Date of submission: November 07, 2025

To, The Secretary Listing Department **BSE Limited** Department of Corporate Services Phiroze Jeejeebhoy Towers, Dalal Street, Mumbai – 400 001 **Scrip Code –539551(EQ), 975516 & 976418**	To, The Secretary Listing Department **National Stock Exchange of India Limited** Exchange Plaza, Bandra Kurla Complex Mumbai – 400 051 **Scrip Code- NH**

Dear Sir / Madam,

Sub: Transcript of Investor's Call -Acquisition of UK-based Practice Plus Group Hospitals Limited

In relation to the investor's call of the Company held on Monday, November 03, 2025 on the acquisition of UK-based Practice Plus Group Hospitals Limited, please find attached the transcript of the said call.

We wish to inform you that the investor's call transcript is also available on the website of the Company at https://www.narayanahealth.org/stakeholder-relations/company-announcements.

This is for your information and records.

Thanking you,

Yours faithfully
For **Narayana Hrudayalaya Limited**

SESHIAH SRIDHAR
Digitally signed by SESHIAH SRIDHAR
Date: 2025.11.07 16:08:45 +05'30'

Sridhar S.
Group Company Secretary, Legal & Compliance Officer

Encl: as above

“Narayana Hrudayalaya Limited Conference Call on Acquisition”

November 3, 2025

NH MANAGEMENT TEAM:

MR. VIREN SHETTY – VICE CHAIRMAN

DR. EMMANUEL RUPERT – CHIEF EXECUTIVE OFFICER & MANAGING DIRECTOR

MS. SANDHYA J – CHIEF FINANCIAL OFFICER

DR. ANESH SHETTY – MANAGING DIRECTOR, OVERSEAS SUBSIDIARY HCCI

MR. NISHANT SINGH – VICE PRESIDENT, FINANCE, MERGERS & ACQUISITIONS & INVESTOR RELATIONS

MR. VIVEK AGARWAL, SENIOR MANAGER, IR FUNCTION

TRANSCRIPT

Nishant Singh: Hi. Good Morning, everyone. My name is Nishant Singh. I Head the IR & Strategy for the Group. I welcome you all to this special call organized to discuss our latest acquisition PPG Hospitals, UK. In this call, we also have with us Dr. Emmanuel Rupert, our MD and CEO, Mr. Viren Shetty, our Vice-Chairman, Dr. Anesh Shetty, MD of our International Operations, Mrs. Sandhya Jayaraman, our Group CFO, and Vivek Agarwal, Senior Manager, IR & Strategy.

With this brief introduction, I will hand over the forum to Anesh to take you through a brief introduction of the target post which we can start the Q&A.

Anesh Shetty: Thank you, Nishant. Thank you everyone for joining us. We thought we'll begin the call by spending the first five minutes just giving an overview about why we decided to enter the UK market and within the market why we decided on Practice Plus Group Hospitals.

So, as most of you, who have been following the company for a while, know it's been about 12.5-13 years since we first entered the Caribbean in the Cayman Islands. The assets have been operational for about 11 years now. And once we overcame the initial 3-4 years of settling in into that market and things started looking very positive, we've always been on the lookout for our next international operation, our next international opportunity.

Through that process over the past, I would say 5-6 years, we have been to almost every developed country which has an opportunity for private healthcare. We've considered definitely every market in the vicinity of Cayman, which is in the Caribbean, as well as most other markets elsewhere as well. And it is challenging for us to settle on something simply because home is in India, a market we are most familiar with, which many would agree is currently one of the world's, if not the world's, most attractive investment market for healthcare globally. So, whatever else we found, it has a very, very high bar to compete against. It has to be meaningfully more attractive than us deploying capital in India, which makes us very, very selective. So, even though we came across several opportunities over the past few years that were good across all sizes and shapes, we never did anything meaningful until today. We're very happy to report that after a long search we believe we've arrived on not just a country that is very, very interesting and attractive but also an asset within that market that we believe will be very, very accretive to our larger picture.

Coming to the UK market, what makes this attractive for us aside from the obvious aspects of being a stable country, a developed country, clear rule of law, business certainty, policy

certainty and things that are more common across various industries. For us, particularly in the business of private healthcare, it is very reassuring to know that across political cycles, irrespective of which party or which orientation was in power, the role of the private sector in being a key pillar of addressing the healthcare needs of the country has been widely and universally acknowledged and is now seen more as a matter of fact and one that will take on an increasingly important role in the years to come. Within that industry as well, we are also comforted by knowing that there have been meaningful success stories with the other large operators, many of which, I would say most of the top large players, are owned by international multinational corporations or international investors. So, we find an interesting market, which not only has growth potential but which is stable in its broader conditions, which has a track record of other operators who are doing wonderful work and who have seen good success as well as a long term future where we can build essentially a multi-decade business scaling and operation.

Within that market, within the UK, we considered several assets. Some of you may know, over the years we've spoken or had fairly early discussions with a whole range of providers, some of whom are very small, some of whom are very, very large, and some in between. We believe Practice Plus fits into the sweet spot in terms of its size. If the asset is too small, then there's not much we as NH can do to add value. At the same time, if it's very, very large, there are certain other complications where it becomes unwieldy, there are other complexities in running that. In terms of size, this is a good, sweet spot where we believe it is large enough for us to not only own 100% of it but large enough for it to have the critical size for us to make a meaningful difference with what we bring to the table, which I'll come to shortly.

Yes, we also note that this asset has certain aspects of the business in terms of its payor profile that are meaningfully different than other peers. We see this as an interesting opportunity. There were certain assets we considered that had a very, very privately oriented payor mix, which is great from a profitability standpoint, but that also leaves less room to improve and less value for us to add. More importantly, it is very, very important for us that we buy a business which has a management with a proven track record that is safe and secured with the new ownership. And we're happy to report that the fantastic management, the entire senior leadership of this organization is going to be staying with us, even though we are buying only one division out of the three. It's a company with three divisions, we're just buying the Hospitals division. But we've secured and aligned the key people in the senior management. And we're very confident in our ability to work with them and they're very bought into the larger vision of what we bring to the table as well.

I'm just going to request Mr. Rakesh to go on mute, please.

So, to continue, so we're very confident and eager to get started with the management team under new ownership. And this is the capable group of people who've been running the business so far and we feel that there is all the ingredients in place for us to essentially make a good attempt at replicating what we've done in Cayman but on a much larger scale and in a much larger market.

So, I think that addresses the two largest questions we got, which is - Why the UK? and Why this particular asset? But also happy to get into the Question & Answer session and answer any specific questions or take this any other direction that you guys want. Nishant, maybe we can start the Q&A.

Sandhya J: Before we get into the Q&A…

Anesh Shetty: Yeah. Sorry, Sandhya, go ahead.

Sandhya J: …I just wanted to clarify one more financial point, which wasn't there in our earlier deck. So, the numbers which we had shared in our deck earlier was pre-IFRS. So, when we reported GBP 20 million as the EBITDA, it was pre-IFRS, which means after adjusting the lease costs. So, if we take the like-to-like post-IFRS EBITDA, which is before the lease costs, it is GBP 29 million for FY25. So, we have since added this in the deck and we will be uploading the revised deck shortly.

Anesh Shetty: Nishant, how do you want to do this?

Nishant Singh: Yeah, so we can start the Q&A session now. We request everyone to now use the 'Raise hand' feature to start posing the questions. I think we already have a raise of hand from Ravindra. Ravindra, can you please go ahead?

