Redefining Primary Care to Transform Healthcare

Dr. Marlow Hernandez
Chairman and Chief Executive Officer
Today’s Presenters

Dr. Marlow Hernandez
Chairman & Chief Executive Officer

Jason Conger
Chief Growth Officer

Pedro Cordero
Chief Population Health Officer

Dr. Richard Aguilar
Chief Clinical Officer

Dr. Merlin Osorio
SVP, Care Management

Gina Portilla
President, Cano Health Medical Centers

Maggie Arias-Petrel
Regional VP of Operations, West Coast

Bob Camerlinck
President, Healthy Partners Medical Centers and Affiliates

Brian Kopy
Chief Financial Officer
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<td>Redefining Primary Care to Transform Healthcare</td>
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<td>Growth Strategy</td>
<td>Jason Conger, Chief Growth Officer</td>
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<td>Population Health Management</td>
<td>Pedro Cordero, Chief Population Health Officer</td>
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<td>Care Management and Clinical Excellence</td>
<td>Dr. Merlin Osorio, SVP, Care Management Dr. Richard Aguilar, Chief Clinical Officer</td>
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<td>Medical Center Operations</td>
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<td>National Expansion: Las Vegas</td>
<td>Maggie Arias-Petrel, Regional VP of Operations, West Coast</td>
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<td>Affiliate Operations</td>
<td>Bob Camerlinck, President, Healthy Partners Medical Centers and Affiliates</td>
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<td>Financial Review &amp; Outlook</td>
<td>Brian Kopy, Chief Financial Officer</td>
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<tr>
<td>Break</td>
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<td>Q&amp;A</td>
<td>Dr. Marlow Hernandez and All Speakers</td>
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Healthcare in America Today – Transactional & Impersonal

- Providers compensated for **volume**, not quality
- The focus is on treating the **sick**, not keeping patients well
Healthcare in America Today – Misaligned Incentives

- Misaligned
- Transactional
- Volume-Based
- Episodic
- Reactive
- Inequitable
Healthcare in America Today – Unsustainable

Health Care Costs Number One Cause of Bankruptcy for American Families

JAMA Network

Editorial
July 20, 2021

Medical Debt as a Social Determinant of Health
Carlos F. Mendes de Leon, PhD; Jennifer J. Griggs, MD, MPH

CNBC
This is the real reason most Americans file for bankruptcy

KEY POINTS

• Two-thirds of people who file for bankruptcy cite medical issues as a key contributor to their financial downfall.

• While the high cost of health care has historically been a trigger for bankruptcy filings, the research shows that the implementation of the Affordable Care Act has not improved things.

• What most people do not realize, according to one researcher, is that their health insurance may not be enough to protect them.

Healthcare Under a Value-Based Care System – Member Focused
Healthcare Under a Value-Based Care System – Mutually Beneficial
US Primary Care Spending is Low, Resulting in Poor Outcomes

<table>
<thead>
<tr>
<th>% Spending on Primary Care</th>
<th>OECD Avg.</th>
<th>US</th>
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</thead>
<tbody>
<tr>
<td>~6%</td>
<td>~14%</td>
<td>~15%&lt;sup&gt;(1)&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

- **63%** of referring US physicians are dissatisfied with the referral process.
- **70%** of US specialists rate background information from referrals as fair or poor.
- **18 million** avoidable visits to US emergency rooms each year.
- **~$850 billion** wasted healthcare spending annually.
- **28%** Americans with 2+ chronic conditions (vs. 18% OECD average).

**Source:**
- 2019 Patient-Centered Primary Care Collaborative Report

<sup>(1)</sup> Represents approximate Cano Health direct patient expense plus monthly capitated payments to affiliate providers (included in third party medical expense), TTM ending 1Q22
Cano Health has Demonstrated Ability to Meaningfully Bend the Cost Curve

- For members enrolling January-June 2019, Cano Health’s medical costs (primary care, inpatient, outpatient) for MA members declined at a ~3% CAGR, even through the impact of COVID in 2020 and 2021.

- In this patient cohort, medical costs would be expected to increase at a ~10% CAGR as members age and acuity rises due to undertreatment of chronic conditions.

- Cano Health’s intensive primary care approach to treating chronic conditions can create superior outcomes for patients, payors, and our overall financial results.

Source: Cano Health internal company analysis
Note: Represents January – June 2019 cohort of members (~26,000), pro forma for acquisitions, from Cano Health’s medical center and affiliate models from major payors across all markets, through December 2021.
Our Model: Investing in Primary Care and Prevention While Forging Life-Long Bonds
Our Model: Combining Access, Quality and Wellness

**QUALITY**
Disease Management, Preventive Screenings, Care Coordination

**ACCESS**
Transportation, 24/7 Urgency Line, Cano@Home, Telehealth

**WELLNESS**
Classes, Physiotherapy, Cano Life
Our Model: Growth, With a Flexible Approach

BUILD
De Novo centers, expansions

BUY
Select acquisitions in new markets

MANAGE
Affiliates, pipeline for scale
Strong Financial Momentum

Members

(1) Membership as of period end

Revenue

(2) Adjusted EBITDA is a non-GAAP measure; refer to the reconciliation table in the Appendix for a reconciliation of Adjusted EBITDA to the most comparable GAAP measure

(3) CAGR based on midpoint of 2022E guidance range

Adjusted EBITDA

(1) Membership as of period end

(2) Adjusted EBITDA is a non-GAAP measure; refer to the reconciliation table in the Appendix for a reconciliation of Adjusted EBITDA to the most comparable GAAP measure

(3) CAGR based on midpoint of 2022E guidance range
Cano Health is Positioned for Continued Success

12 Year History
Setting important value-based care standards while growing significantly every year

Consistent Strategy
Successful Buy/Build/Manage strategy in place since 2016

#1 in Florida
Largest independent value-based care provider in Florida\(^{(1)}\)

Rapid Expansion
Las Vegas, Texas and other new markets growing fast

Profitable
Positive Adjusted EBITDA creates opportunities for growth

Outperforming
Projecting higher 2022 membership, revenue, and Adjusted EBITDA\(^{(2)}\)

Note: Adjusted EBITDA is a non-GAAP measure. Refer to the reconciliation table in the Appendix for a reconciliation of Adjusted EBITDA to the most comparable GAAP measure.

\(^{(1)}\) Company estimate based on publicly available information

\(^{(2)}\) As compared to projections given at March 2021 Investor Day
We are Growing Our Footprint While Preserving Quality

<table>
<thead>
<tr>
<th>Count</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>141</td>
<td>Senior-focused medical centers&lt;sup&gt;(1)&lt;/sup&gt;</td>
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<tr>
<td>400+</td>
<td>Employed primary care providers</td>
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<tr>
<td>1,000+</td>
<td>Affiliate providers</td>
</tr>
<tr>
<td>4,000+</td>
<td>Cano Health employees</td>
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<td>4.7</td>
<td>HEDIS Quality Score&lt;sup&gt;(2)&lt;/sup&gt;</td>
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<tr>
<td>82</td>
<td>NPS score</td>
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Note: All figures as of March 31, 2022 unless otherwise noted
(1) As of June 7, 2022
(2) 2020; National average 2020 HEDIS score was 4.16 out of 5.0
We serve our nation’s rapidly growing senior population so they can live longer, healthier lives.

Primary care is a critical service and a necessary part of our nation’s healthcare system.

Over 95% of our revenue is recurring as monthly payments to provide for the healthcare needs of our members.

Nearly all our revenue comes from federal and state governments, either directly or through health plans.

