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Voss Investment Memo – November 2023 – Long RCM at $10

R1: Shorts are Penny Wise, Pound Foolish

We believe the recent weakness of R1 (RCM) shares provide a unique entry opportunity into a high-quality healthcare IT franchise and that the stock could double or more over the next 2-3 years, as profitability inflects toward an eventual $1 billion in underlying FCF and the company's industry leading, technology-focused position in a secularly growing industry become more apparent.

The company has been hit by a number of headwinds in the last several months, namely a monstrous 95 page short report that questioned accounting integrity (driving 15%+ short interest), a small increase in doubtful accounts that seemed to partially validate the short report, the bankruptcy of a customer, their first ever customer loss, and a general move away from levered stocks (and healthcare services due to weaker spending cadence and utilization, not to mention fears of GLP-1's reducing demand for healthcare services longer term). We go through these issues and conclude that while highlighting some valid concerns, they are extremely short-sighted and entirely miss the forest for the trees and fail to recognize the long runway for RCM adoption and the increasing strategic value of R1. In fact, once digging under the covers, we come to the opposite conclusion of the short report and see cash flows and profitability already inflecting positively, even as R1 onboards its largest customer ever which causes a short-term profitability hit.

In short, we believe all the pieces are coming together for an attractive long term secular compounder. We see a large market opportunity paired with a terrific management team and a business that solves a real need with limited competition, trading at low absolute and relative valuations.

Company Introduction and History

R1 does revenue cycle management for hospitals and physician groups. They offer both End-to-End services (E2E), meaning they entirely replace and rebadge the organization's existing internal team, as well as offer modular solutions, which is providing a point solution to a particular revenue cycle collection challenge (e.g. Underpayment or Denied Claims). Modular solutions is the focus of their Cloudmed acquisition (described below). Their basic underlying pitch is that they can lower costs and improve cash collection times.

While R1 has a long history going back to 2007, the most relevant place to start is probably in 2016, when they renamed themselves R1-RCM (from Accretive Health), while simultaneously doing a landmark strategic transaction with Ascension Health, the second largest hospital operator in the US. Ascension invested a significant amount of money in the company in cash (~$200 million) and along with Towerbrook Capital Partners, (Private Equity JV) collectively owned 40% of the company. As part of this strategic transformation, there was a 10-year revenue cycle management contract signed between the partners. Currently Ascension is still the company's largest customer, although they have added a dozen

or so large E2E clients and new customer Sutter Health could ultimately approach the size of Ascension once fully onboarded.

Cloudmed Acquisition

The Cloudmed acquisition announced on January 10th, 2022 was a pivotal moment in the company's recent history. It closed just barely over a year ago in June 2022, so we are just now beginning to lap the acquisition.

Within a few months of the deal closing, Cloudmed CEO Lee Rivas and essentially his entire C-suite replaced the R1 management team. This is a pretty unusual move, for the *acquired* company to displace existing management. Also notable is that Cloudmed is VC backed and thus R1 now has a large owner in the form of New Mountain Capital. Essentially this was a marriage between New Mountain Capital and the Towerbrook backed initiative driving legacy R1. New Mountain and Towerbrook now collectively own more than 60% of the company.

While we won't dive too much into Cloudmed's history, we will call out a few additional points as we understand them as we think they are relevant to the overall thesis. As mentioned, before being acquired by R1, they were part of the $40 billion PE firm New Mountain Capital. There is a solid podcast from this year interviewing the CEO of New Mountain, Steve Klinsky to give you a general flavor of how they think. The Cloudmed investment was in December of 2017 and it is indeed a collection of several revenue cycle management point solution companies that were cobbled together, starting with the combination of Revint Solutions and IMA Consulting. The other major acquisition was Triage in 2020.

Speaking with others with knowledge of Cloudmed, it's our understanding that the company brought in Lee Rivas to do the heavy lifting of both cultural and technological integration. Lee in turn brought in a whole team of people from his past experiences, including CFO Jennifer Williams and several employees from Change Healthcare (sold to United Healthcare recently). Per a former Cloudmed board member, this was not an easy integration for Lee to take on:

> *"Prior to the Triage acquisition, we had acquired a number of other companies and all of these companies were either mom-and-pop or founder-led, so all of them were experiencing cultural shifts, going from what they were to being part of a much bigger company with a similar but different, more aggressive mission. I can speak to that because my company was one of them and cultural change is difficult…they brought in Lee. At the time, I hadn't known Lee, prior to him joining and I didn't really believe that someone could shift culture, and certainly not shift it quickly. For a lot of reasons, but I'll just fast forward to the punchline, I was personally blown away with how quickly Lee, and then the team of people he put around him, were able to significantly improve the culture of the organization top to bottom. It was a noticeable shift."*

With the acquisitions being integrated successfully, and growth still moving at a solid clip, the company began to position themselves to either be acquired or do their own IPO, leading up to the eventual acquisition by R1.

Business Model

For those familiar with R1, this may be review, but we feel it's important to go through it to better understand the mechanics of the model.

The company has three types of businesses:

1. End to End
2. Co-Managed
3. Modular

End to End revenue cycle management is taking the healthcare organization's entire revenue cycle operations and running it. This includes taking existing employees from the organization and "badging" them as R1 employees. There is often pretty heavy attrition in this case and R1 does have their own employee base as well, both onshore and offshore. Modular are points solutions targeting various aspects of revenue cycle management (for instance, Medicare Underpayment). Finally, Co-Managed is a hybrid whereby R1 doesn't actually take full ownership of employment, but does significant work managing an otherwise internally run revenue cycle.

Under both End to End and Co-managed, in what we understand to be fairly consistent, the contract will define what a hospital or clinic's Net Patient Revenue (NPR) is, and R1's take will be in the 4% range at a fully rolled out level, including some baseline incentive revenues (there might be some wiggle room a little below or above 4% depending on how the incentives are defined). Incentive revenues will be higher margin and likely in the 7-10% range of total Net Operating revenue. Note Co-Managed will have a lower than 4% take rate of revenue but will have a higher margin trajectory on that revenue. As we understand it the vast majority of current NPR is full End to End, with only a couple of customers on Co-Managed contracts.

Although the ultimate EBITDA margin is likely up for debate, the company has been pretty consistent in saying they can generate 30% EBITDA margins on this business in aggregate. We think there are more arguments it could end up being higher (AI, machine learning to automate human capital projects) than lower (wage inflation), but we are reasonably comfortable it will coalesce around 30% in a fully live and stable organization. In fact, as we show later, we believe they are already closer than most believe.

Note the full maturation cycle takes 3 years, as upon initial roll out (first 12 months) the customer is actually unprofitable (-17% contribution margin), then moving to a 17% margin over the next couple of years, and finally closer to 30% in a "Steady State".

Launch

0-12 Months

- Deploy transition resources
- Perform financial assessment
- Invest in infrastructure
- Implement technology

Financial Impact – $M	Mid-Point of Range
Revenue	70
Adj. EBITDA contribution	(12)
Adj. EBITDA contribution %	(17%)

Growth

12-36 Months

- Finalize employee transitions to steady state org structure
- Complete standardization
- Deploy automation

Financial Impact – $M	Mid-Point of Range
Revenue	120
Adj. EBITDA contribution	20
Adj. EBITDA contribution %	17%

Steady State

36+ Months

- Continuous optimization:
  - KPI metric improvement
  - Technology / automation advancement
  - Productivity improvement

Financial Impact – $M	Mid-Point of Range
Revenue	120
Adj. EBITDA contribution	38
Adj. EBITDA contribution %	30%

Thus there is a risk that when larger implementations are occurring, it is suppressing underlying EBITDA/cash flows. To us, this makes their performance this year even more impressive, given they are rolling out their second largest customer ever (Sutter Health).

The Modular revenue is a nice counterbalance as it comes out of the gate highly profitable, and is recognized more quickly.

