Ref: NEPHROPLUS/SE/80

August 19, 2026

To
BSE Limited
P.J. Towers, Dalal Street,
Mumbai – 400 001
Scrip Code: 544647
Through: BSE Listing Centre

To
National Stock Exchange of India Limited
5th Floor, Exchange Plaza, Bandra (E),
Mumbai – 400 051
Scrip Symbol: NEPHROPLUS
Through: NEAPS

Sub.: Transcript of Investors' Conference Call on Q1FY27 Financial Results
Ref.: Regulation 30, 46(2) and other applicable provisions of the Securities and Exchange Board of India (Listing Obligations and Disclosure Requirements) Regulations, 2015.

Dear Sir/Madam,

In continuation to our letter dated July 24, 2026 and August 12, 2026, please find attached Transcripts of the Investors' Conference Call held on August 12, 2026 on the Un-audited Standalone and Consolidated Financial Results of the Company for the quarter ended June 30, 2026.

The transcript of the said Conference Call has been uploaded on our website at www.nephroplus.com

Kindly take the same on record.

Yours faithfully,
For Nephrocare Health Services Limited
(Formerly Nephrocare Health Services Private Limited)

Kathri Kishore
Digitally signed by Kathri Kishore
Date: 2026.08.19 16:53:16 +05'30'

Kishore Kathri
Company Secretary and Head Legal
Membership No.: F9895

Encl: a/a

"Nephrocare Health Services Limited

Q1 FY27 Earnings Conference Call"

August 12, 2026

E&OE - This transcript is edited for factual errors. In case of discrepancy, the audio recordings uploaded on the stock exchange on August 12th, 2026 will prevail

MANAGEMENT: **MR. VIKRAM VUPPALA – CHAIRMAN AND MANAGING DIRECTOR**
MR. KAMAL SHAH – CO-FOUNDER
MR. ROHIT SINGH – GROUP CHIEF EXECUTIVE OFFICER
MR. PRASHANT GOENKA – GROUP CHIEF FINANCIAL OFFICER

MODERATOR: **MR. NAMAN – IIFL CAPITAL**

Moderator: Ladies and gentlemen, good day and welcome to Nephrocare Health Services Limited Q1 FY27 Earnings Conference Call hosted by IIFL Capital. This conference call may contain forward-looking statements about the company which are based on the beliefs, opinions, and expectations of the company as on date of this call. These statements are not the guarantees of future performance and involve risks and uncertainties that are difficult to predict.

As a reminder, all participant lines will be in the listen-only mode, and there will be an opportunity for you to ask questions after the presentation concludes. Should you need assistance during the conference call, please signal an operator by pressing star then zero on your touchtone phone. Please note that this conference is being recorded.

I now hand the conference over to Mr. Naman from IIFL Capital. Thank you, and over to you, Mr. Naman.

Naman: Thank you. Good morning, everyone. On behalf of IIFL Capital Services Limited, I welcome you all to Q1 FY27 Earnings Conference Call of Nephrocare Health Services Limited. We are pleased to have with us the management team, represented by Mr. Vikram Vuppala, Chairman and Managing Director; Mr. Kamal Shah, Co-Founder; Mr. Rohit Singh, Group CEO; and Mr. Prashant Goenka, Group CFO of Nephro Health Services Limited.

We will have opening remarks from the management followed by a question-and-answer session. Thank you, and over to you, Vikram.

Vikram Vuppala: Thank you. Very good morning, everyone. This is Vikram Vuppala, Founder, Chairman and Managing Director. Thanks everyone for joining our first quarter of FY27 Earnings Conference Call. Along with me, I have Kamal, the Co-Founder, we have Group CEO Rohit Singh, and our Group CFO Prashant Goenka on this call.

We began FY27 on a steady note, with Q1 revenues growing more than 20% year-on-year. This steady performance reflects the strength of the platform business we have built over the last 16 years, supported by disciplined execution, a resilient operating model, and the continued trust of our patients, payers, and hospital partners.

The foundation of this platform was laid 16 years ago when we recognized that the growing prevalence of diabetes and hypertension would inevitably lead to a significant increase in chronic kidney disease.

As kidney disease progresses, majority of these patients eventually move to stage five where you require dialysis or a transplant to survive. However, we also realized that delivering dialysis at scale would require addressing three fundamental pillars: quality of care, accessibility, and affordability. These principles continue to guide every decision we make at NephroPlus.

Let me start our core pillar, quality. Dialysis is fundamentally different from most other healthcare services. It is not an elective procedure or a one-time procedure. It is a chronic life-sustaining treatment. Every dialysis session enables a patient to live another few days. In NephroPlus, we take quality as the cornerstone, and hence the quality team does not report into the business team. They report to the Chief Medical Officer directly.

This enables our quality managers to do their clinical audit work without any pressures from the P&L owners. Every clinic undergoes a thorough clinical audit every month from one of the quality managers, and all of our clinics across the network are ranked on clinical outcomes every month.

The second pillar is accessibility. While affordability and quality is supported through reimbursement and focus on clinical care, access to quality dialysis remains a much larger challenge. A patient typically requires dialysis three times every week and cannot be expected to travel long distances for every session.

This is why we have consistently expanded beyond the metro cities in every country that we operate in, bringing organized dialysis care closer to where the patients live. Just this last quarter, we have launched NephroPlus in 17 new cities in India and 5 new cities in Philippines, which is a very important metric that Kamal and I track in terms of improving access to quality dialysis care.

The third pillar is affordability. Dialysis is a lifelong treatment and for most patients, the financial burden can be onerous. Fortunately, dialysis is covered under various central and state government health schemes in India, and in most other healthcare systems globally, it is fully reimbursed by government in some form or manner.

From the very beginning, we built our business around this reimbursement-led model, working closely with health insurance schemes, governments, and other payers to ensure that financial constraints do not become a barrier to access to life-sustaining treatment.

Sincere focus on these three pillars, we have built one of the largest dialysis networks globally. With NephroPlus today operating 550 clinics across 357 cities in 5 countries, making us India's and also Asia's largest dialysis network by volume of treatments we do. Our international operations continue to complement our India business, allowing us to leverage the operating platform and capabilities we have built over several years.

Also, I'd like to mention that India is still in the early days of the dialysis market life cycle. Majority of the patients who need dialysis still do not have access to dialysis, and also 80% of the dialysis capacity is still in the unorganized market wherein hospitals run their own dialysis operations. As hospitals evaluate their dialysis operations' financials closely, they will start outsourcing dialysis operations to pure-play dialysis networks like NephroPlus.

Globally, hospitals do not run dialysis operations as you need two things to make decent margins in dialysis. You need massive scale and you need 100% focus. You need massive scale to generate margins in dialysis, and you need 100% focus to retain those margins. This shift from unorganized to organized dialysis market in India will play out over the next several years giving us good growth opportunity.