Our model is increasingly recognized as a potential solution to our nation’s broken healthcare system.
Strong Long-Term Growth Opportunities

$1.7T+
Addressable Market\(^{(1)}\)

10%+
Long-term Market Share Goal

~15%
Long-term Adj. EBITDA Margin Goal\(^{(2)}\)

~20%
Long-term Annual Organic Revenue Growth Goal\(^{(2)}\)

Positive
Cash from Operations
Expected in 2022

Positive
Free Cash Flow
Expected in 2023

~30%
Annual Revenue Organic Growth Goal 2023-2025

Note: Projections are based on management’s internal expectations and estimates, and are subject to change. Projections are not a guarantee of future results or performance.

(1) Based on Medicare, Medicaid, and Affordable Care Act (ACA) healthcare expenditures in 2021
(2) Long-term market share, revenue growth and margins will be impacted by membership mix, rate of growth, reimbursement environment, and Direct Contracting (ACO REACH) opportunity
Growth Strategy

Jason Conger
Chief Growth Officer
Proven Track Record of Membership Growth

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<tr>
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<th>Membership Growth(1)</th>
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<tr>
<td>1Q20</td>
<td>61K</td>
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<td>2Q20</td>
<td>99K</td>
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<tr>
<td>3Q20</td>
<td>103K</td>
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<td>4Q20</td>
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<td>156K</td>
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<td>227K</td>
</tr>
<tr>
<td>1Q22</td>
<td>269K</td>
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**Inorganic**

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<tr>
<th></th>
<th>24K</th>
<th>45K</th>
<th>54K</th>
<th>57K</th>
<th>29K</th>
<th>129K</th>
<th>131K</th>
<th>148K</th>
<th>190K</th>
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</table>

**Organic**

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<th></th>
<th>38K</th>
<th>54K</th>
<th>49K</th>
<th>49K</th>
<th>87K</th>
<th>129K</th>
<th>131K</th>
<th>148K</th>
<th>190K</th>
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Organic Growth:

- 1Q20: 36%
- 2Q20: 60%
- 3Q20: 58%
- 4Q20: 37%
- 1Q21: 43%
- 2Q21: 30%
- 3Q21: 28%
- 4Q21: 40%
- 1Q22: 63%

Total Growth:

- 1Q20: 122%
- 2Q20: 253%
- 3Q20: 201%
- 4Q20: 155%
- 1Q21: 91%
- 2Q21: 57%
- 3Q21: 105%
- 4Q21: 115%
- 1Q22: 130%

Consistent organic membership growth supplemented by highly accretive acquisition strategy

Note: **Organic growth** represents growth from our base business, as well as growth from building new medical centers, consolidating our existing affiliates, and acquiring small nearby practices to operate or manage (i.e., tuck-ins) whose patients and facilities are blended with our nearby owned medical centers. **Inorganic growth** represents growth from the acquisition of platforms which provide immediate scale and density, and by themselves have the infrastructure to execute on Cano Health's build, buy, and manage growth strategy.  
(1) Membership as of period end. Differences in the included tables are due to rounding and are not significant
Cano Health National Presence

**June 2021**
- 90 medical centers in 3 states; ~280 employed providers
- 156K members
- 800+ affiliate providers in Florida and Puerto Rico

**March 31, 2022**
- 137 medical centers in 6 states; ~400 employed providers
- 269K members
- 1,000+ affiliate providers in 9 states and Puerto Rico

**December 2022E(1)**
- 184-189 medical centers in 6 states; ~500 employed providers
- 290K to 295K members
- 1,000+ affiliate providers in 9 states and Puerto Rico

(1) Estimates are based on management’s internal expectations and are subject to change
Flexible Build/Buy/Manage approach is the cornerstone of our growth strategy which aims to serve the greatest number of patients:

- In the shortest amount of time
- With the least amount of risk
- With the best clinical results and the highest return on investment
Multi-Pronged Approach to Drive Growth and Create Value

**BUILD and Scale**
- Add De Novos in to increase scale and density
- Expand existing centers to meet demand
- Leverage local concentration to create operational and other efficiencies
- Requires capex and some period of losses before profitability

**BUY and Integrate**
- Tuck-in small independent medical centers for additional clinical capacity\(^{(1)}\)
- Acquire platforms to achieve immediate scale and density
- Integrate acquired centers and improve medical center growth and profitability
- Investment provides operational efficiencies and improved cash flow

**MANAGE Affiliates and Grow Direct Contracting (ACO REACH)**
- Grow number of contracted affiliates to strengthen or establish local market presence and pipeline of providers
- Increase Direct Contracting (ACO REACH) membership
- Expand Cano Health’s TAM to all Medicare beneficiaries
- Minimal capital investment; immediate profitability

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(1) Investment similar to “Build”; faster ramp to profitability

Build/Buy/Manage Strategy Provides Differentiated, Balanced, and Sustainable Growth
We Leverage a Continuum of Medical Center Characteristics

Cash Burn (lowest to highest)
Incremental Capacity (least to most)
Ramp to Maturity (shortest to longest)

Note: Capital expenditures are relatively equivalent along the continuum
Tuck-ins and De Novos Present Similar Yet Complementary Characteristics

De Novo Build Dynamics

- Total investment per center ~$3.0M - $3.5M
  - ~$1.5M - $2.0M capex
  - ~$1.5M in losses over first 2 years

Tuck-in Investment Dynamics

- Total investment per center ~$1.5M
- Typically breakeven in Year 1 as we integrate and add services
- Turns profitable (on average) in Year 2

Current environment favors tuck-ins given market valuations, construction costs and lead times, labor shortages, and need for immediate clinical capacity to meet demand

Note: Internal company illustrative estimates based on historical results
We Follow a Disciplined Market Entry Strategy

Criteria:

• High number of Medicare beneficiaries
• High Medicare Advantage penetration
• High % dual eligible for Medicare and Medicaid
• Underserved communities

Cano Health’s Top 25 Target Markets\(^{(1)}\)

• 56% MA penetration
• 25% Dual Eligible for Medicare-Medicaid
• 25% Hispanic
• 15% Black

San Antonio, TX

\(^{(1)}\) Medicare beneficiaries as of May 2022 (Source: CMS)

Source: esri (2022)
Market Development Strategy Relies on Six Key Factors

- Access to Care
- Brand Development and Marketing
- Payor Relationships and Provider Networks
- Services (e.g., Physiotherapy, Dental, Rx Delivery)
- Target Best Locations
- Design Centers to Fit Market Needs
We Benefit from Speed, Scale, and Density

**Financial Leverage**
Improved contractual arrangements with payers, hospitals, specialty networks

**Operational Efficiencies**
Lower operating costs, patient acquisition costs, and third-party medical costs

**Brand Recognition**
Build awareness of Cano Health as a high-quality primary care provider with a commitment to the community
Improves enrollment and ability to recruit and retain the best health care professionals
We are on Track to Continue to Deliver Consistent, Sustainable, Profitable Growth

Growth Avenues:

• Organic growth by building capacity through de novos, tuck-ins, and affiliates to meet demand

• Inorganic growth through M&A provides additional top- and bottom-line growth potential

$1.7T addressable market with opportunity to achieve double-digit market share
Population Health Management

Pedro Cordero
Chief Population Health Officer
Information Gaps Harm Outcomes and Increase Costs

Primary Care Providers (PCPs) Lack Critical Information to Inform Care

- Real-time information for traditional PCPs is limited to what happens in their office
- Large healthcare systems often have more data, but use for proactive prevention is often limited/absent
- Information delays mean missed opportunities to influence utilization and personalize care plans

Traditional PCP View

- Narrow, episodic view of care

Large System / Group PCP View

- Partial view of care based on connections with captive group resources
Cano Health’s Technology Puts the Patient at the Center of Care

