not consecutive) of the last 30 consecutive trading days of the immediately preceding calendar quarter;

- during the five business day period after any 10 consecutive trading day period in which the trading price (as defined in the Indenture) is less than 98% of the product of the closing price of our common stock and the conversion rate for the Notes on each such trading day;

- if the Company calls such Notes for redemption, at any time prior to the close of business on the scheduled trading day immediately preceding the redemption date, but only with respect to the Notes called (or deemed called) for redemption; and

- upon the occurrence of specified corporate events as set forth in the Indenture.

On or after December 15, 2025 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders of the Convertible Senior Notes may convert all or any portion of their Convertible Senior Notes at any time, regardless of the circumstances applicable to conversions prior to December 15, 2025.

We may not redeem the Convertible Senior Notes prior to March 20, 2024. On or after March 20, 2024, the Convertible Senior Notes are redeemable for cash, in whole or in part (subject to minimum redemption amounts), at our option at any time, and from time to time, if the last reported sale price of the common stock has been at least 130% of the conversion price for the Notes then in effect for at least 20 trading days (whether or not consecutive) during any 30 consecutive trading day period (including the last trading day of such period) ending on, and including, the trading day immediately preceding the date on which the Company provides notice of redemption at a redemption price equal to 100% of the principal amount of the Convertible Senior Notes to be redeemed, plus accrued and unpaid special interest, if any, to, but excluding, the redemption date. If the Company redeems less than all the outstanding Convertible Senior Notes, at least $150 million aggregate principal amount of Convertible Senior Notes must be outstanding and not subject to redemption as of the date of the relevant notice of redemption. No sinking fund is provided for the Convertible Senior Notes.

Capped Call Transactions

In connection with the pricing of the Convertible Senior Notes, the Company entered into convertible note hedge transactions (the "capped call transactions") with six initial purchasers or their respective affiliates and other financial institutions (the "option counterparties") of $123.6 million concurrent to mitigate the impact of potential economic dilution to our common stock upon conversion of the Convertible Senior Notes and have an initial strike price of approximately $79.16 per share, which corresponds to the initial conversion price of the Convertible Senior Notes. The capped call transactions cover, subject to customary adjustments, the number of shares of common stock initially underlying the Convertible Senior Notes. The capped call transactions are expected to offset the potential dilution to the Company's common stock upon any conversion of Convertible Senior Notes, with such reduction and/or offset subject to a cap initially equal to $138.8750 per share.

The capped call transactions will expire on March 12, 2026. The capped call transactions are separate transactions and are not part of the terms of the Convertible Senior Notes.

The capped call transactions cover, subject to anti-dilution adjustments, approximately 11,622,176 shares of the Company's common stock, par value $0.001. The capped call transactions are subject to either adjustment or termination upon the occurrence of specified extraordinary and disruption events affecting the Company.

The Company recognized $4.4 million and $3.5 million related to the amortization of debt issuance and offering costs in interest expense, net on the consolidated statements of operations related to the Convertible Senior Notes for the years ended December 31, 2022 and 2021. The effective interest rate was 0.49% for the years ended December 31, 2022 and 2021.

NOTE 9. COMMITMENTS AND CONTINGENCIES

Contingencies

The Company is presently, and from time to time, subject to various claims, investigations, suits and other legal proceedings arising in the ordinary course of business. The Company currently believes that the

outcomes of such proceedings, individually and in the aggregate, will not have a material adverse impact on its business, cash flows, financial position or results of operations. Any legal proceedings are subject to inherent uncertainties, and the Company's view of these matters and its potential effects may change in the future.

Uncertainties

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statues and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with imposition of significant fines and penalties, as well as significant repayments for patient services billed.

On November 1, 2021, the Company received a civil investigative demand ("CID") from the United States Department of Justice. According to the CID, the Department of Justice is investigating whether the Company may have violated the False Claims Act, 31 U.S.C. §§ 3729-3722. The CID requests certain documents and information related to the Company's relationships with third-party marketing agents and related to the Company's provision of free transportation to federal health care beneficiaries and requests information and documents related to such matters. We are continuing to cooperate with the Department of Justice in response to the CID. We are currently unable to predict the outcome of this investigation. Additionally, the Company cannot reasonably estimate the possible loss or range of loss that may result from this action. Regardless of the outcome, this inquiry has the potential to have an adverse impact on us due to any related defense and settlement costs, diversion of management resources and other factors.

On January 10, 2022, Reginald T. Allison, individually and on behalf of all others similarly situated, filed a putative class action lawsuit against the Company, Michael Pykosz, and Timothy Cook, two of the Company's largest stockholders and members of the Company's Board of Directors in the United States District Court for the Northern District of Illinois (Case No. 1:22-cv-00149). On March 25, 2022, Central Pennsylvania Teamsters Pension Fund – Defined Benefit Plan, Central Pennsylvania Teamsters Pension Fund – Retirement Income Plan 1987, and Boston Retirement System's (collectively, the "Northeast Pension Funds") were appointed as the lead plaintiffs in the case. On May 25, 2022, the Northeast Pension Funds along with an additional named plaintiff, the City of Dearborn Police & Fire Revised Retirement System, filed their consolidated amended and restated complaint (the "Amended Complaint").

Plaintiffs allege that the Company and certain of its executive officers made false and/or misleading statements about patient acquisition tactics that purportedly violated the False Claims Act and federal Anti-Kickback Statute, and are purportedly the subject of the CID discussed above. The Amended Complaint includes two categories of claims: (1) claims under the Securities Exchange Act of 1934 based on allegedly misleading public statements throughout the class period of August 6, 2020 through November 8, 2021 (the "Exchange Act Claims"), and (2) claims under the Securities Act of 1933 based on allegedly misleading statements in the registration statements and prospectuses accompanying Oak Street Health, Inc.'s initial public offering and secondary public offerings (the "Securities Act Claims"). The Exchange Act claims are asserted against Oak Street Health, Inc., Michael Pykosz, our CEO and Timothy Cook, our CFO, and also against certain stockholders of as "control persons." The Securities Act Claims are asserted against the same defendants as well as the underwriters of the Company's public offerings, and the Oak Street Health, Inc. directors who signed the registration statements. The Amended Complaint seeks damages, interest, costs, attorneys' fees and other unspecified equitable relief.