At a macro level, we have consistently communicated our growth is driven by three growth levers. The first is increasing guest volumes across our existing clinics through higher utilization of capacity and potential capacity expansion with addition of machines. The second is expanding our footprint within the existing countries through addition of new clinics and selective small

acquisitions. The third is entering new countries and pursuing strategic opportunities including large acquisitions and large PPPs, Public-Private Partnerships.

Together, these three levers provide us with visibility for sustainable long-term growth. Looking ahead, we will continue to invest in expanding our network in existing markets, strengthening our best-in-class technology platform, and selectively entering new markets while maintaining our unwavering focus on clinical excellence and disciplined capital allocation.

With that, I now request Rohit to share his remarks on the business.

Rohit Singh: Thank you, Vikram. Good morning, all, and thanks for joining this earning call. I'll keep my remarks focused on three things. How the business performed, what we are doing on clinical quality, and where we are investing for the next phase of growth.

This quarter, Q1 FY27, was a quarter of good financial performance and continued strategic expansion. Revenue grew 23.7% year-on-year to INR282 crores. Adjusted EBITDA grew 30.7% to INR65 crores, with margins expanding 120 basis points year-on-year to 23.1%. Guests, our term for active patients, grew 13% to 38,262, and we crossed 10 lakhs 30,000 treatments in this quarter, up 13.3%.

We added 26 clinics during the quarter, 19 in India and 7 in the Philippines, taking our network to 550 clinics across 5 countries and 357 cities. Including 307 cities across 25 states in India. International operations now contribute around 45% of the revenue. Every new city we enter extends organized dialysis care into a catchment that did not have it before.

The Philippines and the India model. Our business in the Philippines remains one of the strongest validations of the NephroPlus India model. We added 7 clinics there this quarter and crossed a significant milestone of 50 clinics across 39 cities. In just 6 years since entering the country, we have become the second largest distributed dialysis network.

The India model is much more than a network of clinics. It is a proven operating platform built over 16 years, combining standardized clinical protocols, robust operating processes, and deep expertise in managing reimbursement-driven dialysis ecosystems. It lets us deliver superior outcomes efficiently at scale, and gives us a repeatable blueprint for new geographies. But simply, NephroPlus is a dialysis platform built in India for the world.

On public-private partnership, we deepened our footprints in Bihar this quarter and signed a new contract in Tamil Nadu. We also let go two clinics under the Uttarakhand PPP that were value dilutive. We will not pursue business that does not meet our return thresholds. That discipline is deliberate and we remain positive about PPP opportunities overall.

Clinical quality. Clinical quality is the foundation of everything we do and makes the model replicable. Two proof points in this. First, our early vascular access program in Andhra Pradesh. A catheter in Hemodialysis raises risk to life by roughly four to six times, and mortality risk is the highest in early phase of dialysis. So across 21 centers and 2,000 guests, we moved monthly AVF creations from 15% of the guests to 30%, thus reducing mortality to close to 15%.

Second, the NephroPlus index. A single composite health score derived from seven weighted clinical matrices. It is live across 29 centers in 2600 guests, letting us predict outcomes and intervene at the individual guest level.

Overall, in the coming quarters, we will aggregate it up to clinical cluster, zone, and country levels, giving us a single lens on clinical performance across the network. Alongside this sits the blue book, our manual for putting our guest-first culture into practice at the last mile. Clinical standards can be matched; a culture this deeply embedded cannot be.

Third is build to scale. We launched the NephroPlus International Dialysis Academy, what we call the NIDA, as an in-house program to build a pipeline of renal nurses qualified to work anywhere in the world. The first batch will begin training in the third quarter. Access to trained renal nurses is a genuine constraint on international expansion in this industry, and NIDA is how we intend to solve it structurally rather than market by market.

We are also digitizing the guest and clinical experience through our guest care app and in-center apps, and deploying AI across the organization with process improvements already live in several back-office functions.

International expansion. During the quarter, we incorporated our subsidiary in Kazakhstan, creating a platform to evaluate opportunities across the country and in Central Asia. Our approach to new market remains disciplined. We assess reimbursement, regulation, demand, and long-term sustainability before committing capital.

In Saudi Arabia, we continue to make steady progress. Our first clinic at the Riyadh Hospital became operational in July, and we have commenced home dialysis operations there as well. We have also obtained our medical operator's license and submitted our response to the Ministry of Health tender RFI. With the formal tendering process expected to begin in a couple of months, we remain optimistic about the market, while recognizing these timelines are not fully within our control.

Looking ahead, our priorities remain unchanged. We will continue to expand access to quality dialysis care, strengthen our leadership in India, replicate our proven model internationally, and pursue growth with the same disciplined approach that has defined NephroPlus for these 16 years.

We remain confident in our ability to grow profitably and efficiently while delivering superior clinical quality in every market we serve. With that, I request Prashant to take you through the financials for the quarter.

Prashant Goenka: Thank you, Rohit. And a very warm welcome to everyone joining us today. I will take you through the financial and operational performance of the company for the first quarter of FY27. As Vikram and Rohit highlighted earlier, we have begun the year on a steady note with healthy growth across our key operating and financial parameters.

Revenue for Q1 FY27 grew by 23.7% year-on-year to INR282 crores compared to INR228 crores in Q1 FY26. The growth was primarily driven by higher treatment volumes, supported

by continued expansion of our international business, which also contributed to an improvement in revenue per treatment.

Moving to profitability, our adjusted EBITDA, excluding ESOP cost in Saudi stood at INR65.1 crores compared to INR49.8 crores in the corresponding quarter last year, reflecting a growth of 31%. Adjusted EBITDA margin improved to 23.1% compared to 21.9% in Q1 FY26, supported by operating leverage and increasing share of international business whose base lies on our India model.

Our adjusted PAT, after adding back ESOP expense and Saudi JV expense, stood at INR37 crores compared to INR26 crores in Q1 FY26, registering a growth of 41.7%. Adjusted PAT margin also improved to 13.1% from 11.4% in the corresponding period last year, aided by lower finance cost and the benefits of operating leverage.

Let me now touch upon some of our key operating metrics. Patient volumes or guests, as we refer to them at NephroPlus, continue to remain the most important driver of our business. As of June 2026, our active guest count stood at 38,262 compared to 33,868 as of June 2025, representing a growth of 13%. This translated into a corresponding increase in dialysis treatments performed during the quarter. We delivered 10.3 lakh treatments in Q1 FY27 compared to 9.1 lakh treatments in Q1 FY26, reflecting a growth of 13.3%.

Our revenue per treatment, RPT, stood at INR2,733 during the quarter compared to 2,503 in the same period last year, representing a growth of 9.2%. The improvement was largely driven by a higher contribution from our international operations where treatment realizations remain higher than in India. We also remained focused on disciplined capital deployment and improving capital efficiency. Our annualized adjusted ROCE stood at 21% in Q1 FY27.