- Empowers providers and clinical support staff to deliver better patient care
- Delivers a single pane of glass of the patient’s healthcare experience
- Analytics provide central support for accountable care
- Allows for proactive care management
A Differentiated and Scalable Platform

A VALUE-BASED CARE DELIVERY PLATFORM DRIVEN BY PEOPLE AND TECHNOLOGY

COORDINATES PROCESSES

- Personalized Care Plans
- Wellness Programs
- Disease Management
- Complex Care Management
- Cano@Home
- Cano Life
- 24/7 Urgency Line
- Provider Support
- Ancillary Care
- Member Engagement
- Transportation
- Rx Delivery

USING PURPOSE-BUILT TECHNOLOGY

- Risk Stratification
- Reporting
- Workflow Tools
- Data Aggregation
- Analytics
- Electronic Health Record
CanoPanorama Seeks to Improve the Member Experience and Health Outcomes

- Simplifies member onboarding
- Improves relationships and life-long bonds
- Strengthens Cano Health’s role at the center of healthcare, including social determinants of health

- Presents all patient information on one screen
- Stratifies risk to enable appropriate care
- Removes administrative tasks, allowing the provider to focus on delivering care

- Tracks patient and physician interactions
- Allows proactive analysis of trends and costs
- Informs care throughout the organization to ensure patients get the right care at the right time
Solves Key Population Health Issues

Real-Time
• Facilitates efficient allocation of resources to deliver more effective medical care

Comprehensive
• Aggregates internal and external data to improve care management and deliver personalized care plans

Standardized
• Enables development of and implementation of evidenced-based protocols for high-engagement environments

Analytical
• Applies proprietary algorithms reduce waste and provide high-quality care to patients
• Near real-time notification of patient hospitalizations through Hospital Information Exchange (HIE) data feeds

• Identifies members with higher rates of hospitalization to provide more focused care

• Alerts care management team to establish post-discharge care plan to reduce readmissions
• High level enterprise/regional data tracks major cost drivers
  - Hospital admissions
  - ER visits
  - High-cost procedures
  - Overall medical costs
• Near real-time data provisioning
• Dynamic risk stratification
• Visibility at multiple levels and time frames
• Comprehensive electronic auditing and quality control
• Risk stratification identifies candidates for high-touch intervention

• CanoPanorama during the COVID-19 pandemic:
  - Used to quickly identify high-risk patients for Cano@Home visits
  - Helped prioritize daily outreach, in-home services, food and Rx deliveries
CanoPanorama Drives Improved Access, Quality and Wellness

- Embedded across Cano Health medical centers and affiliates
- Aggregates, synthesizes and analyzes data using Cano Health proprietary algorithms
- Guides clinical workflows for improved patient outcomes
- Generates quality and utilization reports
- Enables Cano Health to solve Population Health needs and supports profitable, sustainable growth
Care Management and Clinical Excellence

Dr. Merlin Osorio
SVP, Care Management

Dr. Richard Aguilar
Chief Clinical Officer
Delivering Superior Results for Patients

- **Fewer Hospital Admissions**
  - Hospital admissions per 1,000
  - 2020 Medicare FFS Benchmark: 275
  - Cano Health (2020): 213
  - 62 (23%) Fewer Hospital Admissions

- **Reduced ER Visits**
  - ER visits per 1,000
  - 2020 Medicare FFS Benchmark: 1,061
  - Cano Health (2020): 549
  - 512 (52%) Reduced ER Visits

- **Lower Mortality Rate**
  - Mortality rate %
  - 2020 Medicare FFS Benchmark: 6.0%
  - Cano Health (2020): 2.4%
  - ~360 bps (60%) Lower Mortality Rate

100% of Eligible Physicians NCQA Certified

Source: 2020 Medicare Fee-for-Service (FFS) Benchmarks were based on Avalere Health’s analysis of Medicare FFS claims data for calendar year 2020 accessed through a Research Data Use Agreement with the Centers for Medicare and Medicaid Services (CMS)

Note: Previously reported 2020 Cano Health metrics included medical center members only and did not include complete data for recently completed acquisitions
1. Based on Cano Health’s 213 hospital admissions per thousand MA medical center and affiliate model members for 2020 as compared to the 2020 Medicare FFS Benchmark of 275
2. Based on Cano Health’s 512 ER visits per thousand MA medical center and affiliate members for 2020 as compared to the 2020 Medicare FFS Benchmark of 1,061
3. Based on Cano Health’s MA medical center and affiliate member mortality rate of 2.4% in 2020 as compared to the 2020 Medicare FFS Benchmark of 6.0%
4. NCQA certification for diabetes and heart disease/stroke (as of December 2021)
Cano Health’s Approach to Care Management Drives Improved Outcomes and Member Experience

- Care Management
- Cano@Home
- Quality Management
- Utilization Management
People and Processes Drive Our High-Touch Approach to Care

- Coordination of care for high-risk patients
- Transition of care planning and implementation post-hospitalization
- Post-ER follow-up visits
- Cano@Home for high-risk and complex care patients
- 24/7 urgency line for all patients
What we provide:

- In-home primary care, short-term episodic care, transition of care post-hospital discharge, medical urgency
- Supplements Cano Health’s 24/7 urgency line
- Care provided by dedicated clinicians who diagnose and treat at the patient’s home

Patients who use Cano@Home:

- Those needing immediate medical attention
- High-risk patients frequently admitted to the hospital
- Complex care patients
- Patients with physical or situational limitations preventing them from receiving care at our medical centers
Quality Management

Identifying Care Gaps to Improve Outcomes and Drive Quality

- Identify gaps in care to improve HEDIS quality and CMS Star ratings for payors
- Reminders and in-house screenings to improve % of members receiving mammograms, colonoscopies, vaccinations
- Improve medication adherence to control blood pressure, diabetes, cholesterol
What we monitor:

- Hospitalization trends to guide primary care improvement
- Generic dispensing rates to manage pharmacy costs
- Physician-level hospital admissions, ER visits, and office visits to guide improved care
- High-cost referrals to monitor appropriateness of care
Utilization Management: Combining Data-Driven Protocols with Localized Support

Early diagnosis of chronic conditions allows for prompt intervention and better outcomes

Medication-related adverse events are estimated to cause up to 20% of hospital admissions in elderly patients

Re-admissions are often avoidable through appropriate transition of care; average 30-day re-admission rate for Medicare population is 16%

Home health care reduces the need for high-cost facility-based care and allows for more frequent preventative care

Addressing socioeconomic factors impacting patients is sometimes a prerequisite to promoting physical wellbeing

Preventative Medicine

Medication Management

Post-Discharge Care Management

Home-Based Care

Social Services Coordination

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(1) Int J Clin Pharm, 2020, 42(5): 1243-1251
(2) MedPac, December 2, 2019
Long-term Commitment to Care Management and Member Experience

- Tailored approach to our patients' needs
- Focus on key areas of superior patient outcomes: care management, Cano@Home, quality management, and utilization management
- Improved member experience and life-long bonds between providers and members are key to reducing hospitalizations, ER visits, and mortality
We Empower Physicians to Focus on the Patient to Deliver Care and Manage Disease

- **Smaller patient panels** allow more time for patient care
- **Clinical support staff** bridge physician shifts, keeping care available and accessible
- **Technology** supports physician focus on patient care
- **Collegial competition** to achieve NCQA certifications and regular interaction among doctors motivates achievement of high-quality care
Patient / Physician Centered Clinical Excellence

- High quality care through standardized clinical approach
- CanoPanorama and clinical support staff allow physicians to spend more time with fewer patients
- Care is coordinated with care management team and specialists