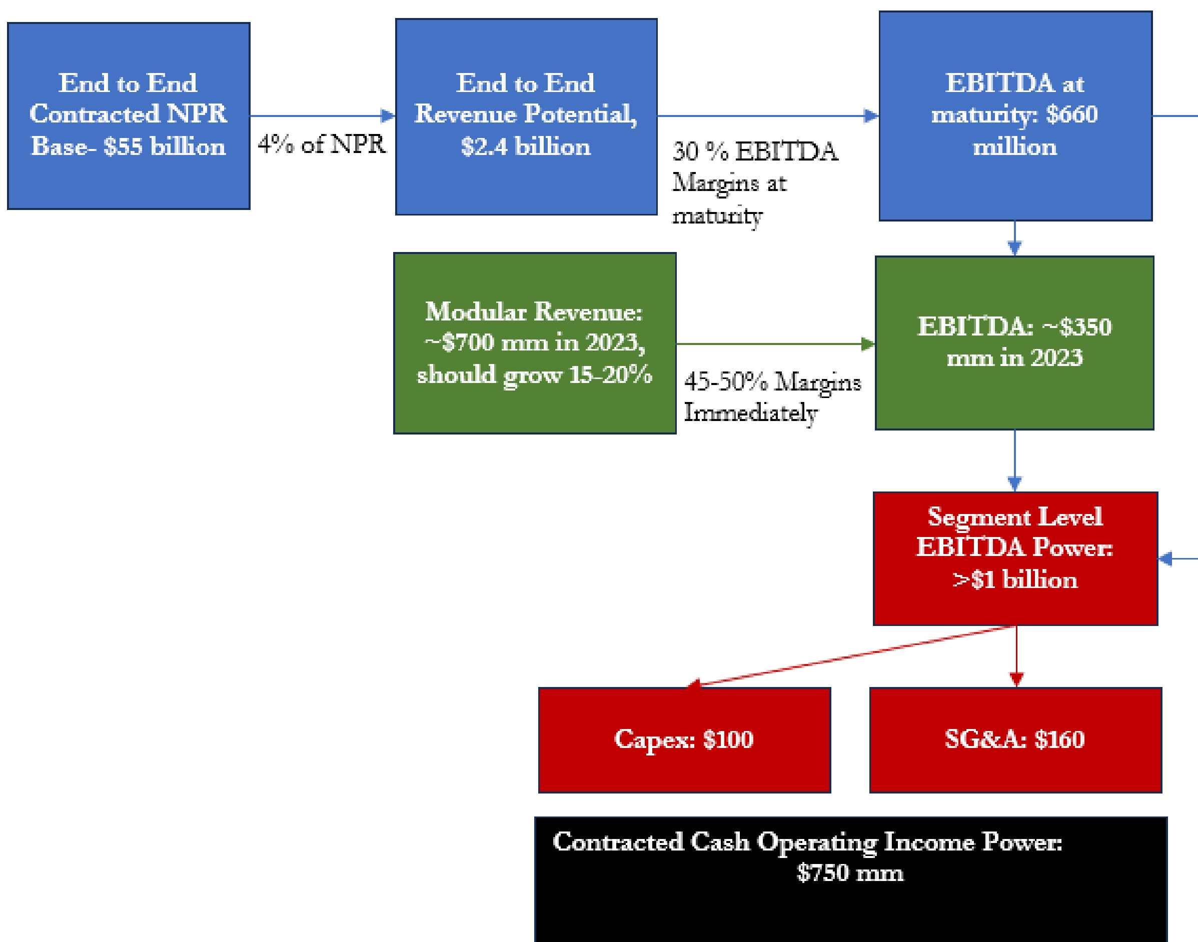
Modular

- R1 provides a la carte solutions for RCM and patient engagement
- Requires least amount of initial investment
- EBITDA positive Year 1
- Highest Adjusted EBITDA margin opportunity

	Revenue		Adj. EBITDA[2]	
	10-20	10-20	3-12	3-12
EBITDA margin[3]			*~50%*	*~50%*

▪ Year 1 ▪ Year 4

So if you want to think of the company's "earning power", you can sketch it out to some degree of accuracy by taking total NPR, multiplying it by ~4% as a take rate and then 30% on EBITDA margins. Then add in your assumptions around modular revenues, and then subtract underlying SG&A and Capex to come to something close to a cash Operating Profit number:



We do not want to place absolute importance on this calculation and think there are various puts and takes (specifically, as we go through below, we think they are already near that 30% margin level), but are more pointing it out to show how current profitability is somewhat obscured because they are in the process of rolling out large new customers. Further, as we discuss next, we believe they have a huge opportunity to keep growing this underlying earnings power.

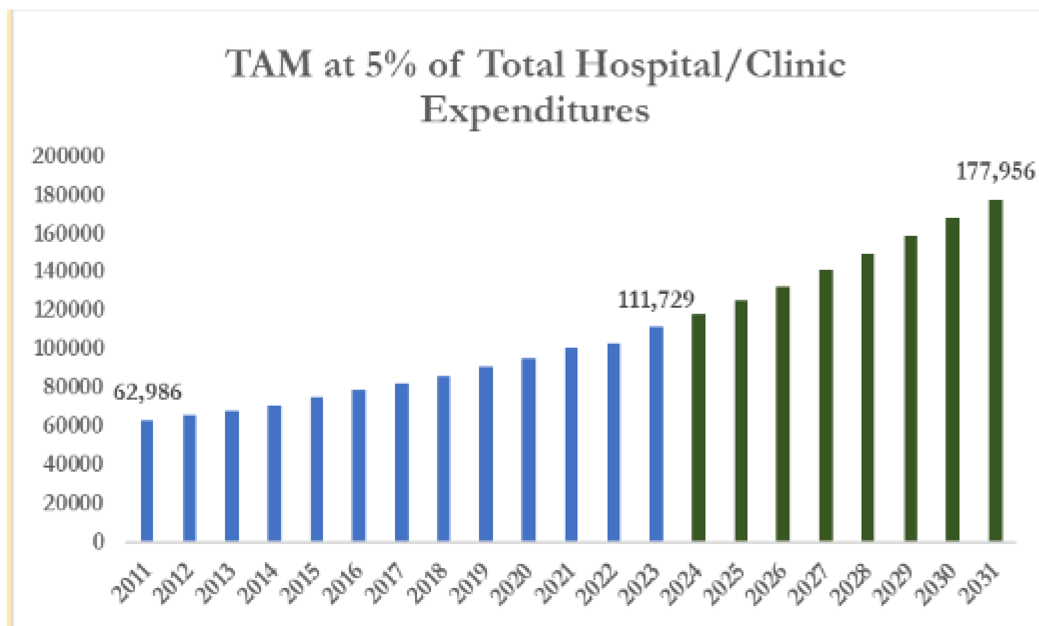
Key Thesis Point 1: Top player in a growing industry that is rapidly shifting towards outsourcing revenue cycle management.

With an aging population, we believe healthcare expenditures will continue to rise over time (i.e., NPR), that more hospitals and clinics will outsource their RCM functions, and that R1 has the most complete and scaled independent solution in the market. In other words, this is a very solid setup as the total TAM is growing, the mix of TAM is beneficial to R1, and R1 is the best positioned to capture a disproportionate share of that growth, e.g., R1 will be "winner take most."

The markets that R1 targets are based on a combination of Hospitals and Physician/Clinic groups. Looking at Centers for Medicare and Medicaid Services (CMS) data, we can see that Hospital expenditures have grown at a 4.7% CAGR since 2011 and are projected to be nearly $1.5 trillion in 2023, then rising 5.7% a year through 2031. Similarly, Physician and Clinical Expenditures grew from $535 billion to $930 billion, and are projected to grow to nearly $1.5 trillion.

Taking the two together, this gets us to $2.23 trillion in current hospital/clinic spending and $3.56 trillion spending by 2031.

Given that total Revenue Cycle Management spend is 4-6% of total expenditures, we can sketch out a growing TAM for R1:



Whether you put a 4% or 6% number on total revenue, it's a very large and growing number. 5% industry growth over an 8-year period is a nice anchor point to start from.

At $111 billion, R1 would be about 2% of TAM currently.

Growth of Outsourcing and Rationale

The underlying market has grown at nearly a 5% rate, and is projected to grow even a little faster to 6% (per JP Morgan research, and much higher according to various other boutique research shops) as a function of aging populations needing more care and healthcare continuing to be an increasing driver of importance for the entire population base.

However, within that $111 billion TAM, we can now look at what % is outsourced versus insourced.

We've seen a few different estimates, and it gets tricky because there are many point solutions and hybrid models where it's challenging to get a true handle on whether something is truly outsourced, but the estimates we have seen point to around 70% being insourced and 30% being outsourced. For instance, in a recent Citi initiation they noted that *"our conversation with industry participants indicates 30% of RCM spend is outsourced. We view the 70% of the market that has yet to be outsourced as the most attractive segment."* In a recent JP Morgan equity research deep dive ("Actionable Insights: Digging in on Revenue Cycle Management," June 8, 2023), they also note that "~70% of RCM solutions are insourced today."

Our thesis is that this 30% will move substantially higher over the coming years. Why?

Coding and Regulatory Complexity

The move from ICD-9 to ICD-10 kicked off a significant uptick in complexity to billing, starting in 2015.

For instance, when billings codes went from ICD-9 to ICD-10, billing complexity actually increased substantially:

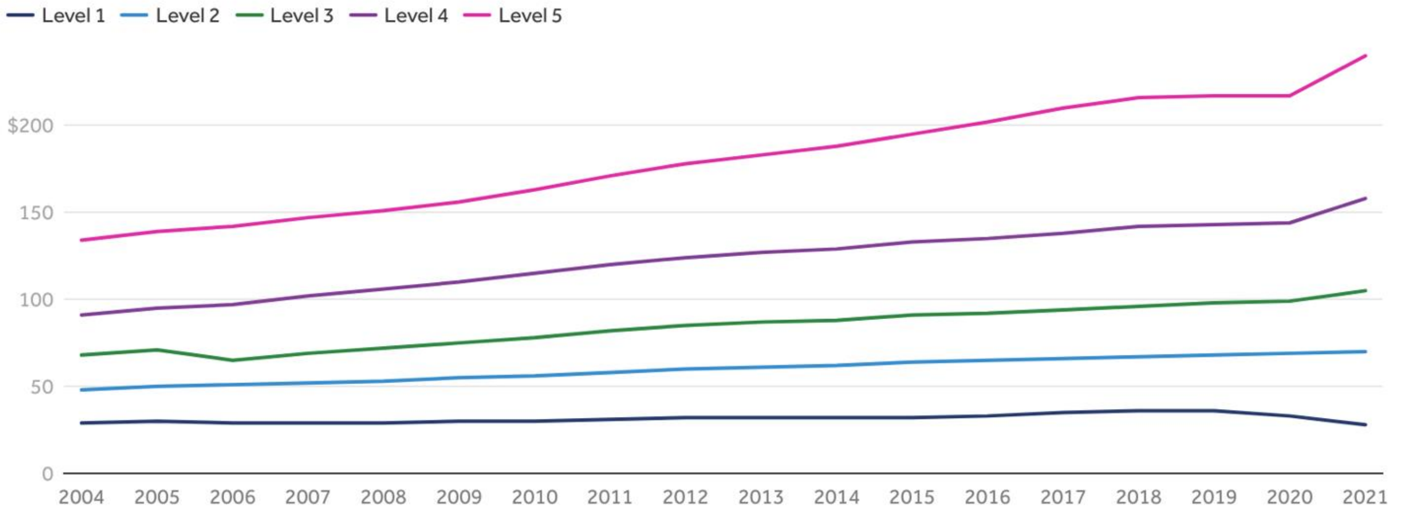
Code set differences

ICD-9-CM codes are very different than ICD-10-CM/PCS code sets:

- There are nearly 19 times as many procedure codes in ICD-10-PCS than in ICD-9-CM volume 3
- There are nearly 5 times as many diagnosis codes in ICD-10-CM than in ICD-9-CM
- ICD-10 has alphanumeric categories instead of numeric ones

While this was introduced in 2015 and should have been resolved somewhat, there are now significant new complications in billings based on emerging "value-based care" vs "fee for service". While in theory value-based care sounds great in that it reimburses doctors/hospitals for the QUALITY of the service rather than just the total services, and provides incentives for those quality metrics, the reality of debating that level of quality between a hospital and an insurance carrier is quite complex.