On capital allocation, we continue to deploy IPO proceeds towards expanding our network and pursuing center acquisitions across both India and international market, as well as paying off our term loans. As on June 2026, we have utilized 68%, which is about INR207 crores, from fresh issue from our IPO proceeds. Our capital expenditure for Q1 stood at INR44 crores towards center acquisitions and growth.

Overall, our Q1 performance reflects continued execution across our growth initiatives while maintaining focus on profitability, capital efficiency, and disciplined expansion. Lastly, as highlighted earlier, our growth strategy continues to be anchored on the three key levers we have previously outlined. We continue to maintain our medium-term growth guidance of 15% to 20% over the next three to five years and remain focused on delivering sustainable and capital-efficient growth. With that, we now open the floor to questions.

Moderator: The first question comes from the line of Akshay Thakur with Helios Capital. Please go ahead.

Akshay Thakur: Hi, sir. Very good morning. And thanks for taking my question. So, my question is on the depreciation line item per se. So just wanting to understand what, when a clinic is set up, what kind of assets comprise the primary capex? What is the life of that capital? My basic understanding is that the primary equipment in the clinic would be the dialyzer, and some other capex things also. So how do you depreciate these assets? What is the timeline?

Management: Yes, so this is Prashant. I'll take this question. On the depreciation front, first of all, I just want to highlight our depreciation as a percentage of revenue has remained flat year-on-year, which is around 8.6% to 8.7%. To answer your question, we depreciate our machines anywhere between 7 to 10 years, depending on the country and the local regulatory requirement.

One of the things that you would have noticed this time is that we have seen two major changes on the depreciation front. One, we are becoming more and more disciplined about our fixed asset. We have deployed a new technology whereby through RFID you are able to track our fixed assets, machines, and which has resulted in far more disciplined approach in deploying the capital assets, resulted in a reduced depreciation cost in markets like India.

Second, in markets like Philippines, we have done seven acquisitions in the last quarter. For these acquisitions, we typically pay a goodwill which results in a, which we then split into intangibles which result in a slightly higher amortization, which result in a slightly higher depreciation, which then sort of dilutes over a period of time as we amortize it over a period of five to seven years, the goodwill amount.

Akshay Thakur: Thank you, sir. Thanks for the comprehensive answer. Another second question is on the fixed capital investments. So, you had mentioned that you spent around 4 million per bed for the Philippines greenfield. Can you, do you have any ballpark figure for the acquisitions you make on a per bed basis?

Management: So, in Philippines, I think, as we indicated earlier, it's a, it's a market with a lot of mom-and-pop shops. There are about 900 clinics, about 150 to 200 are owned by large chains like us, two, three large chains like us, but the remaining 700 clinics are owned by mom-and-pop shops, each one of them own either one or two clinics. Most of our acquisition happens at a single clinic basis or a double clinic basis. These are largely negotiated at a center level.

And as you can imagine, when the discussions or negotiations are happening at a mom-and-pop shop level at a center level, the goodwill amount has a lot of variability in, in, involved in the process. So as a matter of practice, we don't share the details because they tend to be very variable and it also is a competitive information for us.

Akshay Thakur: Okay, sir. Thank you. One question on the working capital part. So, you had mentioned that your working capital days are around 120. So, is there an indicative or understanding on the India part and the Philippines part and the Uzbek part? Is there a differentiation in that number? Can you help us in terms of qualitative sense, can you help us understand the variability in that?

Management: Yes. So, I think as Vikram in previous calls have explained, dialysis is a slightly more different type of industry, right, where structurally the working capital requirements are higher because we deal with the government and the government payment typically comes over three to four months.

So, whenever we look at projects, we look at the ROCE as one of the key metrics. And in the ROCE, we account for the working capital requirement, and only when the project makes sense from a ROCE perspective, we invest in that project. And therefore, working capital is an

expected number and it is, we are very comfortable with it because those, we have accounted for it as we made the investment.

Now to answer your more specific question around how much is the working capital days, while I cannot get into the specifics of the country, but just to give you an idea, one of the key drivers of working capital days is the AR. And compared to last year, our working AR days has improved from 121 days to 101 days.

So, we have seen a 20-day improvement on the back of a lot of digitization, and a lot of AI work that we have done in the company. But having said that, the industry should expect the AR days to remain relatively high because that's the structural part of our industry that we, that we are in.

Akshay Thakur: So, thanks for answering my questions. That was very helpful.

Moderator: Next question comes from the line of Sidharth Negandhi with Chanakya Wealth Creation. Please go ahead.

Sidharth Negandhi: Hi, thanks for taking my question. Just wanted to understand two things. One, the material margin improvement that we are seeing has been fairly robust right and quite good. How much of that is driven by the fact that there is a mix on the international side, and how much of it is driven by inherent sort of cost improvements that you are doing?

The second part is if I look at the center growth, right, we've taken 60 centers, or added 60 centers on a base of 500, taking this to about 550 if my calculations are right, which would be a 12% increase in centers for a 13% guest volume increase.

And therefore, the remaining is, is productivity improvement on a, on an average per center, right? But that obviously would be different for existing centers and new ones established. So, if you could give us some understanding of occupancy or productivity percent on how that has improved?

And the third one, you spoke about AI, and obviously a lot of AI initiatives that are that are reducing the backend operational work and bringing efficiency. Any AI initiatives that are likely to improve patient outcomes that you are working on? Yes, those would be my three questions.

Prashant Goenka: Sure, Siddharth. I think I'll take the first one around margin improvement and then I'll request Vikram and Rohit to help on the other two questions. I think you talked about the margin improvement. Yes, we have seen the EBITDA margin improve by 125 basis points. A good part of that improvement came because our COGS, if you look at the COGS as a percentage of revenue, has improved by 175 basis points.

As we have discussed in the past calls, this is a NephroPlus is a platform play. We have operated in a country like India with the lowest price point and created an operating model that when we take it to other markets with higher price point, we are able to scale more profitably. The same thing happened this quarter.

We were able to take our procurement platform to other markets and we were able to improve our COGS efficiency at a meaningful level, and that is one of the key factors that has driven the improvement in the EBITDA margin. So that's the first question. In terms of the center and the AI, I will…

Vikram Vuppala: Yes. On the center point, Siddharth, this is Vikram. Essentially, we look at capacity utilization from a clinic-by-clinic perspective, right? We don't look at it from a country level optimization perspective, but any clinic which is already heavily utilized, let's say it's 85% utilized in dialysis, you need to have some spare capacity for breathless guests who come in unannounced, right, unplanned. So, capacity utilization, the point around 13%, the addition of 50 clinics, it's at a country-by-country level.