On July 25, 2022, the defendants filed a consolidated motion to dismiss the Amended Complaint. On September 26, 2022, the plaintiffs' opposition to that motion to dismiss was filed, and the defendants reply to that opposition was filed on October 26, 2022. On February 10, 2023, the Court ruled on the motion to dismiss, granting the Company's' motions to dismiss with respect to the plaintiffs' section 12(a)(2) claim and section 11 claim based on misrepresentations from the May 2021 secondary public offering, and denying the remainder of

the motion. Additionally three stockholders, Joseph Miller, the Hialeah Employees' Retirement System and the Employees Retirement System of the City of St. Louis each filed, on November 7, 2022, January 5, 2023 and February 2, 2023, respectively, derivative actions in the Delaware Court of Chancery against certain of our officers and each of the members of Oak Street's Board of Directors (collectively, "Defendants") principally alleging breach of fiduciary duties and unjust enrichment. Generally, the complaint in each derivative action concerns those Defendants' duties relating to certain outreach practices Oak Street allegedly engaged in and its patient transportation program, which are also matters that are the subject of the CID. The Company intends to continue to defend these claims vigorously. Given the uncertainty of litigation, the preliminary stage of the case, and the legal standards that must be met for success on the merits, the Company cannot reasonably estimate the possible loss or range of loss that may result from this action.

NOTE 10. LEASES

ASC 842 Disclosures

Operating and variable lease costs are included in cost of care, excluding depreciation and amortization and corporate, general and administrative expenses in the consolidated statements of operations. Variable lease costs are the portion of lease payments that are not fixed over the lease term. Variable lease costs include real estate payments that are adjusted periodically for inflation or other variables as well as payments for taxes, insurance, maintenance and other expenses. We expense variable lease costs as incurred. The Company elected to combine lease and non-lease components as a single lease component and not include short-term leases, defined as leases with an initial term of twelve months or less, in its consolidated balance sheets. The Company's short-term leases are immaterial. The components of lease expense for the Company's operating leases were as follows for the years ended December 31, 2022 and 2021 ($ in millions):

	For the Year Ended December 31, 2022	For the Year Ended December 31, 2021
Operating lease cost [2]	$ 48.0	$ 21.2
Variable lease cost [2]	10.6	18.9
Total lease cost	$ 58.6	$ 40.1

[2] See Note 2 for discussion of the correction of an immaterial prior period error. The correction of the classification of leasehold improvements resulted in a prior period benefit recorded to operating lease costs during the year ended December 31, 2022. Additionally, as a result of the correction, certain variable lease expenses were re-classified as operating lease expenses during the year ended December 31, 2022. These corrections impacted the comparability of operating and variable lease costs year over year.

The Company entered into leases that resulted in $102.5 million and $65.6 million of right-of-use assets in exchange for operating lease obligations for the years ended December 31, 2022 and 2021, respectively.

The weighted-average remaining lease term and discount rate for operating lease liabilities included in the consolidated balance sheets are as follows:

	December 31, 2022	December 31, 2021
Weighted-average remaining lease term (in years)	8.7	9.9
Weighted average discount rate	4.59%	4.17%

The table below presents the future minimum lease payments under the noncancelable operating leases as of December 31, 2022 ($ in millions):

2023	$	49.6
2024		56.0
2025		55.2
2026		54.6
2027		54.6
2028		53.7
Thereafter		162.7
Total lease payments	$	486.4
Less: imputed interest		(112.5)
Total operating lease liabilities	$	373.9
Reported as:		
Operating lease liabilities, current (1)		24.6
Long-term operating lease liabilities		349.3
Total operating lease liabilities	$	373.9

(1) Included in other liabilities on the consolidated balance sheet

ASC 840 Disclosures

Prior to adoption of ASC 842 as of January 1, 2021, the Company accounted for its lease arrangements under ASC 840, *Leases,* with no ROU assets or lease liabilities being reflected on the consolidated balance sheets. Therefore, the Company recognized $20.1 million during the year ended December 31, 2020 included in the cost of care and corporate, general and administrative expenses in the consolidated statements of operations.

NOTE 11. REDEEMABLE INVESTOR UNITS

Pre-IPO Equity Conversion

While OSH LLC's investor units had no conversion rights related to any of the investor unit classes, in response to a reorganization plan to convert OSH LLC into a corporate form (per the OSH LLC's Amended and Restated Operating Agreement), investor unit holders were eligible to receive capital stock of the Company in number of and with terms relatively consistent to their investor units, as ultimately determined by the Company's Board of Directors.

Prior to the closing of the IPO, the direct and indirect unitholders of OSH LLC completed a series of transactions in accordance with the Master Structuring Agreement that resulted in the Company becoming the ultimate parent company of OSH LLC and the current unitholders of OSH LLC immediately prior to the close of the IPO exchanged their investor units in OSH LLC for common stock of the Company as approved by the Board of Directors of the Company, OSH LLC and OSH Management Holdings, LLC ("OSH MH LLC"). The conversion was an exchange of units between entities under common control and resulted in the unitholders having the same percentage ownership immediately after the IPO as they had prior to the IPO.

- General Atlantic LLC and Newlight Partners LP (the "Lead Sponsors") contributed their respective investor units in the entities through which they currently hold interests in OSH LLC ("Sponsor Blockers") to the Company in exchange for 126,278,767 shares of common stock in the Company, pursuant to a contribution and exchange agreement dated August 10, 2020 by and among the Company and the other signatories party thereto.

- OSH LLC merged pursuant to the merger agreement dated August 10, 2020 by and among the Company, OSH LLC and the other signatory thereto (the "Company Merger") with and into a newly formed subsidiary of the Company, with OSH LLC surviving as a wholly owned subsidiary of the Company. Pursuant to the Company Merger, the other investors in OSH LLC

received a total of 58,240,199 shares of common stock in the Company in exchange for their investor units in OSH LLC.

- OSH MH LLC, the entity through which our employees owned investor units in OSH LLC, merged pursuant to the merger agreement dated August 10, 2020 by and among the Company, OSH MH LLC and the other signatory party thereto (the "Management Merger") with and into a newly formed subsidiary of the Company with OSH MH LLC surviving as a wholly owned subsidiary of the Company. Pursuant to the Management Merger, our employees received a total of 268,817 shares of common stock in the Company in exchange for their investor units in OSH MH LLC.

As a result of the above transactions, all units of redeemable investor units then outstanding, totaling 12,472,242 units as well as their undeclared and deemed dividends of $103.6 million, were converted into 184,787,783 shares of common stock and their carrying value, totaling $545.0 million was reclassified into stockholders' equity on our consolidated balance sheets. See further discussion of the rights and characteristics below related to the investor units.

Redeemable Investor Units

Prior to the IPO, the redeemable investor units consisted of three classes: investor units I, investor units II and investor units III. Due to contingent redemption features, the investor units were presented as temporary equity in the mezzanine section of the consolidated balance sheets before the completion of the IPO.

