



April 29, 2026

BSE Limited

The Listing Department
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25th Floor, Dalal Street
Fort, Mumbai 400 001
Maharashtra, India

BSE Scrip Code: **544309**

National Stock Exchange of India Limited

The Listing Department
Exchange Plaza, Plot No. C/1, G Block,
Bandra Kurla Complex
Bandra (East), Mumbai 400051
Maharashtra, India

NSE Symbol: **IKS**

Dear Sir/Ma'am,

Sub: Transcript of Conference Call held on Friday, April 24, 2026

This is in reference to our letter dated April 23, 2026, regarding the schedule of the Conference Call and submission of the presentation and our letter dated April 24, 2026 regarding the submission of the audio recording of the said Conference Call.

Pursuant to Regulation 30 of the SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015, please find enclosed the transcript of the conference call held on Friday, April 24, 2026, for the "IKS Health Announces Agreement to Acquire TruBridge".

The said transcript has also been uploaded on the Company's website and can be accessed through the following link:

<https://ikshealth.com/ir/sebi-disclosures/update-call-transcript.pdf>

This is for your information and records.

Thanking you.

Yours sincerely,

For Inventurus Knowledge Solutions Limited

Sameer Chavan

Company Secretary and Compliance Officer

Membership No. F7211

Encl: As above

M/s. Inventurus Knowledge Solutions Limited

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“Inventus Knowledge Solutions Limited

Update Conference Call”

April 24, 2026



MANAGEMENT: **MR. SACHIN GUPTA – FOUNDER AND GLOBAL CHIEF EXECUTIVE OFFICER**
MS. NITHYA BALASUBRAMANIAN – WHOLE-TIME DIRECTOR & CHIEF FINANCIAL OFFICER
MR. SARANSH MUNDRA – VP, INVESTOR RELATIONS

MODERATOR: **MS. SEEMA NAYAK – ICICI SECURITIES**

Moderator: Good morning, ladies and gentlemen, and welcome to the IKS Limited Company Update Conference Call hosted by ICICI Securities Limited. 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 this 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 Ms. Seema Nayak from ICICI Securities Limited. Thank you and over to you, ma'am.

Seema Nayak: Hi, good morning, ladies and gentlemen. Thank you for joining us on today's call pertaining to IKS Health's acquisition of TruBridge, a prominent provider of healthcare technology solutions for rural and community hospitals. On behalf of ICICI Securities, I would like to thank the management of IKS Health for giving us the opportunity to host this call. Today we have with us Mr. Sachin Gupta, Founder and CEO; Ms. Nithya Balasubramanian, CFO; and Mr. Saransh Mundra, Head of Investor Relations. I turn it over to Saransh for his brief statement and to take the proceedings forward. Thank you and over to you, Saransh.

Saransh Mundra: Hi, hi everyone. Welcome. I would start with the disclaimer statement before handing off to Sachin. As part of our prepared remarks and Q&A, we may make certain statements that are forward-looking in nature, and these involve significant uncertainty. We don't take any responsibility to update such forward-looking statements, and your discretion is warranted while making any investment decision. Over to you, Sachin.

Sachin Gupta: Thank you, Saransh, and good morning, good evening everyone, depending on which part of the world you're joining from. Thank you for taking the time at short notice to attend our conversation today about what I think is going to be a very significant milestone in the journey of IKS. We're here today to discuss the strategic acquisition of TruBridge that we have embarked upon starting yesterday where we signed a definitive merger agreement.

To cover that topic, I will stratify our discussion into four components. We'll start off with the strategic rationale of the deal, go into a little bit about the transaction itself, talk about the opportunities that the transaction creates from a growth and a market positioning perspective, and then finally end with a sort of a vision and a horizon statement about what value we'll be able to create from this strategic acquisition over the next four years. So, and then of course we'll turn it over to people for Q&A. Hopefully you all will have a bunch of questions that will make for a good dialogue.

With that, let's just dive in. As many of you might recall, in this journey of building the industry's best cloud-native AI-first system of action for the ambulatory care market, one of the things that we learned as we kept building that is that if you remember the big moat that I've described over a period of time that helps delegate chore tasks from these providers' continuum so that they can focus on their core was that we would be perhaps one of the only companies that has the full breadth of the platform, which is about 16-odd tasks that our system of action is able to do on behalf of these providers so that they can focus on their core.

And I've often described the fact that the industry consists of many point solution systems of

action where there are companies that are doing two or three or five of these tasks, and yet we believe that the buying paradigm, especially in some segments of the market and eventually in the entire market, will move from sort of these individual point solutions to a comprehensive platform system of action. So we always believed that that was going to be our medium-to-long-term moat as we go about this mission.

One of the things that we clearly ran into as we were going about that was the system of record. And like I've described in the past, the system of record is obviously a regulatory requirement, it's part of the core operating infrastructure of these large provider organizations. And the reality is that there are a whole bunch of native workflows in the system of record that don't necessarily go away.

And then there is obviously the single source of truth, the longitudinal data. And by longitudinal, I mean the data of the patient across their care journey, no matter where they go in the continuum of care, you know, whether it is the physician's clinic, the hospital, the post-acute rehab settings, it's a single longitudinal source of truth.

And the reality is what we realized is that for a successful platform system of action to really operate and create value, it obviously needs access to the data and it needs to orchestrate all of the actions in the native workflow. Now traditionally, all these actions were being orchestrated in the native workflow using humans, and then eventually we started going from this human-led tech-in-the-loop to a tech-led model by orchestrating these actions through application programming interfaces, APIs, that these systems of record put out there where we can then drive and orchestrate these actions through those APIs.

You can access the data in the system of record through the APIs and we can orchestrate the actions through the APIs. Now as you can imagine, while that was still very effective, the Holy Grail, if you would, would be if you had a deeply integrated platform system of action with the system of record where the platform system of action didn't need to leverage APIs to orchestrate actions in the native workflow, didn't need APIs to access the native data that's lying in the system of record and in a compliant, de-identified way, manipulate that data so that the actions can be orchestrated appropriately.

And obviously it became apparent to us that that would be a very distinct advantage, and especially in the world of AI, generative AI, and then agentic AI, where you can then have intelligent interconnected workflows.

In that world, clearly the moat would get compounded from one part of the moat being we would be the only platform system of action, but the other part of the moat would be if we were able to deeply integrate with a system of record versus the API integration that is traditionally provided, where we could then orchestrate the workflows in the system of record directly, manipulate the data, again in a compliant way, in the system of record directly, create AI training corpus within the system of record. That would become an even greater competitive moat over a period of time.

So in order to compound the moat that we were already creating in the platform system of action and to make that moat, for want of a better term, AI-proof or rather AI-led, where we are

now building and leveraging the AI versus having any reason to worry about the AI, it became apparent to us that if there were market segments that we could find where we could actually become the system of record and the system of action.

And as long as those markets were niche but large markets, and as long as those markets did not put us in competition with other systems of record vendors that are prevalent in the large health system market. Remember, a core segment of our business is the large health system market; there the dominant players are the Epics of the world. We do need to continue to integrate with them and continue to be Switzerland in those market segments, for want of a better term.

We needed to find market segments that were not competitive to the segments where the Epics of the world were playing, that were niche where we could find a niche player that would be a dominant system of record in that niche but large market, and where that system of record had the ability to combine with our platform system of action to create an absolute dominant force in that market. And so we very strategically began a quest for finding such opportunities perhaps about a year ago as we realized how to make our platform system of action most effective.

And very, very happy to note that through a series of conversations, our dialogue developed with TruBridge, which is the absolute leader in the rural hospital market segment, if you would. It's a niche market segment but still a very large market segment. Just to put it in perspective, there are 2,200 rural hospitals in America that drive \$164 billion of revenue. So even as I'm calling it a niche market segment, it's a very large market segment. 20% of America lives in this rural setting, so you're talking about 60 million plus patients driving \$164 billion of revenue across 2,200-odd hospitals.

And TruBridge focuses on the small segment of these hospitals, which is the 0 to 50 beds. Typically, these rural community hospitals tend to be about 0 to 200 beds. TruBridge focuses on the 0 to 50 beds, and by number of hospital count, they have about 700 hospitals, which is maybe 40% plus market share in the 0 to 50 beds and overall 30% market share over the 2,200 beds. So like I said, a leading system of record for the rural healthcare market, which is a niche, but very large market. 20% of America lives in rural healthcare.

It's a market that continues to be under significant challenges, so it's very similar to our traditional physician market. That was the other thing that was really important, is that it's very similar to our traditional physician market, although there is zero overlap with our traditional physician market.

So complementary but similar. How is it similar? It's similar because in these urban populations, the prevalence of chronic disease is very, very high. Lifestyles are sedentary, becoming more and more sedentary, and access to care is very sparse.