<table>
<thead>
<tr>
<th>Metric</th>
<th>Cano Health Medical Centers (TTM ending March 2022)</th>
<th>Other Primary Care Providers</th>
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<tbody>
<tr>
<td>Patient Visits / Day</td>
<td>~14</td>
<td>20+(1)</td>
</tr>
<tr>
<td>Patient Panel (Medicare, Medicaid, ACA)</td>
<td>~400</td>
<td>~1,800-2,000(1)</td>
</tr>
<tr>
<td>Annual Primary Care Visits per Medicare member</td>
<td>7-8 per year(2)</td>
<td>2.2 per year(3)</td>
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<tr>
<td>Sharing of Information/In-house Continuing Medical Education</td>
<td>Monthly</td>
<td>N/A</td>
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(2) Plus 12 to 13 wellness visits per year
Continuing Education and Best Practices Training

• Standardized training and materials on care management programs and quality care outcome measures

• Monthly seminars on performance highlights and Continuing Medical Education (CME)

• Best practices and care guides to promote standardized care across all medical centers:
  - Utilization goals are encouraged through acknowledgement of top-performing physicians
  - Wall laminates in exam rooms provide quick access reference points for physicians on key focus areas
  - Outcome KPIs by physician shared regularly, incl. admissions, ER visits and office visits

Examples of Monthly CMEs

• Modern Prostate Screening and Diagnosis

• Pre-Op Assessment and Management

• Review of Accurate Diagnosis, Documentation and Coding

• The Clot Thickens: Cases in Anti-Coagulation Work-up and Management of DVT (Blood thinners)

• Recurrent Abdominal Pain with Urgency and Diarrhea: Can You Diagnose and Treat?

• Effective Medication Management in Older Adults
100% of eligible Cano Health providers and facilities were recognized by the National Committee for Quality Assurance (NCQA) for:

**Diabetes Recognition Program**: Recognizes clinicians who use evidenced-based measures to provide quality care to their patients with diabetes

**Heart/Stroke Recognition Program**: Recognizes clinicians who use evidenced-based measures to provide quality care to their CVD and stroke patients

*Note*: As of December 2021
Cano Model of Care Kidney Renal Function in Elderly Medicare Advantage Patients

- Two-year retrospective review of laboratory data for patients new to CANO (≤3 mos) with diabetes and CKD 3
- Measured eGFR, A1C, BMI, SBP/DBP at baseline and at various time points for 24 months (Table 1)
- N=1,871 patients
- Preservation of kidney function as represented by eGFR was evident at all time points
- Statistically significant improvements in eGFR values were observed during the first 15 months.
- No significant changes from baseline for months 18 to 24

*American Diabetes Association® (ADA) 82nd Scientific Sessions, New Orleans June 3-7th 2022
Unwavering Focus on Improving Clinical Outcomes

• Maintain a care approach driven by improving health outcomes

• Create continuous learning and development opportunities for physicians

• Focus on building an industry-leading team of physicians and providing them with the time and resources they need to excel

• Upcoming research expected to include dementia, physiotherapy, cardiovascular prevention, and other fields of study
Medical Center Operations

Gina Portilla
President, Cano Health Medical Centers
Cano Health Medical Centers and Membership

141 medical centers across the US\(^{(1)}\)

- 4 medical centers added since March 31, 2022

Staffed by over 400 primary care providers

- Physicians
- Nurse Practitioners
- Physician Assistants

Provide primary care to 177K members:

- 66K Medicare Advantage members
- 5K Medicare DCE members
- 66K Medicaid members
- 41K ACA members

Medical Center Membership\(^{(2)}\)

(in thousands)

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<th>Medicare DCE</th>
<th>Medicaid</th>
<th>ACA</th>
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<td>66</td>
<td>41</td>
<td>177</td>
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Note: Numbers may not add due to rounding

(1) Medical centers as of June 7, 2022

(2) Medical center membership as of March 31, 2022
A Differentiated Value-Based Primary Care Model

Disease Management
Preventive Screenings
Care Coordination
Transportation
24/7 Urgency Line
Cano@Home/Telehealth

QUALITY

Classes
Physiotherapy
Cano Life

ACCESS

WELLNESS
Our Signature Services Combine Access, Quality & Wellness

Primary Care
Transportation
Physiotherapy
Cano Life
Cano Dental
Wellness
Serenity Mental Health
Healthy Heart by Dr. Juan
Social Services
Cano@Home
Wellness Case Study: Serenity Mental Health Offering May Improve Overall Patient Outcomes

• Cano Health acquired Serenity in July 2021
• Adds in-center behavioral health services for our members

Benefits of In-Center Behavioral Health
• Behavioral health and chronic conditions are interrelated; addressing one may improve the other
• Members feel comfortable accessing behavioral health care at their Cano Health medical center
• Medical providers appreciate having behavioral health partners on site and available to help
• Interdisciplinary approach benefits both members and primary care providers
Texas

Signatory Services
- Primary Care
- Transportation
- 24/7 Urgency Line
- Cano Life
- Social Services*
- Physiotherapy
- Serenity Mental Health*
- Cano Dental
- Healthy Heart*

* Presently in San Antonio only; future expansion planned
Signature Services

- Primary Care
- Transportation
- 24/7 Urgency Line
- Cano Life
- Social Services
- Physiotherapy
Signature Services

- Primary Care
- Transportation
- 24/7 Urgency Line
- Cano Life
- Physiotherapy
- Social Services
New Mexico

Signature Services

- Primary Care
- Transportation
- 24/7 Urgency Line
- Cano Life
- Social Services
- Physiotherapy
- Healthy Heart
Our Signature Services in Motion

1. 1.800.794.3311 | CANOHEALTH.COM
2. 1.800.303.6948 | CANOHEALTH.COM
3. 1.800.370.0569 | CANOHEALTH.COM
4. 1.800.303.6948 | CANOHEALTH.COM
5. 786.370.0569 | CANOHEALTH.COM
6. 786.370.0569 | CANOHEALTH.COM
7. LLÁMENOS AL 813.605.7411
8. 305.928.6685 | CANOHEALTH.COM
The Result:

High Member Satisfaction and Word of Mouth Referrals to Our Medical Centers

NPS 82

Reason for Enrollment

- 61% Center-Driven Enrollment
- 24% TV/Other media
- 15% Community Outreach

61% of enrollments require no direct marketing spend

Source: Cano Health internal data; NPS for TTM ending March 31, 2022
Strong and Scalable Operations

• We address critical needs in key value-based care markets across the country
• We deliver a comprehensive suite of signature services to our members
• We aim to achieve best-in-class member onboarding and loyalty
• We have an operating model designed for scalability
• We seek to successfully optimize costs as we grow and expand
National Expansion:
Las Vegas

Maggie Arias-Petrel
Regional VP of Operations, West Coast
Healthcare Challenges in Nevada

Nevada’s seniors encounter significant healthcare challenges\(^{(1)}\)

- Percentage of seniors with a dedicated health care provider is 48\(^{th}\) in the nation
- Clinical care quality for seniors is 49\(^{th}\) in the nation
- Cancer screenings for seniors are 49\(^{th}\) in the nation

Nevada’s adult minorities face healthcare disparities

- 43% of Hispanics, 39% of Native Americans, and 35% of Blacks do not have a dedicated healthcare provider compared to 29% of whites\(^{(2)}\)
- 39% of COVID cases reported through April 2022 were among Hispanics (who make up 30% of the state population)\(^{(3)}\)

Cano Health Medical Centers are purpose-built to tackle Nevada’s healthcare challenges

- Providers and staff reflect the population we serve; we understand the needs of our patients
- Center culture is welcoming, vibrant and inclusive; our members are our family

\(^{(1)}\) United Health Foundation, America’s Health Rankings Senior Report 2021
\(^{(2)}\) Kaiser Family Foundation, 2020
\(^{(3)}\) CDC (May 2022)
Las Vegas (Clark County) Is an Ideal Market for Cano Health

• Growth of 65+ population outpacing U.S. total 65+ population growth
  - 330,000+ seniors; growing 4.6% annually (2019-2020)\(^1\)
  - 43% faster than the 3.2% annual growth of the U.S. 65+ population (2019-2020)\(^1\)

• 46% Medicare Advantage Penetration\(^2\)

• ~60,000 residents are dual-eligible for Medicare and Medicaid\(^3\)

• Population is majority minority\(^4\)
  - 36% Hispanic
  - 12% Black
  - 7% Asian/Pacific Islander

• Poverty Rate is 18% higher than the national average\(^4\)

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\(^1\) American Community Survey, U.S. Census Bureau
\(^2\) CMS, December 2020
\(^3\) Advocate Health Advisers, 2020
\(^4\) U.S. Census (2020)
Cano Health entered Las Vegas in September 2020 and has grown its footprint with both de novos and tuck-ins.