The following table shows OSH LLC's activity related to its investor units as of and for the periods ending:

	Investor Units I	Investor Units II	Investor Units III-A	Investor Units III-B	Investor Units III-C	Investor Units III D	Investor Units III E	Total
Outstanding December 31, 2019	382,572	509,796	7,915,830	568,613	747,661	876,147	—	11,000,619
Issued	—	—	—	—	—	—	1,471,623	1,471,623
Conversion	(382,572)	(509,796)	(7,915,830)	(568,613)	(747,661)	(876,147)	(1,471,623)	(12,472,242)
Outstanding December 31, 2020	—	—	—	—	—	—	—	—

In February 2020, OSH LLC issued 1,471,623 units of investor units III-E in exchange for $230.0 million. The price per unit was $156.29. There was $5.6 million in legal fees recorded as a reduction of equity as result of the capital raise.

Prior to the equity conversion that occurred as a result of the IPO, the redeemable investor units had the following rights and characteristics:

Dividends

Dividends were payable in cash, if declared, by OSH LLC's Board of Directors or upon a liquidation, deemed liquidation event or as determined by the Board of Directors in its sole discretion. OSH LLC did not declare dividends for the years ended December 31, 2020, 2021, or 2022.

Preferred Return

Whether or not declared or approved by the Board of Directors, the holders of the investor units accrued a preferred return in the amount of 8%, per annum, on the varying balance of each investor units' unreturned capital contribution beginning on the date of initial investment. This preferred return was cumulative and took into account, in determining the satisfaction of the preferred return, all distributions resulting from or paid to members holding investor units in connection with a dissolution or deemed liquidation event.

The following table shows accumulated dividends on the redeemable investor units on a cumulative basis as of the periods presented below:

	August 10, 2020*		
	Units	Per Unit	Total
Series			
Investor Units I	382,572	$ 8.53	$ 3.3
Investor Units II	509,796	10.15	5.2
Investor Units III-A - Issued prior to December 1, 2015	1,872,409	10.48	19.6
Investor Units III-A - Issued after December 1, 2015	6,043,421	7.90	47.7
Investor Units III-B	568,613	5.51	3.1
Investor Units III-C	747,661	11.34	8.5
Investor Units III-D	876,147	8.98	7.9
Investor Units III-E	1,471,623	5.64	8.3
			$ 103.6

* Note these accumulated dividends were included in the pre-IPO equity conversion to common stock discussed in the section "Pre-IPO Equity Conversion" above. As a result, there were no remaining accumulated dividends as of December 31, 2022 and 2021.

Redemption

OSH LLC's investor units had no mandatory redemption provisions. The investor units were redeemable upon the following events: an acquisition, an asset transfer or the sale, lease, transfer or other disposition of all or substantially all of the assets of OSH LLC ("Deemed Liquidation Event"), and OSH LLC determined that it did not fully control the effectuation or consummation of events that would be considered a Deemed Liquidation Event. This was because: (i) OSH LLC's Board of Directors was required to approve such a transaction, and (ii) the holders were collectively entitled to elect 5 of the 8 Board Members which gave them a majority of the Board of Directors, giving the investor unit holders effective control of the Board of Directors. Therefore, the investor units were required to be presented outside of permanent equity as mezzanine equity on OSH LLC's consolidated balance sheets.

Liquidation

In the event of a liquidation, dissolution or winding up of OSH LLC, the holders of each of the various types of investor units would receive liquidation preference, prior and in preference to any distribution of any of the assets or surplus funds of OSH LLC to the holders of founders' units, equal to the greater of (i) the applicable liquidation preference (the applicable liquidation preference is described in the OSH LLC Sixth Amended and Restated Limited Liability Company Operating Agreement) or (ii) the amount the holders of the investor units would receive if such holders had converted their units into founders' units immediately prior to such liquidation event.

Voting Rights

Founders' units and investor units, specifically excluding the investor units III-B, were collectively referred to as "voting units." On any matter presented to the members for their action and consideration at any meeting, each holder of outstanding voting units was entitled to cast the number of votes equal to the number of whole units held of record by such holder as of the record date for determining those members entitled to vote on any such matters.

NOTE 12. STOCKHOLDERS' EQUITY/MEMBERS' DEFICIT

Pre-IPO Equity Conversion

The unitholders of OSH LLC immediately prior to the close of the IPO exchanged their founders' units, incentive units and profits interests in OSH LLC for common stock of the Company as approved by the Board of Directors of the Company, OSH LLC and OSH Management Holdings, LLC ("OSH MH LLC").

- Pursuant to the Company Merger, the investors in OSH LLC received a total of 226,940 shares of common stock in the Company in exchange for their incentive units in OSH LLC.

- Pursuant to the Management Merger, our employees received a total of 37,884,061 shares of common stock, 22,612,472 of which are subject to service-based vesting (RSAs), and also received 14,313,416 options to purchase common stock of the Company at a strike price equal to the IPO price in exchange for their founders' units and profits interests in OSH MH LLC.

As a result of the above mentioned conversion, all units of members' capital (founders' units, incentive units and profits interests) then outstanding, totaling 3,456,634 were converted into 38,111,001 shares of common stock, 22,612,472 of which are considered RSAs. The carrying value of $7.0 million was reclassified into common stock and additional paid in capital on our consolidated balance sheet.

2020 Tender Offer

Upon OSH LLC's Board of Directors' approval, OSH LLC issued a Tender Offer to Purchase for cash dated March 30, 2020 (the "2020 Tender Offer") which expired on April. 27, 2020 up to $20.0 million of eligible units at a purchase price of $156.29 per eligible unit. Founders' units, incentive units and profits interests that were not subject to vesting or risk of forfeiture and, if there was a hurdle value applicable to the profits interests, that were awarded prior to March 30, 2018, were eligible to be tendered to OSH LLC for purchase. This 2020 Tender Offer allowed the directors, officers and employees (including the founders) the option to have their eligible units repurchased; unit holders were permitted to sell any number of any class of eligible units, subject to a 10% threshold. The 2020 Tender Offer was not conditioned on any minimum number of eligible units being tendered, and OSH LLC was not contractually obligated to redeem these units.