Ravindra: Hello, am I audible? Hello?

Nishant Singh: Yes, you're audible.

Ravindra: Yeah, this is Ravindra from Bangalore. So, I'm a retail investor. Actually, see, over the weekend I got hold of the Annual Report of the acquired company. So, I was going through that. I have

a few questions around that. So, firstly, I want to clarify that we are going to acquire only the Hospital division, that's the Secondary Care division, am I right?

Anesh Shetty: That is correct.

Ravindra: Right. Okay. So, I'm looking at the revenue for the financial year ending '24, okay. So, as per that, the revenue in terms of Indian rupees is around 2,660, it comes. I'm taking an exchange rate of 116, okay. So, in million terms, it is 229. That has been reported in the Annual Report last year. So, in your deck, I think the numbers are not matching as such, that's the one thing. So, am I correct on that?

Anesh Shetty: Yeah, we're happy to take that question offline. Nishant, and the team will reach out to you to reconcile that currency conversion.

Ravindra: Not just currency conversion, it's 229 and also the EBITDA numbers, everything looks very, very different. Because I'm looking at the Annual Report of the reported company.

Anesh Shetty: Sure.

Ravindra: Okay. So, based on that I have a few questions, right. Because I think it would have been better if the deck had been prepared with updated numbers so that it would reflect real value of the company as such. Because when I'm calculating all the numbers, for example, the Secondary Care margins, it's coming around 11.8% for me based on the Annual Report reported numbers of September'2024. So, when we look at the deck, it doesn't give me that bullish stance as such.

Viren Shetty: Ravindra, if I may, the thing that was announced was of the overall holding company, yes, the one with three business verticals.

Ravindra: Right, right. I'm just taking the Secondary Care.

Viren Shetty: We understand, yes. The thing about disentangling a business that has three verticals into one is that there will be cross charges. There are certain things that reflect across multiple balance sheets. So, the company is in the process of disentangling, which may lead to slight adjustments here and there. As we close down this process over the next quarter and so, we'll be able to give you a much better picture of the Hospitals-only business.

But right now, the businesses within themselves also render services to the subsidiaries and so that may be part of the reason why some few million here and there may be a discrepancy. But as far as the audited numbers that we have, this is what is there. But the next quarter will give us a much better picture.

Sandhya J: What we have given you, Ravindra, in our deck what we've given is the carved out financials that have been diligenced by our diligence partners and extrapolated for the full period. So, therefore, this is the number that we will be acquiring and integrating with our balance sheet. What you see in the public domain has, like Viren said, other than Hospital data also mixed up and, therefore, you will not be able to reconcile it. You should take the number we are presenting as the correct number.

Ravindra: Because they have strictly bifurcated everything, so that's why I'm having this question because it gives a lot more bullish stance than what has been reported. I don't know but it should have been better that if you had...

Viren Shetty: Any other questions, Ravindra

Ravindra: Yeah. So, again going on, I have few questions, say, for example, what happens to the liabilities on books? So, how much liability? Because as you say, you are taking only certain, only one division.

Viren Shetty: Yeah, that's fine. We can answer this now.

Sandhya J: Yeah. So, Ravindra, other than the liability for the leases and the regular liabilities for creditors, we are not taking on any liability on our books. So, we are acquiring the company on a debt-free basis. So, whatever liabilities you are seeing in the balance sheet, which is uploaded in the company house, those will be left behind. Only the regular creditors and lease liabilities, we are taking over.

This also answers Rishabh Doshi's question on the chat.

Ravindra: Okay. That means there will be no term loan as such, we will be repaying or will not be taking over the term loan as such. That's what you're saying?

Sandhya J: The seller will take care of the repayment. We are acquiring the company on a debt-free basis.

Ravindra: Okay. Okay. So, again, if I take that point, you are giving a very bullish stance as such. So, okay.

Viren Shetty: Any other questions, Ravindra?

Ravindra: I think, what about the dividend distribution as such, because company has been paying regular dividends. Is there any stance on that, like how that will be accounted for, whether we will get some part of the dividends as such?

Viren Shetty: We can answer that.

Sandhya J: So, our current plan, we do intend to continue with our current dividend policy, which we have.

Ravindra: No-no, I am not talking about the NH, because this company has been paying a dividend regularly. Last year they paid around GBP 34 million as a part of an entire company. So, we are taking a part of the company, that means there is an embedded dividend within that. So, has there been any arrangement?

Viren Shetty: Yeah, we haven't a call yet on what the inter-company dividend would be between the subsidiaries and the main. We are still in the process of merging and acquiring these companies and consolidating the account sheets and taking over the Finance department. We will have a much better sense of this over the coming quarters. But as of now, it will be hard for us to comment.

Ravindra: Okay. Okay. Fine. Apart from that, yeah, actually I had a lot of numbers related since you…

Viren Shetty: Fine. Maybe we can move on to the next person. And if the queue exhausts, you can join back again.

Ravindra: Sure. Sure. Yeah, thanks.

Viren Shetty: Thanks, Ravindra.

Nishant Singh: Prithvi, can we have the question, please?

Prithvi: Yeah. Anesh, just, you know, a couple of questions. Obviously, the first one, you know, you mentioned about UK saying stable government or, you know, stable policies, growth, a track record of international investors, etc. But this might be the case with even other European nations, right. So, why particularly UK? You know, how is UK market different or, you know, what kind of growth levers are you looking in the UK market?

Anesh Shetty: Sure. So, we did consider other opportunities in various other markets. So, just with regards to the country itself, you know, we see a track record of every larger, if you take the Top 5 healthcare providers, barring 1, which is a not-for-profit, the others have demonstrated consistent growth in revenue terms as well as in earnings with some volatility. And they're all owned by international investors as well for the most part, barring 1 or 2.

The second thing is that in terms of the total health spend, the percentage contributed by the private sector is still in its infancy. There is, we believe, a long journey ahead and meaningful change that could happen in the decades to come. So, if you combine the entire spend by the private sector, it's approximately 16%-17% of the grand total. So, it is still relatively the benefit of a low base.

Having said that, it's not just the market that is the country, it's also the asset. There are certain other, you know, markets that also have certain similar favorable dynamics or certain other favorable aspects but it's also a question of identifying the country as well as the asset within that country that fits our criteria. And for the most part, Practice Plus within the UK was a good intersection of many things that we were looking for.

Prithvi: Okay, got it. So, you're mentioning that the country might incrementally move from NHS to private and private sector will benefit from that?

Anesh Shetty: It's not, I mean, it's not something that, you know, one would obviously be able to predict in the short term. There are periods where it's taken the other way as well. If you look at historically, there are periods when the dependency on the private sector increases, there are periods where it decreases. But for the large part, we think that this is a relatively low base.

So, there is certain safety that we're not going to see a drastic reduction in the levels where it is right now because we don't want to be fighting against, you know, the headwinds of a decreasing, shrinking market. That's always hard to do. So, from that perspective, this is an option we narrowed down on.

Prithvi: Got it. And, you know, one of the key reasons why Cayman has done exceptionally well for you people is that you were able to replicate more or less Indian cost structure for the international realizations. So, how should we look at UK? I mean, can you take Indian doctors, Indian medical staff to UK? How about the law state? Can you import equipment from India? So, how does the entire cost structure work?

Also, because the hospital is currently at 8% EBITDA margin, how do we look at margins, you know, in a 3-5 years down the line?

