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Tickled PINC to buy Premiere at 8x EBITDA

April 6th, 2017
Premier, Inc. | PINC
Price: $32.26
12 Month Target Price: $44.75, 39% upside
Market Cap: $4.55 billion
Enterprise Value: $4.68 billion
Headquarters: Charlotte, North Carolina

Premier, Inc. (PINC) is engaged in healthcare supply chain management and healthcare IT services. It is the second largest GPO (Group Purchasing Organization) player in the nation with ~32% market share while also having a significant healthcare IT business that is a combination of SaaS software and healthcare IT consulting. Premier is unique in that 64% of the company is owned by its "members," or more accurately, hospitals and other healthcare organizations that Premiere advertises are more like strategic partners. Ten prominent executives from various health organizations sit on Premier's board. It is also unique in our view as a vendor neutral platform that has access to both clinical and operational data.

Premier's core value proposition is to find ways to lower costs for healthcare organizations, something that is a national focus as healthcare costs continue to rise. They claim to serve over 3,750 hospitals in the United States, have access to over 40% of all hospital discharges, and process more than $50 billion in supply chain spend annually, across 2,200 contracts and 1,200 suppliers.

Premier has many of the characteristics we like in stocks:

1) High margins (30%+ consolidated EBITDA margins since IPO)
2) Sticky, predictable revenues (97% retention of their GPO business, 92% for Software) with high barriers to entry and low cyclicality
3) Strong product set (strong KLAS rankings)
4) Oligopoly industry
5) Strong FCF generation with relatively low capex
6) Understandable reasons for recent derating that will likely clear up over next 12-18 months
7) Relatively low leverage
8) Likely acceleration of revenue growth in the back half of 2017 and potentially 2018

The stock trades ~8.5x NTM EBITDA and ~16x NTM earnings, so discounts to the S&P currently despite a superior profile.

We target 10x 2018 EBITDA by year end, which seems achievable given likely ~10% EBITDA CAGR (8% organic revenue), based on a DCF, trading and takeout comps, a SOTP, and some analysis based on how their multiple moves with organic revenue growth. We also find the Healthcare IT space generally attractive as it has de-rated significantly relative to the S&P despite still having, in our opinion, secular tailwinds. Premiere has de-rated the most but seems poised to benefit the most, hence our pick of Premier vs. Cerner/Allscripts. Although a takeout is not part of the thesis, Premier would appeal to many players looking to bolster their healthcare offerings (IBM, Cerner, etc.).

At 10x our 2018 EBITDA (near consensus), the stock would have about 30% upside, to about $41. We put this as a starting point target price but believe if/when the narrative turns on the stock from "worried about a healthcare spending pause" to "secular growth story" the company could get back to 12x EBITDA, where it traded originally at its IPO and where its one clear cut comp, MedAssets, was bought out at (despite an inferior profile and a significantly lower market valuation).

If they demonstrate further competitive takeaways and show sustained growth in SaaS, a higher multiple is possible, in our view, while we find it hard to model the company below 7x EBITDA and think the visibility is solid to that EBITDA.

Key Thesis Points

1) **Unique value proposition** - The most interesting thing about PINC is their unique *vendor neutral* ability to obtain data from across the healthcare spectrum (supply chain, clinical, etc.). This is mostly because of #2 below, which we believe potentially gives them a competitive advantage over pure Healthcare IT names like Cerner.
2) **Ownership structure** - Over 60% of the company is owned by hospitals and the board is stacked with these hospital owners, incentivizing alignment of goals and sharing of data. For instance, Premier is constantly engaged in "collaboratives" whereby hospitals come together to analyze difficult challenges and come up with solutions.
3) **Secular tailwinds** - PINC's stated goal is to reduce costs for hospitals, something we believe is going to be a critical factor going forward in healthcare. While there may be a temporary "pause," we believe the company is ultimately well positioned to take advantage of the current healthcare environment. In fact, amongst all healthcare IT, PINC may be one of the best advantaged to thrive in the shift from more of a spending focus (e.g. EMR) to saving focus (how can we cut out $200 million in annual costs?). Having read Cerner strategic plans, much of their strategy revolves around these areas of PINC strength as well (value based reimbursements, population health). Given's PINC's positioning, takeout offers are certainly not out of the question. Once they pay down their revolver, an LBO might also be possible.
4) **All time low valuations –** The stock sits at an all-time low valuation across most metrics since its September 2013 IPO, including having de-rated from over 12x EBITDA to under 8.5X EBITDA, and 24x earnings to 15.5x earnings. While we would expect the stock to sell off further in a market crash, we think a lot of the downside has been de-risked, certainly on a relative basis. We can envision a bull case where it gets back to these original multiples, specifically given that the market has rerated substantially over that time.
5) **Growth acceleration-**The company had a relatively weak Q1 and Q2, but guidance implies acceleration of organic growth in the back half, and there are reasons to believe management has solid visibility here.
6) **Highly rated products-** The company's consulting/advisory business is getting top rankings from KLAS, the key scoring metric used by the industry. Additionally, hot button areas of consulting like value based reimbursement, reduction, and population health, are where KLAS specifically calls out PINC's strengths. We believe this portends well for future business and potential competitive takeaways in the GPO space, as their consulting business makes the GPO more efficient.
7) **Oligopoly in core industry-** Their GPO business is highly concentrated between Premier (32% share), the newly combined Vizient (46% share), and HPG (16%), with further consolidation occurring at the margins and the creation of Vizient resulting in some market disruption (see #8 below).
8) **Market share gainer**- We believe they have an opportunity to capture market share from Vizient, who was involved in a major merger, which has resulted in clients doing an 18-24 month evaluation of new GPO partners. The 18 month point hits in April, and the company claims their RFP channel is at all-time highs. While not critical to the thesis, some significant competitive takeaways might push the stock closer to a Bull case.
9) **Strong/Sticky Customers**- both their GPO and SaaS businesses have well over 90% retention rates and both have "mission critical" elements with high switching costs.
10) **Margins Get "Less Bad"**- margins have crashed with their acquisition of Acro pharma and some additional spend in anticipation of revenues on the Performance side. We think higher growth from their low margin Product business will continue to hamper EBITDA margins (but not total EBITDA), but over the next 2-4 quarters the declines will moderate.
11) **Obamacare Staying in Place**- the recent failure to repeal Obamacare arguably removes some uncertainty for the stock, certainly in the short term. While management would have you believe the primary focus of hospitals will be the same with or without Obamacare (e.g. cutting costs), the uncertainty around "repeal and replace" was likely impacting sentiment on the stock. We still believe this remains a medium term risk, as there is still a "rubber hits the road" moment for Obamacare sometime in the future, but in the short term it is likely a positive.

Key Risks

1) **GPO Sustainability and Competition-** It is hard to know for certain how the GPO model will evolve over the coming years. As of now nearly every hospital has one, and those that have struck on their own have returned later, but it's possible the model could come under regulatory pressure. For instance, if the move towards value based healthcare results in fewer total services, it would impact the revenues they get from their suppliers as the revenue is mostly based on volume (specifically pharmaceuticals). There are also other ways to obtain medical supplies, and smaller regional competitors seem to be taking some share, although mostly from Vizient.

2) **Permanent sellers -** Each quarter hospital owners can redeem their shares, which while increasing the float will put pressure on the stock price. Recently the company has been buying out the shares to mitigate that pressure, but it is an ongoing headwind that will not subside anytime soon and larger redemptions could keep sentiment low.
3) **Capital Allocation-** We question the effectiveness of their capital allocation strategy, particularly some pricey acquisitions they made in 2015 at over 14x sales (CECity). Additionally, management talks about having a "lot of fire power", so poorly received acquisitions are a risk, as are execution of their current acquisitions. Since CECity, they seem to have reigned themselves in, so after a clear pattern of poor capital allocation they have started buying back stock instead.
4) **Hard catalysts -** There are fewer hard, idiosyncratic catalysts than we typically like to have. For instance, we have no evidence that any takeout would occur, although perhaps hospital groups could band together and buy out the public shares, or maybe someone like IBM would be interested in buying them, or perhaps an LBO is possible given the relatively low debt levels. **The catalysts are resolution of Obamacare with things changing less than expected, acceleration of revenues growth in the back half of 2017, and margin declines getting smaller and smaller, which results in a general narrative shift from "uncertainty" to "secular tailwinds".**
5) **General complexity -** This is a complex company, and we don't necessarily see it moving towards simplification, something we generally prefer. If anything, it's been getting more complicated with recent acquisitions.
6) **Hospital Owner Double Edged Sword -** We believe the positives outweigh the negatives, but in some cases PINC management, which is controlled by mostly hospital executive board members, may make decisions that are clearly better for the hospitals but not necessarily better for PINC's shareholders. It's unclear what mechanisms the company has in place to manage this, given the heavy composition of hospital executives on the board. In many cases, PINC's stock price may be relatively insignificant to the overall operations of the hospitals. This dynamic might make a takeout more challenging.
7) **General Market Downturn-** this is a bit more of a relative call. Although PINC has a low beta, if the market crashes there isn't enough on the idiosyncratic side that it won't go down some as well, although we suspect less than the market as a whole, given low cyclicality and low starting multiple.

Business:

Despite the company reporting in two segments (Supply Chain Management and Performance), you can really break up their businesses into four pieces, each with ***very*** different unit economics/characteristics:

1) GPO (Supply Chain Management)
2) Specialty Pharma and Direct Outsourcing (Supply Chain Management)
3) SaaS Software (Performance)
4) Consulting (Performance)

In the table below, you can see that GPO dominates from a revenue standpoint, but is even more significant from an EBITDA perspective (note that EBITDA are our estimates):

Business	% Revenues	% EBITDA
GPO (aka Administration fees)	36%	74%
Specialty Pharma/Direct Sourcing (aka Product)	40%	7%
SaaS Revenues	16%	12%
Advisory Services Reveneus	8%	8%

Obviously, the GPO business has by far the highest EBITDA margins (we estimate they are running near 85% EBITDA margins and rising), the Specialty Pharma/Direct Sourcing has the lowest (we estimate 5-7% EBITDA margins), while it's hard to know how to break down the differences between SaaS and Advisory, although we suspect SaaS is in the mid 30% range and Consulting/Advisory in the mid-20s.

GPO and SaaS are the least lumpy, evidenced by 90% plus retention rates on both areas, and the relatively recurring nature of each one. Given the dominance of the GPO business on the financials, we spend the most time on it.

GPO Business

What is a GPO? It is a Group Purchasing Organization. Basically they act as an intermediary between the hospitals and all the suppliers of non-labor medical services. GPOs are extremely common in the industry. About 97% of all hospitals use a GPO

in some way and on average a hospital will use two to four GPOs. The list of products they provide is pretty much all encompassing outside of the doctors themselves (from K):

"medical and surgical products, pharmaceuticals, laboratory supplies, capital equipment, information technology, facilities and construction, food and nutritional products..."