So that holy grail of lowering cost of care in chronic disease patients by getting proactive, improving quality of care by freeing up the provider's time and allowing providers to engage with the patients, and improving access to care by giving the providers time to do more with less proactively, that logic applied in the rural health system market as much as it applied in our

traditional ambulatory market.

Moreover, another big similarity was that even though the market we're talking about is the rural hospital market, nearly 60% to 70% of care that is provided in rural hospitals actually tends to be outpatient, which is essentially very similar to the outpatient care that we provide, our providers provide in our traditional customer base of physician groups.

So that also gave us the confidence that a lot of the capabilities that we had built for our traditional physician market would actually be relevant to that rural hospital setting because 60% or 70% of the care that's provided is actually outpatient care, which is very similar to our physician care.

So fully complementary market, very large at \$164 billion, a dominant system of record in that market, also a system of record that already recognizes like we do that the true winner in this market or in various segments of these markets will be the right combination of a native system of record that's a leader and a native platform of action -- platform system of action company.

And I think their ability and their recognition of the fact that they needed to start embarking on an integrated system of action is reflected in the fact that they proactively launched an RCM business deeply integrated with their system of record back in 2013. And the whole idea was, if I were just to recap, our overall platform system of action consists of 16-odd features, of which maybe about seven to eight features can be called revenue cycle.

And so they started building what you would call a partial platform system of action proactively, deeply integrated with their system of record in recognition of the same understanding that we had, which is that the real winner in any segment is going to be the right combination of a platform system of action and native system of record. So it was with these realizations that we got excited about the opportunity to bring TruBridge into our fold.

The other reason, as we move to the next slide, is when you combine a system of action with a system of record, it truly starts to create a new operating system for healthcare that has a flywheel effect on both patient engagement, patient quality of care, cost of care, and access to care.

Now how does it do that? What it does is, as you all know, the system of record has, as I've been saying, the single source of truth longitudinal data. It has the native backbone for all the workflows that the hospital has to work and orchestrate, be it things like computerized physician order entry, discharge of patients, all of that native workflows are embedded in the system of record.

And what we would do to our system of action is we would ingest all that data, aggregate it, normalize it, analyze it, and then start to convert it into the true strategic moat that would get created here, which is this proprietary AI training corpus. See, the difference between data that's lying in a system of record and an AI training corpus is the fact that one needs to truly aggregate, normalize, structure the data.

Once you start to do that, then you start to create what I call a longitudinal dataset, which is a dataset of patients across the continuum of care that is labeled. As you know, labeling is very,

very important for AI, that has awareness of the actions taken, right?

So it's longitudinal, it's labeled, it has awareness of the actions taken, and then that starts to create this AI training corpus of data that really links what I call clinical context with actions taken and financial outcomes delivered.

That, ladies and gentlemen, becomes the true moat of this combination. Because that moat really lies at the confluence of the data in the system of record and the system of action coming in. And being able to in a compliant, de-identified way manipulate that data so that that then becomes what you need to agentically orchestrate interconnected workflows to basically eliminate all these tasks that we eliminate through our system of action and orchestrate them in the native backbone itself.

So the users in the hospital don't have to go out of the native backbone, which is the EHR, to orchestrate these tasks; they're getting orchestrated in the native backbone. And it's that proprietary AI training corpus and then the native agentic workflows that one is able to build leveraging that proprietary AI training corpus that starts to create a structural long-term moat. And I think this is very important.

I don't want to necessarily overemphasize but actually can't overemphasize, that one of the big rationales of this strategic combination is going to be our ability to continue to build this proprietary AI training corpus. And what's really sort of interesting about this is the more actions you keep taking, the more this proprietary AI training corpus keeps learning because it gets more clinical context, it gets more understanding of what actions taken. Gets more understanding of what the financial outcomes were derived from that.

And it just keeps on maturing more and more and gets more and more intelligent over a period of time. So I think that's one of the most important strategic rationales of this. And why I believe that this puts IKS in a place from where we can truly be an AI-led platform system of action that is orchestrating all these actions in the native workflow of the EHR. It eliminates any lag that you would have from the friction, because traditionally what happens is the platform system of action has to integrate with the system of record through middleware.

That creates latency, it creates friction, it creates perhaps some errors in the data. And if you're able to do this in an integrated manner, it truly starts to reduce human involvement. Now we fundamentally believe that the human-in-the-loop will still be important, it will continue to be important. But the ability to dramatically reduce the human-in-the-loop is also evidenced by the fact that if you look at the TruBridge business and specifically the RCM part of the system of action that they've built.

You know, it's about a \$220 million business and they do that business using, give or take, 3,500 FTEs globally, right? Which is a whole different, if we want to put a revenue per FTE metric, it's a whole different revenue per FTE metric than the revenue per FTE metric that one is able to deliver in our -- technology-led platform system of action in the RCM part of it. So I think the evidence is clear that it definitely leads to reduced human involvement.

And if you're able to do all that effectively. So if you go to the next slide, then a lot of these actions that I'm talking about in the platform system of action truly get transformed from what

were asynchronous type actions that happen outside the native workflows or outside the system of record. And are then fed back into the system of record asynchronously through APIs, they can actually happen real-time in the native workflows.

For example, take something like our post-visit documentation, the ambient scribing technology, Scribble Now instead of it being a post-visit tool, now it can truly function like a clinical co-pilot where during the live encounter it is servicing diagnosis for the doctor, suggesting diagnosis based on the conversation. It's actually servicing care gaps that they need to plug, documentation that they need to plug in order to be able to bill in the most comprehensive compliant manner as possible.

So like I said, it transforms from a post-visit documentation tool to a true clinical co-pilot. Or if you take some of the revenue cycle actions within our platform system of action. It starts to really go from, all of these things around payers deny claims, those claims have to be worked at the back end after they're denied.

Now if you are in the native workflows of the EHR, you can actually build denial prediction algorithms because you already have, like I said, the clinical context, the action taken, and the outcomes achieved from the past. You start to predict denial, and based on the prediction of denial, you are doing real-time checks in the workflow itself where you're correcting the documentation and the coding and the charge capture, which actually eliminates the denials in the first place instead of having to work them at the back end.

So again, you move from a reactive platform system of action to what I call a proactive real-time platform system of action where both of those are combined effectively. Several other examples of tasks like these that get fundamentally transformed as you integrate the system of record and the system of action. And you know, the one other thing that I've heard is people say oh my god, even SaaS technology in the world of agentic AI is going to get redundant.

And I think it's really important to understand what when people say SaaS is going to get redundant or AI will replace SaaS, what they're effectively saying is what is the SaaS business model? The SaaS business model is that you are orchestrating tasks within the core system of record in the native workflows, but those tasks are being orchestrated by humans and the SaaS technology providers charge you on a usage based on the per human that is using the technology or the per seat license.

Now imagine a world where all of those processes that the humans orchestrate are getting autonomously orchestrated by agentic AI. Let's imagine that world going forward, although I believe in healthcare you'll always have some human in the loop, but for argument's sake, let's say that it gets totally autonomously orchestrated, then you don't need the humans.

So the argument people were making is if you don't need the humans, then how will the SaaS companies charge a per-user usage fee on an ongoing basis? But the reality is, the reality is yes, you don't perhaps you don't need the humans, but for autonomous agents to be able to orchestrate these tasks, they need access to that AI training corpus, that key corpus that I keep saying links the clinical context with the actions taken and the outcomes achieved, that longitudinal de-identified labelled action aware data layer that I'm talking about.

And that ladies and gentlemen is the moat that we are talking about creating here. No matter what happens in that scenario, yes, the pricing model of SaaS, which is true in even TruBridge's case, will eventually change from per user per month to an outcome-driven pricing. But even in the world of fully autonomous interconnected agentic orchestration of all the tasks in our system of action, if that were to be a reality.

First it gives us an opportunity to be the leader to build that ourselves. Second, what it does is even if that were to come, it moves us from a SaaS pricing model to an outcome-based pricing model and guess what IKS at its core already has experience with the outcome-based pricing model. So I think it was really, really important for me to lay out this strategic rationale, which is the core of why we are embarking on this transaction in the first place.

And then just to summarize the benefits of the integrated model Saransh if we go to the next slide. They could be summarized in five buckets. You have uniloed real-time data, the users don't need to switch from one application to the other, there is a closed-loop virtuous continuous learning cycle that gets built into that AI training corpus, which is that whole writing back as sort of labelling the as you write back the data you're labelling it.

The other thing that it does is starts to build the cross-client AI. So think about what you learn about a payer in one client, how that's applicable towards another client, you can start to build all of that in a cloud-native AI-first system of action. And then over a period of time, think about the ecosystem advantages that it starts to build and the stickiness that it creates.