On Apr. 27, 2020, OSH LLC purchased all eligible units, other than profits interests subject to a hurdle value, at a price of $156.29 per eligible unit net to the sellers in cash, without interest. OSH LLC purchased profits interests that had a hurdle value at a price for each profits interests equal to the excess of $156.29 over the per profits interests amount of that hurdle value net to the sellers in cash, without interest. The purchase price offered in the 2020 Tender Offer for eligible units was the same for all classes of eligible units (other than profits interests, for which the purchase price was adjusted to reflect the applicable hurdle value), even though their relative priorities in distributions may differ. The following units were tendered to OSH LLC:

	Number of Units Tendered	Purchase Price per Unit	Total Purchase
Founders' Units	107,208	$ 156.29	$ 16.8
Incentive Units	1,142	156.29	0.1
Profits Interest Hurdle Value $265,158	17,622	136.04	2.4
Profits Interest Hurdle Value $346,107	3,684	129.91	0.5
Profits Interest Hurdle Value $386,277	1,495	126.90	0.2
Total Common Units	131,151		$ 20.0

The units (including profits interests) were repurchased at an amount per unit in excess of the fair value, which resulted in additional unit-based compensation expense of $0.6 million within corporate, general and administrative expenses in the consolidated statements of operation for the year ended December 31, 2020. Members' capital cannot be reduced to less than the stated value of common shares outstanding; therefore, any additional value above the remaining ownership is a direct reduction to members' deficit. Accordingly, $5.9

million was recorded as a reduction in members' capital and the remaining $13.5 million was recorded in accumulated deficit at the time that the 2020 Tender Offer was completed.

NOTE 13. STOCK AND UNIT-BASED COMPENSATION

Post-IPO Equity Awards

2020 Omnibus Incentive Plan

On August 5, 2020, the Company's Board of Directors adopted the 2020 Omnibus Incentive Plan (the "2020 Plan,"). Under the 2020 Plan, employees, consultants and directors of our Company and our affiliates that perform services for us are eligible to receive awards. The 2020 Plan provides for the grant of incentive stock options ("ISOs"), non-statutory stock options ("NSOs"), stock appreciation rights, restricted stock awards ("RSAs"), performance awards, other share-based awards (including restricted stock units ("RSUs")) and other cash-based awards. The maximum number of shares available for issuance under the 2020 Plan may not exceed 62,590,091 shares (subject to annual increases as approved by the Board of Directors).

Stock Options Activity

The following is a summary of stock option activity, excluding PSOs, as of and for the year ended December 31, 2022:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding, December 31, 2021	14,945,566	$ 21.89	8.61	$ 177.2
Granted	1,892,035	17.05		
Exercised	(745,982)	21.00		
Canceled and forfeited	(559,538)	23.57		
Outstanding, December 31, 2022	15,532,081	$ 21.28	7.73	$ 15.2
Options exercisable as of December 31, 2022	9,012,113	$ 21.32	7.57	$ 4.6

The aggregate intrinsic value of options exercised for years ended December 31, 2022, 2021 and 2020 was $4.2 million, $1.9 million and $0.4 million, respectively. Aggregate intrinsic value represents the difference between the exercise price of the option and the closing price of the Company's common stock on the date of exercise. The fair value of options granted for years ended December 31, 2022, 2021 and 2020 was $16.5 million, $10.0 million and $90.1 million respectively.

Valuation of Stock Options, excluding PSOs

The grant date fair value of stock options granted was estimated using a Black-Scholes option-pricing model with the following weighted average assumptions:

	December 31, 2022	December 31, 2021	December 31, 2020
Risk-free interest rate	1.92%	0.83%	0.31%
Volatility	50.46%	49.55%	64.98%
Expected term to expiration (years)	6.24	6.25	6.23
Expected dividend yield	0.00%	0.00%	0.00%
Estimated fair value	$ 8.74	$ 28.29	$ 6.07

Performance Stock Options Activity

During the year ended December 31, 2022, the Company granted PSOs to certain of its executives, with 50% of the option shares vesting at the end of year two and the remaining 50% of the option shares vesting at the end of year three, subject in each case to the satisfaction of certain performance-based conditions. The PSOs

generally expire ten years from the date of the grant. The fair value of performance stock options granted for the year ended December 31, 2022 was $42.4 million.

The following is a summary of PSO activity as of and for the year ended December 31, 2022:

	Number of Options	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding, December 31, 2021	—	$ —	—	$ —
Granted	4,551,505	17.46		
Exercised	—	—		
Canceled and forfeited	(195,271)	21.96%		
Outstanding, December 31, 2022	4,356,234	$ 17.45	8.95	$ 19.0
Options exercisable as of December 31, 2022	—	$ —	—	$ —

Valuation of Performance Stock Options

The grant date fair value of PSOs was estimated using a Black-Scholes option-pricing model with the following weighted average assumptions:

	December 31, 2022
Risk-free interest rate	2.48%
Volatility	51.37%
Expected term to expiration (years)	6.09
Expected dividend yield	0.00%
Estimated fair value	$ 9.32

The determination of fair value of stock options (ISOs and PSOs) on the date of grant using a Black-Scholes option-pricing model is affected by the estimated fair value of the Company's common stock as well as assumptions regarding a number of variables that are complex, subjective and generally require significant judgement to determine. We calculate the expected term for our employee stock options based on the simplified method as we have insufficient historical data about exercise patterns. We base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

We use an average historical stock price volatility of a peer group of comparable publicly traded healthcare companies representative of our expected future stock price volatility, as we do not have sufficient trading history for our common stock. For purposes of identifying these peer companies, we consider the industry, stage of development, size and financial leverage of potential comparable companies. For each grant, we measure historical volatility over a period equivalent to the expected term.

RSU Activity

RSUs granted generally vest ratably over four years. The following is a summary of RSU transactions as of and for the year ended December 31, 2022:

	Unvested Shares	Grant Date Fair Value
Unvested, December 31, 2021	476,628	$ 47.30
Granted	2,651,309	17.76
Vested	(157,782)	40.78
Canceled and forfeited	(441,767)	21.28
Unvested, December 31, 2022	2,528,388	$ 21.53

During the years ended December 31, 2022, 2021, and 2020, the weighted average grant date fair value of RSUs granted was $17.76, $57.27, and $31.82, respectively.

PSU Activity

The Company granted PSUs to certain of its employees during the year ended December 31, 2022 with the units vesting in April 2023, subject in each case to the satisfaction of certain performance-based conditions. The following is a summary of PSU activity as of and for the year ended December 31, 2022:

	Unvested Shares	Grant Date Fair Value
Unvested, December 31, 2021	111,184	$ 33.73
Granted	455,426	23.66
Vested	—	—
Canceled and forfeited	(28,397)	24.17
Unvested, December 31, 2022	538,213	$ 28.03

During the year ended December 31, 2021, the weighted average grant date fair value of PSUs granted was $33.73. There were no PSUs granted during the year ended December 31, 2020.

RSA Activity

The RSAs were granted as part of the pre-IPO conversion (see Note 12).

