IDH Finance plc

Annual report for Bondholders

Year ended 31 March 2014

Contents

Presentation of financial data

This report summarises consolidated financial and operating data derived from the audited consolidated financial statements of Turnstone Midco 2 Limited, the parent company of IDH Finance plc. The financial information provided has been derived from our records for the years ended 31 March 2014 and 31 March 2013 which are maintained in accordance with UK GAAP.

The report includes the period prior to the closing of the notes offering by IDH Finance plc, which took place on 30 May 2013 ("closing").

We have not included financial information prepared in accordance with IFRS in this Annual report. UK GAAP differs in certain significant respects from IFRS. These differences could be material to the financial information included herein. See "Risk factors—Risks related to our indebtedness and the Additional Notes—We have not included any IFRS or US GAAP financial information in this Annual report". A summary of certain significant differences between UK GAAP and IFRS that our management believes could have a significant impact on our financial statements is included in "Summary of certain differences between UK GAAP and IFRS".

Non-UK GAAP financial measures

We have presented certain non-GAAP information in the Annual report. This information includes "EBITDA", which represents earnings before interest, tax, depreciation, amortisation and one-off exceptional and strategic items. Our management believes EBITDA is meaningful for investors because it provides an analysis of our operating results, profitability and ability to service debt. EBITDA is also used by management to track our business development, establish operational and strategic targets and make important business decisions. EBITDA is the measure commonly used by investors and other interested parties in our industry.

We have also included other measures in this Annual report, some of which we refer to as "key performance indicators" ("KPIs"), including EBITDA margin, gross profit margin, NHS dentistry services turnover as a percentage of total turnover, total annual UDA delivery percentage, UDA contract uplift (as defined herein), private dentistry services turnover as a percentage of total turnover, like-for-like private turnover growth, administrative expenses as a percentage of turnover and total number of dental practices. We believe that it is useful to include these non-UK GAAP measures as they are used by us for internal performance analysis. These other non-UK GAAP measures should not be considered in isolation or construed as a substitute for UK GAAP measures in accordance with UK GAAP. For a description of certain of our KPIs, see "Management's discussion and analysis of financial condition and results of operations—Description of key line items—Other financial information (non-UK GAAP)".

Information presented in this report and described as like-for-like excludes any practices or other operating units trading in the group in the current financial year or the year ended 31 March 2013 but not in both.

References to "Integrated Dental Holdings", "IDH" and "the group" refer to Turnstone Midco 2 Limited and all of its subsidiaries.

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Forward-Looking Statements

This Annual report includes statements that are forward-looking in nature. Forward-looking statements involve known and unknown risks, uncertainties and other factors which may cause the actual results, performance or achievements of the company to be materially different from any future results, performance or achievements expressed or implied by such forward-looking statements.

Summary

Integrated Dental Holdings ("IDH") is the leading provider of dental services in the United Kingdom. Our dentists offer a broad range of primary care dental services in our dental practices, including dental examinations, fillings and extractions, as well as more specialised dental services such as cosmetic dentistry and orthodontics.

During the year ended 31 March 2014 we have taken some significant strategic steps:

- The acquisition of 60 additional dental practices to increase our network from 532 to 585 dental practices throughout England, Scotland and Wales.
- The acquisition on 16 April 2013 of the Dental Buying Group ("dbg"), a healthcare services business, operating a membership model targeted at primary care providers. The services provided include equipment maintenance and calibration, training and compliance and introductions for insurance, card processing, payment plans and employment law.
- The refinancing of bank facilities and some shareholder loans through the issue of £200 million of Senior Secured 6% Notes, £125 million of Floating Rate Notes and £75 million of Second Lien Notes.

Financial Highlights

- EBITDA before exceptional items for the year ended 31 March 2014 increased to £67.8 million, 20.3% up on the year to 31 March 2013.
- Turnover was £407.5 million, with year on year turnover growth of 16.8% predominantly driven by acquisitions throughout the year.
- UDA delivery percentage increased from 96.0% to 96.7% for the year ended 31 March 2014.
- Like-for-like private turnover growth was 8.6%
- Gross margin percentage was 48.3% for the year ended 31 March 2014, an improvement of 0.9% from the year ended 31 March 2013.
- Administrative expenses, excluding depreciation, goodwill amortization and exceptional items, as a percentage of turnover was 32.0%, an improvement of 0.2% from the year ended 31 March 2013.
- Pro-forma EBITDA at 31 March 2014, adjusted as if the acquired dental practices and Dental Directory had been part of the group at 1 April 2013 was £84.8 million.
- Operating cash flow for the year ended 31 March 2014 was £54.8 million, 13.4% of turnover.
- Maintenance capital expenditure for the year ended 31 March 2014 was £17.9 million.
- Normalised cash conversion adjusting for one-off items in working capital and maintenance capital expenditure was 78.9%.
- Cash and cash equivalents at 31 March 2014 was £6.9 million and net debt was £401.6 million.
- Gearing levels are 5.93 times LTM EBITDA and 5.66 times pro-forma LTM EBITDA with debt adjusted for the 2014 additional issue of Floating Rate Notes.

Q4 Financial Highlights

- EBITDA before exceptional items of £19.1 million for the three months ended 31 March 2014 ('Q4 FY14'), an increase of £3.0 million or 18.7% from the three months ended 31 March 2013.
- Turnover for Q4 FY14 of £106.7 million with year-on-year turnover growth of 13.1%.
- Q4 FY14 like-for-like private turnover growth of 8.4%
- Gross margin percentage for the three months ended 31 March 2014 was 48.4%, an increase of 0.7% from the three months ended 31 March 2013.
- 20 practices were acquired during the quarter.
- Operating cash generated of £18.2 million in the three months to 31 March 2014.
- Maintenance capital expenditure for the quarter ended 31 March 2014 was £5.1 million.

Recent developments

- Post year-end, in connection with our strategy to drive value and grow our business through acquisitions of suppliers of consumables, materials, equipment and services, on 17 April 2014, we acquired HM Logistics Limited ("The Dental Directory"), a distributor of dental consumables and materials to dental practices throughout the United Kingdom. The Dental Directory distributes a catalogue of up to 27,000 products from its central logistics platform through its on-line and mail order service, including dental consumables, specialist products including orthodontics and oral hygiene and implant products and dentistry equipment ranging from dental chairs and cabinetry to digital imaging systems. The Dental Directory also carries out services such as installation and maintenance and has a handpiece repair business. For the year ended 31 December 2013, The Dental Directory had adjusted sales of £103.9 million and adjusted EBITDA of £8.7 million. The Dental Directory Acquisition increases our presence in the consumables, materials, equipment and services supplier market business that we began with the acquisition of dbg on 16 April 2013.
- Subsequently, we have refinanced the drawdown from our Revolving Credit Facility used for the purchase of Dental Directory through the issue of a further £100 million of Floating Rate Notes.
- In addition, since 31 March 2014, the group has acquired a further seven dental practices.

Certain definitions

In this Annual report:

- "2013 Issue Date" means 30 May 2013, the date on which the Existing Notes were issued;
- "2013 Notes Issuance" means the issuance of the Existing Notes on the 2013 Issue Date;
- "2014 Issue Date" means 9 May 2014, the date on which the Additional Notes were issued;
- "2014 Issuance" refers to the offering of the Additional Notes;
- "Additional Notes" means the £100.0 million in aggregate principal amount of the Issuer's senior secured floating rate notes due 2018 issued under the Senior Secured Notes Indenture on the 2014 Issue Date;
- "Area Team" means one of the local teams that act on behalf of NHS England in each of their respective 27 areas of England, with responsibility for primary care contract management;
- "BDA" means the British Dental Association;
- "BidCo" means Turnstone Bidco 1 Limited;
- "Board" or "Directors" means the Board of Directors of EquityCo;
- "Carlyle" means The Carlyle Group;
- "CMA" means the United Kingdom's Competition and Markets Authority;
- "Collateral" means the share capital of the Issuer and each of the Guarantors, and substantially all the assets of the Issuer and the Guarantors, in each case as is more specifically described under "Description of the Senior Secured Notes—Security";
- "CQC" means the Care Quality Commission;
- "Dental Directory Acquisition" means the acquisition by us on 17 April 2014 of all of the issued shares of H M Logistics Limited, a supplier of dental products, including orthodontics, oral hygiene, surgical accessories and equipment throughout the United Kingdom, which trades under the business name "The Dental Directory";
- "Department of Health" means the UK Department of Health;
- "EquityCo" means Turnstone Equityco 1 Limited;
- "EU" means the European Union;
- "Euro" or "€" means the lawful currency of the Member States of the European Union participating in the European Monetary Union;
- "Existing Notes" means the Existing Senior Secured Notes and the Second Lien Notes;
- "Existing Senior Secured Floating Rate Notes" means the £125.0 million aggregate principal amount of the Issuers senior secured floating rate notes due 2018 issued in connection with the 2013 Notes Issuance;
- "Existing Senior Secured Notes" means the Existing Senior Secured Floating Rate Notes and the Senior Secured Fixed Rate Notes;
- "Floating Rate Notes" means the Existing Senior Secured Floating Rate Notes and the Additional Notes;
- "FSMA" means the Financial Services and Markets Act 2000;
- "GDS Contract" means a general dental services contract with NHS England;
- "Guarantees" means the Senior Secured Notes Guarantees and the Second Lien Notes Guarantees;
- "Guarantors" means the Parent Guarantor and the Subsidiary Guarantors;
- "HMRC" means HM Revenue & Customs;
- "IDH" means Integrated Dental Holdings;
- "IFRS" means the International Financial Reporting Standards;
- "Indentures" means the Senior Secured Notes Indenture and the Second Lien Notes Indenture;
- "Intercompany Loans" means the subordinated, payment-in-kind intercompany loans by which MidCo on-lent the proceeds of the Subordinated Shareholder Loans to the Parent Guarantor and by which the Parent Guarantor

on-lent such proceeds to BidCo, which were wholly repaid or capitalized in connection with the 2013 Notes Issuance;

- "Intercreditor Agreement" means the intercreditor agreement amongst the Parent Guarantor, the Issuer, the Trustee, the Subsidiary Guarantors, ING Bank N.V., London Branch, as facility agent, the lenders under the Revolving Credit Facility Agreement and the Security Agent dated as at 30 May 2013 to govern the relationships and relative priorities of, amongst others, the holders of the Notes and the lenders under the Revolving Credit Facility;
- "IRS" means the US Internal Revenue Service;
- "Issuer" means IDH Finance plc;
- "MidCo" means Turnstone Midco 1 Limited, a wholly owned subsidiary of EquityCo;
- "NHS" means the UK National Health Service;
- "NHS England" means the independent national health services commissioning board, an executive non-departmental public body under the Department of Health in England, formerly known as the NHS Commissioning Board;
- "Notes" means the Senior Secured Notes and the Second Lien Notes;
- "Old Senior Credit Facilities" means the senior credit facilities governed by the amendment and restatement agreement relating to a senior facilities agreement dated 16 March 2011, amongst, *inter alios*, Turnstone Midco 2 Limited, Turnstone Bidco 1 Limited, ING Bank N.V., London Branch, The Governor and Company of the Bank of Ireland, Lloyds TSB Bank PLC and Société Générale, London Branch, as Mandated Lead Arrangers, dated as at 11 June 2012, which were repaid with proceeds from the 2013 Notes Issuance;
- "Palamon" means Palamon Capital Partners;
- "Parent Guarantor" means Turnstone Midco 2 Limited, the parent company of the Issuer;
- "PDS Contract" means a personal dental services contract with NHS England;
- "Pound", "pounds sterling", "U.K. pound" or "£" mean the lawful currency of the United Kingdom;
- "Predecessor ADP" means ADP Primary Care Services Limited and its consolidated subsidiaries prior to 11 May 2011;
- "Predecessor IDH" means Pearl Topco Limited and its consolidated subsidiaries prior to 11 May 2011;
- "Proceeds Loans" means the proceeds loans dated on or about the 2013 Issue Date and on or about the 2014 Issue Date from the Issuer to BidCo, representing the net proceeds of the 2013 Notes Issuance and the 2014 Notes Issuance respectively;
- "Prospectus Directive" means EU Prospectus Directive (2003/71/EC) (and amendments thereto, including directive 2010/73/EU, to the extent implemented in the Relevant Member State);
- "Qualified Institutional Buyer" or "QIB" has the meaning given by Rule 144A under the US Securities Act;
- "Qualified Investors" means persons who are "qualified investors" within the meaning of Article 2(1)(e) of the Prospectus Directive;
- "Registrar" means Elavon Financial Services Limited;
- "Regulation S" means Regulation S under the US Securities Act;
- "Revolving Credit Facility" means the revolving credit facility governed by the Revolving Credit Facility Agreement;
- "Revolving Credit Facility Agreement" means the £100.0 million super senior revolving credit facility agreement dated as at 20 May 2013, amongst, *inter alios*, the Parent Guarantor, BidCo and Credit Suisse AG, London Branch and J.P. Morgan Limited as arrangers;
- "Rule 144A" means Rule 144A under the US Securities Act;
- "Second Lien Notes" means the £75.0 million aggregate principal amount of the Issuer's 8 1/2% second lien notes due 2019 issued in connection with the 2013 Notes Issuance;
- "Second Lien Notes Guarantees" means the guarantees of the Second Lien Notes on a senior subordinated basis by the Guarantors;

- "Second Lien Notes Indenture" means the indenture governing the Second Lien Notes dated as at the 2013 Issue Date by and amongst, *inter alios,* the Issuer and U.S. Bank Trustees Limited, as Trustee;
- "Security Agent" means U.S. Bank Trustees Limited;
- "Security Documents" means the agreements entered into between, amongst others, the Security Agent, the Issuer and the Guarantors pursuant to which security interests in the Collateral are granted to secure the Notes, which as at the Issue Date will consist of (i) an English law governed debenture entered into by the Issuer and the Guarantors on or about the Issue Date, (ii) a Scots law governed bond and floating charge entered into by the relevant Guarantor on or about the Issue Date and (iii) a Scots law governed share pledge entered into by the relevant Guarantor on or about the Issue Date;
- "Senior Secured Fixed Rate Notes" means £200.0 million aggregate principal amount of the Issuer's 6% senior secured fixed rate notes due 2018 issued in connection with the 2013 Notes Issuance;
- "Senior Secured Notes" means the Senior Secured Fixed Rate Notes and the Floating Rate Notes;
- "Senior Secured Notes Guarantees" means the guarantees of the Senior Secured Notes on a senior secured basis by the Guarantors;
- "Senior Secured Notes Indenture" means the indenture governing the Senior Secured Notes dated as at the 2013 Issue Date by and amongst, *inter alios*, the Issuer and U.S. Bank Trustees Limited, as Trustee, as described in "Description of the Senior Secured Notes";
- "Sponsors" means, together, Carlyle and Palamon;
- "Subsidiary Guarantors" means those companies set out under "Listing and general information—Subsidiary Guarantors";
- "Subordinated Shareholder Loans" means the loan notes issued by MidCo to funds managed by Carlyle and Palamon in connection with our acquisition by them, in each case with the terms described in "Description of other indebtedness—Subordinated Shareholder Loans and Intercompany Loans";
- "Transfer Agent" means Elavon Financial Services Limited, UK Branch;
- "Trustee" or "Trustees" means U.S. Bank Trustees Limited;
- "UDA" means unit of dental activity;
- "UK GAAP" means the generally accepted accounting practices in the United Kingdom;
- "UK Government" means the government of the United Kingdom;
- "United Kingdom" or "UK" means the United Kingdom of Great Britain, Northern Ireland, Guernsey, Jersey and the Isle of Man;
- "United States", "US" or "U.S." means the United States of America, its territories and possessions, any State of the United States of America, and the District of Columbia;
- "US dollars" or "US$" means the lawful currency of the United States;
- "US Exchange Act" means the United States Securities Exchange Act of 1934, as amended;
- "US GAAP" means the generally accepted accounting principles in the United States;
- "US Securities Act" means the United States Securities Act of 1933, as amended; and
- "we" or "us" means the Parent Guarantor and its consolidated subsidiaries, unless the context requires otherwise.

Risk factors

The risks described below should be carefully considered, together with all of the other publicly available information regarding IDH in assessing any investment decision regarding IDH. The risks below are not the only risks facing IDH. Additional risks and uncertainties not currently known to IDH, or that IDH considers to be immaterial, may also materially and adversely affect its business or operations. Any of the risks described could have a materially adverse effect on IDH's results of operation and financial condition and its ability to service its debt including the Senior Secured Notes, the Floating Rate Notes and the Second Lien Notes.

Risks related to our business

Our business activities are exposed to significant health and safety risks, and we may also be subject to future liability due to unforeseen health and safety risks.

Health and safety risks are inherent in the services that we provide and are always present in the dental practices that we operate. Our business activities are, in particular, exposed to significant risks, relating, for example, to the transmission of infections (including blood-borne infections, such as HIV) and other risks, to dentists, employees and patients, associated with medical practices generally and dental practices specifically. If an incident occurs because of a failure to comply with health and safety regulations by us or our employees, we may be held liable or fined, and any registration certificates or licences we require to operate our business or our dental practices could be suspended or withdrawn for such failure. This may have a material adverse impact on our reputation, business, financial condition, results of operations and prospects. From time to time we have experienced health and safety incidents.

Our operations are subject to licensing and regulation under national and local laws and regulations in the United Kingdom relating to the protection of human and occupational health and safety, including those governing the handling and disposal of medical samples and biological, infectious and hazardous waste, as well as regulations relating to the safety and health of dental professionals and staff. Our dental practices are also required to comply with specific regulations for dentists, including sterilisation and decontamination rules. In addition, we must meet extensive requirements relating to workplace safety for personnel in dental practices who could be exposed to various biological risks such blood-borne pathogens (including HIV), which require work practice controls, protective clothing and equipment, training, medical follow-ups, vaccinations and other measures such as needlestick prevention.

Moreover, we could incur substantial costs and sanctions, including civil and criminal fines and penalties, enforcement actions, or the suspension or termination of our licences to operate as a result of violations of our responsibilities under these laws and regulations, which could have a material adverse effect on our business. We also may become subject to claims from employees or other persons, such as those alleging injury or illness resulting from exposure to materials they handle or to which they are exposed or to patients with whom they come into contact. Health and safety regulations are likely to become more stringent over time, and our costs to comply with these requirements are likely to increase.

We handle personal data including sensitive patient data in the ordinary course of our business, and any failure to maintain the confidentiality of that data could result in legal liability for us and reputational harm to our business.

We receive, generate and store significant volumes of personal data including sensitive information, including patients' medical information. We are therefore subject to privacy laws and regulations and related security protocols with respect to the use, transfer and disclosure of protected health information intended to protect the confidentiality, integrity and availability of such information, and the privacy of the individuals.

Privacy regulations and related security protocols establish a complex regulatory framework on a variety of subjects, including:

- the circumstances under which the use or disclosure of protected health information is permitted or required without the specific freely given consent of the patient;
- a patient's rights to access, amend and receive a statement of certain disclosures of protected health information;
- requirements to notify patients of privacy practices for protected health information;
- administrative, technical and physical safeguards required of entities that use or receive protected health information; and
- the protection of computing systems that store protected health information.

The European data privacy regime under the European General Data Protection Regulation also impacts us and our operations.

If we do not adequately safeguard confidential patient data or other protected health information, or if such information or data is or are wrongfully used by us or disclosed to an unauthorised person or entity, our reputation could suffer and we could be subject to significant fines, penalties and litigation.

We are exposed to litigation risks, including litigation risks related to medical negligence and disputes with employees.

From time to time we are subject to various actual and potential claims, lawsuits and other proceedings relating principally to breaches of contract, breaches of employment legislation, common law causes of action for civil damages, negligence and personal injury, and other claims. Some of the claims, lawsuits and proceedings against us may involve claims for substantial monetary damages and the cost of defending against such claims has been and may be significant. Moreover, such claims could divert our senior management's attention from our day-to-day operations and negatively affect our business. If we fail in defending such claims, it may result in substantial monetary damages, which may materially and adversely affect our financial condition and results of operations. Whether or not we are successful in defending against them, such claims may also cause significant damage to our reputation and result in decreased demand for our dental services, thereby making it more difficult to attract dentists or tender for new NHS dentistry contracts.

Although we believe that our dentists are solely liable in the case of claims alleging medical or professional negligence, claimants may attempt to bring us into proceedings in respect of such claims.

Failures of our information technology systems, including failures resulting from system conversions under the new NHS dentistry contract, could disrupt our operations and cause the loss of UDA claims, customers, patients or business opportunities.

IT systems are used extensively in virtually all aspects of our business, including reporting, billing, patient information processing and storage, logistics and the management of systems monitoring our performance. Our operations depend on the continued and uninterrupted functioning of our IT systems. As part of our efforts to increase our operational efficiency and leverage our economies of scale, upon each acquisition we have centralised and insourced a number of functions previously carried out by individual dental practices, including IT, compliance, regulatory, legal, finance, human resources, health and safety, risk management, talent sourcing, training, marketing, insurance and logistics functions. Whilst we believe centralisation and insourcing of these functions have made our operations more efficient, such activities have to a certain extent also made such functions more vulnerable to a catastrophic failure at the site or sites at which the IT systems underlying such functions are physically located. In addition, there is the risk that the process of centralisation and insourcing disrupts the normal functioning of our IT systems, resulting in losses of information or disruption to our operations. IT systems are vulnerable to damage from a variety of sources, including telecommunications or network failures, human acts and natural disasters. Moreover, our IT systems may be subject to physical or electronic break-ins, computer viruses and other similarly disruptive problems.

For example, in September 2013, we experienced an IT problem relating to dental practice back office management systems following a software upgrade. This temporarily disrupted our operations and resulted in lost clinical time, which was estimated at between £0.9 million and £1.1 million of EBITDA, though we were able to recover at least a portion of this lost time by scheduling additional sessions during the following quarter.

We record and claim UDAs via our IT systems. If possible changes to the NHS dentistry contract are implemented we could be required to update our IT systems to address changes under the new regime. UDAs may only be claimed under the contracts from which they arose if such claims are made within one contract year of the service giving rise to the UDA claim. If, whether due to our inability to update our IT systems upon changes to the new NHS dentistry contract or to a failure of our information systems or otherwise, we are unable to claim UDAs by the required deadline, such UDAs may be lost, and we may underperform on the applicable contract. The result of such underperformance may include reduction in UDA volumes or even the loss of such contracts, which could have an adverse effect on our business, financial condition and results of operations.

Failure to continue to comply with quality of care standards could adversely impact our reputation.

We are subject to a high level of regulation and oversight. The CQC is our primary regulator in England and Wales. The CQC sets quality of care standards that we are required to meet. Some of these standards are stringent, and require significant costs for us to comply with them. By law, our dental practices in England and Wales must be registered and licensed with the CQC to show that they are meeting certain essential standards of quality and safety. Non-compliance with such standards may result in a range of enforcement actions taken by the CQC, ranging from fines and public admonition to facility closure, and could materially and adversely affect our business, financial condition and results of operations. In addition to the cost of compliance and fines or disruptions to our business, non-compliance, or alleged non-compliance, may lead to unfavourable national press coverage, which could have

the effect of damaging our reputation with our patients and with NHS England, and which could materially and adversely affect our business, financial condition and results of operations. Such effects may be exacerbated if we brand our practices on a national scale and such coverage is leveled at our brand.

Our inability to attract and retain dentists, hygienists, nurses, practice managers and other key dental professionals could adversely affect our business, financial condition and results of operations.

The success of our dental practices depends on attracting and retaining qualified, skilled and experienced dentists, hygienists and nurses. Our success also depends on our ability to attract and retain qualified practice and regional managers, in addition to senior management at the group level. In the future, if competition for the services of these dental professionals increases, we may not be able to continue to attract and retain such dentists, or may only be able to do so at unsatisfactory rates. We have previously experienced periods in which a shortage of qualified dentists in the United Kingdom and our inability to fill vacancies had a negative adverse effect on our operations, and we may experience similar periods in the future. In particular, our ability to attract and retain dentists could be negatively affected by any adverse change in our reputation, which may be exacerbated if we brand our practices on a national scale. We may also experience localised shortages of dentists, as the availability and distribution of NHS dentists can vary widely across regions. For example, historically we have had, and continue to have, difficulty attracting and retaining dentists in the southwest of England. Vacancies, whether localised or on a national scale, result in lower rates of UDA delivery and may partly reflect variable levels of spending on NHS dentistry by the NHS, and thereby affect our ability to perform under our contracts and our results of operations. Furthermore, our plans for future talent sourcing and retention of highly trained dental professionals may not materialise or may be more expensive than expected.

Our business depends on personal relationships and the professional reputation of our dentists with patients who refer other patients to our dental practices. Dentists who have left our practices who have strong relationships with their local health community may draw business away from us. If we lose, or fail to attract and retain, skilled dentists, hygienists, nurses and other key dental professionals, our turnover and earnings could be adversely affected.

When necessary, we have attempted to overcome shortages in the supply of dentists, hygienists and nurses in the United Kingdom by recruiting dentists, hygienists and nurses from outside the United Kingdom, particularly from South Africa and Eastern Europe. If shortages in the supply of dentists, hygienists and nurses in the United Kingdom occur again, we may be unable to fill vacancies in the future if immigration processing and obtaining NHS and GDC approvals becomes more difficult, particularly for dental professionals who are not citizens of the EEA. An inability to fill vacancies with non-UK citizens during times of shortage of dental professionals in the United Kingdom could result in underperformance in our contracts and a corresponding loss of turnover or, if such underperformance is significant and persistent, decreased volumes under, or losses of, our NHS dentistry contracts.

In addition, foreign-trained dental professionals typically exhibit higher levels of turnover compared to our UK dental professionals; we spend substantial resources and time training our staff, and any increase in staff turnover in an industry where shortages in the supply of qualified dentists is common could increase our operating costs and impact the quality of the services we provide.

Any change to the legal classification of contracts under our operating partnerships could have a material adverse effect on our business, financial condition and results of operations.

Certain of our clinical directors act as partners in dental practices we acquire through partnership structures. This allows us to both exercise control over the partnership and maintain the NHS dentistry contract without NHS England's consent to assignment. If our clinical directors were no longer willing to be identified as partners in our dental practice partnerships, due to, for example, the risks and liabilities associated with acting as partner, and we were unable to replace them, we could effectively lose the benefit of the relevant NHS dentistry contract with the affected partnership. Additionally, as there is no direct contractual nexus between us and NHS England in respect of NHS dentistry contracts held by a partnership, payments for NHS dentistry services provided by a partnership have historically made directly to accounts that belong to the relevant partnership, and for certain dental practices we acquired in the past, we have no direct control over these accounts, other than through our clinical directors. While we have modified the payments structure for new acquisitions of dental practices that are partnerships, and are in the process of transitioning the payment structure across our estate, any loss of payments in the interim could adversely affect our revenues, and therefore our financial condition and results of operations. We rely on relevant NHS regulations that permit the transferability of NHS dentistry contracts between partners in a partnership to transfer contracts to our clinical directors. If such regulations were modified it could render us unable to transfer, and thereby benefit from, NHS dentistry contracts held by our partnerships. If we lost NHS dentistry contracts held by our dental practices organised as partnerships, which dental practices constituted approximately 22% of our practices at 31 March 2014, or the inability to transfer such contracts, it could materially and adversely affect our revenues, and therefore our financial condition and results of operations.

Our ability to grow our business relies significantly upon our acquisition strategy and there can be no guarantee that sufficient or appropriate acquisition opportunities will be available to us, that financing will be available on acceptable terms or that, once acquired, new businesses will be successfully integrated into our operations.

To date, our growth has been largely attributable to acquisitions of other small and medium-sized independent dental practices and their integration into our existing network. We plan to continue to expand our business organically through similar acquisitions. In the year ended 31 March 2014, we completed 60 acquisitions of dental practices, and in the year ended 31 March 2013, we completed 49 such acquisitions.

The success of our acquisition strategy depends on the ability of our senior management to identify suitable acquisition candidates, to accurately assess the value, strengths, weaknesses, contingent or other liabilities and potential profitability of such acquisition candidates, to obtain any necessary permits or approvals from bodies such as the NHS and the Competition and Markets Authority (the "CMA") to operate such acquisition candidates and to integrate the operations of such businesses once they are acquired. Our success in making additional acquisitions depends on the availability of, and competition for, suitable acquisition candidates. Successful integration of acquired practices will depend on our ability to effect any required changes in operations or personnel, and may require renovation or other capital expenditures or the funding of unforeseen liabilities. The integration and operation of any future acquisitions may expose us to certain risks, including the following: difficulty in integrating the acquired businesses in a cost-effective manner, including the establishment of effective management information and financial control systems; unforeseen legal, regulatory, contractual, labour or other issues arising out of the acquisitions; significant unexpected liabilities or contingencies arising from the acquisitions; potential disruptions to our ongoing business caused by our senior management's focus on the acquired companies; and post-acquisition performance not meeting our expectations or plans. There can be no assurance that our future acquisitions will be made on appropriate terms or at an acceptable cost or can be successfully integrated. A failure to identify appropriate acquisitions or to properly integrate them once acquired could have a material adverse effect on our business, results of operations, financial condition or prospects.

We are subject to competition legislation that affects our ability to acquire dental practices. Whilst the UK dental market is as a whole highly fragmented, we have a high market share of dental practices and UDAs in certain localities. The CMA, the UK's competition regulator, may review acquisitions we make for purposes of compliance with competition law. Following any such review, the CMA may prohibit us from making acquisitions in certain areas in which we have a high market share, or may require us to divest other dental practices if we do acquire new practices in such areas. This could limit our ability to acquire new dental practices and grow, particularly in markets we find attractive. If we do not comply with competition laws, we may be subject to significant sanctions.

On 8 April 2014, our largest competitor, Oasis Healthcare, announced its acquisition of our second-largest competitor, Smiles Dental. Following this acquisition we may face increased competition from Oasis Healthcare in the acquisition of dental practices, as well as other competitors.

We have historically financed acquisitions of dental practices through a variety of sources, including our own cash reserves and debt financing. Whilst we intend to continue to finance acquisitions from these sources in the future, we may have insufficient cash reserves to fund acquisitions and adverse market conditions or other factors may prevent us from obtaining debt finance on acceptable terms or at all.

If we are unable to implement our acquisition strategy, obtain sufficient financing or integrate acquired businesses successfully, our business and prospects for growth could be negatively affected.

We may face significant challenges in implementing our strategy to acquire supplier businesses.

In connection with our strategy to drive value and grow our business through acquisitions of suppliers of consumables, materials, equipment and services, we acquired dbg in 2013 and The Dental Directory on 17 April 2014. Although certain key members of The Dental Directory's management have agreed to continue their work with us, we as a group have historically focused our business on the ownership and operation of dental practices, and do not have significant experience as a group in operating suppliers and distributors of goods. There is a risk, therefore, that we will be unable to implement this strategy successfully and that we will be unable to achieve the cost savings or synergies that we expect from these or future acquisitions. For example, if certain of our competitors or other customers cancel their contracts with The Dental Directory due to our ownership of The Dental Directory, it would result in a decrease in The Dental Directory's EBITDA. Moreover, our existing suppliers may also react unfavourably to our acquisition of other suppliers by, for example, aggressively competing with suppliers we own as to price. The process of integrating these businesses and implementing this strategy will require the dedication of management resources that may temporarily divert management attention from our core dental practice business or other opportunities.

The Dental Directory, dbg and other consumables, materials, equipment and services supplier businesses we may acquire are characterized by risks different from those affecting our dental practices.

There are risks associated with supplier and distributor businesses generally and the dental and medical devices market in particular. Such risks include:

- Competition with other suppliers and distributors;
- Disruptions to supply, warehouse, transportation, logistics, IT or distribution networks;
- Product safety requirement compliance and product liability;
- Pricing and margin pressures; and
- Demand for the products in which these businesses specialise.

For example, in our dbg business, we have seen an increase in resignations of dbg's members for the membership renewal cycle from July 2013 to January 2014, which we believe is due to the end of a discounted membership scheme for general practitioners. We have also faced aggressive pricing from other materials suppliers in recent months, which has impacted dbg's sales of materials and dentistry-related equipment. Our inability to appropriately address such risks could make it difficult to implement our strategy, limit our ability to achieve expected cost savings or synergies, and have a material adverse effect on our business, financial condition and results of operations.

The CMA may review the Dental Directory Acquisition.

Notification of mergers is voluntary in the United Kingdom, and we did not seek pre-merger clearance for the Dental Directory Acquisition from the CMA. As such, there is a risk that the CMA may choose to open a review of the Dental Directory Acquisition (which it may do at any time in the four months following the public announcement of the Dental Directory Acquisition), which would potentially prevent us from integrating or effectively controlling The Dental Directory prior to the completion of any CMA review. In addition, the conclusion of any CMA review may result in the imposition of remedies, such as prohibition of the Dental Directory Acquisition, divestment of parts of The Dental Directory, the transfer of certain property rights, the regulation of prices or the requirement to give certain undertakings as to the method and standard of supply of products to competitors. The opening of a review by CMA or the imposition of any of these remedies could limit or entirely eliminate any benefit we expect from the Dental Directory Acquisition.

We rely on continued patient demand for dental care, and a decrease in patient demand could adversely impact our business, results of operations and financial condition.

Our future growth depends on our ability to maintain our existing high-quality services and, through successful sales and marketing activities, maintain increased demand for our dental services. Any number of factors such as health and safety incidents, problems in our dental facilities, negative media or social media coverage, or general patient dissatisfaction, whether legitimate or not, could lead to a deterioration in our reputation and the public perception of the quality of our dental services, which in turn could lead to a loss of business support for our operations. Any impairment of the value of our brand and registration could similarly have a material adverse effect on our business, results of operations, financial condition or prospects. Additionally, the possible transition to a new NHS dentistry contract and a business model that will focus more on quality care will make our UDA delivery more reliant on patient outcomes and feedback. Demand for our services, particularly for our private dentistry services, is also strongly dependent on macroeconomic factors. There can be no guarantee that demand for our services will grow or continue, and any decrease in demand and any such failure could have a material adverse effect on our business, results of operations, financial condition or prospects.

Our costs of operations are subject to price inflation, but UDA values, which make up a majority of our turnover, are subject to UK Government determination which may not reflect the actual inflation rate, resulting in increases to our cost of doing business that we are unable to pass on, which could adversely affect our results of operations and financial condition.

We are subject to price inflation in the purchase of our materials and services and to inflation in respect of the fees paid to our dentists and the wages paid to staff. At the same time, a significant portion of our turnover is paid under NHS dentistry contracts with prescribed annual adjustments for UDA values for inflation. Historically, the UDA contract uplift recommendations made by the Review Body on Doctors' and Dentists' Remuneration (the "DDRB"), an independent review body that made recommendations to the Department of Health, were implemented. However, in each of the years ended 31 March 2013 and 2014, the DDRB did not make recommendations as to contract uplift, and the contract rates were set by the UK Government. The UK Government has announced contract uplift of 1.5% in respect of the twelve months ended 31 March 2014 and 1.6% in respect of the twelve months ended 31 March 2015 in England (with an uplift of 1.47% in Wales and 1.71% in Scotland). If increases under our NHS dentistry contracts do not meet the price inflation and fee and wage inflation we experience in our business, the result would be an erosion of our profitability as the price we are paid for our services would decline in real terms. Depending on

the quantum of inflation we experience, this could have an adverse effect on our financial condition and results of operations.

We may be subject to claims for recoupment of amounts paid under NHS dentistry contracts.

We are paid for NHS dentistry services under each of our 507 NHS dentistry contracts in equal monthly instalments of our annual contracted value. As such, we may receive payment for services not yet rendered, or for services that will not be rendered. Following the close of the contract year, we may be subject to claims for recoupment of amounts paid under NHS dentistry contracts where we were overpaid in respect of underperformance of UDA delivery. If we are found to have been overpaid in respect of a NHS dentistry contract, such sums may be subject to recoupment by NHS England. Amounts claimed in respect of such recoupment may be significant, and if we do not have cash or financing available at the time the recoupment is required, it may be difficult for us to repay such amounts. In addition, if a dentist working in one of our dental practices fraudulently claims UDAs in respect of services not actually performed, we may be liable for reimbursing NHS England for amounts received in respect of such NHS dentistry contract, and we may be unable to effectively recoup our losses from the fraudulent dentist.