Unlike distributors they do not carry inventory. They negotiate in bulk, and then get paid by the suppliers in what is called an "Administrative fee." They claim to work with other 1,200 suppliers and have 2,200 contracts.

"Contracted suppliers pay us administrative fees ***based on the purchase volume*** *of goods and services sold to our healthcare provider members under the contracts we have negotiated."*

As we understand it, the payment flow is that PINC gets ~2.2% of total purchase spending, then shares 30% of that spend with the hospital members and keeps 70% as a "Net Administrative Fee." So their revenues for the GPO is almost 100% dependent on the total purchasing spend running through their network of hospitals and suppliers.

In addition to hospitals, they also have GPO programs for long term care/senior living facilities, independent physicians, and even education and hospitality (called Premier REACH). They recently made a material acquisition to bolster themselves in this space, paying $379 million for Innovatix and Essensa. They already owned 50% of Innovatix.

GPO is a very high margin business. They don't report the EBITDA margin separate from Product, but we estimate it's doing about an 85% margin (and rising), and has been growing consistently in the 6-10% range (until this most recent quarter guiding for closer to 5%). It's extremely high gross margin since they are only counting the Net revenue vs. Gross and they benefit greatly from scale.

GPO is a sticky business. The company cites a 97-98% customer retention rate. Pulling your GPO is massively disruptive, akin to ripping and replacing your ERP as it's a mission critical service. On the supplier side, we believe there is generally less leverage than one might believe, as being part of GPO is a huge money saver for suppliers. As opposed to marketing to every hospital, signing a GPO contract effectively does a lot of the marketing for the supplier. Given the large number of suppliers, large number of hospitals, and very few "at scale" GPOs, we believe GPOs generally have strong competitive positioning, although certain supplies that "sell themselves" may be exceptions.

How do they grow? It is less about competitive takeaways (although this is possible and a thesis point), and less about total spend rising, and more about increasing penetration within a given hospital. For instance, many doctors like to source many of their own products that they learned about in medical school, even if it's more expensive. Premier will spend time and money trying to educate doctors and doctor groups on the efficacy of certain products in their GPO library, and thus generate more spend per hospital, per GPO. Premiere is uniquely able to do this with all the data they have from their hospital network and their analytic software (on the Performance side). So while total spend volume and total hospitals may impact revenue growth at the margins, most of the driving force is around penetration rates in existing hospitals.

According to the Healthcare Supply Chain Association, 72% of all hospital purchases run through a GPO. Some believe 80% is the benchmark utilization rate GPOs will be striving for, as it's a win-win. The more a hospital uses a GPO, in theory the greater discounts it can get, while the GPO also gets more Admin Fees. The CEO has commented a few times that they are still underpenetrated within their existing hospitals, and that they expect they can continue to grow in this fashion, albeit likely at a slightly slower pace than 7%-10% organically.

GPO Industry:

The GPO industry currently is top heavy with the three top players making up over 90% of market share (Vizient, 46%, Premier at 31%, and HPG at 15%). It wasn't this concentrated until relatively recently.

MedAssets (MDAS) was probably the best comp for Premier until it was announced it would be acquired by Pamplona Capital for $2.7 billion late in 2015 (the deal was completed January 27, 2016). MedAssets was similar to Premier in the sense that it had both a substantial GPO business (~$300 million in Net Administrative fees) as well as a IT consulting business (~$180 million run rate). It did differ from Premier a bit by also having a large Revenue Cycle Management (RCM) business (~$260 million), but its overall profile was reasonably similar at the time of acquisition (relatively low revenue growth, ~30% EBITDA margins).

However, the company had some issues, notably losing a gigantic client shortly before getting acquired in Tenet (5-6% of 2016 revenues). Tenet subsequently moved to another large GPO, HealthTrust (HPG). Additionally, the company's long time CEO, John Bardis, stepped down for "personal reasons" in early 2015 and the overall company performance was poor enough to begin to attract activist investors like Starboard Value.

After the acquisition, the company was promptly split up between its GPO business and Revenue Cycle Management business. The GPO business was combined with a recently constructed behemoth, VHA-UHC. In April of 2015 VHA and UCH (University HealthSystem Consortium) completed a huge merger encompassing $50 billion in purchasing volume and 5,200 health systems. Apparently not satisfied, they then tacked on MedAsset's GPO business, which was hardly just a tack on as they were essentially the number 1 and number 2 in market share at that point. This combined gargantuan is now known as Vizient, and commands almost half of the GPO market.

In addition to general background on the GPO industry, we point out the MedAssets's takeout for a couple reasons:

1) **Transaction Comparable**: MedAssets, despite having lower growth and higher leverage was taken out at a material premium to what PINC trades at now. Below is a snapshot of the two (PINC now vs. MDAS):

Metric	MDAS	PINC	Delta
EV/EBITDA NTM	10.76x	8.54x	-20.6%
EV/Sales NTM	3.39x	2.78x	-17.9%
Adj. P/E FY1 (guidance)	25.49x	17.05x	-33.1%
Sales Growth (FY1/FY0)	5.80%	31%	25.2%
Organic Sales Growth (FY1/FY0)	0.50%	6.1%	5.6%
Adj. EBITDA Growth (FY1/FY0	0.40%	15%	14.6%
Adj. EPS Growth (FY1/FY0)	-8.90%	17%	25.9%

2) **Industry Upheaval**: We believe this vast consolidation has resulted in many hospitals taking the opportunity to review their current GPO provider, and it upped the potential for displacement as Premiere now has the opportunity to show off their technology stack. The company claims they have "record RFPs" and that they believe the sales cycle lasts 18-24 months. If that is true, there is the potential for some material upside wins over the next 12 months as April of 2017 would represent month 18 since the MedAssets acquisition (and month 24 since VHA-UCH). In the most recent quarter, the first such win came in the form of Wake Forest Baptist. Management commentary indicates there could be more coming.

GPO Competition and the "Future" GPO:

Competition comes from many different angles. For instance, some hospitals have banded together to form Integrated Delivery Networks (IDN). Part of an IDN's mission could be to become large enough that they can do their own supply sourcing and "cut out the middleman," aka the GPO. As of now this does not seem to be really picking up legitimate traction, but is something to watch.

Regional GPOs are also competition for the larger national players. For instance, Vizient lost some business recently to ROi, a more regional GPO, that was well publicized. The article suggests this could be a potential trend, and is something to watch. The quote from the CEO suggests there is risks to merging with other GPOs as it creates a new opportunity to evaluate the competition:

"TPC's move from Vizient to a smaller GPO is an early sign of what most experts have said would happen after VHA-UHC Alliance acquired MedAssets and created a mega-GPO now known as Vizient. Both companies were already the result of multiple mergers and acquisitions, and many providers, including TPC's membership, have expressed frustration that the GPOs' cultures haven't successfully merged as the businesses combined.

TPC CEO Geoff Brenner said he understood that MedAssets had a fiduciary responsibility to its shareholders to sell but contends members' interests in some cases got lost in the process. TPC has been a member of the GPO since 2010, from an initial MedAssets agreement.

'As a customer pulled into that, it really leaves you as a taste, of, I don't want to do that again,' Brenner said. 'I wouldn't be surprised if you see more organizations look at the mega-GPO trend and try to find a culture that looks more like their own.'

Although Premier has heavy concentration with member/owners, it's possible a member/owner would become frustrated with Premier's size and culture, sell out their shares, and then move away from Premier. This has not happened yet, as far as we can tell, but it is a risk (although as we highlight, also an opportunity for Premiere to seize market share from Vizient).

It's our understanding that university based hospitals tend to utilize GPOs a bit less than community hospitals, although we are still attempting to uncover why that is. These university hospitals may have contracts with more traditional distributors like VWR (ticker VWR) or Thermo Fisher Scientific (TMO), and potentially more direct sourcing.

And, of course, many supplies are purchased either through wholesale (with no contract) or through having direct manufacturer contracts. There have been predictions that GPO would lose some share over time, although it's not clear to us this is actually occurring (in fact, potentially the opposite), as Premiere claims most of its growth comes from further penetration within the existing customer base.

Net-net, it's our view that there remains penetration runway and potential displacement opportunities that, on average, will be more powerful than any lost customers or incremental shifts in markets share. In concert with Premiere's premium consulting and SaaS services that can provide analytics for additional savings, members would be less inclined to leave Premiere than other less IT savvy GPOs.

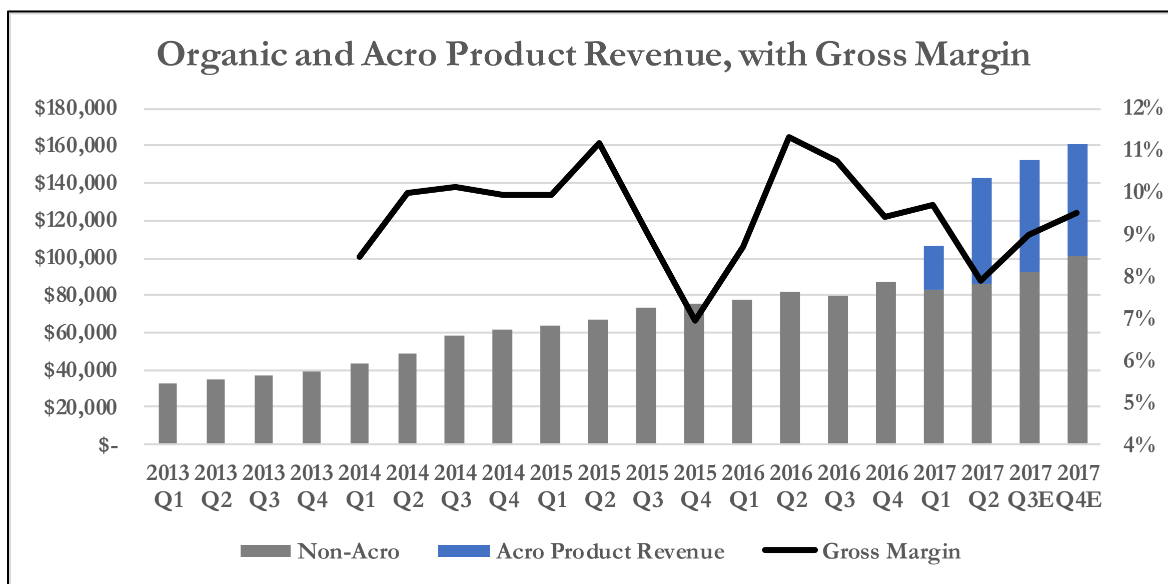
Specialty Pharmacy and Direct Sourcing:

PINC's specialty pharmacy segment is about a $560-$580 million run rate revenue business now, but has gross margin under 8%, and EBITDA margins likely closer to 4-6%.