We optimize it at a micro clinic level wherever there is utilization improvement that can be done with addition of a guest in a center with low utilization we go for it, but highly utilized centers we cannot go. So, we can't add up underutilized, well utilized, and heavily utilized clinics and look at it at a macro level. That's on the point number two. On the AI question, I will ask Rohit to answer the question.

Rohit Singh: Thanks, Vikram. On the AI front, as I briefly mentioned that we have taken several initiatives to improve processes, and that's still work in progress and we still see a lot of headroom for improvement there, and that will continue. To answer your precise question around AI initiatives for guest clinical improvements that is happening. We are definitely focusing on data. We are working on NephroPlus index, and we will be effectively using AI to interpret that data and probably look at some forecasting tools in future.

Vikram Vuppala: Yes, I'll just add to what Rohit has said on AI on the clinical side. I think last quarter we mentioned about our reform.ai application, right? That way we can make sure that the processes are followed to the T using CCTV cameras and our AI algorithms, much better than any other manually driven audits, right?

If the, the nurses are wearing gloves in, whenever they are touching the machine surface, whenever they're touching our guests, that improves clinical outcomes. In a manual audit process, you can never ensure 100%. You can ensure 90%, 85% through auditing, but this is live auditing that's happening, and alerts get created which go to the center manager, the cluster manager, and the quality manager. That's point number one.

Second one is we still are a little bit distance away from predicting adverse events using clinical data and AI algorithms. Our first attempt at predicting adverse events, the confidence level was not up to the extent that we were expecting. So that initiative is the second phase of that initiative is underway, but that's the holy grail. If we can look at the clinical data from the past and proactively identify adverse, potential adverse events over the next few days on our guests.

And we proactively intervene and manage that prevention aspect of that adverse event, that's the holy grail. Nobody in the world has done it. We have failed in our last attempt. We are still working on our second attempt. That's the macro-overview on the clinical impact side.

Sidharth Negandhi: Thanks for a very detailed and very useful response and wish you all the best. This was really helpful. Thank you.

Vikram Vuppala: Thank you, Siddharth.

Moderator: Thank you. Next question comes from the line of Aniket Singh with Kotak Institutional Equities. Please go ahead.

Aniket Singh: Alright, sir. Thank you for the opportunity. So, I was going through your presentation and in one of your slides you have mentioned that it's an asset light expansion model, with low amount of capex required. So, what is, what is our moat here that that is leading to strong growth for us? Is it our network that we are operating at such a large level that our costs are rationalized?

And what is the key differentiation that we are providing to the customers? So, for example, if a customer is going to a private hospital compared to coming to a Nephrocare clinic, is there any particular differentiation in the customer experience?

Vikram Vuppala: Yes, thanks Aniket for the question. This is Vikram. Essentially in dialysis business, throughout the world, you need massive scale and 100% focus, as I mentioned in my opening remarks, right? If you look from a network moat perspective, NephroPlus has been EBITDA negative for the last -- for the first 11 years. PAT negative for 13 years. So, you need massive scale to amortize a high fixed cost business. Like this dialysis business is like an airlines business, and you need massive scale to amortize your fixed costs.

So, any player who wants to enter the dialysis business, they will have to build that scale and they have to be 100% focused. From a barrier to entry or a moat perspective, right? It's not a high margin business at low scale, like a pathology business. This is a very different business.

The second point is at a network level, at a platform level, we have built four distinct levers which enable us to create supernormal margins compared to any other player. The first one being global procurement of our consumables which are the most expensive cost item in a country like India.

In consumables we have various levers, be it even contract manufacturing of low complexity consumables. The second one is efficient human resource management. Because we are only focused on dialysis, we have training academies to create fresh talent which are at much lower competitive costs and much better trained compared to procuring talent from the market. So that gives us the competitive edge on the HR front.

The third one is our in-house biomedical team. Throughout the world, most of the dialysis networks use contracts with manufacturers on their maintenance and repairs. We believe that there is information asymmetry between manufacturers and service providers where the service providers are usually taken for a ride. So, 8 years back we built our own biomedical team and this now is applicable in every country we operate, where we do preventive maintenance.

A dialysis machine is just like a car. If you take care of the car really well, then the repair cost will be much lower. Whereas a service center, if you go to a service center with a car, they will

mention three, four technical terms and bill you very high because there is information asymmetry. So biomedical is a huge lever for us.

Fourth is the lean operating model which we have built in India. So, because of the lowest price point in the world, we have built an audit function, we have built operational overheads, the finance overheads, HR overheads in a very lean and mean manner.

From your last question on what's the difference when a patient goes to a hospital operated dialysis unit versus a NephroPlus, to give you an idea, hospitals don't generate more than 1% of their revenue from dialysis operations. It's not even the 10th profit driver of a hospital. It's a loss-making business mostly because they neither have the scale nor focus.

The hospitals do not have the bandwidth because the ortho, oncology, specialties are where the profit drivers are and they would rightfully so focus on the other specialties where the profits are higher. Hospitals do not focus on dialysis operations, whereas for NephroPlus that's our only department that we do, right, it's a pure-play focused dialysis network.

The way we run the clinical protocols, the way we standardize the clinical responses to complications, the way we do the service level audits, the financial audits, the pilferage related, vigilance related audits, no hospital has the ability nor the bandwidth to run like NephroPlus, right. There is a distinct difference and hence the hospitals are partnering with us throughout the country. There are more than 300 private hospitals who have partnered with us. That's the reason.

Aniket Singh: Thank you, sir. Thank you for that detailed answer. So just to continue on that point, the private hospitals are partnering with Nephrocare. So, you provided that they these partners provide you space and utilities, and I'm assuming that we would be installing our own machines. And how does this revenue share agreement work?

Because as you mentioned that it's less than 1% or 2% margin for these hospitals. So, like, we are also taking revenue from those operations. So, is it just the low investments from their side that is leading them to give the business to us or is it something different in the terms of the agreement that we have?

Rohit Singh: So, Aniket, this is Rohit here. So, when we partner with these hospitals, typically they provide us space and utilities, and all the other investments in the equipment and furniture and other assets are done by us. So, it is purely built, own, operate kind of model there. And why do hospitals partner with us? Obviously because we got the scale so that we are able to run the operations profitably.

And for hospitals, as Vikram mentioned, this is not a big profit driver. And hence, and also it helps them free their operating bandwidth. Their focus on dialysis, as since it is not the most profit generating one, is one of the services that the hospital provides. It is not the focus service. For us, this is 100% of our revenue. Hence it is our 100% focused service.

So, there is operating bandwidth that gets freed for the hospital partners, there is no upfront capex investment there, and they get the desired unit economics because they are partnering with us, so the unit economics is taken care of, and NephroPlus delivers world class quality dialysis.