Anesh Shetty: Sure. So, just addressing the comment on Cayman, you know, we do have clinical as well as non-clinical staff from every other country as well. But even to the extent that we are able to take people from India, we can't pay them an Indian salary, obviously. They earn just as much as they would in any other equivalent opportunity in that market. So, we're not looking at essentially an on-site labor arbitrage opportunity. In healthcare services, that's very difficult to do. So, for example, for decades now India and other South Asian countries have been sending thousands, tens of thousands, in fact, of nurses to the UK and, obviously, they earn just as much as any other nurse.

So, the reason we were able to drastically alter the cost structure in Cayman and have a lasting competitive differentiation in cost compared to peers in the region is because of the entire ecosystem of operational changes we were able to begin, which is the most part underpinned by our technology platform, which does scale across markets. So, we run, as you know, in Cayman, we operate on an entire technology platform that's built and owned by us. That gives us the opportunity to perform every single transaction with far fewer human touch points or far fewer people involved and far less steps than competitors. So, whether it's a revenue cycle process of processing an invoice, whether it's processing payroll, whether it's admitting or discharging patient, every individual process is done with fewer touch points. And when you add it all together, we just get a very different, simpler, leaner operation.

We think a lot of this is replicable in the UK. Obviously, the scale is different, the market is larger. You know, we'd have to go through that learning journey. In Cayman, it took us a while to get there. That was also the first time we were doing that. We're confident we won't take as many years as we took in Cayman. But you are right in the broader sentiment that with what we've done in Cayman, which is meaningfully alter the cost structure on the backbone of our technology and other broader capabilities, that's also what we hope to do in the UK.

And through the process of our diligence on this asset, we've developed a good degree of conviction working with the management as well, that this is possible. So, we had senior members of their team come to Cayman, see what we've done and really pressure test the hypothesis that 'Can we replicate this or largely replicate this in the UK?'. And there was, you know, unanimous agreement that many elements of this, what we've done in Cayman from

an efficiency standpoint, can be replicated here. Of course, they have to be adapted but directionally, I think you are right.

Prithvi: If I have to ask you for a number, right, you know, some broad-based number, say 5 years down the line, once you implement all these things or should we look at EBITDA margin as well as revenue growth?

Anesh Shetty: Yeah, I think it's a little, you know, very, very early to say that but what would help is you do have the historical growth rates of the company in, both revenue and margin. You know, it's early days for us to comment on that. We hope to develop a view that we'd be happy to share in the years, I mean, in the quarters to come when we meet next time. But I think for now the direction that we have is we are internally quite confident that there are advantages we bring to the table, both from a revenue trajectory as well as earnings. The management is confident in the path they are on. They've started many things, even pre-dating us. So, even if we did not close this transaction, they are already at an inflection point with certain investments and changes they are making to improve their revenue trajectory. And we're lucky to be entering at the right opportune time.

Prithvi: So, let me put it this way, you know, if you have to look at ROCE, right, eventually, you know, everything has to translate to returns. Given that there is such a large investment and you have India as an alternative market, so what kind of ROCE are you looking at?

Anesh Shetty: Yeah, so just, I mean, our conservative, you know, base case is by FY29-30 or so we want to be, you know, in the range of 20%-22% from a ROCE perspective is where we see. Now, a lot of that is driven by, you know, the entry price, which we know, certain assumptions around the trajectory the company is on, as well as certain assumptions around the difference we can bring to the table. But, you know, we wouldn't have entered this if that wasn't a high conviction thesis that we had that by FY29-30, approximately in that range, we'll be within the 20%-22% ROCE level.

For the reason you said, because of the alternative opportunities for us, yeah.

Prithvi: So, one final question before I get back into queue again. Will this be, I mean, after assuming the interest cost for the entire GBP 150 million debt, will it be EPS neutral in the first year and then it will turn positive or will it be earning dilutive in year one?

Anesh Shetty: Yeah, there's a little bit of nuance to that question. I'll hand it over to Sandhya to walk you through that thinking there.

Sandhya J: So, as far as EPS is concerned, it will be neutral, maybe mildly favorable also in the first year. How it picks up from there, we'll have to see based on the performance of the business.

Prithvi: OK, that answers. I'll join back in the queue.

Nishant Singh: Thanks, Prithvi. Harith, can we have your question, please?

Harith: Hi, good morning. Thanks for the opportunity. So, in the presentation you've talked about attracting more private payor patients, so currently the mix is around 93% coming from NHS. So, if you can talk about how this mix has trended over the last few years and do you expect this to change or improve materially in the next few years? And what are some of the steps that you're looking at in terms of attracting more private payor patients?

Anesh Shetty: Yeah. No, thank you. So, if you just look at the competitive landscape, so if you look at the large, the only publicly listed asset that's available with robust data is Spire. So, Spire currently has about, as of the recent half year, about 35% of their payor mix being NHS, the rest combination of self-pay and PMI, which is their private medical insurance. The other assets have, you know, the other equivalent assets, Circle, which is ADQ owned, around the similar range. Ramsay Health, which is, I would say closer to PPG than the others, has between 60%-70% NHS. So, Practice Plus is definitely an outlier being at 93%. But this is a factor of where they've started off the journey in the origins of the company and where they're trended.

So, to your question on, you know, they started out being 100% NHS. This movement to, you know, 93% is a little more, 90%-93% is a little more recent. And it is our intention as well as the management's intention, Bridgepoint, their erstwhile owner as well, even if this transaction did not happen they are on the trajectory to increase the percentage of their payor mix from private sources. And we are definitely going to enable that journey.

It's a little hard to give you, you know, a hard number as to where we'll be in 6 months and a year, et cetera. It's still early days for us. But that is definitely the intention. And they've taken some very concrete steps and decisions, not just on individuals but also on asset selection and certain assets they've recently acquired as well to enable that.

Harith: Okay. And within the NHS part of the business, you know, given pricing is, you know, set by the government, what are the steps that we can undertake from a margin improvement standpoint?

Anesh Shetty: Yeah, so it's a very fair system to be, to be honest. Broadly, in a nutshell, NHS England would pay you, that is a private hospital, the same as they would pay themselves, which is their own

hospital. And this is also largely inflation linked accounts for changes in wages. So, you know, aside from HCA, which is, I would say, next to Zero NHS, all the other players that are privately owned as well as publicly listed do vocally state that, you know, there is a role, a meaningful role, for an NHS in a broader payor mix because it is stable, it is secured, it is sustainable and it is largely inflation linked.

So, it's not something that, you know, we would individually do to influence reimbursement, etc., because we're just a very small cog in a very large wheel. But in terms of improving margins within an NHS framework, you know, you have all the levers of cost, around cost structure and operational efficiency, because in some way the price is set to be largely sustainable or close to sustainable for the government themselves. So, as long as we can have, execute on a strategy that improves our day-to-day operations and our cost structure and differentiates ourselves compared to peers, both public and private, then the profitability, even being a predominantly NHS payor mix, starts looking very, very different from what it is now.

Harith: Okay, one last one, more of an observation. When I look at the specialty mix, it's skewed towards Orthopedics. And I understand that, you know, NHS backlog could be a reason here and the high number of elective procedures in the Ortho specialty. Are there any other specialties where you think a similar dynamic exists, where, you know, there's a high proportion of elective procedures, which you can target and you see as an opportunity?