In this case PINC takes on the role of distributor, as they take "title" to the pharmaceutical products and then resell to the hospitals/members. Up until August, 2016, this was a relatively small part of their business, at about $350 million in revenue and roughly $25 million in EBITDA (before corporate expense allocation).

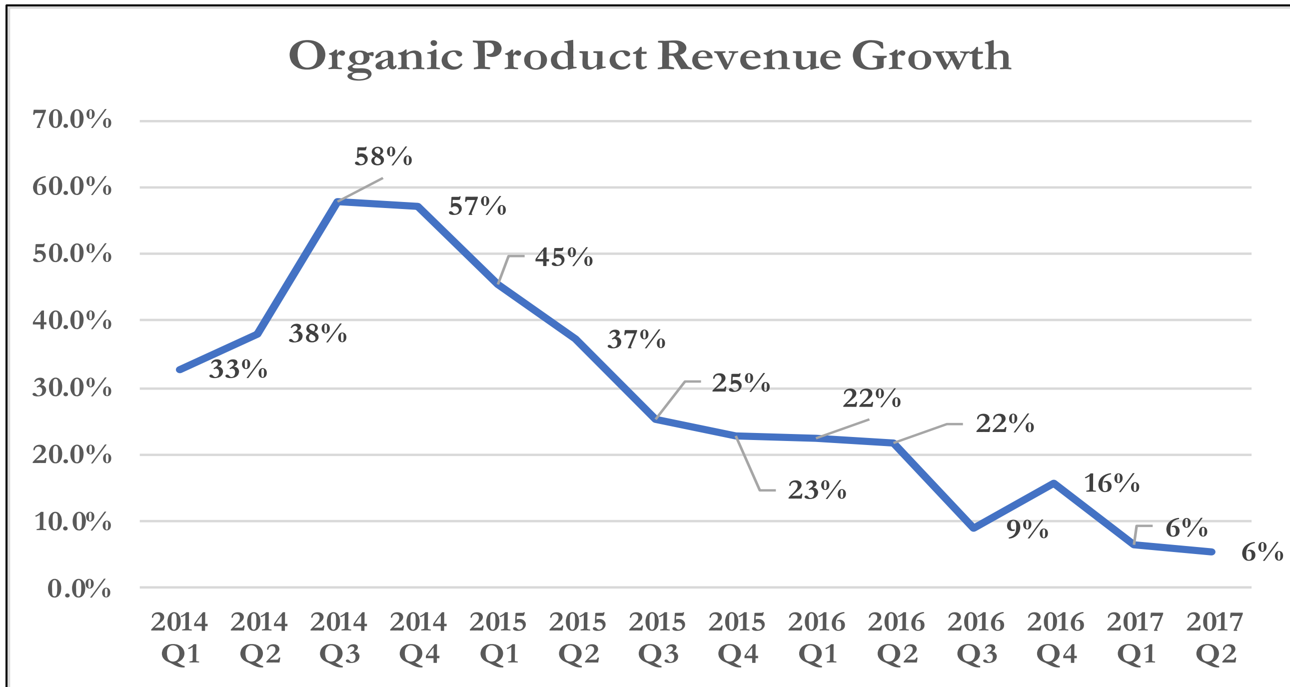
In August 2016, they bought a company called Acro Pharmaceuticals for .4x sales (probably about 6-7x EBITDA, not a bad price given comps) that nearly doubled their exposure to this area. This is a very low margin business and potentially lumpy, complete opposite of GPO and hence annoying that they combine the two for Adjusted EBITDA within "Supply Chain Management." For instance, weakness in the recent quarter and lowering of guidance to the "lower end of the range" was entirely attributable to issues they had on the pharmacy side and weakness in specific drug treatment sales (specifically hepatitis C).

So this segment has had the optical effect of significantly lowering EBITDA margins within the Supply Chain Management business, although also optically shows significant revenue growth. We have attempted to map out the product revenues, along with gross margin, below, splitting out Acro projected revenue from core Product revenue.



We believe gross margins will rebound somewhat as we attribute some of the decline in Q2 to some temporary disruptions in Acro that the CFO said had been "remedied" during Q2.

Underlying organic growth is worth watching though, as it has dipped recently, yet still gets guided towards 15-20% growth:



A question we asked is: **why get into this business at all**, outside of it being a relatively high revenue growth area? As we understand it, hospitals/GPO clients were demanding it, and it is particularly helpful to monitor and manage patient care plans for chronically ill patients. This business allows hospitals, apparently, to "keep close" with their chronically ill patients, who are a small percentage of the patients, but a large percentage of total spend. With these products, it is easier for the hospital to track that the chronically ill patients are actually buying and taking their medications, and allows them to proactively reach out if they see a patient has slipped. In this sense, this business is about keeping down readmissions, which is a key factor in value based reimbursements (e.g. lower readmissions = hospitals get more money from payers, specifically Medicare).

There are actually two pure play comps here that we include in our comp universe: Diplomat (DPLO) and Pharmerica (PMC).

PINC's SaaS Offerings

SaaS (Software as a Service) Healthcare IT makes up about 65% of the total "Performance" segment revenue. They have a variety of SaaS software offerings that combined are currently doing about $240 million run rate sales, with growth in the 10-15% range and EBITDA margins well above 30% (although these are both estimates since their Advisory Services and SaaS revenues/EBITDA have not been de-aggregated).

They appear to have a legit ERP business that competes with Oracle and Lawson, "Premier Supply Chain & ERP," which is the number one ranked ERP solution in healthcare, according to KLAS. This is a relatively new offering, created in 2015, and allegedly has strong integration with their GPO data to give hospitals better analytical capabilities. Recently at HIMSS, per William Blair, they noted that a third of their ERP sales are to hospitals *outside of their GPO members*, which is bullish to the efficacy of the product as well as long term potential to turn the ERP customers into GPO customers. ERP is a spectacular business in general in that it is mission critical, highly recurring, and high margin.

The other half of these offerings are various forms of data analytics. The mousetrap, as we understand it, is that Premier has unique insight into aggregated data from their thousands of hospitals. Thus, they claim they can look at various things and present them to individual hospitals like:

1) Compare aggregate costs being paid by other organizations vs. what customer is paying.

2) Connecting clinical outcomes with supplies. For instance, they can run analytical studies on which supplies (pharma as well) are resulting in fewer readmissions, and which are generally most effective for patient health. The goal here is to shine light on which medical products are actually providing the most value.

At the recent HIMSS conference (the largest Healthcare conference, by far), they were promoting a product called Service Line Analytics, which "integrates enterprise-level cost data (from supply chain systems) and quality data (from the organization's clinical and quality products) into a single enterprise data analytics offering." It can look at data from over 1,200 hospitals. Their pricey acquisition of CECity and Healthcare Insights (see Risks) in mid-2015 offered additional data analytics on the ambulatory side, which is helpful for hospital systems that have both hospitals and numerous satellite clinics.

What is interesting to us about all this is that they have the unique ability to aggregate data from many different places as a Vendor Neutral platform, and have the first party data to add significantly more insight. For instance, they can get clinical data from Epic and Cerner (with patient names washed out, of course), the two dominant ERP players, that they can combine with numerous other datasets and marry the data to get insights linking supplies (as well as doctors, geographies, and locations) to patient success factors. IBM awarded Premier with their 2014 "Beacon Award" for information management and data analytics (PremierConnect and PremiereConnect Enterprise). As we understand they are still active partners with IBM and while it's certainly not a Base Case, it's not inconceivable that IBM would want to acquire Premier to further their burgeoning healthcare ambitions (note IBM bought Merge partly for Merge's Vendor Neutral image archiving platform).

Advisory Services

There are two sub-parts to the Advisory Services piece of the business:

1) Consulting: contracts signed with a hospital to help advise on them long term plans to take out costs. For instance, a hospital will come to Premier needing to take out $50 million in annualized costs from a variety of sources, and Premier will get paid partly on normal hourly consulting charges, but also partially a contingent payment based on the demonstrated success of the cost savings.
2) "Collaboratives" which are actually contracts signed by many hospitals working with Premier to tackle specific issues. The idea being the hospitals are working together to analyze data and set standards and reporting around certain large issues like "Bundled payments" and "Population health."

Consulting

As we understand it this represents a strong majority of the Advisory Services business. It's clear that Premiere does some of the best consulting/advisory services around. They recently got awarded top ratings by KLAS in three distinct areas of consulting, all of them emerging and growing, as well as more broadly the best consulting firm.

They were named best in KLAS for:

a) Overall Healthcare management consulting (a new category)
b) Value-Based Care Consulting (2nd straight year)
c) Financial Improvement Consulting (a new category)
d) Strategy, Growth, and Consolidation consulting (a new category)

Given these awards, it was a little surprising to see Advisory services be the source of weakness in the last quarter, as EBITDA margins continued to decline. However, based on their commentary regarding guidance and visibility, we will see a material uptick in Advisory Services in the back half of 2017 (from CFO, Q2 2017 call):

"Performance Services revenue of $85.9 million increased sequentially over the prior quarter, but does reflect a 3% year-over-year decrease. ***This primarily results from Advisory Services revenue****, which was impacted by the timing of engagements in the current year compared to the prior year, which represented a particularly strong advisory services quarter.*

We expect Performance Services segment revenue growth to accelerate in the second half driven ***by anticipated revenue recognition from some large advisory services engagements*** *and from the ambulatory regulatory reporting that occurs in our third quarter."*

Collaboratives

Collaboratives bring together hospitals to tackle large scale problems. As of their last K, they had collaboratives that include general best practices (QUEST collaborative), Bundled Payments, Population Health Management, and several others. The participating hospitals pay for the appropriate subscription services within the Collaborative while it is ongoing. The idea, as we understand it, is to always have several rolling Collaboratives going on at once.

The best known collaborative is the QUEST collaborative. This collaborative has been ongoing for several years (started 2008) and is designed to show that if a group of hospitals come together and share best practices on process, it can save lives. Premier makes the rather grandiose claim that by their estimation hospitals using the QUEST system has saved ~160,000 lives through 2015, and revised up to 176,000 in 2016 (along with saving $15 billion in healthcare spending and improving readmission rates by 32%). Although we are somewhat skeptical of these numbers in a vacuum, they did receive national recognition in April, 2016 by winning a the National Quality Forum (NQF) award. Their more recent launching of "QUEST 2020" ensures the program will continue for at least a few more years.