Nine locations convenient to the city’s senior dual eligible population:

1. 3265 East Tropicana Ave
2. 5701 West Charleston Blvd
3. 4469 West Charleston Blvd
4. 3860 West Lake Mead Blvd
5. 1905 Civic Center Dr
6. 2235 East Lake Mead Blvd
7. 2285 East Flamingo Rd
8. 1650 West Craig Rd
9. 29629 W Horizon Ridge Pkwy

Source: esri (2022)
Las Vegas Market: Key Achievements

Operational Achievements

- 91 NPS (Las Vegas medical centers, 1Q22)
- 7.7 annual clinical visits per Medicare Advantage member
- 90% bilingual staff, 65% bilingual providers
- Introduced Cano@Home program

Quality Achievements

<table>
<thead>
<tr>
<th></th>
<th>1Q21</th>
<th>1Q22</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions</td>
<td>153</td>
<td>132</td>
<td>-14%</td>
</tr>
<tr>
<td>ER visits</td>
<td>357</td>
<td>202</td>
<td>-44%</td>
</tr>
</tbody>
</table>
Strong Las Vegas MA Membership Development

Las Vegas Medicare Advantage Membership and MCR, 4Q20-1Q22

Medical Cost Ratio (MCR) = Third Party Medical Expense/Capitated Revenue

<table>
<thead>
<tr>
<th>Quarter</th>
<th>MA Members</th>
<th>Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>4Q20</td>
<td>54</td>
<td>3</td>
</tr>
<tr>
<td>1Q21</td>
<td>386</td>
<td>3</td>
</tr>
<tr>
<td>2Q21</td>
<td>570</td>
<td>3</td>
</tr>
<tr>
<td>3Q21</td>
<td>843</td>
<td>5</td>
</tr>
<tr>
<td>4Q21</td>
<td>1,097</td>
<td>8</td>
</tr>
<tr>
<td>1Q22</td>
<td>1,874</td>
<td>9</td>
</tr>
</tbody>
</table>

Medical Cost Ratio:
- 4Q20: 90.5%
- 1Q21: 78.1%
- 2Q21: 63.0%
- 3Q21: 0%
- 4Q21: 10%
- 1Q22: 20%

Medical Cost Ratio (MCR) = Third Party Medical Expense/Capitated Revenue
Member Profile and Feedback

- Name: Fanny
- Medical Center: Tropicana, Las Vegas
- Enrollment date: November 2021
- How she found us: Referred by friend
- Chronic conditions: Diabetes, depression, insomnia
- 83 years old
- Language: Spanish
- Average visits per week: 3

“My Cano Family: I am very happy to have joined you! I feel young and rejuvenated again! You have given me hope every day. I understand and take better care of myself. All the doctors and staff are extremely caring and give me the best care and attention. You truly are my familia! Viva La Vida Cano!”
Our Focus on Building Scale and Density Continues

Key Objectives

• Build pipeline of future physicians
  - Medical students from UNLV and Touro University Nevada expected to begin rotations at Cano Health Medical Centers in 3Q22

• Drive membership growth leveraging available capacity

• Continue to build scale and density with additional centers

• Expect to have 20 medical centers in the Las Vegas area by end of 2024
Affiliate Operations

Bob Camerlinck
President, Healthy Partners Medical Centers and Affiliates
How Cano Health’s Affiliate Model Works

• Affiliate providers treat patients at independent practices and accept a wide range of insurance and patient types
  - Traditional Medicare
  - Medicare Advantage
  - Commercial insurance (adult, pediatric)
  - Medicaid, ACA

• Affiliate providers contract with Cano Health for Medicare Advantage (MA) and/or Direct Contracting (DCE)

• Cano Health recognizes 100% of capitated revenue from payors, is responsible for the third-party medical costs, and manages risk

• Cano Health pays affiliate providers a monthly primary care provider (PCP) capitated payment and shares savings (capitated revenue less third-party medical expense) and quality bonuses
Cano Health has 1,000+ affiliate providers who provide primary care for nearly 92K Cano Health members.

Cano Health affiliates provided primary care to ~54K Medicare Advantage members, ~36K Direct Contracting members, and ~2K other members (primarily Medicaid).

(1) Affiliate membership as of March 31, 2022
A Beneficial Model for Providers and Cano Health

For Providers

• Access to Cano Health’s value-based Medicare Advantage contracts with various payors

• Training and tools (e.g., utilization reports, data analytics)

• Predictable monthly primary care capitated payments

• Increased revenue potential through value-based care shared savings, quality bonuses

• Continued ability to serve patients outside of value-based plans (e.g., adult and pediatric commercial insurance)

For Cano Health

• Increases market scale and density, providing leverage with payors and specialists

• Generates earnings with minimal capital investment

• Provides pipeline of primary care locations and providers for future Cano Health medical centers

• Expands Direct Contracting membership through enrollment of affiliate providers into Cano Health’s direct contracting program
Direct Contracting: Cano Health’s Newest Line of Business

What it is

- Direct Contracting is part of CMS Innovation Center’s effort to transition 100% of traditional Medicare beneficiaries to value-based models by 2030
- Cano Health is one of a select number of participants in the program(1)
- Builds on Cano Health’s experience in expanding access to value-based Medicare Advantage plans through affiliate providers

How it works

- Direct Contracting members are assigned to Cano Health employed providers and participating affiliates based on both retrospective claims data and voluntary alignment
- Cano Health receives monthly capitated payments from CMS; responsible for 100% of the member’s Part A and B cost of care (global risk); surplus (capitated payments less third-party medical expense) is shared with affiliates
- Affiliate providers are rewarded for improving quality while reducing the cost of care (shared savings), and receive a predictable stream of capitated monthly payments for direct contracting members

(1) Operating as America’s Choice Healthcare
We Provide Affiliates with Tools to Improve Outcomes and Reduce Costs

- Guidance on ways to increase patient participation in their own care to reduce costs and increase shared savings
  - Proactive scheduling of follow-up appointments
  - Goal of 7-8 primary care visits per year
  - Rapid response to patient calls to avert unnecessary ER visits
- IT support (HIE, EMR and HIPAA consultation)
- Access to data and decision support tools
- Peer-to-peer advisory services
- Support for:
  - Transitional care management
  - Chronic care management for high-risk patients
  - Peer-to-peer advisory services
  - Advance patient risk stratification
Rapid Direct Contracting Membership and Revenue Growth

Cano Health’s Direct Contracting Membership (1)

- Program launched in April 2021
- New assignments made yearly in January based on contracts submitted to CMS in the fall of the prior year
- Capitated Revenue PMPM $1,300+ in 2022
- MCR expected to be in the low 90% range for full year 2022
- 2022 Adjusted EBITDA margin expected to be low single digits; improvement expected over time