Certain of our operations are capital intensive and require significant capital investment and planning to support successful growth.

Our existing dental practices require expenditures on maintenance to repair ordinary wear and tear, to upgrade outdated equipment and to standardise the suite of dental equipment across our estate. For the year ended 31 March 2014, our maintenance capital expenditure was approximately £17.9 million. Similarly, acquisitions of dental practices also require a certain amount of upfront capital expenditure, with the average three-chair practice acquired requiring approximately £25,000–£75,000 in capital expenditure. When we grow organically through new contract acquisition and new builds, or merge together existing practices, considerably more capital expenditure, up to £300,000 or more, is required. Our central support functions, particularly our IT systems, also require regular capital expenditure. If we do not generate sufficient cash flow from our operations or have funds available for future borrowing under our existing credit facilities to cover these capital expenditure requirements, we may not be able to make such capital expenditures, which may negatively impact our competitive position and, ultimately, our revenues and profitability. Moreover, to the extent that our investments in capital expenditure does not generate the expected levels of returns in terms of efficiency or improved cost profile, or it takes longer to achieve such expected levels, there could be an adverse effect on our business, financial condition and results of operations.

We operate in a highly fragmented and competitive environment in certain geographic regions, and an inability to compete successfully with our competitors in these regions could result in a loss of market share, contracts or patients.

The dentistry industry in the United Kingdom is highly fragmented and competitive, particularly in certain geographic areas. Whilst we do not compete with any one competitor in each of the local markets in which we operate, our competitors include other national DBCs as well as regional and local independent dental practices, and we face current and prospective competition for patients and contracts from these competitors. In certain regions of the United Kingdom, we believe there has been an over-commissioning of UDAs, which has resulted in intense competition in those areas for patients. If we are unable to compete effectively, our business, financial condition and results of operations may be materially and adversely affected.

Whilst the market remains highly fragmented overall, on 8 April 2014, Oasis Healthcare, our largest competitor, announced its acquisition of our second-largest competitor, Smiles Dental. The acquisition resulted in Oasis Healthcare owning more than 280 dental practices, according to its announcement. We may face increased competition from this combined group, including in respect of acquisitions of dental practices.

Our inability to retain senior management could adversely affect our operations.

We rely upon the experience of our senior management team to identify acquisition opportunities, maintain relationships with key players in the dentistry industry and understand the technical and strategic elements of our business. Whilst we have attempted to establish policies and remuneration schemes designed to retain and properly incentivise our management team, no assurance can be given that these strategies will be effective in retaining key members of management. If one or more of our executives or other key personnel are unable or unwilling to continue in their present positions, we may not be able to replace them easily, and our business may be disrupted, which may materially and adversely affect our results of operations and financial condition. In addition, if any of our executives or other key personnel joins a competitor or forms a competing company, we may lose know-how and other key members of management, which may also have an adverse effect on our business, financial condition and results of operation.

Weakness in economic conditions could adversely affect demand for our services, which could in turn adversely affect our business, financial condition and results of operations.

An economic downturn in the United Kingdom or UK Government austerity measures would increase the risks associated with our business, including the risk of reduced levels of government funding for the NHS and the risk of a lack of demand for our dental services generally. Most patients, unless exempt, are responsible for contributing to the cost of the dental services they receive. Even if government funding for dentistry is not significantly affected, macroeconomic weakness and high unemployment rates may result in non-exempt patients who are unable or unwilling to make their required contributions to the cost of their dental services, thereby driving down demand for dental services and affecting our UDA delivery rates. More generally, a decrease in household disposable incomes, or the perception thereof, in times of economic downturn can lead to a reduction in individuals' healthcare expenditure, which has had and could have in the future a negative impact on more discretionary spending, such as spending on our private dentistry services.

We may fail to deliver UDA volumes under our NHS dentistry contracts, or we may reach those volumes over a longer period of time than originally expected, which could have a negative impact upon our results of operations and the financial performance of our business.

Many of our NHS dentistry contracts require the dental practice holding the contract to reach certain volumes within a certain period of time. If, whether due to underperformance, poor management, lack of demand or any other reason, a dental practice fails to meet 96% of its UDA volumes at least once every three years, volumes under the contract may be reduced, or the entire contract may be lost. In addition, as we are paid each month for 1/12 of the contract value under NHS dentistry contracts, any underperformance in terms of UDA delivery must be repaid to the NHS after the end of the contract year of underperformance. Significant underperformance could thereby result in large repayments to the NHS, and we may not have cash or financing available at such times to make such repayments, which could adversely impact our financial condition.

Loss of our ability to use certain properties subject to long-term leases through reclamation by the landlord could adversely affect on our business.

The majority of our dental practices are situated on leased properties. A typical lease has a term of approximately 15 years in length. As with all leases, the landlord is entitled to serve notice to reoccupy the property at the end of the lease term. If landlords in respect of such properties chose to exercise their rights under such clauses, our dental practices may have to relocate to an alternative site and find other surgery space, perhaps upon short notice. In particular, this risk could materialise in situations where the landlord is also a dentist who previously sold the practice to us. He or she may exercise his or her right to reclaim the leased surgery space and it may be difficult for us to reopen the dental practice in a timely manner and we would have the additional challenge of a competing dental practice in the space where our dental practice previously traded in the event the dentist secures an NHS dentistry contract.

Our business and results of operations are subject to seasonal factors, and extreme weather conditions can affect our levels of activity and hence our turnover.

Our patients are less likely to attend or make dental appointments during inclement or severe weather conditions, particularly when transportation is disrupted. During such periods, we tend to experience a decrease in demand for our dental services and a reduction in our turnover, particularly in UDA delivery rates. If such weather events occur near the end of the contract year, we may experience difficulty achieving our annual UDA delivery targets.

Our insurance may be inadequate to cover future liabilities and our insurance premiums may increase substantially.

We may be subject to significant losses from claims, liabilities, hazards and disasters. Whilst we currently maintain insurance which we believe is adequate and consistent with industry practice, we may experience losses in excess of our insurance coverage or claims not covered by our insurance. Furthermore, there can be no assurance that we will be able to obtain insurance coverage in the future on acceptable terms or at all. Any such losses not covered by insurance may have a material adverse effect on our financial condition and results of operations.

A substantial portion of our assets are represented by goodwill, and we may never realise the full value thereof or we may be required to write down the value of our goodwill.

We have recorded a significant amount of goodwill. Total goodwill, which represents the excess of cost over the fair value of the net assets of the businesses we acquire, was £614.8 million as at 31 March 2014, or 81% of our total assets.

We perform goodwill impairment testing on an annual basis. If we were to conclude that a future write-down of our goodwill is necessary, we would have to record the appropriate charge, which could result in a material adverse effect on results of operations. A write-down of our goodwill may result from, amongst other things, deterioration in our performance or a decline in expected future cash flows.

Changes in tax law related to the deductibility of certain types of interest may result in increased tax costs.

Under UK law, interest payments in respect of indebtedness are generally deductible from taxable profits. If, however, a company is considered thinly capitalised—that is, if it has more debt than it either could or would borrow acting in its own interests—the deductibility of interest on amounts of debt considered "excessive" (or greater than would arise if the company was acting at arms length from the lender) may be treated as distributions of equity instead of interest in respect of indebtedness for tax deductibility purposes. The determination of whether a company is thinly capitalised is made on the basis of a company's self-assessment, negotiated with HMRC, of its true, arm's-length borrowing capability, as if it were borrowing on a stand-alone basis from a third-party lender. Amounts of interest paid on debt in excess of such borrowing capability are treated as distributions on equity and are not deemed to be deductible for tax purposes. At present, we negotiate with HMRC the amount of interest under our Subordinated Shareholder Loans that is not paid on indebtedness in excess of our borrowing capability and that therefore may be deducted for tax purposes. We have an agreement in place with HMRC in respect of tax year 2012-2013 and are negotiating with HMRC regarding tax year 2013-2014. However, if the law were to change to standardise or reduce the amount of indebtedness considered "excessive", we may no longer be able to deduct as much, if any, interest accrued under our Subordinated Shareholder Loans, which would effectively increase the amount of taxes we pay on our taxable profits.

We may not be able to tender for new NHS contracts if we do not comply with applicable laws.

The UK Government has implemented a procurement policy requiring potential suppliers of goods and services to the government, including us as providers of NHS dentistry services, to self-certify their recent tax compliance history as part of contract tender processes, and to comply with health and safety equality and other laws. If we do not comply with such laws, we may not be able to participate in tenders for new NHS dentistry contracts, which could adversely affect our results of operations and prospects.

We may be subject to organised action by our dentists or other employees, which could decrease our profitability and negatively affect our results of operations.

Self-employed dentists working in our dental practices could act collectively to demand a higher portion of contracted fees for the services they perform in our dental practices. Whilst none of our employees are currently unionised, no assurance can be made that such employees will not become unionised in the future. Any such collective action or unionisation by our self-employed dentists or employees, whether targeting us specifically or not, could have the effect of increasing our costs, thereby adversely affecting our results of operations.

The interests of our shareholders could conflict with your interests.

A majority of our equity interests are beneficially owned by Carlyle and Palamon. See "Principal shareholders". As a result, Carlyle and Palamon are able to control matters requiring shareholder approval, including the election and removal of our directors, our corporate and management policies, potential mergers and acquisitions, payment of dividends, asset sales and other significant corporate transactions. The interests of both Carlyle and Palamon could conflict with the interests of the holders of the Notes, particularly if we encounter financial difficulties or are unable to pay our debts when due. For example, Carlyle or Palamon could cause us to pursue acquisitions, divestitures, financings, dividend distributions or other transactions which, in their respective judgement, could enhance their equity investments, even though such transactions might involve risks or decrease the market value of the Notes. Such transactions may not trigger a "Change of Control" under the Senior Secured Notes Indenture. Furthermore, Carlyle or Palamon may sell all or any part of their respective shareholding at any time or look to reduce their holding by means of a sale to a strategic investor, an equity offering or otherwise.

We are exposed to currency fluctuation risks that could adversely affect our profitability through our acquisition of The Dental Directory.

The Dental Directory's business is subject to a certain degree of foreign exchange risk related to purchases of consumables and materials in euros. In connection with the Dental Directory Acquisition, we have rolled over The Dental Directory's existing €2.0 million foreign exchange forward call contract, which terminates in August 2014, and we are currently evaluating the need to enter into foreign exchange derivative contracts in the future. We otherwise currently do not have a policy of hedging our currency risk. We generate revenue in pounds sterling, and because of this we are unable to match revenue generated in euros with purchases made by The Dental Directory

using euros. Significant changes in the value of the pound sterling relative to the euro could adversely affect the results of operations of The Dental Directory.

Risks related to our industry

Any change in the employment status of dentists in our dental practices could have an adverse effect on our business, financial condition and results of operations.

Our dentists are self-employed, independent contractors. Because of their non-employee status, we do not pay pension contributions, employer National Insurance contributions, holiday pay or medical negligence insurance in respect of our dentists, and our dentists do not have the rights of employees under the Employment Rights Act 1996. If HMRC reassessed our business model and objected to the self-employed status of the dentists in our dental practices it could lead to significant costs and tax consequences for our business. In addition, we have in the past been subject to conflicting, non-precedential employment tribunal determinations regarding the employment status of our dentists. To the extent employment tribunals would begin to consistently consider dentists to be our employees, we may also be exposed to new areas of liability under employment law. The occurrence of any of the foregoing would materially and adversely impact our business, financial condition and results of operations.

Changes to Value Added Tax ("VAT") legislation, or the judicial interpretation of VAT legislation, resulting in the application of VAT in respect of the services we provide to our dental practices could have an adverse impact on our results of operations.

VAT is a tax charged on most business transactions in the United Kingdom. A hypothetical VAT-registered business adds VAT to the prices at which it sells its goods and services and reclaims the VAT it pays for the goods and services it purchases. The current standard rate of VAT in the United Kingdom is 20%. Dentistry, however, is a VAT-exempt service under applicable VAT legislation, which means that most dental services are exempt from VAT and charges for supplies amongst groups of dentists are exempt from VAT provided that they relate to the provision of services or facilities that are predominantly medical in nature and are necessary to allow the recipient of such services and supplies to perform dentistry. We have structured our operating subsidiaries such that two of our operating subsidiaries, Petrie Tucker and Partners Limited ("PTPL") and Whitecross Dental Care Limited ("Whitecross"), provide services in terms of payroll, the provision of supplies and estate management, amongst others, to the majority of our dental practices. Under this arrangement, we consider the services provided by PTPL and Whitecross to be VAT exempt, insofar as they relate to the provision of services or facilities that are predominantly medical in nature and are necessary to allow the recipient of such services and supplies to perform dentistry. If, however, HMRC successfully challenged our VAT-exempt status, the costs of our operations would effectively increase by an additional 20%, which would materially and adversely impact our business, financial conditions and results of operations. In addition, if VAT rates were to increase our cost base would be negatively affected to the extent of such increase, and we would not be able to recover such increase in VAT costs.

We are in the process of negotiating sectorised partial exemption schemes with HMRC in connection with integrating dbg and The Dental Directory into our VAT group. If we are unable to integrate dbg and The Dental Directory into our VAT group as expected, we would lose a portion of the expected benefits of such acquisitions.

We are subject to numerous legal and regulatory requirements governing our activities, and if we fail to comply with such requirements, we may be subject to substantial fines or sanctions which could have a material adverse effect on our financial condition and results of operation or could impact our ability to conduct our business.

The provision of our dental services is subject to a high level of regulation and oversight. These regulatory requirements relevant to our business cover the entire range of our operations, from the initial acquisition of new practices, which are subject to registration and licensing requirements, to the sourcing of dentists and recruitment and appointment of dental support staff, occupational health and safety, duty of care to patients, clinical standards, the conduct of our dentists, other dental professionals and support staff, and other stringent requirements. The majority of our operations are regulated by the same body, the CQC, or its equivalent in Scotland and Wales. We are also subject to regulations imposed by the Health and Safety Executive, which is the national UK independent regulator for health and safety in the workplace and some legal entities may be required to hold a license with Monitor, the health sector regulator in the UK. Furthermore, new regulations, regulatory systems or regulatory bodies may be introduced, for example, the CQC is changing the way it regulates, inspects and rates health care services and consultations on this are ongoing. We are unable to predict the content of new legislation and regulations and their effect on our business. There can be no assurance that our operations will not be adversely affected by regulatory developments.

A failure to comply with government regulations or the receipt of a negative report that leads to a determination of regulatory non-compliance or the failure of any of our dental practices to cure any defect noted in an inspection

report, for example, could result in reputational damage, fines and/or the revocation of the licence of any of our dental practices.

Regulatory action could also result in our management deciding to cease providing dental services in a particular region or to close a particular practice because of negative publicity or regulatory sanction. In addition, regulatory action in relation to one or more of our practices, regardless of the substantive merit or the eventual outcome of such action, may have a material adverse effect upon our reputation and our ability to attract and/or retain patients, expand our business or seek licences for new dental practices, either nationally or within the regional area in which the dental service which is subject to the regulatory action is located. Any failure to comply with applicable regulations could have a material adverse effect on our business, financial condition, results of operations or prospects.

The terms of any new NHS dentistry contract, are uncertain, and the final terms of any such new NHS dentistry contract could be different from those we expect, which could have undesirable consequences for us and could result in material changes to our business.

The UK Government is currently reviewing the regulatory framework related to NHS dentistry and the NHS dentistry contract, with the goal of making NHS dentistry more efficient, accessible, high quality and focused on preventative care. Whilst it is not yet certain if or when a new NHS dentistry contract will be introduced and adopted by an Act of Parliament, as with any significant regulatory change, there exists the risk that we may not adapt to the change, or the change may prove costly or limit our ability to execute our business model and strategy. For example, the UK Government has indicated that a new NHS dentistry contract, if any, may move away from compensation based on UDA volumes, and instead reward dentists based on a combination of number of patients registered, number of patient visits and quality metrics that measure clinical patient outcomes and the quality of the patient experience. The UK Government and the GDC have also indicated that non-dentist staff such as hygienists will be able to carry out preventative services without a referral from a dentist, potentially adding competition to dental practices by independent hygienists. Since the final terms of any proposed new NHS dentistry contract are uncertain, we cannot anticipate all risks that might arise upon the adoption of any such new NHS dentistry contract, including risks that may specifically target our business model, and we cannot provide assurance that dentistry will remain under the purview of the NHS. If any such new NHS dentistry contract has terms different from those we expect, our business, financial condition and results of operations could be materially adversely affected, and it could result in material changes to our business, financial condition, results of operations or prospects.

We rely on contracts with publicly funded entities in the United Kingdom such as the NHS for a substantial proportion of our revenues, and changes to levels of funding or funding priorities under such contracts could adversely affect our business, results of operations and financial condition.

NHS dental services accounted for 85% of our total revenues for the year ended 31 March 2014. Overall NHS spending is currently significantly constrained as a result of the UK Government's efforts to reduce growth in government spending, with the UK Government having announced efficiency savings up to £20 billion in the NHS. Whilst dental expenditures have not declined in nominal terms, contract uplifts have not kept up with inflation, resulting in a decline in the price paid for our NHS dentistry services in real terms. Any decline in government funding for NHS dentistry services, whether in nominal or real terms, could result in lower overall volumes of UDAs, lower prices per UDA, fewer new contract tenders or other measures that could cause declines in our turnover and materially adversely affect our business, financial condition and results of operations.

We may become subject to additional regulation by Monitor, the health sector regulator in the UK, which could restrict our future growth through acquisitions because of our high-level indebtedness, result in additional regulatory oversight, increase our costs and limit our ability to grow.

The Health and Social Care Act 2012 sets out Monitor's core responsibilities as the sector regulator of NHS-funded health care services and tasks Monitor with promoting the provision of health care services that are economic, efficient and effective. The legislation provides that all NHS providers of health care services must hold an NHS provider licence issued by Monitor, unless they are exempt.

On 1 April 2014 The National Health Service (Licence Exemptions, etc.) Regulations 2013 came into force and the regulations set out exemptions to the requirement for a provider of NHS services to hold a licence with Monitor. Regulation 5 exempts persons providing "primary dental services" commissioned by (or under delegated authority from) NHS England in accordance with Part 5 of the NHS Act 2006 as NHS England is already well placed to enforce standards equivalent to those included in Monitor's standard licence conditions. This means that where a legal entity is providing private dental services under Part 5 of the NHS Act 2006 (i.e., pursuant to a GDS contract) there is no requirement for that legal entity to hold a licence. However, if the legal entity provides other NHS services, it will require a licence unless it qualifies for another exemption. For example, Regulation 8 exempts from

the requirement to hold a licence for providers whose turnover from supplying NHS services is less than £10 million in a relevant business year.

The legal entity who provides the NHS services must be licensed. For example, where a provider is part of a wider corporate group, such provider will need to be licensed in its own right if it is the legal entity responsible for providing the services (rather than the parent company) and in the case of partnerships, each partnership which provides NHS services must be licensed unless an exemption applies. The licence sets out the conditions the licence holder must meet in order to provide NHS-funded services and examples of standard conditions include obligations about pricing and anti-competitive behaviour. If any legal entity owned by us is regulated by Monitor, we could be subject to potentially significant costs of compliance and monitoring. In addition, based on Monitor oversight of other UK healthcare sectors, regulation by Monitor may entail financial and clinical health checks of our business, and Monitor may prohibit us from participating in new contracts, transferring contracts or acquiring new dental practices because of our high level of indebtedness. If these or other circumstances were to materialise, they could materially and adversely affect our business, financial condition and results of operations.

Risks related to our capital structure

Our substantial indebtedness could have a material adverse effect on our financial health and could prevent us from fulfilling our obligations with respect to the Floating Rate Notes and the Senior Secured Notes Guarantees.

Following the completion of the 2014 Notes Issuance we continue to have a significant amount of outstanding debt with substantial debt service obligations. As at 31 March 2014, on a pro forma basis after giving effect to the 2014 Notes Issuance and the application of the proceeds therefrom, we would have had an aggregate principal amount of third-party financial debt of £500.0 million outstanding, excluding accrued interest and unamortised debt issuance costs. We would also have had £100.0 million available for borrowing under the Revolving Credit Facility.

Our significant leverage could have important consequences for our business and operations and for you as a holder of the Notes, which may include, but may not be limited to:

- subjecting us to additional regulation or oversight or limiting our ability to acquire or transfer NHS dentistry contracts;
- making it more difficult for us to satisfy our payment obligations with respect to the Notes, the Revolving Credit Facility and our other debts, liabilities and obligations;
- requiring us to dedicate a substantial portion of our cash flow from operations to payments for the service of our debt, thus reducing the availability of our cash flow to fund investments in our business and for other general corporate purposes;
- limiting the availability of funds for our working capital, capital expenditures, investments, acquisitions and our other general corporate purposes;
- limiting our flexibility in planning for, or reacting to, changes in our business, patient demand, competitive pressures and the patients we serve;
- placing us at a competitive disadvantage compared to any of our competitors that have lower leverage or greater financial resources than we have;
- increasing our vulnerability to general and industry-specific adverse economic conditions;
- negatively impacting credit terms with our creditors; and
- limiting our ability to borrow additional funds and subject us to financial and other restrictive covenants.

Any of these or other consequences or events could have a material adverse effect on our ability to satisfy our debt obligations, including our obligations in respect of the Floating Rate Notes and Senior Secured Notes Guarantees.

Despite our current level of debt, we may still be able to incur substantially more debt in the future, which may make it difficult for us to service our debt, and impair our ability to operate our businesses.

We and our subsidiaries may be able to incur substantial additional debt in the future. Although the Revolving Credit Facility Agreement and each of the Indentures contain restrictions on the incurrence of additional debt, these restrictions are subject to a number of significant qualifications and exceptions, and under certain circumstances the amount of debt that could be incurred in compliance with these restrictions could be substantial and we may be able to secure such additional debt with Collateral or other assets. Under the Indentures, in addition to specified permitted indebtedness, we are able to incur additional indebtedness so long as on a pro forma basis our fixed charge coverage ratio (as defined in each of the Indentures) is at least 2.00 to 1.00, and in the event such indebtedness is

secured indebtedness, our consolidated senior secured leverage ratio (as defined in each of the Indentures, which, amongst other things, exclude certain specified permitted indebtedness from the calculation of such ratio) is no more than 4.75 to 1.00. Under the terms of the Indentures, we are permitted to incur future debt that may have substantially the same covenants as, or covenants that are more restrictive than, those of the Indentures. Moreover, some of the debt we may incur in the future could be structurally senior to the Notes and may be secured by collateral that does not secure the Notes. In addition, the Indentures and our Revolving Credit Facility Agreement do not prevent us from incurring obligations that do not constitute indebtedness under those agreements. The incurrence of additional debt would increase the leverage-related risks described in this Annual report.

We may not be able to generate sufficient cash to service our indebtedness, including due to factors outside our control, and we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make principal or interest payments when due on our indebtedness, including amounts drawn under the Revolving Credit Facility Agreement and our obligations under the Senior Secured Notes (including the Floating Rate Notes) and the Second Lien Notes, and to fund our ongoing operations, will depend on our future performance and ability to generate cash which, to a certain extent, is subject to regulatory general economic, financial, competitive, legislative, legal and other factors, as well as other factors discussed in these "Risk factors", many of which are beyond our control. In addition, upon the maturity of the Revolving Credit Facility, or any replacement credit facility, the Notes or any other debt which we may incur, if we do not have sufficient cash flows from operations and other capital resources to pay our debt obligations, or to fund our other liquidity needs, we may be required to, amongst other things:

- reduce or delay business activities and capital expenditures;
- sell assets;
- obtain additional debt or equity capital;
- restructure or refinance all or a portion of our debt on or before maturity; or
- forego opportunities such as acquisitions of other businesses.

There can be no assurance that any of these alternatives can be accomplished on a timely basis, on satisfactory terms or at all. In addition, the terms of our existing and future debt, including those terms contained in the Indentures and the Revolving Credit Facility Agreement, may limit our ability to pursue any of these alternatives.

If we are not able to refinance any of our debt, obtain additional financing or sell assets on commercially reasonable terms or at all, we may not be able to satisfy our debt obligations, including under the Notes. In that event, borrowings under other debt agreements or instruments that contain cross-default or cross-acceleration provisions may become payable on demand, and we may not have sufficient funds to repay all our debts.

In addition, any failure to make payments of interest or principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which could harm our ability to incur additional indebtedness. For a discussion of our cash flows and liquidity, see "Management's discussion and analysis of financial condition and results of operation—Liquidity and capital resources".

The Floating Rate Notes and drawings under the Revolving Credit Facility Agreement bear, and any future variable interest rate debt we incur will bear, interest at floating rates that could rise significantly, thereby increasing our costs and reducing our cash flow.

The Floating Rate Notes and drawings under the Revolving Credit Facility Agreement bear interest at floating rates of interest per annum equal to GBP LIBOR, as adjusted periodically, plus a spread. These interest rates could rise significantly in the future. There can be no assurance that hedging will be available on commercially reasonable terms or at all, or that we will enter into any interest rate hedging. Hedging itself carries certain risks, including that we may need to pay a significant amount (including costs) to terminate any hedging arrangements. To the extent that interest rates or any drawings were to increase significantly, our interest expense would correspondingly increase, reducing our cash flow. In connection with the 2013 Notes issuance, and to hedge our variable interest rate exposure under the Existing Senior Secured Floating Rate Notes, we amended the terms of our previous interest rate swaps and rolled them into a new, three-year, £125.0 million interest rate swap. No assurance can be made that we will be able to roll over this interest rate swap upon its expiration in 2016 on acceptable terms or at all. We also rolled over the mark-to-market balance owed under our previous interest rate swaps into the new interest rate swap. As at 31 March 2014, we estimate the mark-to-market balance owed under our existing interest rate swap to be £2.1 million.

The manner of calculating GBP LIBOR is under review by European regulators and others. There can be no assurance that GBP LIBOR will continue to be calculated as it has been historically, if at all.

We are subject to restrictive covenants which limit our operating and financial flexibility.

Our Revolving Credit Facility Agreement and each of the Indentures contain covenants which impose significant restrictions on the way we operate, including restrictions on our ability to:

- incur or guarantee additional debt and issue preferred stock;
- in the case of the Second Lien Notes, layer debt of the Issuer and the Guarantors;
- make certain payments, including dividends or other distributions;
- make certain investments or undertake acquisitions, including participating in joint ventures and undertaking capital expenditure;
- prepay or redeem subordinated debt;
- engage in certain transactions with affiliates;
- create unrestricted subsidiaries;
- agree to limitations on the ability of our subsidiaries to make distributions;
- sell assets, or consolidate or merge with or into other companies;
- sell or transfer all or substantially all our assets or those of our subsidiaries on a consolidated basis;
- consummate a change of control;
- issue or sell share capital of certain subsidiaries; and
- create or incur certain liens.

Any future indebtedness may include similar or other restrictive terms. These restrictions could materially and adversely affect our ability to finance our future operations or capital needs or to engage in other business activities or consummate transactions that may be in our best interests.

In addition, the Revolving Credit Facility Agreement requires us to maintain a specified maximum ratio of drawn super senior debt to EBITDA before exceptional items, tested quarterly. Our ability to meet that financial ratio can be affected by events beyond our control, and we cannot assure you that we will meet such financial ratio. A breach of any of those covenants, ratio or restrictions could result in an event of default under the Revolving Credit Facility Agreement. Upon the occurrence of any event of default under the Revolving Credit Facility Agreement, subject to applicable cure periods and other limitations on acceleration or enforcement, the relevant creditors could cancel the availability of the Revolving Credit Facility Agreement and elect to declare all amounts outstanding under the Revolving Credit Facility, together with accrued interest, immediately due and payable. In addition, a default under the Revolving Credit Facility Agreement could lead to an event of default and acceleration under other debt instruments that contain cross-default or cross-acceleration provisions, including under the Senior Secured Notes Indenture and the Second Lien Notes Indenture. If our creditors, including the creditors under the Revolving Credit Facility, accelerate the payment of those amounts, we cannot assure you that our assets and the assets of our subsidiaries would be sufficient to repay those amounts in full, to satisfy all other liabilities of our subsidiaries that would be due and payable and to make payments to enable us to repay the Notes, in full or in part. In addition, if we are unable to repay those amounts, our creditors could proceed to enforce the security interest in any Collateral granted to them to secure repayment of those amounts.

These covenants could affect our ability to operate our business and may limit our ability to react to market conditions or regulatory developments or take advantage of potential business opportunities as they arise. For example, such restrictions could adversely affect our ability to finance our operations; pursue acquisitions, investments or alliances; restructure our organisation; or finance our capital needs.

We have not included any IFRS or US GAAP financial information in this Annual report.

We prepare our financial statements on the basis of UK GAAP, which differs in certain significant respects from IFRS and US GAAP. We have not presented a reconciliation of the financial statements of EquityCo to IFRS or US GAAP in this Annual report. As there are significant differences between UK GAAP, IFRS and US GAAP, there may be substantial differences in our results of operations, cash flows and financial condition if we were to prepare our financial statements in accordance with IFRS or US GAAP.

Management's discussion and analysis of financial condition and results of operations

The following discussion and analysis of IDH's financial condition and results of operations should be read in conjunction with the audited consolidated financial statements and the related notes thereto contained in this Annual report.

Certain information in the discussion and analysis set out below includes forward-looking statements that involve risks and uncertainties. See "Forward-looking statements" and "Risk factors" for a discussion of important factors that could cause actual results to differ materially from the results described in the forward-looking statements contained in this Annual report.

Overview

We are the leading provider of dental services in the United Kingdom, with 507 NHS dentistry contracts across our network of 585 dental practices throughout England, Scotland and Wales. We have a market share of approximately 5% in terms of number of dental practices and 6.6% in terms of revenues. Our dentists offer a broad range of primary care dental services in our dental practices, including dental examinations, fillings and extractions, as well as more specialised dental services such as cosmetic dentistry and orthodontics. We operate in the UK dental market, which benefits from stability in terms of volume and pricing and from increased government focus on improving access to dental services. In the year ended 31 March 2014, we recorded turnover of £407.5 million and generated EBITDA of £67.8 million.

Our core business is the provision of primary care dental services under long-term contracts with NHS England, which we refer to as "NHS dentistry services". NHS dentistry services accounted for 85% of our turnover for the year ended 31 March 2014. The majority of our dental practices also provide private dentistry services, including general dentistry, hygienist, and cosmetic and specialist services, such as sedation, implants and orthodontics. Private dentistry services accounted for 13% of our turnover for the year ended 31 March 2014. Services provided by dbg (which we acquired on 16 April 2013) generated 2% of our turnover for the year ended 31 March 2014. 90% of our dental practices are located in England, with 6% in Scotland and 4% in Wales.

We provide NHS dentistry services in England and Wales pursuant to contracts competitively tendered with the NHS specifying targeted annual volumes of units of dental activity ("UDAs") for the contracted dental practice or entity. We refer to these contracts as "NHS dentistry contracts". Unlike other UK health subsectors, such as care homes, there is no single NHS dentistry contract. Instead, our individual dental practices enter into separate NHS dentistry contracts with NHS England (or, in the case of Wales, with Welsh health boards). As at 31 March 2014, our dental practices were contracted under 507 such NHS dentistry contracts. Each NHS dentistry contract in England and Wales for UDAs specifies a fixed UDA volume per year target, and each UDA delivered under an NHS dentistry contract is assigned a fixed value in a given year, with the number of UDAs per treatment varying based on the treatment provided. Approximately 94% of our NHS dentistry contracts, covering 74% of our turnover in the year ended 31 March 2014, consist of general dentistry services ("GDS") contracts, which we refer to as "evergreen" as they have no fixed term and roll over indefinitely so long as 96% of the UDA performance targets are met at least once every three years. None of our GDS contracts have ever been terminated. UDA rates are set annually and historically have benefited from annual price increases ("contract uplifts"), with the announced contract uplift for the contract year ending 31 March 2015 constituting a 1.6% increase over the prior contract year for England (with an uplift of 1.47% in Wales and 1.71% in Scotland). Unlike other UK healthcare sectors, NHS dentistry services providers benefit from individually negotiated contracts.

In connection with our strategy to drive value and grow our business through acquisitions of suppliers of consumables, materials, equipment and services, on 17 April 2014, we acquired HM Logistics Limited ("The Dental Directory"), a distributor of dental consumables and materials to dental practices throughout the United Kingdom. The Dental Directory distributes a catalogue of up to 27,000 products from its central logistics platform through its on-line and mail order service, including dental consumables, specialist products including orthodontics and oral hygiene and implant products and dentistry equipment ranging from dental chairs and cabinetry to digital imaging systems. The Dental Directory also carries out services such as installation and maintenance and has a handpiece repair business. For the year ended 31 December 2013, The Dental Directory had adjusted turnover of £103.9 million and adjusted EBITDA of £8.7 million. The Dental Directory Acquisition increases our presence in the consumables, materials, equipment and services supplier market business that we began with the acquisition of dbg on 16 April 2013.

We are paid for our NHS dentistry services in equal monthly instalments of our annual contracted value. This results in a well-matched cash flow and cost profile as we typically receive payments on our NHS dentistry contracts prior to paying related costs. Private dentistry services are typically paid for by the patient prior to treatment.

A typical dental practice for us has three or more dental chairs, with three or four self-employed, independently contracted dentists offering primary care dental services under an NHS dentistry contract, supported by three to four nurses employed by us. As at 31 March 2014, more than 2,300 self-employed, independently contracted dentists worked in our dental practices, supplemented by approximately 100 dentists not assigned to a single practice, which we refer to as "locums", and supported by approximately 5,600 dental and central support staff. In addition, approximately 300 hygienists work across our dental practices.

We own the NHS dentistry contracts and infrastructure of our dental practices and employ the dental support staff, whilst contracting with self-employed dentists for provision of dental services. We believe our business model is attractive to dentists as we enable dentists to focus on dentistry by taking on the administrative, regulatory and compliance burdens associated with running a dental practice. Amongst our most significant costs are dentist fees and costs for laboratory work and materials, all of which are directly linked to volumes of sales and activity.

Significant factors affecting results of operations

Sourcing and acquisition of additional dental practices

Acquisitions of dental practices are the core driver of our growth. A limited number of new NHS dentistry contracts become available in each year, so the primary method for growing our revenues is through acquiring dental practices with NHS dentistry contracts in place. Since 12 May 2011, we have acquired 130 dental practices. We employ a disciplined acquisition strategy centred on the acquisition of practices with NHS dentistry contracts with three or more chairs. With our acquisitions of The Dental Directory and dbg, we have also expanded into the dental and medical consumables and materials distribution, supply and services businesses, where we see significant cost savings, synergies and opportunities for growth in supplying both our own practices and third-party customers.

Acquisition strategy

We buy practices to acquire their GDS evergreen contracts, and also focus on the acquired practices' historical UDA delivery rates, the retention of key personnel and complementary private revenue generation in such practices. Our acquisition strategy is impacted by the sourcing, availability and pricing of dental practices for purchase. In terms of sourcing, we have a large and experienced acquisition team which identifies potential acquisition opportunities on the basis of our acquisition strategy, and recently have generated leads for approximately 77% of the acquisitions internally. We pay finders' or brokers' fees for those acquisition leads not developed internally.

Scope for additional consolidation

With approximately 11,900 dental practices, the large majority of which are independent, the UK dental market is highly fragmented, and we believe there is scope for additional consolidation as dentists retire or sell their dental practices to become independent contractors with us, whether due to the administrative, regulatory and compliance burden of owning their own dental practice or otherwise. Within the large number of independent dental practices throughout the United Kingdom, we estimate that approximately 400–600 practices are available for acquisition in an average year, and the number of acquisitions we make depends on the quality and pricing of those practices that are available for purchase at a given time. In addition, our strategy of driving value and growing our business through acquisitions of suppliers of consumables, materials, equipment and services has increased the addressable market for growth through acquisitions.