Although a relatively small piece of Performance Revenue (and within Advisory Services), we think it's important to call attention to the Collaboratives business for a couple reasons. First, it's a way to keep Premier as being a thought leader. They work with their members to come up with large, overarching problems, then present their findings not just to their members, but also to the government and other groups. Management claims to have a strong relationship with Tom Price, the current Secretary of Health and Human Services, and these collaboratives help build that relationship.

It also shows in a tangible (albeit maybe fluffy) way that hospitals within Premier's member network are willing to actively engage and work with each other, building the case that Premier is a legit contributor to the eventual goal of nationwide interoperability and cooperation.

Why Does This Opportunity Exist?

We believe there are 4-5 key reasons why this opportunity exists:

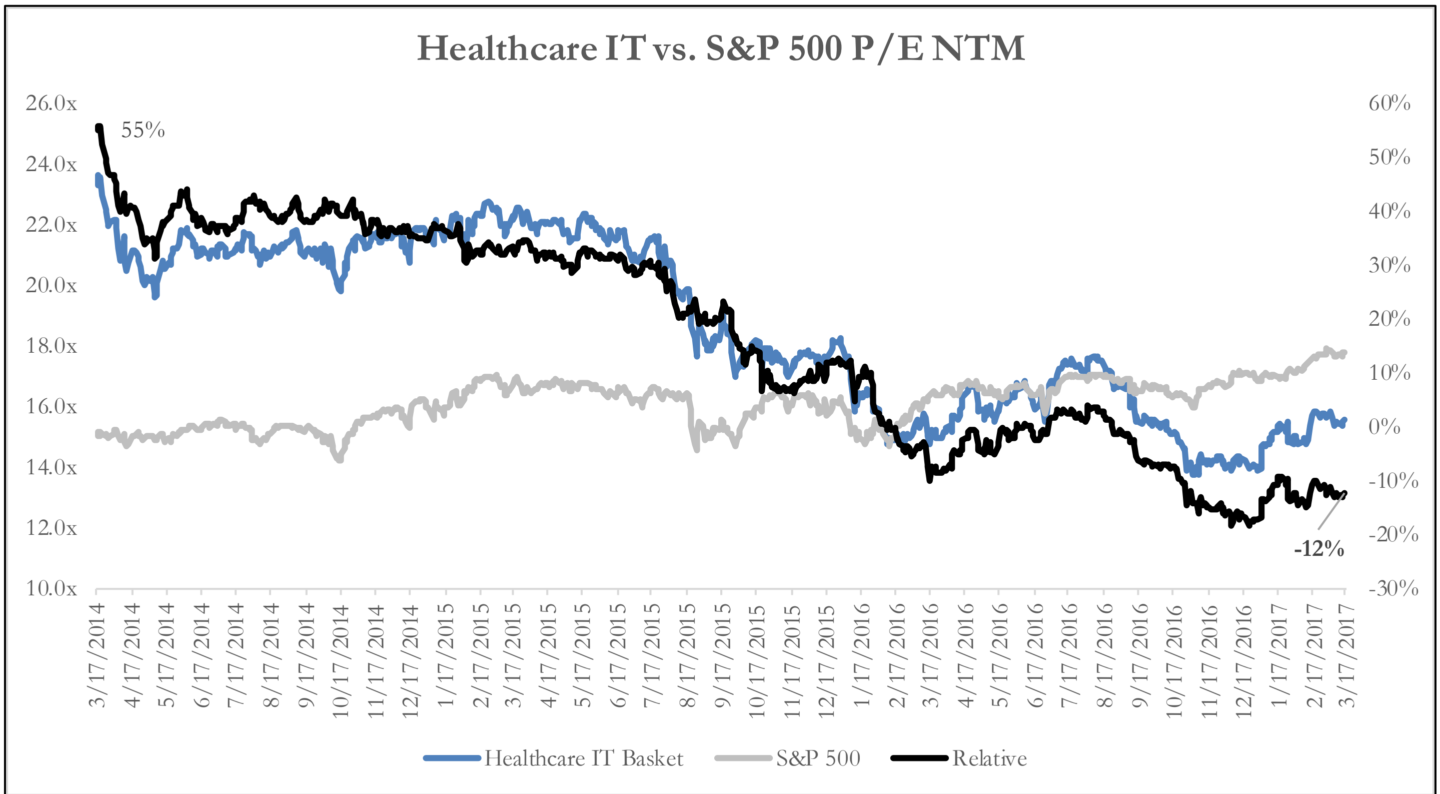
1) General derating of Heathcare IT
2) PINC's EBITDA Margins Declining
3) Relatively weak recent results
4) Weakness in Specialty Pharma
5) Lack of obvious trading comps (once MedAssets went private)

Of these five, we discuss the first four in detail below, while #5 will likely remain an ongoing headwind unless Vizient does an IPO.

General Derating of Healthcare IT

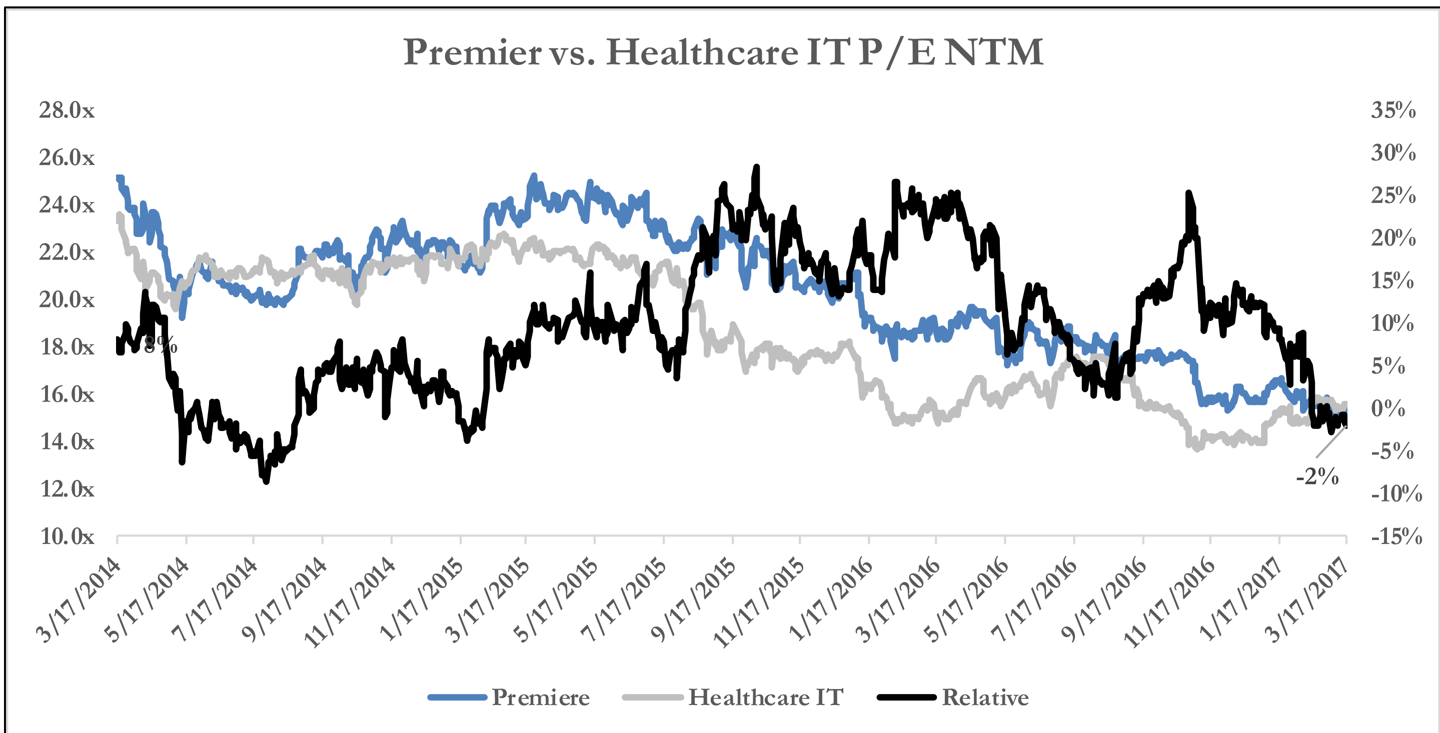
Healthcare IT has been pretty heartily de-rated (both absolute and relative to the S&P) as many are worried about a "pause" in spending as hospitals assess what is going to happen with Obamacare. Consider a basket of the following names: CERN, ATHN, QSII, PINC, CPSI, MDRX, and MCK.

Over the last three years, their median P/E multiple has moved from a 55% premium to the S&P to a 12% discount to the S&P.



Some of this derating is justified. For instance, average sales growth has slowed materially, from about 13-15% the last three years to 7% now, with margins holding in check, not rising like you might hope.

PINC is no exception. In fact, it has de-rated relative to the Healthcare IT group:



Is the failure to "repeal and replace" Obamacare bullish for Premiere and other Healthcare IT? We are not sure. The company talks about the Obamacare issue constantly and is unsurprisingly optimistic. For instance, in their latest slideshow the company points out that the general bi-partisan healthcare trends are relatively favorable to Premiere (at least in theory);

Regardless of the changes in Washington:

Health systems and **providers face the same challenges**:

- Reduce the cost of care
- Improve quality and outcomes
- Better manage the health of the populations they serve.

Bi-partisan support to move to fee for value expected to continue as many of the underlying tenets of the ACA, such as MACRA, were bi-partisan.

Premier believes it remains well-positioned to help members excel in a value-based care environment.