So, their objective of dialysis at a quality is taken care of by freeing their bandwidth and capex saving.

Vikram Vuppala: Yes, just to add to what Rohit is saying, the hospitals -- no hospital in the world makes money on pure dialysis operations. They make money from the adjacencies of dialysis, which is kidney transplants, ICU admissions, lab procedures, pharmacy, fistula procedures, and so on. When they outsource to NephroPlus, they continue to make money on the adjacencies without worrying about the core loss-making dialysis operations that they have.

So, in an ideal world, 100% of the hospitals should outsource dialysis, but this is, we are in the early stages of the maturity of the dialysis market, right. 16 years back when we started, 0% was the organized market. All the hospitals were running their own dialysis operations. 16 years later it's 21%, 22%. But still there is 78%, 79% of the hospitals who are running their own dialysis operations in a very inefficient and not so measured quality clinical outcomes manner, right.

So, this will take a long period of time for the conversion from the unorganized market to the organized market. But it's a fundamental financial, unit economics related decision as Rohit mentioned. This is not a clinical quality improvement initiative. This is a pure financial optimization initiative from the hospital side.

Aniket Singh: Got it. And sir, lastly, as I'm seeing that rising revenue per treatment for you have been, has been growing for at a CAGR of around 11%. So, what is driving this? Is it a shift to international markets where realizations are high? Because that mix is also improving for us for the past couple of years. And do you expect this mix to continue to rise and the share of India business will continue to decline over the coming years as you continue to expand in international markets?

Prashant Goenka: Yes, hi, Aniket. This is Prashant. I'll take this question. So, I think there are a couple of things that drove that CAGR that you mentioned. I think one, obviously the improving international mix is the primary driver of that CAGR. As we have stated before, it is, we aim to add a new international market every 12 to 18 months.

And that strategy will remain a key focus area for us, and we are constantly working on it. For example, you have seen Rohit talk about Saudi, we have done a Stock Exchange disclosure on Kazakhstan opening an entity. So, we continue to share a few things with the market, but there are many more things that we are doing from a business development perspective.

So, in terms of the international revenue, currently standing at 45%, it was 30% a year and a half back. That number will continue to inch up slowly, with India being the core platform, right. So, it's not that the international growth is coming at the expense of India growth slowing down. The India platform will continue to grow because without the India platform, we really cannot make the kind of profit we make internationally. But the fact that new countries are getting added, that number will continue to inch up.

Second, on the 11% CAGR, one more thing that we should notice, in Philippines, we saw a 60%, 55% to 60% price increase in October 2024. In dialysis you will see the price typically increases

slowly and once in a while there is a lumpy price increase. So, in Philippines that price increased after 10 years and now probably that will remain at same level for a certain period of time.

That also is coming as a factor in that CAGR number that you drove. So, one should not expect that same CAGR number to continue forever. The numbers will fluctuate up and down depending on the international market we enter in and how the mix changes.

Aniket Singh: Got it, sir. Thank you. Thank you, sir. For answering all my questions.

Moderator: Thank you. Next question comes from the line of Pranav Chawla with JM AMC. Please go ahead. Mr. Chawla, please unmute yourself and go ahead with your question. Since there is no reply from the line of Mr. Chawla, we will move to the next participant. That is Kushal Chovatia with Nomura. Please go ahead.

Kushal Chovatia: Yes, hello. So, so first of all, can you let me know what was the contribution in revenue of the currency this quarter? The revenue growth, how much was due to the fluctuation in currency?

Prashant Goenka: So Kushal, this is Prashant here. I'll answer this question. This quarter we did not see much from the forex front. We only saw a 20 lakhs favorable outcome due to the forex side of things. Currencies were largely flat in this quarter compared to last year. So not too much action on that front.

Kushal Chovatia: Okay. And can you let us know what is your capex guidance for this year? And split it into between India and Philippines?

Prashant Goenka: So Kushal, we typically don't give guidance on the capex front. For this quarter as I mentioned, we have done about INR44 crores worth of capex. That compares to INR43 crores same quarter last year. We have indicated in our calls that we intend to open 40 to 50 clinics in India every year. 10 to 15 clinics in Philippines every year. And we intend to open a new international market every 12 to 18 months. And that is the extent of what guidance we are providing in terms of our capex plans, more at a strategic level.

Kushal Chovatia: Okay. And any assumption on the tax rate which you can provide for the financial year, so this quarter we saw just a 20% tax.

Prashant Goenka: Yes, so we operate, currently operate at scale in three markets, India, Philippines, and Uzbekistan. There are a few other markets, but these three markets predominantly drive the numbers. India and Philippines are similar market where the tax rate is 25%. Uzbekistan, if we maintain our healthcare services revenue at more than 90% of the revenue comes from healthcare, then there is no corporate tax.

So, Uzbek is at 0% tax rate. So, I think the composite of the three depends on the revenue mix. But I think a 20, the current number probably reflects a good proxy you can use. The numbers may fluctuate a little bit depending on the mix, but the current numbers are a good proxy.

Kushal Chovatia: Okay. Yes. Thank you. That's all.

Moderator: Thank you. Next question comes from the line of Pranav Chawla with JM AMC. Please go ahead.

Pranav Chawla: Hello. Am I audible?

Moderator: Yes, please go ahead.

Pranav Chawla: So sorry sir for the previous issues. Sir, I'm not sure if you've highlighted this earlier in the call, but what has led to the sharp increase in other expenses as a line item?

Prashant Goenka: So actually, other expenses if you compare it to the last quarter, it has improved by 133 basis points, meaning it has reduced by 133 basis points. Of course, if you compare it to the same quarter last year, it has deteriorated. There are two, three factors at play. One ECL provisions that we take quarter-on-quarter, which is typically in the range of 2% to 2.5% of the revenue. And again, this is driven by a model, as we discussed earlier, in the dialysis business, structurally the AR cycle will be three to four months.

And to ensure that we have a very strict way of modeling the AR related items, with the help of KPMG, we have arrived at a ECL model, and we use the number that comes from the model, where there are different aging buckets and loss rate and all the other modeling factors. Basis that, we arrive at an ECL provision that we take every quarter, which tends to be between 2%-2.5% of the revenue. So that is one factor which has grown up in line with the revenue also growing up.

The second factor is as we became a public company, there are a few other cost items that comes in. The audit fees increase, there are more, legal fees that comes in with respect to all the things that a public company has to do that you didn't do as a private company. So that is the other factor that has come into the numbers. Third, I think as we stated earlier, we are looking to grow internationally in newer markets. We are building capability on that front, whether it is business development.

In many markets, we invest upfront in building the foundation, even before the market starts. So, there is some amount of investment that is done on business development and other foundational activity to grow internationally. So, all those three factors combined have resulted in other expenses to be at the level it is currently. But on a previous quarter to this quarter basis, it has actually reduced by 133 basis points.