Anesh Shetty: Yeah, that's the right way to think about it. So, the existing specialty mix, not just for us but other private providers as well, is largely reflective of what the NHS chooses to outsource as well as their backlogs and the other factors as well. So, this is a lot of heavily skewed towards Orthopedics, Ophthalmology, you know, General Surgery; these kinds of things. There are certain other services and specialties where other providers have a good chunk of their revenue mix coming from which Practice Plus doesn't. So, that's an easy opportunity for revenue enhancement without any additional investment in infrastructure.

So, to your question, you know, there are several services that we've already identified where it is possible to start in the existing infrastructure without adding, you know, hard infrastructure, just some operational execution and some people and teams and clinical orientation. We definitely will be assisting the company to start these services and grow within the same property footprint.

Harith: Got it. Thanks, Anesh. I'll get back in the queue.

Anesh Shetty: Sure.

Nishant Singh: Thanks, Harith. Raman, can we have your question, please?

Raman: Yes. Thank you, Sir. I just have 2-3 questions. First is, I just want to understand, it's more or less like a follow up on the previous participant's question. So, majority of our revenue comes from NHS, I just want to understand the payment cycle. And are we shifting towards like is there any plan to shift more towards private players? Because my understanding is the margin mix between NHS and private player, private players have better margins. So, if you can help me clarify that.

Anesh Shetty: Sure. Sure.

Sandhya J: Yeah, I'll take that question.

Anesh Shetty: Yeah, go ahead, Sandhya.

Sandhya J: Yeah. So, in terms of payment cycle, NHS pays within 15 days on average. So, the company almost operates on virtually zero working capital. As far as the private pay piece is concerned, I think Anesh just explained to the previous speaker the dynamics around that. So, I think that question is answered.

Raman: Okay.

Anesh Shetty: Yeah, but happy to essentially just answer quickly. Essentially, yes, you are right. The private payors do pay a rate like for like basis, that is more than the NHS. But, you know, each has its own attributes that would make it attractive and a good mix between all would be the ideal outcome.

And to your question on whether our intention is to increase the non-NHS sources, that is PMI and self-pay. Yes, that is our intention and we hope to make good progress on that.

Raman: My second question is our total bed capacity is 330 beds with respect to the acquiring entity. What's the operational bed out of this?

Anesh Shetty: So, they're all operational. In fact, the way the market is oriented there because the procedures are more shorter stay, daycare, lower in acuity. Unlike in India, which is the market we're all familiar with, the bed isn't the fundamental unit of measuring capacity, etc.,

there are other units that are more reflective of capacity. So, yeah, in our parlance, when we say capacity and operational beds, all these beds are operational. Yeah.

Raman: So, are we having any Capex to increase the number of beds?

Anesh Shetty: No, we don't need to increase the number of beds because the bed wouldn't necessarily be the bottleneck or the driver of throughput or capacity. But in the current footprint, we don't anticipate any Capex being spent on a bed addition.

Viren Shetty: But to the larger question of can these existing infrastructures do more, the answer is yes. There's scope for significant throughput enhancement, both through the existing specialties, adding more volumes and adding more bolt-on specialties.

Anesh Shetty: Yeah.

Raman: And my final question is with respect to the Birmingham Centre, when will it achieve breakeven?

Anesh Shetty: Yeah, Raman, so that's a centre that was recently acquired by one of the other peers as part of a merger and disinvestment. So, it's in a great location. The centre is our newer centre, I would say the newest centre, it's still in a sort of a pre-commissioning phase and that's why you have operating losses. Some aspects are commissioned, some haven't. We hope to update you and the rest of the followers maybe in a quarter or two once we get a better sense of where we are in that. Yeah.

Raman: And, Sir, I just have one technical question. What's the difference between centre EBITDA and adjusted EBITDA?

Anesh Shetty: Yeah. So, essentially, centre EBITDA would just be the profitability at the business unit in aggregate, combining all the business units. But then between the centre EBITDA and what we would finally land up with is our corporate costs, you know, things like our IT contract, central staffing, payroll, everything that forms a central shared service. These hospitals, unlike what we see in NH in India, in isolation are small units. They're relatively small. So, a lot of their costs are shared across the entire organization. So, that would be the difference.

Sandhya, you want to add anything there?

Sandhya J: Yes. So, there are divisional overheads and corporate overheads that come between the centre and the adjusted EBITDA. The only item on the adjusted EBITDA is the adjustment for

the Birmingham losses which we have called up. Other than that, the adjusted EBITDA is equal to the EBITDA as we measure pre-IFRS in NH parlance.

Raman: Sure.

Nishant Singh: Yeah, Kaustabh, may we have your question, please.

Kaustabh: Sure. Firstly, congratulations, guys. I think it's very heartwarming to see an Indian entity make global presence. So, kudos on that. I have a couple of questions.

The first question is NH in India is known for its focus on throughput, the DNAs of throughput, which is very counterintuitive to the industry versus what the other peers track, right. What will be the, would it be essentially the same kind of DNA and focus that you guys will be able to implement in the UK entity? And what will be the benefits that you guys can derive from integrating Athma, which is your tech stack, in the UK acquired entity? Is there any quantitative versus qualitative target or some projection you guys have made internally to determine the benefits that come from integrating Athma?

Anesh Shetty: Thank you, Kaustabh, not just for your initially kind words but for asking our favorite question. But, yeah, so, you know, one reason we like this company is because there is a very good philosophical alignment and match in terms of the importance of operational efficiency and throughput. So, I will call out an important fact about this company that we really, really admire. There is no private provider at this scale and above, so they may be smaller but at this scale and above, that we know of, that can operate at a 90%-93% NHS payor mix and have the margins that this asset has. So, even before we come in, this is a management team and a company that is efficient, that is focused on throughput, that understands the value of simplifying processes and automating either with software or with other interventions. And that's very much how we like to think of it. So, it is very, very heartwarming to see that and that really attracted us to this company because we're not trying to bring in a very large culture change, we're just enabling them with our platform, with our tools, with what we bring to the table to just turbocharge what they're already doing.

So, to your second question around the Athma technology platform, yes, absolutely, it's very similar to what we've been able to do in Cayman. We believe that in time, hopefully sooner than later, we are able to infuse our technology and digital capabilities to automate away things that don't need to be done, to simplify the way a lot of processes happen. In markets like Cayman, like the UK, like Europe there are many, many, many steps to take a patient from admission to discharge that have nothing to do with the clinical care, that have nothing to do

with their disease but it's just administrative steps and functions to either record the care, document the care and get paid for it. And this is ideal fertile feeding ground for us to come in with our broader capabilities and what we've already built to identify opportunities for improvement and efficiency.

Kaustabh: Splendid! Splendid! Thanks for that.

My next question is, in India, Narayana is known to be one of the most efficient and most capable hospitals for robotic surgeries and robotic capabilities. Do we have any plans or if you can comment on the same robotic surgery capabilities of the UK entity?

Anesh Shetty: So, it's slightly different market dynamics. So, in India, private hospitals, especially the larger private hospitals, generally tend to do tertiary care and complex care, organ transplants, open heart surgery, etc. In the UK, for the most part, there are exceptions in some of the London hospitals, but for the most part the private providers are doing work that isn't that high in acuity but they're doing it at scale at throughput, largely helping the NHS with their backlog. So, your robotic work, your organ transplants these kinds of things would still tend to happen in the NHS, not in the private sector. So, it's a meaningfully different level of acuity that we would see either compared to Cayman and India.