Cano Health’s Direct Contracting Revenue

- ~$90M (2) in Year 1 (2021)
- ~$650M (3) in Year 2 (2022E)

DCE as % of Total Members

- ~4% in Year 1 (2021)
- 15% in Year 2 (2022)

Notes:
(1) Approximate membership on April 1, 2021 and January 1, 2022. As in 2021, expect attrition in 2022 as members relocate, convert to MA, pass away, etc.
(2) Revenue for April-December 2021
(3) Revenue based on average expected monthly membership in 2022
Most Cano Health Direct Contracting members are cared for by affiliate providers

- **2021:** As of December 31, 2021, 18 affiliates provided primary care to ~230 members each
- **2022:** As of January 1, 2022, 217 affiliates are providing primary care to ~164 members each

<table>
<thead>
<tr>
<th></th>
<th>December 31, 2021</th>
<th>January 1, 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCE Members at Cano Medical Centers</td>
<td>~3,500</td>
<td>~5,400</td>
</tr>
<tr>
<td>DCE Members at Affiliates</td>
<td>~4,200</td>
<td>~35,600</td>
</tr>
<tr>
<td>Total Direct Contracting Members</td>
<td>~7,700</td>
<td>~41,000</td>
</tr>
<tr>
<td>Affiliates Contracted for DCE</td>
<td>18</td>
<td>217</td>
</tr>
<tr>
<td>DCE Members Per Affiliate</td>
<td>~230</td>
<td>~164</td>
</tr>
</tbody>
</table>
Direct Contracting is Expanding Our National Provider Footprint

<table>
<thead>
<tr>
<th>% of Cano Health Direct Contracting Affiliate Providers by State(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
</tr>
<tr>
<td>New York/New Jersey</td>
</tr>
<tr>
<td>Texas</td>
</tr>
<tr>
<td>California</td>
</tr>
<tr>
<td>Other(1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Program builds our knowledge and experience in new markets (e.g., New York, New Jersey, Arizona)

(1) As of January 1, 2022. Other states: AZ, IL, NM, NV
The Affiliate Model and DCE Provide Cano Health with a Significant Opportunity to Pursue Rapid Growth

Affiliate model provides a flexible, capital light approach for growth
Pipeline of primary care providers
Provides value-based care to fee-for-service Medicare members

What’s Next for DCE:
• Transition to ACO REACH in January 2023
  - Economics of ACO REACH are very similar to Direct Contracting
• Expect continued growth in affiliate providers and membership
• Expect improved profitability as program matures
Financial Outlook

Brian Kopy
Chief Financial Officer
Strong Financial Momentum

**Members**

(1) Membership as of period end

**Revenue**

(2) Adjusted EBITDA is a non-GAAP measure; refer to the reconciliation table in the Appendix for a reconciliation of Adjusted EBITDA to the most comparable GAAP measure

(3) CAGR based on midpoint of 2022E guidance range
Maintaining Guidance for Full Year 2022

<table>
<thead>
<tr>
<th></th>
<th>FY 2022</th>
<th>FY 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>June 7, 2022</td>
<td>May 9, 2022</td>
</tr>
<tr>
<td>Total Membership</td>
<td>290,000 - 295,000</td>
<td>290,000 - 295,000</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$2.8B - $2.9B</td>
<td>$2.8B - $2.9B</td>
</tr>
<tr>
<td>Medical Cost Ratio (MCR)(^{(1)})</td>
<td>76.0% - 76.5%</td>
<td>76.0% - 76.5%</td>
</tr>
<tr>
<td>Adjusted EBITDA(^{(2)})</td>
<td>$230M - $240M</td>
<td>$230M - $240M</td>
</tr>
<tr>
<td>Total Owned Medical Centers</td>
<td>184 - 189</td>
<td>184 - 189</td>
</tr>
</tbody>
</table>

Maintaining 2022 guidance for total membership, total revenue, Adjusted EBITDA guidance, and total owned medical centers

Maintaining 2022 Total MCR at 76.0% - 76.5%; 2H22 Total MCR expected to be significantly lower than 1H22 Total MCR

Further 2022 Details:
- Interest expense: $60M - $65M
- Stock compensation expense: $60M - $65M
- De novo losses: ~$70M
- Capital expenditures: $40M-$60M
- Medical centers: 184-189

\(^{(1)}\) Medical Cost Ratio = Third Party Medical Expense / Total Capitated Revenue

\(^{(2)}\) Adjusted EBITDA is a non-GAAP financial measures. Please refer to the reconciliation table in the Appendix for a reconciliation of Adjusted EBITDA to the most comparable GAAP measure.
Diversified Approach to Facilitate Value-based Care Arrangements

**Medical Center Model**
- Higher capital investment
- Standardized clinical protocols and care coordination programs generally result in lower MCR
- As providers improve health outcomes, Cano Health captures greater share of cost savings

**Affiliate Model**
- Lower capital investment
- Offers visibility into local market medical center model; potential to convert in future
- Cano Health population health data and strategies generally result in greater shared savings for providers

**Both Models Offer Benefits to All Parties**

<table>
<thead>
<tr>
<th>Party</th>
<th>Medical Center Model</th>
<th>Affiliate Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor</td>
<td>Superior patient outcomes through alignment and coordination; attractive fixed margin</td>
<td>Strong patient outcomes through alignment; attractive fixed margin</td>
</tr>
<tr>
<td>Provider</td>
<td>Highly predictable income in an employed setting</td>
<td>Ability to increase income through alignment of incentives while remaining independent</td>
</tr>
<tr>
<td>Member</td>
<td>Receives ancillary and wellness services at no additional cost</td>
<td>Increased engagement with physician versus fee-for-service Medicare</td>
</tr>
<tr>
<td>Cano Health</td>
<td>High quality care improves MCR over time</td>
<td>Capital efficient growth; serves as an important source of clinical capacity</td>
</tr>
</tbody>
</table>
Diverse Membership Mix Across Medical Centers and Affiliates

1Q22 Membership by Medical Centers and Affiliates

- Medicare Advantage: 66K
- Medicare DCE: 5K
- Medicaid: 66K
- ACA: 41K
- Total Medical Center: 177K
- Medicare Advantage: 36K
- Medicare DCE: 2K
- Medicaid: 54K
- ACA: 92K
- Total Affiliate: 269K

(1) Membership as of March 31, 2022
Note: Differences in totals are due to rounding, and are not material
1Q22 Revenue Driven by Medicare Advantage, Medicare DCE, and Medicaid

Illustrative Percentage of 1Q22 Revenue by Medical Centers and Affiliates

(1) This breakdown of 1Q22 revenue has not been audited and is being provided for illustrative purposes only
(2) Other Revenue includes fee-for-service, pharmacy and other revenue

Note: Differences in totals are due to rounding, and are not material
Illustrative 2022E Adjusted EBITDA for Medical Centers and Affiliates\(^{(1,2)}\)

- Medical Centers: $215M - $220M
- Affiliate: $125M - $130M
- Corporate: (~$110M)
- 2022E Adj. EBITDA: $230M - $240M

Strong Adj. EBITDA\(^{(1)}\) contribution expected from both Medical Centers and Affiliates

---

\(^{(1)}\) Adjusted EBITDA is a non-GAAP measure

\(^{(2)}\) Breakdown of Adjusted EBITDA is being provided for illustrative purposes only and is not a guarantee of future results
Illustrative Patient Level Unit Economics Side-By-Side

Medical Center Model

**Illustrative PMPM Economics For a Single Mature Medicare Advantage Patient**

<table>
<thead>
<tr>
<th></th>
<th>Medical Center Model</th>
<th>Affiliate Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Revenue</td>
<td>$1,350</td>
<td>$1,240</td>
</tr>
<tr>
<td>(Less): Third Party Medical Costs</td>
<td>(820)</td>
<td>(930)</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$530</td>
<td>$310</td>
</tr>
<tr>
<td>% MCR</td>
<td>61%</td>
<td>75%</td>
</tr>
<tr>
<td>(Less): Direct Patient Expense</td>
<td>(150)</td>
<td>(130)</td>
</tr>
<tr>
<td>(Less): Operating and Other Expense</td>
<td>(50)</td>
<td>(30)</td>
</tr>
<tr>
<td>Adj. EBITDA(2)</td>
<td>$330</td>
<td>$150</td>
</tr>
<tr>
<td>% Margin</td>
<td>24%</td>
<td>12%</td>
</tr>
</tbody>
</table>

At maturity, Medical Center Adjusted EBITDA margins are typically significantly higher than Affiliate margins; driven by demographics and higher patient engagement.