The following is a summary of RSA transactions as of and for the year ended December 31, 2022:

	Unvested Shares	Grant Date Fair Value
Unvested, December 31, 2021	16,090,990	$ 14.71
Granted	—	—
Vested	(9,762,571)	15.34
Canceled and forfeited	(385,319)	16.66
Unvested, December 31, 2022	5,943,100	$ 13.54

Employee Stock Purchase Plan

On August 5, 2020, the Board of Directors adopted, and the OSH LLC's and OSH MH LLC's majority unitholders approved, the 2020 Employee Stock Purchase Plan (the "ESPP") for the issuance of up to a total of 2,386,875 shares of common stock. In addition, the number of shares available for issuance under the ESPP will be increased annually on January 1 of each calendar year beginning in 2021 and ending in and including 2030, by an amount equal to the lesser of (A) 1% of the shares outstanding on the final day of the immediately preceding calendar year and (B) such smaller number of shares as is determined by our Board of Directors, subject to an increase each January. In no event will more than 30,000,000 shares of our common stock will be available for issuance under the ESPP. Each offering period will be approximately six months in duration commencing on January and July 1 of each year and terminating on June 30 or December 31. The ESPP allows participants to purchase common stock through payroll deductions of up to 15% of their eligible compensation. The purchase price of the shares will be 85% of the lower of the fair market value of our common stock on the grant date or purchase date.

During the years ended December 31, 2022 and December 31, 2021, 256,396 and 125,859 shares of common stock have been purchased under our ESPP. The shares purchased each offering period are distributed to the employees in the month following the end of the period.

Pre-IPO Equity

In 2013, OSH LLC's Board of Directors adopted an equity incentive plan, subsequently replaced by the Equity Incentive Plan in 2015, in which OSH LLC had granted awards in the form of incentive units options to employees, officers, directors, consultants, and other service providers of the Company. In 2015, OSH LLC's Board of Directors adopted the Equity Incentive Plan (the "Equity Incentive Plan"). Under the Equity Incentive Plan, OSH LLC granted awards in the form of profits interests to employees, officers, and directors.

Profits Interests

Before the Company completed its IPO in August 2020 and adopted the 2020 Plan, OSH LLC entered into award agreements ("profits interests award") which granted profits interests of OSH LLC. These profits interests represented profits interest ownership in OSH LLC tied solely to the accretion, if any, in the value of OSH LLC following the date of issuance of such profits interests. Profits interests participated in any increase of OSH LLC value related to their profits interests after the hurdle value had been achieved and OSH LLC's profits interests received the agreed-upon return on their invested capital.

The profits interests awards generally vested either over a requisite service period or were contingent upon a performance condition. OSH LLC granted 1,095,067 profits interests awards during the year ended December 31, 2020.

Prior to the closing of the IPO, the outstanding profits interests were converted into common stock, RSAs and options (see Note 12 for further discussion on the conversion).

The following is a summary of profits interests transactions as well as the profits interests outstanding as of and for the year ended December 31, 2020:

	Profits Interests	Weighted-Average Grant Date
Outstanding, December 31, 2019	1,910,797	$ 12.68
Granted	1,095,067	55.03
Vested	271,710	8.96
Forfeited/Repurchased	(60,947)	9.75
Conversion	(2,944,916)	28.49
Outstanding, December 31, 2020	—	$ —
Vested outstanding, December 31, 2020	—	—

Stock and Unit-Based Compensation Expense

The following table is a summary of stock-based compensation expense by function ($ in millions):

	For the Years Ended		
	December 31, 2022	December 31, 2021	December 31, 2020
Corporate, general and administrative	131.0	156.4	77.3
Sales and marketing	4.1	3.4	0.1
Cost of care	3.8	1.6	—
Total stock and unit-based compensation expense	138.9	161.4	77.4

As part of the pre-IPO equity conversion discussed in Note 12, the profits interests that were subject to vesting over a period of continuous employment or service and were unvested upon the conversion were converted into RSAs and options that vest over the remaining requisite service period from the original grant dates. The unvested profits interests that were subject to vesting upon the Sponsor's Exit performance condition were

converted into RSAs and options that cliff vest between two years post IPO and four years from the original grant dates.

As a result of this conversion and modification of vesting terms from Sponsor's Exit to service-based vesting, the Company accounted for 984,560 RSAs and options as a Type III modification (the award was not probable to vest prior to the modification but it was probable of vesting under the modified condition). The stock compensation expense recorded for these modifications was $78.4 million, $116.3 million, and $49.5 million for the years ended December 31, 2022, 2021 and 2020 respectively.

As of December 31, 2022, the Company had approximately $88.7 million in unrecognized compensation expense related to all non-vested awards (RSAs, options, PSUs and RSUs) that will be recognized over the weighted-average period of 2.10 years. The total fair value of shares vested was $156.2 million, $17.2 million and $2.9 million for the years ended December 31, 2022, 2021 and 2020 respectively.

NOTE 14. INCOME TAX

Income tax benefit related to continuing operations differ from the amounts computed by applying the statutory income tax rate of 21% to pretax loss for the years ended December 31, 2022, 2021 and 2020, respectively, as follows ($ in millions):

	For the Years Ended		
Income tax provision (benefit)	**2022**	**2021**	**2020**
At statutory rate	$ (107.1)	$ (87.5)	$ (40.3)
State taxes	(27.8)	(12.4)	(2.4)
State valuation allowance	27.9	12.0	2.4
Federal valuation allowance	75.0	52.0	16.7
Transaction expenses	0.4	—	—
Stock/unit-based compensation	21.5	30.0	15.7
Partnership book losses not subject to tax	(2.0)	5.6	7.5
Earnout payments	8.3	—	—
Deferred tax true-up	0.1	(3.7)	—
Permanent items	3.9	2.1	0.4
Total deferred income tax provision (benefit)	$ 0.2	$ (1.9)	$ —

The deferred income tax provision of $0.2 million as of December 31, 2022 was comprised of federal income taxes for $0.1 million and state income taxes for $0.1 million. The deferred income tax benefit of $1.9 million as of December 31, 2021 was comprised of federal income taxes for $1.5 million and state income taxes for $0.4 million. As of December 31, 2022, 2021 and 2020, the Company had no unrecognized tax benefits.