Pranav Chawla: Got it. Sir, another question that I wanted to check with you. Have we seen any price hike in India with CGHS price hikes coming through for some of the corporates?

Rohit Singh: Yes. Hi, Pranav. This is Rohit here. Yes, we observed a price increase in the CGHS last year October, and I think Prashant had briefly mentioned that in the dialysis business, price increases on an annual basis are marginal, but on a periodic basis, say a large period of say 8 to 10 years' time period, there is a lumpy price increase.

So, we witnessed that in CGHS as well, this price increase came after probably 10 years to 11 years, and there's a 35% odd price increase that we increased. So, this is very much as per the lines or the trends in the dialysis business and we have factored that and seen it in CGHS as well.

Pranav Chawla: Got it. If there is nobody in the queue, can I ask a couple of more?

Rohit Singh: Yes, please.

Pranav Chawla: Sir, depreciation and amortization as a line item, we have seen that sequentially declining, despite we doing a couple of acquisitions in Philippines this quarter. Is there anything to read into this?

Prashant Goenka Sorry, say that one more time? Depreciation and amortization as a line item?

Pranav Chawla: Yes, as a percentage, absolute value has declined on a Q-o-Q basis, despite we doing a couple of acquisitions this quarter. Is there anything to read into this line item?

Prashant Goenka: No. I think, as I mentioned, there are a couple of things at play in that number. Number one, we are using lot more technology to drive much more disciplined capital allocation. For example, in all the countries we are now using RFID to tag our assets and do a real-time tracking of our machines. So, we have now more intelligence at a center level how many machines we have, how many idle machines we have at a network level.

Last year we were deploying about 50 machines every month in terms of replacement and other type of activity. In the last three months we have hardly given any new machines, but utilized our machines on a more efficient basis. Of course, it's a one-time benefit you get when you bring a new technology like this. So, we benefited from that.

On the other side, Philippines, we did the acquisition, seven acquisitions, which was towards the end of the quarter. So, the corresponding goodwill and the amortization of the intangibles of the goodwill also played into the numbers. But I would say that there is not much to read into the numbers, but there will be some healthy improvements in the number on a marginal basis.

Pranav Chawla: Got it. And sir, on the Dubai business, can you just highlight any, is there any update over here, because sequentially we have seen the losses go up. How many centers you would have added? What would, how are you seeing that business transform, and any medium to long-term guidance on when the next round of tendering would happen and how do you expect to ramp up on the Dubai or the Saudi piece?

Rohit Singh: So, Pranav, I'll take this, Rohit here. So Saudi right now we are in the investment phase. We are building foundation; we are preparing for the tender. We have built a team there, so the approach is to be ready for the tender when it comes. Right now, there is an EOI was submitted, but we are still awaiting the tender documents to come out from the Ministry of Health.

So, it's, and given the volatile situation there also in that region right now, I think we are three to four quarters away from realizing any benefits or having a clear visibility, but I think this will be a journey or tendering process will go to next few quarters to come.

Pranav Chawla: So, Rohit, for the rest of the fiscal, should we assume these INR3 odd crores sort of a loss on the JV side should continue for the rest of the fiscal? And then we start to realize revenue?

Rohit Singh: So, we are not giving any guidance on the loss assumptions for the Saudi as I am saying that we are in the investment stage and we started one clinic there in Saudi. So, this may fluctuate a bit, but again I said there is no clear visibility on the tendering timelines, which could take one to two quarters or probably longer. So as soon as we have visibility on the timeline, we will be able to kind of answer that more precisely.

Pranav Chawla: And one last if I can squeeze in. Sir, we have recently incorporated a subsidiary in the EU region. Can you highlight when do you expect this business to start and what kind of a business model is followed in that geography?

Rohit Singh: So, we have registered a company there, but we are still exploring, I think Kazakhstan as a market looks interesting, but we are yet to kind of form a view on that. Market is similar to that of Philippines with a universal coverage. Price points are little on the lower side around $75. And there are already standalone centers and private players in the market. So, we are still forming an approach on the market, so it will be too early for us to comment on that market.

Pranav Chawla: Got it. Thank you so much, sir, for your time. Thank you.

Moderator: Thank you. Next question comes from the line of Shubh Mehta with ICICI Securities. Please go ahead.

Shubh Mehta: Yes, thank you for the opportunity. Sir I wanted to understand the broad nature of 19 new clinics which we added in India geography. Is it a greenfield or brownfield or PPP sort of nature if you can give us some sense over there?

Vikram Vuppala: So, Shubh, I'll take that question. India had a blend of all three. We had PPP centers added in Bihar, we had four private clinics added, and then we also had one or two Greenfields. So, it was a blend of all three, fairly balanced in that phase.

Shubh Mehta: All right. And if you can quantify, sir, what is current RPT for India at present, like since you have mentioned that we have seen some hikes over there? If you can give us some figure over there?

Vikram Vuppala: Yes, so I think while India is a basket of many price points, PPP is different, captive is different and all that. I think in our previous calls we have mentioned the high-level RPT for each country. So, the India RPT remains at a $22, $23 price point. That is the RPT which is at the average level for the country.

Shubh Mehta: All right. And sir on the Philippine side, so we have added 7 assets new, 7, we have acquired 7 new assets over there. Can you tell us like the bed capacities, on an average as we have seen that there are 10 beds average for over a business. However, for seven new assets is its higher side of the bed capacities over there or how, how are the dynamics over there?

Rohit Singh: Shubh, we've mentioned that earlier also that our Philippines business is averaging 10 to 12 beds center, and it's safe to assume that these new are also following a similar trend. So, I think there is no great outlier in that place.

Shubh Mehta: All right. And how is utilization over there, sir? Mean, since it is an acquired asset.

Rohit Singh: So, we again look at a network level utilization, so it's fairly...

Management: 74% is the number that we have listed at the consolidated level and that's a good reflection of all markets.

Shubh Mehta: All right. That's all from my side. Thank you so much.

Moderator: Thank you. Next question comes from the line of Devang Patel with Sameeksha Capital. Please go ahead.

Devang Patel: You mentioned some delay in Saudi Arabia roll out of clinics, but to recoup these INR3 odd crores of losses, how many clinics do we need to reach, to achieve a breakeven?

Rohit Singh: So, Devang, Saudi Arabia is a tender market. So, it's not about how many clinics, it is about the tender. So once the tender clarity is achieved, and depending on the scale of the tender, there could be, I mean, it is a one tender that will be resulting into X number of clinics, which is still unknown.

So, the better way to look at it is when the tender is out and what are the timelines of tender, and that will take care of the investment if we are able to secure the tender. There is still a probability that we may not be able to secure the tender in the Saudi as well. So, it's a tender market.