Valuation and accuracy

The price paid for a particular acquisition depends in part on the NHS dentistry contracted revenues as well as the private dentistry services revenues and the costs of the target dental practice, along with competition to acquire such practice, which may be intense. We price each acquisition on the basis of a multiple of the estimated EBITDA generated by our due diligence process. Our results of operations are therefore impacted by the accuracy of our due diligence, as well as by our success in integrating the dental practices we acquire into our group, and implementing our cost structure onto such dental practices. On a portfolio basis, we believe the expected EBITDA projections resulting from our acquisition team's due diligence have been accurately reflected in post-acquisition results, and acquired practices have generally enjoyed EBITDA consistency before and after their acquisition by us. We believe our due diligence methodology produces accurate results and allows us to acquire dental practices at attractive multiples of EBITDA valuations as we know that the number of contracted UDAs, UDA delivery percentage and private revenue generation tend to maintain consistency, dentist costs are contracted, and we are able to apply our known cost base to the dental practices we acquire. The non-orthodontic dental practices we acquired in the twelve months ended 31 March 2013 contributed £7.4 million of EBITDA before head office costs and exceptional items in the twelve months ended 31 March 2014 compared to our due diligence estimate of £7.6 million of EBITDA before head office costs and exceptional items, and the non-orthodontic dental practices we acquired in the twelve months ended 31 March 2012 contributed £6.5 million of EBITDA before head office costs and exceptional items in the

twelve months ended 31 March 2014 compared to our due diligence estimate of £6.5 million of EBITDA before head office costs and exceptional items.

Availability of dentists and other dental professionals

Without dentists, our dental practices cannot provide dental services or generate revenue from either NHS dentistry services or private dentistry services. It has historically proven difficult to attract dentists to work in certain regions of the United Kingdom, such as the southwest of England. This can impact our results in that we may not be able to deliver contracted UDAs in respect of NHS dentistry services in localities where we have NHS dentistry contracts if we are unable to source dentists in or to such localities. We have a central talent sourcing function and primarily attract dental graduates and dentists qualified in the United Kingdom. In the past, we have also addressed shortages of dentists (whether nationwide or local) by attracting dentists from overseas. Of our dentists, approximately 43% are British. We believe that we have benefited from the UK Government's increased investment in additional graduate training places and the training and retention of dental school graduates.

Sourcing and retention of hygienists and nurses also affect our results. Hygienists operate in conjunction with dentists, but following recent changes no longer require a referral from a dentist to provide a limited number of services and so are, to a certain extent, a source of revenue generation complementary to our dentists. Dentists are prohibited from providing dental services to patients without a nurse present, so the recruitment and retention of nurses also drive our results and operational efficiency. During the contract year ended 31 March 2014, we implemented a salary increase for our nurses, as well as training initiatives for hygienists and nurses aimed at improving sourcing and increasing retention for both hygienists and nurses.

Dental chair efficiency and utilisation

We refer to our ability to utilise our dentists' time and drive efficiency in terms of revenue generation as "time in the dental chair", or "the time a dentist spends with patients". The drivers for maximising time in the dental chair consist of maximising opening hours and patient numbers and minimising downtime for maintenance and non-dentistry burdens.

We have scope to increase time in the dental chair by extending our opening hours, as most of our practices do not currently offer weekend or evening services. Because our dentists' hours and workload in practice tend to be fixed to weekday trading days and normal trading hours, our results of operations are affected by the number of trading days in a year and by other factors that result in closure or fewer trading days. We also leverage our central support function to drive patient numbers, and to that end we have implemented a variety of targeted marketing efforts that are aimed at attracting new patients and increasing visit frequency from existing patients.

We regularly invest in capital expenditures to provide new chairs and other equipment, and to make our suite of chairs and equipment uniform across our estate, which we believe will reduce money and time spent on maintenance. By removing the administrative, compliance and regulatory burdens of dentists, we believe that we provide dentists with a platform for maximising the time they spend with patients, and thereby increasing UDAs delivered, private dentistry services revenue generated, and overall quality of care and patient satisfaction.

Private revenue

For the year ended 31 March 2014, we generated £54.4 million in turnover, or 13% of our total turnover, through the provision of private dentistry services. Private dentistry services, including general dentistry, hygienist and cosmetic services, are provided by most of our dental practices, along with such practices' NHS dentistry services offering. Private dentistry services are one of the key drivers of our organic growth, and our expansive offering of private dentistry services provides us with opportunities to complement revenues we generate under our NHS dentistry contracts. Private dentistry services are provided solely at the election of the patient who funds the work (whether out-of-pocket or through insurance or payment plans), and on average the cost of private dentistry services is higher than the cost of comparable NHS dentistry services. The result is that revenues generated from private dentistry services tend to be significantly more sensitive to general macroeconomic conditions and the level of disposable income available to our patients than revenues generated from NHS dentistry services. Prices for private dentistry services are set by the individual dentist working within guidelines determined by us. We generally compensate dentists for the provision of private dentistry services on a fixed percentage of fees paid for private dentistry services provided.

Dentist fees, costs of laboratory work and costs of materials

We believe that up to 70% of our costs (including all of our cost of sales and certain of our administrative expenses, such as certain support staff costs) are variable and tied to sales volumes and activity. Our cost of sales, which was £210.8 million for the year ended 31 March 2014, is primarily comprised of dentist and hygienist compensation, the cost of materials and cost of laboratory work performed. Dentists working in our practices are self-employed,

independent contractors who pay us a notional licence fee and receive a fixed rate per UDA delivered (in the case of the majority of NHS dentistry services) and a percentage of fees paid for private dentistry services. We negotiate dentist contracts on an individual basis, depending in part on demand for dentists and UDA prices prevalent in the locality in which the relevant dentist operates, and such fees are agreed in our associate contracts with our dentists. We also use floating dentists (locums), who generally receive higher fees per UDA than dentists operating out of one dental practice. We believe these arrangements align dentists' economic interests with ours. Our second most significant variable cost is the cost of materials. The cost of materials we procure for our dental practices are subject to general inflationary pressures in line with the macroeconomy. We have been able to drive efficiencies and achieve economies of scale in the procurement of materials by selecting the range of materials used by our practices and purchasing such materials on the basis of volume discounts. Our third most significant variable cost is the net costs of laboratory work performed, which we generally split evenly with dentists. Both the costs of materials and the net costs (after dentist contribution) of laboratory work performed are directly tied to our sales volumes and activity.

We believe that our recent acquisition of The Dental Directory, together with our acquisition of dbg in 2013, will provide significant cost savings and synergies in the acquisition of dental consumables and materials for our dental practices.

Practice overhead, head office costs

Practice overhead and head office costs constitute the primary components of our administrative expenses, which were £130.6 million, or 32.0% of our turnover (after excluding depreciation, amortisation of goodwill, amortisation of grant income and exceptional items), for the year ended 31 March 2014. We benefit from low property costs for our dental practices, with rent costs constituting less than 3% of our turnover for the year ended 31 March 2014.

Practice overhead includes the salaries of support staff, which consist of nurses and administrative support at the dental practice, the provision of equipment and estate management.

Head office costs include the salaries of management and central support function employees providing IT, compliance, regulatory requirements, property and equipment maintenance, legal, finance, human resources, marketing, health and safety, risk management, talent sourcing, training, insurance and logistics services to our dental practices, our central support systems, central support overhead and the costs related to leasing our headquarters building.

Regulatory environment

Our results of operations are also affected from time to time by changes to the regulatory environment in relation to the healthcare generally, and dentistry specifically, in the United Kingdom. Because 85% of our turnover in the year ended 31 March 2014 was generated in the provision of NHS dentistry services, we are particularly affected by UK Government policy in relation to contracts and funding for the provision of dental services. This includes the framework of contracts for the provision to provide dentistry, the determination of UDA volumes for a particular locality and the determination of UDA indexation of UDA prices for contract uplifts. Under the current contract framework, which was introduced in 2006, the value of NHS dentistry contracts is primarily based on the volume of UDAs delivered. Each UDA delivered under an NHS dentistry contract is assigned a fixed UDA rate, which varies by contract year-to-year, with the number of UDAs per treatment varying based on the actual treatment provided.

Local contracting

Our results are also affected by the determination of the number of UDAs required for a particular locality. Area Teams on behalf of the NHS determine the number of UDAs required for a locality, and then solicit tenders for contracts to provide such UDAs. The Area Teams take into account demand for dental services, population, demographics, socioeconomic factors and the penetration of dentistry access in an area when determining the number of UDAs for such locality. Increased numbers of UDAs in a particular locality will result in new contracts for the provision of NHS dentistry services, for which we may tender. If UDAs allocated to a particular locality do not meet the contracted targets, the number of contracted UDAs may be reduced through cuts to contracts where practices have failed to meet the 96% UDA performance target in three consecutive years.

NHS budget

Whilst funding for certain other UK healthcare sectors has been subject to funding freezes or cuts due to government austerity measures, historically UDA prices have been subject to annual contract uplift, with increases of 0.5% and 0.5% for the contract years ended 31 March 2012 and 2013, respectively, 1.5% for the contract year ending 31 March 2014 and an announced increase of 1.6% for the contract year ending 31 March 2015 in England (with an uplift of 1.47% in Wales and 1.71% in Scotland). Under the current system, UDA rates vary significantly depending on the locality in which the dental services related to such UDAs were provided. Any standardisation of UDA rates

by averaging rates across the United Kingdom would tend to benefit our turnover, as we believe that our current average UDA rate is slightly below the national average.

General regulatory requirements

Our costs of operations are also impacted by regulation more generally as it relates to health and safety, quality of care and other regulatory requirements with which we are required to comply in providing dentistry services. As the leading provider of dental services in the United Kingdom, we believe we are well placed to respond to and comply with regulatory changes in terms of having both dedicated regulatory and compliance teams to minimise such costs, and a sizeable revenue base and infrastructure to absorb increased costs.

Proposed NHS dentistry contract charges

Under proposed changes to the current contract frameworks, which we estimate will be implemented, if at all, no earlier than 2016–2017, NHS dentistry contracts could combine aspects of fixed payments for a given level of care time, number of patients treated, clinical outcomes, patient experience and patient safety. We believe that these changes, if they occur, will generally prove revenue neutral, and that we will be able to leverage our scale to derive a competitive advantage in terms of patient recruitment and delivery of quality care under any new NHS dentistry contractual framework.

Description of key line items

Profit and loss account (UK GAAP)

Set out below is a brief description of the composition of the key line items of our profit and loss account under UK GAAP.

Turnover

Turnover represents the income received in the ordinary course of business for dentistry goods or services provided to the extent that we have obtained the right to consideration. Turnover derived from NHS dentistry contracts in England and Wales is recognised on the volume of dental activity delivered in the financial period. Turnover from all private dental work and NHS patients in Scotland is recognised on the completion of each piece of treatment carried out, with the exception of orthodontic treatment, which is recognised based on the stage of completion reached during the course of treatment.

Cost of sales

Cost of sales represents the operating expenses incurred in the delivery of our dental goods and services, including dentist compensation, laboratory work costs, dental materials and prostheses.

Other operating income

Other operating income primarily represents additional income to assist in the upkeep of premises received from Scottish health boards and is based on the proportion of NHS treatment carried out by a dental practice in Scotland. Other operating income also includes income received from property rentals.

Administrative expenses

Administrative expenses represent all operating expenses that are not directly attributable to the actual provision of our dentistry services, including dental practice staff costs, property services and facilities management costs and other variable dental-related expenses and rent. Administrative expenses also includes head office costs, including central staff and employee support costs, premises costs, communications and systems costs, legal and professional fees, and marketing and development costs. In addition, administrative expenses includes goodwill amortisation and depreciation of owned assets.

Operating profit

Operating profit represents the sum of (i) gross profit, (ii) other operating income and (iii) administrative expenses.

Loss on disposal of assets

Loss on disposal of assets consists of the net loss from the sale of assets, including dental practices and the related goodwill to a third party.

Interest receivable and similar income

Other interest receivable and similar income represents interest earned on our money deposited with financial institutions.

Interest payable and similar charges

Interest payable and similar charges represent interest payable on bank loans, the amortisation of bank loan arrangement fees, hedging costs and certain other charges, including accrued interest.

Tax on loss on ordinary activities

Tax is based on the results for the accounting period and takes into account taxation deferred because of timing differences between the treatment of certain items for taxation and accounting periods.

Equity minority interests

Equity minority interests represent the share of the profits less losses on ordinary activities attributable to the interests of equity shareholders in subsidiaries which are not wholly owned by us.

Other financial information (non-UK GAAP)

Set out below is a brief description of other non-UK GAAP financial information.

Gross profit margin

Gross profit margin represents gross profit divided by turnover.

EBITDA margin

EBITDA margin represents EBITDA before exceptional items divided by turnover.

NHS dentistry services turnover as a percentage of total turnover

NHS dentistry services turnover as a percentage of total turnover represents turnover generated through the provision of NHS dentistry services under NHS dentistry contracts divided by turnover.

Total annual UDA delivery percentage

Total annual UDA delivery percentage represents the total number of UDAs we deliver in a given year divided by our total number of contracted UDAs in place at the end of a given year.

Normalised annual UDA delivery percentage

Represents total annual UDA delivery percentage described above, normalised for the UDA shortfall resulting from the one-off decline in UDA delivery percentage in certain of our dental practices due to the conversion of IT systems in the Predecessor ADP dental practices.

UDA contract uplift

UDA contract uplift represents the percentage increase of UDA prices under each NHS dentistry contract over the prior year's prices in each respective NHS dentistry contract.

Private dentistry services turnover as a percentage of total turnover

Private dentistry services turnover as a percentage of total turnover represents turnover generated through the provision of private dentistry services divided by turnover.

Like-for-like private turnover growth

Like-for-like private turnover growth represents the total private revenue generated by all the practices owned for the whole of a financial year divided by the private revenue generated by the same practices in the preceding financial year.

Administrative expenses as a percentage of total turnover

Administrative expenses as a percentage of total turnover represents administrative expenses, less depreciation, amortisation of goodwill and amortisation of grant income and exceptional items, divided by turnover.

Total number of dental practices

Total number of dental practices represents the total number of dental practices we own as at a specified date.

Results of operations for the years ended 31 March 2013 and 31 March 2014

The following tables set out the key line items from the consolidated profit and loss account and consolidated cash flow statements for the years ended 31 March 2013 and 31 March 2014 and from the balance sheet at 31 March 2013 and 31 March 2014.

Consolidated profit and loss account

(£ in millions)	For the year ended 31 March 2013	For the year ended 31 March 2014
Turnover	**349.0**	**407.5**
Cost of sales	(183.5)	(210.8)
Gross profit	**165.4**	**196.7**
Other operating income	1.8	1.7
Administrative expenses	(152.8)	(179.8)
Operating profit	**14.5**	**18.6**
Loss on disposal of assets	(3.6)	(0.5)
Profit on ordinary activities before interest and taxation	**10.9**	**18.1**
Interest receivable and similar income	–	–
Interest payable and similar charges	(70.3)	(54.3)
Loss on ordinary activities before taxation	**(59.4)**	**(36.1)**
Tax on loss on ordinary activities	1.9	2.0
Loss on ordinary activities after taxation	**(57.5)**	**(34.1)**
Equity minority interests	0.1	(0.1)
Loss for the financial year	**(57.4)**	**(34.1)**

Consolidated balance sheet

(£ in millions)	As at 31 March 2013	As at 31 March 2014
Intangible assets	558.0	614.8
Tangible assets	68.2	83.3
Fixed assets	**626.2**	**698.1**
Stocks	6.2	7.6
Debtors	28.6	44.9
Cash at bank and in hand	42.4	6.9
Current assets	**77.2**	**59.4**
Total assets	**703.4**	**757.5**
Share capital	–	411.0
Share premium account	–	–
Profit and loss reserve	(109.2)	(143.3)
Total shareholders' (deficit)/funds	**(109.2)**	**267.7**
Minority interest	**(0.1)**	–
Creditors: amounts falling due within one year	**66.0**	**65.2**
Creditors: amounts falling due after more than one year	731.7	414.4
Provisions for liabilities and charges	15.0	10.2
Non-current liabilities	**746.7**	**424.6**
Total equity and liabilities	**703.4**	**757.5**

Consolidated statement of cash flows

(£ in millions)	For the year ended 31 March 2013	For the year ended 31 March 2014
Net cash inflow from operating activities ..	53.9	54.8
Senior facility loan interest paid and interest rate swap cash paid	(18.1)	(24.3)
Syndicate charges paid	(1.5)	(1.7)
Returns on investments and servicing of finance	(19.5)	(26.0)
Net cash outflow after returns on investment and servicing of finance	34.3	28.8
Taxation	(0.3)	0.2
Capital expenditure	(14.5)	(23.5)
Net cash inflow before acquisitions	19.5	5.5
Acquisitions and disposals	(45.6)	(93.6)
Net cash outflow before financing	(26.1)	(88.1)
Debt issue costs	–	(15.4)
Financing	49.6	68.0
Increase/(decrease) in cash in the financial year	23.5	(35.5)

Other financial data

(£ in millions, except as specified)	For the year ended 31 March 2013	For the year ended 31 March 2014
Other profit and cash flow data		
EBITDA before exceptional items[1]	56.3	67.8
Estimated pro forma adjusted EBITDA[2]		84.8
EBITDA margin[3]	16.1%	16.6%
Gross profit margin[4]	47.4%	48.3%
Maintenance capital expenditure[5]	11.8	17.9
Cash conversion[6]	76.5%	57.0%
Other debt and credit data		
Net senior secured debt[7]		326.6
Net total debt[8]		401.6
Ratio of net senior secured debt to estimated pro forma adjusted EBITDA		3.85
Ratio of net total debt to estimated pro forma adjusted EBITDA		4.74

Key performance indicators

	For the year ended 31 March 2013	For the year ended 31 March 2014
NHS dentistry services turnover as a percentage of total turnover	87.4%	84.9%
Total annual UDA delivery percentage[9]	96.0%	96.7%
Private dentistry services turnover as a percentage of total turnover	12.6%	13.4%
Like-for-like private turnover growth[10]	2.8%	8.6%
Administrative expenses as a percentage of turnover[11]	31.8%	32.0%
Total number of dental practices[12]	532	585

	For the year ended 31 March 2012	For the year ended 31 March 2013	For the year ended 31 March 2014	For the year ended 31 March 2015
£ per UDA contract uplift[13]	0.5%	0.5%	1.5%	1.6%

The following table reconciles EBITDA before exceptional items to operating profit:

	For the year ended 31 March 2013	For the year ended 31 March 2014
Operating profit	14.5	18.6
Depreciation	11.8	13.6
Amortisation of goodwill	29.3	34.0
Amortisation of grant income	(0.7)	(0.5)
Exceptional items*	1.4	2.1
EBITDA before exceptional items	**56.3**	**67.8**

* Exceptional items in respect of the year ended 31 March 2014 consisted of the costs associated with changes in senior management, including advisory fees. Exceptional items in respect of the year ended 31 March 2013 consisted of integration costs related to the acquisition and integration of Predecessor ADP into Predecessor IDH, including expenses incurred in closing the Predecessor ADP head office, redundancy and compensation payments made to staff, legal and professional fees and consultancy fees.

We are not presenting EBITDA before exceptional items and other EBITDA-based measures as measures of our results of operations. EBITDA before exceptional items and other EBITDA-based measures have important limitations as analytical tools, and you should not consider them in isolation or as substitutes for analysis of our results of operations. EBITDA before exceptional items, estimated pro forma adjusted EBITDA and related leverage and coverage ratios are not measurements of financial performance under UK GAAP and should not be considered as alternatives to other indicators of our operating performance, cash flows or any other measure of performance derived in accordance with UK GAAP. Our management believes that the presentation of EBITDA before exceptional items and EBITDA-based measures is helpful to investors as measures of our operating performance and ability to service our debt. Our EBITDA before exceptional items and our other EBITDA-based measures may not be comparable to similarly titled measures used by other companies.

(1) EBITDA before exceptional items represents operating profit before depreciation of goodwill, amortisation of grant income and exceptional items. Accordingly, EBITDA before exceptional items can be extracted from our consolidated financial statements by taking operating profit and adding back depreciation, amortisation of goodwill, amortisation of grant income and exceptional items.

(2) Estimated pro forma adjusted EBITDA for the year ended 31 March 2014 has been calculated following the methodology set out in the IDH Finance Plc Offering Memorandums dated 22 May 2013 and 6 May 2014. The estimated adjusted EBITDA of the Acquired Dental Practices is management's estimate of the annual EBITDA of the 60 dental practices acquired at different dates during the period between 1 April 2013 and 31 March 2014, less the actual results consolidated in EBITDA before exceptional items from the date of acquisition. For the dbg and The Dental Directory, the EBITDA adjustments are the full year effect of ownership and the synergies described in the Offering Memorandums dated 22 May 2013 and 6 May 2014.

The following table reconciles estimated pro forma adjusted EBITDA to EBITDA before exceptional items:

(£ in millions)	Year ended 31 March 2014
EBITDA before exceptional items	67.8
Estimated adjusted EBITDA of the Acquired Dental Practices	4.7
Adjusted EBITDA of dbg	1.4
Adjusted EBITDA of The Dental Directory	10.9
Estimated pro forma adjusted EBITDA	84.8

(3) Represents EBITDA before exceptional items divided by turnover.

(4) Represents gross profit divided by turnover.

(5) Represents capital expenditures excluding acquisitions refurbishments. Maintenance capital expenditures include capital expenditures required for routine maintenance, equipment replacement, additional equipment purchases, building refurbishment not in connection with an acquisition and capital expenditures associated with practice relocations, but exclude capital expenditures made in connection with acquisitions.

(6) Represents EBITDA before exceptional items, less maintenance capital expenditures, divided by EBITDA before exceptional items.

(7) Represents total senior secured borrowings less available cash at bank and in hand.

(8) Represents total borrowings less available cash at bank and in hand.

(9) Represents the total number of UDAs per dental practices owned at the beginning of a given contract year delivered in such year, divided by the total number of contracted UDAs in place in respect of such dental practices at the end of that contract year. This percentage is calculated based on the agreed total number of UDAs at 31 March of the applicable year and, in respect of the percentage calculated on the agreed total number of UDAs at 31 March 2014, immaterial changes to such percentage may occur pending final agreement with Area Teams regarding overperformance paid or carried over to the next contract year. Because UDAs are delivered under full year contracts, interim UDA delivery is not useful in an analysis of annual UDA delivery percentage.

(10) Represents total private revenues generated by all the practices owned for the whole of the year ended 31 March 2014 divided by the private revenue generated by the same practices in the corresponding periods of the preceding years.

(11) Represents administrative expenses, less depreciation, amortisation of goodwill, amortisation of grant income and exceptional items, divided by turnover.

(12) Represents the total number of dental practices we own as at a specified date.

(13) Represents the nationwide price per UDA per year contract uplift promulgated by the UK Government in a given year. Uplift for 2015 represents an announced uplift of 1.6% in England (with an uplift of 1.47% in Wales and 1.71% in Scotland).

Year ended 31 March 2014 compared to the year ended 31 March 2013

In the year ended 31 March 2014, we acquired 60 dental practices and opened one new dental practice for a total of 585 dental practices in our estate as at 31 March 2014. We also acquired dbg on 16 April 2013.

Turnover

Turnover for the year ended 31 March 2014 has increased by £58.6 million, or 16.8%, from £349.0 million for the year ended 31 March 2013 to £407.5 million for the year ended 31 March 2014. This increase was primarily due to the contribution to turnover from acquisitions, however, we have also experienced increased turnover for NHS dentistry services and private dentistry services in our existing practices. Of this increase, our dentistry services business contributed £51.5 million of turnover growth and our non-dentistry services businesses, including dbg, contributed £7.0 million of turnover growth, in each case for the year ended 31 March 2014 compared to the year ended 31 March 2013. The increase in turnover is further analysed in the table below:

Turnover (£ in millions)	**For the year ended 31 March 2013**	**For the year ended 31 March 2014**	**Movement**
Practices owned as at 1 April 2012	336.5	345.7	9.2
Practice disposals for merger control clearance	0.9	–	(0.9)
Practices acquired or opened during the twelve months ended 31 March 2013	11.6	32.0	20.4
Practices acquired or opened during the year ended 31 March 2014	–	22.8	22.8
Total dental practice turnover	**349.0**	**400.5**	**51.5**

The 51 practices acquired or opened during the year ended 31 March 2013 contributed turnover of £32.0 million for the year ended 31 March 2014, an increase of £20.4 million over such practices' contributions to the year ended 31 March 2013, reflecting our ownership of these practices for the full year. The 61 practices acquired or opened during the year ended 31 March 2014 contributed turnover of £22.8 million for the year ended 31 March 2014, reflecting the immediate impact on our turnover from these acquired practices.

Turnover generated by practices owned at 1 April 2012 increased by £9.2 million, or 2.8%, from £336.5 million for the year ended 31 March 2013 to £345.7 million for the year ended 31 March 2014, due to an 8.6% increase in turnover generated by private dentistry services, and a 1.9% increase in turnover generated by NHS dentistry services that includes the 1.5% NHS dentistry contract uplift for the contract year ended 31 March 2014 and is based on the UDA delivery levels for the contract year.

These increases were partially offset by a one-off decrease in UDA delivery percentage resulting from the conversion of IT systems in Predecessor ADP dental practices during the year ended 31 March 2013.

Cost of sales

Cost of sales increased by £27.3 million, or 14.9%, from £183.5 million for the year ended 31 March 2013, to £210.8 million for the year ended 31 March 2014. Gross profit margin increased by 0.9 percentage points, from 47.4% for the year ended 31 March 2013 to 48.3% for the year ended 31 March 2014. The increase in our cost of sales is primarily the result of the full-period costs of the 51 practices acquired or opened in the twelve months ended 31 March 2013 and the in-period costs of the 61 practices acquired or opened in the year ended 31 March 2014, as well as the increase in sales volumes. Margins have improved through the roll-out of an employed regional dentist programme, leading to a reduction in the use of more expensive locums, and we have also worked with laboratories and material suppliers to limit cost increases.

Other operating income

Other operating income decreased by £0.1m, or 8.1%, from £1.8 million for the year ended 31 March 2013 to £1.7 million for the year ended 31 March 2014. We generate other operating income primarily from income received from Scottish Health Boards to assist in the upkeep of our dental practices (which are based on the proportion of NHS treatment carried out by each dental practice) and property rental income.

Administrative expenses

Administrative expenses increased by £27.0 million, or 17.7%, from £152.8 million for the year ended 31 March 2013, to £179.8 million for the year ended 31 March 2014. This increase was the result of the increase in the number of practices and the consequent growth in staff costs, rent and other establishment costs, an increase in the charge taken for the amortisation of goodwill and the full-year effect of the costs of investment in certain head office functions, including acquisitions, IT, human resources, finance and legal support.

Loss on disposal of assets

Loss on disposal of assets decreased by £3.2 million, or 87.8%, from £3.6 million for the year ended 31 March 2013, to £0.4 million for the year ended 31 March 2014. Costs incurred in the year ended 31 March 2014 relate to the disposal of one dental practice in addition to the sale of freehold assets and the loss on disposal thereof. Costs incurred in the year ended 31 March 2013 relate to the disposal of seven dental practices, of which six were required by the United Kingdom's Office of Fair Trading (a predecessor of the CMA).

Interest payable and similar charges

Interest payable and similar charges decreased by £16.0 million, or 22.8%, from £70.3 million for the year ended 31 March 2013, to £54.3 million for the year ended 31 March 2014. This decrease was the result of the capitalisation of subordinated shareholder loans in May 2013 in connection with the 2013 Notes Issuance, and was partially offset by interest charges from an increased amount of debt drawn to fund acquisitions.

Tax on loss on ordinary activities

Our tax benefit gained on loss on ordinary activities increased by £0.1 million, from £1.9 million for the year ended 31 March 2013, to £2.0 million for the year ended 31 March 2014. This increase was the result of the recognition of the deferred tax asset arising from capital allowances on asset purchases, and was partially offset by the effect of a change in future tax rates.

EBITDA before exceptional items

EBITDA before exceptional items increased by £11.4 million, or 20.3%, from £56.3 million for the year ended 31 March 2013, to £67.8 million for the year ended 31 March 2014, primarily as a result of the contribution from acquisitions and improved trading performance, including like-for-like growth in private dentistry services of 8.6%. This increase was partially offset by an increase in administrative expenses as a percentage of turnover of 0.2 percentage points due to investment in certain head office functions.

NHS dentistry services turnover as a percentage of total turnover

NHS dentistry services turnover as a percentage of total turnover decreased 2.5 percentage points, from 87.4% for the year ended 31 March 2013, to 84.9% for the year ended 31 March 2014. This decrease primarily resulted from the increase in turnover from private dentistry services and the addition of services provided by dbg.

Total annual UDA delivery percentage

Our total annual UDA delivery percentage for the twelve months ended 31 March 2014 was 96.7%, an increase of 0.7 percentage points over our total annual UDA delivery percentage of 96.0% for the year ended 31 March 2013.

Private dentistry services turnover as a percentage of total turnover

Private dentistry services turnover as a percentage of total turnover increased 0.8 percentage points, from 12.6% for the year ended 31 March 2013, to 13.4% for the year ended 31 March 2014. This increase primarily resulted from growth in like-for-like performance from increased volumes, an increase in prices recommended to dentists at the beginning of the financial year and the acquisition of practices with a higher level of participation from private dentistry revenues of those practices revenue.

Like-for-like private turnover growth

Like-for-like private turnover growth was 8.6% for the year ended 31 March 2014, as compared to 2.8% for the year ended 31 March 2013. The increase in growth primarily resulted from an increase in volumes of private dentistry services and the effect of a price increase recommended to dentists.

Administrative expenses as a percentage of turnover

Administrative expenses as a percentage of total turnover increased 0.2 percentage points, from 31.8% for the year ended 31 March 2013, to 32.0% for the year ended 31 March 2014. This increase primarily resulted from higher staff costs from pay rate increases for nurses and practice staff from 1 April 2013, and the full-year effect of investments in systems and headcount of certain head office functions.

Total number of dental practices

Our total number of dental practices increased by 53, or 10.0%, from 532 at 31 March 2013 to 585 at 31 March 2014, due to the acquisition of 60 dental practices, the opening of one new dental practice, seven mergers of practices and the disposal of one practice.

Liquidity and capital resources

"Liquidity" describes the ability of a company to generate sufficient cash flows to meet the cash requirements of its business operations, including working capital needs, capital expenditures, debt service obligations, other commitments, contractual obligations and acquisitions. Our primary sources of liquidity are provided by cash generated from our operating activities and our third-party financings. Our liquidity requirements arise primarily to meet our debt service obligations, to fund acquisitions and to fund capital expenditures.

We primarily rely on cash flow from operations and borrowings under our Revolving Credit Facility to fund capital expenditures and acquisitions, and to provide funds required for our operations. Our debt service obligations consist primarily of interest payments on the Notes and principal and interest payments on amounts drawn under the Revolving Credit Facility. We expect to fund acquisitions in the future primarily through drawings under the Revolving Credit Facility and with cash generated by our operations. We expect to fund capital expenditures primarily with cash generated by our operations. Although we believe that our expected cash flows from operating activities, together with available borrowings under the Revolving Credit Facility, will be adequate to meet our expected general liquidity needs and debt service obligations, we cannot assure you that our business will generate sufficient cash flows from operations to meet these needs or that future debt or equity financing will be available to us in an amount sufficient to meet our liquidity needs, including making payments on the Notes or on our other debt when due. If our cash flow from operating activities is lower than expected, or our capital expenditure requirements exceed our projections, we may be required to seek additional financing, which may not be available on commercially reasonable terms, if at all. Our ability to arrange financing generally and our cost of capital depends on numerous factors, including general economic conditions, the availability of credit from banks, other financial institutions and capital markets, restrictions in the instruments governing our debt and our general financial performance.

Cash flows

The table below summarises our consolidated cash flow statement for the years ended 31 March 2013 and 2014.

(£ in millions)	For the year ended 31 March 2013	For the year ended 31 March 2014
Net cash inflow from operating activities	53.9	54.8
Returns on investments and servicing of finance.....	(19.5)	(41.4)
Taxation……..	(0.3)	0.2
Capital expenditure	(14.5)	(23.5)
Acquisitions and disposals.....	(45.6)	(93.6)
Financing	49.5	68.0

Our net cash inflow from operating activities for the year ended 31 March 2014 increased by £0.9 million, or 1.7%, from £53.9 million for the year ended 31 March 2013 to £54.8 million for the year ended 31 March 2014, primarily due to increased NHS dentistry contracts. Cash outflows from returns on investments and servicing of finance increased by £21.9 million, or 112.3%, from outflows of £19.5 million for the year ended 31 March 2013 to outflows of £41.4 million in the year ended 31 March 2014 primarily due to fees incurred in respect of the 2013 Notes Issuance. Cash outflows from capital expenditures increased by £9.0 million, or 62.7%, from £14.5 million for the year ended 31 March 2013 to £23.5 million for the year ended 31 March 2014, primarily due to a higher number of acquisition refurbishment and practice relocation projects, our dental chair replacement programme and IT projects related to business continuity. Cash outflows from acquisitions and disposals were £93.6 million for the year ended 31 March 2014, an increase of £41.4 million from the year ended 31 March 2013 due to the acquisition of dbg in April 2013 and the timing of acquisitions (49 practices were acquired in the year ended 31 March 2013 compared to 60 practices acquired in the year ended 31 March 2014). Cash inflows from financing for the year ended 31 March 2014 were £68.0 million, primarily resulting from the 2013 Notes Issuance, offset by the repayment of the Old Senior Credit Facilities.

Capital expenditures

Capital expenditures, excluding acquisitions for the year ended 31 March 2014 and for the year ended 31 March 2013 were £21.1 million and £14.1 million, respectively. Our capital expenditures have primarily been made in relation to equipment upgrades and replacements, the merging of small practices into other practices, investment in IT infrastructure and the refurbishment of newly acquired dental practices. In the year ended 31 March 2014, approximately 85% of our capital expenditures constituted maintenance capital expenditures, which we define as capital expenditures excluding acquisitions refurbishments, and approximately 15% of our capital expenditures constituted capital expenditures in connection with acquisitions, or acquisitions refurbishment. Our maintenance capital expenditures constituted 4.4% and 3.4% of our turnover in the years ended 31 March 2014 and 2013, respectively. We expect our maintenance capital expenditures to increase over the medium term as we implement a programme to update the equipment throughout our estate in an effort to drive long-term cost savings and maximize dental chair efficiency and utilization through a targeted spend on new equipment purchases and maintenance.

Our capital expenditures are generally spread through the course of a given year. We expect our capital expenditures to continue to increase year-on-year as we acquire additional dental practices, and we expect to make capital expenditures equivalent to approximately 4.75% of turnover in the twelve months ending 31 March 2015, primarily consisting of capital expenditures in respect of existing practices, IT systems and equipment upgrades. We plan to fund our future capital expenditures with cash from operating activities. We intend to continue to acquire dental practices at a rate comparable to our historical rate of acquisitions.

Working capital requirements

We do not currently have significant short-term or long-term working capital requirements, as we typically receive payments under our NHS dentistry contracts prior to paying costs related thereto. Payments under our NHS dentistry contracts are made to us by NHS England, with payment of 1/12 the contract value paid at the beginning of each month. We collect the patient contributions on behalf of the NHS and remit such amounts to the NHS in arrears approximately two weeks thereafter. Three to six months following the contract year-end (31 March), we receive a statement detailing each UDA performance under each contract. If, at the end of the contract year, a practice has not performed all the UDAs allocated under its contract, NHS England may seek to reclaim UDAs paid for but not performed. Any payment of reclamation must be made after the end of the contract year of underperformance. Changes in our working capital are included in our net cash inflow from operating activities.

Contractual obligations and commercial commitments

The table below sets out our contractual obligations and commitments as at 31 March 2014.

£ in millions	Less than 1 year	1–5 Years	More than 5 years	Total
Floating Rate Notes	–	125.0	–	125.0
Senior Secured Fixed Rate Notes	–	200.0	–	200.0
Second Lien Notes	–	–	75.0	75.0
Deferred consideration	5.3	5.5	–	10.8
Operating leases	10.3	37.6	46.1	94.0
Total contractual obligations	**15.6**	**368.1**	**121.1**	**504.8**

Following the 2014 Issuance, the contractual obligation for the Floating Rate Notes has increased to £225 million due within 1-5 years.