Deferred Tax Assets and Liabilities

Deferred income taxes reflect the net tax effects of loss and credit carryforwards and temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Significant components of our deferred tax assets for federal and state income taxes as of December 31, 2022 and 2021 were as follows ($ in millions):

Deferred income tax assets:	**2022**	**2021**
Federal net operating loss carryforwards	$ 168.6	$ 102.2
State net operating loss carryforwards	54.5	30.3
Deferred revenue	8.6	7.4
Reserves and accruals	—	0.3
Stock/unit-based compensation	13.8	3.7
Interest expense limitation	4.8	4.6
Deferred rent	15.4	5.5
IBNR reserve	—	0.9
Payroll accruals	1.5	8.4

Deferred income tax assets:	2022	2021
Allowance for doubtful accounts	1.1	0.8
Accrued professional fees	—	0.3
Other intangibles	0.3	2.5
Total deferred tax assets	$ 268.6	$ 166.9
Valuation allowance	$ (262.5)	$ (159.4)
Net deferred income tax assets	$ 6.1	$ (159.4)
Deferred income tax liabilities:		
Other intangibles	$ (1.8)	$ (2.2)
Fixed assets	(0.8)	(1.1)
Prepaids	(2.0)	(1.8)
Outside basis difference in a partnership	(1.7)	(2.4)
Net deferred income tax liabilities	$ (6.3)	$ (7.5)
Net deferred income taxes	$ (0.2)	$ —

Realization of our deferred tax assets is dependent upon future earnings, if any, the timing and amount of which are uncertain. Because of our lack of U.S. earnings history, the net U.S. deferred tax assets have been materially offset by a valuation allowance.

In evaluating its ability to realize the net deferred tax assets, the Company considered all available positive and negative evidence, including its past operating results and the forecast of future market growth, forecasted earnings, future taxable income and prudent and feasible tax planning strategies. As of December 31, 2022 and 2021, the Company has recorded a valuation allowance of $(262.5) million and $(159.4) million, respectively, as the Company has concluded that it is not more likely than not the deferred tax assets will be realized. The valuation allowance increased by $103.1 million and $73.6 million for the years ended December 31, 2022 and 2021, respectively.

On December 31, 2022, the Company had federal and state net operating loss ("NOLs") carryforwards of approximately $803.0 million and $764.7 million, respectively. The Federal NOLs arising in taxable years beginning before December 31, 2017, in the amount of $61.3 million, will begin to expire in the years 2033-2037. Federal NOLs rising in taxable years beginning after December 31, 2017, in the amount of $741.7 million, will be carried forward and have an indefinite life. However, the utilization of the NOLs carryforward is limited to 80% of taxable income. The state NOLs will begin expiring in 2032 and extend through 2040. On October. 20, 2021, the Company acquired 100% of the outstanding stock of Rubicon. This transaction resulted in the Company acquiring approximately $35.0 million and $25.0 million of Federal and State NOLs, respectively. These NOLs are subject to Section 382 limitations and are embedded within the totals above.

As a result of the Rubicon transaction, the Company recorded a $1.9 million tax benefit in continuing operations for the period ending December 31, 2021. In accordance with the rules of tax law ordering, the Company performed a scheduling exercise on the acquired taxable temporary differences to determine which deferred tax assets were realizable. This is a one-time purchase accounting tax benefit that was recorded related to Rubicon. In the event of future transactions, additional tax benefits may be deemed necessary.

The Company remains subject to U.S. federal, state and local, or non-U.S., income tax examinations by tax authorities for all years before 2017 to the extent acquired carryover NOLs from 2013-2017 are utilized on the returns. As of December 31, 2022, the tax years 2019 through 2021 remain fully open in the U.S.

The Company recognizes interest and penalties related to income tax matters in income tax expense. The Company had no amounts accrued for interest or penalties for the years ended December 31, 2022 and 2021.

NOTE 15. VARIABLE INTEREST ENTITIES

The Physician Groups or entities were established to employ healthcare providers, contract with managed care payors and to deliver healthcare services to patients in the markets that the Company serves. Oak Street Health, MSO LLC ("OSH MSO"), a wholly owned subsidiary of the Company, was formed in 2013 to provide a wide range of management services to the Physician Groups. Activities include but are not limited to operational support of the centers, marketing, information technology infrastructure and the sourcing and managing of health plan contracts.

The Company evaluated whether it has a variable interest in the Physician Groups, whether the Physician Groups are VIEs, and whether the Company has a controlling financial interest in the Physician Groups. The Company concluded that it has variable interests in the Physician Groups on the basis of its Administrative Service Agreement ("ASA") which provides for reimbursement of costs and a management fee payable to the Company from the Physician Groups in exchange for providing management and administrative services which creates risks and a potential return to the Company. The Physician Group's equity at risk, as defined by U.S. GAAP, is insufficient to finance its activities without additional support, and, therefore, the Physician Groups are considered VIEs.

In order to determine whether the Company has a controlling financial interest in the Physician Groups, and, thus, is the Physician's primary beneficiary, the Company considered whether it has i) the power to direct the activities of Physician Groups that most significantly impact its economic performance and ii) the obligation to absorb losses of the Physician Groups that could potentially be significant to it or the right to receive benefits from Physician Groups that could potentially be significant to it. The Company concluded that the shareholders and employees of the Physician Groups are structured in a way that neither shareholders, employees nor their designees have the individual power to direct the activities of the Physician Groups that most significantly impact its economic performance. Under the ASA, OSH MSO is responsible for providing management and administrative services related to the growth of the patient population of the Physician Groups, the management of that population's healthcare needs and the provision of required healthcare services to those patients. The Company has concluded that the success or failure of OSH MSO in conducting these activities will most significantly impact the economic performance of the Physician Groups. In addition, the Company's variable interests in the Physician Groups provide the Company with the right to receive benefits that could potentially be significant to it. The single member of the Physician Groups is a member and employee of the Company. As a result of this analysis, the Company concluded that it is the primary beneficiary of the Physician Groups and therefore consolidates the balance sheets, results of operations and cash flows of the Physician Groups. The Company performs a qualitative assessment of the Physician Groups on an ongoing basis to determine if it continues to be the primary beneficiary.

The tables below illustrate the VIE assets and liabilities and performance of the Physician Groups ($ in millions):

	December 31, 2022	December 31, 2021
Total assets	$ 1,002.0	$ 596.2
Total liabilities	$ 930.8	$ 564.4

	For the Years Ended		
	December 31, 2020	December 31, 2021	December 31, 2020
Total revenues	$ 2,150.1	$ 1,424.4	$ 865.3
Medical claims expense	1,643.2	1,107.4	615.9
Cost of care	220.7	149.2	63.8
Total operating expenses	$ 1,863.9	$ 1,256.6	$ 679.7

Physician Group revenues consist of amounts recognized for services provided to patients and includes capitated revenue and a portion of the Company's other revenue and excludes certain care management services. All capitation arrangements are executed at the Physician Group level.