Vikram Vuppala: Yes. Just to add to what Rohit is saying, Devang, this is an investment phase. We are running this clinic to showcase our clinical outcomes in that country. Saudi, Ministry of Health and other regulators, they want -- they do not give so much value to overseas clinical outcomes. They want the interested companies who want to participate in the tender to set up a few clinics in Saudi Arabia and demonstrate clinical outcomes in their regulated market environment.

So, this is a binary market. You win one of the four clusters in the tender; you have a business. If you don't win, you pack the bags and leave the market. So, we are currently in the investment phase, it's very early days. It's not that we add four, five clinics and we'll be able to achieve break even. That won't happen.

Devang Patel: So, in case we win a tender, we are not sure we will recoup the losses and break even.

Vikram Vuppala: No, no, if you win the tender, obviously any project, any market that we enter, we will make the scenario analysis, right? If we win the tender, we will more than recoup all the historical losses, right? That's when it makes sense.

Devang Patel: Okay. And we've made all the investments we needed to or do we need -- this before we win a tender, these costs can go up further?

Rohit Singh: So, Devang, right now, as I mentioned, that we have started one clinic and this is more of a showcase clinic where we are showcasing our clinical and execution capabilities. But now when the tender terms are out, that would require us to increase our footprints it'll be a nationwide tender when and maybe divided into zones which we still don't know. So, the point is we will be required to make more investments depending on the tender terms which would be known to us in time to come.

Devang Patel: That's all from my side. Thank you so much.

Moderator: Thank you. Next question comes from the line of Anuj Goyal with Bastion Research. Please go ahead.

Anuj Goyal: Yes. Hi, sir. Thanks for the opportunity. So, my first question would be, can you explain the unit economics per bed for India and international markets, like the peak margins and the peak ROCE per bed when it gets, when it gets matured? Some sort of that.

Prashant Goenka: Hi Anuj, this is Prashant. I'll take that question. We don't provide unit economics at a country level, but in terms of unit economics at a consolidated level, I think you can look at our P&L. Some of the key drivers of the unit economics are obviously, consumable heavy business, so COGS is a key element, which is about 22% of the cost.

Hospital share is another big component of unit economics, and the salary payment to the technicians and nurses is a third component. But all that information you can take it from the P&L which is shared at the consolidated level to get the unit economics.

Anuj Goyal: So, sir, is there any angle of, like with peak margins per clinic in India operations or international operations, is there any angle of that?

Prashant Goenka: No, so I think, unlike some of the other industries, we don't have a new versus mature model in this industry. We typically take a running center in most cases, and the opex break even happens within the first few months, and the capex break even happens over a period of time depending on the country. So, I think the P&L will give you the required details to model out the unit economics.

Anuj Goyal: Alright, alright, sir. And my second question would be that, is there any angle of customer loyalty in your business? Because I've read somewhere that the guest doesn't even choose the bed which is allocated to them for the treatment. So, is there any angle?

Rohit Singh: So, Anuj, I think given that it's a reimbursement business and it's a therapy that is prescribed by the nephrologist typically, so there is definitely a customer angle. He is free to choose to get dialyzed whichever clinic they find the right quality and the proximity and right outcome. So, there is definitely a customer angle, but then there is also a part angle around who's the payer for that treatment for that particular customer or the patient or the guest that we call them.

So, it's a blend of both essentially, that where the payers are, like in the Philippines market it is a completely PhilHealth, right, totally complete, everybody is covered in that. So, in that case the guests are free to move around more freely. In India depending on who is the payer for them

and which center is entertaining that payer or has a empanelment with that payer, those options are selected and then there is an angle around their practicing nephrologist's proximity and the quality of the center. So, it's a blend of proximity, clinical quality, payer mechanism, all put together is are the decision influencers for a guest, customer.

Anuj Goyal: Alright, alright sir. Got it. Thank you and all the best.

Moderator: Thank you. Next question comes from the line of Simran Thakkar with Beas Capital. Please go ahead.

Simran Thakkar: Thank you so much for taking my question. The first question goes like this. The material cost reduction it's quite impressive over here. And we understand it is more towards Renova reprocessing. Right? So, on the field visit, what we understood are there were some discrepancies on the reuse protocol. So, could you please help us understand what's the central protocol reuse that you all have laid out? That's the first question. Shall I go for the second?

Rohit Singh: So, Simran, let me address this first and then we can go to the second question. Reuse protocol. So, India being a highly out-of-pocket market to begin with, slowly transforming, healthcare is a state subject. There are regulations and little preferences, not always regulation, guidelines and preferences from various payers, various contracts, various micro markets. So, there is no linearity around it. But how NephroPlus operates is that we, for us to take a decision, we, if there is reuse options available, we have it not on the count but on the fiber bundle volume.

So, our decision making is very clinically oriented, not just pure count oriented. But having said so, there are guidance's which are given or preferences given by each payer in a different market. So, it's a blend of both. So, once you will go to one location to other location, you will see that difference depending on the region and the payer piece of it.

But to answer your point on the reduction of the COGS, it's essentially blend of several things, right. The economy of scale playing in, we also have negotiated better terms with our suppliers, and obviously optimization in the utilization also. So, it's a blend of all and not just the reuse count which drives the COGS reduction.

Simran Thakkar: Understood, sir, very well explained. So, my second question goes like this. As you densify in the larger metros, say suppose for Mumbai, we'd like to understand how is your city level or pin code expansion approach over here? That's the second question.

Rohit Singh: So, Simran, we are fairly, what do you call, comfortable in operating in smaller towns also. Because a business model enables us to go into those pockets and offer that clinical excellence level in every part of the world. So, we have not focused on any pin code specific expansion. We have focused on increasing access across the country, as that we are operating in 300 plus cities now in India.

So, we are fairly, we are not focused around any one or two particular metros, we are very comfortable in any part of the world, in any part of the country. In fact, our 75% plus of the clinics are in Tier 2 and Tier 3. That clearly shows you the approach of the company, how

operationally comfortable we are, and how passionate we are about increasing access to quality dialysis across the country and not in concentrating it in a geography or a few different metros.

Simran Thakkar: Understood. Thank you for taking my questions.

Moderator: Thank you. Next question comes from the line of Pawan Kumar with Shade Capital. Please go ahead.

Pawan Kumar: Thank you for the opportunity. Am I audible?

Moderator: Yes, yes. Pawan, please go ahead.

Pawan Kumar: Yes. So, my first question is...

Moderator: Mr. Kumar, please go ahead.

Pawan Kumar: Yes. So, my first question is like you are growing pretty good in the international market. Can you tell me what's the market share in Philippines and Uzbekistan market?

Rohit Singh: So, we are the second largest network by the footprint in the Philippines right now. Roughly largest chain has 58 odd clinics, and total clinics in the Philippines market in a standalone setup right now is around 900. And we are operating right now 51 of them. So, you can estimate the market size based on that, 6%-7% at the moment.