Here the Kaiser Family Foundation quantifies this by showing how much more complex claims have cost to process/get reimbursement:



The No Surprises Act, introduced January 2022, has added additional burden/complexity. While again this bill was done to make it harder for hospital and physicians to pull "surprise charges" on patients (often the result of mismatches between what the patient was originally billed and what insurance reimbursed), it has resulted in a headwind for providers, as they have to provide "good faith estimates" of costs up front and have some restrictions on adding additional costs to that afterwards. It also results in claims complications, as more claims go to the Independent Dispute Resolution because patients decide they were overcharged. The effect of this is an ongoing elongation of the cash collection cycle.

The point is, very little has happened to make collections simpler, and a number of things have happened to make it harder.

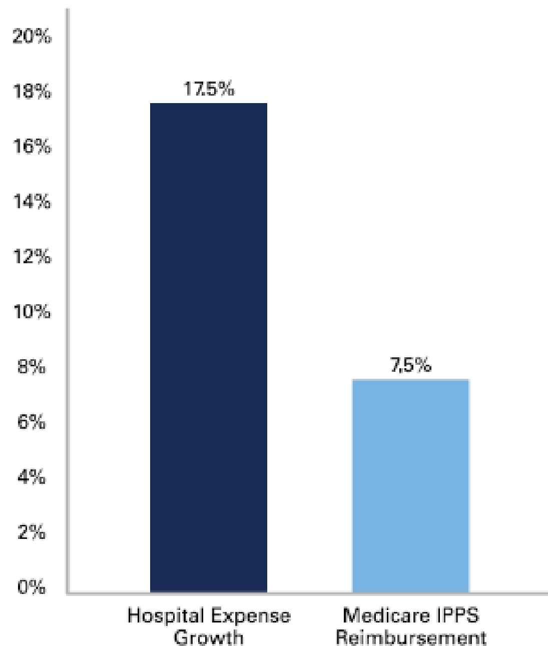
Rising Wages

We spoke to a former CFO of Sutter Health (R1's large new customer) who gave us a lot more additional perspective from someone who actually did the decision making. First, he notes, rising wages (in more expensive cities especially) are changing the labor calculus:

"And if you think about most of the systems, they tend to be in relatively high-cost areas. And whether that's California, whether that's New York City, whether that's Seattle, I mean, you think of a large system and the changes are their back office is probably in a place that's fairly high cost. And what you're looking for is to basically take that cost and put it somewhere else where it will cost you $.60 or $.65 on $1, versus $1 on $1.

In other words, wage arbitrage. It's fairly well documented that Hospitals margins have been under pressure since COVID. Looked at in another way, Hospital Expenditure Growth has outpaced Medicare reimbursements, as AHA shows here:

Figure 1. Cumulative Hospital Expense Growth is More Than Double the Cumulative Increases in Medicare IPPS Reimbursement, 2019-2022



Source: FY 2020-2022 IPPS Final Rule

Less Talent

Related to wage arbitrage, there are also simply not enough educated people to do these jobs. The Sutter CFO explains:

> *"Number two is literally the ability to find the people to do the work. And if you think about billers, billers are probably not that hard to find. Coders are another story. And, today, coding is huge in the billing process where 15 years ago, coding was not a huge part of it, it was certainly part of it, but not like it is today.*
>
> *Every bill gets some part of it coded and coders are very difficult to find. So, if you can find a partner who has a better ability to recruit coders than you, that's something that's very significant in your thought process because the faster you can code, the faster you can bill and the faster you can collect as well as if you get high-quality coding, you're going to get better reimbursement. And I don't mean that by upcoding, I mean that by accurately coding. Because if you don't accurately code something, the bill gets rejected, it gets bounded back, you go back and forth. So you want high quality folks if you can find an outsourcer who can recruit better people than you, even if it was at the same dollar, you didn't achieve the wage differential, it's still something that you would want to do if they could recruit better people than you can."*

To summarize, billing complexity and regulatory requirements have increased significantly, labor is much more expensive, and in many cases the local talent simply does not exist. Healthcare organizations are

increasingly determining that they should outsource this critical function to a specialized firm that has developed best practices through people management and technology.

R1's Competitive Positioning

This author used to be a project manager at Epic Systems, which is now essentially in a duopolistic race for Electronics Medical Records with Cerner. When I started, Epic had just landed a giant multi-billion dollar contract with Kaiser Permanente that shocked the healthcare world. Epic at the time was still relatively unknown and landing Kaiser was a large and reputable reference customer that ultimately led to them becoming the clear industry leader.

Why is this relevant to R1? Well, we believe the same "winner take most" dynamic is likely to occur in the outsourced Revenue Cycle Management space. We think with R1 successfully rolling out Sutter Health, a bit of a tipping point is likely emerging whereby R1 has a large lead over other independent competitors in terms of reference customers and social proof. And we would argue that is incredibly important, as this industry herds due to a focus on "who has done it before"?

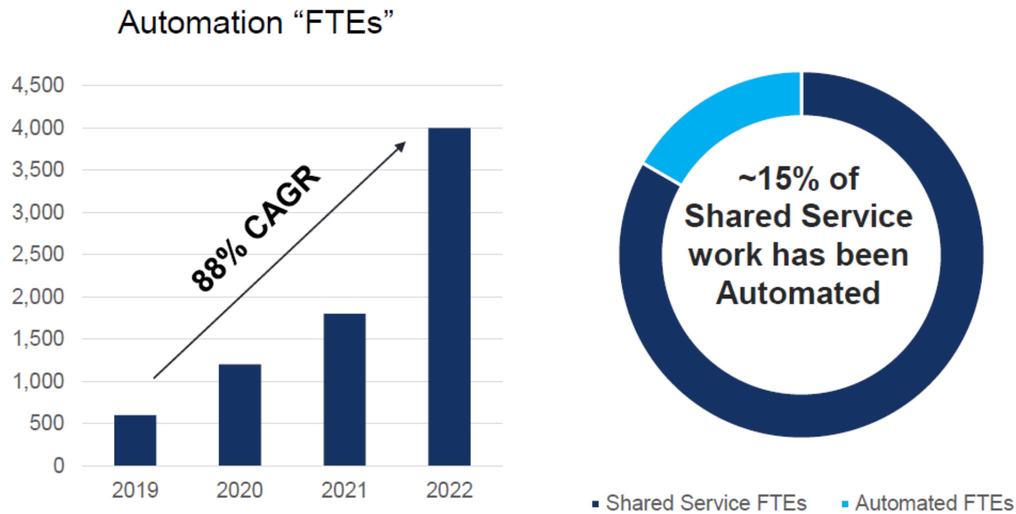
Until R1 acquired Cloudmed, one could argue that they weren't that different from competitors like Conifer and Parallon. After all, all three "emerged" from essentially their in-house revenue cycle management divisions, Conifer from Tenet and Parallon from HCA (and R1 from Ascension).

We believe with Cloudmed's technological focus and vast access to data ($900 billion of NPR across all EMRs), a bit of a network effect is likely to take hold, as R1's army of engineers (most of their $100 million+ in capex is directed towards software development) are utilizing Machine Learning and, yes, AI, to automate processes (driving further efficiency of economics to be shared with customers). Recently they announced a "collaboration" with Microsoft to utilize large language models as a way to improve coding productivity.

We believe there is a significant opportunity to both expand margins and expand technological leadership. As discussed, Lee Rivas has a technology-oriented background and has been very consistent and outspoken since becoming CEO about the opportunities Machine Learning and AI have for the company. This started at Cloudmed before R1 acquired them, according to a former:

"The goal was to employ machine learning anywhere we could, and they invested significant dollars, material dollars in that, in the years that I was there. I don't know what's happened since they've been with R1 so I can't really speak to that but, yes, it was a material investment and there were armies of engineers working for the company."

In a recent presentation, the company noted they had now automated 15% of Shared Service work, and that were now 4,000 "Automation FTEs", which we understand to be robot workers:



We believe as they continue to automate their still human capital heavy workforce, they will continue to generate additional dollar savings that can be partially captured in margin for R1, and partially used as a competitive differentiator to win new business by being able to generate greater savings.

As a vendor independent of insurance companies, we believe they may also get better access to the data as customers will not be as concerned with sharing it. Here is a Lifepoint VP (Customer) expressing that potential advantage over Change Healthcare (owned by United Healthcare):

"It's a unique one and with their taking Change Healthcare (United), and historically Change Healthcare has helped with certain AI, it's just such a weird flavor there where I think you'd rather have a vendor that sits independent of linking so much to the payor side."