In a January fireside chat with JP Morgan, the CEO elaborated on these points a bit, stating:

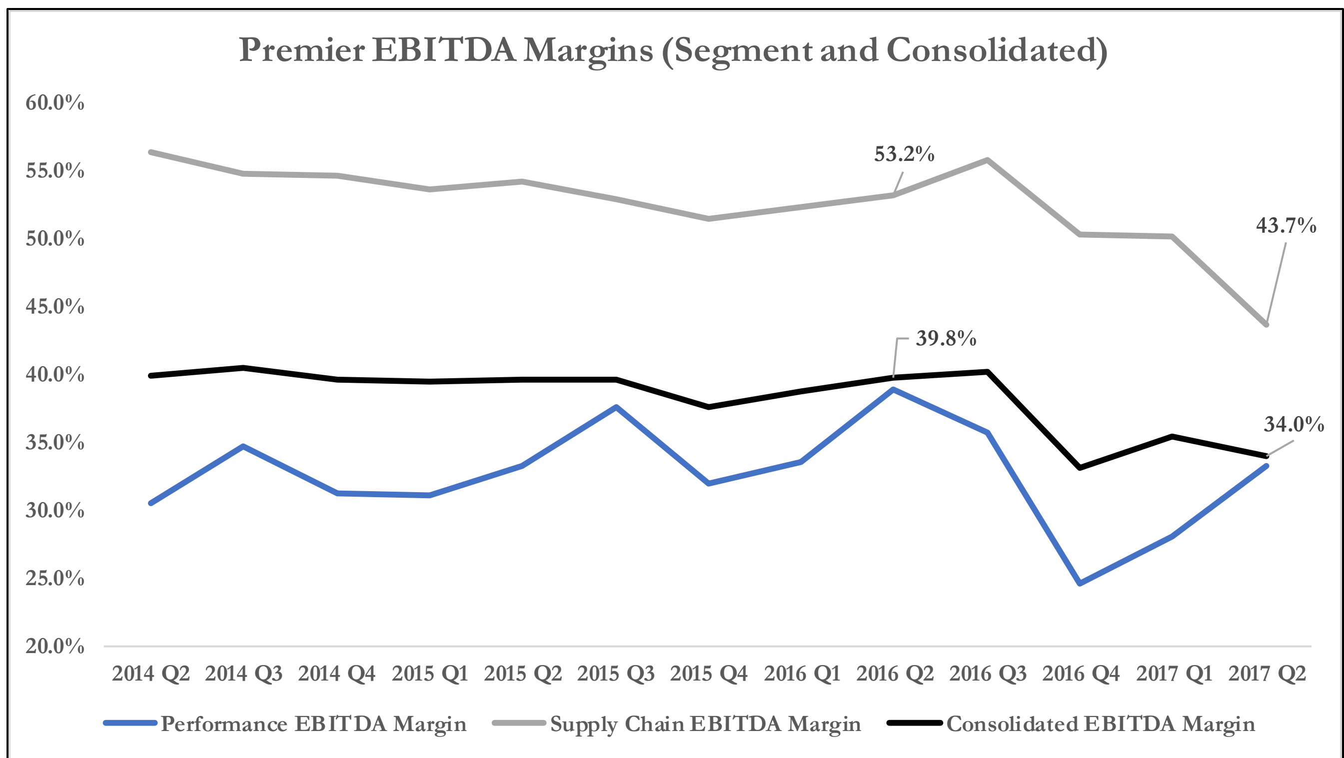
> Devore (CEO): *Yeah. So we do know Tom Price. We've already submitted to the Trump administration and the Republicans our recommendations for the modifications to the healthcare plan. He is a deeply knowledgeable leader of HHS. So we're not in a situation where you have a leader who's not deeply knowledgeable in healthcare. He has put forward multiple proposals for the reform of healthcare. The Republicans tend to support MACRA and the new payment legislation. They tend to be very cost focused. They were actually the originators of the value-based purchasing design that we have today… So our sense is that they need to get the political benefit of the headline of repealing Obamacare, which we believe they will get. But then the really hard work of transforming the payment delivery models and shifting the risk to providers for accountability around how they're delivering care and the cost, quality, safety and outcomes of that care, we think will continue.*
>
> Analyst Question*: But your healthcare systems (have become) paralyzed before we know. So I mean could we see a period of time where hospitals say, I'm not going to buy any incremental systems or buy incremental data because I'm not sure exactly what it's going to look like. I know I'm moving forward. I know we're moving towards this value-based care, but we don't have a lot of incremental dollars.*
>
> Devore (CEO): ***No. I would say we're actually seeing the opposite****, which is they know that they stood to benefit by $150 billion as an industry from the Obamacare model. That $150 billion goes away… What we're seeing and where we're doubling down is major cost transformation that has to occur. So we're seeing bigger, larger scale cost reduction opportunities, which require data, technology and advisory services. We're also seeing healthcare systems say, I need to clinically transform my entire IDN. And so, they're basically saying, we can't afford to wait because we know it's going to be measuring the same kinds of things and the risk is going to be shifted to us.*

To us, not repealing and replacing does not necessarily mean the Obamacare model is going to stay as is for the long term, and hence the recent news is perhaps a positive in the short term (purely for sentiment), but longer term it is still unclear. As mentioned above, PINC believes that no matter what the political environment, the #1 goal of hospitals is to work to cut costs.

A risk here is that while Performance may do well, the real cash cow (GPO) will ultimately be negatively impacted from legislative changes, as hospitals will be pressured to have a more discerning eye on what to purchase, and lower purchase volumes translate to lower revenues for Premiere. This cost focus and value based reimbursement approach is somewhat counteracted by what will almost certainly be a growth in demand for services as the population in the United States continues to age.

PINC's EBITDA Margin Declining

Premiere's EBITDA margin is clearly declining, specifically the reported Supply Chain margins:

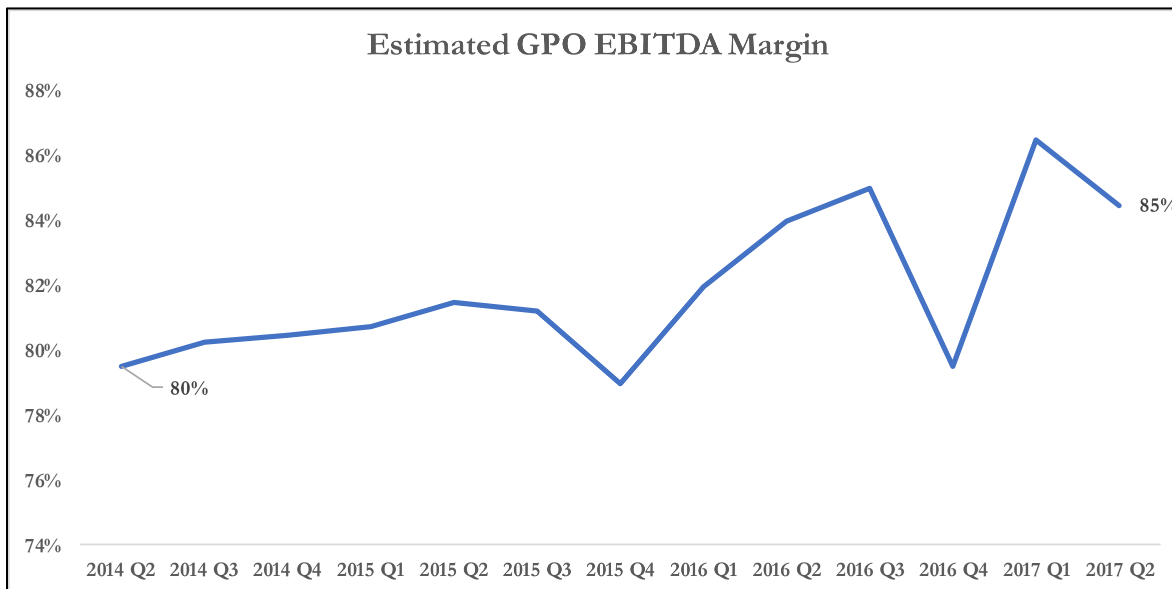


Specifically, consolidated EBITDA margins, while holding very steady at 40% from IPO onward, have recently contracted materially to 34%, and the culprit is pretty clearly the Supply Chain business. Is the business getting disrupted? Normally this is something of a red flag.

However, we believe it's entirely due to product mix, specifically their acquisition of Acro Pharmaceuticals, which closed in August of 2016. Compared to the ~80-85% EBITDA margins the GPO business does, Acro has very low margins, but is high revenue. Unfortunately Acro gets reported within the Supply Chain Management operating segment, creating a negative mix-shift effect on reported Supply Chain Management EBITDA margins.

While we do not have perfect disclosure here, we do at least have the gross margins on "Product" revenue, which as we understand is all housed in Supply Chain Management. The *gross margin* of product revenue consistently runs between 7% and 11%, vs. what we believe is above 80%+ EBITDA margin of the Supply Chain revenue.

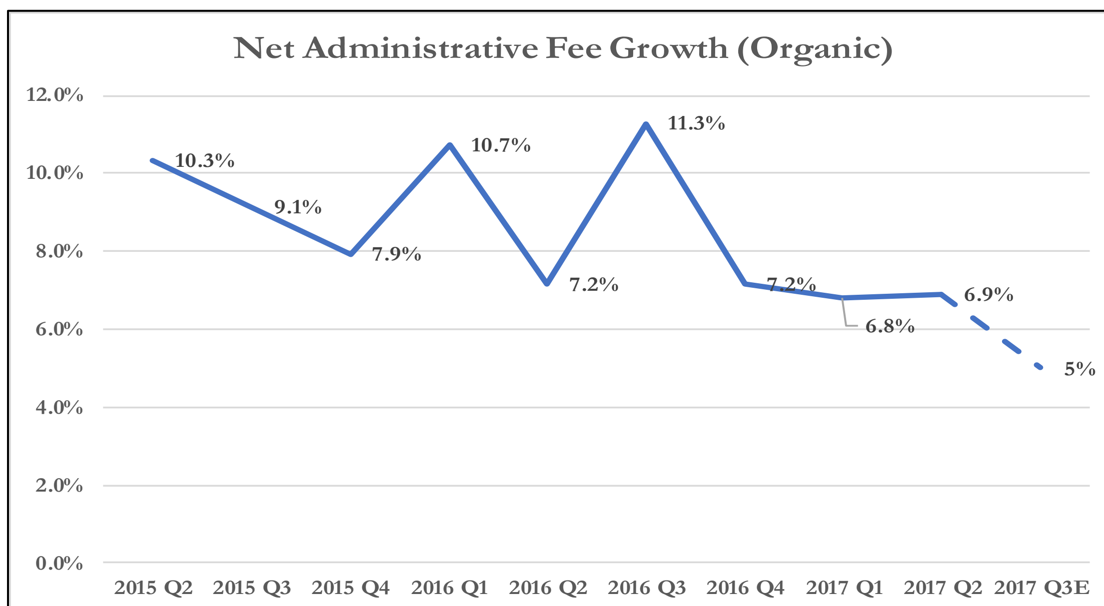
If we assume the Product Revenue has a relatively constant 8% EBITDA margin, which is likely generous (based on gross margin along with comps like Diplomat and Pharmerica), and then make small tweaks based on the Product gross margin (e.g. if Product gross margin is 11%, we tweak the Product EBITDA margin higher, and vice versa), then you can see that the GPO EBITDA margins have actually been rising from around 80% to closer to 85%:



If the Product EBITDA margins are actually closer to 5%, then the underlying strength in GPO is even more pronounced (and GPO margins may be closer to 90%). Thus, a concern we initially had that almost stopped us from looking at the stock more closely was that margins appeared to be in free fall. **This is not the case, we believe; in fact the opposite**. Once the company laps their acquisition of Acro in a few quarters it will begin to become more apparent, and consolidated margins can potentially strengthen or at least stabilize once again.