And there's nothing wrong about it. It's just the nature of the market and we're happy to identify where we can add value in terms of enhancing the scope of services they have with our clinical background. If it leads in a direction where it leads to more complex work and someday, you know, robotic and advanced work, so be it. But I don't think that will be the initial focus.

Kaustabh: Sure, got you. My next question is, is price discrimination subsidizing the lower end of the pyramid? Is it even relevant in UK given it's a developed market with essentially a wealth distribution that is not as skewed as India? So, is price discrimination subsidizing the lower end of the pyramid in terms of customers? Is it possible? Is it on cards for you?

Anesh Shetty: No, that's not really how it works because the NHS has essentially, you know, a tariff that you get paid. You don't decide that, that's what you get paid. You can obviously increase volume and quality, etc., but that's essentially decided tariff. There are self-pay patients, essentially like in India, they're paying cash. You know, they're shopping around because they don't want to wait on a waiting list, etc. So, they're paying cash. So, over there, yes, there is more of a free rein in pricing, which within reasonable limits.

Kaustabh: Got it.

Anesh Shetty: Then on the other end, which is privately insured, again, it's like in other markets where you have a negotiated tariff with the insurance company and the patient is not responsible for that. So, in the non-NHS, there are two buckets, self-pay and PMI. In the self-pay bucket, there is some element of what you're saying but it's not as prevalent. But in PMI, it's also a fee schedule.

Kaustabh: Understood. Fair enough. My last question is, since we already have been operating in Cayman, which is a UK administered territory, and now we're in UK, do we have any benefits in terms of our learnings from our operations in Cayman, dealing with the UK regulator? Do we at all have any benefits in that direction?

Anesh Shetty: I don't think so because they're differently regulated. I mean, Cayman is a British overseas territory but that doesn't flow down in any meaningful way in terms of clinical regulation. Of course, all providers in the UK are wonderfully regulated by the CQC and related bodies. And it's a very robust, time-tested, fair system in our experience. And another good attribute about this company is, it's in a good group, a select group where every asset we operate, every unit is rated good or excellent by the CQC, which are the Top 2 ratings. So, every asset that this company operates is good or excellent. So, they're doing a phenomenal job with regards to their regulatory requirements and compliance. And we definitely look to continue that.

Kaustabh: Amazing! That's all of my questions. Thanks for answering and congratulations once again.

Nishant Singh: Yeah, Ramesh, please go ahead.

Sandhya J: Ramesh, I think, already asked.

Nishant Singh: Ramesh has already asked? So, we'll move to Shivam. Shivam, can we have your question, please?

Anesh Shetty: Sorry, if we could just request, if anybody has asked a question and wants to get back in the queue, if you could lower your hand, please, and then raise it again so we can keep track of who's next. Thank you.

S. Ramesh: S. Ramesh. I haven't asked a question yet.

Viren Shetty: Yeah, Ramesh, go ahead, please.

S. Ramesh: So, just to understand the transaction.

Nishant Singh: We're not able to hear you, Ramesh. Can you please be a bit louder?

S. Ramesh: Just hold on. Can you hear me now?

Viren Shetty: Not well, Ramesh.

S. Ramesh: Just hold on.

Viren Shetty: Yeah, that's fine. Go ahead.

S. Ramesh: Yeah. So, if you look at your overall transaction cost, is it all in cost or is there any other adjustment you expect? And in terms of other charges and asset valuation, everything is included in the valuation?

Anesh Shetty: Sandhya, do you want to take that?

Sandhya J: The cost is all in cost. However, typically, as in every deal, there is a 4%- 5% deal cost, which comes for diligence, for stamp duties, for lawyers, etc. So, that will come on top of the costs that we have indicated.

S. Ramesh: So, this cash cost is already paid or it will be done in the second quarter?

Sandhya J: In Q3, yes, we will pay. We have signed, we have not closed. Closing will happen by end of week. At that point in time, we will make the payment.

S. Ramesh: Okay, fair enough. So, that means your Q3 results will show the consolidated impact of this acquisition, right?

Sandhya J: Yes, from the date of closing.

S. Ramesh: Okay. So, if you look at the value of this acquisition, now obviously, you know, you possibly have done the homework or you would have possibly assessed similar acquisitions elsewhere in the world or in India. So, have you also considered similar acquisition opportunities in India? Because that is your home market, that is the reason why I am asking this question.

And why is the private equity firm, which has owned this asset, is selling now? Is it just because they are catching in on their value over the years or is there any other structural reason why they are getting? Because the NHS itself has been going through a lot of political

debate in the UK, so in terms of your own value proposition, what is it that you are adding to that business? And why is the existing investor selling, if I may ask?

Viren Shetty: So, the second question, first, Ramesh. The investor is a bridge point to the private equity fund, they reached the end of their lifecycle. So, they have to return money to investors and they need to offload this asset as well as the other two that are part of Practice Plus Group. So, that is why they are selling and that is why we are taking up.

To the question that you asked first, are we looking at opportunities in India? Yes, of course, we look at opportunities constantly in our core markets. We have identified quite a few. We have tied up with real estate developers, we bought land, we are building in Bangalore, Calcutta, Raipur in the projects that we disclosed. And here and there, M&A opportunities do come up. But a lot of the time private equity backed M&A opportunities in India tend to be priced very, very aggressively. And in all the calculation that we make, the payback tends to get quite stretched. And, so, that is why it is still something we do consider but either they are too small and not that we are able to do much with it or the few opportunities that get written about in the newspapers, the ones in India, are beyond our ability to afford.

S. Ramesh: Okay. So, if you look at the manpower cost for this UK asset, it is about 39%, doctors plus the others. So, what are the controllable levers you have in terms of pension liability and given that there is also a currency risk involved? So, when you look at your overall ROCE target, have you built in any increase in this manpower cost, assuming that, you know, consumables and the other operating expenses is something which possibly is within your control?

And to the extent to which, you know, you are talking about the NHS patients, accounting to more than 90%, so is all the increase in the cost built into this overall revenue mix and to what extent can you make up any increase in margins required to the self-paying patients?

Viren Shetty: Yeah. Anesh, if we can talk about the inflation linked tariff, please.

Anesh Shetty: Yeah. So, to Ramesh's first question, the composition of the P&L to various cost heads is not very different from what we see in India or in other larger markets. And as Viren mentioned, you know, the NHS sets its tariff the same for all providers largely. And it does reflect, a tariff increase does reflect the cost of inflation of medical goods, wages and other services. So, there is that element of being insulated from that. That's also passed down to the private insurers as well with some delay.

S. Ramesh: So, is it fair to assume that your UK asset is going to be something of an annuity business over time?

Anesh Shetty: It's a bit early to say that but let's address that maybe in a couple of…once we are settled in there, yeah.

S. Ramesh: Okay. Thank you very much and wish you all the best. Appreciate it.

Anesh Shetty: Thank you. Thank you very much.

Nishant Singh: Shivam, can we have your question, please?

Shivam: Yeah. Am I audible?

Nishant Singh: Yeah.

Shivam: So, actually, I was asking that there's a shortage of healthcare workers in UK and given that the NHS isn't very keen on letting people come from outside, what stance do we have on that?

Anesh Shetty: As a private provider, you know, you're slightly more insulated from the workforce shortages compared to the public employers who have a lot of other factors to consider and wage constraints. So, for the most part, because of the acuity of services not being tertiary and above, and because of the attractive workplace that private workplaces offer compared to public workplaces, the shortage, the larger shortage, is not that much of a concern for the private sector and particularly for PPG.