So I really feel like as we execute on this strategy for the very large, the niche but large and very important rural healthcare market in the US, this puts us in a unique position to truly become a dominant integrated system of record and platform system of action player that is a very, very long-term defensible thesis over a period of time.

That's the high level of the strategic rationale. Again, this is a conversation that I'm happy to continue to have. I would ask everybody, if you're genuinely interested in the company, please try to internalize it. I know I've been accused in the past of perhaps using too much jargon and so please in the questions or otherwise, if you think I'm still using too much jargon, challenge me/

Challenge us and we will try to keep simplifying it so that you really understand because the core of the value of this transaction outside of the obvious financial value will lie in our ability to demonstrate and make this happen more than anything else. With that, diving a little into the transaction overview. So IKS is buying TruBridge, which is listed on the NASDAQ, for an overall enterprise value of \$557 million, which is about \$427 million in equity value and then we inherit their debt of about \$130 million.

That will lead to a total debt of a little under \$600 million for IKS at the time of closing, which we have secured for a 5-year term on a fairly decent interest rate of a SOFR plus 275 bps, which eventually slides down to SOFR plus 175 bps as our leverage ratio keeps coming down. And this puts our starting leverage at a little over 3x EBITDA, which traditionally speaking I would say is a bit more than I'd genuinely like.

But I think given the strategic rationale and the rapid pace at which we think we can deleverage

through internal accruals given that the deal is instantly EPS accretive at close and there is a whole bunch of opportunity to drive both synergies and growth in that niche but very large rural healthcare market, we feel very, very confident and comfortable because along with this, you know, right at the very start, we also end up with nearly a 5x interest coverage on the EBITDA that we will be generating pre-synergies.

So I think that's the fundamentals of the transaction. Quickly about TruBridge, like I was saying, trailing 12 months 2025 calendar year, which is also their fiscal year, \$347 million in revenue, about \$126 million of that comes from the EHR business and about \$221 million comes from the RCM business. That demonstrates that they were one of the early visionaries to say that you have to build at least a partial system of action deeply integrated with the EHR to truly be able to bring the relief that these healthcare providers need to make them both financially viable, but then also be able to, as you expand the system of action, enable providers to do more with less.

The other thing that's very interesting about TruBridge we'll delve into is that for every piece that they've embarked into, they've taken a tech-led approach. So they've built technology not just in the EHR but also in all the three dimensions of their cycle: front office, middle office, and back office. Doing all that, they've been delivering an adjusted EBITDA of about \$69 million in fiscal 25 and obviously the opportunity to continue to grow that.

Next slide, I think very important, the deal is, like I was saying, expected to be PAT and EPS accretive instantly at close. And that is demonstrated by the fact that the combined business, if you take trailing 12 months calendar 25, would be about \$698 million in revenue and \$159 million in EBITDA, but really \$186 million in EBITDA when you adjust out a couple of items from TruBridge's \$43 million EBITDA \$9.5 million in ESOP costs which will obviously go away.

And then several non-recurring expenses that will naturally go away, a large expense around being a public company in the US, some large expenses around one-time consulting services that they were using. So when you do that, their adjusted EBITDA really adds up to \$69 million. Ours continues to be \$117 million because we don't generally adjust our EBITDA. And so together we start off at \$186 million EBITDA on about \$698 million in revenue at close.

And when you take the \$69 million EBITDA, put the \$36 million of interest cost for the SOFR plus 275 for the \$565 million of debt that is attributed to this transaction of the total \$600 million debt, and then based on our estimates of the amortization of acquisition intangible assets and the recurring depreciation that they have on their capex, it starts to instantly be accretive to the tune of about \$5 million.

Now obviously these numbers will hopefully probably get a little bit better because the final actual enterprise value of the transaction might change a little bit from that \$557 million because it's a function of how much net debt they have at the time of close. This \$130 million of net debt was at March 31st.

And so given that it's probably going to take somewhere between three to four months to close this transaction, that \$130 million, given that they're a cash flow generating business, that \$130

million of debt will come down, which will then take down our total debt or possibly the debt attributable to this deal and the interest cost associated with it. So certainly will be EPS accretive from the get-go even prior to any synergies whatsoever.

That's a little bit of a high-level overview of the transaction itself. Let's dive into the market, why do we think this is an interesting market even though it's a difficult market from the market's own financial performance. First, let's just talk about, see, again, I just want to remind everybody when we talk about our platform system of action, there's about 16 to 18 tasks depending on which market it is that we delegate out of the provider's workflow and do for them better, cheaper, faster at scale, right? These are the chore tasks.

Now of that, there are probably about seven to eight tasks that can be grouped together to call them RCM tasks across the front office, middle office, and back office. For these seven to eight RCM tasks, the reality is that the RCM market is still highly fragmented. The top five players have less than 20% market share, there's 400-plus players, and then there's a massively long tail. So, there's really no significant leaders that have emerged across the healthcare continuum on the revenue cycle.

And then when you look at the rural hospital RCM market, the way to think about it, like I was saying, is the rural hospital market is about \$164 billion of the \$1.75 or \$1.8 trillion of the overall hospital market. And they spend, we have taken a take rate just on these, remember, on these seven or eight RCM tasks. This is not our full platform system of action, this is just the RCM part of it.

We're taking a take rate of 2%. Why are we taking two percent? because today's take rates, by the way, in their business are even higher, they're closer to 3%. But we're modeling it at 2% because we believe that as we ourselves build agentic AI-based orchestration of tasks that can be orchestrated autonomously or even with some human in the loop, there will be some price compression, so we took a very, very conservative number. That itself comes to about a \$3.5 to \$4 billion RCM TAM within these rural hospitals.

Now the revenue that's running through TruBridge 's 700 hospitals is about \$32 billion of the \$164 billion. So remember, there's 2,200 hospitals, TruBridge operates in the small hospital segment of that market, so 0 to 50 bed hospitals, and those 700-odd hospitals drive about \$32 billion of revenue. And taking that sort of 2% odd take rate, that creates a \$660 million immediately addressable TAM. And TruBridge's RCM revenue is around \$220 million, so it creates about \$450 million of white space in their captive install base.

Please keep in mind that \$450 million is assuming some rate compression, which, you know, we can't predict how quickly that would happen, so we've just taken it a little bit conservatively. And so that becomes the immediate low-hanging fruit that we can go after to drive growth in the TruBridge customer base.

It's a simple cross-sell of, you know, the other thing that, you know, you might recall is but we had also thought of doing cross-sell in the Acuity deal, it took longer than expected. I think there's one big distinction here: the buyer of the electronic health record is the same as the buyer of the revenue cycle. The buyer of the electronic health record is the CEO, the CFO, and

the CMO.

The buyer of the revenue cycle is the CEO, CFO. And so we're not going to now cross-sell a new service into a different part of their organization, and that creates a whole different type of immediacy in the opportunity that it creates from a growth perspective. So this \$450 million-odd is going to be just the immediate low-hanging fruit.

Now when we start to model the other tasks that are part of our platform system of action and those being cross-sold also into the TruBridge EHR install base, that \$440-\$450 million number expands dramatically. We think in the immediate term it becomes close to \$600 million, but then even expands dramatically.

The other thing that's interesting is there are already several other rural hospital customers where TruBridge is providing RCM services or the RCM system of action independent of their EHR. Now that gives us another growth avenue as we continue to build on that, that creates because that market overall is about a \$3.5 billion RCM market, the rural healthcare market.

Even if you take out the TruBridge install base of \$660 million, you're still talking about a \$3 billion hospital market on which there is about 30% penetration. So there's a \$1 billion outsourced rural hospital market, and that's growing at 12% to 13%. So in addition to the RCM cross-sell in the TruBridge customer base, there is also RCM selling opportunity in the non-TruBridge EHR install base. Again, something that IKS knows to do from its legacy business.

So that's one of the big growth drivers in this opportunity. Just to give you a quick sense of the technology stack for RCM, like I was saying, TruBridge has always taken a tech-first approach in whatever system of record and system of action that they have built. And so they have very significant technology interventions, proprietary technology interventions across the front, middle, and back office of the revenue cycle.

All the way from patient engagement tools like Get Real Health to their own clearinghouse, which by the way is not only going to be useful in orchestrating the revenue cycle for TruBridge, but also parts of that clearinghouse would be relevant in our traditional ambulatory business.

Remember, in our traditional ambulatory physician business, we use outside third-party vendors as the clearinghouse. Now if we're able to repurpose TruBridge's clearinghouse in those settings, that will also give us some cross-leverage there. And then there's a very exciting tool that TruBridge owns called TruCode, which is a coding assistance tool. And that actually is a pure SaaS model that's been growing pretty significantly over the years. And we actually believe that the TruCode tool, while it's a very integral part of their revenue cycle offering, is also sold stand-alone outside of the TruBridge customer base.