Operating expenses consist primarily of medical claims expense, a majority of which are third-party medical claims expenses and administrative health plan fees, and exclude fees to perform payor delegated activities and provider excess insurance costs. Cost of care, excluding depreciation and amortization primarily includes provider salaries and benefits and other clinical operating costs which are reported in cost of care, excluding depreciation and amortization in the consolidated statements of operations. These amounts do not include intercompany revenues and costs, principally management fees between OSH MSO and the Physician Groups, which are eliminated in consolidation.

There are no restrictions on the Physician Groups' assets or on the settlement of its liabilities. The assets of the Physician Groups are all current and can be used to settle obligations of the Company. The Physician Groups are included in the Company's obligated group; thus, creditors of the Company have recourse to the assets owned by the Physician Groups. There are no liabilities for which creditors of the Physician Groups do not have recourse to the general credit of the Company. There are no restrictions placed on the retained earnings or net income of the Physician Groups with respect to potential dividend payments.

NOTE 16. RELATED PARTIES

Humana

Humana held over 5% of our common stock during the year ended December 31, 2021 but below 5% during the year ended December 31, 2022. Additionally, a Humana representative served on our Board of Directors from 2020 until his retirement, effective September 7, 2021. Humana no longer has a representative on the Board of Directors as of September 7, 2021. Therefore, Humana is no longer a related party for the year ending December 31, 2022, and as such, the Company has included prior year transaction amounts only on the consolidated balance sheet and consolidated statement of operations. During the years ended December 31, 2021 and 2020, our related party transactions with Humana included capitated managed care contracts, which resulted in capitated revenue and related receivables. Within the Company's other revenue, revenues from Humana were included in both fee-for-service revenue and care coordination and care management revenue. The receivable associated with the fee-for-service revenue was recorded in other receivables. The unearned portion of the care coordination revenue was recorded as a contract liability in both the current and long-term other liabilities accounts. The Company also incurred medical claims expense related to the Humana payor contracts which were included in medical claims expense. Related unpaid claims were included in the liability for unpaid claims financial statement caption. The Humana Alliance Provision contains an arrangement for a license fee that is payable by the Company to Humana for the Company's provision of health care services in certain centers owned or leased by Humana. The license fee is a reimbursement to Humana for its costs of owning or leasing and maintaining the centers, including rental payments, center maintenance or repair expenses, equipment expenses, special assessments, cost of upgrades, taxes, leasehold improvements and other expenses identified by Humana and was included in cost of care expenses, excluding depreciation and amortization in the consolidated statement of operations. The related liabilities were recorded within other liabilities on the consolidated balance sheet. We continued to have these transaction types with Humana during the year ended December 31, 2022, however, they are no longer considered related party transactions.

Blue Cross Blue Shield of Rhode Island

Blue Cross Blue Shield of Rhode Island ("BCBSRI") owns 49.9% of our joint venture, OSH-RI, LLC, and one of our Board members served as president and CEO of BCBSRI through the year ended December 31, 2020. The Board member has not served in this role since 2020, and as such we have only presented 2020 information herein. Total capitated revenue associated with the BCBSRI payor contract was $11.3 million for the year ended December 31, 2020. Total medical claims expenses related to the BCBSRI payor contract was $10.6 million for the year ended December 31, 2020.

NOTE 17. NET LOSS PER SHARE

The following table sets forth the computation of basic and diluted net loss per common share ($ in millions).

	For the Years Ended		
	December 31, 2020	December 31, 2021	December 31, 2020
Numerator:			
Net loss	$ (509.7)	$ (414.6)	$ (219.3)
Less: Net loss attributable to non-controlling interests	(0.5)	(5.2)	(4.1)
Less: Undeclared and deemed dividends attributable to unitholders prior to restructuring as part of IPO	—	—	(27.2)
Less: Net loss attributable to OSH LLC prior to restructuring as part of the IPO	—	—	(67.5)
Net loss attributable to OSH Inc. stockholders	(509.2)	(409.4)	(120.5)
Denominator:			
Weighted average common stock outstanding - basic and diluted	230,132,551	222,553,237	218,825,324
Net loss per share - basic and diluted	$ (2.21)	$ (1.84)	$ (0.55)

The Company's potentially dilutive securities, which included outstanding stock options (including PSOs), unvested RSUs (including PSUs), unvested RSAs, shares to be issued under the ESPP and shares issuable upon conversion of our Convertible Senior Notes have been excluded from the computation of diluted net loss per share as the effect would reduce the net loss per share. Therefore, the weighted average number of common shares outstanding used to calculate both basic and diluted net loss per share was the same. The Company excluded the following potential common shares, presented based on amounts outstanding at each period end, from the computation of diluted net loss per share for the periods indicated:

		For the Years Ended		
		December 31, 2022	December 31, 2021	December 31, 2020
Stock options (including PSOs)		19,888,315	14,945,566	14,958,969
RSUs (including PSUs)		3,066,601	587,794	216,804
RSAs		5,943,100	16,090,990	21,599,118
Employee Stock Option Plan		95,207	63,284	—
Convertible Senior Notes	*	11,622,176	11,622,179	—
		40,615,399	43,309,810	36,774,891

* The Company entered into capped call transactions to mitigate the impact of potential economic dilution to our common stock upon any conversion of our Convertible Senior Notes. The capped call transactions are expected to offset the potential dilution to the Company's common stock upon any conversion of the Convertible Senior Notes up to a cap price of $138.8750 per share. See Note 8 for further details on the capped call transactions.

NOTE 18. QUARTERLY FINANCIAL INFORMATION (unaudited)

The following table sets forth selected unaudited quarterly consolidated statements of operations data for each of the eight quarters in the fiscal years 2022 and 2021 ($ in millions). The information for each of these eight quarters has been prepared on the same basis as the audited annual consolidated financial statements included in this Annual Report on Form 10-K and, in the opinion of management, includes all adjustments, which consist only of normal recurring adjustments, necessary for the fair statement of the results of operations for these periods in accordance with GAAP. This data should be read in conjunction with the audited consolidated financial statements and related notes included in this Annual Report on Form 10-K.