This brings us to the largest competitor: Optum360. Optum is now owned by United Health, meaning the company you would be working with to maximize reimbursements is also owned by an insurance provider. As one industry participant we spoke with equated it, "It's like hiring the IRS to do your taxes." We don't want to completely downplay Optum as a competitor, because they were part of a fairly impressive Change Healthcare before being acquired by United Health. Additionally, they are almost certainly the most recognized name in outsourced revenue cycle for large institutions. However, it is our thesis that winning new business will be challenging for them given their association with an insurance provider. The Lifepoint VP we spoke with, for instance, ranked them 4 out of 4 (i.e. last) in the RFP process.

Perhaps the most credible independent competitor is Ensemble Healthcare. Like R1, Ensemble is one of the only End to End competitors who can legitimately say they are an independent vendor. Ensemble even attempted (but failed) to do an IPO in late 2021 (horrible timing). While we do view Ensemble as a real competitor, especially in mid-level organizations, and suspect they will win their fair share of business there, we believe R1 will win the lion's share of larger customers due to their having large reference customers and their keen focus on leading technology.

Here, for instance, is a Lifepoint Health exec ($2.8 billion NPR) explaining why they chose R1 over competitors (whose RFP included Ensemble, Conifer, and Optum):

> *"Yes, I think the road map is highly impressive. I think there's a ton of offerings that are available here. And I always take the vision of I want to know where the road map is, what your*

offerings are. We may not need all of your offerings day one…but it's good to know that when it evolves, that we can tap into some of that."

And then, the customer references:

> *"And I think when you look at the competitors that also use what R1's offerings are, it compares favorably to a similar size in org. So, you* ***already have the belief that they can handle the larger health systems that are out there****, we do tend to compare ourselves and want to understand, hey, to work somewhere else, that's good news for potentially seeing that same value add."*

We do not believe Ensemble has anywhere near the size of customers that R1 has, between Ascension, Intermountain, Sutter, and AMITA, among others, and they certainly have nothing like the Cloudmed asset, which covers nearly $900 billion of NPR and is a big data behemoth.

For what it's worth, a former Cloudmed board member had this to say about Ensemble:

> *"Ensemble's success story is an uber-impressive success story, and I say that as someone who competed against them and got his teeth kicked in a couple of times. What Judson and his team have done, it's very impressive, and I want to be careful because I'm intimately familiar with the size of Ensemble and its client base. It's not even in the same league. What they do and what they do for their clients they do really, really well, but I just don't see them being able to truly replicate what R1/Cloudmed brings, and certainly nowhere near the scale that they have."*

To summarize, it's our belief that this is a "winner take most" industry that is inflecting towards accelerating outsourcing and R1 is in pole position to capitalize on the ongoing shift. We believe they have very capable management that are technologically and long term focused and their burgeoning roster of high profile customers significantly increase the chances that they emerge as the clear leader in a very large market.

Key Thesis Point 2: Recent Stock Headwinds and Short Seller Concerns Miss the Big Picture (aka "Why This Opportunity Exists")

After collapsing to near $7 late last year during the management transition and a guide down because of an industry wide issue with slower payor processing times, the stock **had** staged a nice rally to over $18 during the summer months. It's been rough sledding since then with numerous concerns and headwinds hitting the stock. While we won't claim all these issues are complete nothing-burgers, we don't think any of the items change the underlying thesis. Indeed, we believe the setup is improving as positive catalysts have been delayed while negative issues are now at the forefront of people's minds.

Below we go through the key issues as we see them, and how we interpret them:

1. **Debt Levels**

We believe a chunk of the decline in the shares has been due to the company's debt levels, accumulated in part as part of the Cloudmed acquisition. ⅔ of the ~$1.8 billion in debt is variable rate debt, and a large chunk of it matures in 2026 (~$1.2 billion). While 2026 is still reasonably far away, we believe any stock with moderate levels of floating rate debt has been hit pretty hard in this environment. It is our belief that cash flows are just now inflecting upwards as earnings quality improves significantly post-Cloudmed acquisition work. We expect them to pay down a substantial part of this debt before maturity. However,

if cash flows fail to keep inflecting as outlined in Thesis Point #3 below, this could ultimately turn into a greater concern.

2. Bankrupt Customer

We believe the No Surprises Act was sufficiently burdensome to put one of their customers into bankruptcy. Indeed, when it was announced in late July that American Physician Partners was closing shop, it was probably the idiosyncratic domino that has brought the stock to where it is today as it puts fears of contagion into investor's minds.

We view this as unfortunate but not very relevant in the grand scheme of things. APP represented < 1% of 2023 EBITDA and was, as we understand it, somewhere around $650M in NPR. From a headline perspective, it feeds the idea that R1 is having A/R problems, something we address later, but we view it as an isolated incident. Also, usually when a similar firm goes bankrupt they might remain a customer and simply restructure their debt as opposed to entirely liquidate. Nevertheless, it does speak to the potential risk that one can lose customers in different ways.

3. Lost Customer

A key part of the thesis was that RCM is incredibly sticky and that organizations choosing to uproot their current revenue cycle and shift it to another vendor means it is very unlikely that a customer will leave. And this had been true for R1, up until the latest quarterly earnings report where, on the same day, their one long suffering customer Pediatrix announced they would terminate services with R1. Pediatrix was a relatively new customer and not very profitable (again, a tiny % of total EBITDA), but was modeled to ultimately become more profitable and thus implied earnings power was diminished by losing them. Additionally, the reputational blow in theory could be even worse. While we cannot claim this is a "good" thing by any measure, we would note that, again, this was a relatively small customer (~$1 billion NPR) and was by all accounts a ridiculously complicated customer to onboard. For instance, while Sutter Health is all on Epic Systems, Pediatrix had numerous EMR systems (dozens if not hundreds) that they had subcontracted with that needed integration/interfaces. Additionally, this was their one very well-known problem customer (who also happened to be a public company, making the issues more visible to the investing world) and part of the reason the stock tanked in the Fall of 2022. In other words, you never want to lose a customer, but this customer was not only relatively small but also clearly an outlier in complexity, and for over a year had been by far the most likely customer to leave R1. The fact that they have only lost a single customer still speaks to the strength and stickiness of their offering. We would also note that Cloudmed has a 117% net revenue retention rate on their customer base.

4. No New Customers in 2023- Meaning 2024 Numbers at Risk, Sutter Phase 2 Not Announced

In a way, R1's high visibility model also leaves it exposed when anything gets delayed. Management had been confident about signing $4 billion in new NPR End to End contracts by the end of the year, but as of this date has still not announced one and even suggested the signings could push into Q1 of 2024, per Lee Rivas on the Q3 2023 earnings conference call:

> *"Yeah. The thing I want to be careful of is just putting pressure on the teams, so – and look, my experience, which is relatively short, but I also have to track the history of this business on what's happened with the contract negotiations is that is – it is literally impossible to predict exact timing. What I would say is that we have a couple of deals that are late stage enough for me to have confidence to say a couple of months that*

whether that's December 31 or January 30 or February, it's hard for me to predict. So, it's hard for me to give you specificity on the exact timing."

While it's true management could be making their late-stage pipeline up, we also understand these are large organizations making large, oftentimes 5–10-year commitments to make major changes to a critical aspect of their organization. By the same token, R1 is best served to take a longer-term view and not sign a "quick deal" just to appease Wall Street, even if it is taking months longer than they thought.

We are quite confident that large new customers are coming, it's just a question of when, not if. Now that 2024 numbers have come down to reflect a potential delay in these revenues, we believe there is far more potential for "upside surprise" and honestly would not be shocked if 2-3 deals were announced in the next few months. Lee has been consistent in saying they can onboard between $8 and $9 billion of NPR a year, and that if anything he expects to scale that UP over time.

Before discussing what we believe has been the biggest overhang on the company, we would like to summarize items #2-4. Basically, on a base of $50 billion NPR they have lost ~$2 billion and not yet signed the $4 billion they thought they would by the end of year. The $2 billion lost was from two of their lowest quality customers, and the $4 billion we fully expect to have signed in the next few months–perhaps coming in well above $4 billion.

In our view, far more attention should be paid to the successful rollout of Sutter, Phase 1, which in our view has far greater long-term ramifications for the long-term value drivers. We think a catalyst (or alternatively a risk) will be when they more formally outline the timing on Sutter Phase 2, which would put thoughts to ease on how Phase 1 is going. Although there have been some management shuffles at Sutter, Lee is adamant that he now refers prospective customers to Sutter as a reference customer. We do acknowledge that a significant part of the thesis hinges on Sutter being a happy, successful customer, and would point to a much more significant delay of Sutter Phase 2 as a potential thesis breaker, although at the current stock price we believe there would be limited downside even if R1 didn't sign any new customers at all.

5. Short Report

We believe the "crushing blow" to the stock was a massive, 94 page, throw everything against the wall, short report by Jehoshaphat Research. Jehoshaphat, who describes himself as a "fraud buster", attempted to paint the picture of the company as so grim that the company is "uninvestable." It uses vivid and evocative language like "grotesque corporate grift", "penny stock", "emerging credit storm", and "desperate accounting measures", and ultimately accuses the Cloudmed management team of made-up accounting.

The timing and substance of the report was surprising to us, to say the least, as a major part of our developing BULL thesis was that the Cloudmed's management team was uniformly excellent, above board, and that indeed earnings quality almost immediately IMPROVED once they took over.