Deferred consideration

Deferred consideration (including earnouts) is payable in respect of certain of our acquisitions based on the performance of the acquired business typically in one to five years following the acquisition. In the case of certain of our recent acquisitions, fees paid to selling dentists may represent a significant portion of the future EBITDA generated by such acquired dental practices above an EBITDA target agreed in the consultancy services agreements entered into in connection with such acquisitions.

Operating leases

Contractual obligations for our operating leases reflect our annual commitments under non-cancellable operating leases, including in respect of premises for rent, vehicles provided to certain members of our management team and various other types of office equipment.

Off-balance sheet arrangements

We are the obligor under a letter of credit issued by Lloyds Bank in the amount of £1.8 million to our clinical directors in respect of liabilities they may incur as partners in certain of our dental practices.

Financial risk management

Market risk is the potential loss arising from adverse changes in market rates and consists of risks relating to foreign exchange rates, interest rates and market prices. We are not exposed to market price risk as we do not own assets the value of which is determined by market prices. We have historically been exposed to limited foreign exchange risk, as we have historically entered into limited foreign currency transactions and as we do not own any trading subsidiaries outside the United Kingdom. However, in connection with the Dental Directory Acquisition, we will become exposed to some foreign exchange risk, as The Dental Directory purchases some of the products it distributes using foreign currencies. In connection with the Dental Directory Acquisition, we rolled over The Dental Directory's existing €2.0 million foreign forward call contract, which terminates in August 2014. We are currently evaluating the need to enter into foreign exchange derivative contracts in the future.

We are exposed to interest rate risk primarily in relation to our debt service obligations, which historically have consisted of debt under the Old Senior Credit Facilities, and at present consist of obligations under our Floating Rate Notes and obligations outstanding under our Revolving Credit Facility. As at 31 March 2014, we have £147 million in financial debt subject to variable interest rates consisting of £125.0 million of Floating Rate Notes and £22.0 million drawn on our Revolving Credit Facility. Following the 2014 Issuance we have £225.0 million in financial debt subject to variable interest rates, consisting entirely of the Floating Rate Notes. The outstanding amounts due under the Revolving Credit Facility were repaid with the proceeds from the 2014 Issuance.

The Floating Rate Notes and drawings under our Revolving Credit Facility expose us to interest rate risks relating to fluctuations in GBP LIBOR. We historically managed the variable interest rate exposure under the Old Senior Credit Facilities through interest rate swaps covering exposure for a portion of the principal outstanding. In connection with the 2013 Notes Issuance, and to hedge our variable interest rate exposure under the Existing Senior Secured Floating Rate Notes, we amended the terms of our existing interest rate swaps on the 2013 Issue Date and rolled them into a new £125.0 million interest rate swap with a termination date of 1 June 2017. We also rolled over the mark-to-market balance owed under our existing interest rate swaps into the new interest rate swap. As at 31 March 2014, we estimate the mark-to-market balance owed under our existing interest rate swap to be

£2.1 million. Our Senior Secured Fixed Rate Notes and Second Lien Notes bear interest at a fixed rate. For fixed rate debt, interest rate changes affect the fair market value of such debt, but do not impact earnings or cash flow.

We are generally not exposed to consumer credit risk. Certain of the procedures undertaken by our dental practices may be paid for under payment plans which we contract to Medenta. While we are not exposed to the credit risk under such payment plans, we are required to carry a consumer credit license in respect of the provision of consumer credit. Whitecross holds our consumer credit license, and undertakes all work made pursuant to such payment plans.

Internal controls

The ultimate source of internal controls is our Board. Our Board has delegated to senior management the establishment and implementation of a system of internal controls appropriate to our business. These controls include the safeguarding of assets; the maintenance of proper accounting records; the reliability of financial information; and compliance with appropriate legislation, regulation and best practice, and are overseen by our independent auditors and our audit committee. At the dental practice level, internal controls are primarily managed by our practice managers and our area and regional managers. In general, the implementation of our internal controls is manual and focused on the prevention of fraudulent UDA claims and the theft of cash. We have previously suffered from breaches of our internal controls that were immaterial to our overall results, including misclaimed UDAs, the theft of petty cash and fraud related to the acquisition of a dental practice. We are currently undertaking a programme to bolster our internal controls by implementing certain automated processes and procedures.

Critical accounting policies and estimates

Our financial statements have been prepared in accordance with UK GAAP. The preparation of these financial statements requires us to make estimates and assumptions that affect the amounts of assets and liabilities we report. We continually evaluate our estimates and assumptions and base them on historical experience and other factors, including expectations of future events that we believe are reasonable under the circumstances. Actual results may differ from these estimates. Whilst we do not believe that any of such estimates and assumptions have material implications for our results of operations or financial condition or are material due to a high degree of subjectivity or judgement, the following are significant accounting policies which are determined, to the extent described above, on the basis of estimates and assumptions.

Revenue recognition

Turnover derived from NHS dentistry contracts in England and Wales is recognised based on the volume of dental activity delivered in the financial period, limited to the overall total contract value of the NHS dentistry contract. Turnover from all private dental work and NHS patients in Scotland is recognised on the completion of each piece of treatment carried out, with the exception of orthodontic treatment, which is recognised based on the stage of completion reached during the course of treatment.

Work required for refurbishments

Any refurbishment of properties in our property portfolio is subject to multiple quotes from external third parties. Additionally, all properties in our property portfolio must meet required regulatory standards. Our property portfolio is managed internally by a property management team and supported by external consultants who review our practices and recommend improvements in meeting regulatory compliance in connection with our properties. Part of our internal central property management support function involves regulatory compliance in connection with our properties. Our property management team also manages a defined capital expenditure cycle and dilapidation schedule in respect of our leased and freehold properties.

Goodwill

Purchased goodwill (representing the excess of the fair value of the consideration and associated costs given over the fair value of the separable net assets acquired) arising on consolidation is capitalised. Positive goodwill is amortised to nil by equal annual instalments over its estimated useful life of 20 years, representing the period over which the group expects to benefit from the assets acquired. The carrying value of goodwill is evaluated when there is an indicator of impairment. We use forecast cash flow information and estimates of future growth to determine the discount rate for assessing any impairment of goodwill. If our results of operations in future periods are adverse to the estimates used for impairment testing an impairment charge may be triggered.

The fair value of the consideration includes both actual and deferred consideration. Where the deferred consideration is contingent upon the future trading performance of an acquired asset, an estimate of the present

value of the likely consideration is made. The contingent deferred consideration is reassessed annually and a corresponding adjustment is made to the goodwill arising on acquisition.

Defined benefit scheme

Details of the principal actuarial assumptions used in calculating the recognised liability or surplus for the defined benefit plans are given in note 24 to the audited financial statements for the twelve months ended 31 March 2014, which are included in this Annual report. Changes to the discount rate, mortality rates and actual return on plan assets may necessitate material adjustments to this surplus in the future.

Deferred tax balances

Deferred tax is recognised in respect of all timing differences that have originated but not reversed as at the balance sheet date in a financial period, where transactions or events that result in an obligation to pay more tax or a right to pay less tax in the future have occurred as at the balance sheet date.

A net deferred tax asset is regarded as recoverable and is recognised in the financial statements only when, on the basis of all available evidence, it can be regarded as more likely than not that there will be taxable profits against which to recover forward tax losses and from which the future reversal of underlying timing differences can be deducted.

Deferred tax is measured as at the average tax rates that are expected to apply in the periods in which the timing differences are expected to reverse based on tax rates and regulations that have been enacted or substantively enacted as at the balance sheet date.

Results of operations for the three months ended 31 March 2013 and 31 March 2014

The following tables set out the key line items from the consolidated profit and loss account and consolidated cash flow statements for the three months ended 31 March 2013 ("Q4 FY13") and 31 March 2014 ("Q4 FY14").

Consolidated profit and loss account

(£ in millions)	For the three months ended 31 March 2013	For the three months ended 31 March 2014
Turnover	**94.4**	**106.7**
Cost of sales	(49.4)	(55.1)
Gross profit	**45.1**	**51.6**
Other operating income	0.5	0.4
Administrative expenses	(40.2)	(45.6)
Operating profit	**5.4**	**6.4**
Loss on disposal of assets	(2.9)	(0.2)
Profit on ordinary activities before interest and taxation	**2.4**	**6.2**
Interest receivable and similar income	–	–
Interest payable and similar charges	(17.8)	(7.9)
Loss on ordinary activities before taxation	**(15.3)**	**(1.7)**
Tax on loss on ordinary activities	2.5	1.4
Loss on ordinary activities after taxation	**(12.8)**	**(0.3)**
Equity minority interests	–	–
Loss for the financial period	**(12.8)**	**(0.3)**

Consolidated statement of cash flows

(£ in millions)	For the three months ended 31 March 2013	For the three months ended 31 March 2014
Net cash inflow from operating activities	15.6	18.2
Senior facility loan interest paid and interest swap cash paid	(4.6)	(11.4)
Syndicate charges paid	(0.3)	(0.4)
Returns on investment and servicing of finance	(4.9)	(11.8)
Net cash inflow after returns on investment and servicing of finance	10.7	6.4
Taxation	(0.2)	–
Capital expenditure	(4.5)	(8.4)
Net cash inflow/(outflow) before acquisitions	6.0	(2.0)
Acquisitions and disposals	(20.2)	(25.4)
Net cash outflow before financing	(14.2)	(27.4)
Financing	40.2	17.0
Increase/(decrease) in cash in the financial period	26.1	(10.4)

Key performance indicators

	Q1 FY14	Q2 FY14	Q3 FY14	Q4 FY14
Other profit and cash flow data				
Turnover (£m)	98.7	97.6	104.4	106.7
EBITDA (£m)	15.4	15.6	17.7	19.1
LTM EBITDA (£m)	59.0	61.5	64.8	67.8
Operating profit (£m)	4.0	4.0	4.2	6.4
NHS dentistry services as a percentage of turnover	85.6%	85.0%	84.6%	84.4%
Private dentistry as a percentage of turnover	12.7%	13.3%	13.7%	13.8%
Like-for-like private turnover growth	5.6%	7.6%	12.6%	8.4%
Gross profit margin %	47.8%	48.9%	48.0%	48.4%
Administrative expenses as a percentage of turnover	32.7%	33.3%	31.4%	30.9%
EBITDA margin	15.6%	16.0%	17.0%	17.9%
Number of dental practices	550	561	570	585
Maintenance capital expenditure (£m)	4.6	4.4	3.8	5.1
Cash conversion after maintenance capital expenditure	23.7%	67.6%	60.6%	72.0%
Proforma EBITDA (£m)	70.3	71.6	73.0	84.8

Differences between UK GAAP and IFRS

The consolidated financial statements of the Parent have been presented in accordance with UK GAAP, which differs in certain significant respects from IFRS. We have not prepared financial statements in accordance with IFRS or prepared a reconciliation of the financial statements of the Parent to IFRS and, accordingly, cannot offer any assurance that the differences described below would, in fact, be the accounting principles creating the greatest differences between the financial statements of the Parent prepared under IFRS and under UK GAAP. In addition, we cannot estimate the net effect that applying IFRS would have on our results of operations or financial condition, or any component thereof, in any of the presentations of financial information in this Annual report. Notwithstanding this, the effect of such differences may be material.

The differences between UK GAAP and IFRS described below are not necessarily differences that have existed throughout the period covered in the financial statements. This statement is not intended to provide a comprehensive list of all such differences specifically related to the Parent or to us or to the industry in which we operate. IFRS is generally more restrictive and comprehensive than UK GAAP regarding the recognition and measurement of transactions, account classification and disclosure requirements. No attempt has been made to identify all disclosure, presentation or classification differences that would affect the manner in which transactions and events are presented in the financial statements or the notes thereto.

Financial statement presentation

Under IFRS, the presentation of the balance sheet is based on either a current/non-current split of assets and liabilities or based on liquidity where such a presentation provides information that is reliable and more relevant. Under UK GAAP, the balance sheet cannot be presented on a liquidity basis only.

Under UK GAAP, the cash flow statement is based on changes in cash which represent cash in hand and deposits repayable on demand less overdrafts repayable on demand. Under IFRS, the cash flow statement based on changes in cash represents cash in hand and deposits repayable on demand and cash equivalents, which are short-term highly liquid investments, less overdrafts repayable on demand, which form an integral part of an enterprises cash management.

There are several presentational differences between IFRS and UK GAAP in respect of the balance sheet, including: (1) software development and purchased software costs are recognised within tangible assets under UK GAAP but are reclassified as an intangible asset under IFRS, and (2) cash placed on short-term deposit with original maturities

of greater than three months are classified as cash at bank and in hand under UK GAAP but are reclassified as a financial asset under IFRS.

The disclosures in the explanatory notes to the financial statements are also more extensive under IFRS than UK GAAP.

Business combinations

UK GAAP requires that intangible assets be separately recognised in a business combination only if they can be disposed of separately without disposing of the business of the entity and if their value can be measured reliably on initial measurement.

IFRS requires that all the intangible assets at the acquisition date be recognised separately in the consolidated financial statements if they meet the definition of an intangible asset and if their fair value can be measured reliably. In contrast to UK GAAP, an intangible asset is required to be recognised if it arises from contractual or other legal rights, regardless of whether those rights are transferable or separable from the entity or from other rights and obligations. Under IFRS, there is a rebuttable presumption that the fair value of the intangible asset can be measured reliably if it has a finite useful life.

UK GAAP requires that goodwill is amortised over its estimated useful life and tested for impairment annually and if events or changes in circumstances indicate that its carrying value may not be recoverable. IFRS prohibits the amortisation of goodwill. Instead, the acquirer must perform a goodwill impairment test annually and if events or changes in circumstances indicate that its carrying value may not be recoverable, in accordance with IAS 36.

Under IFRS, all acquisition related costs, except costs to issue debt or equity, are recognised immediately in the income statement. Under UK GAAP, these costs can be capitalised as part of goodwill.

Deferred taxes

IFRS takes a balance sheet approach to deferred tax whereby deferred tax is recognised in the balance sheet by applying the appropriate tax rate to the temporary differences arising between the carrying value of assets and liabilities and their tax base. Under UK GAAP, deferred tax is provided in respect of timing differences arising in the profit and loss account. UK GAAP permits, but does not require, the discounting of deferred tax liabilities. IFRS prohibits discounting.

Loans and borrowings

Under UK GAAP, loans and borrowings such as bank debt are recognised at the nominal value of the debt assumed. Under IFRS, the debt is recognised initially at fair value, net of transaction costs incurred. It is then subsequently stated at amortised cost using the effective interest rate method. The effective interest method is used to calculate the amortised cost of the debt and to allocate the associated interest expense over the relevant period. The effective interest rate is the rate that exactly discounts the cash flows associated with the debt to its net carrying amount at initial recognition.

Financial instruments

Under UK GAAP, certain financial instruments, such as derivative financial instruments, are not recorded in financial statements where the underlying transaction to which they are associated is recorded. IFRS requires many financial instruments, such as derivative financial instruments, to be carried on the balance sheet at fair value

Industry

Overview of the UK healthcare system

Government spending on healthcare in the United Kingdom (excluding pharmaceuticals) for the twelve months ended 31 March 2014 was approximately £137 billion, broadly in line with spending in the previous year in nominal terms. The provision of healthcare in the United Kingdom is dominated by the National Health Service (the "NHS"), a public sector body, and its affiliates. The NHS was founded in 1948 under the principles of universality and equality, to provide publicly funded access to medical care to all residents of the United Kingdom. Despite numerous political, administrative and organisational changes, the NHS remains a universal service that provides healthcare on the basis of need and not on ability to pay. The NHS is funded through taxation and national insurance contributions. Private health insurers and independent providers of healthcare play a comparatively small role in the healthcare sector in the United Kingdom. The UK Office for National Statistics estimated that the independent sector (not-for-profit and for-profit) accounted for approximately 17% of the total healthcare expenditure in the United Kingdom, with the NHS contributing 83%, in each case for the twelve months ended 31 March 2013. Excluding certain prescribed drugs and primary care eye and dental care, which require patient contributions (other than for certain exempt groups) all public healthcare services provided by the NHS are free to the patient. Healthcare and health policy for England is the responsibility of the UK Government, whereas in Scotland and Wales it is the responsibility of the respective devolved governments. In England, the NHS is supervised by the Department of Health.

The UK healthcare system

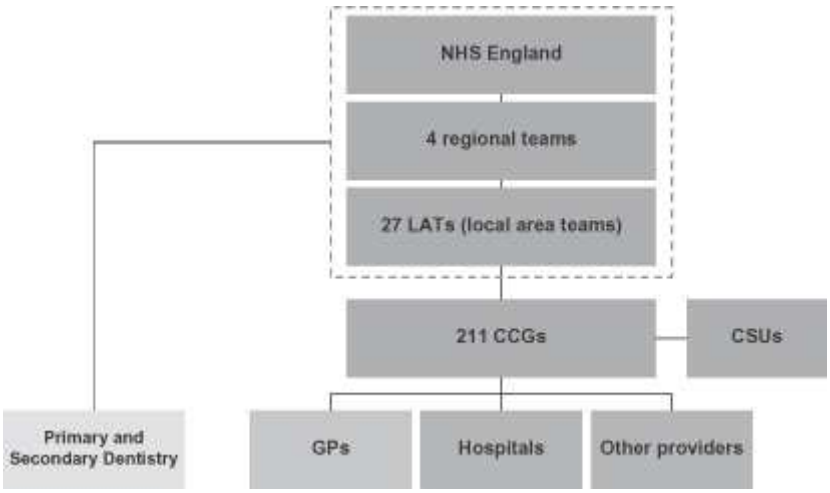
The UK healthcare system is divided into the primary and secondary care subsectors. Primary care consists of routine medical care, check-ups and outpatient medical services. Primary care service providers include general practitioners ("GPs"), dentists, opticians, pharmacists, NHS walk-in centres and NHS Direct (the NHS's online and telephone health advice and information service). These services are delivered by a wide range of independent contractors on behalf of the NHS, including GPs, dentists, pharmacists and optometrists. Care that goes beyond primary care is referred to as "secondary care" (also known as "acute care"), which consists of hospital-based care and specialised consultative healthcare accessed through referral from a primary or community health professional, such as a GP. Secondary care services include emergency and urgent care, acute care, ambulance services and mental health and elder care services.

Dentistry is essentially a primary care discipline insofar as the vast majority of patient care takes place in an outpatient surgery setting and most treatments are routine and are provided by generalists. Dental treatments beyond the primary level include, amongst others, orthodontics, restorative and paediatric treatments and complicated surgical extractions (both in-patient and out-patient). Primary care dentistry makes up the majority of the total dental market and is weighted towards NHS dentistry services.

NHS

In an effort to reduce costs and modernise the healthcare system, independent healthcare service providers have been permitted to compete and offer their services in certain subsectors of the NHS. Due to capacity and capital constraints, private sector involvement in the NHS has grown. The extent of private sector involvement is determined by the need and willingness of the NHS to outsource these services.

The following diagram presents the NHS organisational structure:



Clinical Commissioning Groups ("CCGs") and Area Teams share the responsibilities for commissioning services for their local communities, with Area Teams acting on behalf of the NHS England (in England) in respect of dental services. The NHS Commissioning Board has regional and local teams to facilitate relationships with providers, but operates as one national body.

Area Teams play a key role in the oversight of commissioning, maintaining a focus on addressing unequal access to healthcare and ensuring the right balance between consistency and the adoption of national frameworks and localisation. They also support the coordination of some of NHS England's nationwide initiatives. The Area Teams in England have taken on direct commissioning responsibilities for GP services, dental services, pharmaceutical services, and certain aspects of optical services, and as such represent the interface for the majority of services at a local level, though the contracting party for such services is NHS England.

Area Teams and CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities or private sector providers. They must, however, be assured of the quality of the services they commission, taking into account both National Institute for Health and Care Excellence ("NICE") guidelines and CQC data regarding service providers.

Budget environment

For the year ended 31 March 2014, the UK Government budget for the NHS in England was £95.6 billion. According to the Budget 2014, planned NHS expenditures are £108.3 billion for the twelve months ended 31 March 2015, respectively. In addition, the UK Government has confirmed that its policy is that expenditure for 2015-2016 on health, schools and Official Development Assistance ("ODA") will be protected from cuts.

The UK dental service market

Introduction

The dentistry services market in the United Kingdom is critical to ensuring the oral health of the UK population, with over one million patient contacts per week occurring within NHS dentistry services alone. Oral health is not only important to a patient's appearance and sense of well-being, but also to overall physical health. According to the World Health Organization, oral diseases are the most common of the chronic diseases worldwide and are important public health problems because of their prevalence, their impact on individuals and society, and the expense of their treatment. Cavities and gum disease may contribute to many serious conditions, such as diabetes, cardiovascular diseases and respiratory diseases, and lead to serious infections.

Residents of the United Kingdom are entitled to receive all clinically necessary dental treatment from the NHS. Primary care NHS dentistry services are available to adults and children without registration in England and Wales from dentists who are contracted to provide NHS dentistry. In Scotland, adults and children must be registered with a dentist to receive treatment.

Dental treatment in the United Kingdom can be either fully funded or part-funded by the NHS or privately funded by the patient (whether directly or through the use of a dental payment plan or insurance). Free NHS dental treatment is available for specified groups of patients who are exempt from payment, such as children, new and expectant mothers, and individuals on certain benefits. In addition, in Scotland all dental examinations are free to the patient. Patients not exempt from payment pay a contribution toward the cost of NHS dentistry services. Patients with low incomes who do not fall into any of the specified groups of patients who are exempt from payment may be entitled to reduced patient contributions.

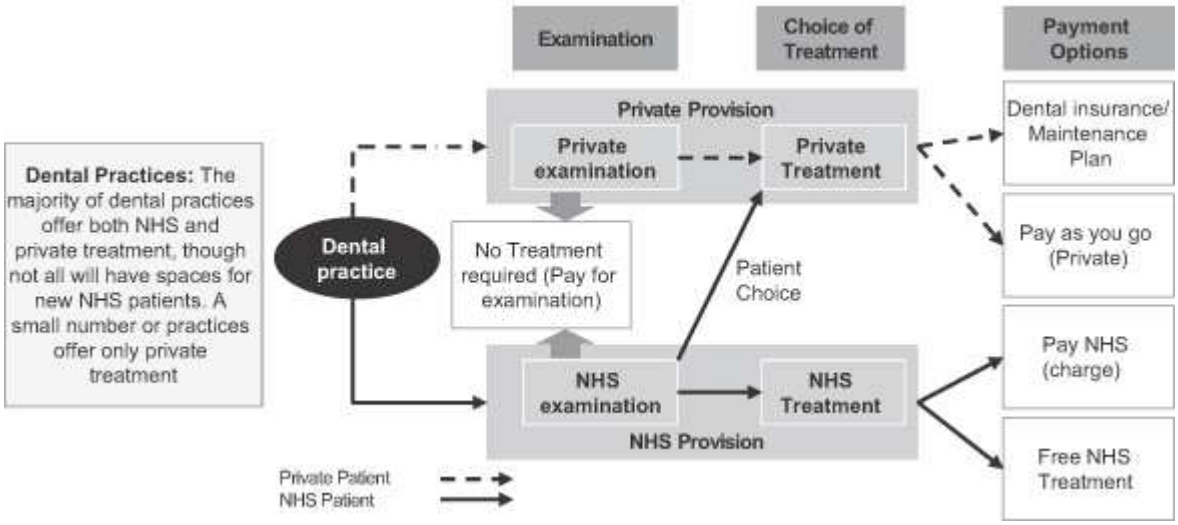
Any treatment needed to keep mouth, teeth and gums healthy and free of pain may be made under NHS dentistry services. In England, this includes dentures, root canals, extractions, crowns and bridges, any preventive treatment needed such as a scale and polish, an appointment with a dental hygienist, fluoride varnish or fissure sealants, the removal of wisdom teeth if necessary, silver-coloured (amalgam) filings or white fillings where clinically appropriate, and orthodontics for under-18s if considered clinically necessary.

Patients have the option of choosing private dentistry services, NHS dentistry services or a combination of private and NHS dentistry services depending on their preferences. NHS dentistry services are almost exclusively provided by the private sector with the vast majority of dentists practising in primary care settings offering NHS dentistry services or a combination of NHS and private dentistry services, with fewer than 10% of dentists carrying out private dentistry services only. Laing & Buisson estimated in 2013 that just over 22% of patients received wholly private dentistry care, and 2% of patients received a mix of private dentistry services and NHS dentistry services. In contrast to NHS dentistry services, private dentistry services differ in that:

- treatment prices are set by the dentist and are typically more expensive than NHS prices;

- there are no subsidised patients, and patients typically pay the full amount for their treatment at the time of their visit;
- patients receive faster service and the range of treatments, technologies and materials available is unrestricted; and
- private dentists' patient lists are typically half the size of those in NHS practices.

The following diagram presents a typical patient journey for NHS dentistry services and private dentistry services:



Market overview

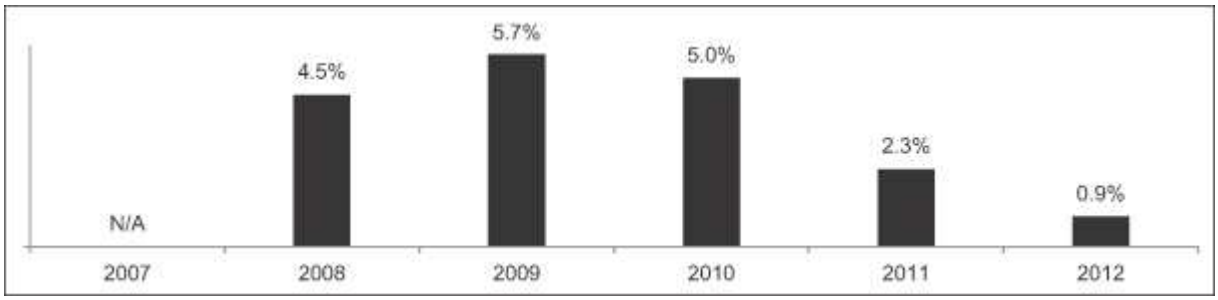
According to Laing & Buisson, the primary care dentistry market in the United Kingdom generated £3.6 billion in spending on NHS dentistry services and £2.2 billion in spending on private dentistry services, in each case in the twelve months ended 31 March 2014. The NHS funding of NHS dentistry services represents less than 3% of the overall UK Government health expenditure on the NHS.

The primary care dentistry market has seen significant growth, with overall spending increasing by a compound annual growth rate of approximately 5% in nominal terms between the twelve months ended 31 March 1998 and the twelve months ended 31 March 2013. The economic downturn softened demand for private dentistry in the twelve months ended 31 March 2008 and 2009 as recessionary impacts held back consumer purchasing, with patients shifting from private to NHS dentistry to save on costs. From the twelve months ended 31 March 2005 to the twelve months ended 31 March 2014, private dentistry experienced a compound annual growth rate of less than 1% per annum in nominal terms. In contrast, NHS dental expenditure has remained resilient in the downturn and maintained positive nominal growth, with annual growth of 4% over the same period in nominal terms. Historically, NHS funding for dentistry has not shown a strong correlation to the macroeconomic environment underpinning the stability of the sector throughout economic cycles.

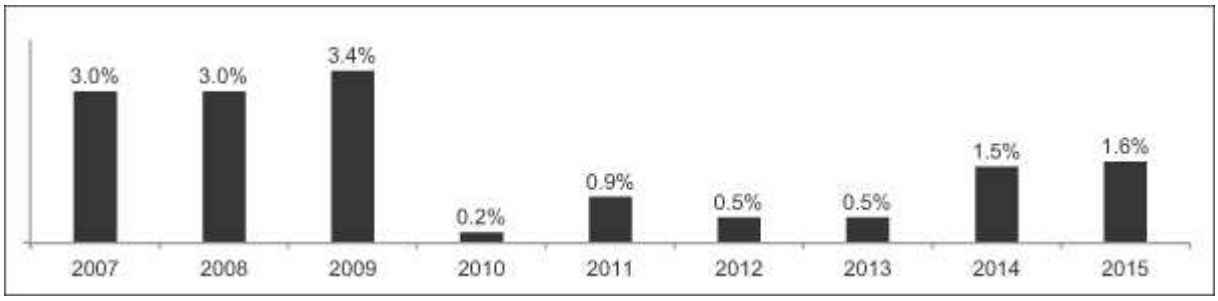
Since the introduction of UDA-based contracts to commission NHS dental services in 2006, both UDA volumes and values have increased each year. An additional 1.8 million patients had access to a NHS dentist in England in the 24 months ended 31 December 2013 compared to the 24 months ended 31 March 2006, driven by the UK Government's continued commitment to increase access to NHS dentistry. Over the same period, UDA values were steadily adjusted upwards, with a price increase of 1.5% for the contract year ending 31 March 2014, and with a price increase of 1.6% announced by the UK Government for the contract year ending 31 March 2015.

The following charts show UDA volume growth from 2007 to 2012 and contract uplift from 2007 to 2015:

UDA volume growth:



UDA value growth:



Source: Doctor's and Dentist's Remuneration Board, Department of Health, NHS Information Centre. Uplift for 2015 represents an announced uplift of 1.6% in England, 1.47% in Wales and 1.71% in Scotland.

Supply and demand

According to the General Dental Council, there were approximately 39,000 dentists registered to practice dentistry in the United Kingdom at the end of 2011. The number of primary care dentists was estimated to be 29,500 as at March 2010, with the vast majority, some 27,000, offering NHS dentistry services or a combination of NHS and private dentistry services. Dental practices are typically either small or medium-sized private businesses owned either by an individual or a partnership of dentists, or are owned by a dental body corporate. Compared to other European countries, the United Kingdom has one of the lowest rates of dentists per capita, with only approximately 500 dentists per one million members of the population. This compares to approximately 650 in France and approximately 800 in Germany.

Since 2000, the number of dentists in the United Kingdom has steadily increased, but the United Kingdom still has an estimated shortage of about 2,000 NHS dentists. Access to NHS dentistry services continues to grow; however, less than 56% of the population accessed NHS dentistry services as at December 2012, substantially below the UK Government's target access rate of 64%.

Significant efforts have been made by the UK Government to improve the supply of dentists to address historical shortages. These efforts have focused on opening new UK dental schools and expanding enrolment, and attracting more EEA-qualified dentists into the United Kingdom. Since 2002, there has been an expansion in the number of places available for students at dental schools in the United Kingdom. In England alone, training places increased by approximately 25% in 2005 (from 670 to 840 places), which helped offset the impact of older dentists retiring and resulted in a progressive increase in UK-educated dental graduates from 2009. This was accompanied by a substantial capital investment programme focused on new training facilities, most recently manifesting itself in the opening of two new dental schools in the southwest of England and in Scotland in 2007 and 2008, respectively. According to the General Dental Council, the inflow of dentists from the EEA has continued, with registered dentists increasing to 6,723 at December 2011 from 5,053 at December 2007, aided by a change of UK Government requirements for such dentists to practice in the United Kingdom.

Significant unsatisfied demand for more NHS dentistry services persists, as only 29.9 million patients in England were seen by a NHS England dentist in the 24 months ending December 2013, an increase of only 1.8 million over the March 2006 baseline. Overall, 55.9% of the population of England was seen by an NHS England dentist in the 24 months ended 31 December 2013. Meeting the UK Government target of 64% would provide access to NHS dentistry to approximately four million new patients in England. Demand continues to be driven by an ageing population and an increased public understanding of the importance of good dental hygiene.

Highly regulated market

As with other healthcare sectors, the UK dental market is a highly regulated market in which dental professionals must be registered with the regulatory body, the General Dental Council, in order to work in the United Kingdom. Since April 2011, the activity of dentists in England has also been subject to regulation by the CQC, which is responsible for ensuring that the care and treatment provided by all dental practices in England meet government standards of quality and safety. See "Business—Regulation". Under the current contract system the provision of NHS dentistry services is subject to more regulatory oversight than private practice due to the nature of the tendering process and the importance of strong relationships with NHS England.

We believe that the highly regulated nature of the provision of NHS dentistry services provides a competitive advantage to existing market participants, due in part to:

- *Evergreen GDS NHS contracts*. The majority of NHS dentistry contracts are evergreen GDS contracts with no contracted end date, resulting in a limited number of new NHS dental contracts being put out for competitive tender. NHS contracts are unlikely to be moved to another supplier unless there is significant underperformance. See "Business—NHS framework contracts".
- *Ability to attract and retain qualified dentists*. Dental qualifications are required to work within a practice and overseas dentists need to go through UK registration processes before they can practice in the United Kingdom. We believe this works to the advantage of larger market participants, like us, who are better able to absorb talent sourcing and retention costs, including in respect of overseas sourcing when necessary.
- *NHS relationships*. The process for awarding UDAs can be lengthy and is often done by tendering to the general market. However, we believe that preferred and existing suppliers with track records of delivering UDA targets have historically been more successful in winning contract tenders. Large-scale suppliers of NHS dentistry services also tend to have strong relationships with NHS England.

Market trends

We believe that there is significant scope for growth in demand for dental services in the United Kingdom as the market remains underdeveloped in terms of both spending and the supply of dentists. Structural growth factors have driven real growth in NHS dental spending over the last decade, and provide strong prospects for continued future growth.

The sector benefits from a number of favourable long-term trends in healthcare generally and dentistry in particular, including, amongst others, an ageing UK population, increased dental health expectations and increasing public understanding of the importance of good dental hygiene, as well as technological advances facilitating access to new treatments to more patients at lower costs.

NHS dentistry is considered a key front-line service of the UK Government. Despite recurring cycles of macroeconomic volatility, NHS volumes and values have both remained stable. The UK Government remains committed to increasing access to NHS dentistry. For example, in February 2013, the Department of Health announced a £30 million injection into NHS dentistry to allow more patients to register with a dentist, which was the second year in which additional dental funding was provided. Around 40% of the UK population does not visit the dentist on a regular basis, with the majority of this population base receiving dental treatment irregularly and a small proportion never visiting a dentist.

UK dental spending and dentists per capita remain low compared to other western European countries. According to Laing & Buisson, average spending on primary care dentistry per capita amounted to just over £90 in the twelve months ended 31 March 2014 in the United Kingdom, with patient spending (on NHS and private dentistry) per capita at £46 and the remaining £44 funded by the NHS. Over the last few years, the UK Government has made substantial investments in increasing capacity in UK dental schools, with some additional capacity beginning to enter the market with approximately 918 dentists graduated in 2013, an increase of approximately 36% compared to 2004, to meet this shortfall in the supply of dental services.

The highly fragmented UK dental market provides considerable scope for consolidation for nationwide operators with the platform and resources to drive consolidation. The consolidation trend in the UK primary care dentistry market is expected to continue over the long term, as existing corporate groups continue to expand.

Business

Overview

We are the leading provider of dental services in the United Kingdom, with 507 NHS dentistry contracts across our network of 585 dental practices throughout England, Scotland and Wales. We have a market share of approximately 5% in terms of number of dental practices and 6.6% in terms of revenues. Our dentists offer a broad range of primary care dental services in our dental practices, including dental examinations, fillings and extractions, as well as more specialised dental services such as cosmetic dentistry and orthodontics. We operate in the UK dental market, which benefits from stability in terms of volume and pricing and from increased government focus on improving access to dental services. In the year ended 31 March 2014, we recorded turnover of £407.5 million and generated EBITDA of £67.8 million.

Our core business is the provision of primary care dental services under long-term contracts with NHS England, which we refer to as "NHS dentistry services". NHS dentistry services accounted for 85% of our turnover for the year ended 31 March 2014. The majority of our dental practices also provide private dentistry services, including general dentistry, hygienist, and cosmetic and specialist services, such as sedation, implants and orthodontics. Private dentistry services accounted for 13% of our turnover for the year ended 31 March 2014. Services provided by dbg (which we acquired on 16 April 2013) generated 2% of our turnover for the year ended 31 March 2014. 90% of our dental practices are located in England, with 6% in Scotland and 4% in Wales.