In fact, traditionally IKS has been one of the customers of TruCode, which is a coding assistance tool, it's a tool that coders use to deliver better, more accurate, compliant coding. And so the potential market in which one can sell the TruCode tool actually itself is about \$650 million TAM, and so one of our endeavors will be to accelerate that sales motion.

And then last but not the least, they've got some very interesting analytics technologies that they have on the back end of the revenue cycle, like Viewgol. So a comprehensive front-to-back revenue cycle platform of action, which is remember about 8 of the 18 tasks of our overall platform system of action, which is truly technology-led.

So the revenue cycle is the predominant vector of growth. As you know, the EHR market is highly sticky and highly mature, and so just anyways let's take a quick look at the EHR market. And the EHR market, like I was saying, has about 2,200-odd rural hospitals, of which 700-odd are TruBridge clients.

Now given that those 700 tend to be the smaller hospitals, they're highly dominant, they have 40% market share in that 0 to 50-bed hospital range, and that's where TruBridge tends to operate, they have about \$32 billion of revenue flowing through those customers. So overall, 40% penetration in the 0 to 50-bed market and about between 25% and 30% penetration, closer to 30% penetration in the overall rural hospital market.

What this does is it creates two other vectors of growth opportunity. One, as we modernize and truly take their EHR architecture to a cloud-native AI-first technology architecture, what this will do is it'll allow us to go penetrate more dominantly some of the other 0 to 50-bed hospitals, but slowly even perhaps go upstream into the 50 to 200-bed hospital range, which then becomes a growth market.

And so those would be the two vectors of growth as it relates to the EHR market, which will be a slower vector of growth than the RCM market, which really will be the biggest vector of growth. And then in addition to RCM, there will be the other features in the platform system of action that IKS has that we'd be able to bring.

A quick overview on the overall tech stack that TruBridge has and what are some of the key competitors. Like I was saying, the RCM stack has technology interventions across the front, middle, and back office. There are some pure-play RCM players, they're not systems of record, they're not even really systems of action, but they are much more human BPO-type of RCM players like Med-Matrix and CorroHealth that one often runs into in this rural hospital market segment.

On TruCode, which is their encoder SaaS technology, coding assistance technology, the two major competitors are 3M and Optum. What's interesting is that lately we've seen TruBridge take market share in a small way from 3M and Optum, which are the dominant players in this space.

We've already spoken about the EHR. Like I was saying earlier, we were very careful to look for niches where there is no competitive angle at all with the Epics of the world, the Athenas of the world, the eClinicalWorks of the world, the NextGens of the world, with whom we need to integrate deeply in our other legacy part of the business, which is the physician business. So we definitely did not want to create even the semblance of a dynamic of competitiveness there.

And so the only two EHRs that are meaningful competitors in the rural hospital market tend to be MEDITECH and then Oracle, which is basically Cerner. As they lost market share to Epic in the large health system space. They've been trying to come downstream into this space, not so

successfully, but really MEDITECH has been the more successful player in this space. So I would say the rural hospital market is already a mature market and nearly already mature enough to be just a two-player market between TruBridge and MEDITECH, with Oracle trying to be the challenger to the two main incumbents, which are MEDITECH and TruBridge.

And then what they are doing, obviously, because they have not been able to build their own comprehensive system of action outside of RCM, they are using other vendors to complete their system of action. For example, for virtual clinical documentation or ambient clinical documentation, they are partnering with, you know, the Microsoft-owned company called DAX.

There are obviously other players even in rural healthcare that are pure-play documentation systems of action like Augmedix and Abridge and Ambience Healthcare. And then of course on the patient engagement side where they actually have their own technology play, which I think we'll be able to bolster dramatically with our latest AI-led autonomous patient engagement technology that we've built, is players like Phreesia, which is a publicly traded company in the US.

But again, I think especially in markets like these, these rural hospitals have no appetite for buying point solution tools outside of the system of record that don't work in the native system of record. So I think we'll have a very, very distinct advantage here.

I'll end this section by saying, like I was saying earlier, the TruCode encoder, which is a coding assistance tool, of which IKS itself is a customer, actually has potential well above and beyond the TruBridge install base. And it really is shown in scenarios where autonomous coding -- agentic autonomous coding, will not be a reality because remember one thing: Generative AI is a non-deterministic technology. Coding is a deterministic outcome.

So Generative AI will not be able to solve coding in a fully autonomous way in most of the specialties. Very few specialties might get really close to autonomous. And so coding assistance is going to be a reality in the world of medical coding for a long, long time, and hence TruCode Encoder becomes a really interesting growth vector opportunity not only in the TruBridge install base, but in the entire healthcare continuum, if you would.

So that's an overview of TruBridge and the growth vectors. Again, the biggest growth vector and the most immediate is continuing to grow the RCM platform of action, or the RCM part of the platform of action, in their installed base, EHR installed base. Take the RCM platform of action to the non-EHR installed base within the rural healthcare setting, and then start to also sell other features of IKS's platform system of action into their EHR installed base because they're already plugging in other partners in that installed base.

So those would be the three big low-hanging fruit growth vectors to start with. And then of course as we modernize the EHR and truly build it in an integrated cloud-native AI-first system of record plus system of action, there'll be a real, real opportunity to then manifest all of the other features of our system of action outside of revenue cycle in the TruBridge EHR installed base.

Last but not the least, value creation. So again, I just want to reiterate, the biggest driver of this

transaction for us is to create a long-term strategic moat that truly puts us at the forefront of leveraging AI to magnify our impact versus perhaps being concerned about what AI does to us. I think that that is a very, very, very critical part of the value creation. But before I dive into the specifics of the overall vectors of value creation, let's just look at how TruBridge and IKS are better together.

Let me go to Slide 21; first of all, customer segments. As you know, IKS traditionally was focused on ambulatory care, which is physician groups, single specialty, multi-specialty, and large health system-owned physician groups. And now more and more so, we are doing end-to-end platform deals with mid-sized health systems as well and their physician groups. So that's been the traditional IKS market. Like I was saying, the TruBridge market, which is the rural and community hospitals, which is predominantly 0 to 200, but some in the community are even under 400, that is the TruBridge core market.

So there's complete complementarity, and yet a lot of the other features of our care enablement platform, which is our platform system of action, are applicable to the TruBridge install base because even though they are hospitals, 60% to 70% of the work that is done in the hospitals is ambulatory in nature, which is the work that our system of action is built for. Again, so a complementary market but a market in which our core capabilities are very, very relevant.

And then last but not the least, from a delivery standpoint, they really are a strong local presence company. We are truly an entity that has been able to build a strong blended delivery model for the human-in-the-loop part of our platform that leverages the right combination of talent in the US and India to deliver most cost-effective outcomes. And I think that is a huge complement that we will bring to the TruBridge operating model and their success over a period of time.

So net-net, I think a creation of a very complementary organization that creates a long-term strategic moat for us, the four key vectors to summarize are: one, like I was saying, having a deeply embedded EHR system of record in such a large, but niche market segment that is already mature actually creates a tremendous long-term moat, especially as we modernize that EHR and convert their data into what I keep calling this AI training corpus.

I think it's a huge opportunity. That AI training corpus then allows us to actually execute on this AI-first strategy so that we can truly leverage AI as a tremendous tailwind. And in recognition of that, we're actually launching the start of building a small language model. We'll start with an acute RCM small language model.

Now why a small language model? Small language model has two benefits, right? It starts to build its own -- it's built out of its own proprietary data, and over a period of time it reduces the cost of compute, right? So otherwise you're leveraging the LLM, the data is no longer proprietary because the LLM has access to all of that data.

In a small language model that sits on top of the LLM, now the data is proprietary, it's a self-learning loop, and the cost of compute is much lower because you're using the LLM much lesser, it's this SLM sitting on top of the LLM that is actually driving a lot of the Generative AI that you're going to use to orchestrate.

We'll start on the RCM side and then we'll expand these SLMs into other tasks in our platform system of action over a period of time. Growth opportunities, like I said, low-hanging fruit growth opportunity is the RCM part of the platform system of action cross-sell into the TruBridge customer base and then adjacent to their customer base, the 50 to 200 bed customer base.

And then actually going from RCM to other features in our platform system of action, including but not limited to our ambient scribing product. And then of course that \$650 million plus market potential for TruCode, which consists of opportunities even outside TruBridge installed base that can be leveraged. And all this, we have a pretty large, further scalable efficient operating platform with 17,000-plus people, of which 2,000 are clinically trained, 800-plus technologists.