---

(1) Illustrative economics for a mature Medicare Advantage patient, on a PMPM basis. Values are rounded to nearest $10.
(2) Adjusted EBITDA is a non-GAAP measure. Refer to the reconciliation table in the Appendix for a reconciliation of Adjusted EBITDA to the most comparable GAAP measure.
Growing Geographic Footprint

- Includes Puerto Rico from 2019 onward
- Number of tuck-ins and builds in 2022 and 2023 are estimates based on management’s internal projections, and are subject to change

**Medical Centers & Affiliates**

**Affiliates only**

1,000+ affiliates in 9 states + Puerto Rico

**Cano Health Medical Centers**

<table>
<thead>
<tr>
<th>State</th>
<th>2020</th>
<th>2021</th>
<th>1Q22</th>
<th>June 7, 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>64</td>
<td>101</td>
<td>106</td>
<td>110</td>
</tr>
<tr>
<td>Texas</td>
<td>4</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Nevada</td>
<td>3</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>California</td>
<td>--</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Illinois</td>
<td>--</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>New Mexico</td>
<td>--</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>71</td>
<td>130</td>
<td>137</td>
<td>141</td>
</tr>
</tbody>
</table>

Expect to add **54-59 medical centers in FY 2022**
- 7 added in 1Q22: 5 FL, 1 NM, 1 NV
- 4 added in FL since March 31, 2022
- Expect 43 to 48 to be added in 2H22

Expect to add ~25 medical centers in 2023

(1) Includes Puerto Rico from 2019 onward

Note: Number of tuck-ins and builds in 2022 and 2023 are estimates based on management’s internal projections, and are subject to change
Robust Acquisition Performance

Strong Track Record of Accretive Acquisitions

- **2009**: CanoHealth Founded
- **2017**: Comfort Health + 2 Tuck-in Transactions
- **2019**: Belén Medical Centers + 7 Tuck-in Transactions
- **2018**: Rangel Medical Center + 5 Tuck-in Transactions
- **2020**: PCP + 2 Tuck-in Transactions
- **2021**: Healthy Partners + 14 Tuck-in Transactions

37 transactions between 2017 and 2021: rigorous investment process and integration plan with clearly defined execution benchmarks
Proven M&A Playbook with Multiple Levers to Drive Growth

Consistent M&A Strategy

Membership Growth
Grow MA and DCE membership

Utilization
Seek to reduce medical cost ratio

Quality
High HEDIS quality ratings

Population Health
Develop documentation accuracy and KPIs

Operational Excellence
Focus on contract improvements, service line additions, integration, etc.
Significant Existing and Funded Medical Center Embedded Adj. EBITDA Opportunity in Addition to Profitable Affiliate Model

Illustrative Adj. EBITDA By Medical Center Vintage

- **De Novo Medical Center Adj. EBITDA**
- **Acquired Medical Center Adj. EBITDA**

($ in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>De Novo</th>
<th>Acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$0.5</td>
<td>$0.1</td>
</tr>
<tr>
<td>Year 2</td>
<td>$1.2</td>
<td>$1.7</td>
</tr>
<tr>
<td>Year 3</td>
<td>$1.7</td>
<td>$1.8</td>
</tr>
<tr>
<td>Year 4</td>
<td>$2.4</td>
<td>$2.3</td>
</tr>
<tr>
<td>Year 5+</td>
<td>$3.0</td>
<td></td>
</tr>
</tbody>
</table>

De Novo Medical Center Count at Year-End 2022E ~80

(x) Embedded Adj. EBITDA ~$2.3M

De Novo Embedded Adj. EBITDA Potential ~$185M

Acquired/Tuck-in Medical Center Count at Year-End 2022E ~105

(x) Embedded Adj. EBITDA ~$3.0M

Acquired Embedded Adj. EBITDA Potential ~$315M

Embedded Medical Center Adj. EBITDA Opportunity (~$500M

Assumes approximately 40 de novos and approximately 15 tuck-ins during 2022

Note: Adj. EBITDA is a non-GAAP measure. Refer to the reconciliation table in the Appendix for reconciliation of Adj. EBITDA to the most comparable GAAP measure. Estimated financial performance for each medical center is before corporate expenses and does not add back de novo losses or adjust for the impact of mid-year de novos and mid-year acquisitions prior to 2021. Medical centers vary in size and capacity. Estimated number of medical centers and Adj. EBITDA for 2022 is based on management’s internal projections and subject to change.

(1) Includes tuck-in acquisitions; Embedded Adj. EBITDA based on mix of large-scale and tuck-in medical centers

(2) Embedded Medical Center Adj. EBITDA does not include Corporate Overhead
Self-funded Operating Model

- Cash from Operations supports organic growth
- Medical centers provide attractive embedded Adj. EBITDA as they mature
- Affiliates generate positive cash flows and enhance market growth opportunities

Multi-Faceted Growth Strategy

- Access, Quality and Wellness drive enrollment growth and improved outcomes
- Buy, Build, Manage strategy offers flexibility and optionality
- Target and secure most profitable markets through Speed, Scale and Density

Strong Short- and Long-Term Organic Growth Opportunities

- Targeting annual revenue organic growth of ~30% for 2023-2025; 20%+ thereafter
- Targeting long-term Adj. EBITDA margin of ~15%
- Expect to be CFO positive in 2022
- Expect to be FCF positive in 2023
## Adjusted EBITDA Reconciliation