	Quarter Ended							
	12/31/2022	9/30/2022	6/30/2022	3/31/2022	12/31/2021	9/30/2021	6/30/2021	3/31/2021
Revenues:								
Capitated revenue	$565.8	537.9	516.1	506.1	382.4	376.7	346.7	291.2
Other revenue	11.9	7.8	7.6	7.7	11.7	12.0	6.4	5.5
Total revenues	577.7	545.7	523.7	513.8	394.1	388.7	353.1	296.7
Operating expenses:								
Medical claims expense	446.6	427.4	391.6	379.4	318.1	309.8	281.4	199.7
Cost of care, excluding depreciation and amortization	130.1	113.6	98.9	95.2	90.1	76.3	67.0	60.3
Sales and marketing	43.8	44.1	42.6	33.8	38.9	30.5	25.9	24.1
Corporate, general and administrative expenses	79.5	81.7	94.9	88.7	82.4	77.0	74.2	73.1
Depreciation and amortization	9.9	9.1	8.4	7.8	6.1	4.5	3.9	3.3
Total operating expenses	709.9	675.9	636.4	604.9	535.6	498.1	452.4	360.5
Loss from operations	(132.2)	(130.2)	(112.7)	(91.1)	(141.5)	(109.4)	(99.3)	(63.8)
Other income / (expense)								
Interest expense, net	(1.4)	—	(0.5)	(0.6)	(0.7)	(0.6)	(1.0)	(0.2)
Other	(0.5)	(0.2)	(35.1)	(5.0)	—	—	—	—
Total other income / (expense)	(1.9)	(0.2)	(35.6)	(5.6)	(0.7)	(0.6)	(1.0)	(0.2)
Income before income taxes and non-controlling interests	(134.1)	(130.4)	(148.3)	(96.7)	(142.2)	(110.0)	(100.3)	(64.0)
Provision for income taxes	0.2	—	—	—	(1.9)	—	—	—
Net loss	$(134.3)	(130.4)	(148.3)	(96.7)	(140.3)	(110.0)	(100.3)	(64.0)
Net income / (loss) attributable to noncontrolling interests	(1.4)	0.3	0.8	(0.2)	(1.7)	(0.6)	(2.3)	(0.6)
Net loss attributable to the Company	$(132.9)	(130.7)	(149.1)	(96.5)	(138.6)	(109.4)	(98.0)	(63.4)
Net loss per share - basic and diluted	$(0.56)	(0.56)	(0.66)	(0.43)	(0.62)	(0.49)	$(0.44)	$(0.29)

NOTE 19. SUBSEQUENT EVENTS

Proposed Transaction with CVS Health

On February 7, 2023, the Company entered into the Merger Agreement with a subsidiary of CVS Health, pursuant to which (and subject to the terms and conditions in the Merger Agreement) such subsidiary of CVS Health will acquire all of the outstanding shares of the Company's common stock in a transaction structured as a merger of an indirect wholly-owned subsidiary of CVS Health with and into the Company, with the Company continuing as a surviving corporation. Under the terms of the Merger Agreement, at the effective time of the Merger (the "Effective Time"), each share of the Company's common stock that is issued and outstanding as of immediately prior to the Effective Time (other than shares of common stock (i) held by the Company as treasury stock as of immediately prior to the Effective Time, (ii) owned by such subsidiary of CVS Health or any of its subsidiaries (including Merger Sub) as of immediately prior to the Effective Time, (iii) owned by stockholders who have properly exercised appraisal rights under Delaware law and (iv) subject to outstanding Company restricted stock awards) will be automatically cancelled and converted into the right to receive $39.00 per share in cash, without interest thereon.

As a result of the Merger, the Company will become an indirect wholly-owned subsidiary of CVS Health. The completion of the Merger is subject to certain customary closing conditions, including, among others, the adoption of the Merger Agreement by the Company's stockholders and the expiration or termination of the applicable waiting period under the HSR Act.

The Merger Agreement contains certain customary termination rights for the Company and a subsidiary of CVS Health. If the Merger Agreement is terminated under certain specified circumstances and receipt of regulatory approval has not been obtained by such time, such subsidiary of CVS Health will be required to pay

the Company a termination fee of $500 million. If the Merger Agreement is terminated under other certain specified circumstances, including due to the Company accepting a superior proposal, the Company will be required to pay such subsidiary of CVS Health a termination fee of $300 million.

Corporate and Stockholder Information

Headquarters:
Oak Street Health, Inc.
30 W. Monroe Street
Suite 1200
Chicago, Illinois 60603

Corporate website:
www.oakstreethealth.com

Common Stock:
Listed on the New York Stock Exchange
Ticker Symbol: OSH

Annual Meeting of Stockholders:
Thursday, April 27, 2023, 8:30 a.m. CT
Meeting live via Internet – please visit
www.proxydocs.com/OSH for more details and to register

Company Information:
Oak Street Health, Inc.'s website – www.oakstreethealth.com – contains a wide range of information about the company, including news releases, financial reports, investor information, corporate governance, career opportunities and information on the Company's corporate responsibility and sustainability efforts. Printed materials such as the Annual Report on SEC Form 10-K, proxy statements, and other company information may be requested by contacting Mediant, Inc. at (866) 648-8133 or paper@investorelections.com.

Transfer Agent:
American Stock Transfer & Trust Company
www.astfinancial.com
e-mail: help@astfinancial.com
(800) 937-5449 or (718) 921-8124

Investor Relations:
investorrelations@oakstreethealth.com
https://investors.oakstreethealth.com/overview/default.aspx

Ethics and Compliance:
We are committed to maintaining a values-based, ethical performance culture as expressed by our Code of Conduct. These standards, along with our more detailed compliance plan and program, guide our approach toward preventing, detecting and addressing misconduct as well as assessing and mitigating business and compliance risks. Confidential and anonymous reporting is available through our third-party hotline number 833-347-0008 or www.lighthouseservices.com/oakstreethealth.

Annual Report on Form 10-K:

We will furnish without charge to each person whose proxy is being solicited, upon request of any such person, a copy of our Annual Report on Form 10-K for year ended December 31, 2022, as filed with the SEC, including the consolidated and combined financial statements and schedules thereto ("2022 Form 10-K"), excluding exhibits. Requests for copies of such report should be sent to Oak Street Health, Inc. 30 W. Monroe Street, Chicago, Illinois 60603, Attention: Investor Relations. Copies of any exhibit to the 2022 Form 10-K will be forwarded upon receipt of a written request to our Investor Relations department at such address, subject to a reasonable charge for copying and mailing.

Certifications:
The most recent certifications by our chief executive and chief financial officers pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 are filed as exhibits to the accompanying 2022 Form 10-K.

Independent Registered Public Accounting Firm:
Ernst & Young LLP

Board of Directors and Executive Officers
Mike Pykosz, Chief Executive Officer, Chairman and Director

Geoffrey Price, Chief Innovation Officer and Director

Dr. Griffin Myers, Chief Medical Officer of Provider Engagement and Director

Robbert Vorhoff, Director

Srdjan Vukovic, Director

Paul Kusserow, Director

Kim Keck, Director

Dr. Regina Benjamin, Director

Julie Klapstein, Director

Cheryl Dorsey, Director

Dr. Mohit Kaushal, Director

Brian Clem, President & Chief Operating Officer

Timothy Cook, Chief Financial Officer

Robert Guenthner, Chief Legal Officer


Oak St.
Health