So we can really accelerate both the modernization of the electronic health record and then leveraging that modernization to dramatically and rapidly build I think a one-of-its-kind industry-first integrated platform system of action and system of record that is cloud-native, that is AI-first, that is able to have the best chance to agentically intelligently orchestrate interconnected workflows to delegate all these chores of healthcare so that providers can focus on their core.

Of course, from a synergy perspective, there'll be opportunities on G&A, there'll be significant opportunities from a delivery transformation perspective. TruBridge obviously has a significant headcount in the US doing the human-in-the-loop as it relates to RCM, there'll be opportunities there. And obviously that gives us confidence in some of the financial opportunities that this transaction creates.

And you know, in addition to this very important strategic rationale, which then creates a truly defensible long-term moat that leverages AI versus the one that worries about AI, we also thought that we will combine that with giving you all a sense of where we can take the business financially.

And as you know, trailing 12 months December 31st, 2025, we're about a INR1,000 crores EBITDA business with a net debt of about INR300 crores. And we feel like while it is not easy to predict the exact trajectory of our runway over the next 3 to 4 years because there's so much work to do, there's also so much more to learn.

I feel like we've learned enough through the process of bringing this transaction together that we feel comfortable to say that we should be, in my -- and please, I want to caveat this again and again, this is not a guidance, and I know that even if I say that you guys will assume whatever it is, but this is our true north.

This is the financial manifest of all the execution that I talked about, all the vectors of growth, all the vectors of the strategic transformation of the EHR, creation of that AI training corpus moat, the financial translation, all the synergies that we've already envisioned, all the operating transformation.

We think that we would be disappointed with ourselves perhaps. Of course, there's still more to

learn, if by the end of FY30 we've not delivered something in the range of a INR3,000 crores EBITDA and gotten our net debt levels back to -- the net debt levels that we were at in December 2025, which eventually is very close to zero in the larger context.

So I think, net-net makes for a very, very exciting growth opportunity and one that is strategically defensible in the true medium to long-term, makes us an undeniable leader in a niche, but very large and important market segment like rural healthcare, allowing us to continue to bolster our strength in the ambulatory setting, which is our traditional physician group setting.

And in order to just -- when we put our -- when we did our bottom-up math and we arrived at this number of nearly INR3,000 crores of EBITDA potentially, we said, how do we gut check this number because when you just look at it, it suddenly feels like, "Oh my god, you're tripling your EBITDA in 4 years, it's like 31% CAGR from December 2025 to March 2030."

But when you put it in perspective, if we look at our 10-year trajectory at IKS, as we go to the next slide, please. Look at our 10-year trajectory at IKS, we've actually delivered 28% revenue growth and 33% EBITDA CAGR. So that gave us the confidence that it's kind of in line with the type of growth that we've been able to deliver.

If you remember even when we acquired AQuity, which really is one of the proofs of our abilities to do a large transaction, at the time of closing the deal, the pro forma EBITDA was 24%, we were able to take that to the early to mid-30s in a little over 4.5, 5 quarters. We were able to integrate two equal-sized companies into one significant organization.

One of the learnings was that the cross-sell took longer, we analyzed why it took longer and we applied those learnings here to say why will this cross-sell work versus that one taking longer. Remember I said the buyers in the AQuity cross-sell were very different. We were cross-selling features of our platform to a totally different buyer base within the large customer organization than we would be selling here, the buyers are exactly the same.

So we learned that through the AQuity transaction. And yet, over a period of time, we have now started executing multiple cross-sell deals even in the AQuity install base, one that we just sold recently was in -- towards the end of Q4 that is going to be announced soon.

So I feel like we do have an organic and an inorganic execution track record that makes us feel like embarking on what will be this very strategic journey to create a very exciting long-term defensible story to improve healthcare in the US.

Next steps, going into the transaction, we signed the agreement yesterday. It's expected to take 90 to 120 days to close. In that timeframe, we absolutely operate like totally independent companies, focus on our individual objectives, work through the regulatory approval process, which includes the HSR approval from the FTC, which is the Federal Trade Commission.

Once the transaction closes, we anticipate a 4 to 5-year, four to five quarter integration process where we start combining ourselves into one company. And we've factored all of that into sort of this 4-year journey that I just described to you all a couple of minutes ago.

That's really where I'll end the conversation with the last slide. Again, I would say our traditional moat was we were building the only platform system of action. As we evolved, we understood that the platform system of action moat needs to be further bolstered by if we were to combine it in niche markets with the system of record, that would make it really long-term defensible.

Here we have the opportunity to be able to do that and really build an AI-first integrated platform system of action system of record. TruBridge specifically has some exciting growth opportunities within its install base that we will rapidly work on.

And together I think we'd have created an industry-leading scalable and efficient operating platform which I really believe will be the new operating system at least for rural healthcare and then continue to build upon our traditional physician install base.

So I will pause there at this point and I guess turn it over to the operator and we can go into the Q&A.

Moderator: Thank you very much. We will now begin the question and answer session. We will take the first question from the line of Keyur Ladhawala from ValueQuest. Please go ahead.

Keyur Ladhawala: Yes. Thanks for the comprehensive commentary and congratulations to Sachin and the management team on the acquisition. Sachin, my first question to you was, can you give us some color on the competitive intensity in the rural segment across both the EHR and RCM verticals? Can we leverage IKS's learnings and deep domain expertise to enhance TruBridge's right to win in the rural segment? And also if you could help us understand what is the existing overlap between the RCM and EHR clients?

Sachin Gupta: Super. Thank you for the wishes, Keyur, and for the thoughtful question, I appreciate it. Saransh if you don't mind going to Slide 18 so that I can answer Keyur's question on the competitive intensity. So Keyur, as if you're able to see the slide, what we've done is we've laid out the key competitors across all of the key offerings that TruBridge has within the rural healthcare market. So let's first focus on the EHR, right in the middle.

Like I was trying to say, the EHR market is already very mature for the rural healthcare setting. I think it's already more or less a two-player market with TruBridge and MEDITECH being the leading pairs and Oracle after some of the setbacks they've had in their traditional Cerner large health system market segment.

They've been coming a little bit downstream to try and play in this rural market. So if you want, the way to think about it is TruBridge and MEDITECH are the two dominant incumbents and Oracle Cerner is a challenger. I couldn't tell you yet, I'm not smart enough or not close enough to say whether Oracle is a worthy challenger in this space or not, but they are certainly trying to make inroads from an EHR perspective.

So I feel like that the EHR install base that they have is pretty stable, as it anyways mostly is in mature markets like this. And I think actually if we're able to modernize the EHR rapidly, we'll be able to perhaps even capture market share further. Second, if you look at the other big growth opportunities in the RCM stack, the RCM part of the platform system of action and

honestly Keyur really there, it is really like MEDITECH, for example, does not really have an RCM offering at all.

In fact, prior to this transaction, MEDITECH was having conversations with us about whether we should combine our RCM capabilities and our RCM part of the platform system of action with their EHR. So they don't have an RCM offering. Oracle has formally exited the RCM space after trying it twice.

And so what you have is what I call the sort of pure-play BPO vendors, if you would, Med-Metrix and CorroHealth, that are trying to focus on this small-to-mid rural hospital market. And so I would say that at least in the 700-odd hospitals where the TruBridge EHR is installed, it creates a very, very defensible and competitive right to win for TruBridge.

And I think you also asked what is the penetration of TruBridge in their current EHR install base from an RCM perspective. And in that current install base like I was saying of a 650 million they're about \$220 million, so about 30%. So about 230-240 hospitals of their 700 EHR install are today buying RCM from them.

So it creates a pretty large white space from RCM. So in those 700, the right to win is dramatic, which is the lowest-hanging fruit growth opportunity for us. And where IKS will further bolster their right to win in that install base is that we have a much more efficient global delivery model.

TruBridge has done its own attempts to build its own captive presence in India, but has really not had that much success. And one of the other complementary natures of this thesis is the fact that IKS already has an optimized offshore-enabled delivery model for the human-in-the-loop part of RCM.

So I think in that RCM stack, the right to win in the balance 500-odd hospitals where the RCM doesn't exist is dramatic. And then even beyond the 700, which is another 1,500 hospitals in the rural setting where TruBridge already has 300 customers, 400 customers, there is an opportunity to actually go full-stack RCM there even if the EHR is not installed. So I think tremendous rights to win there.

As it relates to encoder, which is their TruCode business, there are two very large players, 3M and Optum, but given how large they are, they've actually become sort of aircraft carriers. So I will say that in the encoder business, you can think of TruCode as a challenger rather than the incumbent.

But what we've seen is over the last 2 to 3 years, there's been tremendous growth in that business and including IKS, for example, using TruCode. So I think given that many companies tried to completely autonomize medical coding and failed when they realized that it's a deterministic outcome that GenAI really can't service by itself.