And on the Uzbekistan front, we are the only private operator. Rest all dialysis is provided by the government. But the Uzbekistan market is close to 9,000 patients and we are servicing close to 1,800 of them right now.

Pawan Kumar: And what competitive advantage we are really offering their vis-a-vis the competition?

Rohit Singh: So obviously, I think Prashant had also mentioned in the beginning of the call, Philippines is a very mom-and-pop fragmented market. So NephroPlus being the second largest player has a huge brand value. We have this economy of scale, the scale value, and at the same time we have the operation capabilities to go in every corner of the country.

So, there's operating leverage that we have, we have a brand leverage and the efficiency leverage that we have over other individual players there. And over the time period this will only grow as we keep growing on those geographies.

And on the Uzbekistan front, we have mentioned that previously also that we have demonstrated very strong clinical outcomes and we have delivered the project in record time as compared to any other provider in that region. So definitely there is a lot of goodwill that we have generated in the ecosystem by our operations for the last five years there.

Pawan Kumar: Okay. And sir, talking about the Indian market, like you have a pretty good market share, what is the viability of D2C kind of like a private clinic kind of business, is it really viable in the long run? Can you give me some color on that?

Vikram Vuppala: Yes. This is Vikram. Thanks, Pawan. India is still in the very early stages of the dialysis market maturity, right? As I said, 16 years back there was no pure-play dialysis network in India. We started that whole concept and today the organized market is 20%. Throughout the world, except India and Indonesia, dialysis is done in standalone clinics, not inside hospitals, because people with kidney failure are immunocompromised.

Clinically and financially, it makes more sense for standalone clinics, but the Indian regulatory ecosystem is still coming to terms with standalone clinics. Because everyone is so used to the hospital-based model, the comfort of the nephrologists, the comfort of the government payers and the regulation comfort.

We are talking to them; we are advocating the growth of standalone clinics. We currently run 25 standalone clinics in India, but it'll take long time before standalone becomes the mainstream. This is early days in the ecosystem. Over the next 5 to 10 years, you will see a lot more standalones than the in-hospital model.

Pawan Kumar: And same is applicable globally also, like most of the businesses run through like the tender or maybe the government sponsored schemes?

Vikram Vuppala: So, there are two models globally. One model is the tender model, which is the Uzbekistan, the Saudi model. The second model is the Philippines model, the US model, the Saudi model, where there are clinics in private setups which are reimbursed by the health schemes. Like imagine a standalone clinic in India reimbursed by Ayushman Bharat, right? That's the second type of model where you're running in a private setup, but you're reimbursed by a state health scheme or an insurance scheme.

Moderator: Thank you. Mr. Kumar, please rejoin the queue for more questions. Next question comes from the line of Nilanjan Karfa with TCG AMC. Please go ahead.

Nilanjan Karfa: Yes, yes, thank you. So sorry for that. I was saying that in the past we have not split out the patients between India, Philippines and the various markets basically. Would you want to do that going forward? I'll tell you the reason. If you look at how our centers have expanded. So roughly I guess between same time last year and this year, the total network has expanded upwards of I think 10%, 11%, out of which almost one third is almost 30% plus expansion in the standalone clinic itself.

A very high percentage of it in Philippines where the revenue growth is obviously expected to be very high. So, it makes very difficult for us to figure out how the core revenue growth is there, from let's say the same, something very similar to let's say the same store sales growth that we use in consumer companies or retail companies. Would you want to talk about how the same set of centers did over the last 12 months?

Vikram Vuppala: Yes. Nilanjan, this is Vikram. I think this NephroPlus, we need to understand it as a platform story rather than a country-level story, right? The India is the core business, is the driver of the platform. The platform is built on 16 years of the experience that we have generated in the India platform. This is -- the market is very, very different from the other segments that you mentioned, right. We are more comfortable to discuss on the console level at the platform level, because at

the end of the day, we are not looking at a country level objective, we are looking at a platform level objective.

The investments, capital allocations have to be ROCE accretive at the platform level, while India is the core and it generates the efficiencies across all markets, we do not want to mention country by country details and go into the micro because today we are in five countries, in the next 5 to 10 years we will be in 10 to 15 countries. There's no point in going into country-by-country mechanics, which is the way all the large global dialysis players, the two listed players, Fresenius and DaVita also look at. So, we only would be able to discuss at the platform console level.

Nilanjan Karfa: Sure. So that was part first part of my question. The second part was actually the organic growth itself, right? Because we are obviously going into increasing number of centers in the same country and going out as well in different countries. And that's the broad plan for us. So, on organic basis how much we are going?

So, if you can, if you want to still talk about let's say we have three lines, like the captive clinic, the PPP and the standalone, how each of these three lines have grown let's say versus last year?

Rohit Singh: So Nilanjan, I think we have mentioned this earlier also. We have three levers of growth. One is same center growth. Second is increasing footprint in the existing markets. And third is a market expansion or a big M&A or a PPP, right?

So, and we have also mentioned that our network level we are maintaining a 74% utilization. So, the way to look at it is the utilization of the network and our guest count. That would give you a flavor around the growth of the organization and that's where we would also want to focus on.

Vikram Vuppala: Yes. At the macro level, Nilanjan, what happens is unlike a pathology lab, right, it's not a unlimited, so to speak, capacity. Dialysis is a fixed capacity business. Only three cycles in India can be done in India. You can't do more cycles on the same machine, right, because four hours is mandatory treatment time. Pre and post included it's four and a half hours.

So, when you have several, several, let's say many, hundreds of clinics at peak capacity, let's say 85%, as I mentioned earlier, those clinics there is little bit of a price growth, very little volume growth that you can expect. So unlike other segments in healthcare, this is not the same store sales growth story. This is all the dialysis clinics across the world only grow by addition of capacity. Because you can only do three cycles in a day per machine. So, the way people need to understand this market is, you add capacity, you will grow.

Because in that same capacity, you have maxed out on the capacity and this is a chronic every other day treatment. So, you can't increase the price way too much. And as I think Rohit and Prashant told, it's a lumpy price increase business, where every 5 to 10 years suddenly CGHS price increases by 35%, PhilHealth price increases by more than 50% and so on. So, this is much more of an execution game around disciplined capacity addition while making sure that the network level utilization is continues to be healthy. That's the game.

Nilanjan Karfa: Okay, got a fair perspective to look at actually. Perfect. Thank you so much. Thank you.

Moderator: Thank you. Ladies and gentlemen, due to time constraints, we have reached the end of question-and-answer session. I now hand the conference over to the management for closing comments.

Management: I think we have mentioned all the details in our opening remarks. We thank everyone for joining this call, and look forward to the next Earnings Call. Thank you so much for joining.