We provide NHS dentistry services in England and Wales pursuant to contracts competitively tendered with the NHS specifying targeted annual volumes of units of dental activity ("UDAs") for the contracted dental practice or entity. We refer to these contracts as "NHS dentistry contracts". Unlike other UK health subsectors, such as care homes, there is no single NHS dentistry contract. Instead, our individual dental practices enter into separate NHS dentistry contracts with NHS England (or, in the case of Wales, with Welsh health boards). As at 31 March 2014, our dental practices were contracted under 507 such NHS dentistry contracts. Each NHS dentistry contract in England and Wales for UDAs specifies a fixed UDA volume per year target, and each UDA delivered under an NHS dentistry contract is assigned a fixed value in a given year, with the number of UDAs per treatment varying based on the treatment provided. Approximately 94% of our NHS dentistry contracts, covering 74% of our turnover in the year ended 31 March 2014, consist of general dentistry services ("GDS") contracts, which we refer to as "evergreen" as they have no fixed term and roll over indefinitely so long as 96% of the UDA performance targets are met at least once every three years. None of our GDS contracts have ever been terminated. UDA rates are set annually and historically have benefited from annual price increases ("contract uplifts"), with the announced contract uplift for the contract year ending 31 March 2015 constituting a 1.6% increase over the prior contract year for England (with an uplift of 1.47% in Wales and 1.71% in Scotland). Unlike other UK healthcare sectors, NHS dentistry services providers benefit from individually negotiated contracts.

In connection with our strategy to drive value and grow our business through acquisitions of suppliers of consumables, materials, equipment and services, on 17 April 2014, we acquired HM Logistics Limited ("The Dental Directory"), a distributor of dental consumables and materials to dental practices throughout the United Kingdom. The Dental Directory distributes a catalogue of up to 27,000 products from its central logistics platform through its on-line and mail order service, including dental consumables, specialist products including orthodontics and oral hygiene and implant products and dentistry equipment ranging from dental chairs and cabinetry to digital imaging systems. The Dental Directory also carries out services such as installation and maintenance and has a handpiece repair business. In their last financial year, the year ended 31 December 2013, The Dental Directory had adjusted sales of £103.9 million and adjusted EBITDA of £8.7 million. The Dental Directory Acquisition increases our presence in the consumables, materials, equipment and services supplier market business that we began with the acquisition of dbg on 16 April 2013.

We are paid for our NHS dentistry services in equal monthly instalments of our annual contracted value. This results in a well-matched cash flow and cost profile as we typically receive payments on our NHS dentistry contracts prior to paying related costs. Private dentistry services are typically paid for by the patient prior to treatment.

A typical dental practice for us has three or more dental chairs, with three or four self-employed, independently contracted dentists offering primary care dental services under an NHS dentistry contract, supported by three to four nurses employed by us. As at 31 March 2014, more than 2,300 self-employed, independently contracted dentists worked in our dental practices, supplemented by approximately 100 dentists not assigned to a single practice, which we refer to as "locums", and supported by approximately 5,600 dental and central support staff. In addition, approximately 300 hygienists work across our dental practices.

We own the NHS dentistry contracts and infrastructure of our dental practices and employ the dental support staff, whilst contracting with self-employed dentists for provision of dental services. We believe our business model is attractive to dentists as we enable dentists to focus on dentistry by taking on the administrative, regulatory and

compliance burdens associated with running a dental practice. Amongst our most significant costs are dentist fees and costs for laboratory work and materials, all of which are directly linked to volumes of sales and activity.

History

Predecessor IDH, our predecessor group, was founded by a practising dentist in 1996. It listed on the Alternative Investment Market of the London Stock Exchange in 2002 and delisted in 2004. In 2006, it was acquired by Legal & General Ventures and was subsequently sold to Merrill Lynch Global Private Equity in 2008. On 11 May 2011, we were acquired by Carlyle and Palamon and were simultaneously merged with Associated Dental Practices, which owned 133 dental practices at that time. Associated Dental Practices was founded in 1985 by a group of dentists and experienced rapid expansion through both organic growth and acquisitions. Associated Dental Practices was acquired by Kaupthing Capital Partners in 2007 and was subsequently sold to a consortium led by Palamon in 2009. We have expanded significantly through both acquisitions and organic growth, and we have gradually consolidated our position as the leading provider of dental services in the United Kingdom.

Dental services

We are the leading provider of dental services in the United Kingdom. Our dental services consist of NHS dentistry and private dentistry services. We are not active in the secondary care dental services market. Our NHS dentistry and private dentistry services accounted for 85% and 13%, respectively, of our turnover in the year ended 31 March 2014.

As at 31 March 2014, we had a network of 585 dental practices in the United Kingdom, which provide both NHS and private dentistry services. More than 80% of our dental practices have three dental chairs or more and on average we have approximately four dental chairs per dental practice. A typical dental practice for us has three to four self-employed, independently contracted dentists offering primary care dental services under an NHS dentistry contract, supported by three to four nurses employed by us. In addition, approximately 300 hygienists work across our practices, the majority of whom are self-employed, independent contractors.

In the year ended 31 March 2014, our top 200 dental practices generated approximately 60% of our EBITDA before exceptional items. In the year ended 31 March 2014, more than 98% of our dental practices generated positive EBITDA before head office costs and exceptional items. Only 11 of our dental practices made an aggregate loss in the year ended 31 March 2014. We are focused on improving the performance of the minority of our dental practices that is loss-making, including by marketing these dental practices to new and lapsed patients.

NHS dentistry services

Through our NHS dentistry contracts, we provide the majority of our dental services to NHS patients. In the year ended 31 March 2014, turnover generated by our NHS dentistry services was £346.0 million, or 85% of our total turnover. We provide primary care dental services such as dental examinations, periodontal treatment, amalgam fillings, endodontics and extractions, as well as fitting bridges, crowns and dentures. Our dentists also provide advice on how to care for teeth and gums in order to prevent oral health problems.

Our dentists have a duty of care to offer and carry out all treatments that are within their professional capabilities, and they refer patients to appropriate specialised dentists if a specific dental service is outside their capabilities. However, during the course of a treatment, NHS patients can choose to receive private dentistry services offered by the same dentist.

Our NHS dentistry services are funded by the NHS, and by fixed patient contributions depending on whether or not such person is exempt, and varying in amount based on the type of treatment. The patient contribution is set by the NHS and revised annually. The full amount is contributed by the NHS where patients are exempt from payment. Exempt patients include students under 19 years of age, the unemployed and new and expectant mothers. In addition, certain low income patients may be entitled to partial exemptions, depending on their income.

Private dentistry services

We provide our private dentistry services to both NHS patients and non-NHS patients. In the year ended 31 March 2014, turnover generated by our private dentistry services was £54.4 million, or 13% of our turnover. All NHS patients can elect to receive private treatment, and private dentistry services may be provided as enhancements or add-ons to NHS dentistry services. In general, we provide our private dentistry services in the same dental practices where we provide our NHS dentistry services. We work to expand patient choice by broadening our offering of private dentistry services. Whilst dentists working in our dental practices may educate patients as to our private dentistry services, the choice of private dentistry services lies solely with the patient.

Certain cosmetic and advanced dental treatments can only be offered as part of our private dentistry services. The most common treatments that patients opt for privately include white fillings, advanced crowns and bridges, advanced dentures, implants, teeth whitening, facial aesthetics, hygienist services, orthodontics and treatments by specialised dentists. Other specialist dentistry services offered in some of our dental practices include sedation dentistry services, oral surgery, domiciliary services (that is, the treatment of patients outside of their dental surgery and at their residence), and oral pathology and maxilla facial surgery, which includes the diagnosis and treatment of oral lesions such as oral cancer. We also provide private periodontal services (that is, the advanced care of gum diseases) and advanced endodontic dental services (such as root canal therapy).

Typically, appointments for private dentistry services can be made in a few days whereas appointments for NHS dentistry services can take several weeks, making private dentistry services attractive to patients with greater disposable income. Follow-up appointments for private dentistry services can be arranged sooner and with more convenience than for NHS dentistry services.

Our private dentistry services are entirely funded by our patients. Private dentistry services are typically paid in advance of treatment. Whilst most patients opting for private dentistry services pay out-of-pocket, we also accept payment under certain dental insurance plans. The prices of private dentistry services are set by the individual dentist working within guidelines determined by us. The cost to the patient of private dentistry services (such as a white filling) is higher than the cost of a comparable NHS primary care dental service (such as an amalgam filling), with higher prices for more-complex procedures.

Provision of services to our dental practices

Whilst dentists working in our dental practices and the hygienists, nurses and other staff that support them provide services to patients, we provide services such as procurement and estate management to our dental practices through a management contract between two of our operating subsidiaries, PTPL and Whitecross, and our dental practices.

Provision of consumables, materials, equipment and services

In connection with our strategy to drive value and grow our business through acquisitions of suppliers of consumables, materials, equipment and services, on 17 April 2014, we undertook the Dental Directory Acquisition. The Dental Directory distributes a catalogue of up to 27,000 products from its central logistics platform through its on-line and mail order service, including dental consumables, specialist products including orthodontics and oral hygiene and implant products and dentistry equipment ranging from dental chairs and cabinetry to digital imaging systems. The Dental Directory also carries out services such as installation and maintenance and has a handpiece repair business. The Dental Directory Acquisition increases our presence in the consumables, materials, equipment and services supplier business that we began with the acquisition of dbg on 16 April 2013, a supplier and servicer of medical and dental equipment and supplies. We had previously contracted with The Dental Directory and dbg for the provision of certain of our dental equipment, and we believe that each of the acquisitions will deliver significant cost savings and synergies to us and will allow us to drive economies of scale in terms of purchasing and other efficiencies that will benefit all customers of The Dental Directory and dbg (including our dental practices).

NHS framework contracts

Overview

We provide our NHS dentistry services to patients under various types of framework contracts with NHS England. The Area Teams (known as PCTs prior to 1 April 2013) administer the NHS budget on behalf of the NHS and NHS England tenders contracts on behalf of the NHS to dental care providers such as us. Under the current NHS system, which was introduced in 2006, the value of the framework contracts is primarily based on volume, specifically UDAs. Accordingly, our dental practices are remunerated based on the number of UDAs they complete in a contract year.

Payments under the framework contracts are made to us by NHS England, with payment of 1/12 of the contract value paid at the beginning of each month. Three to six months following the contract year-end (31 March), we receive a statement detailing UDA performance under each contract. If, at the end of the contract year, a practice has not performed all the UDAs allocated under its contract, NHS England may seek to reclaim UDAs paid for but not performed. Any reclamation of payment must be made after the end of the contract year of underperformance. We also receive mid-year UDA performance statements and, if a dental practice has failed to meet 30% of its annual target by 30 September, the Area Team may adjust payments made under such contract for the remainder of such contract year to correspond to an annual performance of two times of what the dental practice has achieved to 30 September. Dental practices are only paid for exceeding the number of UDAs contracted on a case-by-case basis upon approval by NHS England.

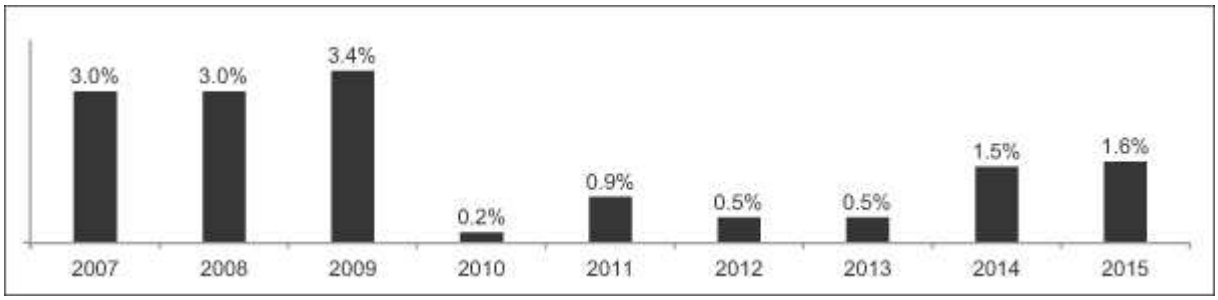
In general, UDA values differ across the United Kingdom and amongst our dental practices. The average value of a UDA in England is currently approximately £25.00. The number of UDAs awarded for a particular treatment depends on the type of treatment provided. Dental treatments are split into four bands based on the type of treatment, the number of UDAs applicable to such treatment and the patient contribution in respect of such treatment, as set out in the table below:

	Treatment included	Number of UDAs	Patient charge England	Patient charge Wales
Band 1	Examination, prevention and advice, radiographs and scale and polish	1	£ 18.50	£ 13.00
Band 2	Band 1 plus all fillings, root canal therapy and extractions	3	£ 50.50	£ 42.00
Band 3	Band 1 and 2 plus any medical device constructed by a lab including crowns, bridges and dentures	12	£ 219.00	£ 180.90
Band 1a	Urgent treatment to include advice, 1 filling and 2 extractions	1.2	£ 18.50	£ 13.00

Patients treated at our Scottish dental practices pay 80% of the gross cost of each course of treatment up to a maximum of £384, other than exempt patients, whose treatments are paid for by the regional Scottish Health Boards.

The value per UDA to date has been subject to annual contract uplifts as recommended by the DDRB and promulgated by the Department of Health, which may or may not accept the DDRB's recommendation. The contract year ending 31 March 2014 saw a contract uplift of 1.5%, and the UK Government has announced a contract uplift of 1.6% in England (with an uplift of 1.47% in Wales and 1.71% in Scotland) in respect of the contract year ending 31 March 2015. Historically, UDA values have never declined in nominal terms since their introduction in 2006.

The following table presents the contract uplifts for each of the contract years (ending 31 March) since 2007:



Types of NHS dentistry contracts

There are two primary types of NHS dentistry contracts:

- General Dentistry Services ("GDS") contracts are evergreen contracts with no end date that automatically roll over upon the achievement of targeted UDA volumes. Generally, the volume of UDAs contracted under GDS contracts cannot be reduced unless volume targets are not met. Absent the termination events described under "—Key terms of NHS dentistry contracts", a GDS contract may only be terminated if less than 96% of the target UDA volumes under that contract are met in each of three consecutive years. Volumes of UDAs under the contract can only be varied by mutual consent. For the year ended 31 March 2014, approximately 74% of our turnover was generated under GDS contracts.
- Personal Dentistry Services ("PDS") contracts are fixed-term contracts, usually with terms of three to five years. PDS contracts can typically be converted into GDS contracts. Like GDS contracts, the volume of UDAs contracted under PDS contracts cannot generally be reduced unless volume targets are not met. For the year ended 31 March 2014, approximately 6% of our turnover was generated under PDS contracts.

In Scotland, non-salaried dentists are compensated on the basis of the number of patients registered with them and for procedures performed. Scottish dental practices may also receive additional practice allowances to assist in the upkeep of their premises. Whilst we do perform dental services in Scotland, Scotland does not employ volume targets, and earnings of dental practices in Scotland are uncapped. For the year ended 31 March 2014, 3.1% of our turnover was generated in Scotland.

In addition to general dental services, we provide specialised dental services that a general dentist may not be able to carry out. These services may be added on to our GDS or PDS general dentistry services contracts, or may be

subject to separate framework contracts with NHS England, but none of these contracts were material to our results for the year ended 31 March 2014:

- Orthodontic treatments are subject to a system similar to the UDA system, with the value of the framework contracts primarily based on units of orthodontic activity ("UOA"). Each orthodontic treatment equals 21 UOAs—that is, one UOA attributed to the examination and 20 UOAs attributed to the fitting of the brace and the ongoing related dental care of the patient. Payments under these framework contracts are made to us on a monthly basis, with any shortfalls trued up following the contract year-end.
- Sedation dentistry services are contracted and paid in a manner similar to UOAs.
- Oral surgery, which includes the extraction of difficult to remove teeth that a general dentist may not be able to perform, are contracted based on a target number of patients or visits or by types of treatment, and depend on referral volumes. Payments under these framework contracts are made to us on a monthly basis, with any shortfalls trued up following the contract year-end.
- Domiciliary services, which include the treatment of patients outside of a dental surgery (usually at a patient's residence), are contracted based on a target number of patients or visits. Payments under these framework contracts are made to us on a monthly basis, with any shortfalls trued up following the contract year-end or in areas following submission of claims.
- Oral pathology and maxilla facial surgery services, which include the diagnosis and treatment of oral lesions such as oral cancer, are mostly carried out as secondary care, and paid by the NHS based on a course of treatment.

Key terms of NHS dentistry contracts

The specific terms of any given NHS dentistry contract vary depending on the Area Team and the outcome of negotiations at the time the contract is awarded by NHS England. In addition to the terms related to contract duration, volumes and prices described above, all our NHS dentistry contracts include a general quality of care requirement. Failure to meet this quality of care requirement could result in loss of the applicable contract. NHS dentistry contracts also include limitations on assignment and, in most cases, a change of control absent consent of NHS England. Our NHS dentistry contracts are also generally terminable by NHS England upon certain insolvency events, if the contracted entity's financial situation is such that NHS England considers that NHS England is at risk of material financial loss or on grounds the contracted party is unsuitable for reasons such as disqualification, sanction or criminal activity. For other breaches of such contracts, such as underperformance in terms of UDA volumes, the contracts are only terminable by NHS England after service of notice on the contracted party of the breach and a provision of time for the contracted party to cure such breach. In our experience, NHS England has been willing to renegotiate contracts for lower volumes of UDA in lieu of terminating contracts due to underperformance. Out of our 507 NHS dentistry contracts, none of our GDS contracts have been terminated.

Tendering of new contracts

A majority of NHS dental contracts in England and Wales were allocated in 2006. Because most of these are GDS contracts with no fixed end date, a limited number of new NHS dental contracts are issued for competitive tender each year. In practice, new dental contracts tend to be issued for tender only if:

- the Area Team has identified a shortfall in the existing supply of NHS dental treatment compared with the estimated need for dental services in that geographic locality;
- a dentist holding an existing NHS dentistry contract dies, retires or decides to abandon his or her contractual rights; or
- NHS England terminates a dental practice's contract in accordance with its terms.

Tenders are advertised through various channels which we monitor. Tenders for contracts are competitive, and winning bids tend to be those determined by the Area Team to offer the best price, quality of service and care, compliance and timetable, along with other localised factors.

New framework agreement proposals and pilot programmes

The UK Government has proposed changes to the current model of contracting NHS dentistry services that would move away from a strictly volume of services metric (namely, UDAs) to an approach that takes into account preventative treatment and increased access to dentistry services. The proposed changes would replace the UDA system with remuneration based on capitation (that is, the number of patients treated), an activity measure (yet to be determined) and quality of care metrics, including clinical outcomes, patient experience and patient safety. Whilst

precise timing remains uncertain, we expect that changes to the current model, if any, would be fully implemented no earlier than 2016–2017.

In order to test the proposed payment models prior to implementation across the UK dental market, the Department of Health began a pilot programme in May 2011, which was expanded and revised in April 2013. The Department of Health have announced that they will test a prototype contract in 2015/16. Currently, three pilot payment schemes are being tested. The UK Government has announced that, if the proposed changes are adopted as law, the final framework contract will combine aspects of each of these pilot programmes. The three types of pilot framework contracts are:

- Pilot 1, Guaranteed Income Model. Under this pilot programme, payment for services is fixed so long as a given level of care time is provided for NHS patients, with some portion of remuneration for dentistry services based on achieving quality of care targets.
- Pilot 2, Weighted Capitation and Quality Model. Under this pilot programme, 90% of the payment for dental services is based on the number patients treated, with prices weighted by age, sex, and the socioeconomic and demographic profiles of the locality. Of the remainder of the payment, 6% is linked to clinical outcomes and effectiveness, 3% is linked to the patient experience and 1% is linked to patient safety.
- Pilot 3, Weighted Capitation and Quality Model Plus Fee for Complex Care. This pilot programme is similar to Pilot 2, but with the added element that the provision of complex care is remunerated separately in addition to payments for the weighted capitation and quality model.

We have been involved in the development, testing and review of various pilot programmes on behalf of the NHS and we are currently testing pilot programmes in partnership with the NHS in seven of our practices. We believe that our involvement in the development of these pilot programmes will provide us with a competitive advantage by allowing us to prepare for coming changes and by giving us a voice in their implementation. However, as the actual policy changes have not yet been finalised by the UK Government and the exact timeline of the implementation has not yet been set, no assurance can be given that the new framework agreements will be implemented in the manner we expect, or at all.

We believe that changes to the current model of contracting NHS dentistry services, if any, present an opportunity for us. As the leading provider in the market, we have the capacity, scale and resources to quickly adapt to change. Specifically, we believe that capitation requirements will make the recruitment of patients more important, and that our IT systems, developing CRM capabilities and sales and marketing resources provide us competitive advantages in patient recruitment. Since it is likely there will be a quality component to any new contracting arrangement, we also believe that our clinical governance procedures and dentist, hygienist and nurse training resources will also benefit us compared to our smaller competitors. The proposed focus on preventative care and increased responsibilities for hygienists and nurses could help us operate more efficiently, with dentist time being spent delivering more critical treatments. We may also benefit from any standardisation of UDA rates. Any change would affect the provision of dental services throughout England and Wales, so we believe that the UK Government will work to make any such change essentially revenue neutral to the industry so as not to disrupt the provision of dental services or encourage a migration of dentists into private dentistry services.

Dental professionals

Dental professionals in our workforce consist of highly trained dentists who are self-employed, independent contractors, and a team of dental staff which includes practice managers, highly skilled dental nurses, hygienists and dental assistants.

Dentists

Dentists working in our dental practices are self-employed, independent contractors known as dental surgeons, and we enter into contracts with our dentists using our standardised associate agreement which has been reviewed by the BDA and which we understand to comply with HMRC requirements for independent contractors. We provide the dentist with the facilities, equipment, staff, materials and patient list in exchange for notional monthly licensing fees paid by dentists to us. We individually negotiate the associate agreements with each dentist working in our dental practices, and so are able to vary the compensation paid to dentists based on prevailing rates in the applicable local markets for dentists. Under the associate agreements with dentists, dentists receive a fixed percentage fee per UDA delivered, in the case of NHS dentistry services, and a percentage of fees paid for private dentistry services delivered. Contracts with dentists in our dental practices typically are evergreen, but terminable by either party upon four months' notice and include non-compete terms that prevent dentists from competing against us within a certain geographic radius of our dental practice after such contracts' termination. We also have arrangements with dentists, some of whom are our employees, that are not assigned to any single dental practice but provide services where they

are most needed, including in response to local shortages or areas in the United Kingdom that do not have full-time dentists. A small number of our dentists are employees.

To legally practice dentistry in the United Kingdom, a dentist must be registered with the General Dental Council (the "GDC"), the regulatory body for dentistry, and must also abide by regulations promulgated under the CQC. Of our dentists, approximately 43% are British. In the past, we actively sourced dentists from EEA countries and non-EEA countries due to the shortage of dentists in the United Kingdom. The UK Government has invested in additional dental graduate training places, which has driven increased registrations in dental school intake within the United Kingdom, though the Department of Health recently announced a 10% decrease in training places due to concerns about a future oversupply of dentists. The NHS has also improved talent sourcing efforts to increase the number of dentists offering NHS primary care dentistry by, amongst other things, introducing a new Overseas Registration Exam which replaced the longer International Qualification Exam. We now primarily attract dental graduates and dentists qualified in the United Kingdom, and we are continuing to increase our presence in certain areas of the United Kingdom that have typically experienced the greatest levels of dentist shortages. The distribution of NHS dentists can vary widely across regions, and historically the sourcing of dental graduates and dentists has been particularly difficult in southwest England.

Because dentists working in our dental practices are self-employed, independent contractors, we do not contribute to their pensions, provide holiday pay, make employer National Insurance contributions or take other actions that would be necessary if dentists working in our dental practices were our employees. Dentists working in our practices have the freedom to treat a patient in the manner determined in their professional opinion to the best of their medical skill. As a result, dentists are solely liable for any medical negligence liability that occurs as a result of their performance of dentistry services. Dentists are required as a matter of professional conduct to carry their own medical negligence liability insurance coverage.

Providing quality care for our patients is our first priority, and to that end we focus on making training opportunities available to our dentists. We are currently rolling out an in-house training academy for our dentists, hygienists and dental nurses in order to ensure that our dentists stay abreast of the latest medical and technological developments in the provision of dental services.

Other dental professionals

Dental staff and employees support the work of dentists in our dental practices, and they include practice managers, dental nurses, independent dental hygienists, technicians working in dental laboratories and dental therapists. The clinical role of these non-dentists and dental professionals has expanded in recent years, allowing nurses and hygienists to take on greater responsibility in their respective practices, thereby increasing the time dentists are able to spend on more complex tasks. Like the dentists themselves, many of our dental employees are required to register with the GDC.

Dental nurses provide support to dentists in surgery and other clinical environments and are responsible for, amongst other duties, dental instrument sterilisation, operative care, the preparation of treatment materials and various clerical duties such as updating patient records. A nurse is required to be present whenever a dentist is treating a patient. We have historically experienced relatively high rates of churn amongst our nurses, and we are currently implementing initiatives, including increased salaries and training, to reduce such churn.

Dental hygienists perform a wide range of procedures, such as providing local analgesics, scaling and polishing teeth, treat patients who are under conscious sedation (provided that a registered dentist remains in the room throughout these treatments) and providing general oral health advice. Dental hygienists are able to book and carry out certain limited procedures without a referral from a dentist. Most of our approximately 300 dental hygienists are independent contractors. Typically, we pay hygienists on the basis of work performed.

Dental therapists are legally permitted to handle preventive care and extractions or fillings under the supervision of a dentist, and dental technicians manufacture dental appliances such as braces, crowns, dentures and bridges.

Patients

Our patient base is broad, and generally reflects the diversity of the UK population, with a slight bias toward patients from less-privileged socioeconomic groups.

Sales and marketing

We have implemented a variety of targeted marketing efforts that are aimed at attracting new patients and increasing visit frequency from existing patients. IT is a key focus in our marketing strategies. We are focused on online marketing efforts through a rebranded and interactive website with improved search engine capabilities that enable users to customise their searches for appointments, education and general questions about our business and the

dentistry industry. Our marketing is also directed at minimising the number of patients we lose due to excessive waiting room times to book appointments and receive information.

A strong reputation for excellence in the provision of dental services is our best marketing tool, as dentistry services are often dependent on local word-of-mouth and referrals. We are also pursuing new marketing platforms to reach a greater number of potential patients, including through social media campaigns that focus on our track record of a strong reputation for excellence in dental services.

Quality of care

We are focused on providing services that achieve high quality and patient satisfaction rankings. We have consistently maintained high quality ratings across our dental services. In addition to requirements under our NHS dentistry contracts to meet certain standards of quality of care, we are overseen and regulated by the CQC, which inspects and rates all health and social care providers, including dental care providers, in England.

Clinical governance

We have a dedicated team of clinical directors devoted to clinical excellence led by our Clinical Services Director. As part of our clinical governance efforts, our clinical directors manage the clinical aspect of our dental practices, investigate patient complaints, respond to regulatory inquiries and conduct periodic audits and site visits of our dental practices. We also work closely with NHS England, Area Teams, the CQC and professional bodies to update our clinical practices and ensure we provide consistent, high-quality care to our patients.

Acquisitions

Overview and strategy

We have grown by pursuing selective acquisitions to expand our network of dental practices and NHS dentistry contracts. In the period beginning 12 May 2011 and ended 31 March 2014, we acquired 130 dental practices and invested approximately £129.5 million in dental practice acquisitions. Our acquisition strategy is to target dental practices with three or more dental chairs (the average practice acquired since 12 May 2011 has had four chairs) that benefit from GDS NHS dentistry contracts. We also focus on the historical UDA delivery rates of potential acquirees and the retention of key personnel.

Acquisition process

We have a large and experienced acquisition and integration team. The focus of our experienced acquisition team centres on building and developing the acquisition pipeline, improving deal conversion rates and reducing due diligence and acquisition timelines. Our acquisition team identifies potential acquisition opportunities on the basis of our acquisition strategy described above, recently generating leads for approximately 77% of the acquisitions we make internally, and maintains a database of potential acquisition targets. Once an acquisition target has been identified, we ask the target to respond to a detailed information request and one of our acquisition managers visits the target and obtains a copy of the target's NHS dentistry contract. Depending on the legal structure of the target dental practice, we choose the legal structure for the acquisition and may contact NHS England in respect of the target's NHS dentistry contract to ascertain whether NHS England will consent to assignment of the contract to us. We then issue an offer letter to the vendor, subject to, amongst other things, due diligence and the retention of key employees.

We have a detailed due diligence process that we undertake in respect of each acquisition carried out by our acquisitions team and outside counsel. The focus of our due diligence is historical UDA delivery rates, private dentistry revenues, and the cost base of the target dental practice. Based on these data we are able to produce an expected EBITDA, and thereby a valuation, by applying expected cost savings and efficiencies experienced by such practices when integrated into our estate. On a portfolio basis, we believe that the expected EBITDA projections resulting from our acquisition team's due diligence have been accurately reflected in post-acquisition results, and acquired practices have generally enjoyed EBITDA consistency before and after their acquisition by us. We believe our due diligence methodology produces accurate results and allows us to acquire dental practices at attractive multiples of EBITDA valuations as we know the number of contracted UDAs, the UDA delivery percentage and private revenue generation tend to maintain consistency, and we are able to apply our known cost base to the practices we acquire. The non-orthodontic dental practices we acquired in the twelve months ended 31 March 2013 contributed £7.4 million of EBITDA before head office costs and exceptional items in the twelve months ended 31 March 2014 compared to our due diligence estimate of £7.6 million of EBITDA before head office costs and exceptional items, and the non-orthodontic dental practices we acquired in the twelve months ended 31 March 2012 contributed £6.5 million of EBITDA before head office costs and exceptional items in the twelve months ended 31 March 2014 compared to our due diligence estimate of £6.5 million of EBITDA before head office costs and

exceptional items. We seek to retain and incentivise key personnel in the practices we acquire. On average, approximately 7% of the consideration we pay for dental practices is allocated as deferred consideration, which we pay into escrow accounts for release to the vendor upon the achievement of certain financial and operational results post-acquisition, such as EBITDA, UDA delivery and turnover generated by private dentistry services.

Our extensive experience in acquiring and consolidating dental practices has also enabled us to develop a "tried and tested" process for integrating dental practices into our estate. After acquiring a dental practice, we outfit it with our suite of IT systems and equipment, and implement our management systems. In most cases, the dental practices we acquire are immediately cash positive and require little working capital, as we begin receiving payments under such acquired practices' NHS dentistry contracts at the beginning of the first month we own them.

Legal structure of acquisitions

We structure the acquisition of a dental practice in one of four ways depending on whether the applicable Area Team consents to the target dental practice's NHS dentistry contract being assigned to us and the legal status of the target dental practice. Typically, our NHS dentistry contracts prohibit assignment without the consent of the applicable Area Team and contain change of control provisions.

Assignment

In a situation in which the Area Team consents to the assignment of the applicable NHS dentistry contract, we assign such contract to our trading company, Whitecross, in place of the seller of the acquired practice.

Acquiring an incorporated dental practice

Some of the dental practices we acquire already hold their NHS dentistry contract in an incorporated entity. In such situations we acquire the shares of the incorporated entity and it becomes a subsidiary.

Incorporation

In a situation in which the Area Team does not consent to assignment of the contract and we are acquiring a practice from a sole proprietor or partnership, we may request that such sellers incorporate their practice into a limited company and obtain consent from the Area Team for the NHS dentistry contract to be reissued in the name of that company. Assuming such consent is obtained and there are no change of control provisions in the newly issued contract (or consent is obtained to the change of control), we then acquire the shares in the limited company. This route of acquisition is rarely used now as a result of the formulation of the partnership structure described below which does not, we are advised, require the consent of the Area Team at any stage.

Partnership

In a situation in which the Area Team does not consent to assignment of the contract and we are acquiring a practice from a sole proprietor or a partnership, we add two or more of our clinical director employees to become partners with the sole proprietor or join in partnership with the existing partners (as applicable). There is an obligation to notify the Area Team of such admissions but obtaining their consent to the change in status of the contractor is, we are advised, not required. In the case where our clinical directors join an existing partnership, legally, their admission to that partnership effectively dissolves the existing partnership and creates a new one. However, notwithstanding the dissolution of the existing partnership and equally, where a new partnership is formed with a sole proprietor, we believe, after consultation with external counsel, that existing law provides that the new partnership continues to hold and benefit of the NHS dentistry contract previously held by the predecessor partnership or sole proprietor (as applicable). Typically, the original partners or sole proprietor retire from the partnership shortly after the completion of the acquisition. As at 31 March 2014, 22% of our dental practices were organised as partnerships.

We have in the past experienced an increased unwillingness on the part of Area Teams to assign contracts, and most of our recent acquisitions have therefore been undertaken pursuant to the partnership structure described above.

Acquisition opportunities

Whilst the UK dental market is highly fragmented, with approximately 11,900 dental practices, only a small number of high-quality acquisition targets meeting our criteria come up for sale in any given year. We intend to continue to pursue our acquisition strategy of acquiring dental practices meeting our acquisition criteria, including dental practices with three or more chairs, GDS NHS dentistry contracts and strong private dentistry revenue generation, whilst avoiding undue concentration in any one local market. We estimate that approximately 400–600 practices become available for acquisition in an average year. We intend to continue to use amounts drawn under our Revolving Credit Facility for the purpose of funding such acquisitions. On 17 April 2014, we acquired The Dental

Directory, a distributor of dental consumables and materials to dental practices throughout the United Kingdom, and on 16 April 2013, we acquired Dental Buying Group ("dbg"), a small UK supplier of medical and dental equipment and supplies. We had previously contracted with The Dental Directory and dbg for the provision of certain of our dental equipment, and we believe that each of the acquisitions will deliver significant cost savings and synergies to us, and will also benefit their many other customers whom they will continue to supply. We may in the future acquire other non-dental practice businesses in the dental market.

Competitors

We compete in the UK dental services market, a highly fragmented market consisting of a variety of for-profit and not-for-profit groups. We believe that the UK dental services market is made up of approximately 11,900 dental practices. We are the leading provider of dental services in the United Kingdom with 585 dental practices as at 31 March 2014. The remainder of the market is made up of smaller dental practices and dentists working as sole practitioners. We believe our market share in terms of number of dental practices is 5% and approximately 6.6% in terms of revenues for the twelve months ended 31 March 2014. Our next largest competitor, Oasis Healthcare, announced its acquisition of Smiles Dental (previously our second-largest competitor, with a focus on private dentistry) on 8 April 2014. According to the Oasis Healthcare press release announcing its acquisition of Smiles Dentist, the acquisition will result in the Oasis Healthcare group having more than 280 dental practices. Oasis Healthcare focuses on an even split of private dentistry services and NHS dentistry services, whilst Smiles Dental focused on private dentistry services. Whilst we do not compete with any one competitor in each of the local markets for dental services in which we operate, we do generally experience significant competition at the local level from independent dental practices for such services, and that competition may be intense. We compete with other dental practices in both tendering for new NHS dentistry contracts through the NHS tender and in driving customer demand and thereby UDA delivery rates.

Competitors to our consumables, materials, equipment and services supplier business include Henry Schein, Wright Cottrell, Plandent, Dental Sky, BioDelivery Sciences International, Topdental and Glove Club, as well as a large number of smaller local suppliers and distributors.

Regulation

We are subject to regulation by the UK Government and we are particularly impacted by laws relating to the provision of dental services and quality of care, as well as the regulations of the Department of Health. Discussed in more detail below are some of the key laws and regulations under which we operate.

England

As a provider of primary healthcare services within the NHS we are subject to a complex legislative framework designed to ensure that people who use healthcare services such as those provided by us are protected and certain standards of quality and safety are met.

The CQC is an independent body which regulates the provision of health and social care services in England. Its main objective is to protect and promote the health, safety and welfare of those using such healthcare services. The CQC's functions include the registration of healthcare service providers and the ongoing monitoring of such providers through inspections, data analysis and other checks to ensure that standards of quality and safety are met and to encourage ongoing improvements by such providers. The results of such reviews and inspections are published by the CQC and are available for public inspection.