We will not go through all of the points in the report (but are happy to respond to any specific ones), but will go through a few that we feel represent the real thrust of the report (the report absurdly attempts to tie the company's headquarters street name as proof of grift, so we do not feel going through each point is really time well spent). While this list may look daunting, we think most of the points actually reflect strength, not weakness, and are being misinterpreted by the short report.

a. Contract Asset Accounting/Manipulative Accounting

If you were to identify one cohesive focus of the otherwise meandering report, it would be around Cloudmed and their accounting practices. The report uses a combination of disclosures around Contract Assets and quotes from alleged ex-Cloudmed employees to paint a picture of not just aggressive accounting, but potentially willfully manipulative and possibly illegal accounting. The report makes a big deal over the Triage acquisition in particular, and then goes on to say once Cloudmed was acquired, the aggressive practices got EVEN worse. Here is a sample few bullet points from the report:

- **Cloudmed had aggressive revenue recognition practices to begin with; so aggressive that employees who came over from acquiree company, Triage, were uncomfortable and/or confused**
- **Cloudmed had a culture of leaning on employees to say they could/would identify and collect more than they believed they could, ostensibly to help inflate reported revenues**
- **When RCM bought Cloudmed, it brought revenue recognition aggressiveness to even higher heights**
- **This increased revenue recognition aggressiveness has, apparently, paid off in the form of increasing organic growth since RCM bought Cloudmed, but has been tapering off, with organic growth slowing and the Contract Asset DSO cookie jar apparently having been mostly depleted**

We fully admit Contract Assets are lower quality revenue. While they are required accounting based on ASU 2021-08, ("Accounting for Contract Assets and Contract Liabilities from Contracts with Customers") they are two steps removed from cash (will be converted into a receivable, and then into cash) and sometimes even go into Long Term assets because of long turnaround times from Medicare.

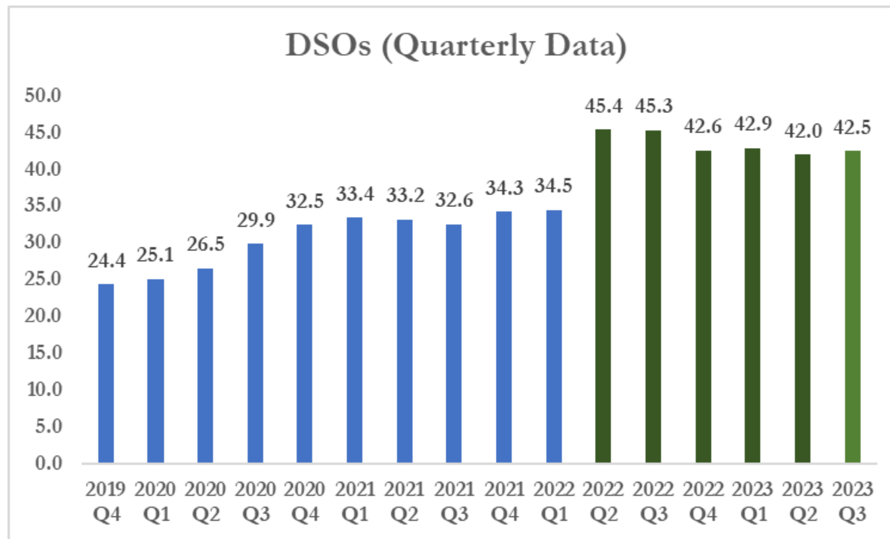
Having said that, and after speaking with both management and others with knowledge, we believe this is a gross mischaracterization of what actually happened. On the contrary, we believe that the company was actually actively working towards what they understood GAAP accounting would require when they went public or were acquired by another public company. Further, we believe that all assets were converted to that accounting treatment prospectively to April 1, 2022, two months before the close of the deal. Thus, not only do we believe there was no manipulation by management, but we also do not believe the reported numbers inflated growth. At this point with two quarters of y/y comps, it's fairly apparent that Cloudmed continues to grow and the "DSO cookie jar" is not "depleted."

We believe a former Cloudmed board member, who not only has an accounting background (CPA) but sold his own business to Cloudmed (then Revint), explains it in a credible way:

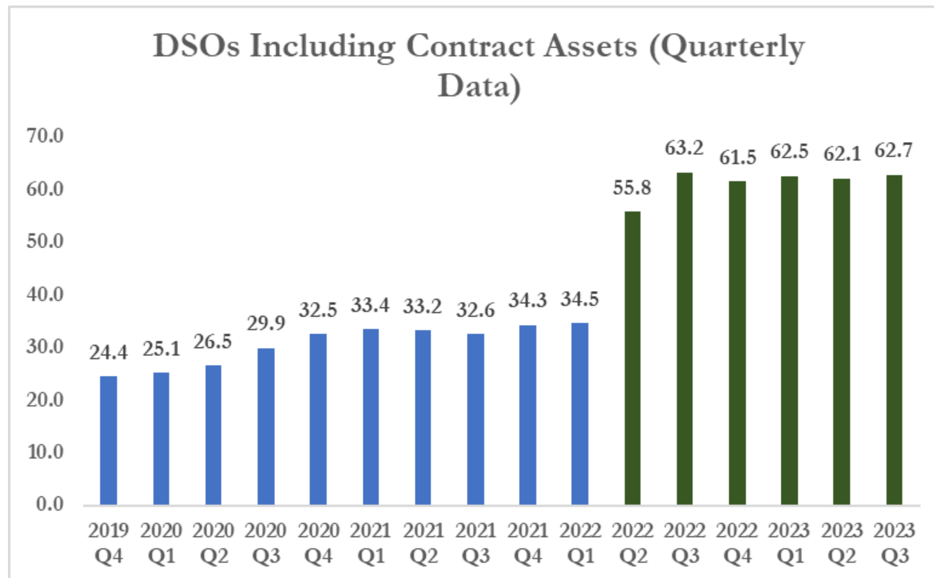
> *"I can tell you firsthand, having sold my company, we were a small mom-and-pop company, we did everything on Quickbooks. Our accounting was very basic. How and when we recognized revenue was uber conservative. What I didn't realize at the time was if we're going to be reporting numbers to the public, that's not the right way to be recording and reporting revenues. I went through first-hand what it means to shift into what is the accounting model we needed to have in place. Deloitte and a whole bunch of other consulting firms, I know McKinsey was involved…all helped set strategy and then back-office accounting…then Deloitte, I know they tested the daylights out of how were recording revenues and were constantly making adjustments to the formulas that were used, to ensure that they were not only accurate, but that they were appropriately reporting the information that was out there…I had the benefit of being a CPA, so I could understand the changes that were being put in place and why they were being put in place, even though if felt uncomfortable by changing from the way we always did it…ultimately they wanted to have the accounting buttoned up and be able to live*

under scrutiny of any audit that would occur or any due diligence that would occur…I never for a second felt that anything was underhanded. If anything, I actually felt the opposite which was, 'Wow this is pretty airtight.' It's a lot of work to get it to be that airtight and accurate and proper but I understood why it needed to be done. I never felt at all pressure to increase numbers for the sake of increasing numbers."

We can see why a short seller might pick up on the rise in DSOs. You can see a clear jump here when Cloudmed was acquired:



If you include Contract Assets the jump is even more stark:



A couple of points on this:

1. The moderate rise in 2019 to 2021 was, as we understand, primarily related to customer mix shift. Whereas previously most of the receivables came from Ascension, which had faster turnover, smaller clients they signed had slower turnover. There may have been some impact from COVID slowing down cycles, which is a potential concern, but it seems to have leveled out and may be reversing, although perhaps more slowly than some customers would like.

2. You can see that after the initial jump from Cloudmed, DSO trends are flat-to-down.
3. The total contract asset balance is only ~5% of total revenue, much lower than other companies we have witnessed have some legitimate accounting issues with Contract Assets.

Indeed, if you are willing to accept that the changes made internally were actually to "button up" the company and not to try and inflate revenues for some unsuspecting acquirer, **we really do not see anything weird at all here.** We would expect Contract Assets to moderately increase as Medicare Underpayment is a prime source of the Contract Assets and that is a faster growing area of Cloudmed, but beyond that we simply recognize it as a small % of moderately lower quality revenue.

b) Ascension Inducement Dividend

Perhaps the most perplexing and glaring mistake of the report, the short seller (who touts himself on accounting prowess), insists that the "insane" Inducement Dividend to convert Ascension's Preferred Equity to Common Equity, somehow needs to be accounted for as amortized cost over the entire 10-year contract with Ascension. In other words, in a transaction that effectively cleaned up the capital structure by swapping out Convertible Preferred to Common (including a premium to account for implied foregone 8% interest), is mistaken for some normal dividend of $592 million, which he presumes was required to keep Ascension's business.

Here is a snippet, which covers several pages of the report:

> How could this conversion be so valuable to RCM that it was worth "paying" $592m for? (Look at RCM's historical net income – like, over its entire history – to get a sense of just how big that number is to this company.)

The snark is a little bit less funny when you have no idea what you're talking about.

To be clear, you COULD make an argument that RCM was generous in the assumptions around interest rate and premium to the value of the Preferred. However, at most this would be a few tens of millions at most, not the $592 million of value he claims needs to be applied to COGS, and even that is certainly debatable.

c) Capitalized R&D

The report makes a big deal over the company's use of capitalized R&D relative to Conifer and Ensemble. While capitalized R&D is indeed a "trick" used to inflate EBITDA by software companies in particular, its use is extremely common, particularly within the healthcare IT industry. Take bellwether Cerner, who was acquired by Oracle for 20x EBITDA and 38x EBIT in 2021 (despite sluggish growth). In 2020 they recorded $295 million of capitalized software development costs on $5.5 billion in revenue, or right around the 5% of sales that R1 is recording.