I think the encoder or the TruCode opportunity is significant. On clinical documentation, obviously, if this transaction closes as you can imagine we would manifest our entire Scribble suite in their entire install base and because of their EHR incumbency, their take on that is just a no-brainer, I mean the customers are dying for it.

And we will install it in a way where it's not just a post-visit ambient clinical documentation but it's a true co-pilot, like I was saying earlier. And then on the patient engagement side, while they have good technology and by the way Phreesia has been generally struggling in the market.

Our patient engagement is already winning against Phreesia and others in the marketplace. It's actually one of the most successful parts of our platform system of action lately, especially as we rolled out our latest version, which is an AI-first and which consists of a patent-pending technology as well.

And so I do think that there is an IKS offering. So think about it as in the clinical documentation and patient engagement the IKS offering will bolster their right to win dramatically. EHR continues to have a right to win which we will mature, encoder they are a challenger to the market, but they are gaining momentum and RCM we'll really, really have a tremendous right to win in their EHR install base and IKS's combination with them will enhance their right to win in even their non-EHR install base. Hope this answers your question, Keyur.

Keyur Ladhawala:

Yes, it does. Thanks, Sachin. And secondly so while you've laid out the rationale of the merger and the value creation opportunities quite well, could you also quantify the synergies that on the basis of your initial workings are likely to flow in?

Sachin Gupta:

So, that is the one thing I don't want to do, Keyur, right? I mean, the reason why I put out a 4-year True North is because what I don't want to do is, look, it is a strategic transformative acquisition. It will have short-term learnings, surprises. I can tell you that if you look at my track record and our company's track record and our management's track record as a public company over the last five quarters that we've declared.

As a company even before we went public, we try to be in the space where we like to under-promise and over-deliver. And hence we intentionally took this strategy of putting a 4-year True North, but I will tell you that when we put a 4-year True North, we factored in a certain amount of uncertainty in the short term, learnings in the short term, mistakes perhaps new mistakes, hopefully not the same mistakes in the short term.

And we still feel like this 4-year True North is what we feel that will be a good definition of success for us. I really would like to avoid going into the specifics of the journey from INR1,000 crores to INR3,000 crores in terms of what are the key drivers. I've given you the growth vectors, you understand already that this is a 40-year-old company with a very large G&A.

There'll be synergies in G&A, they still have a very largely US-centric RCM delivery model. Remember they have 2,000-plus RCM FTEs between actually 3,000 RCM FTEs between US and India already of which 1,000-plus are in the US. So, obviously that creates both operating and G&A synergies, but again let's not go into the specifics.

Give me what I ask of all of you is this is a strategic transformation. This is creating a long-term defensible strategic moat with a lot of thought and carefulness. I've put a 4-year True North, very hard for me to give you even further details even before the transaction has closed.

- Keyur Ladhawala:** Understood. No, fair Sachin. Thanks a lot and wish you all the best.
- Sachin Gupta:** Thank you,
- Moderator:** Thank you. We will take the next question from the line of Aashray Vasa from Nippon AIF. Please go ahead.
- Aashray Vasa:** Hey, hi, hi morning. First of all, thanks for explaining the strategic rationale very, very clear. Two questions. First on, I mean our track record with AQuity suggests we are very strong at turning around, you know, slightly low-margin businesses, but my question is, how difficult is it to do what TruBridge does organically? I mean in the sense of access to rural etc., the EHR etc. Just trying to understand organically does it take too much time?
- Our four-year plan etc., is it just a thing that the opportunity came and we have taken it? That's the first one. And the second one is on TruBridge itself. Obviously the valuation multiple seems favorable for us in the sense their market cap etc., it's been struggling slightly in the last year from a market cap perspective. 6% CAGR over five years, 1.3% last year revenue growth, and there are some when I read about the recent results, there are some issues with regards to retention of customers, contracts, some you know, guidance that's on the revenue front. So just trying to understand the rationale from a seller's point of view? Yes, that's it. Thanks.
- Sachin Gupta:** Okay, great. Thank you for those questions, Aashray. I guess the first part of the question was to put it simply, the timing of the synergies. And as you can imagine, we're not going to provide the details of when the timing plays out. We've provided a four-year timeline. And so as you can imagine, there'll be some synergies that are realized very quickly, right? We talked about significant synergies of being a public company, I mean it's a pretty significantly large number.
- Synergies around ESOP costs, other G&A synergies that'll get realized easily within sort of the first year of operations. Then there is the nature of synergies that are operational, right? Like I said, there's a huge RCM transformation opportunity both from a tech and globalization perspective. Now those synergies obviously take some time because you have to work with the customers to transform the customers, first get the customers comfortable about how they will get transformed from a delivery model perspective and then walk the customers through that journey, hold their hand through that journey.
- So I would say that the G&A synergies will probably come in ahead of the operational synergies. But I feel like, you know, over a two and a half to three year period all the synergies should be fully tucked in. And that's probably as much as I can say about the timing of the synergies.
- As it relates to TruBridge's own performance and the multiple that they are commanding in the market or not commanding in the market, look, I think the simple reality is that like I said earlier, they have tried two attempts in the past at globalizing their RCM operations. And they have been less than successful at those two attempts.
- So one of the complementary natures of this transaction was that IKS already has I won't necessarily call it a perfect but a highly optimized onshore-offshore delivery model as it relates to RCM and significant tech interventions in addition to the tech interventions they've already

built. And so I think that was a very attractive aspect of the thesis, if you would, was that the one area where they have struggled in leveraging a globalized model is a strong suite of IKS.

The other challenge that they had is because they were struggling in that area, you know, their ability to invest significantly in what needs to happen in the EHR from a modernization perspective, building other features of the platform system of action like clinical documentation, became a strain and a drain on their financials. And obviously with IKS coming in, one we already have those features, second, we have a much more agile as well as cost-optimized model to build technology rapidly as well.

So I think all of those together really were becoming important parts of the combination and that's where the arbitrage in the multiple lies, is that, you know, one of the things that we said when we did AQuity was we're starting off as 24% pro forma, we'll get to early to mid-30s in we had said at that point between two to three years. We actually got there faster than we had thought and we actually got further than where we thought we were going to get.

So I feel very similar, you're going to start off with 26% combined pro forma here and, you know, we feel like we'll be in the early 30s, you know, relatively rapidly. And that's how the synergies will play out and that's what makes it attractive.

Now why did they decide to sell? Because I think they've realized that these core competencies are going to be critical and they felt like finding a partner that is able to bring these capabilities natively to them is a much better idea than continuing to try this to try to do this a third time after having tried to do it twice. They tried to first do it through an acquisition of a company called Viewgol, which didn't work very well, and then second they tried to do it in a captive way with using consultants that were helping them and that didn't go well either. So that's sort of the way to think about it.

Aashray Vasa: Got it, perfect. Just on the first one, so organically it would have taken a lot of time and effort to get access to the rural hospitals, physicians, etc.? Just trying to understand, yes.

Sachin Gupta: I'm sorry, were you saying that our ability to drive growth in their install base?

Aashray Vasa: No, no, I'm saying without TruBridge could we have just as an organic entity got access into, yes, the rural part of, yes?

Sachin Gupta: No, no, even if we would have, we would not have gotten access first of all, you're talking about 700 hospitals in their customer base. To sell across 700 hospitals would be a decade, right, number one. And number two, the strategic thesis, where we would be the only company in the world that's truly building an integrated system of record with a platform system of action which is super defensible, that also made it tremendously attractive. So yes, I think doing this organically would be next to impossible.

Aashray Vasa: Perfect, perfect. Thank you so much, all the best.

Sachin Gupta: Thank you.

Moderator: Thank you. We will take the next question from the line of Vishnu Gopal from Marcellus

Investment Managers. Please go ahead

Vishnu Gopal:

Yes. So congrats on the acquisition. And I just had a question regarding the nature of the client. So just wanted to understand, like, what are the nuances of the RCM management between, let's say, a larger hospital system versus the rural healthcare system? That's one. And the second part of the question was, I mean, when the AQuity acquisition was consummated, you had mentioned that the long-tail clients were kind of getting rationalized to focus on the larger guys. So but in the rural healthcare system, by nature all the clients are smaller in size. So how do you look at rationalization or the lack of it in those client base? And does it also signal even in the organic business a readiness to focus on the smaller clients going ahead? Thank you.

Sachin Gupta:

Great, great questions, Vishnu. Thank you so much. So I think let me take the second part of your question first, which is our ability to handle a large number of small customers. And as you know, there are already 700 hospitals in their EHR install base, and most of the RCM is delivered to customers in their EHR install base. Now while IKS does not have a traditional track record of handling a large number of small customers, but we like handling a small number of large customers, Vishnu, the difference here is this: all of the RCM customers are operating on the same operating system, which is their EHR.