The services provided by our dental practices fall within the scope of regulated activities under healthcare legislation and like all relevant service providers we must be registered with the CQC. The regulations stipulate that where the service provider is a body corporate, an individual must also be registered and shall be responsible for the provision of the services by that provider. There are various registration requirements which include providing a statement of purpose setting out the aims and objectives of the service provider and details of the locations at which the services will be provided. All our dental practices are duly registered with the CQC and we have a dedicated person who deals with our CQC registrations and the provision of information to the CQC.

The CQC maintains a public register of all registered service providers and the activities carried out by them, and we are obliged to notify the CQC of certain changes affecting the carrying on of the services (for example, where the service provider is a partnership, it must notify the CQC of any changes in the membership of the partnership) and the occurrence of certain incidences in the provision of such services, which might include allegations of abuse, matters reported to, or investigated by, the police and physical damage to the premises which may have a detrimental effect on the care provided. Failure to register with the CQC or non-compliance with the registration requirements may result in both criminal and civil sanctions. The CQC is also empowered to take enforcement action if a registered service provider fails to comply with relevant regulations. The regulations provide that all

service providers are required to take proper steps to assess and monitor the quality of services being provided and ensure the proper care and welfare of patients. For example, service providers are required to consider the safety and suitability of the premises and equipment used, ensure that appropriate standards of cleanliness are met, have effective complaints procedures in place and maintain accurate patient records. Further, service providers must ensure that they have sufficient levels of staffing and recruit staff with the necessary qualifications, skills and experience. Our CQC registrations manager and clinical directors, amongst others, oversee the provision of services at our dental practices to ensure that our practices meet all applicable CQC standards. None of our dental practices are subject to any ongoing enforcement action by the CQC for non-compliance. Out of our estate of 585 practices, the CQC documented 42 instances of non-compliance at 33 dental practices during the twelve months ended 31 March 2014. Of those 42 instances of non-compliance, each of which we have either already remedied or are in the process of remedying, 26 instances raised minor concerns, 16 raised moderate concerns and none raised a major concern.

There are specific regulations governing dental services contracts. The regulations applicable to both GDS and PDS contracts set out the conditions which must be met by a service provider before a contract for the provision of dental services will be provided by an NHS body. Where applicable conditions are satisfied, a GDS contract may be provided to an individual dental practitioner, dental corporation or partnership and a PDS contract may be provided to an individual dental practitioner or a relevant corporate body. The regulations also prescribe the terms to be included in such contracts, which include: the services to be provided and the manner in which they are to be provided to patients (including the practice address and surgery hours); the type and duration of the contract; the applicable fees and charges; conditions to be met by those who perform the services and provisions regarding complaints, patient records; the provision of information and rights of entry and inspection; and sets out procedures for dispute resolution and the variation and termination of the contract.

Generally, under a GDS contract, the service provider will be required to provide a range of dental services and, in most circumstances, on an ongoing basis subject only to specific termination provisions set out in the legislation. A GDS contract generally provides greater flexibility by allowing the service provider to form partnerships and change the membership of partnerships. PDS contracts are typically granted for a fixed term and do not include any provision for the service provider to form partnerships. However, the service provider has the right to apply to the relevant NHS body to convert the PDS contract into a GDS contract.

Scotland and Wales

Since we also operate dental practices in Scotland and Wales, we are subject to regulation relating to the provision of dental care in Scotland and Wales, which may differ from regulation relating to the provision of dental care in England.

Environment, health and safety

We are subject to numerous separate laws and regulations relating to the protection of the environment and human and occupational health and safety, including those governing the handling, transportation and disposal of hazardous and medical waste. These laws and regulations are enforced either at the national level (health and safety), or at local level. Fire safety laws are enforced by the local fire inspectors and environmental laws enforced by local authorities.

The most significant occupational health and safety law is the Health and Safety at Work etc Act 1974 (the "Health and Safety Act"). The Health and Safety Act imposes a duty of care upon us, not only to our employees but also to our patients and to any visitors to our facilities. We are required to take care to prevent serious accidents and to eliminate from our facilities conditions that could lead to such accidents. Our business activities are, in particular, exposed to significant risks, relating, for example, to the transmission of infections (including blood-borne infections, such as HIV) and other risks associated with medical practices generally and dental practices specifically. We have experienced in the past, and likely will experience in the future, violations of health and safety regulations. We have a dedicated team of experienced health and safety experts to meet our health and safety requirements and address any violations that may occur.

With regard to environmental legislation, the most significant law is the Environmental Protection Act 1990–Part II as amended (the "Environmental Protection Act"). The Environmental Protection Act mandates that all waste is disposed of through a licensed waste disposal agent and that all hazardous and non-hazardous waste disposals be supported by approved documentation. In that respect, we ensure that we only use approved and licensed waste carriers and recyclers.

Failure to comply with such laws and regulations in the future could subject us to, amongst others, civil and criminal fines and penalties, enforcement actions, the suspension or termination of our licences to operate or third-party claims.

We are also committed to reduce the impact of our business on the environment. As a major dental care service provider, we produce a considerable volume of clinical waste at the dental practice level. We have partnered with a waste management company to ensure this waste is collected, processed and disposed in line with all relevant environmental regulations.

Immigration

We have historically relied on foreign dentists (both from within and outside the EEA) to the extent required to address shortfalls in UK dental graduates and UK-qualified dentals to fill vacancies in our dental practices. In such cases, and even though our dentists are independent contractors not employed by us, we must comply with relevant immigration laws for non-EEA workers. In particular, the Immigration, Asylum and Nationality Act 2006 (the "IANA") imposes civil and/or criminal penalties on the provision of work to adults who are subject to immigration controls and have not been granted leave to enter or remain in the United Kingdom or whose leave is invalid, ineffective or subject to conditions preventing them from accepting employment ("illegal workers"). Under this legislation, an employer is subject to civil fines of up to a maximum of £20,000 per worker if it employs an immigrant in a job for which he or she is not authorised. Changes to the law made as at February 2008 created a criminal offence of knowingly employing an illegal worker. Employers prosecuted under the IANA can establish a defence by proving that they checked, copied and retained specific types of documents as specified by the UK Government prior to the commencement of employment. In addition, Area Teams review the immigration papers of foreign dentists as part of their approval process.

Suppliers

The primary equipment and materials required to conduct our business include dental practice equipment and materials such as dental chairs, diagnostic equipment and general dentistry materials, such as crowns, fillings and bridges, radiology equipment, hygiene equipment and other general dental care products.

We centralise and insource the procurement of equipment and materials used in our dental practice to generate economies of scale and lower our costs, and since the acquisition of dbg, we have increased the amount of equipment installation, maintenance and engineering work carried out in-house. We negotiate volume discounts with our suppliers. Our most significant supplier as at 31 March 2014, is Henry Schein Dental, from which we procure dental equipment and equipment maintenance and repairs under a contract that will expire in June 2014. For the year ended 31 March 2014, purchases from our ten largest suppliers constituted 17% of our costs of sales. We generally do not enter into long-term supply commitments with our suppliers. Whilst we believe that most of our equipment and materials are readily available from a large number of suppliers, some of our more specialised equipment, such as handpieces, may only be available from a few suppliers, and any disruption or loss of such suppliers could negatively impact our ability to perform dentistry services. We have acquired The Dental Directory and dbg, who also supply dental supplies and equipment. We had previously contracted with The Dental Directory and dbg for the provision of certain of our dental equipment, and we believe that each of the acquisitions will deliver significant cost savings and synergies to us. In the future, we expect to transfer a portion of the consumables and materials we acquire for our dental practices to The Dental Directory from our current suppliers.

Billing and payment

We have no material billing requirements in respect of patients of our NHS dentistry services. Patients contribute to the cost of NHS dentistry services depending on the type of dental care service they receive, with the balance of payment paid by NHS England. The patient contribution is set by the NHS and revised annually. The full amount is contributed by the NHS when patients are exempt from payment. Exempt patients include students under 19 years of age, the unemployed, new and expectant mothers, and pensioners. In addition, certain low income patients may be entitled to partial exemptions, depending on their income. Our private dentistry services are entirely funded by our patients, whether through out-of-pocket payments or certain dental insurance plans. Private dentistry services are typically paid in advance of treatment. Whilst most patients opting for private dentistry services pay out-of-pocket, we also accept payment under certain dental insurance plans.

Payments under our NHS dentistry contracts are made to us by NHS England, with payment of 1/12 of the contract value paid at the beginning of each month. We collect patient contributions on behalf of the NHS and remit such amount to the NHS in arrears approximately two weeks thereafter. Three to six months following the contract year-end (31 March), we receive a statement detailing each UDA performance under each contract. If, at the end of the contract year, a practice has not performed all the UDAs allocated under its contract, NHS England may seek to reclaim UDAs paid for but not performed. Any payment of reclamation must be made after the end of the contract year of underperformance. We also receive mid-year UDA performance statements and, if a dental practice has failed to meet 30% of its annual target by 30 September, the Area Team may adjust payments made under such contract for the remainder of such contract year to correspond to an annual performance of two times of what the

dental practice has achieved to 30 September. Dental practices are only paid for exceeding the number of UDAs contracted on a case-by-case basis upon approval by NHS England.

Real and personal property

We lease our executive offices, which are located at Europa House, Europa Trading Estate, Stoneclough, Kearsley, Manchester, M26 1GG, United Kingdom. We also at 31 March 2014 were party to 637 property leases, 554 of which are dental surgeries in various locations throughout Great Britain, along with 15 leased or licensed car parks. We typically lease dental surgeries on behalf of our dental practices pursuant to long-term leases. The landlords under approximately 165 of our long-term leases of dental surgeries are dentists from whom we have purchased dental practices. In some cases we also lease space for our dental practices from Area Teams. In connection with the Dental Directory Acquisition, we also acquired leasehold interests in The Dental Directory's central warehouse and a number of other properties. We hold freehold interests in 31 properties, primarily in relation to dental surgeries for which we have acquired the freehold interest upon purchasing the dental practice, but we did not acquire these properties intending to hold them for the long term, and may enter into sale-leaseback arrangements in respect of these properties in the future. Rates (UK business property taxes) paid in respect of a dental practice are reimbursed to us by NHS England in proportion to such dental practice's proportion of NHS dentistry services performed to private dentistry services and, as a result, the majority of the rates paid in respect of our dental practices are reimbursed. Our property portfolio is managed internally by a property management team and supported by external specialists where appropriate. Part of our central property management support function involves regulatory compliance in connection with our properties. Our property management team also manages a defined capital expenditure cycle and dilapidation schedule in respect of our leased and freehold properties.

We are also party to certain operating leases in respect of approximately 155 vehicles leased by us for use by certain members of our management team, including certain of our clinical directors and regional managers, as well as operating leases in respect of office equipment, such as copier machines.

Intellectual property

Whilst our know-how, copyrights, business processes and other intellectual property rights are important to our business, we do not consider any single piece of intellectual property to be of material importance in relation to our business as a whole. We are not currently engaged in any material intellectual property litigation, nor do we know of any material intellectual property claims outstanding.

Information technology systems

IT systems impact virtually all aspects of our business, including record-keeping, patient information processing and storage, data security, marketing and sales, compliance logistics and practice and performance management. Our IT strategy is driven by the dual goals of promoting growth of our business whilst ensuring data security.

We have implemented a centralised IT platform that brings together many of our IT functions in one data warehouse based at our head office and managed by an experienced team of information specialists. Our practice performance management IT systems are critical to the management of our business, and we have implemented unified practice management software across our entire estate and dashboard capabilities for our area and regional managers and dentists working in our dental practices to monitor UDA delivery rates. We have completed an upgrade in IT infrastructure that includes a data centre in Manchester, England, and new servers, security systems and firewall technology. We are working with SunGard to implement the business continuity plans approved by our Board. In addition, we are developing backup and recovery databases for use in our head office and dental practices, system for use in our head office as well as in individual dental practices. These systems back up our data several times a day to make sure that the abundance of sensitive patient information we have stored at our hundreds of practices is safely managed in one central location. We also leverage our IT systems in marketing through search optimisation and the development of a customer relationship management system.

We are preparing our IT systems for any potential changes to data retention and regulation that could be introduced as part of changes to the NHS dentistry contract framework.

Independently contracted dentists and employees

Dentists working in our dental practices are self-employed and independent. As at 31 March 2014, we had approximately 2,300 dentists working in our 585 dental practices, either part-time or full-time or through a partnership. We also have arrangements with approximately 100 dentists, which we refer to as locums, who as at 31 March 2014 were not assigned to a single practice, but can fill dentist vacancies on an as-needed basis to provide dental services where they are most needed. We also have approximately 50 practising dentists who are our employees. We individually negotiate the associate contracts with dentists working in our dental practices, and so

are able to vary the compensation paid to dentists based on prevailing rates in the applicable local markets for dentists. Under our associate contracts with dentists, dentists receive a fixed percentage fee per UDA delivered, in the case of NHS dentistry services, and a percentage of fees paid for private dentistry services delivered. Contracts with dentists in our dental practices typically are for a term of two years and include non-compete terms that prevent dentists from competing against us for our NHS dentistry services patients within a certain geographic radius of our dental practice.

We also employ highly skilled dental support staff who provide a broad range of clinical and administrative support services for our dentists, including 25 clinical technicians (all of whom are self-employed, independent contractors) in our practices across the UK. In addition, as at 31 March 2014, approximately 300 hygienists worked across our practices, the majority of whom were self-employed, independent contractors.

The following table sets out the number of our dentists and dental support and central staff, as at 31 March 2014:

	As at 31 March 2014
Dentists	2,465
Hygienists	343
Dental and support and central staff	5,622
Total	**8,430**

Central support function

Our business model focuses on leveraging our economies of scale and offering services and support to our dentists and dental practices by assuming many of the administrative responsibilities associated with running a dental practice and centralising and insourcing them to our central support function. In addition to managing the performance of our dental practices, our central support function also provides the following services: IT, compliance, regulatory, legal, finance, human resources, health and safety, risk management, talent sourcing, training, insurance, property oversight, the administration of patient records, acquisitions, payroll, marketing, information sharing and logistics functions. For the year ended 31 March 2014, our central support function resulted in costs of £28.7 million, which constituted 7.0% of our turnover for the year.

Insurance

Our operations are subject to various actual and potential claims, liabilities, hazards and disasters. We carry a variety of insurance policies, including policies in respect of property and material damage, business interruption, combined commercial liability, and directors' and officers' liability. We believe that our insurance coverage is adequate and customary for a business of our size in our industry. Our self-employed, independently contracted dentists are obliged by professional licensing standards to carry their own medical negligence insurance, and we are typically not subject to medical negligence liability.

Legal proceedings

In the normal course of our business, we may be involved in legal, arbitration or administrative proceedings. Additionally, we operate in a closely regulated industry. As such, in the ordinary course of business, we are subject to national and local regulatory scrutiny, supervision and control. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine.

We are currently, and have in the past been, subject to employment tribunal claims brought by former employees.

On the basis of current information, we do not expect that the actual claims, lawsuits and other proceedings to which we are subject, or potential claims, lawsuits and other proceedings relating to matters of which we are aware, will ultimately have a material adverse effect on our results of operations, financial condition or liquidity. The most significant actual or potential claims, lawsuits and other proceedings of which we are currently aware are described below.

From time to time we are subject to claims and disputes related to the recoupment of amounts paid under NHS dentistry contracts and other disputes with Area Teams (or prior to 1 April 2013, PCTs) and NHS England. Each of the claims arises from allegations of overstated contract payments, patient charge collection claims or the use of stratified sampling to quantify assertions for inappropriate claims. Specifically regarding stratified claims, please note the NHS Litigation Authority decided it is not appropriate to base claims on stratified or extrapolated figures, but only actual amounts claimed. Furthermore, following the abolition of PCTs on 1 April 2013, it remains to be seen whether successor Area Teams will take such claims forward.

Tax

On the basis of current information, we are not aware of any proceedings by HMRC in respect of our tax planning or treatment.

Management

Board of directors of the Issuer

Board of directors

The Issuer is a public limited company incorporated under the laws of England and Wales. The following table sets out certain information with respect to the current members of the Issuer's board of directors:

Name	Age	Title
Terry Scicluna	56	Executive Director
Mark Robson	51	Executive Director
Jean Bonnavion	43	Non-Executive Director
Eric Kump	44	Non-Executive Director
Alexis Stirling	41	Non-Executive Director

Board of directors of the Parent Guarantor

Board of directors

The Parent Guarantor is a private limited company incorporated under the laws of England and Wales. The following table sets out certain information with respect to the current members of the Parent Guarantor's board of directors:

Name	Age	Title
Paul Pindar	55	Non-Executive Chairman
Terry Scicluna	56	Executive Director
Mark Robson	51	Executive Director
Jean Bonnavion	43	Non-Executive Director
Louis Elson	51	Non-Executive Director
Eric Kump	44	Non-Executive Director
Alexis Stirling	41	Non-Executive Director

Set out below is a brief description of the business experience of the individuals who serve as members of our Board.

Paul Pindar. Mr. Pindar joined our Board in July 2012 as non-executive Chairman. In February 2014, he retired as the Chief Executive Officer of Capita plc, a leader in business process management and outsourcing solutions in the United Kingdom. Mr. Pindar is currently Chairman of Great Ormond Street Hospital. He acted as non-Executive Director of the retailer Debenhams from 2006 to 2010, and from 2004 to 2007, he was Chairman of the Corporate Development Board of the National Society for the Prevention of Cruelty to Children. Mr. Pindar is currently a member of the Senior Advisory Board of TowerBrook Capital Partners.

Terry Scicluna. Mr. Scicluna is the Chief Executive Officer of Integrated Dental Holdings. His appointment became effective and he was appointed to our Board in November 2013. Mr. Scicluna has nearly 35 years of UK healthcare and retail experience. Prior to joining Integrated Dental Holdings, Mr. Scicluna spent nine years with Alliance Boots where he held various senior positions, including from 2010 to 2013 as International Managing Director responsible for all Boots stores and brands outside of the United Kingdom with turnover of £2 billion. Mr. Scicluna was Managing Director of Unichem for Alliance Boots from 2007 to 2008, and was Chief Operating Officer of Alliance Boots and Deputy Managing Director of its Alliance Pharmacy from 2002 to 2007. Mr. Scicluna was also Chief Operating Officer of the GAME Group from 2008 to 2010.

Mark Robson. Mr. Robson is the Chief Financial Officer of Integrated Dental Holdings. His appointment became effective in February 2012, and he was appointed to our Board in July 2012. Mr. Robson is a qualified chartered accountant with extensive experience in the consumer and leisure retail sectors including public- and sponsor-owned entities. He was previously Chief Financial Officer at Thorntons PLC (confectionary retailing and production), Somerfield Limited (food retailing), SFI Holdings Limited (pub and bar chain), Claire's Accessories (UK) Limited (children's fashion) and Alldays PLC (the convenience store group).

Jean Bonnavion. Mr. Bonnavion joined our Board in 2011 as a non-executive Director. He is currently a Partner at Palamon. He has served as an observer or member of the board for many Palamon investments, including Towry and SAV Credit. Prior to joining Palamon in 2005, Mr. Bonnavion spent eight years working in management

consulting for Bain & Company in Paris and London. He also worked for the French Railways in London for two years as part of the Eurostar marketing team.

Louis Elson. Mr. Elson joined our Board in 2014 as a non-executive Director. Currently, he is co-founder and managing partner at Palamon, where he has managed investments in the European healthcare sector for the past 14 years. Mr. Elson has also participated in a number of other investments with Palamon, including Towry, SAR, OSG, Red and Feelunique. Prior to his career in private equity, Mr. Elson worked in investment banking at Goldman Sachs and in publishing at Time Inc. Mr. Elson has also held directorships in a number of companies in a variety of industries over the past twenty years.

Eric Kump. Mr. Kump joined our Board in 2011 as a non-executive Director. Since 2010, Mr. Kump has acted as a Managing Director at Carlyle with responsibility for coverage of the UK market. Prior to joining Carlyle, Mr. Kump was a Managing Director and head of the London-based private equity team of Dubai International Capital ("DIC"). Whilst at DIC he was on the board of various investments including Alliance Medical, Almatis, Travelodge, Mauser Group and Merlin Entertainments Group. Prior to that, he was a Managing Director with Merrill Lynch Global Private Equity ("MLGPE"), where he was a member of the investment committee and a director of numerous portfolio companies. Whilst at MLGPE, he focused on investments in a range of industries, including financial services, consumer, distribution, industrial and healthcare.

Alexis Stirling. Mr. Stirling joined our Board in 2011 as a non-executive Director. Currently, Mr. Stirling is a director in the European buyout team at Carlyle, with a particular focus on business and consumer services sectors. Prior to joining Carlyle, Mr. Stirling was an Investment Director with Apax Partners and PPM Capital and he has previously been a board member or an observer on the Boards of RAC, Addison Lee, NBTY Europe, Orizonia, Focus Wickes, PCM Uitgevers and Promethean.

Key members of senior management

In addition to the board of directors discussed above, the following individuals form the key members of the senior management of the Parent Guarantor:

Name	Age	Title
Terry Scicluna	56	Chief Executive Officer
Mark Robson	51	Chief Financial Officer
Annette Spindler	46	Chief Operating Officer
Debra Lee	52	Growth and Acquisitions Director
Steve Williams	44	Clinical Services Director
Elizabeth McDonald	42	Company Secretary and General Counsel
Jeremy Perkin	40	Group Financial Controller

Set out below is a brief description of the business experience of other key members of senior management of the group not already described.

Debra Lee. Ms. Lee joined Integrated Dental Holdings in 2012 and is responsible for the development of its acquisition and business strategy. Prior to joining our team, Ms. Lee was the head of global sales for HCL and she worked for Capita plc in its Big Ticket Group Sales division, winning approximately £1.5 billion of new business for Capita. Prior to this, Ms. Lee was the head of local government business development at British Telecom and worked in a variety of other posts, developing new markets for small technology businesses.

Steve Williams. Mr. Williams qualified as a dental surgeon in 1992 from Manchester University. After an initial period in private practice, he joined Integrated Dental Holdings in 2004 and has held a series of roles with us, including Clinical Director, Regional Manager and Director of Clinical Services. In May 2011, he was appointed to the board of IDH as Clinical Services Director. In this role he leads the clinical and health and safety teams in ensuring that clinical and safety governance regimes are embedded throughout our entire organisation with a focus on improving quality. Mr. Williams manages relationships with both local and central government organisations to ensure the protection of existing contracts as well as securing new opportunities.

Annette Spindler. Ms. Spindler is the Chief Operating Officer of Integrated Dental Holdings. Her appointment became effective in April 2014. Ms. Spindler has a wealth of experience within the retail and pharmacy sectors. She was previously Marketing Director of Lloyds pharmacy part of parent company Celesio AG, Managing Director of Scholl Retail which included Podiatry clinics (previously owned by Alliance pharmacy), Marketing Director of Alliance Pharmacy (part of Alliance Boots), Sales, Marketing & Property Director at Brantano Footwear (including international—Middle East).

Elizabeth McDonald. Mrs. McDonald was admitted as a solicitor by the Law Society of England and Wales in 1996. Prior to joining us as our General Counsel and Company Secretary in 2012, Mrs. McDonald was the Legal Director

and Company Secretary of the Peel Airport Group, and was integral in the sale of several airports in the United Kingdom and in the restructuring of the Peel Airport Group. Prior to that, Mrs. McDonald was the Legal Director of KCOM Group PLC.

Jeremy Perkin. Mr. Perkin joined Integrated Dental Holdings in December 2008 as Group Financial Controller. Prior to joining our team, Mr. Perkin held a series of roles with KPMG LLP including the role of Senior Manager, Audit. Mr. Perkin is a qualified chartered accountant and a member of the Institute of Chartered Accountants in England & Wales (ACA).

The business address for each of the Board and the senior management team of the group is Europa House, Europa Trading Estate, Stoneclough Road, Kearsley, Manchester M26 1GG, United Kingdom.

Committees

Audit Committee

Our Audit Committee is chaired by Paul Pindar and is composed of the following members: Eric Kump and Jean Bonnavion. The role of the Audit Committee is to monitor and review our internal financial controls, risk management systems and audit function, external auditor independence and objectivity, and the effectiveness of the external auditor review process. The Audit Committee will also develop and implement our policy on the engagement of, and make recommendations to the board in relation to the appointment of, external auditors. The Audit Committee meets at least once every twelve months.

Remuneration Committee

Our Remuneration Committee is composed of Terry Scicluna, Paul Pindar, Mark Robson, Eric Kump and Jean Bonnavion. The responsibilities of the Remuneration Committee include determining the remuneration and performance targets for senior executives and any employees who earn a salary greater than £110,000 per year, the award of rights under equity incentive plans and the setting of all management bonus schemes.

Compensation of directors and senior management

The aggregate salary and fees, performance-related remuneration and bonuses, pension contributions and other benefits paid to the directors and senior management listed under "—Board of directors of the Parent Guarantor" and "—Key members of senior management" in the year ended 31 March 2014 was £1.4 million excluding severance and other transition payments to directors and senior management that have left us during such period.

Management employment agreements

Our senior management is compensated by way of a fixed annual salary and an annual bonus. The annual bonus is typically determined based on the proportion by which our EBITDA before exceptional items exceeds budget and certain personal objectives, in both cases reasonably determined by the Board. The Remuneration Committee reviews compensation packages for all senior executives and any employees who earn a salary greater than £110,000 per year, and all other employee compensation packages are reviewed annually by the Board.

Share ownership

Certain members of the board of directors and senior management of the group indirectly own shares of EquityCo. See "Principal shareholders".

Principal shareholders

As at the date of this Annual report, the issued share capital of the Issuer consisted of 50,000 ordinary shares with a total par value of £1.00. All the issued share capital of the Issuer is held by the Parent Guarantor, a private limited company incorporated under the laws of England and Wales and a wholly owned subsidiary of MidCo, a private limited company incorporated under the laws of England and Wales. Other than the preference shares, the issued share capital of MidCo is held by EquityCo, a private limited company incorporated under the laws of England and Wales.

Ownership in EquityCo

EquityCo has three classes of ordinary equity capital. The ordinary shares of EquityCo are designated as A1, A2 and B shares. The A1 ordinary shares have a nominal value of £0.01 and the A2 shares and B shares each have a nominal value of £0.04. The following table sets out certain beneficial ownership information regarding the holders of over 5% of the ordinary shares in EquityCo, and the number and percentage owned by each shareholder as at 31 March 2014:

	Carlyle[1]		**Palamon[2]**		**Management[3]**		**Total**	
	(‘000)	%	(‘000)	%	(‘000)	%	(‘000)	%
A1 Ordinary Shares	1,282	64.4	400	20.1	–	–	1,682	84.5
A2 Ordinary Shares	–	–	–	–	18	0.9	18	0.9
B Ordinary Shares.....	–	–	–	–	291	14.6	291	14.6
**Total ..... **	**1,282**	**64.4%**	**400**	**20.1%**	**309**	**15.5%**	**1,991**	**100.0%**

(1) The Carlyle Group is the beneficial owner of shares in EquityCo held by CEP III Participations S.à.r.l. SICAR, an investment vehicle for Carlyle.

(2) Palamon Capital Partners is the beneficial owner of shares in EquityCo held by its fund Palamon European Equity II, L.P. In addition, ADP Primary Care Acquisitions Limited, an entity controlled by Palamon, holds preference shares in MidCo with a par value of £20 million.

(3) Current and former members of our senior management hold interests in the ordinary shares of EquityCo indirectly through their interests in Turnstone Management Investments Limited. No member of management individually or together with such member of management’s immediate family members or personal trust beneficially holds more than 5% of the ordinary shares of EquityCo.

Information about our principal shareholders

Carlyle

Funds formed and managed by The Carlyle Group hold 64.4% of our equity interests. The Carlyle Group is a global alternative asset manager with more than $189 billion in assets under management across 118 funds and 106 fund of funds vehicles as at 31 December 2013. Founded in 1987 in Washington, DC, Carlyle has grown into one of the world’s largest and most successful investment firms, with more than 1,500 professionals operating in 34 offices in North America, South America, Europe, the Middle East, North Africa, Sub-Saharan Africa, Japan, Asia and Australia. Carlyle’s investment in IDH is made through its current European Buyout funds, which has approximately €5.4 billion under management.

Palamon

Funds formed and managed by Palamon Capital Partners hold 20.1% of our equity interests. Palamon Capital Partners is a private equity partnership that invests in service-oriented businesses and businesses with high growth potential throughout Europe. Palamon has approximately €1.3 billion under management. Palamon’s other investments in the healthcare industry include SARquavitae, Prospitalia, Polikum and Ober-Scharrer.

Subscription and Shareholders Agreement

On 28 January 2011, EquityCo, MidCo and BidCo, inter alios, entered into a subscription and shareholders' agreement (the "Subscription and Shareholders' Agreement"), amended on 11 May 2011, relating to the shares held in EquityCo by each of Carlyle and Palamon (together, the "Lead Investors") and certain members of our senior management, and governing the management and affairs of EquityCo and its subsidiaries.

The Subscription and Shareholders' Agreement contains provisions, amongst other things, regulating (i) the proceedings and general meetings of the Board, the BidCo board of directors and the board of directors of Turnstone Management Investments Limited, (ii) matters which are reserved for the prior written consent of the Lead Investors, (iii) restrictions and rights on transfers of debt and equity instruments in EquityCo or Turnstone Management Investments Limited (including rights of first offer and tag-along and drag-along rights), (iv) pre-emption rights, (v) acquisition and rescue issues, (vi) the manner and process of exit, (vii) rights and obligations of holders of debt and equity instruments in EquityCo or Turnstone Management Investments Limited (including distributions and ranking), (viii) the rights and obligations of Management, (ix) rights and obligations of EquityCo, MidCo, the Parent Guarantor, BidCo and Turnstone Management Investments Limited and (x) matters relating to indemnification of the parties under the Subscription and Shareholders' Agreement.

Certain relationships and related party transactions

In the ordinary course of business we may enter into transactions with related parties. Described below are the most significant transactions with related parties.

Letter of credit to clinical directors

Certain of our clinical directors act as partners in the dental practices we acquire through partnership structures. In order to indemnify such clinical directors against the risks inherent in these arrangements, Lloyds TSB has issued a letter of credit in favour of such clinical directors in the amount of £1.8 million, which letter of credit is issued under our Existing Senior Credit Facility.

Service contract

Paul Pindar, our non-Executive Chairman, was until his retirement in February 2014 also the Chief Executive Officer of Capita plc, a business process outsourcing and recruitment company in the United Kingdom. Capita plc currently provides all back-office systems for maintaining our NHS dental records. We believe that the terms for the provision of services provided to us by Capita plc are no less favourable to us than would be negotiated with an unrelated third party on an arm's-length basis.

Turnstone Midco 2 Limited

Annual report and consolidated financial statements

Registered number 07496754

Year ended 31 March 2014

Contents

Strategic report for the year ended 31 March 2014

The directors present the Strategic report for the year ended 31 March 2014.

Principal activities

The principal activity of the company during the year was to act as a holding company. The principal activity of the group of companies owned by Turnstone Midco 2 Limited ('the group') is the operation of dental practices.

The group provides a range of National Health Service ('NHS') and private dental services from practices located in England, Wales and Scotland and support services to other third party dental practices.

Business ownership

The IDH group is jointly owned by The Carlyle Group ('Carlyle') and Palamon Capital Partners ('Palamon').

Founded in 1987, Carlyle is one of the world's largest alternative asset managers. Palamon, founded in 1999, is an independent private equity partnership focused on providing equity for European growth services companies.

Carlyle and Palamon have joint control of Turnstone Equityco 1 Limited (trading as 'IDH'). Carlyle's majority holding is owned by CEP III Participations S.à.r.l. SICAR, an investment vehicle for Carlyle. Palamon's ownership of the group is through its fund Palamon European Equity II, L.P. As at 31 March 2014, IDH senior managers held 15.5% of the equity interest in the company.

The equity funding is split between preference and ordinary share capital, with the ordinary capital being designated 'A1', 'A2' and 'B' for ownership identification. 'A1' ordinary shares have a nominal value of £0.01, 'A2' and 'B' ordinary shares have a nominal value of £0.04.

Ownership Structure

Number of shares (% of total)	Management		Carlyle		Palamon		Total	
'A1' Ordinary ('000)	-	-	1,282	64.4%	400	20.1%	1,682	84.5%
'A2' Ordinary ('000)	18	0.9%	-	-	-	-	18	0.9%
'B' Ordinary ('000)	291	14.6%	-	-	-	-	291	14.6%
Total	**309**	**15.5%**	**1,282**	**64.4%**	**400**	**20.1%**	**1,991**	**100.0%**

Business review

The group owns and manages a national chain of dental practices, with 585 sites at 31 March 2014 (2013: 532). In common with the majority of dental practices in the UK, the group's practices offer a mixture of NHS and private treatment to patients. With around 85% of its revenue coming from NHS contracts (2013: 87%), the group is the largest provider of NHS dentistry in the UK.

The main trading entities of the group are Petrie Tucker and Partners Limited, Whitecross Dental Care Limited and IDH Limited (formerly ADP Dental Company Limited). The business has continued to grow during the year through a mixture of corporate and practice acquisitions.

The group's revenue during the year was principally derived from long-term fixed value contracts with NHS Local Area Teams ("LATs"). Provided the group achieves certain performance related criteria on an annual basis, the fixed-income nature of the contracts in England and Wales provides the group with stability and visibility over its revenue and profit streams. In addition the group has variable income streams based on treatment provided to patients under private contract and to NHS patients in Scotland.

During the year to 31 March 2014, the group acquired 60 practices, opened 1 greenfield site, merged 7 practices and completed the disposal of 1 practice.

Consolidated profit and loss account
Turnover for the year ended 31 March 2014 amounted to £407.5 million (2013: £349.0 million) and profit on ordinary activities before interest and taxation was £18.1 million (2013: £10.9 million).

After charging goodwill amortisation of £34.0 million (2013: £29.3 million), depreciation of £13.6 million (2013: £11.8 million) and crediting the amortisation of grant income of £0.5 million (2013: £0.7 million), earnings before interest, tax and exceptional items ('EBIT before exceptional items') was £20.7 million (2013: £15.9 million).

The group's key profit performance indicator is earnings before interest, tax, depreciation, amortisation and exceptional items ('EBITDA before exceptional items'). For the year ended 31 March 2014 EBITDA before exceptional items was £67.8 million (2013: £56.3 million).

Strategic report for the year ended 31 March 2014 *(continued)*

Business review *(continued)*

Finance expenses of £54.3 million (2013: £70.3 million) and the loss arising from the disposal of one dental practice of £0.4 million (2013: loss of £3.6 million from the disposal of seven practices) results in a loss on ordinary activities before tax of £36.1 million (2013: £59.4 million). The loss on ordinary activities after tax for the year amounts to £34.1 million (2013: £57.5 million).

Consolidated balance sheet
Goodwill and intangible assets amount to £614.8 million (2013: £558.0 million) and arose from the acquisition of the Integrated Dental Holdings ('IDH') and Associated Dental Practices ('ADP') groups in May 2011 together with the acquisition of further dental practices over the past three years and of the DBG Topco Limited group of companies (together 'the Dental Buying Group' or 'DBG') on 16 April 2013. Tangible assets of £83.3 million (2013: £68.2 million) include £24.5 million (2013: £15.6 million) of additions during the year resulting from upgrades to the group's dental practices, equipment and facilities.

On 30 May 2013, the group re-financed its existing debt and raised £400 million through the issue of £200 million of senior secured fixed rate notes, £125 million of senior secured floating rate notes and £75 million of second lien notes. The proceeds were used to repay the group's existing bank debt along with £50 million of the outstanding shareholder debt. On the same date, the group also entered into an agreement with a syndicate of banks to provide a £100 million Super Senior Revolving Credit Facility ('SSRCF') to fund future acquisitions of dental practices.

At 31 March 2014, borrowings amounted to £408.5 million (2013: £740.7 million). This comprises £408.5 million (2013: £288.1 million) of senior borrowings including the senior secured, floating rate and second lien notes in addition to amounts drawn under the SSRCF of £22.0 million, net of unamortised arrangement fees.