Shivam: Okay. And given the NHS is very tight on the budget, do we have a process in which we can get away from the NHS payor mix?

Anesh Shetty: Yeah. So, you know, we answered that previously as well. The intention is to move away with certain changes that have been made on the ground with regards to people as well as asset selection and marketing efforts. We'll continue to do that. And the intention will be to increasingly attract, you know, more private and self-pay patients.

Shivam: The way we have started the insurance, providing insurance in India, will we be doing that business as well there?

Anesh Shetty: No, we're just entering as a provider now. And it's still early days.

Shivam: Okay, sure. Thank you.

Anesh Shetty: Thank you.

Nishant Singh: Thanks, Shivam. Shreyansh, can we have your question?

Shreyansh: Yeah, hi. I had a couple of questions. So, the first one is, if you could give, of the 330 beds what's the kind of utilization currently for the beds?

Anesh Shetty: Yeah. So, as earlier mentioned, you know, bed isn't the unit of utilization. There are other capacity levers about, you know, theatre sessions and theatre utilization. But if you take beds as well, as well as theatre, you know, other metrics of utilization, it'll approximate be closer to 50%-55%. So, as Viren mentioned, there is adequate room to accommodate additional volume in the same properties.

Shreyansh: Got it, got it. So, since it's 50%-55%, so trying to understand what stops, as given the backlog that NHS has, you know, from increasing this utilization? And why is it, you know, at that level?

Anesh Shetty: So, backlog doesn't translate into NHS willing to pay for it. They need to have funds to pay for it because, you know, the backlog largely exists because they do not have the funds to, you know, render the services within their own property or to pay for it in the private sector. That is one constraint. And also, the intention would be to attract non-NHS patients as well. And that, like in any market, whether India or otherwise, has its own learning curve about understanding the patient acquisition journey. It's more consumer choice because they can go wherever they want and addressing those, you know, those levers.

Shreyansh: Got it, got it. And my last question is, so by when do we expect, you know, the tech systems to be integrated into the UK, into the hospital?

Anesh Shetty: It's a journey. So, we'll start immediately with low-hanging fruit, you know, certain things that are easier to do but certain core systems will take more time, a couple of quarters, maybe longer than others. So, it's a journey and it won't be one date when systems transition. It will be module by module, application by application. And, you know, the benefits will, we hope, correspondingly flow incrementally over the years as well.

Shreyansh: Got it, got it. That's all from my end. Thank you so much and all the best.

Nishant Singh: Thanks, Shreyansh. Nidhi, can we have your question, please?

Nidhi: Yeah, sure. Hi, thank you so much for taking my question and congratulations on the strategic partnership. Just wanted to understand how is the ecosystem for private hospitals versus NHS? And who would be our targeted audience, our targeted customers?

Anesh Shetty: So, sorry, Nidhi, could you be a little more specific? What do you mean by ecosystem for private hospitals? Sorry about that.

Nidhi: So, when we talk about all the major services being catered by NHS, what type of, you know, services we would be catering to?

Anesh Shetty: Yeah, okay. So, largely, you know, the biggest success story in private outsourcing is Ophthalmology and Cataracts. That's well served. The others would be what you'd expect, Orthopedics, a lot of Joint replacement, Arthroscopy, Gastroenterology procedures, General Surgery, etc. You know, these would be the more, think of anything that's elective, short stay and is not life-threatening or critical, it's not, you know, emergency trauma and things like that.

Nidhi: Right. And, fundamentally, what we would be catering to over a longer period of time given that we are going to reduce our dependency on NHS to catering to non-NHS segments? Like, who would be our, you know, audience with regards to the cash payment patients or is it going to be more on insured size where corporates do not have coverage on those insurances where they are going to cater the services?

Anesh Shetty: If I understood your question right, the non-NHS typical patient profile is somebody who has private insurance. This is in the country largely, for many people, employer provided for some individually purchased as well. I think that's fairly similar to what we see in India as well. So, that kind of person would be the target demographic.

Nidhi: Right. And just the last one, On margin side like our consolidated margins would be diluted with this acquisition, so even on a longer term, let's say, we are able to achieve 8%-9% or maybe 10% kind of margins which the industry is catering at the moment, how do you see this planning on a longer term? Where are we going to find a pace on our consolidated books?

Anesh Shetty: Yeah. Sandhya, you want to take that?

Sandhya J: Yeah. It's a forward-looking view we don't want to give but we have given a certain idea on how we look at the next 12 months margin in the deck that we have shared. We are hoping that we can build on that and improve on the margins. Anesh spoke about all the cost and efficiency variables that we have, so over a period of time we will have to build on these

levers. But we have shared a kind of an indicative number in the deck we have put up for the next 12 months.

Nidhi: Right. Got it. Thank you. I'll get back in the queue.

Nishant Singh: So, now we'll go to Niranjan and Kapil because Ravindra, Prithvi, we've already answered and we'll get back to them again. But, Niranjan, can we have your question, please?

Viren Shetty: Niranjan, can you hear us?

Anesh Shetty: Maybe we move to Kapil and come back to Niranjan.

Viren Shetty: Yeah, fine. Kapil, can we get your question, please?

Kapil: Yes, please. I would just like to get some more clarity on the answer relating to the impact of the acquisition on consolidated EPS. Now, just considering the present profitability rate of Practice Plus Group and after considering the interest to be borne on funding costs, would this acquisition to the EPS be mild or moderate or more? If you can please give some indication.

Sandhya J: Broadly flat. If at all, mildly positive.

Kapil: I see. All right.

Viren Shetty: That's it, Kapil?

Kapil: Yes, please. Yes.

Viren Shetty: Thank you. Damayanti?

Damayanti: Yeah, hi. Thank you for the opportunity. Just want to understand, you are getting already established doctor's team there and the incremental update which will come from this transaction is that you will bring in more efficiency. So, two points. So, you don't need to add on any doctors, even you don't need any infra in near term. And just with the existing capacity which they have, you try to bring in more technology to drive the growth. Is my understanding correct? At least, this should be the setup in medium term?

Anesh Shetty: Largely. But, you know, once we get in and understand more about the market, if there are interesting opportunities, you know, straight off the bat we will look at starting other services, new services within the same properties, which would require new doctors. But if there's

anything, you know, the company has been exploring certain other opportunities as well. And, you know, we'll evaluate them as and when we get settled in.

Damayanti: Okay. So, there is like a good headroom to add on more services and for that you might need to expand your team a bit.

Anesh Shetty: Yes-yes.

Damayanti: Okay. And just from the segments or categories which is currently served, you mentioned about few segments. So, from NHS outsource work will that be the key opportunity which will continue? Or you think since the backlogs continue to increase at the NHS, you can see more businesses coming in other categories as well?

Anesh Shetty: No, I think the services that usually form the bulk of what private providers do is fairly known and constant. Of course, certain things may change here and there but not in the short term.

Damayanti: Okay. And my last question is, what will be the key offering to you when you target more of these private or self-funded patients, apart from, you know, they don't have to wait for the treatment, which is a case with NHS? But from your perspective, what will the key pull factor, if you can help us understand?

Anesh Shetty: Sure. So, for the private patients, you know, the competition isn't the NHS, it's other private providers and, you know, the standard levers such as quality, brand, location, etc. But, more importantly, we believe that, you know, cost, either to a private insurance, to a PMI provider or to a self-paid patient cost of treatment is something they're very, very sensitive to. So, if we are able to meaningfully lower the cost and offer an equivalent quality option at a meaningfully different price then that becomes very interesting. Even in markets where Practice Plus is successful in attracting private patients, they're doing so at a price advantage to the others and we hope to continue to build upon that.