When speaking with the company and other industry participants, we believe this capex relative to Ensemble and Conifer is actually being quite well spent, in building out its automation capabilities. We believe they roughly have about $25 million in maintenance capex while the extra $75 million is to effectively extend their technological lead versus competitors. We will detail that a bit later in the report.

d) New Mountain Lockup

New Mountain Capital has a lockup that expires at the end of December. The short report author believes people have simply "forgotten about it" and that "nobody is talking about it." From our conversations with

management and investors, it's fairly well understood and is something that is frequently brought up (specifically the combined ownership of over 50% between two players).

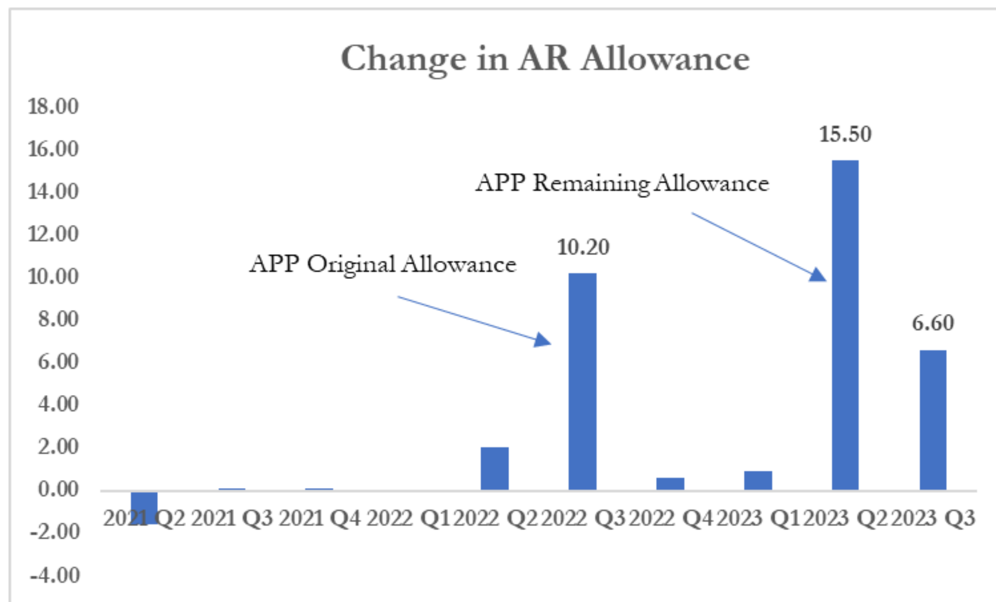
To state upfront, we have no idea what New Mountain's intentions are. They originated Cloudmed in 2017, and their average investment is "around 5 years", according to CEO Steve Slinksy. However, in the same interview, he makes a note of his firm's use of "Continuation Funds" which allow for investments to be held significantly longer.

Our base case assumption is that New Mountain continues to hold their position, specifically at these levels, although honestly we are somewhat ambivalent about it. Ultimately for the company to rerate higher it will need to be less concentrated in its control, although New Mountain exiting at first opportunity would not provide the best optics. Additionally, we think the Short author is possibly confusing a traditional IPO lockup, whereby employees and executives can all rush to the exits at once, and this investment, where most of the shares unlock are the private equity position.

e) AR Allowance

The Short Author spends a lot of time predicting that a "credit storm" is brewing for the company and goes on to make a number of (in our view speculative) assumptions. For instance, he notes that customer Quorum Health's credit rating was recently downgraded and speculates a $10 million promissory note may belong to them. He further concludes that if Quorum Health went bankrupt it would be "disastrous" for R1, despite Quorum only being a $1 billion NPR customer (~2%).

If APP had not gone bankrupt, we don't think this thesis would even be discussed. You can see from the change in doubtful accounts two of the three spikes in Doubtful Accounts were both fully related to that customer.



Unfortunately, as you can see, the short seller was partially validated with another $6.6 million sequential increase (management says $7.5 million) in the latest quarter.

Whether $6.6 or $7.5, we are talking about a very small amount of dollars relative to total EBITDA. It's 2.5% of total receivables and less than .4% of sales. While we will monitor this and suspect there could be

some additional modest doubtful accounts due to the increasing pressures on healthcare providers, particularly with smaller Cloudmed customers, we do not think this in any way alters the underlying thesis.

Key Thesis Point 3: Profitability is Beginning to Inflect Post Cloudmed Integration

When the Cloudmed acquisition first occurred, the financials became an absolute mess, to the point that we could not really tell what was going on. There were gigantic EBITDA add-backs, huge working capital headwinds and to really rub salt in the wounds, the company's core business had to guide down because of lower incentive revenue fees, further muddying the financial picture. The "Other Expenses" line we felt were/are particularly egregious. "Other Expenses" include all kinds of questionable add backs like "Strategic initiatives", huge "Business Acquisition and Integration" costs, "Facility Exit Charges", and outsourcing operations to the Philippines). Every working capital line on the cash flow statement was negative, with Q4 turning in an astounding -$241 million of working capital adjustments.

Taken at face value, the company was making massive internal changes to build out the infrastructure for the next leg of growth, but gosh it was hard to tell what was really going on. Had they just made a disastrous acquisition or were they spending the needed money to become a much larger company?

You could be forgiven for putting the company in the "too hard" bin and moving on, as we pretty much did at the time.

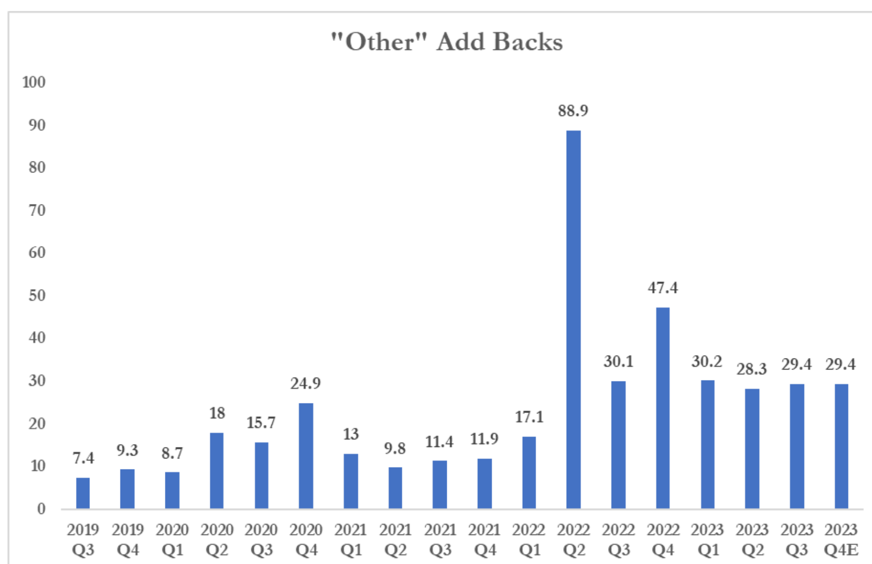
Now, however, after the one year anniversary of closing Cloudmed, we believe there are tangible signs that the acquisition is indeed proving to be successful and the model is beginning to assert itself. Now, we have to say there is still hair here, but we believe that once the financials fully reflect the earnings potential of the company the stock will likely be much higher. We believe things are going from "complex" to "simpler" (if not simple), which is good enough for now.

Here are a few points that we have received push back on in developing the idea:

1. **What About All Those Add Backs?**

We think the add backs are trending significantly lower and, per management, will drop another 50% or more in 2024, significantly increasing the quality of the EBITDA going forward.

Here is what they look like now, including implied Q4:



Nearly $30 million a quarter is still too high for us, especially more than a year removed from Cloudmed. However, they started the year by guiding it to be $123 million, and it has come down at least modestly to $117, which we believe is a function of new management being a bit more conservative as well as executing well, saving some previously assumed costs. We believe they also added an unexpected $12 million restructuring charge in Q3 that kept Q3 higher than it would have been otherwise.

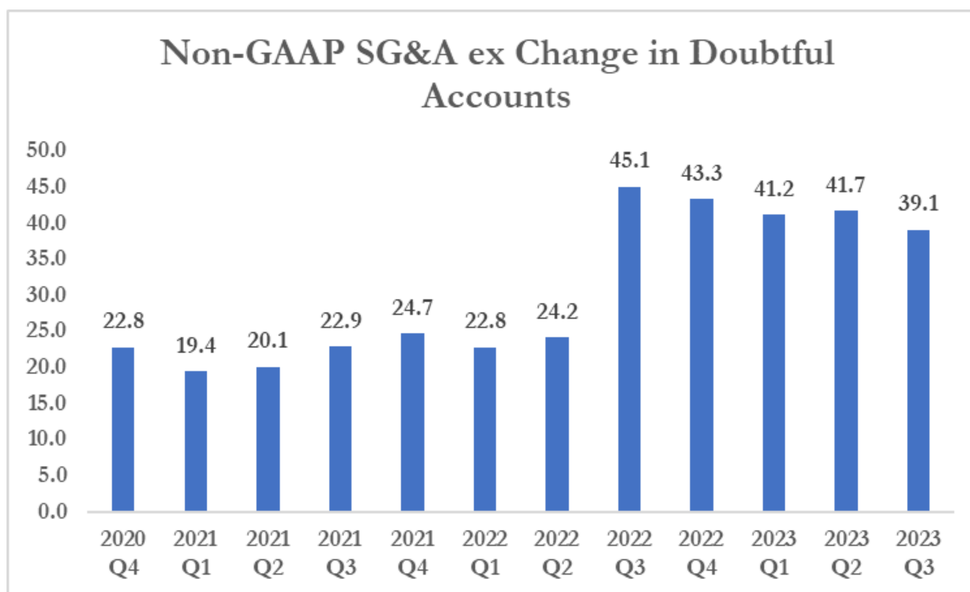
It is our expectations (and a metric that we will be watching) that this will move closer to under $10 million a quarter by the end of 2024 and be no more than $60 million for the year (half of 2023), and then moving closer to zero the following year.