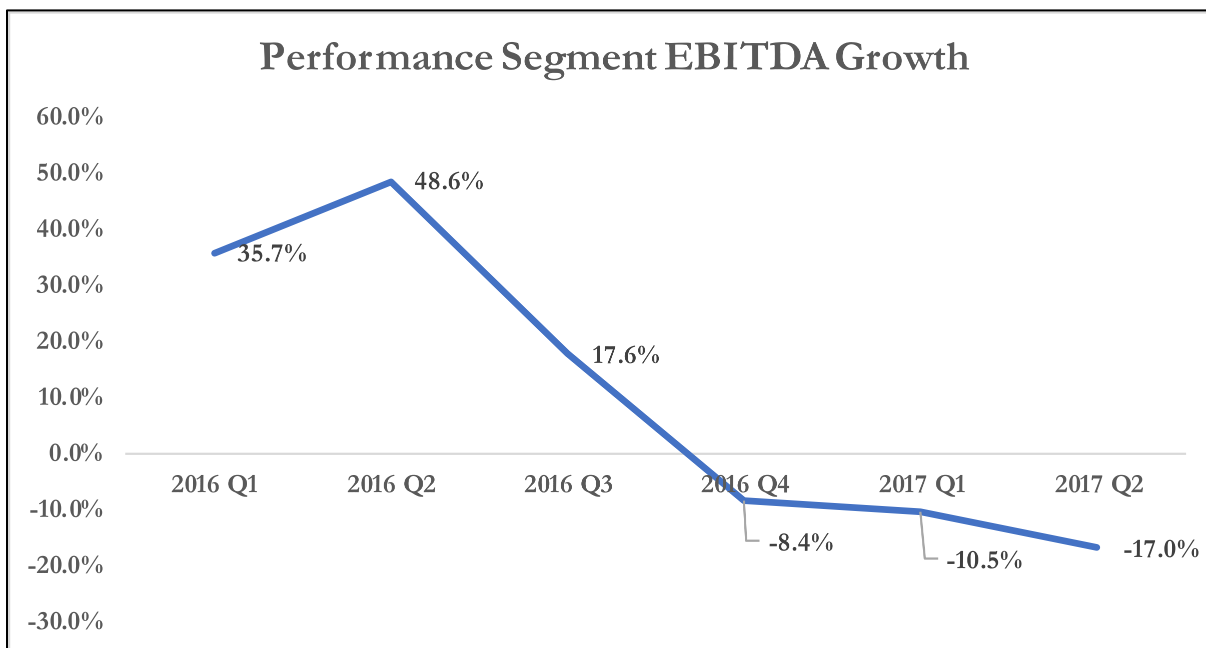
Relatively Weak Recent Results and Guidance

The results the last few quarters have not been great, and the last quarter did nothing to change the optics. It's pretty clear the GPO revenue growth is decelerating. If you look at the last several quarters, Net Administrative Fee growth was in the 8-10% range (pretty much all organic), but it recently dipped to 7%, and guidance for Q3 implied a dip to 5% as they "lapped a tough comp." It is true, in Q3 last year they hit 11% growth, but I believe it was still disappointing for some to see a continued deceleration in Q3 on the biggest cash cow.



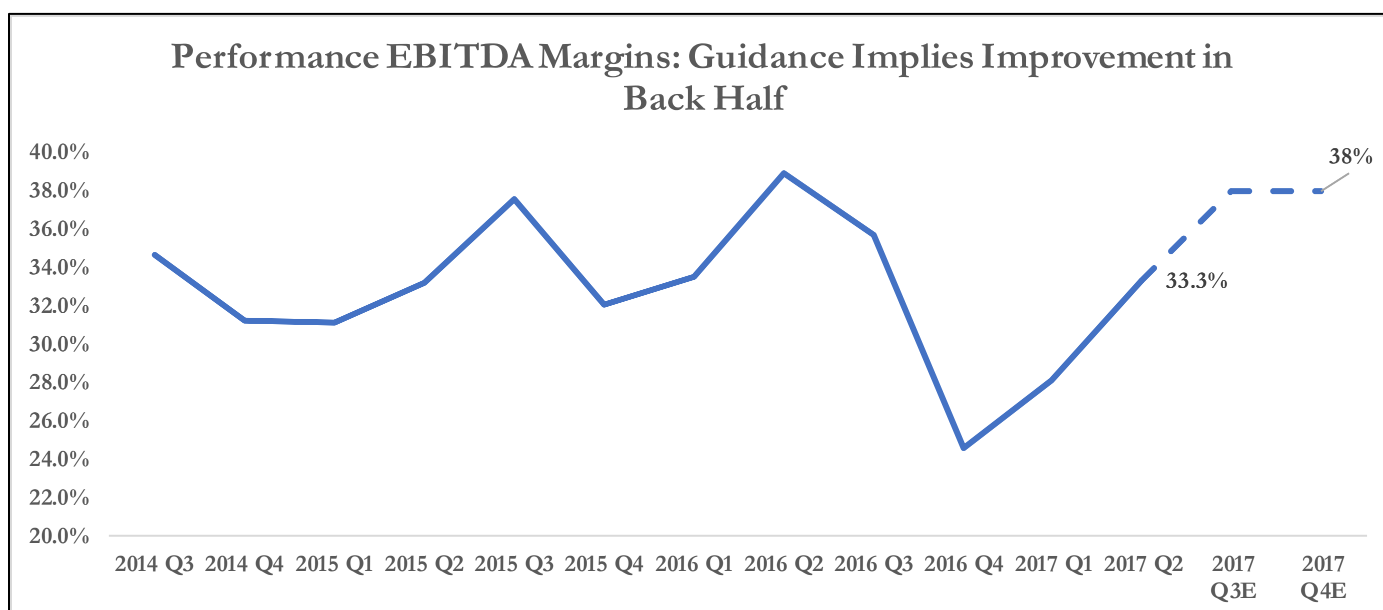
Furthermore, from our conversations with IR, it sounds like 5% might be closer to the "new normal" of organic growth, with potential upside coming if they get additional competitive takeaways but likely not in the back half of 2017. Competitive takeaways do in fact take a couple quarters to ramp up, so we believe that will be a 2018 story. We would argue that continued 5% growth in what amounts to royalty revenue is not so bad for a company trading at 8.5x EBITDA.

EBITDA in the Performance segment continued a miserable three-quarter trend as well, getting worse in Q2 by declining 17%.



The declines coincides with the CECity acquisition rolling off from inorganic to organic. Incidentally, the CECity acquisition resulted in a fairly quick guide down in revenues, although not EBITDA. Their initial guidance of "$60-$70 million in revenues" from CECity was reduced in Q3, 2016, to "$40-$50 million in revenues", although curiously they kept their EBITDA contribution intact at $24 million at the midpoint, implying an extreme ramp up in EBITDA margins. If that EBITDA is occurring, it's not really showing up in the aggregated results, indicating lower margins from other areas (like Advisory Services) or lower contributions from CECity. We believe this dents management's credibility in making acquisitions and forecasting future returns, as the price they paid, well over $400 million, was only marginally credible at a $65 million dollar run rate and highly suspect at just $45 million in revenues.

However, based on their guidance, and making some assumptions on Supply Chain profitability and Corporate Overhead, EBITDA Margins are implied to materially expand back to where they were in early 2016:



In fact, if you buy the guidance, pretty much everything in Performance gets better in Q3 and Q4, as the table below shows:

Performance Segment Summary	1st Half 2017	Back Half 2017
Revenue Growth	1.5%	17.2%
EBITDA Growth	-14.3%	45.7%
EBITDA Margins	30.8%	37.5%

We believe this belies a couple things. One CECity has by far their biggest quarter in Q3, and the growth there helps Q3. Second, we believe Advisory services is rather lumpy but based on commentary it is picking up materially in the back half of the year. We believe the company has good visibility into their revenue base and has some flexibility on cost controls, giving us confidence that there will not be a large miss here. We discuss this more in the Valuation section.

Second, on the Specialty Pharma side, the company effectively took down guidance in the last quarter (Q2, 2017). One change was arguably cosmetic. They lowered revenue guidance by $20 million due "solely" to purchase accounting adjustments from their acquisition of Innovatix and Essensa. As we understand it, revenue they originally thought they could book as revenue was moved to Account Receivable. So, they will still be receiving the cash and the transaction is part of ongoing business operations, but they were forced to haircut the revenue (but will be keeping it in Adjusted EBITDA).

More material was that they currently expect their Supply Chain revenue to be at the "lower half of those (guidance) ranges" as they identified some issues with Acro and generally weak hepatitis C related headwinds. Luckily, these two headwinds are both affecting Product revenues, which are low margin, so the EBITDA impact is almost immaterial.

Specialty Pharma Weakness

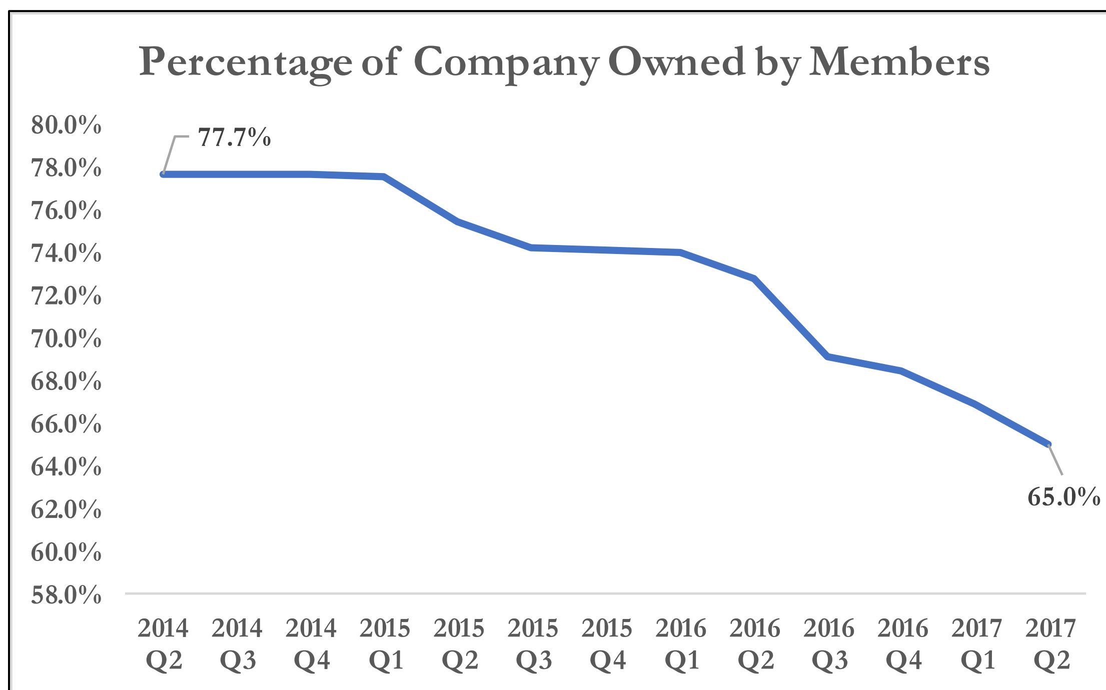
As mentioned above, Specialty Pharma has been weak, and it's been industry wide. Both Diplomat and PharMerica, decent pure play comps, put up pretty terrible numbers and guidance. We do not have unique insight into when/how this reverses itself, and note it is an ongoing sentiment risk. However, in terms of the overall value of the company, we think it is only marginally important. Looking at our SOTP below, we assign less than $2 of total value to the Specialty Pharma division.