Damayanti: Yep. And my last point is, the other players who are in the private space, I understand they might be also investing a lot in technology, right. So, what will be the, you know, key offer from you? Because in markets like Cayman, I understand, you are the only player, right, and that's why your focus on technology, etc., could lead to great results. But maybe in the UK market, things are very different on the competition part.

Anesh Shetty: Yeah. So, Cayman, so we're not the only player. We wish we were the only player in Cayman but, no, there are others. But it's a small market. So, there are a few other players, you are right. UK is a much larger market. So, in different locations, obviously, they're going to be

more players. Yes, like any business, they continue to invest in technology and some of them have very good systems. And, you know, we believe that the efficiencies that we are able to derive, we hope will be, you know, better than the competition. But let's see.

Damayanti: Okay, this is helpful. Thank you, Anesh.

Anesh Shetty: Thank you so much.

Nishant Singh: Okay, can we move to Niranjan now.

Viren Shetty: Yeah, Niranjan, can you hear us?

Niranjan: Yeah. On the previous question you mentioned we are planning to increase the…

Anesh Shetty: Niranjan, we're not able to hear you.

Niranjan: Hello?

Viren Shetty: Maybe you can type your question in the box, Niranjan. We'll move on to Alankar.

Anesh Shetty: Viren, what do you want to do about the questions on the chat? Should we address them offline?

Viren Shetty: Let's finish up. No, we'll finish up the queue and then we will address.

Anesh Shetty: Okay.

Viren Shetty: Alankar.

Alankar: Yeah, hi. Good afternoon, everyone, and congrats on the acquisition. Sir, firstly, you spoke about increasing the private mix gradually over NHS, you also spoke about margins. Can you comment a bit about the growth aspect for PPG? Asking this question because if you look at the 5-year CAGR it was about 12%, if you look at the last 2-year CAGR it's about 9%. So, did PPG see any COVID linked bump up in the earlier part of the 5-year cycle? And is the 9% growth, which you've seen over the last couple of years, is it more indicative of what the asset can deliver without any significant increase in the private contribution?

Anesh Shetty: Yeah. So, thanks, Alankar, for the question. So, you know, COVID did not play a meaningfully different role compared to usual for this asset. Having said that, they are on a growth trajectory, like you said, which was in the longer term 12%-14%, nearer term 9%, with their

existing, you know, payor mix. A lot of that depends on…By the way, none of this is with adding sites except the Birmingham, which is not yet operational. They've been largely static with the number of sites. So, this you can consider the organic growth year-on-year.

You know, we see no reason why that should slow down. In fact, there are certain interesting opportunities with adding more services now that we are involved within the same properties that would further build upon that. But it's still early days, we'll get a better grip of the growth that we can expect to see on a shorter term year-on-year basis, maybe in a couple of quarters.

Alankar: Understood. The second question is more on the transaction, actually two questions there. Firstly, how should we look at the purchase price allocation for this acquisition? Possible to share any broad split between goodwill and intangibles?

Anesh Shetty: Sandhya.

Sandhya J: It is too early actually, we are still working through with the auditors. We have just signed the transaction, after closing the auditors will go through the details and then we'll have a better view of this. So, we are not in a position to answer this question at the moment but we will answer as soon as we have better visibility on this.

Alankar: Got it. And the final one, apart from the 150 million pounds debt, will the rest of the acquisition be funded entirely by Cayman's balance sheet?

Sandhya J: The entire acquisition is been funded by Cayman balance sheet. 40 million is going as equity, the rest of it is a leveraged buyout and, therefore, it is a debt on the books of the target.

Alankar: So, no India balance sheet cash will be used to fund the acquisition?

Sandhya J: No.

Alankar: Okay, understood. Thank you. That's it from my side.

Viren Shetty: Thanks, Alankar. Niranjan, would you like to speak?

Niranjan: Yeah, am I audible to you?

Viren Shetty: Yeah, go ahead.

Niranjan: Yeah, for the previous question you mentioned we are planning to increase the non-NHS part, right. What are the strategies and plans for increasing the non-NHS part?

Viren Shetty: Sorry, strategies for increasing?

Anesh Shetty: The non-NHS, the patient mix.

Niranjan: Yeah, yeah. Yes.

Viren Shetty: That has been answered already. I think just in the interest of time, maybe we'll move on to the other questions. Any other question, Niranjan?

Niranjan: Yeah. And also one more question is, the PPT I saw, it is the 4th largest player in NHS and for the other 3 players what is the percentage share of non-NHS part?

Anesh Shetty: So, that also we answered previously. Yeah.

Nishant Singh: Thanks Niranjan.

Viren Shetty: If we can go to Ravindra, please.

Ravindra: Yeah, hello? Am I audible?

Anesh Shetty: Yeah.

Ravindra: Yeah, thanks for the opportunity once again. So, just one kind of a broader question, as per last year's Annual Report, there is a cash on books in the company around ₹600 crores, sorry, ₹400 odd crores. Is there any arrangement between the parties that how this cash is to be used? Or do we get any benefit out of this deal to NH?

Sandhya J: We are acquiring the company on a zero debt basis. There is working capital of about GBP 5 million that is being left behind in the company. Other than that, the rest of the cash and the debt will be cleared by the seller.

Anesh Shetty: Thank you.

Ravindra: Okay, that's fine. Just have one last question. What is the interest cost that we are going to operate for this acquisition? Like GBP 150 million, as you said, what would be the interest cost?

Sandhya J: Yeah. We have borrowed at about SONIA plus 200 bps on average.

Ravindra: Okay. Currently I think they are having 6.25%. I think it's a floating interest rate, that's what they are operating.

Sandhya J: So, their interest rate is not relevant for us because we are acquiring on a debt-free basis. So, we are acquiring at a SONIA plus 200 bps kind of range.

Ravindra: So, what would be the ballpark figure, just for the calculation?

Viren Shetty: SONIA plus 200 bps, Ravindra.

Sandhya J: 6+. 6 odd.

Ravindra: Okay. Okay, more or less the same range.

Sandhya J: Yeah.

Ravindra: Okay, thanks.

Anesh Shetty: In the interest of time, if we can move on to Prithvi, Viren.

Viren Shetty: Yeah, yeah. Prithvi.

Prithvi: Thanks. I just have a couple of questions. One, going forward if you have to move cash from Cayman to UK, for Capex, etc., is the cash taxable? And what will be the tax rate?

Sandhya J: So, equity is not taxable. At the moment, we do not intend to move cash from Cayman. The target is sufficiently cashflow positive to take care of its own Capex requirements, Prithvi.

Prithvi: Okay, got it. Second, Viren, I mean, obviously it took 7-8 years for you to get into another geography, can we assume that for the next few years the focus will be on UK before looking for something else?

Viren Shetty: If you're worried about our inability to stick to one geography, please rest assured the UK is a very large market. There's a lot of learning that we have to make and there is tremendous scope for growth. We are pursuing still in the Caribbean opportunities there because it is highly synergistic with the Cayman hospital that we run as well as in India, which is our core target market. Whatever we're spending in the UK is small compared to how much we're planning to invest in India in expanding our core market here. This came about because we see a good opportunity to grow in a developed country where there's a very large and growing need for private healthcare.