2. Is the Company Exaggerating that Cloudmed/Modular revenues run at 45% and that End to End contract margins (at maturity) run at 30%?

If you buy into the idea that the Other add backs costs are indeed winding down, the next piece of the puzzle is to examine whether their margins are coming in as advertised: 45% for Modular revenues and 30% margins for mature End to End customers. The key here is to monitor the underlying SG&A expense, as they separate this from the segment economics, so as:

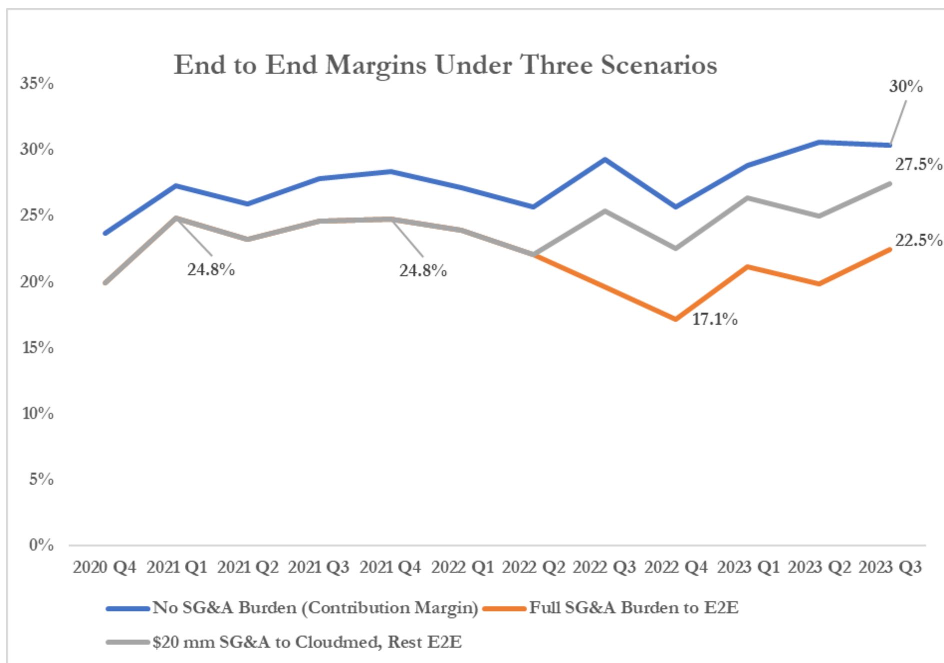
Total Adjusted EBITDA= End to End EBITDA+ Modular EBITDA - SG&A expense

If the model was not working you might see them stuff more expenses into SG&A. Below is our normalized SG&A expense for the company after subtracting changes in doubtful accounts:



We looked at underlying margins in three ways with varying levels of “SG&A burden” but keeping Modular margins at 45% for consistency:

1. No SG&A burden (Blue line). This is more like a contribution margin.
2. Full SG&A burden (Orange line). This is draconian as it puts Cloudmed SG&A onto the End to End line.
3. $20 mm a quarter to Cloudmed, rest to End to End (Gray line). **We think this is probably the best reflection of underlying reality.**



The blue line suggests that, from a customer contribution perspective, the company is already achieving 30% margins, even as a significant percentage of their customer revenues are still not fully mature. The orange line is a bit draconian as it puts all SG&A expense, even Cloudmed expense, onto the E2E segment. If we put roughly 2/3rds of SG&A expense burden on the segment, they are now running at a 27.5% EBITDA margin.

In short, we believe from a contribution margin perspective, 45% for modular and 30% for E2E is easily achievable and is already being roughly achieved. If you tack on a full SG&A burden, which we expect to grow at near inflation levels (2-4%) from roughly $160 mm this year, we estimate Modular may be closer to 40% while E2E is currently closer to 27.5%, although we fully expect leverage on the SG&A line, as well as gross margin improvements. We expect SG&A to grow roughly at inflation from here on out.

A 30% aggregate EBITDA margin is in our view entirely reasonable. In fact, we think 35% aggregate margin may still be reasonable as they continue to automate more processes, contracts continue to mature, and they continue to scale their revenue base.

3. Is Cash Starting to Convert?

As mentioned, in addition to all the cash EBITDA add backs, there was a significant working capital headwind that was pushing true FCF into negative territory. Additionally, rising interest rates were adding significant cash interest.

We believe both underlying FCF and actual FCF are starting to inflect up, and should continue to do so in 2024 as:

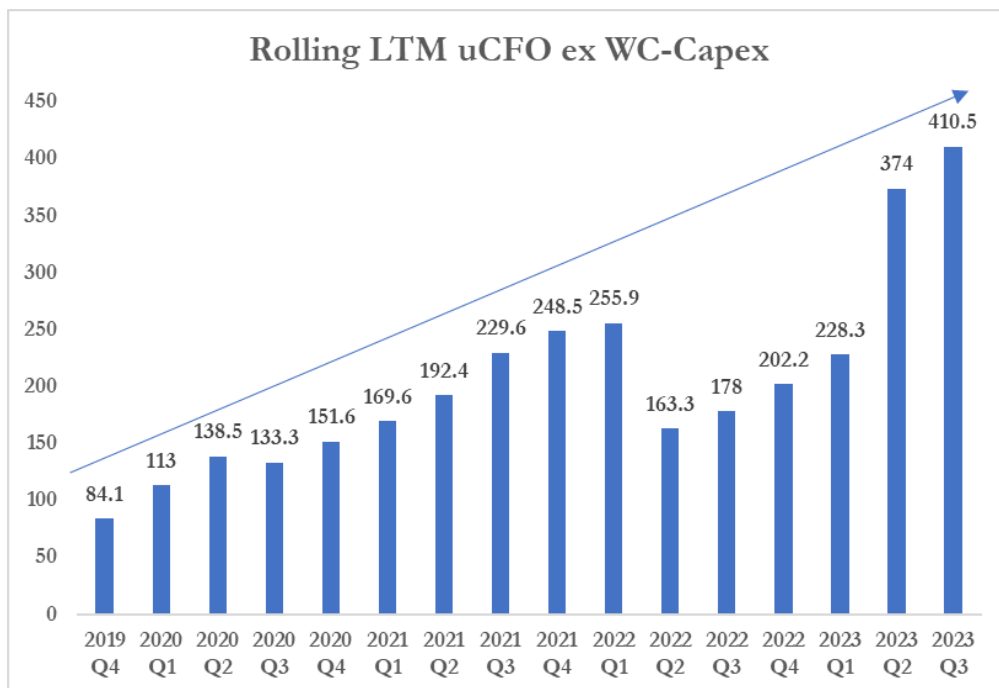
a) Additional high margin module revenue grows 15-17.5%, with is an immediate EBITDA and cash contributor
b) Sutter Phase 1 begins to show maturity and profitability
c) Working capital continues to improve/normalize

There will be a headwind of Sutter Phase 2, likely launching in mid-2024, as well as new business they expect to announce in the coming months, but we believe the items above can more than absorb that.

To understand whether **normalized operating cash flows** were inflecting, we looked at the following:

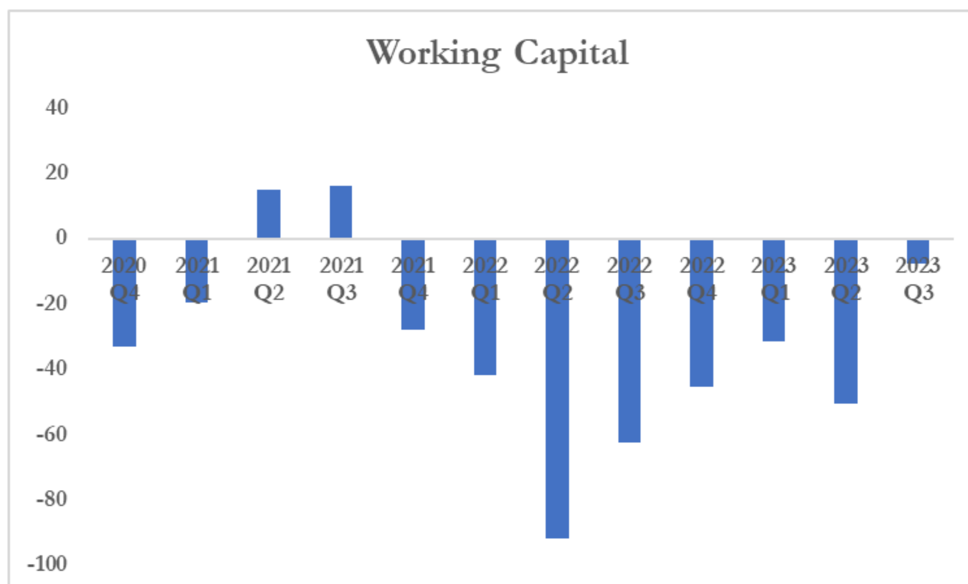
Cash Flow from Operations ex changes in Working Capital+Interest Expense (i.e.. unlevered)- Capex.

This dings them on their full capex spend but also assumes working capital more or less normalizes over time. In this case, on a rolling LTM basis we get this:



You can see that prior to Cloudmed, the company was on a pretty good cash flow trajectory, Cloudmed undoubtedly disrupted that trend, but they are now re-emerging on a new, high level, even without a lot of new mature customers.

Working capital, while still a material headwind, is quickly flattening out closer to 0 (-7.5 million in Q3). We believe once again that the Cloudmed acquisition had one time significant impacts to working capital that are just now flattening/resolving.