So what happens is even though the number of customers is large, the type of work that you're doing the RCM for, which is all rural hospital care delivery, which is very similar to physician care delivery by the way, the type of work is the same. And second, all of it is being done in their one EHR.

Now in the traditional IKS business, when we have the small number of large customer thesis, that is because what happens, Vishnu, is there each of the customers often is in a different system, which is the system of record is different, so we have to integrate with a different system of record because we are Switzerland, right?

And the type of care delivery that they are doing is different, right? We have single specialty customers. Within a single specialty, there's derm, there's GI, there's urology, there's ophthalmology, all of that, right? So each of those is different in nature. Then there's multi-specialty, then there's hospital-owned medical groups that have a totally different orientation.

So the beauty here is the type of work that we're doing RCM for, number one, and the system on which we're doing RCM is all one, which allows us for 80% of the work to treat this as one large customer and drive a lot of efficiencies. So even though there are 300 small RCM customers, they're all on the same system with the exact same type of service delivery, which is rural healthcare of which 70%-80% is outpatient. It allows us to build that standardized engine and treat them as one large customer.

Now for the balance 20%, yes, we have to create a slightly differentiated customer management layer where each of the customers will feel like they are being treated uniquely, and that investment for managing the customers differently has already been factored into our plan.

But I think it's very important, I think your question is brilliant to know that why does IKS feel comfortable in managing a large number of small customers in the TruBridge customer base

when traditionally in the IKS business or even in the AQuity business, we were not comfortable handling a large number of small customers. But I hope this clarifies, because it's a very, very important distinction.

Vishnu Gopal: Sure, this clarifies. And just on the nuances of the RCM business between larger hospital systems and the rural hospital systems.

Sachin Gupta: Yes. So clearly, like I was saying, these rural hospital systems, even though they are hospitals, 70% of the care being delivered is outpatient care, which is IKS' traditional strong suite, right? Physician delivery, physician-based outpatient care is IKS' strong suite. The balance 30% also, if you really think about it, is critical care but there is no really tertiary, quaternary care, specialty surgeries, complex surgeries.

Those type of infrastructure doesn't exist in rural settings at all. That's where the RCM for tertiary, quaternary care can get a little bit more complex. That's why when we analyzed the RCM capabilities needed to do justice to these rural hospital settings, they are very proximate from a capability perspective to the strengths that we already have and that's how we were comfortable.

Nithya Balasubramanian: And it's also important to note, I think Sachin mentioned this earlier, that for a larger hospital system, because of the scale, what they end up spending on RCM is somewhere in the zip code of 4% to 5%. That's almost double in a rural community hospital. They end up spending somewhere in the zip code of 7% to 10% on RCM. So the value proposition from outsourcing becomes even more stronger for these smaller hospitals.

Vishnu Gopal: Great, great. Thank you and wish you all the best.

Sachin Gupta: Thank you, Vishnu.

Nithya Balasubramanian: Thank you.

Moderator: Thank you. We will take the next question from the line of Chirag Kachhadiya from Motilal Oswal Financial Services. Please go ahead.

Chirag Kachhadiya: Yes, hi, Sachin. I have one question. As you mentioned, the integration will take four to five quarters' timeframe. Can you specify the steps or actions you will take to, you know, integrate the operations of this TruBridge?

Sachin Gupta: Okay. So, look, I think there's obviously a significant amount of work involved in the integration, right? And so the first aspect of the integration is to learn. And given that we are both public companies and from an FTC perspective, the Federal Trade Commission perspective, we really can't do too much work prior to the close of the transaction. So the first two, three months will be to really understand the operating nuances of their structure and work with them together to arrive at what a combined operating structure would look like. That's the first thing.

Then maybe by Q2 post-close, we will start embarking on making our journey towards that new operating structure, start to realize some of the G&A benefits of a combined operating

structure, and slowly but surely start to embark on the operational transformation. Probably, it'll be early Q3 by the time we start the operational transformation. Because we'll also, you know, a big part of the first two quarters will be meeting with their customer base, understanding the nuances of the customer base.

It's always fun to have an outside-in view. But when you dive in, the inside-out view becomes much more informative and instructive about the nuances that have to be applied in how you do this. And so I would say Q1 post-close learning, Q2 actioning, start to combine into one organization structure, start to realize G&A, really start to understand the customer base, and perhaps towards the end of Q2, early Q3 post-close is when we start actioning the operational transformation.

There's also a lot of work to be done in understanding the next level details of the tech debt, you know, what it will take to overcome the tech debt because a big vector of this will be to modernize the EHR and move it to a true cloud-native AI-first model. So there's the tech piece, yes. And we do all this in a way where we keep a keen focus on one, customer retention. Customer retention is key. That's the gold mine of this transaction.

Second, talent retention. The key talent will have to be identified in the first quarter and retaining the talent will be critical. And third, as we embark on our transformation, how do we keep a keen eye on energizing growth again? So I think those would be the three key vectors of or three key considerations that we will keep in mind as we embark on the integration effort.

Chirag Kachhadiya: Okay. And Sachin, if we look at the employee -- total number of employee headcount in TruBridge versus our entity, I mean, and if we compare it with the overall revenue which both these entities make, I mean, there's a vast difference. So why is that?

Sachin Gupta: Simply because that's what I said, right? The EHR business is a pure tech business. So that really has a very, very low marginal cost. And even the RCM business, like I said, is highly tech-led. And so that's really where the magic is, right? And this is even before they've made it truly AI-first.

And so that's what I keep saying is having that system of record combined right now with the platform system of action for RCM and eventually all the systems creates a fundamentally different leverage in how much human-in-the-loop you need to be able to orchestrate these actions, and that's what you see as evidence in their numbers. They are a tech organization.

Chirag Kachadia: Okay, all the best.

Sachin Gupta: Thank you, Chirag.

Sachin Gupta: Let's take the next question. We'll come back to Vamshi when he's able to.

Moderator: Thank you. We will take the next question from the line of Abhishek Gupta from Axis Asset Management Company. Please go ahead.

Abhishek Gupta: Good morning, Sachin sir. Thank you so much for the explanation on the acquisition and the presentations. So sir, just to start with, you know, just give me an example like how does this EHR capabilities which you are acquiring differentiate from the other EHR bodies like Epic and all, and how are you going to take these capabilities towards the bigger hospital and all?

Sachin Gupta: So actually, Abhishek, that is not our intent at all. We are not trying to take this EHR capability to the bigger hospitals. What we're doing is we are taking the EHR that is already installed in the small hospital base and we're going to deeply integrate our platform system of action with the EHR to make it a combination that becomes highly sticky and defensible and both financially advantageous to the customers and to us over a period of time.

We are not envisioning taking this EHR to large hospitals. The only endeavor will be once we modernize their EHR, we will attempt to take it from the 0 to 50 beds, which is where they're strong, to the next segment, which is sort of the 50 to 200 beds. But the idea is not to take it to the large hospital segment at all.

In fact, in that segment, we don't even want to be known as an EHR player at all because there we integrate our platform system of action with the prevalent EHRs in that market, so there is no question of trying to drive that EHR in that market.

Abhishek Gupta: Sir, last question from my side is just that we -- as we have always said that we will grow faster than the industry. And as the both companies get combined are we still maintaining that guidance?

Sachin Gupta: Okay, so I think somebody has background. See on the growth, like I said, I need two-three quarters to better understand this market once it closes to know what exactly the growth trajectory will look like in the rural healthcare market. We're not changing our aspirations in our traditional market segment at all. That market segment, which is the physician group market segment, we are continuing to say we will want to continue to capture market share, which means we'll grow faster than the 12% that the industry is growing at.

In this market, I think and that's why I've put out a four-year true north on the earning side, because I don't want to make the mistake of prematurely being able to tell what the growth trajectory will look like. I'm very confident or rather fairly confident on where I think the margin trajectory of the business will go. But on the growth, I want to wrestle with the growth for two-three quarters after close and then I'll have a better understanding of what the growth will look like in the TruBridge traditional rural healthcare.

Moderator: We will take the next question from the line of Madhuchanda Dey from MC Pro.

Madhuchanda Dey: I have some very fundamental questions, pardon me for my lack of understanding of this acquisition. So the first question is, as you mentioned, that the first low-hanging fruit for you would be to take the RCM to the hospitals where they are not present but present with the EHR. And the second stage would be to take it to the larger audience where they are not present at all but within that range of smaller hospitals.

So my question is, what makes you confident that your RCM solutions will be superior to the competitor or put it differently, what does this acquisition bring to the RCM solution which was

not there? Is it something to do with technology, something to do with cost? If you could just shed light on that?