So, we can't give a commitment on 7-8 years but just that we've made a commitment here and we will continue to invest in this.

Prithvi: That's clear. One final question. Anesh, you mentioned Spire Hospital, that has 35% payor mix from NHS. If I look at margins, they make close to 18% EBIDA margin. Is it fair to assume that's something that you will look forward for this acquisition, maybe in 5-7 years down the line if the payor mix changes?

Anesh Shetty: Yeah. So, the more fair comparison would be to say best-in-class like say Circle, which has the same capital structure, which is all leased assets. Spire has half their assets, approximately half owned and only half leased. So, one would have to account for a lease effect, which I think you've not done to arrive at that figure. But, yes, to the broader question, I think there are other competitors in the market operating at a meaningfully higher level of profitability accompanied with a different payor mix and we see no reason why we shouldn't get there sooner or just as much. Yeah.

Prithvi: So, just squeezing one more question. What will be the realization difference between NHS and the private insurance and the self-pay in UK?

Anesh Shetty: Yeah, it's a good question. It depends on location, who the hospital is, who the insurer is. But, broadly, for many procedures PMI would pay anywhere from 20%-30% more than NHS. But it just depends. These are individual contracts, it's not publicly available but it's just a broad industry guidance, this is a consensus number.

Prithvi: Okay.

Viren Shetty: Thanks, Prithvi.

Prithvi: Thanks. All the best.

Viren Shetty: Nitin, you get the last word.

Nitin: Thank you so much and congratulations, team, for a very interesting acquisition. Just a couple of housekeeping questions to start off. One is, from a Capex perspective, with the plans that you have right now, did you envisage any meaningful Capex for the business over the next, say, 3-4 years?

Sandhya J: Yes, the business has regular routine maintenance and refurbishment Capex, which the business will continue to incur. Will be in the range of GBP 10-20 million every year but that's baked into our financial plan.

Viren Shetty: These businesses are fully asset light. All the buildings are leased from private lessors as well as the NHS and a lot of the equipment is leased as well. So, the growth will happen in a very Capex light manner.

Nitin: Obviously, very early days for you but do we, for example, Birmingham Center is there, are we on the lookout for adding centers over the next short term or is it going to happen over a period of time?

Viren Shetty: It's a bit of both. Anesh can talk about the consolidation and expansion.

Anesh Shetty: Yeah. So, you know, the Birmingham Center is something that is yet to be fully commissioned. We're eagerly working towards that. The management has looked at certain centers but nothing that is imminent or that can happen right away. These are things we'll look at. There are one or two opportunities. But as Viren mentioned, these are structured, from a capital structure perspective very different from what we're used to in India, where they're very, very light and loaded towards the end just pre-commissioning when you're bringing in medical equipment and they're largely leased and that appears to be how the industry broadly operates there.

Nitin: And, Sandhya, what kind of cash breakeven period are we looking at for this transaction? How many years do we start to cash breakeven, from an investment perspective?

Sandhya J: So, it's a leveraged buyout. So, we are positive that we will be able to pay for the loan that we have taken on the books of the target from the cashflows of the target itself. From an IRR point of view, it is crossing our threshold IRR; high double digits. So, with that I think you can understand the payback because it's not a number we are officially disclosing.

Nitin: Sure, sure.

Sandhya J: But this I think gives you an idea.

Nitin: Perfect. And from a PBT perspective, when do you think this transaction on its own starts to make a meaningful impact to our consol numbers?

Sandhya J: From the first quarter of full integration it will be significantly material in our consolidated number. But from a PBT point of view, it will take maybe 2 years because of the margin profile of the rest of the businesses.

Nitin: Something like FY28 or thereabove.

Sandhya J: Yes, yes.

Nitin: Okay, thank you so much.

Viren Shetty: There are a couple of questions on the chat. A lot has been answered, I will skip those. In terms of how does this align with NHS global expansion delivery priorities? Anesh had answered that already because this is something that's highly in sync with our value system and it is a growing market and it is a place where it is stable, where it has a very strong and secure market.

Question about are we planning to do Cardiac Care or Oncology? We are not ruling it out. As of this point, the Practice Plus does not offer Cardiac Care nor Oncology, it offers more General Surgery. It's something we'll definitely be in discussions with the NHS as well as with existing service plate but the buildings are simply not configured for this sort of work. So, on the existing asset base, it may not. As we get more comfortable, both in terms of the leverage this has and what expansion would actually look like, we would consider other service lines.

EBITDA margin guidance.

Sandhya J: So, we have given a next 12 months broad guidance in our deck itself for the pre-IFRS EBITDA. The lease costs, you can assume, similar to what is there in the balance sheet today because there aren't any additional lease costs that are coming onboard. So, that will give you a post-IFRS indication. But those are indicative numbers, we cannot give forward-looking guidance.

Viren Shetty: This is a good question. How much of the NHS contract influences or constrains the growth of operations? The answer is it doesn't constrain. This provides the base of every hospital, which assures you a level of breakeven. Everything we do above that is either through volume growth in more NHS contract revenue, adding more departments or increasing the private pay business. So, it is a very useful thing to have for the entire hospital group, and it is something we won't materially alter. In fact, we'll try and grow as much as we can but private pay and other service lines add on top of that.

Nidhi's question, what percentage can afford private hospital services? As of our understanding, in London it is slightly higher but across the rest of the UK it is much lower. Anesh, do we have a percentage figure that's publicly available?

Anesh Shetty: I mean, not in that exact sense but the amount of people who privately access care has been steadily growing over time. But what we'll be really looking to do is lower the cost of self-pay care and PMI care and, hopefully, that improves this number.

Viren Shetty: So, the next question is, what is the component of absolute depreciation for the acquired entity?

Sandhya J: It's about 8 million pounds.

Viren Shetty: And the net assets that we'd be acquiring?

Sandhya J: About 30 million pounds. The rest are Right to Use assets.

Viren Shetty: Yeah. The next question is on impact on near-term EPS. We said it's slightly positive to neutral.

Vinay's question, is there a correlation between NHS waiting lists and hospital capacity? I think Anesh answered that. The waiting list is more in terms of ability to pay. The NHS waiting lists are because they are challenged in the current way the whole thing is structured and their ability to pass through. It does mean there is an assured business, yes, because as a more efficient low-cost operator, the NHS would be very happy to partner with hospital groups like us to be able to clear the waiting lists and it's something that we will continue to grow on.

The debt level on consol level.

Sandhya J: Sure. So, we have given the debt that we are taking on the books for this acquisition, we've also given the long-term debt plan for India and Cayman. We are in silent period and we cannot disclose a forward number at the moment but I think you can calculate with the data that we've made available.

Viren Shetty: As for the question of other QIP plans, as we mentioned earlier, there is no real need for it now but it's not something we will rule out at some point in the future because we do not want the debt level to constrain our expansion, provided it's done in a measured and conservative manner.

Nishant Singh: So, as there are no more questions, we would like to conclude our session. There's one more question on the chat.

Viren Shetty: Whether Tamil Nadu is in expand…

Sandhya J: We cannot comment right now on the NHS business strategy because we are in silent period. If you have any specific questions, please dial into our Investor Call in 2 weeks from now and we will answer questions relating to NHS strategy.

Viren Shetty: But if you have a hospital in Tamil Nadu that you'd like to sell us then please get in touch.

Nishant Singh: Okay, thank you everyone. Please feel free to reach out to us in case you have any further follow-on questions. Thank you.

END OF TRANSCRIPT