The £452.6 million loan to due to Turnstone Midco 1 Limited as at 31 March 2013 was repaid in full on 30 May 2013 as part of the re-financing described above.

Consolidated cash flow statement
The net cash inflow from operating activities of £54.8 million (2013: £53.9 million) reflects the strong cash generation properties of the group.

After the servicing of external finance costs and the cash flows associated with the acquisition of further practices during the year, the closing cash balance was £6.9 million (2013: £42.4 million). The cash position at 31 March 2013 reflects the drawdown of acquisition financing through debt facilities and loan notes in advance of a number of large acquisitions made during the first week of April 2013.

Subsequent events

On 17 April 2014, the group, through a newly formed subsidiary of Turnstone Bidco 1 Limited, acquired the entire share capital of HM Logistics Limited, also known as The Dental Directory Group.

On 9 May 2014, the group raised £100 million through the issue of additional senior secured floating rate notes. The proceeds were used to repay the group's existing borrowings against the Super Senior Revolving Credit Facility and for general corporate purposes.

In addition, to the date of this report, the group has acquired a further seven dental practices.

Principal risks & uncertainties

Regulatory risks
The results of the group are impacted by the regulatory environment related to health and safety, quality of care and data protection, principally through the costs related to compliance. The group's practices are subject to regular review by the Care Quality Commission ('CQC') and could be closed if compliance with CQC guidelines cannot be demonstrated. As the leading provider of dental services in the United Kingdom, the group is well placed to respond to and comply with regulatory changes through dedicated regulatory and compliance teams.

NHS contract
The NHS contract for the dentist in England and Wales, introduced in April 2006, provides clear benefits to the group, both in terms of income stability and visibility and therefore dentist retention. However, as with any system, there are likely to be modifications to it, potentially through the introduction of a new contract structure. The extent of such modifications and the impact which they may have on the group, either in a favourable or adverse manner have not yet been drafted into legislation. However, IDH maintains a close dialogue with the Government in developing the new contract and is currently involved in seven new contract pilots to ensure that the business is well prepared for any future changes.

Strategic report for the year ended 31 March 2014 *(continued)*

Principal risks & uncertainties *(continued)*

Clinicians and other qualified staff
The group requires skilled clinicians, hygienists and nurses in order to care for its growing patient base. The expansion of the EU over recent years and the increased capacity of UK dental schools have increased the supply of clinicians available to the group. The improved supply, coupled with the fixed nature of dentist's contracts has improved the retention of dentists within the group. The directors recognise the importance of quality clinicians for ensuring the continued success of the group. The group manages the risk associated with the supply of clinicians through training and development programmes to enhance retention and a recruitment strategy to ensure that the growth in patient numbers can be treated. The group has invested in its own training resource, the IDH Academy, which opened on 29 May 2013 together with an accompanying on-line training system.

Financial risk management

The Board of Directors has overall responsibility for the establishment and oversight of the group's risk management framework. The group's activities expose it to a variety of financial risks: credit risk, liquidity risk, market (including currency and interest rate risk) and inflation risk.

The group's risk management policies are established to identify and analyse the risks faced by the group, to set appropriate risk limits and controls to monitor risks and adherence to limits. Risk management policies and systems are reviewed regularly to reflect changes in market conditions and the group's activities.

Credit risk
Credit risk is the risk of financial loss to the group if a customer fails to meet its contractual obligations. The nature of the group's contracts with LATs means that credit risk is minimised for a significant proportion of group revenue. The patient's contribution to NHS charges is usually collected before treatment in order to minimise risk to the group. Payment is also requested in advance for major courses of private treatment. Cash deposits are held with institutions with a minimum credit rating of BBB (Standard and Poor's) or Baa (Moody's).

Liquidity risk
Liquidity risk is the risk that the group will not be able to meet its financial obligations as they fall due. The group's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due, under both normal and stressed conditions, without unacceptable losses or risking damage to the group's reputation.

The group regularly monitors its cashflow forecasts and currently maintains funds on demand to meet all operational expenses including the servicing of financial obligations. The group's bank facilities and other borrowings are disclosed in note 17 of the financial statements.

Market risk
Market risk is the risk that changes in foreign exchange rates and interest rates will affect the group's income.

The group has limited currency risk as all operations are carried out in the United Kingdom and all income, expenses and facilities are denominated in Sterling. However, as materials are sourced by suppliers internationally, the group is indirectly exposed to currency risk as suppliers adjust their UK price lists for changes in material prices denominated in foreign currencies. This risk is managed through competitive tendering for the group's significant supply contracts.

Following the re-financing completed on 30 May 2013, the group entered into two fixed interest rate contracts totalling £125 million. In addition to the fixed rate nature of a further £275 million of the group's senior secured and second lien notes, interest charges are fixed in respect of 95% of the group's total drawn debt (2013: 71%). Further details are set out in note 17.

Inflation risk
Inflation risk is the risk that the cost of key services and products procured by the group will rise with inflation and affect the group's income. The rates paid under the terms of the group's NHS contracts are reviewed on an annual basis and, over the course of the past few years, the annual uplifts have typically been lower than the rate of both RPI and CPI.

The group undergoes a regular review of key suppliers through its procurement programme to mitigate cost increases, using tendering processes where possible. In addition, the group seeks to rationalise its supplier base to benefit from its scale.

Strategic report for the year ended 31 March 2014 *(continued)*

KPIs – financial and non-financial

The KPIs set out in the table below are fundamental to the business and reflect focus on the drivers of value that will enable and inform the management team to achieve the business plans, strategic aims and objectives.

Financial KPIs

Year ended 31 March	2014		2013	
	£m	% revenue	£m	% revenue
NHS turnover	346	84.9%	305	87.5%
Private turnover	54	13.4%	44	12.5%
Other turnover	8	1.7%	-	0.0%
Total turnover	**408**	**100.0%**	**349**	**100.0%**
Gross profit	197	48.3%	165	47.4%
EBITDA before exceptional items	**68**	**16.6%**	**56**	**16.1%**
Operating profit	19	4.6%	14	4.2%
Net bank and bond debt	409		288	
Net cash inflow from operating activities	55		54	
Net cash inflow after returns on investment & servicing of finance *(excluding issue costs of £15m in 2014)*	29		34	

Year ended 31 March	2014	2013
Like-for-like private turnover growth	8.6%	2.8%
£/UDA annual contract uplift	1.5%	0.5%
Administrative expenses as a percentage of turnover	32.0%	31.8%
Number of practices	585	532
Employees (average number)	5,622	4,931
UDA delivery (% of total contract)	96.7%	96.0%
Total UDAs delivered (million)	12.3	10.6
Total UOAs delivered (million)	0.4	0.3

(1) UDA – Units of Dental Activity, measures set by the LAT as part of the contract terms.
(2) UOA – Units of Orthodontic Activity, measures set by the LAT as part of the contract terms.
(3) Employees – excluding self-employed dentists.
(4) Administrative expenses as a percentage of turnover excludes depreciation, amortisation and exceptional items.

Strategic report for the year ended 31 March 2014 *(continued)*

Outlook & strategy

Whilst the market continues to be challenging for dentistry in the UK, with the pressures on NHS funding and consumer spending, the directors believe that the group continues to be well positioned to take advantage of further opportunities. In particular, the group will continue to focus on delivering growth through:

- delivering high quality care and promoting the highest clinical standards;
- optimising delivery of its existing NHS contracts;
- exploring opportunities to tender for new contracts;
- diversifying our revenues through new initiatives in private dentistry;
- implementing improved systems and processes to increase productivity, efficiency and oversight;
- investing in the equipment and buildings of our practice estate;
- growing our portfolio through new practice acquisitions; and
- using the size of our portfolio and systems to procure materials and services more efficiently and effectively.

WHM Robson
Director
20 June 2014

Directors' report for the year ended 31 March 2014

The directors present their report and the audited consolidated financial statements of Turnstone Midco 2 Limited for the year ended 31 March 2014.

Financial risk management

Please refer to the Strategic report for a description of the group's financial risk management processes.

Future developments

Please refer to the business review section of the Strategic Report for a description of future developments.

Proposed dividend

The directors do not recommend the payment of a dividend for the year (2013: £nil).

Directors

The directors who held office during the year and to the date of this report were as follows:

J Bonnavion	
L Elson	(Appointed 30 November 2013)
J Heathcote	(Resigned 30 November 2013)
E Kump	
P Pindar	
WHM Robson	
T Scicluna	(Appointed 30 November 2013)
R Smith	(Resigned 30 November 2013)
A Stirling	

The directors benefitted from qualifying third party indemnification provisions in place during the financial year and to the date of this report. The group also provided qualifying third party indemnity provisions to certain directors of subsidiary companies during the financial year and to the date of this report.

Statement of directors' responsibilities

The directors are responsible for preparing the Strategic Report, Directors' report and the financial statements in accordance with applicable law and regulations.

Company law requires the directors to prepare financial statements for each financial year. Under that law the directors have prepared the group and parent company financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under company law the directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the group and the company and of the profit or loss of the group for that year. In preparing these financial statements, the directors are required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and accounting estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the company and the group will continue in business.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the company's transactions and disclose with reasonable accuracy at any time the financial position of the company and the group and enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the company and the group and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors are responsible for the maintenance and integrity of the company's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Directors' report for the year ended 31 March 2014 *(continued)*

Employees

The group is an equal opportunities employer and does not discriminate between employees on the grounds of race, ethnic origin, age, sex or sexual orientation.

Applications for employment from disabled persons are given full and fair consideration with regard paid only to the ability of candidates to carry out satisfactorily the duties of the job. Should an existing employee become disabled, every effort is made to ensure continuing employment with retraining arranged where necessary. Disabled persons share in the opportunities for career development and promotion while training takes account of any special needs.

Briefing and consultative procedures exist throughout the group to inform employees on matters of concern to them, the financial and economic performance of their business units and to provide opportunities for comment and discussion.

Political and charitable contributions

The company made no political or charitable contributions during the year (2013: £nil).

Policy and practice on the payment of creditors

It is the group's policy in respect of all suppliers, including self-employed dentists, to agree payment terms in advance of the supply of goods and to adhere to those payment terms.

Post balance sheet events

On 17 April 2014, the group, through a newly formed subsidiary of Turnstone Bidco 1 Limited, acquired the entire share capital of HM Logistics Limited, also known as The Dental Directory Group.

On 9 May 2014, the group raised £100 million through the issue of additional senior secured floating rate notes. The proceeds were used to repay the group's existing borrowings against the Super Senior Revolving Credit Facility and for general corporate purposes.

In addition, to the date of this report, the group has acquired a further seven dental practices.

Disclosure of information to auditors

The directors who held office at the date of approval of this Directors' report confirm that, so far as they are each aware, there is no relevant audit information of which the company's auditors are unaware; and each director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that the company's auditors are aware of that information.

This statement is given and should be interpreted in accordance with Section 418 of the Companies Act 2006.

Independent auditors

PricewaterhouseCoopers LLP have indicated their willingness to continue in office and a resolution that they be reappointed will be proposed at the Annual General Meeting.

By order of the Board

WHM Robson
Director
20 June 2014

Europa House
Europa Trading Estate
Stoneclough Road
Kearsley
Manchester
M26 1GG

Independent auditors' report to the members of Turnstone Midco 2 Limited

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

- give a true and fair view of the state of the group's and of the company's affairs as at 31 March 2014 and of the group's loss and cash flows for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- the financial statements have been prepared in accordance with the requirements of the Companies Act 2006.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The group financial statements and parent company financial statements (the "financial statements"), which are prepared by Turnstone Midco 2 Limited, comprise:

- Consolidated profit and loss account for the year ended 31 March 2014;
- Consolidated balance sheet as at 31 March 2014;
- Company balance sheet as at 31 March 2014;
- Consolidated cash flow statement for the year ended 31 March 2014; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in the preparation of the group and parent company financial statements is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the group's and the parent company's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual report and consolidated financial statements (the "Annual report") to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on other matter prescribed by the Companies Act 2006

In our opinion the information given in the Strategic Report and the Directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Independent auditors' report to the members of Turnstone Midco 2 Limited *(continued)*

Other matters on which we are required to report by exception

Adequacy of accounting records and information and explanations received

Under the Companies Act 2006 we are required to report to you if, in our opinion:

- we have not received all the information and explanations we require for our audit; or
- adequate accounting records have not been kept by the parent company, or returns adequate for our audit have not been received from branches not visited by us; or
- the company financial statements are not in agreement with the accounting records and returns.

We have no exceptions to report arising from this responsibility.

Directors remuneration

Under the Companies Act 2006 we are required to report to you if, in our opinion, certain disclosures of directors' remuneration specified by law are not made. We have no exceptions to report arising from this responsibility.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Statement of directors' responsibilities set out on page F-8, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the company's members as a body in accordance with Chapter 3 of Part 16 of the Companies Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Martin Heath (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
20 June 2014

Consolidated profit and loss account

for the year ended 31 March 2014

	Note	2014 Acquisitions £'000	2014 Continuing operations £'000	2014 Total £'000	2013 £'000
Turnover	*2*	**30,066**	**377,445**	**407,511**	348,952
Cost of sales		**(13,516)**	**(197,333)**	**(210,849)**	(183,508)
Gross profit		**16,550**	**180,112**	**196,662**	165,444
Other operating income		**5**	**1,661**	**1,666**	1,812
Administrative expenses		**(12,644)**	**(167,112)**	**(179,756)**	(152,762)
Operating profit	*3*	**3,911**	**14,661**	**18,572**	14,494
Analysed as					
EBITDA before exceptional items		**7,779**	**59,998**	**67,777**	56,334
Depreciation		**(499)**	**(13,124)**	**(13,623)**	(11,815)
Amortisation of goodwill		**(3,318)**	**(30,671)**	**(33,989)**	(29,329)
Amortisation of grant income		**-**	**510**	**510**	666
Exceptional items - restructuring costs	*3*	**(51)**	**(2,052)**	**(2,103)**	(1,362)
Operating profit		**3,911**	**14,661**	**18,572**	14,494
Loss on disposal of assets	*6*			**(442)**	(3,631)
Profit on ordinary activities before interest and taxation				**18,130**	10,863
Interest receivable and similar income	*7*			**67**	37
Interest payable and similar charges	*7*			**(54,253)**	(70,288)
Loss on ordinary activities before taxation				**(36,056)**	(59,388)
Tax on loss on ordinary activities	*8*			**1,980**	1,908
Loss on ordinary activities after taxation				**(34,076)**	(57,480)
Equity minority interests				**(50)**	80
Loss for the financial year	*20*			**(34,126)**	(57,400)

The group has no material recognised gains and losses during the current or previous year other than those stated above and therefore no separate statement of total recognised gains and losses has been presented.

There were no differences between the historical cost profit and losses and the figures noted in the consolidated profit and loss account.

The notes on pages F-16 to F-44 form part of these financial statements.

Consolidated balance sheet

at 31 March 2014

	Note	**2014**		2013	
		£'000	**£'000**	£'000	£'000
Fixed assets					
Intangible assets	*10*		**614,834**		557,994
Tangible assets	*11*		**83,268**		68,179
			698,102		626,173
Current assets					
Stock	*13*	**7,573**		6,238	
Debtors	*14*	**44,907**		28,558	
Cash at bank and in hand		**6,936**		42,403	
		59,416		77,199	
Total assets			**757,518**		703,372
Capital and reserves					
Called up share capital	*19*	**410,961**		-	
Profit and loss account	*20*	**(143,284)**		(109,158)	
Total shareholders' funds/(deficit)	*21*		**267,677**		(109,158)
Minority interest			**(34)**		(84)
Total capital employed			**267,643**		(109,242)
Creditors: amounts falling due within one year	*15*		**65,245**		65,951
Non-current liabilities					
Creditors: amounts falling due after more than one year	*16*		**414,413**		731,686
Provisions for liabilities and charges	*18*		**10,217**		14,977
			424,630		746,663
Total equity and liabilities			**757,518**		703,372

The notes on pages F-16 to F-44 form part of these financial statements.

The financial statements were approved by the Board of Directors on 20 June 2014 and were signed on its behalf by:

WHM Robson
Director

Company balance sheet
at 31 March 2014

	Note	**2014**		2013	
		£'000	**£'000**	£'000	£'000
Fixed assets					
Investments	*12*		**411,011**		**-**
Current assets					
Debtors (includes £nil falling due after more than one year, 2013: £452,622,000)	*14*		**-**		461,082
Total assets			**411,011**		461,082
Capital and reserves					
Called up share capital	*19*	**410,961**		**-**	
Profit and loss account	*20*	**(10)**		(2)	
Total shareholders' funds/(deficit)	*21*		**410,951**		(2)
Creditors: amounts falling due within one year	*15*		**60**		8,462
Non-current liabilities					
Creditors: amounts falling due after more than one year	*16*		**-**		452,622
Total equity and liabilities			**411,011**		461,082

The notes on pages F-16 to F-44 form part of these financial statements.

The financial statements were approved by the Board of Directors on 20 June 2014 and were signed on its behalf by:

WHM Robson
Director

Consolidated cash flow statement

for the year ended 31 March 2014

	Note	**2014 £'000**	2013 £'000
Net cash inflow from operating activities	*25*	**54,765**	53,861
Returns on investments and servicing of finance	*26*	**(41,422)**	(19,515)
Net cash inflow after returns on investment & servicing of finance		**13,343**	34,346
Taxation		**245**	(336)
Capital expenditure	*26*	**(23,535)**	(14,467)
Acquisitions and disposals	*26*	**(93,554)**	(45,623)
Net cash outflow before financing		**(103,501)**	(26,080)
Financing	*26*	**68,034**	49,526
(Decrease)/increase in cash in the financial year	*28*	**(35,467)**	23,446

The notes on pages F-16 to F-44 form part of these financial statements.

Notes to the financial statements

1 Accounting policies

Basis of preparation

The financial statements have been prepared on the going concern basis, under the historical cost convention and in accordance with applicable United Kingdom accounting standards and the Companies Act 2006.

A summary of the more important group accounting policies, which have been applied on a consistent basis with the prior year, is set out below.

Basis of consolidation

The consolidated financial statements include the financial statements of the company and its subsidiary undertakings made up to 31 March 2014. The acquisition method of accounting has been adopted. Under this method, the results of subsidiary undertakings or dental practices acquired or disposed of in the financial year are included in the consolidated profit and loss account from the date of acquisition or up to the date of disposal. Profits and losses on intragroup transactions have been eliminated on consolidation.

Partnerships

Certain members of the group management team act as partners on behalf of group companies in a number of dental practice partnerships. These partnerships are held on trust on behalf of a number of group companies. All profits arising from partnership activity are transferred to a group trading company.

As a result, the group considers that it has control of these partnerships and consequently the results of the partnerships are consolidated into the group's financial statements. The partnerships are accounted for in accordance with the group's accounting policies.

Turnover

Turnover represents the income received in the ordinary course of business for dentistry goods or services provided to the extent that the group has obtained the right to consideration. Turnover derived from NHS contracts in England and Wales is recognised on the volume of dental activity delivered in the financial year. Turnover from all private dental work and NHS patients in Scotland is recognised on the completion of each piece of treatment carried out, with the exception of orthodontic treatment, which is recognised based on the stage of completion reached during the course of treatment.

Goodwill

Purchased goodwill (representing the excess of the fair value of the consideration and associated costs over the fair value of the separable net assets acquired) arising on consolidation in respect of acquisitions is capitalised. Positive goodwill is amortised to nil by equal annual instalments over its estimated useful life, which is 20 years, being the period over which the group expects to benefit from the assets acquired. The carrying value of goodwill is evaluated when there is an indicator of impairment. When it is determined that the carrying value exceeds the recoverable amount, the excess is written off to the profit and loss account.

In calculating the goodwill, the total consideration, both actual and deferred, is taken into account. Where the deferred consideration is contingent and dependent upon future trading performance, an estimate of the present value of the likely consideration payable is made. This contingent deferred consideration is re-assessed annually and corresponding adjustment is made to the goodwill arising on acquisition.

On the subsequent disposal or termination of a business acquired, the profit or loss on disposal or termination is calculated after charging the unamortised amount of any related goodwill.

Investments

Investments held as fixed assets are stated at historic purchase cost less amounts written off for impairment.

Notes to the financial statements *(continued)*

1 Accounting policies *(continued)*

Tangible fixed assets and depreciation

Tangible fixed assets are stated at historic purchase cost less accumulated depreciation. The cost includes the original purchase price of the asset and the costs attributable to bringing the asset to its working condition for intended use.

Depreciation is provided on all tangible fixed assets, at rates calculated to write off the cost of each asset less expected residual value over its expected useful life on a straight line basis as follows:

Freehold and long leasehold buildings	-	50 years
Leasehold improvements	-	Over the shorter of the term of the lease or the asset's useful life
Fixtures, fittings and equipment	-	4-10 years

Where the residual value of an asset is material it is reviewed at the end of each financial year, to ensure that it has been depreciated on an appropriate basis.

Impairments of fixed assets and goodwill

Impairment write downs are recognised in the profit and loss account when the book value of the asset is higher than the higher of the net realisable value of the asset or the value in use.

The value in use of assets is calculated using discounted forecast cash flows linked to the asset or income generating unit.

Stock

Stock is stated at the lower of cost and net realisable value (net realisable value is the price at which stocks can be sold after allowing for costs of realisation). In the case of raw materials and consumables, cost includes purchase price less trade discounts, transport and handling costs, calculated on an average price basis over the financial year. Provision is made for obsolete, slow moving and defective stock.

Taxation

The charge for taxation is based on the results for the financial year and takes into account taxation deferred because of timing differences between the treatment of certain items for taxation and accounting purposes.

Deferred taxation

Deferred tax is recognised in respect of all timing differences that have originated but not reversed at the balance sheet date, where transactions or events that result in an obligation to pay more tax in the future or a right to pay less tax in the future have occurred at the balance sheet date.

A net deferred tax asset is regarded as recoverable and therefore recognised only when, on the basis of all available evidence, it can be regarded as more likely than not that there will be suitable taxable profits against which to recover carried forward tax losses and from which the future reversal of underlying timing differences can be deducted.

Deferred tax is measured at the average tax rates that are expected to apply in the periods in which the timing differences are expected to reverse based on tax rates and laws that have been enacted or substantively enacted by the balance sheet date. Deferred tax is measured on a non-discounted basis.

Cash

Cash for the purpose of the cash flow statement, comprises cash in hand and deposits repayable on demand, less overdrafts payable on demand.

Leases

Operating lease rentals are charged to the profit and loss account on a straight line basis over the period of the lease.

Notes to the financial statements *(continued)*

1 Accounting policies *(continued)*

Pensions

The group makes contributions to the National Employment Savings Trust ('NEST'), a defined contribution pension scheme, on behalf of its employees. In addition, the group also operates a stakeholder defined contribution pension scheme, to which the group makes no contributions on behalf of its employees. The assets of these schemes are held separately from those of the group in an independently administered fund.

The group also operates a pension scheme providing benefits based on final pensionable pay. The assets of the scheme are held separately from those of the group. Contributions to the scheme are charged to the profit and loss account as incurred. The amounts for other finance income and the actuarial loss arising from the actual and expected return on assets and the changes in assumptions underlying the present value of scheme liabilities have not been recognised in the profit and loss account and the statement of total recognised gains and losses on the grounds of materiality, but are disclosed in note 24.

Government grants

Grants received to assist with the purchase of tangible fixed assets are credited to deferred income and are amortised over a period to match the life of the asset acquired. Revenue grants are recognised in the profit and loss account in the financial year in which they are received.

Provisions

Provisions are recognised when the group has a present obligation as a result of a past event, it is probable that a transfer of economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a discount rate which reflects current market assessments of the time value of money. The increase in the provision due to the passage of time is recognised as an interest expense.

Issue costs on bank loans and related fees

Issue costs related to bank loans are amortised over the term of the loan at a constant rate on the carrying amount.

Minority interests

Equity minority interests represent the share of the profits less losses on ordinary activities attributable to the interests of equity shareholders in subsidiaries which are not wholly owned by the group.

Preference shares

Preference shares which are redeemable on a specific date are classified as liabilities. The dividends on these preference shares are recognised in the profit and loss account as an interest expense.

Notes to the financial statements *(continued)*

2 Segmental analysis

The turnover, loss on ordinary activities before taxation and net liabilities of the group relate to its principal activity of dental services. All services are provided in the United Kingdom.

3 Operating profit

	2014	2013
	£'000	£'000
Operating profit is stated after charging/(crediting):		
Depreciation – owned assets	**13,623**	11,815
Amortisation of goodwill	**33,989**	29,329
Operating lease rentals: plant and machinery	**862**	666
Operating lease rentals: land and buildings	**10,970**	9,644
Other operating income	**(1,666)**	(1,812)
Amortisation of grant income	**(510)**	(666)
Exceptional items - restructuring costs	**2,103**	1,362

Other operating income
Additional income to assist in the upkeep of premises is received from Scottish health boards and is based on the proportion of NHS treatment carried out by a dental practice. Income is also received from property rentals.

Restructuring costs
Costs incurred during the years ended 31 March 2014 and 31 March 2013 relate to redundancy payments to staff and associated legal and professional fees.

Auditors' remuneration
During the year, the group obtained the following services from the company's auditors and their associates:

	2014	2013
Amounts receivable by the auditors and their associates in respect of:	**£'000**	£'000
Fees payable to the company's auditors for the audit of the parent company and the consolidated financial statements	**8**	1
Fees payable to the company's auditors and their associates for other services:		
The audit of the company's subsidiaries	**231**	173
Other assurance services	**25**	-
	264	174

Notes to the financial statements *(continued)*

3 Operating profit *(continued)*

In addition, the following services were received from the company's auditor and its associates during the year.

Amounts receivable by the auditors and their associates in respect of:	**2014 £'000**	2013 £'000
Tax advisory services	**32**	**-**
Other advisory services	**674**	**-**
	706	**-**

Other advisory services relate to financial and commercial due diligence carried out in respect of certain acquisitions and reporting and structuring advice in respect of the senior secured, floating rate and second lien notes issued by the group on 30 May 2013.

4 Employees

There were no persons employed by the company.

The average monthly number of persons employed by the group (including directors) during the financial year was as follows:

	2014 No of employees	2013 No of employees
Surgery staff	**3,377**	2,943
Administration staff	**2,245**	1,988
	5,622	4,931

The staff costs of these persons were as follows:

	2014 £'000	2013 £'000
Wages and salaries	**83,642**	66,849
Social security costs	**5,936**	4,602
Other pension costs	**342**	**-**
	89,920	71,451

Notes to the financial statements *(continued)*

5 Directors' remuneration

The directors received no emoluments from the company for their services during the year (2013: £nil).

	Group 2014 £'000	Group 2013 £'000
Directors' emoluments	**978**	748
Benefits in kind	**29**	21
Compensation for loss of office	**458**	-
	1,465	769

No directors accrued retirement benefits under money purchase or defined benefit pension schemes. Certain directors received no emoluments from the group for their services.

The aggregate of remuneration for the highest paid director was £727,000 (2013: £407,000), which included compensation for loss of office of £458,000 (2013: £nil) and benefits in kind of £7,000 (2013: £2,000).

6 Loss on disposal of assets

	Group 2014 £'000	Group 2013 £'000
Loss on disposal of freehold properties	**(281)**	-
Loss on disposal/closure of practices	**(163)**	(3,630)
Profit/(loss) on disposal of other tangible fixed assets	**2**	(1)
	(442)	(3,631)

During the year, the group disposed of one dental practice (2013: seven). Six of the seven practices disposed of during the previous year resulted from an Office of Fair Trading review of the acquisitions of IDH and ADP in May 2011.

Notes to the financial statements *(continued)*

7 Interest and similar items

	Group 2014 £'000	Group 2013 £'000
Interest payable and similar charges		
Senior secured notes	**(10,053)**	-
Floating rate notes	**(5,817)**	-
Second lien notes	**(5,340)**	-
Bank loans and overdrafts	**(2,982)**	(14,264)
Fixed rate interest swap charges	**(1,829)**	(3,930)
Amortisation of issue costs of bank loans and related fees	**(17,918)**	(3,438)
Other interest payable – unwinding of discount (note 18)	**(291)**	(353)
Syndicate charges	**(1,684)**	(1,429)
Interest payable on loan from parent	**(8,339)**	(46,874)
Total interest payable and similar charges	**(54,253)**	(70,288)
Interest receivable and similar income		
Bank deposit interest	**67**	37
Total interest receivable and similar income	**67**	37
Net interest payable and similar items	**(54,186)**	(70,251)

8 Tax on loss on ordinary activities

a) Analysis of tax credit for the financial year

	Group 2014 £'000	Group 2013 £'000
Current tax		
Corporation tax at 23% (2013: 24%)	**-**	-
Total current tax charge for the year (note 8(b))	**-**	-
Deferred tax		
Deferred tax credit in the year	**(2,735)**	(2,304)
Adjustment in respect of the previous year	**(265)**	159
Effect of change in tax rate	**1,020**	237
Total deferred tax credit for the year	**(1,980)**	(1,908)
Tax credit on loss on ordinary activities	**(1,980)**	(1,908)

Notes to the financial statements *(continued)*

8 Tax on loss on ordinary activities *(continued)*

b) Factors affecting the current tax credit for the financial year

The current tax credit for the financial year is lower (2013: lower) than the standard rate of corporation tax in the UK for the year ended 31 March 2014 of 23% (2013: 24%). The differences are explained below:

	Group 2014 £'000	Group 2013 £'000
Loss on ordinary activities before taxation	**(36,056)**	(59,388)
Loss on ordinary activities before taxation multiplied by the standard rate of corporation tax in the UK of 23% (2013: 24%)	**(8,293)**	(14,253)
Effects of:		
Depreciation in the year in excess of capital allowances	**2,699**	1,853
Expenses not deductible for tax purposes	**5,563**	13,571
Unrelieved tax losses	**436**	-
Utilisation of brought forward losses	**(106)**	(1,102)
Other short term timing differences	**(299)**	(69)
Current tax credit for the year (note 8(a))	**-**	-

Factors affecting current and future tax charges

The group has estimated non-trade losses of £22.2 million (2013: £29.7 million) available for carry forward against future non-trade profits. Deferred tax assets of £4.4 million (2013: £6.8 million) in respect of these losses have not been recognised as their future recovery is uncertain or not currently anticipated.

The main rate of corporation tax was reduced from 24% to 23% from 1 April 2013. Further reductions to 21% from 1 April 2014 and to 20% from 1 April 2015 were substantively enacted in the Finance Act 2013 and the deferred tax asset at 31 March 2014 has been re-measured accordingly.

9 Parent company result

The company has taken advantage of Section 408(4) of the Companies Act 2006 and consequently a profit and loss account for the company is not presented.

The company's loss of £8,000 (2013: £1,000) arises solely from audit fees incurred in respect of the audit of the parent company and group financial statements.

Notes to the financial statements *(continued)*

10 Intangible fixed assets

Group	Goodwill £'000
Cost	
At 1 April 2013	613,417
Practice acquisitions (note 29)	30,638
Subsidiary acquisitions (note 29)	59,591
Fair value adjustments	600
At 31 March 2014	**704,246**
Accumulated amortisation	
At 1 April 2013	55,423
Charge for the year	33,989
At 31 March 2014	**89,412**
Net book value	
At 31 March 2014	**614,834**
At 31 March 2013	557,994

A number of changes have been made to the provisional fair value adjustments to the book values of the acquired assets and liabilities reported in the 31 March 2013 financial statements. The cumulative effect of these changes is to increase the goodwill arising from the acquisitions undertaken during the year ended 31 March 2013 by £600,000. The adjustments principally reflect an increase in the carrying value of creditors acquired to reflect pre-acquisition liabilities that were identified during the year.

Notes to the financial statements *(continued)*

11 Tangible fixed assets

Group	Freehold property £'000	Leasehold improvements £'000	Fixtures, fittings and equipment £'000	Total £'000
Cost				
At 1 April 2013	2,711	2,471	85,081	90,263
Acquisitions (note 29)	1,823	75	3,010	4,908
Additions	2,627	125	21,725	24,477
Disposals	(556)	(24)	(278)	(858)
At 31 March 2014	**6,605**	**2,647**	**109,538**	**118,790**
Accumulated depreciation				
At 1 April 2013	38	569	21,477	22,084
Charge for the year	71	268	13,284	13,623
Disposals	(18)	(8)	(159)	(185)
At 31 March 2014	**91**	**829**	**34,602**	**35,522**
Net book value				
At 31 March 2014	**6,514**	**1,818**	**74,936**	**83,268**
At 31 March 2013	2,673	1,902	63,604	68,179

As at 31 March 2014, no assets are held under finance leases or hire purchase contracts (2013: none).

Company

The company does not own any tangible fixed assets (2013: none).

Notes to the financial statements *(continued)*

12 Fixed asset investments

Company	£'000
Investments at cost in subsidiary undertaking at 1 April 2013	-
Additions	411,011
Investments at cost in subsidiary undertaking at 31 March 2014	**411,011**

The company owns 100% of its immediate subsidiaries, Turnstone Bidco 1 Limited and IDH Finance Plc.

The cost and book value of its investment in Turnstone Bidco 1 Limited is £410,961,479 (2013: £3). On 30 May 2013, the company subscribed for 410,961,476 £1 ordinary shares in Turnstone Bidco 1 Limited in exchange for £410,961,476 of the outstanding loan amount (including accrued interest) due from Turnstone Bidco 1 Limited at that date (see also note 14).

On 7 May 2013, the company also subscribed for 50,000 £1 ordinary shares at par in IDH Finance Plc, a newly incorporated subsidiary company.

The table below provides details of the company's subsidiary undertakings. All companies are indirectly owned with the exception of Turnstone Midco 1 Limited. All of the non-trading entities are holding companies for investments in other group companies.

The group holds 100% of the ordinary share capital of all of the companies listed (with the exception of Healthcare Buying Group Limited, in which the group holds 92.6% of the ordinary share capital and Denture Excellence Limited, in which the group holds 75% of the ordinary share capital) and all companies are included in the consolidation.

In the opinion of the directors the value of the company's investment in its subsidiaries is not less than the amount at which it is shown in the balance sheet.