<table>
<thead>
<tr>
<th>($ in millions)</th>
<th>2Q21</th>
<th>3Q21</th>
<th>4Q21</th>
<th>1Q22</th>
<th>LTM 1Q22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net income (loss)</td>
<td>(36.3)</td>
<td>(64.8)</td>
<td>0.5</td>
<td>(0.1)</td>
<td>(100.7)</td>
</tr>
<tr>
<td>Interest expense, net</td>
<td>9.7</td>
<td>16.0</td>
<td>14.9</td>
<td>13.3</td>
<td>53.9</td>
</tr>
<tr>
<td>Income tax expense (benefit)</td>
<td>(2.0)</td>
<td>0.5</td>
<td>0.8</td>
<td>1.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Depreciation and amortization expense</td>
<td>7.9</td>
<td>17.0</td>
<td>18.7</td>
<td>19.0</td>
<td>62.6</td>
</tr>
<tr>
<td><strong>EBITDA</strong>(1)</td>
<td>(20.7)</td>
<td>(31.3)</td>
<td>34.9</td>
<td>33.3</td>
<td>16.2</td>
</tr>
<tr>
<td>Stock-based compensation</td>
<td>3.6</td>
<td>9.5</td>
<td>14.8</td>
<td>13.8</td>
<td>41.7</td>
</tr>
<tr>
<td>De novo losses</td>
<td>8.5</td>
<td>10.2</td>
<td>16.0</td>
<td>15.8</td>
<td>50.5</td>
</tr>
<tr>
<td>Acquisition transaction costs and other</td>
<td>17.1</td>
<td>12.4</td>
<td>8.9</td>
<td>9.9</td>
<td>48.4</td>
</tr>
<tr>
<td>Restructuring and other</td>
<td>2.8</td>
<td>2.3</td>
<td>2.4</td>
<td>2.6</td>
<td>10.1</td>
</tr>
<tr>
<td>Change in fair value of contingent consideration</td>
<td>(0.5)</td>
<td>(3.9)</td>
<td>(7.5)</td>
<td>(4.7)</td>
<td>(16.6)</td>
</tr>
<tr>
<td>Loss on extinguishment of debt</td>
<td>13.2</td>
<td>0.0</td>
<td>(0.1)</td>
<td>1.4</td>
<td>14.5</td>
</tr>
<tr>
<td>Change in fair value of warrant liabilities</td>
<td>(39.2)</td>
<td>14.6</td>
<td>(58.3)</td>
<td>(27.2)</td>
<td>(110.1)</td>
</tr>
<tr>
<td><strong>Adjusted EBITDA</strong>(1)(2)</td>
<td>(15.2)</td>
<td>13.8</td>
<td>11.1</td>
<td>45.0</td>
<td>54.8(3)</td>
</tr>
</tbody>
</table>

Note: Numbers may not sum due to rounding

(1) EBITDA and Adjusted EBITDA are non-GAAP financial measures. A non-GAAP financial measure is a performance metric that departs from GAAP because it excludes earnings components that are required under GAAP. Other companies may define non-GAAP financial measures differently and, as a result, our non-GAAP financial measures may not be directly comparable to those of other companies.

(2) Adjusted EBITDA is EBITDA adjusted to add back the effect of certain expenses, such as stock-based compensation expense, de novo losses, acquisition transaction costs, restructuring and other charges, loss on extinguishment of debt, and changes in fair value of warrant liabilities. Adjusted EBITDA is a key measure used by our management to assess the operating and financial performance of our business in order to make decisions on allocation of resources.

(3) LTM as of Q1'22 have been derived as follows: (i) the applicable consolidated financial statements for the year ended December 31, 2021, less (ii) the applicable consolidated financial statements for the three months ended March 31, 2021, plus (iii) the applicable consolidated financial statements for the three months ended March 31, 2022.

### Notes:
- **A**: Represents non-cash compensation charges
- **B**: Represents costs associated with the ramp up of de novos and losses incurred up to 12 months post-opening
- **C**: Represents legal and professional fees related to historical acquisitions and debt financings
- **D**: Includes one-time legal, IT, severance and various other non-recurring items
- **E**: Represents the non-cash change in the value of contingent considerations related to acquired practices
- **F**: Represents costs related to amended or previously repaid debt
- **G**: Represents non-cash impact from change in warrant liabilities
Disclaimer

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Forward-Looking Statements.

This Presentation contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. Forward-looking statements relate to future events or involve known and unknown risks, uncertainties and other factors which are, in some cases, beyond our control and could materially affect actual results, performance or achievements. Such forward-looking statements include, without limitation, our anticipated results of operations, including our financial guidance for the 2022 fiscal year and our Medicare Cost Ratio, interest expense, stock compensation expense, de novo losses, capital expenditures and break-down of Adjusted EBITDA for 2022; our expectations regarding our financial outlook, including our long-term market, margin and annual organic revenue growth goals and our expectation regarding 2022 cash from operations and 2023 free cash flow; our business strategies; our expectation regarding our costs and our belief that our approach to medical care will create superior outcomes; our expectation regarding the number of medical centers, employed and affiliate providers, members and states in which we will be operating; our expectation that we can build capacity through de novos and tuck-ins; our expectation that inorganic growth through M&A will provide additional growth potential; our expectation that the number of DCE membership and affiliate providers will continue to grow and contribute significantly to our revenue growth; our expectation regarding the existence of significant medical center embedded Adjusted EBITDA opportunity; and our expectation regarding our prospects and plans, and other aspects of our operations or operating results. These forward-looking statements generally can be identified by phrases such as "will," "expects," "anticipates," "FORESEES," "forecasts," "estimates" or other words or phrases of similar import. It is uncertain whether any of the events anticipated by the forward-looking statements will transpire or occur, or if any of them do, what impact they will have on our results of operations and financial condition.

Important risks and uncertainties that could cause our actual results and financial condition to differ materially from those indicated in forward-looking statements include, among others, changes in market or industry conditions, regulatory environment, competitive factors, market developments and technological advances, our ability to manage growth, our ability to execute our business as a result of the restrictions on our ability to raise capital; our ability to continue to execute on our acquisition strategy and integrate our acquisitions and achieve desired synergies; changes in laws and regulations applicable to our business; our ability to maintain our relationships with health plans and other key payors; the impact of COVID-19 or another pandemic on our business and results of operation; our future capital requirements and sources and uses of cash, including funds to satisfy our liquidity needs; and our ability to attract and retain qualified talented independent physicians. For a detailed discussion of the risks and uncertainties that could cause our actual results to differ materially from those expressed or implied by the forward-looking statements, please refer to our filings with the Securities and Exchange Commission (the “SEC”), including the risk factors identified in the Annual Report on Form 10-K filed with the SEC on March 14, 2022. Unless otherwise specified, all information provided in this Presentation is as of the date hereof. New risks emerge from time to time and it is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those expressed in any forward-looking statements we may make. Except as required by law, we undertake no obligation to update any forward-looking statements to reflect events or circumstances after the date of such statements. You should, therefore, not rely on these forward-looking statements as representing our views as of any date subsequent to the date of this Presentation.

This Presentation also contains certain non-GAAP financial measures as defined by the SEC rules. These non-GAAP financial measures, such as EBITDA, Adjusted EBITDA, and Adjusted EBITDA margin, have not been prepared in accordance with United States generally accepted accounting principles (“GAAP”). These non-GAAP financial measures should not be considered as alternatives or substitutes for certain financial performance measures calculated in accordance with GAAP. We believe that these non-GAAP financial measures provide useful information regarding certain financial and business trends relating to our financial condition and results of operations. Our management uses these non-GAAP measures to compare our performance to that of prior periods for trend analyses, for purposes of determining management incentive compensation, and for budgeting and planning purposes. We believe that the use of these non-GAAP financial measures provides an additional tool for investors to use in evaluating ongoing operating results comparing our financial results with those of other companies. Certain of our non-GAAP financial measures are calculated in accordance with the most directly comparable GAAP measures, and therefore are capable of being reconciled to their most directly comparable GAAP measures, in accordance with GAAP. The principal limitation of these non-GAAP financial measures is that they exclude certain expenses and income that are required by GAAP to be recorded in our financial statements. In addition, we are subject to inherent limitations as they reflect the exercise of judgments by management about which expense and income are excluded or included in determining these non-GAAP financial measures. In addition, other companies may calculate non-GAAP financial measures differently or use other methods to calculate their performance measures for comparison. Accordingly, reconciliation is not available without unreasonable effort, although it is important to note that these factors could be material to our results computed in accordance with GAAP. You should review our financial statements filed with the SEC for further information regarding our use of non-GAAP financial measures.

Unless stated otherwise, all information in the Presentation is as of March 31, 2022. LTM as of Q1’22 have been derived as follows: (i) the applicable consolidated financial statements for the year ended December 31, 2021, less (ii) the applicable consolidated financial statements for the three months ended March 31, 2021, plus (iii) the applicable consolidated financial statements for the three months ended March 31, 2022.