Sachin Gupta:

Yes, so look, I think in the install base where they already have the EHR, when we integrate our RCM stack deeply with the EHR for example, if you like I was calling out the denial prediction engine, right? Now what is RCM? In the end, you send claims for the care that was provided to the insurer, the insurer pays you for the claims or denies the claims. If they deny the claims, you have to work on those claims and still try to get them collected by providing supporting documentation, changing coding, whatever it is right? And so it's a very reactive cycle.

Now if you're deeply integrated in the EHR on a real-time basis at the point of charge entry, at the point of clinical documentation, if you are able to predict through this AI training corpus that we would have created by in a compliant way leveraging the data in the EHR, which has both the clinical context but also the labelling of the actions taken and the outcomes achieved from those actions, you will now start to predict denials. If you predict denials correctly and you fix them at the point of care itself, then when the claim goes out, it doesn't get denied at all.

And fundamentally that transforms the RCM outcomes. Also, it reduces the cost of the RCM because you don't have to do that much effort at the back end, right? So I think it totally transforms both the outcomes and the cost of the RCM, which if you do not have deep integration into the system of record, you are not able to do those things on a real-time basis even if you were able to produce those insights asynchronously. So I think that would be one clear example of an RCM intervention through this integration that fundamentally transforms both outcomes of RCM and cost of outcomes.

There are obviously several other interventions like those that come into play, including but not limited to the real-time coding interventions. The real-time clinical documentation interventions, the whole process of prior authorization within the revenue cycle that often leads to a whole bunch of uncompensated care. So a bunch of examples like that. Really good question and hopefully this example gives you a sense of why our right to win in the TruBridge EHR customer base through the deep EHR integration of our RCM stack fundamentally transforms outcomes and cost.

Madhuchanda Dey:

But my question is, this TruBridge is already a technology company, why could they not do it on their own?

Sachin Gupta:

Yes, and I think that's where I was trying to go with this earlier is that, remember, in this platform system of action, it needs tech but it also needs human-in-the-loop. All the human-in-the-loop that they've generally had has been in the US. And that creates a different type of a cost structure. And it really needs globalized human-in-the-loop to successfully orchestrate this because remember, some of these interventions are not autonomous from a technology perspective.

It's tech plus human-in-the-loop. And the human-in-the-loop TruBridge in all candour has not been able to execute successfully from a globalized human-in-the-loop perspective, which IKS has the expertise around and that we will bring again as a complementary strength to the process.

Madhuchanda Dey: So it's basically your global delivery model that will be a great help to them, right? To this entity. The last question that I have is that you are already a user of TruCode as you mentioned, as IKS, right? So what value do you add to TruCode through this acquisition? I mean, because you mentioned something like a \$650 million kind of opportunity.

Sachin Gupta: Yes, so look, first of all, what we bring is yes, can you hear me, ma'am?

Madhuchanda Dey: Yes, sure. Yes.

Sachin Gupta: Okay. Yes, so the way to think about it is one, if you look at IKS's traditional customer base, it's the large physician groups and the large health systems. TruCode is a very applicable product for all of those. So the value we bring to TruCode is an access to that market that TruBridge never had access to, right? So it allows us to bring TruCode as an offering to the large hospitals and the large health systems and the large physician groups, which TruCode never had access to. That's number one.

And the second, we are executing coding at a very different scale than TruBridge does themselves. And so remember TruCode also is a tool that continues to learn. And hence all of the work that we are doing in coding will now become a virtuous feedback loop into TruCode and we keep enhancing the rules that are embedded in TruCode and allow it to assist better and better over a period of time. So two things: one, the market of the large systems and the large physician groups. And two, all the feedback of coding at a different scale than the scale that TruBridge has.

Moderator: Thank you. We will take the next question from the line of Chetan Shah from Jeet Capital. Please go ahead.

Chetan Shah: Yes, hi. Sachin and team, congratulations on a great acquisition. Just one specific question. Can you just quantify the size of opportunity? We know the addressable opportunity for IKS is \$200 billion plus, but post this acquisition, what's the size of the cake will look like? That's the only question I have. Thank you.

Sachin Gupta: So you're talking about what is the additional TAM that we get from this transaction?

Chetan Shah: Yes, Sachin. Yes, yes.

Sachin Gupta: Yes. Sure. So, like I said, it's a combination, right? So when you look at the TruBridge EHR install base, the TAM opportunity in just their EHR install base is about \$600 million for our platform system of action. A large part of it comes from RCM, but there are other parts of our system of action that also would get installed in their install base potentially. So, there's at least a \$600 million opportunity in their EHR captive install base.

Now when you expand that opportunity into their non-EHR RCM customers, that multiplies very rapidly because like I said, that is already a \$1 billion outsourced market growing at 12% to 13%. And so, depending on what share of that market we are able to capture, that outsourced market itself is about \$1 billion today, and that total market is about \$3.5 billion to \$4 billion. So that becomes another market, an adjacent market in the rural hospital setting that we can sell to.

So, this is I would say maybe the serviceable obtainable TAM immediately, lowest-hanging fruit is a little north of \$600 million, and then there's a \$3 billion plus TAM of rural hospitals that are very adjacent that could also be TruBridge's customers but not EHR customers, that also becomes part of the TAM.

Chetan Shah:

Yes, thanks. And just for my clarification, our existing set of offering which we do traditional opportunity, can this be getting integrated into our newer business which we acquired and getting it merged, and will that expand the size of the TAM as an overall offering, maybe, you know, four quarters down the line or six quarters down the line once everything gets integrated?

I'm just trying to understand that apart from a completely new vertical as a business opportunity, are we also expanding our existing offering itself as a size of TAM so that, you know, if one wants to look at the business from a decade point of view as a strength and opportunity? Some color on that.

Sachin Gupta:

Yes, the way to think about that would be that our platform system of action as a percentage of the rural hospital's revenue overall would be at least about 5% of their revenue. So if you really think about it in the TruBridge install base, if our full platform system of action were to be installed, that itself becomes about \$1.5 billion. The full platform manifest.

And so that's when if you're talking about our capabilities fully manifesting into TruBridge's install base even outside of RCM, that becomes about a \$1.5 billion opportunity in their EHR install base.

Moderator:

Thank you. We will take the next question from the line of Vamshi Krishna from Kotak Securities. Please go ahead.

Vamshi Krishna:

Hi, thanks for the opportunity again and congrats on the acquisition, Sachin. So most of my questions on the business have been answered. Just one question on the calculation of pro forma earnings. I think TruBridge also had around \$12 million impact from amortization of acquired intangibles related to the acquisition that you alluded to. So why has that not been included in the calculation?

Saransh Mundra:

No, so Vamshi, as you know, right, the entire thing will go into the pot. So, if you look at their schedule, right, their schedule was on a reducing trend over the next few years. What will happen now is that the separate parts of the business, which is the EHR business and within the financial health, maybe the coding and the and the financial health business, will get evaluated separately and based on the length of the relationships that they've had with their customers, a new asset life will be created, right?

So, while you see historically what the numbers were, it was on a declining trend. And what we've now put is sort of a constant number, and we can discuss that in more detail. But as you know, right, this is also going to be validated again by valuation experts. But that's it for now.

Vamshi Krishna:

Okay. So, the PAT accretion of \$5 million, so is there a revision to that number likely given the higher charge and that...

Saransh Mundra:

There might be minor uptick or downtick. But again, see, we haven't taken any synergies in that

PAT accretion, right? I mean, our interest cost we've assumed at the highest possible levels...

Vamshi Krishna: I understand that, Saransh. Just the \$12 million number is a little large compared to the PAT accretion that you have mentioned. So that's where I was just wondering what the number could have been for FY '27.

Saransh Mundra: We don't expect that number to, yes, Vamshi, we don't expect that number to move significantly.

Vamshi Krishna: Understood.

Moderator: Thank you very much. Ladies and gentlemen, we will take that as the last question for today. For any further queries, you may reach out to the Investor Relations team of IKS Health Limited. I now hand the conference over to Mr. Saransh Mundra for closing comments. Over to you, sir.

Saransh Mundra: Thank you everyone, thank you for joining at such short notice. If you have any more questions, please feel free to reach out. My details are there on the Press Release and most of you have my contact.

Sachin Gupta: Yes, and thank you for all your support and interest so far, and we're excited about this next phase of journey to create a truly differentiated leader in now two segments of the US healthcare market and one that has probably a most effective defensible and competitive moat over a period of time. Thank you everyone. Bye-bye.

Moderator: Thank you members of the management. On behalf of ICICI Securities Limited, that concludes this conference. Thank you all for joining us today and you may now disconnect your lines. Thank you.

Please note that this transcript has been edited for readability.