Name of subsidiary	Principal activity	Country of incorporation
Turnstone Bidco 1 Limited	Non-trading	England
IDH Finance Plc	Non-trading	England
@TheDentist Ltd	Dormant	England
1A Dental Practice Limited	Dental practices	England
Adelstone Dental Care Limited	Dental practices	England
Aesthetix Limited	Dental practices	England
ADP Ashford Ltd	Dental practices	England
IDH Limited	Dental practices	England
ADP Healthcare Acquisitions Limited	Non-trading	England
ADP Healthcare Limited	Dormant	England
ADP Healthcare Services Limited	Non-trading	England
ADP Holdings Limited	Non-trading	England
IDH Mansfield Ltd	Dental practices	England
ADP No.1 Limited	Non-trading	England
ADP Yorkshire Ltd	Dormant	England
Alemdent Limited	Dental practices	England
A-Z Dental Holdings (Subsidiary Number 1) Limited	Dormant	England
A-Z Dental Holdings (Subsidiary Number 2) Limited	Dormant	England
A-Z Dental Holdings Limited	Non-trading	England
Bramora Limited	Dental practices	England
Broomco (4270) Limited	Non-trading	England
Butler and Finnigan Dental Practice Ltd	Dental practices	England
Castle Hill Dental Practice Limited	Dental practices	England
Church Street Dentists Limited	Dental practices	England
Clarendon Dental Practice Limited	Dental practices	England
Community Dental Centres Limited	Dental practices	England
Cromwell Dental Practice Limited	Dental practices	England
DBG (UK) Limited	Healthcare goods and services	England
DBG Acquisitions Limited	Non-trading	England
DBG Subsidiary Limited	Dormant	England
DBG Topco Limited	Non-trading	England
Dental Health Care Limited	Dormant	England
Dental Talent Tree (Recruitment) Limited	Dental recruitment	England

Notes to the financial statements *(continued)*

12 Fixed asset investments *(continued)*

Name of subsidiary	Principal activity	Country of incorporation
Denture Excellence Limited	Dental practices	England
DH Dental Holdings Limited	Non-trading	England
Diverse Acquisitions Limited	Non-trading	England
Diverse Holdings Limited	Non-trading	England
Diverse Property Investments Limited	Non-trading	England
Du Toit and Burger Partnership (Harwich) Ltd	Dental practices	England
Du Toit and Burger Partnership (Ipswich) Ltd	Dental practices	England
Du Toit and Burger Partnership (Silvertown) Ltd	Dental practices	England
Du Toit and Burger Partnership (Stratford) Ltd	Dental practices	England
Du Toit and Burger Partnership (Sudbury) Ltd	Dental practices	England
Du Toit and Burger Partnership Limited	Dental practices	England
Durgan and Ashworth Dental Care Limited	Dental practices	England
Euxton (No 1) Limited	Dental practices	England
Falchion Orthodontics Limited	Dental practices	England
Fallowfield (No 1) Limited	Dental practices	England
Family Dental Care Limited	Dental practices	Scotland
Ffolliot Bird Associates Limited	Dental practices	England
First Choice Dental Limited	Dental practices	England
Fleetwood Practice Limited	Dental practices	England
Healthcare Buying Group Limited	Non-trading	England
Hessle Grange Dental Care Limited	Dental practices	England
Hillcrest Ionian Limited	Dental practices	England
Hirst and O'Donnell Ltd	Dental practices	England
IDH 324 & 325 Ltd	Dental practices	England
IDH 331 Ltd	Dental practices	England
IDH 341 Ltd	Dental practices	England
IDH 346 Ltd	Dental practices	England
IDH 363 Limited	Dental practices	England
IDH 403 Ltd	Dental practices	England
IDH 406 Ltd	Dental practices	England
IDH 418 Ltd	Dental practices	England
IDH 437 Ltd	Dental practices	England
IDH 441 to 444 Ltd	Dental practices	England
IDH 449 Limited	Dental practices	England
IDH 450 Limited	Dental practices	England
IDH 474 Limited	Dental practices	England
IDH 476 Limited	Dental practices	England
IDH 477 Limited	Dental practices	England
IDH 622 Limited	Dental practices	England
IDH Acquisitions Limited	Non-trading	England
IDH Group Limited	Non-trading	England
Integrated Dental Holdings Limited	Non-trading	England
Jackro Healthcare Services Limited	Dental practices	England
KH&GW Limited	Dental practices	England
M C Dentistry Limited	Dental practices	England
Mainstone Health Limited	Dental practices	England
MyDentist Limited	Dormant	England
Natural Management Ltd	Non-trading	England
Offerton Fold Dental Practice Ltd	Dental practices	England
Orthocentres Limited	Dental practices	England
Orthoworld 2000 Limited	Dental practices	England
Orthoworld Limited	Non-trading	England
OurDentist Ltd	Dormant	England
Padgate (No 1) Limited	Dental practices	England
Palmerston Precinct Practice Limited	Dental practices	England
Pearl Bidco Limited	Non-trading	England
Pearl Cayman 1 Limited	Non-trading	Cayman Islands
Pearl Cayman 2 Limited	Non-trading	Cayman Islands
Pearl Topco Limited	Non-trading	England
Petrie Tucker and Partners Limited	Dental practices	Scotland*
Phoenix Dental Practice Limited	Dental practices	England
Phoenix Dental Limited	Dental practices	England
PJ Burridge Ltd	Dental practices	England
Priory House Dental Care Limited	Dental practices	England

Notes to the financial statements *(continued)*

12 Fixed asset investments *(continued)*

Name of subsidiary	Principal activity	Country of incorporation
Q Dental Care Limited	Dental practices	England
Q Dental Surgeries Limited	Non-trading	England
Queensferry Dental Surgery Limited	Dental practices	England
Richmond House Practice Limited	Dental practices	England
Richard Flanagan & Associates Limited	Dental practices	England
S L S Dental Care Limited	Dental practices	England
Salcombe Dental Practice Limited	Dental practices	England
Shadeshire Limited	Non-trading	England
Silverdale Dental Care Ltd	Dental practices	England
South Tyneside Smiles Limited	Dental practices	England
Speed 8599 Limited	Dormant	England
Speed 8600 Limited	Dormant	England
TAG Medical Limited	Medical equipment and testing	England
The Crescent Specialist Dental Centre Ltd	Dental practices	England
The Domiciliary Dental Practice Limited	Dental practices	England
The Plains' Dental Practice Limited	Dental practices	England
The Village Practice Ltd	Dental practices	England
Unnati Limited	Dental practices	England
Viren Patel and Associates Limited	Non-trading	England
Westhoughton (No 1) Limited	Dental practices	England
Whitecross Dental Care Limited	Dental practices	England
Whitecross Group Limited	Non-trading	England
Whitecross Healthcare Limited	Non-trading	England
Whitecross Supplies Limited	Dormant	England
Wishaw Cross Dental Care Limited	Dental practices	Scotland

*Countries of operation – England, Scotland and Wales

In addition to the limited companies listed above, the company controls the following partnerships, all of which are engaged in dental practice activities, through the appointment of members of the management team as partners, acting on behalf of certain group companies:

Name of partnership
1A Dental Practice Partnership
1A Group Dental Practice Partnership
Amit Rai and Fizan Tahir Partnership
Armley Dental Practice Partnership
Aspire Dental Practice Partnership
Bank House Dental Practice
Bolton and Bury Dental Practice Partnership
Brassey Avenue Dental Practice Partnership
Brinsworth Lane Dental Care Partnership
Caldy Road Dental Practice Partnership
Carcroft Dental Practice Partnership
Castle View House Dental Practice Partnership
Central Dental Practice Partnership
Chantry Dental Practice Partnership
Chequer Hall Dental Practice Partnership
Cherry Orchard Dental Practice Partnership
Colne & Earby Dental Practice Partnership
Cottage Dental Practice Partnership
Crown Dental Practice Partnership
Dalton Dental Surgery Partnership
Dividy Road Dental Practice Partnership
Fearnhead Dental Surgery Partnership
Feidr Fair Partnership Dental Practice
Filey Dental Care Centre Partnership
Florence House Dental Practice Partnership
Gairloch House Dental Practice Partnership
Green Lane Dental Practice Partnership

Name of partnership
Red Rose Dental Group
Rhos Road Dental Practice Partnership
Rhyl and Abergele Elwy Dental Partnership
River Wye Dental Practice Partnership
Severn Street Dental Practice Partnership
Shelldrake Drive Dental Practice Partnership
Sneyd Green Dental Practice Partnership
Stanhope Road Dental Practice Partnership
The Abbey Parade Dental Practice Partnership
The Birley Moor Dental Practice Partnership
The Boulevard Dental Practice Partnership
The Burnby Dental Practice Partnership
The Burnham Dental Practice Partnership
The Bury Dental Practice Partnership
The Caulfield Dental Surgery Partnership
The Church House Dental Practice Partnership
The Cowpen and Waterloo Dental Practice Partnership
The Crab Tree Lane and Church Street Dental Practice Partnership
The Crossgates Lane and Chapeltown Road Dental Practice Partnership
The Dental Surgery Partnership
The Fairfield Dental Practice Partnership
The Grainger Stockton , Birtley and Stanley Dental Practice Partnership
The Haverflatts Lane Dental Practice Partnership
The Helston Dental Practice Partnership
The Kenton Park Dental Practice Partnership
The Killingworth Dental Practice Partnership
The Kings Norton Dental Practice Partnership

Notes to the financial statements *(continued)*

12 Fixed asset investments *(continued)*

Name of partnership
Hampton Court Dental Centre Partnership
Harbour Dental Practice Partnership
Hartlepool Dental Practice Partnership
Haslingden Dental Surgery Partnership
High Street Dental Practice Partnership
Hollinwood Dental Practice Partnership
Horncastle Dental Practice Partnership
Jefferies Reed and Associates
JF Scott Dental Surgeon Partnership
Kettering Central Dental Practice Partnership
Kings Specialist Dental Practice Partnership
Lambert Coutts & Associates Dental Practice Partnership
Low Fell Dental Practice Partnership
Lyme Dental Surgery Partnership
Mayo Dental Clinic Partnership
Mill Dental Practice Partnership
Mostyn House Dental Practice Partnership
Mount Folly Square Dental Practice Partnership
Narborough Road South Dental Practice Partnership
Newcastle and Wallsend Dental Practice Partnership
North Marine Road Dental Practice Partnership
Northgate Dental Health Practice Partnership
Old Brewary Yard Dental Practice Partnership
Picton Road Dental Practice Partnership
Railway Road Dental Practice Partnership

Name of partnership
The Lacey Dental Practice Partnership
The Loddon Dental Practice Partnership
The London Road Dental Practice Partnership
The Lyppard Dental Centre Practice Partnership
The Marden House Dental Practice Partnership
The Nelson Street Dental Practice Partnership
The Newcastle Dental Care Practice Partnership
The Newland Avenue and Castle Street Dental Practice Partnership
The Peterborough Dental Practice Partnership
The Peterlee Dental Practice Partnership
The Queen Street Dental Practice Partnership
The Sea Road Dental Practice Partnership
The Southwick and Whitburn Dental Practice Partnership
The Trewergie Dental Practice Partnership
The Warner Street Dental Practice Partnership
The White House Dental Practice Partnership
Thomas Street Dental Practice Partnership
Tower Gardens Dental Practice Partnership
Trinity Terrace Dental Practice Partnership
Tuebrook Dental Practice Partnership
VI Dental Centre Partnership
West Lodge Dental Practice Partnership
Westbury Park Dental Practice Partnership
Weymouth and the Bridges Dental Practice Partnership

Group

The group does not own any fixed asset investments (2013: £Nil).

13 Stock

	Group 2014 £'000	Group 2013 £'000
Raw materials and consumables	**7,573**	6,238

The company holds no stock (2013: £Nil).

Notes to the financial statements *(continued)*

14 Debtors

	Group 2014 £'000	**Company 2014 £'000**	Group 2013 £'000	Company 2013 £'000
Amounts falling due after more than one year				
Amounts owed by group undertakings	**-**	**-**	-	452,622
Amounts falling due within one year				
Trade debtors	**3,938**	**-**	2,259	-
Amounts owed by group undertakings	**-**	**-**	-	8,460
Amounts owed by related undertakings	**213**	**-**	141	-
Other debtors	**10,210**	**-**	756	-
Prepayments and accrued income	**20,894**	**-**	17,513	-
Corporation tax recoverable	**135**	**-**	336	-
Deferred tax asset	**9,517**	**-**	7,553	-
	44,907	**-**	28,558	8,460
	44,907	**-**	28,558	461,082

The amounts owed by group undertakings falling due after more than one year are unsecured and are subject to an interest charge ranging between 12% and 15% per annum. The amount receivable at 31 March 2013 includes accrued interest of £84.1 million. On 30 May 2013, the company subscribed for 410,961,476 £1 ordinary shares in Turnstone Bidco 1 Limited in exchange for £410,961,476 of the outstanding loan amount (including accrued interest) due from Turnstone Bidco 1 Limited at that date (see also note 12). The remaining £50,000,000 due at 30 May 2013 was settled in cash by Turnstone Bidco 1 Limited on the same date.

Amounts owed by group undertakings falling due within one year are unsecured, are not subject to an interest charge and are repayable on demand.

The amounts owed by related undertakings reflect expenses paid on behalf of Turnstone Management Investments Limited, a company registered in England and which holds investments in Turnstone Equityco 1 Limited on behalf of group management.

Deferred tax

The elements of deferred taxation are as follows:

	Group 2014 £'000	Group 2013 £'000
Accelerated capital allowances	**10,981**	9,341
Other short term timing differences	**(1,464)**	(1,788)
	9,517	7,553

	Group £'000
At 1 April 2013	7,553
Credit in the year (note 8)	2,735
Adjustment in respect of the previous year (note 8)	265
Effect of change in tax rate (note 8)	(1,020)
Arising from the acquisition of subsidiary undertakings (note 29)	(16)
At 31 March 2014	**9,517**

Notes to the financial statements *(continued)*

15 Creditors: amounts falling due within one year

	Group 2014 £'000	**Company 2014 £'000**	Group 2013 £'000	Company 2013 £'000
Bank and other borrowings (note 17)	**-**	**-**	10,893	-
Trade creditors	**12,877**	**-**	8,430	-
Amounts owed to group undertakings	**-**	**60**	-	8,462
Corporation tax	**197**	**-**	224	-
Other taxation and social security costs	**1,899**	**-**	1,330	-
Deferred consideration for acquisitions	**5,329**	**-**	2,912	-
Accruals and deferred income	**44,943**	**-**	42,162	-
	65,245	**60**	65,951	8,462

Included within accruals and deferred income falling due within one year are unamortised Government grants totalling £0.32 million (2013: £0.51 million). The amount amortised during the year was £0.51 million (2013: £0.67 million).

Included within bank and other borrowings as at 31 March 2013 are unamortised issue costs and associated professional fees of £3.74 million.

The amounts owed to group undertakings are unsecured, are not subject to an interest charge and are repayable on demand.

	Government grants £'000
At 1 April 2013	1,061
Grants received during the year	19
Unamortised grants acquired through acquisition of subsidiary	126
Amortisation (note 3)	(510)
At 31 March 2014	**696**

Notes to the financial statements *(continued)*

16 Creditors: amounts falling due after more than one year

	Group 2014 £'000	**Company 2014 £'000**	Group 2013 £'000	Company 2013 £'000
Bank and other borrowings (note 17)	**408,535**	**-**	277,211	-
Loan owed to parent	**-**	**-**	452,622	452,622
Deferred consideration for acquisitions	**5,499**	**-**	1,302	-
Accruals and deferred income	**379**	**-**	551	-
	414,413	**-**	731,686	452,622

The above accruals and deferred income relate wholly to unamortised Government grants.

Included within bank loans are £13.47 million (2013: £12.12 million) of unamortised loan issue costs and associated professional fees.

The loan owed to the parent company falling due after more than one year is unsecured and is subject to an interest charge ranging between 12% and 15% per annum. The amount payable at 31 March 2013 includes accrued interest of £84.1 million. On 30 May 2013, the company issued 410,961,476 £1 ordinary shares to Turnstone Midco 1 Limited in exchange for £410,961,476 of the outstanding loan amount (including accrued interest) due to Turnstone Midco 1 Limited at that date (see also note 19). The remaining £50,000,000 due at 30 May 2013 was settled using the cash proceeds received from Turnstone Bidco 1 Limited on the same date in settlement of the loan due to the company.

17 Bank and other borrowings

The company does not hold any bank or other borrowings.

The group bank loans and other borrowings are repayable as follows:

	Group 2014 £'000	Group 2013 £'000
Senior secured, floating rate and second lien notes		
Between two and five years	**325,000**	-
After five years	**75,000**	-
Total senior secured, floating rate and second lien notes	**400,000**	-
Bank loans		
Less than one year	**-**	14,630
Between one and two years	**-**	23,130
Between two and five years	**22,000**	266,206
Total bank loans	**22,000**	303,966
Less: unamortised arrangement fees and related costs	**(13,465)**	(15,862)
	408,535	288,104

Notes to the financial statements *(continued)*

17 Bank loans and note financing *(continued)*

On 30 May 2013, the group re-financed its existing debt and raised £400 million through the issue of £200 million of senior secured fixed rate notes, £125 million of senior secured floating rate notes and £75 million of second lien notes. The proceeds were used to repay the group's existing bank debt along with £50 million of the outstanding shareholder debt. On the same date, the group also entered into an agreement with a syndicate of banks to provide a £100 million Super Senior Revolving Credit Facility ('SSRCF').

- The £200 million of senior secured notes mature at par on 1 December 2018. Interest is payable semi-annually on 1 March and 1 September each year at a fixed coupon of 6% per annum.
- The £125 million of senior secured floating rate notes mature at par on 1 December 2018. Interest is payable quarterly on 1 March, 1 June, 1 September and 1 December each year at a coupon of 3 month LIBOR plus 5% per annum.
- The £75 million of second lien notes mature at par on 1 June 2019. Interest is payable semi-annually on 1 March and 1 September each year at a fixed coupon of 8.5% per annum.
- £22 million has been drawn down against the £100 million SSRCF as at 31 March 2014. Interest is payable in arrears at a rate of LIBOR plus 4% per annum.

On 30 May 2013, as part of an interest rate management strategy, the group cancelled its existing interest rate swap contracts and entered into two new interest rate contracts to swap LIBOR for a fixed rate. One contract for a notional principle amount of £62.50 million matures on 1 June 2017 and interest is fixed at 1.9125%. The second contract, also for a notional principle amount of £62.50 million, matures on 1 June 2017 and interest is fixed at 1.9210%. The fair value of the liability arising from these interest rate swap contracts at 31 March 2014 was £2.1 million.

18 Provisions for liabilities

Group	Above market rental £'000	Vacant property and dilapidations £'000	Total £'000
At 1 April 2013	6,248	8,729	14,977
Arising from acquisitions (note 29)	557	384	941
Fair value adjustments	-	(111)	(111)
Charged to the profit and loss account	-	34	34
Utilised in the financial year	(1,176)	(4,739)	(5,915)
Unwinding of discount	255	36	291
At 31 March 2014	**5,884**	**4,333**	**10,217**

Property provisions

The group has a number of properties where the rentals payable are in excess of the current market rents. Provision has been made to recognise the liability arising from the "above market rental" element of these leases.

The gross provision of £7.2 million (2013: £7.7 million) has been discounted to present value using a rate of 5% (2013: 5%).

The group has a number of vacant and partly sub-let leasehold properties arising from the closure of loss making practices. Provision has been made for the residual lease commitments, together with other outgoings, after taking into account existing sub-tenant arrangements. It is not assumed that the properties will be able to be sublet beyond the periods in the present sub-lease agreements.

Provision has also been made for the costs associated with contractual obligations to return practices to their original condition at the end of the lease and the costs of compliance with existing regulations.

The provisions are expected to be substantially utilised over the next five years.

Notes to the financial statements *(continued)*

19 Called up share capital

Group and company	Number issued	2014 £'000	Number issued	2013 £'000
Allotted, called up and fully paid				
Ordinary shares of £1	**410,961,479**	**410,961**	3	-

On 30 May 2013, the company issued 410,961,476 £1 ordinary shares to its immediate parent, Turnstone Midco 1 Limited, in settlement of £410,961,476 of the outstanding loan balance (including accrued interest) due to Turnstone Midco 1 Limited at that date (see also note 16).

20 Profit and loss account

	Group 2014 £'000	Company 2014 £'000	Group 2013 £'000	Company 2013 £'000
At the beginning of the year	**(109,158)**	**(2)**	(51,758)	(1)
Loss for the financial year	**(34,126)**	**(8)**	(57,400)	(1)
At the end of the year	**(143,284)**	**(10)**	(109,158)	(2)

21 Reconciliation of movements in shareholders' funds/(deficit)

	Group 2014 £'000	Company 2014 £'000	Group 2013 £'000	Company 2013 £'000
Loss for the financial year	**(34,126)**	**(8)**	(57,400)	(1)
Ordinary shares issued	**410,961**	**410,961**	-	-
Net increase in shareholders' funds/(deficit)	**376,835**	**410,953**	(57,400)	(1)
Opening shareholders' deficit	**(109,158)**	**(2)**	(51,758)	(1)
Closing shareholders' funds/(deficit)	**267,677**	**410,951**	(109,158)	(2)

Notes to the financial statements *(continued)*

22 Contingent liabilities

Assigned leases

When disposing of practices, the group has generally assigned the associated leases to the purchaser. In the event that the purchaser defaults on their lease payments and should the landlord be unable to mitigate their losses sufficiently, then there is an obligation on the group to take on these lease commitments.

In the opinion of the directors such eventualities are unlikely, as practices have been disposed of as going concerns, and as a result there is no such provision against such eventualities made in these financial statements. The group has no experience of any leases that it has assigned, in relation to dental practices, reverting back to it.

Partnership guarantees

A number of individuals in the management team have joined partnerships as part of the group's acquisition of the trade and assets of those partnerships. The partners hold their interest in the partnership under a trust deed on behalf of one of the group companies. In order to indemnify the partners against specific risks in relation to this arrangement, a guarantee is in place supported by a letter of credit from the group's bank for £1.80 million (2013: £1.80 million).

23 Commitments under operating leases

At 31 March 2014, the group had annual commitments under non-cancellable operating leases as follows:

	Group 2014 £'000	Group 2013 £'000
Land and buildings:		
Expiring within one year	**240**	130
Expiring between two and five years	**1,425**	1,485
Expiring after five years	**8,685**	8,273
	10,350	9,888
Other:		
Expiring within one year	**180**	55
Expiring between two and five years	**386**	543
	566	598

Notes to the financial statements *(continued)*

24 Pension commitments

Group

The group operates three defined contribution pension schemes. The pension cost charge for the financial year represents contributions payable by the group to the schemes and amounted to £342,000 (2013: £nil).

There were no outstanding or prepaid contributions at either the beginning or end of the financial year (2013: £nil).

The group also operates a pension scheme providing benefits based on final pensionable pay. The pension scheme was acquired as part of the acquisition of Pearl Topco Limited. The scheme is closed to new members and has no active members.

Over the year to 31 March 2014 the group did not contribute directly to the scheme, however, the cost of insuring death in service benefits and other trustee expenses were paid by the group and amounted to £52,000 (2013: £30,000). The group does not expect to make contributions to the scheme or for the costs of the scheme to change significantly in the next financial year.

The latest full actuarial valuation for which results are available, was carried out as at 6 April 2011 and was updated for FRS 17 'Retirement benefits' purposes to 31 March 2014 by a qualified independent actuary.

The major assumptions used in this valuation were:

	2014	2013
Expected return on plan assets	**4.8%**	4.6%
Rate of increase in pensions in payment and deferred pensions	**3.5%**	3.4%
Discount rate applied to scheme liabilities	**4.2%**	4.0%
Inflation assumption	**3.5%**	3.4%

The assumptions used by the actuary are chosen from a range of possible actuarial assumptions which, due to the timescale covered, may not necessarily be borne out in practice.

Mortality assumptions are based on standard mortality tables which allow for future mortality improvements. The assumptions are that a member who retires at the age of 65 in 2014 will on average live for a further 24.7 years (2013: 24.5 years) after retirement if they are male and 26.6 years (2013: 26.4 years) if they are female.

Notes to the financial statements *(continued)*

24 Pension commitments *(continued)*

Scheme assets

The fair value of the scheme's assets, which are not intended to be realised in the short term and may be subject to significant change before they are realised, and the present value of the scheme's liabilities, which are derived from cash flow projections over long periods and are thus inherently uncertain, were:

	Percentage of plan assets 2014	**Value 2014**	Percentage of plan assets 2013	Value 2013
		£'000		£'000
Equities	**41%**	**1,806**	28%	1,301
Bonds	**58%**	**2,554**	70%	3,266
Property	**1%**	**65**	1%	61
Cash	**0%**	**7**	1%	17
Total market value of assets		**4,432**	100%	4,645
Present value of scheme liabilities		**(4,287)**		(4,558)
Surplus in the scheme – pension asset		**145**		87
Related deferred tax liability		**-**		-
Net pension asset		**145**		87

The figures show the scheme to be in surplus as at 31 March 2014. A surplus can only be recognised to the extent that it is recoverable through reduced future contributions or by a refund from the scheme. As the scheme is paid up and there is no agreement with the trustees to refund any monies, the surplus has not been regarded as recoverable and has not been recognised on this basis.

The amounts for other finance income and the actuarial loss arising from the actual and expected return on assets and the changes in assumptions underlying the present value of scheme liabilities have not been recognised in the profit and loss account and the statement of total recognised gains and losses on the grounds of materiality.

The expected rates of return on the assets in the scheme were:

	Long term rate of return 2014 %	Long term rate of return 2013 %
Equities	**7.00**	8.00
Bonds	**4.00**	3.50
Property	**6.25**	6.25
Cash	**1.50**	1.50

The expected returns have been based on the current split by investment sector of the assets of the scheme, using average expected returns for each sector. The expected returns have been reduced to allow for expected investment expenses.

Notes to the financial statements *(continued)*

24 Pension commitments *(continued)*

Movement in surplus during the year:

	2014 £'000	2013 £'000
Surplus in the scheme at the start of the year	**87**	496
Current service cost	**(21)**	(21)
Other finance income	**29**	43
Actuarial gain/(loss)	**50**	(431)
Surplus in the scheme at the end of the year	**145**	87

Changes in the present value of the defined benefit obligation are as follows:

	2014 £'000	2013 £'000
Opening defined benefit obligation	**(4,558)**	(3,717)
Current service cost	**(21)**	(21)
Interest cost	**(177)**	(173)
Actuarial gain/(loss)	**170**	(730)
Benefits paid	**299**	83
Closing defined benefit obligation	**(4,287)**	(4,558)

Changes in the fair value of plan assets are as follows:

	2014 £'000	2013 £'000
Opening market value of plan assets	**4,645**	4,213
Expected return on scheme assets	**206**	216
Actuarial (loss)/gain	**(120)**	299
Benefits paid	**(299)**	(83)
Closing market value of assets	**4,432**	4,645

Analysis of amounts that would be included in other finance income

	2014 £'000	2013 £'000
Expected return on pension scheme assets	**206**	216
Interest cost on pension scheme liabilities	**(177)**	(173)
	29	43

Notes to the financial statements *(continued)*

24 Pension commitments *(continued)*

Analysis of amount that would be recognised in the statement of total recognised gains and losses

	2014 £'000	2013 £'000
Actual return less expected return on scheme assets	**(120)**	299
Experience gains and losses arising on scheme liabilities	**6**	(22)
Changes in assumptions underlying the present value of scheme liabilities	**164**	(708)
Actuarial gain/(loss)	**50**	(431)

The group does not expect to make any contributions to the pension scheme during the next financial year.

Five year record

	2014 £'000	2013 £'000	2012 £'000	2011 £'000	2010 £'000
Defined benefit obligation	**(4,287)**	(4,558)	(3,717)	(3,214)	(2,968)
Plan assets	**4,432**	4,645	4,213	4,135	3,789
Surplus	**145**	87	496	921	821
Experience adjustments on plan liabilities	**6**	(22)	(103)	**-**	(48)
Experience adjustments on plan assets	**(120)**	299	159	138	327

Note that, in order to provide comparable information, the five year historical disclosures provided above reflect the accounts of Pearl Topco Limited for the years ended 2010 and 2011.

25 Reconciliation of operating profit to net cash inflow from operating activities

	Group 2014 £'000	Group 2013 £'000
Operating profit	**18,572**	14,494
Amortisation of goodwill	**33,989**	29,329
Depreciation	**13,623**	11,815
Amortisation of grant income	**(510)**	(666)
Increase in stock	**(746)**	(461)
Increase in debtors	**(4,857)**	(2,698)
Increase in creditors	**589**	4,951
Decrease in provisions	**(5,895)**	(2,903)
Net cash inflow from operating activities	**54,765**	53,861

Notes to the financial statements *(continued)*

26 Analysis of cash flows

	Group 2014 £'000	Group 2013 £'000
Returns on investment and servicing of finance		
Senior facility loan interest paid	**(2,932)**	(14,264)
Senior secured, floating rate and second lien note interest paid	**(19,063)**	-
Interest rate swap cash paid	**(2,426)**	(3,799)
Bank interest received	**67**	37
Arrangement fees and associated professional costs	**(15,366)**	-
Syndicate charges paid	**(1,702)**	(1,489)
Net cash outflow for returns on investments and servicing of finance	**(41,422)**	(19,515)
Capital expenditure		
Purchase of tangible fixed assets	**(21,136)**	(14,183)
Capital grants received	**19**	105
Purchase of freehold property	**(2,716)**	(389)
Proceeds on sale of freehold property and other tangible fixed assets	**298**	-
Net cash outflow for capital expenditure	**(23,535)**	(14,467)
Acquisitions and disposals		
Acquisition of subsidiary undertakings (including associated costs)	**(59,567)**	(17,531)
Cash acquired on acquisition of subsidiary undertakings	**1,684**	1,922
Acquisition of practices (including associated costs)	**(33,354)**	(29,369)
Proceeds from sale of practices (net of costs)	**17**	797
Deferred consideration paid	**(2,109)**	(1,305)
Professional fees paid in respect of acquisitions in progress at the balance sheet date	**(225)**	(137)
Net cash outflow for acquisitions and disposals	**(93,554)**	(45,623)
Financing		
Drawdown of bank loans	**47,307**	54,399
Repayment of bank loans	**(329,273)**	(19,333)
Proceeds from issue of senior secured, floating rate and second lien notes	**400,000**	-
Amounts borrowed from parent	**-**	14,460
Repayment of loan from parent	**(50,000)**	-
Net cash inflow from financing	**68,034**	49,526

Notes to the financial statements *(continued)*

27 Reconciliation of net cash flow to movement in net debt

	Group 2014 £'000	Group 2013 £'000
(Decrease)/increase in cash in the financial year	**(35,467)**	23,446
Drawdown of bank loans	**(47,307)**	(54,399)
Repayment of bank loans	**329,273**	19,333
Proceeds from issue of senior secured, floating rate and second lien notes (net of fees)	**(384,460)**	-
Amounts borrowed from parent	**-**	(14,460)
Repayment of loan from parent	**50,000**	-
Total cash movement in net debt	**(87,961)**	(26,080)
Accrued interest on loan from parent	**(8,339)**	(46,874)
Issue of ordinary shares in settlement of loan from parent	**410,961**	-
Amortisation of loan arrangement fees	**(2,674)**	(3,438)
Release of loan arrangement fees on redemption of senior facilities	**(15,263)**	-
Total non-cash movement in net debt	**384,685**	(50,312)
Total movement in net debt	**296,724**	(76,392)
Net debt brought forward	**(698,323)**	(621,931)
Net debt carried forward	**(401,599)**	(698,323)

28 Analysis of changes in net debt

	At the start of the year £'000	Cash-flows £'000	Other non-cash changes £'000	At the end of the year £'000
Cash and cash equivalents				
Cash at bank and in hand	42,403	(35,467)	-	**6,936**
Debt				
Bank and other borrowings	(288,104)	(102,494)	(17,937)	**(408,535)**
Loan owed to parent	(452,622)	50,000	402,622	-
Total debt	(740,726)	(52,494)	384,685	**(408,535)**
Total net debt	(698,323)	(87,961)	384,685	**(401,599)**

Notes to the financial statements *(continued)*

29 Acquisitions

Acquisition of DBG Topco Limited

On 16 April 2013, the group acquired 100% of the issued share capital of the DBG Topco Limited group of companies (together 'the Dental Buying Group' or 'DBG') for consideration of £28.0 million. Following the transaction, the group owns 92.6% of the issued share capital of Healthcare Buying Group Limited, a newly 6incorporated company formed to acquire DBG Topco Limited. The principal activity of DBG is the provision of healthcare goods and services for members of the UK dental and medical professions.

The adjustment required to the book values of the assets and liabilities of the DBG group acquired in order to present the net assets at the provisional fair values in accordance with group accounting principles was £1.1 million, details of which are set out together with the resultant amount of goodwill arising.

	Book value	**Provisional fair value adjustments**	**Fair value**
	£'000	**£'000**	**£'000**
Tangible fixed assets	294	-	294
Stock	882	(557)	325
Debtors	1,838	(165)	1,673
Cash	591	-	591
Creditors	(2,357)	(303)	(2,660)
Corporation tax	78	(34)	44
Deferred taxation	6	18	24
Provisions	(15)	(20)	(35)
Net assets acquired	1,317	(1,061)	256
Goodwill			27,766
			28,022
Satisfied by:			
Cash			27,420
Acquisition expenses			602
			28,022

During the period from 16 April 2013 to 31 March 2014, DBG contributed turnover of £12.1 million and EBITDA of £1.9 million (before intra-group eliminations) to the group. In addition, DBG generated operating cashflow, before capital expenditure, of £880,000 for the same period.

In the nine month period to 31 March 2013, DBG Topco Limited reported consolidated turnover of £5.9 million, operating profit of £420,000 and a loss after tax of £407,000.

Notes to the financial statements *(continued)*

29 Acquisitions *(continued)*

Corporate acquisitions

During the year the group acquired the entire issued share capital of 18 companies incorporating dental practices. None of these acquisitions were material in their own right. The details are shown in aggregate below:

Name of acquisition	Date of acquisition
DH Dental Holdings Limited	2 April 2013
Q Dental Care Limited	2 April 2013
Viren Patel and Associates Limited	2 April 2013
Q Dental Surgeries Limited	2 April 2013
Phoenix Dental Practice Limited	4 April 2013
Castle Hill Dental Practice Limited	9 April 2013
Richmond House Practice Limited	29 April 2013
The Domicilliary Dental Practice Limited	30 April 2013
Palmerston Precinct Practice Limited	3 May 2013
Unnati Limited	7 May 2013
Church Street Dentists Limited	8 August 2013
Phoenix Dental Limited	21 August 2013
Clarendon Dental Practice Limited	23 September 2013
Hillcrest Ionian Limited	3 December 2013
Falchion Orthodontics Limited	31 January 2014
Butler and Finnigan Dental Practice Ltd	27 February 2014
Alemdent Limited	26 March 2014
Aesthetix Limited	31 March 2014

	Book value	Provisional fair value adjustments	Fair value
	£'000	£'000	£'000
Tangible fixed assets	1,797	-	1,797
Stock	241	-	241
Debtors	86	-	86
Cash	1,093	-	1,093
Creditors	(2,640)	-	(2,640)
Corporation taxation	(713)	-	(713)
Deferred taxation	(40)	-	(40)
Provisions	(64)	(223)	(287)
Net liabilities acquired	(240)	(223)	(463)
Goodwill			31,825
			31,362
Satisfied by:			
Cash			25,617
Deferred consideration			4,469
Acquisition expenses			1,276
			31,362

Included within the cash consideration are loans made by the acquiring entities to the acquired company in order to settle vendor shareholder loans of £8.69 million.

The adjustment to provisions results from properties where the lease terms upon acquisition are such that rentals payable are in excess of the current market rents. Provision has been made to recognise the liability arising from the "above market rental" element of these leases. Provision has also been made for the costs associated with contractual obligations to return practices to their original condition at the end of the lease and the costs of compliance with existing regulations.

Notes to the financial statements *(continued)*

29 Acquisitions *(continued)*

Unincorporated acquisitions

The group also acquired the businesses of 39 unincorporated dental practices in the year. None of these acquisitions were material in their own right; the details are shown in aggregate below.

	Book value	Provisional fair value adjustments	Fair value
	£'000	£'000	£'000
Tangible fixed assets	2,817	-	2,817
Stock	24	-	24
Provisions	-	(619)	(619)
Net assets acquired	2,841	(619)	2,222
Goodwill			30,638
			32,860
Satisfied by:			
Cash			30,686
Deferred consideration			737
Acquisition expenses			1,437
			32,860

Of these acquisitions, 34 were via the acquisition of trade and assets from partnerships, which retain control of the NHS contract. The partners hold their interest in the partnership on behalf of group companies under a deed of trust.

The adjustment to provisions results from properties where the lease terms upon acquisition are such that rentals payable are in excess of the current market rents. Provision has been made to recognise the liability arising from the "above market rental" element of these leases. Provision has also been made for the costs associated with contractual obligations to return practices to their original condition at the end of the lease and the costs of compliance with existing regulations.

30 Post balance sheet events

On 17 April 2014, the group acquired the entire share capital of HM Logistics Limited, also known as The Dental Directory Group.

Since 31 March 2014, the group has acquired five incorporated dental practices and two unincorporated dental practices.

The total consideration was £73.7 million.

On 9 May 2014, the group raised £100 million through the issue of additional senior secured floating rate notes. The proceeds were used to repay the group's existing borrowings against the Super Senior Revolving Credit Facility and for general corporate purposes.

31 Controlling party

The immediate parent undertaking is Turnstone Midco 1 Limited.

The results of the company and of the group are also consolidated in the financial statements of Turnstone Equityco 1 Limited. Turnstone Equityco 1 Limited is the parent undertaking of the largest group to consolidate these financial statements. No other financial statements consolidate the results of the group.

At 31 March 2014 and throughout the year, the ultimate controlling party of Turnstone Midco 2 Limited is considered by the directors to be CEP III Participations S.a.r.l. SICAR, an investment vehicle for The Carlyle Group.