One strategy to hedge this risk would be to short Diplomat or PharMerica in concert with a Premiere long, as both companies have inferior profiles but are more expensive than Premiere (see table in Valuation).

Unique Share Structure and Board Composition

Premiere has a unique share/ownership structure that not only impacts the P&L but is relevant strategically and we would be remiss not to discuss how it works and our take on it.

When the company went public September 26, 2013, it did so with 78% of the company owned by its hospital members and offered under 20% of the company to the public. The company refers to these member owner shares as B shares. Over the last few years, this ownership dynamic has changed.



Exchanging Shares

What is the mechanism for this change? Every year, 1/7th (~16 million) of the Member's equity becomes available to exchange, and the vast amount of the exchange occurs when the shares first come up for redemption availability in October. So seasonally, you will see a large number of shares redeemed during the calendar Q3 timeframe (fiscal year Q1). From 2014 to 2016, the total number of shares redeemed has been in the 5 to 6 million range, so roughly 1/3 of the total possible shares that can be redeemed are being requested for redemption.

There is some netting out here, as current Members have "first rights" to buy additional shares from members who want to sell, and this does happen. The other decision point is how Premier wants to redeem the shares. They can either be converted 1:1 for the common A shares, or Premier can decide to effectively engage in a buy back and purchase the shares with cash. Up until the most recent quarter, Premier had always chosen to settle with shares, effectively creating a larger trading float. However, in the most recent quarter Premier spent $100 million buying back many of the B shares, perhaps indicating for the first time they felt their stock was undervalued.

We asked why Members redeem their shares (a form of insider selling), and were told that the Members either needed the liquidity or were looking to diversify their initial investment in Premiere into other areas. Although we would find it a bit more bullish if there were no redemptions, we also do not think these hospitals are doing detailed valuation analysis as to the value of Premiere and it does not necessarily signal that the Members are unhappy with Premiere. It strikes us a fairly orderly and consistent, and probably part of an initial 5-7 year plan by the majority of the hospitals.

Cash Flow and Tax Implications

One reason this structure was built in the first place was to leverage the tax exempt nature of many of the hospitals. Without getting too into the weeds, basically what happens is the company gets a large tax break by funneling profits through the non-profits. Although this sounds a bit sketchy, what ends up happening is Premiere sends the taxes saved by having this structure back to the members, and so does not really directly benefit itself from the structure.

So Members, even the ones who are not tax-exempt, get the equivalence of a preferred stock dividend by holding the B shares, and that value they get is based on the difference between Premiere would have paid in taxes (fully taxable, 40% rate) and what they actually do. The only difference is the dividend is not guaranteed should Premiere become unprofitable or less profitable, it is essentially just returning tax savings.

This is not a small number. Every quarter it's been between $22 and $24 million that is effectively removed from Free Cash Flow, and embodies what they call Adjusted FCF.

Below is a table showing the traditional FCF number (CFO-Capex) reconciled to the payments made to the Members.

Cash Flows	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2
Cash from Ops	22,719	116,117	132,101	100,533	41,827	96,537
Capex	-17,141	-21,741	-15,802	-22,306	-16,966	-17,359
FCF	**5,578**	**94,376**	**116,299**	**78,227**	**24,861**	**79,178**
Distributions to Members	-22,432	-23,029	-22,504	-24,742	-22,493	-22,137
Adjusted FCF	**-16,854**	**71,347**	**93,795**	**53,485**	**2,368**	**57,041**

In this case, the Adjusted FCF is really a more relevant metric to use. If the B shares did not exist, they would be paying the $22 million (from Q2) anyway.

Board Structure

The board is gigantic at 16 members strong, with ten of them being CEOs of large Integrated Delivery Networks from their member group. In addition, CEO Susan Devore and five other independent directors sit on the board. We have mixed opinions on this. On the positive side, it creates a partnership like environment whereby these influential healthcare leaders can tell Premiere exactly what the most pressing issues are and how to tackle them. On the other hand, in our opinion, it gives a little too much power to the customers. I would prefer them whittle the IDN members down to five, so that the CEO plus the independent directors had more decision making power. There is a risk that these board members are going to protect their hospital systems' interests first and foremost, and Premiers' interest second. However, at the moment this structure lines up roughly with the ownership dynamic, so until that changes appreciably I think it's appropriate.

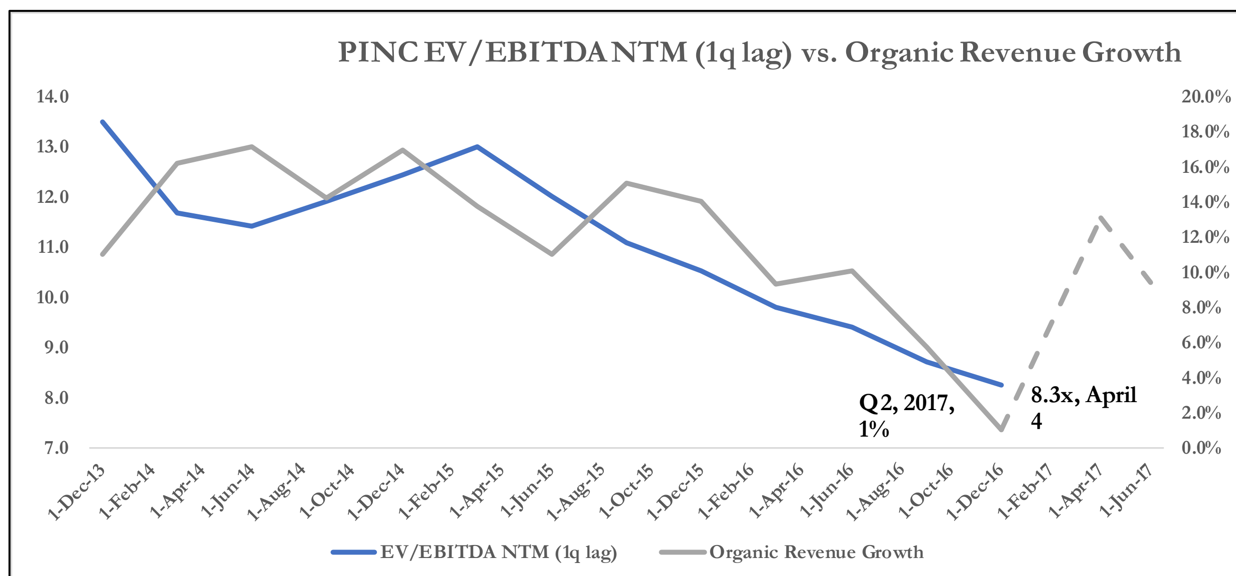
Valuation

All valuation methods give us comfort that the stock will revert to the 10-12x EBITDA range and in the 18-20x Earnings/FCF range, which gives us 25-45% upside off 2018 EBITDA and Earnings/FCF estimates.

We look at valuation in three ways:

1) DCF
2) Relative/Comp Valuation
3) SOTP

To start though, we always like to get some handle on how the market is valuing the company. We found that there is a pretty strong correlation between organic revenue growth and EV/EBITDA multiple, shown below:



Based on our understanding of guidance and inorganic contributions, management is forecasting organic growth to reaccelerate in Q3 and Q4 to the 10-13% range in Q3 and Q4. Based on this general trendline, the company would revert to 10-11x EBITDA if they were able to achieve this organic growth. Is there reason to believe this is the case? While there is certainly the chance the company will miss, we point out a few factors:

1) High visibility into revenue and generally low miss rate

On the Q2 call, the CFO commented they have 93% visibility into their 2nd half revenue guidance:

> *"So I would remind you that at the beginning, for the whole business, not broken out by segment, but we talked about visibility of 86% to 90% of our guidance range. What I would tell you is, at this point in the year,* ***we are up in the 91% to 95% range of visibility at the halfway point in the year with close to high 90% visibility for Performance Services, so good visibility in terms of feeling confident that the revenue will produce itself in the second half of the year.*** *We do have, as I've talked about in the past, some large advisory service engagements where they are performance-based in nature, so we know that savings have been delivered, but until we actually get that process attested to with the client that's when the revenue recognition occurs, and that process has been playing out. And we'll see that happen in the back half of the year."*

The biggest revenue miss the company has had was last quarter, when they missed by 2.7%, and a significant piece of this was a purchase accounting adjustment they had to make from Innovatix. Other than that, the largest miss was 2.2%, followed by 1.4%. They have beaten on revenues in 11 of 14 quarters (although 3 of the last 4 misses have come in the last twelve months).

2) CECity now fully organic and rolling into its biggest quarter in Q3

This is the second full organic quarter for CECity, which they are guiding to 45% revenue growth, and Q3 is by far the segment's biggest quarter due to seasonal reporting requirements, representing about 40% of total reveues. Although it's a relatively small revenue contribution, the extra $6 million or so can add 2% or so to total organic revenues.