We expect working capital to remain a headwind going forward, but a much more modest one, as it will be born mostly out of growth in the business (ongoing AR/Contract asset growth along with Lease Liabilities).

Actual FCF in the most recent quarter was $77 million, a number we expect to move closer to $100 million a quarter, implying the company is closer to 12x FCF before considering any incremental cash flows from onboarding Sutter, growth in Cloudmed, additional signed customers, and additional maturing customers, plus any incremental benefits from technology automation.

Valuation Considerations

In our Base Case Model, we assume that on average they can add $5 billion in net NPR over the next three years, and that their Modular business grows between 12-15%. This is well below what their onboarding capacity is ($8-9 billion) and well below what we believe management's goals are (and below Modular's 2023 growth rate), but given they have yet to sign significant contracts in 2023 we are taking a slightly more conservative approach to growth. Embedded in this is $1 billion in utilization growth (e.g. same store sales growth) and $4 billion in net new NPR signings. The $1 billion in utilization growth would be below long term industry forecasts of 5-6%m, but given the current dynamic environment we feel it is prudent.

By 2026, we believe the company will be running E2E NPT of $70 billion and Modular revenue near $1 billion (from $50 billion and $760 mm in 2023, respectively). Factoring in $135 mm in capex and $180 mm of SG&A, and we believe they would have increased their underlying, **fully deployed EBIT power to $1.1 billion.**

Our actual 2026 forecast is a bit lower, but still comes to around $950 mm of EBITDA-Capex.

Given they are a limited tax payer currently, we put a full 25% tax rate on this, implying uFCF of $714 and levered FCF of $650 mm, **implying they are trading at 7.5x 2026 levered FCF, fully taxed.**

We then target 15x, giving a two year target of $21 assuming 1% annual equity dilution from stock based comp.

	2023	2024	2025	2026
NPR End	50,000	60,000	65,000	70,000
NPR Average	42,463	48,333	58,000	63,500
Take Rate	3.75%	3.80%	3.85%	3.85%
E2E Revenue	1571	1837	2233	2445
E2E Contribution	496	531	645	773
Modular Revenue	696	801	921	1036
Modular Contribution	331	380	437	492
Total Contribution	827	911	1083	1265
Non-GAAP SG&A	191	175	180	186
Adjusted EBITDA	636	736	903	1079
Capex	100	115	125	130
Adj EBITDA-Capex	536	621	778	949

Bear/Bull Cases

In a Bear Case, we more or less assume the company stops adding new E2E customers (3.8% NPR CAGR, below the projected normal utilization growth), so that NPR at the end of 2026 sits at 56 billion (from ~$50 billion today). Further, Modular growth goes from 7.5% to 5% to 2.5% (despite management saying this quarter that "we expect continued growth in our modular business. That will be strong growth for us."). We assume no underlying customer margin expansion from technology automation and assume SG&A and Capex continue to grow modestly.

In this case, we still get to EBITDA-Capex of $725 in 2026, or $450 mm in levered FCF, on the back of a maturing, fully rolled out Sutter contract. We apply a 10x multiple to what we view as fairly consistent FCF on a company that will now be significantly delevered. Implied EV/(EBITDA-Capex would be 8.5x).

In a Bull Case, we believe they can add closer to their implementation capacity ($8-9 billion NPR) a year for the next few years, and get to near $80 billion NPR by the end of 2026. We assume 17.5% Modular growth and assume E2E contribution margin gets to 34% from ongoing technology automation initiatives. In this case, we believe the company will get more material credit as a technology focused healthcare compounder, and will generate a 20x FCF and 16x EBITDA-Capex multiple.

Here is a summary of our cases:

2026 Estimates

Case Summary	EBITDA-Capex	FCF	Multiple	Price	Up/Down	Implied EBITDA-Capex
Bear	$725	$457	10x	$ 9.63	-10%	8.5x
Base	$949	$666	15x	$ 21.05	97%	12.2x
Bull	$1,155	$821	20x	$ 34.58	224%	15.6x

Our target price realizations are over a two year period, as we would expect by the end of 2025 to be pricing in 2026 numbers.

Note in each case we have some reductions in cash interest from assumed delevering, and in each case assume a 1% burn rate from stock based comp equity issuances, resulting in 475 mm shares at the end of 2026.

Transaction Comps

As another sanity check on valuation, here is a table listing the precedent transaction comps cited by Goldman Sachs in the Change Healthcare merger proxy filed March 5th, 2021, with similar companies acquired at a median of 14.1x.

Selected Precedent Transactions Analysis

Goldman Sachs analyzed certain publicly available information relating to the following selected transactions in the Healthcare Information Technology and Information Services industries since August 2008:

Closing Date	Acquiror	Target	EV/LTM Multiple
August 2008	Apax Partners	The TriZetto Group, Inc.	14.4x
November 2011	Blackstone	Emdeon Inc.	11.2x
June 2012	Veritas Capital	Truven Health Analytics	9.6x
August 2012	Roper Industries, Inc.	Sunquest Information Systems, Inc.	12.6x
November 2014	Cognizant Technology Solutions Corp.	TriZetto Corp.	14.2x
February 2016	Pamplona Capital Management	MedAssets, Inc.	11.5x
April 2016	IBM	Truven Health Analytics	17.0x
June 2016	Veritas Capital	Verisk Analytics, Inc. Healthcare Division	10.1x
October 2016	Quintiles	IMS Health, Inc.	14.4x
September 2017	Internet Brands	WebMD Health Corp.	12.3x
November 2017	Optum	The Advisory Board Company	14.1x
August 2018	Verscend Technologies, Inc.	Cotiviti Holdings, Inc.	18.0x
February 2019	Veritas Capital and Elliott	Athenahealth Inc.	15.2x
August 2019	HealthEquity, Inc.	WageWorks, Inc.	13.6x
October 2020	Churchill Capital Corp III	MultiPlan, Inc.	15.3x

As you can see, there is not a single related transaction comp that went for less than 9.6x, compared to RCM at close to 7x 2025 consensus estimates. Of note, Change Healthcare itself, which had flat-to-negative revenue growth for several years prior to its buyout, was acquired at 14.5x trailing/12.8x forward EBITDA and over 22.0x EV/2022 unlevered FCF (deal announced January 2021).

Potential Catalysts

1. Ongoing realization of profitability inflection and higher quality earnings
2. Signing of new large customers
3. Announced timing on Sutter Phase 2
4. Greater appreciation of technology investment/competitive advantage (will show up in upside profitability)
5. Analyst day in Q1-Q2 2024.
6. Ongoing debunking of short thesis with each passing quarter

Risks

Our risks are more around short term timing and what other buy side expectations are, as one never knows for sure. It's possible some think they will just easily grow 20% a year the next few years, whereas we feel ~15% should be more than enough to drive significant returns. It's possible total revenue growth temporarily slows down before re-accelerating, given the lumpy nature of customer onboarding (ironically this would likely result in temporary increased profitability).

There remains risks around customer concentration (although rapidly declining), shareholder concentration, and the generally dynamic nature of the healthcare industry and healthcare billing. There is also the possibility that major overhauls to simplify hospital billing actually succeed, undermining the company's core value proposition.

The most material item that would change our mind on the fundamental thesis is if we learned that there were major issues with the Sutter implementation. As of now, the CEO claims he is sending prospects to Sutter, and that Phase 1 is going great. If it turned out there were material issues here, though, it would kneecap the thesis that R1 is near a tipping point of demand, would dent the "management quality" thesis, and would potentially threaten 2025-2026 cash flows from Sutter.

Finally, we believe the company will attempt to "reset the NPR deck" on a more normalized basis in the New Year. This involves resetting NPR rates at $50 billion, rather than the $55 billion being used by analysts, to reflect the APP bankruptcy, Pediatrix customer loss, AMIT Health peeling off $1 billion in NPR as part of their initial agreement, and Quorum Health divesting some assets leading to it being closer to $1 billion than $2 billion. While we think most of these things are already known, it is a short term risk that some investors are caught off guard by it.

Summary

R1 currently has very negative sentiment. It is getting hit by both stylistic (floating debt, healthcare IT, SMID) and idiosyncratic factors (accounting, management, customer loss/bankruptcy, negative estimate revisions). While we cannot dismiss all these negatives as "nothing", it is our variant view that "under the covers" things are way better than they appear at first glance. Furthermore, our diligence suggests a very large opportunity with a strong management team that is thinking with the long term in mind.

We believe there is limited downside over the next two years as there is still latent profitability building that will show up from maturing customers and ongoing Modular growth.

Twelve months from now, we think the investment narrative will have transformed significantly as management signs new customers, earnings quality improves substantially, deleveraging begins in earnest, and hospitals become incrementally more healthy, leading to what will be viewed as a scarce high quality healthcare IT asset trading closer to fair value which should put the stock ~100% higher.

Common Terms:

CAGR – Compound Annual Growth Rate	*IRR – Internal Rate of Return*
CAPEX – Capital Expenditures	*LTM – Last Twelve Months*
COGS – Cost of Goods Sold	*M&A – Mergers and Acquisitions*
DCF – Discounted Cash Flow	*NTM – Next Twelve Months*
EBIT – Earnings Before Interest and Taxes	*OPEX – Operating Expenses*
EBITDA – Earnings Before Interest, Taxes, Depreciation & Amortization	*P/E – Price to Earnings*
EPS – Earnings per Share	*P&L – Profit and Loss Statement*
EV – Enterprise Value	*P&S – Parts and Service*
FCF – Free Cash Flow	*SG&A – Selling, General and Administrative Expenses*
GDP – Gross Domestic Product	*TAM – Total Addressable Market*

Disclosures and Notices:

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