3) "Lumpy" Advisory Services revenue likely to revert in back half

Advisory Services, as mentioned, is the lumpiest revenue contributor, and depends partly on projects rolling on and rolling off. Based on management commentary, they have pretty good visibility into new services rolling on, and we believe the last quarter or two represented a trough. CFO commented:

> *"We expect Performance Services segment revenue growth to accelerate in the second half driven by anticipated revenue recognition from some large advisory services engagements and from the ambulatory regulatory reporting that occurs in our third quarter."*

DCF

Our Base Case DCF delivers a price target of $44.65, using an 8% WACC and 3.5% Perpetual Growth. Below is our basic model:

Premiere Inc. Base Case DCF						
Business Line	**2015**	**2016**	**2017E**	**2018E**	**2019E**	**2020E**
GPO (Net Administrative Fees)*	$ 458,997	$ 502,780	$ 555,959	$ 583,757	$ 607,108	$ 625,321
Product (Specialty Pharma)	$ 279,261	$ 326,646	$ 551,188	$ 606,307	$ 654,812	$ 700,649
SaaS	$ 174,701	$ 216,559	$ 237,250	$ 272,838	$ 300,121	$ 324,131
Advisory Services	$ 94,070	$ 116,609	$ 127,750	$ 134,138	$ 140,844	$ 147,887
Total Revenues	$ 1,007,029	$ 1,162,594	$ 1,472,148	$ 1,597,040	$ 1,702,885	$ 1,797,987
y/y		15.4%	26.6%	8.5%	6.6%	5.6%
EBITDA Margins						
GPO (Net Administrative Fees)	83%	85%	85%	86%	86.5%	87%
Product (Specialty Pharma)	5%	5%	5%	5%	6%	6%
SaaS	35%	36%	38%	39%	40%	40%
Advisory Services	25%	25%	25%	25%	25%	25%
EBITDA						
GPO (Net Administrative Fees)	$ 382,787	$ 427,363	$ 472,566	$ 502,031	$ 525,148	$ 544,029
Product (Specialty Pharma)	$ 13,963	$ 16,332	$ 27,559	$ 30,315.36	$ 39,289	$ 42,039
SaaS	$ 61,147	$ 76,952	$ 90,155	$ 106,407	$ 120,049	$ 129,652
Advisory Services	$ 23,517	$ 29,152	$ 31,938	$ 33,534	$ 35,211	$ 36,972
Overhead	$ (88,240)	$ (108,825)	$ (114,790)	$ (119,778)	$ (119,202)	$ (116,869)
Total Adjusted EBITDA	**$ 393,175**	**$ 440,975**	**$ 507,427**	**$ 552,510**	**$ 600,495**	**$ 635,823**
Margin	**39.0%**	**37.9%**	**34.5%**	**34.6%**	**35.3%**	**35.4%**
Stock Based Comp	$ (28,498)	$ (49,081)	$ (24,000)	$ (24,000)	$ (24,000)	$ (24,000)
Capex	$ (70,734)	$ (76,990)	$ (73,607)	$ (71,867)	$ (76,630)	$ (76,414)
Capex as % of Sales	7.0%	6.6%	5.0%	4.50%	4.5%	4%
EBITDA-Capex-SBC	**$ 293,943**	**$ 314,904**	**$ 409,820**	**$ 456,643**	**$ 499,865**	**$ 535,409**
Net Interest	$ 866	$ (1,021)	$ (3,455)	$ (3,455)	$ (3,455)	$ (3,455)
EBITDA-Capex-SBC-Interest	$ 294,809	$ 313,883	$ 406,365	$ 453,188	$ 496,410	$ 531,954
Change in Working Capital	33,201	4,234	0	0	0	0
Tax Rate	40%	40%	40%	40%	40%	40%
FCF (Levered)	$ 210,086	$ 192,564	$ 243,819	$ 271,913	$ 297,846	$ 319,172
FCF (Unlevered)	$ 209,220	$ 193,585	$ 247,274	$ 275,368	$ 301,301	$ 322,627
Reported FCF	$ 201,112	$ 201,773				
FCF Conversion of EBITDA	51.2%	45.8%	48%	49%	50%	50%
Revenue Growth						
GPO (Net Administrative Fees)*		11.6%	10.6%	5%	4%	3%
Product (Specialty Pharma)		17.0%	68.7%	10%	8%	7%
SaaS		25.8%	17.2%	15%	10%	8%
Advisory Services		24.0%	9.6%	5%	5%	5%
Overhead as % of Sales	8.8%	9.4%	7.8%	7.5%	7.0%	6.5%

** In 2017, adding $20 million of purchase accounting revenue that was written down as this is cash revenue received*

Below is a summary of the ascribed valuation based on these numbers:

Item	Total Value	Value/Share	Key Assumptions	
Sum of Current Discounted Cash Flow	$ 959,651	$ 6.70		
Discounted Terminal Value	$ 5,560,190	$ 38.83	g	3.5%
Net Debt	$ (126,612)	$ (0.88)	k	8.0%
Investment in Unconsolidated Affiliate	$ 98,795	$ 0.69	Diluted Shares	143,208
Deferred Purchase Price Payable	-97,500	$ (0.68)		
Total Intrinsic Market Cap Value	**$6,394,525**	**$ 44.65**		
Current Price		**$ 32.26**		
Upside		**38%**		

Sum Of Total Parts

The table below show our SOTP valuation, which equates to a 10x EBITDA multiple in aggregate:

	Proforma Run Rate/Organic Growth						
SOTP	**Revenue**	**Growth**	**EBITDA Margin**	**EBITDA**	**Multiple**	**Value**	**Per Share**
GPO	$538,684	5%	83%	$447,108	12.0x	$5,365,293	$37.97
Product/Pharma	$560,000	15%	4%	$22,400	9.0x	$201,600	$1.43
Advisory Services	$127,750	10%	20%	$25,550	7.0x	$178,850	$1.27
Saas HC IT	$237,250	10%	38%	$90,155	14.0x	$1,262,170	$8.93
Corporate				($100,000)	10.0x	($1,000,000)	($7.08)
Net Cash						($126,612)	($0.90)
Investment in Affiliate						$98,795	$0.70
Deferred Purchase Payable						($97,500)	($0.69)
						$5,882,596	$41.63
Total	$1,463,684			$585,213	10.05		

We assign a 12x multiple to GPO given its dominant market position, extremely high retention rate and relative predictability, and moderate but decelerating growth. We view it as a premium business.

We assign a 9x multiple to the product/specialty pharma business. Although revenue growth is materially higher than GPO, it is a very low margin business with more lumpiness and more dependence on specific drugs (e.g. a decline in Hepatitis C drugs had a material impact on the growth rate). We used Diplomat Pharmacy and PharMerica as pure play comp guides.

We assign the Consulting/Advisory Services a 7x multiple given lumpy but solid long term growth and what we believe are reasonably high EBITDA margins. We also believe the quality of the product is high given KLAS rankings, and the particular strengths of the company (Population Health and Value based reimbursement, along with cost cutting) are focal points for hospitals and likely to see growth in the future.

Finally, we assign the SaaS revenue a 14x multiple given double digit growth, high stickiness (e.g. ERP), strong product quality, and high underlying profitability.

We give Corporate expense a 10x multiple, given that is our aggregate target multiple. Overall this gives us a price target of $41.63, or 31% upside.

Trading and Transaction Comps

The company does not have any direct comps in the GPO space. There are many comps you could come up with, but I have picked two stalwarts in Healthcare IT, Allscripts and Cerner, along with some Medical Supply/Distributor companies like Cardinal Health, Thermo Fisher, and VWR. Additionally, we include two pure play Specialty Pharma Comps (DPLO and PMC). The point of the table below shows that Premier has superior profile (higher growth, higher margins, lower leverage) yet trades at significant discount on most metrics. The stock could easily rerate to 12x 2018 EBITDA and not look particularly expensive vs. this group. This solidifies our belief that the company can return to this pier group average over the next 12-18 months, which lines up with our SOTP, DCF, and organic revenue growth analysis:

Premier Comps	Healthcare IT		Medical Supplies/Distributors			Specialty Pharma			
	MDRX	CERN	TMO	VWR	CAH	DPLO	PMC	Average	**PINC**
Growth									
Sales (Total, 2017 Guidance)	9.5%	8.4%	6.5%	1.6%	7.9%	2.0%	12.0%	6.8%	31.0%
Sales (Organic, 2017 Guidance)	3.0%	8.0%	4.0%	3.0%		-2.0%	7.0%	3.8%	6.5%
Sales 2nd NTM/LTM	5.9%	8.2%	4.5%	3.3%	5.9%	13.6%	8.2%	7.1%	11.1%
EBITDA (NTM/LTM)	12.7%	9.5%	8.5%	5.3%	4.4%	-3.1%	8.0%	6.5%	12.1%
EBITDA (2nd NTM/NTM)	5.7%	8.4%	7.2%	5.5%	5.9%	13.1%	10.5%	8.0%	9.7%
EPS (Guidance 2017)	12.5%	8.5%	11.0%	6.5%	3.4%	-28.0%	-4.6%	1.3%	17.0%
Margin									
Gross Margin (NTM)	47.1%	83.9%	49.1%	28.1%	5.0%	7.1%	15.1%	33.6%	52.9%
EBITDA Margin (NTM)	20.2%	32.9%	25.8%	10.9%	2.6%	2.2%	5.9%	14.4%	32.6%
Valuation									
EV/EBITDA (2017 Guidance)*	10.8x	11.5x	15.5x	11.1x	8.5x	11.5x	8.6x	11.1x	8.6x
EV/EBITDA (2018)	10.1x	10.6x	14.3x	10.5x	8.0x	10.1x	7.6x	10.2x	7.8x
P/E (2017 Guidance)	18.7x	22.6x	16.9x	15.1x	14.8x	27.1x	12.2x	18.2x	16.0x
EV/FCF (NTM)	25.1x	32.5x	23.7x	23.7x	14.4x	16.9x	17.8x	22.0x	17.9x
EV/uFCF (NTM)	17.4x	32.4x	20.8x	17.6x	13.2x	15.3x	14.1x	18.7x	17.2x
Leverage									
Net Debt/EBITDA (NTM)	3.50	0.12	3.11	3.67	0.99	1.37	3.29	2.28	0.23

** Or Consensus if no guidance given*

The takeout valuation of MedAssets is compared to PINC below:

Metric	**MDAS**	**PINC**	**Delta**
EV/EBITDA NTM	10.76x	8.16x	-24.2%
EV/Sales NTM	3.39x	2.66x	-21.5%
Adj. P/E FY1 (guidance)	25.49x	16.64x	-34.7%
Sales Growth (FY1/FY0)	5.80%	31%	25.2%
Organic Sales Growth (FY1/FY0)	0.50%	6.1%	5.6%
Adj. EBITDA Growth (FY1/FY0	0.40%	15%	14.6%
Adj. EPS Growth (FY1/FY0)	-8.90%	17%	25.9%
EBITDA Margin	31.5%	32.6%	

** I estimate organic EBITDA growth in the 8-10% range for PINC*

Valuation Summary

In summary, PINC is our favorite healthcare IT stock.

The table below summarizes our price target, which is $44.75 in a Base Case over the next 12 months.

Base Case **Valuation Summary**	**Base Case**	**Upside**	**Key Rationale**
DCF	$ 44.72	38.6%	2017-18 modestly below consensus
SOTP	$ 41.63	29.0%	12x GPO EBITDA, 10 overall EBITDA
Comps	$ 39.85	23.5%	Inline with peers despite superior profile
Average	**$ 42.07**	**30.4%**	
Current Price	$ 32.26		
12 Month Target	$ 44.75	**38.7%**	Cost of Equity at 8%

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