“Narayana Hrudayalaya Limited
Q4 FY23 Earnings Conference Call”

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Mr. Nishant Singh: Good afternoon, everyone. My name is Nishant Singh. I head the Investor Relations function at Narayana Hrudayalaya. I welcome you all to the Q4 FY23 earnings call of the company.

To discuss our performance and address all your queries today, we also have with us Mr. Viren Shetty - our Executive Vice Chairman, Dr. Emmanuel Rupert - our CEO and MD, Mr. Venkatesh – Group COO, Dr. Anesh Shetty - MD of our overseas subsidiary, HCCI, Cayman, and Durga Prasad - Senior Manager from the team. Our group CFO - Ms. Sandhya, is not available for this call due to some unavoidable reasons.

We hope you have gone through the collaterals, which have been upgraded on the stock exchanges as well as on our website. As usual, before we proceed with this call, we would like to remind everyone that the call is being recorded and the transcript of the same shall be made available on our website as well as on the stock exchange at a later date. I would also like to remind you that everything that is being said on this call that reflects any outlook for the future or which can be construed as a forward-looking statement must be viewed in conjunction with uncertainties and the risks that they face. Post the call, should you have any further queries, please do not hesitate to get in touch with us. We would like to address them with the best of our ability.

With that now, I would like to hand over the call to Dr. Emmanuel Rupert - our CEO.

Dr. Emmanuel Rupert: Consolidated revenue for the current quarter stood at INR 12,216 million reflecting a year-on-year growth of 29.9% resulting in a consolidated fiscal revenue of INR 45,248 million at a year-on-year growth of 22.2%. NHL generated Consolidated EBITDA of INR 2,904 million in Q4 FY23 at a margin of 23.8% against 23.6% of Q3 FY23.

Our Cayman unit continues to contribute significantly to the overall performance. HCCI Q4 FY23 revenue increased to USD 29.3 million against Q3 FY23 revenue of USD 28.2 million. There are one timer income and expenses included in them and adjusted for the same. The Q4 underlying margin is 22.5% for the Group and 18.5% for India.

Our Industry leading average ROCE of over 28% and our targeted CapEx strategy focusing on judicious allocation of capital continues to deliver sharp returns.

I am delighted to share with you that we recently operationalized our New Bone Marrow Transplant Wing in Health City Campus in Q4 FY23 adding to our existing capacity making it one of the largest such facilities in India and also the Asia Pacific region. This unit completed 63 Bone Marrow Transplants in Q4 taking the total Bone Marrow Transplants performed in the unit over the last 1.5 decades to more than

2,000 in India. This coupled with the advanced CAR-T clinical trials i.e. the Chimeric Antigen Receptor T-cell therapy trials in partnership with is an , which is an advanced immunotherapy and precision medicine in partnership with Immuneel with their GMP facility located within our campus makes us one of the very few centers in Asia with end to end treatment for advanced oncology under one roof. The clinical trials which we participated in, we performed more than 20 CAR-T cell therapy out of the 24 and they were successful and 40% of them are nearing their one-year follow up after their CAR-T cell therapy.

Our Leadership in Cardiac Care grew from strength to strength with Cardiac Hospital in Bangalore performing more than 2,250 Cardiac Surgeries and 5,500 Cath lab Procedures and more than 150 minimal access cardiac surgery this quarter. Minimal access cardiac surgery is growing in numbers and they are able to perform very complex valve repair surgeries and coronary artery bypass surgeries using very small incisions of around an inch to 1.5 inches. This continues to be one of the largest cardiac centers in the world. Our Mazumdar Shaw Cancer Center performed 75 robotic Onco surgeries in Q4 and we have been able to extend the sphere of complex work that we do across all our centers. We successfully performed Gujarat's first-ever Mitra Clip Procedure for a very end stage heart failure, repairing the Mitral Valve in very severe heart failure leading to severe Mitral Regurgitation.

The NH Ahmedabad unit also discharged Total Knee Replacement patient within 24hrs of the surgery. And this robust preoperative care is what we are trying to drive across our entire network converting many of the procedures into short stay procedures.

The NSH Howrah completed more than 200 Robotic Onco surgeries in a little over a year.

Our newly acquired Department of Orthopedics, Spine & Trauma in Health City campus has successfully performed a complex Hand Reimplantation Surgery in the quarter. This young person had his forearm severed in an industrial accident and the team of plastic & reconstruction surgeons along with Orthopedicians painstakingly implanted the severed forearm. The unit has been progressing well with the clinical spectrum and does more than 200 procedures a month.

After implementing athmâ, our LIS – Lab Information System across our labs, we have experienced a noteworthy enhancement of 20% in the turnaround time and up to 36% in the Top 5 tests. This improvement in efficiency is across a substantial volume of over 24,000 samples per day. We can now provide our patients and doctors with precise

results in a significantly shorter period.

Athmâ has successfully achieved the prestigious NABH-QCI certification. This recognition granted by the National Accreditation Board for Hospitals (NABH) in collaboration with the Quality Council of India (QCI) and the National Health Authority (NHA) recognizes athmâ as a trusted partner that upholds with the highest standards of interoperability, quality, and safety. It reinforces our commitment to providing our patients and doctors with a reliable and secure platform.

We are transforming our business to offer comprehensive healthcare services by becoming more patient oriented, digitally native and operationally efficient to offer high quality health care at an affordable cost. While continuing to consolidate our operations, we would simultaneously pursue growth opportunities both in India and overseas that derive synergies from our existing operations and maximize value for all our stakeholders.

I would like to hand over to Viren Shetty to share updates on some of our new ventures. Over to you, Viren.

Mr. Viren Shetty: Thanks, Doctor Rupert. When we started Narayana Hrudayalaya in 2000, we sought to transform health care by making high-quality care accessible to all. Nobody said it was possible at that time. But looking back, we are proud to have played a part in putting India on the path to disassociate healthcare access from affluence. At the same time, the medical research field is spending billions of dollars developing cutting edge treatments for diseases that were once considered inoperable. We shouldn't deny our people access to the latest and most expensive treatments but this is only possible when everyone's covered with Comprehensive Health Insurance. The IRDAI has been encouraging new entrants to develop innovative models of health insurance that cover the missing middle and NH would like to play a role in this new landscape.

Our existing health insurance system operates on a fee-for-service model. It will pay you when you get sick, does nothing for you when you're healthy and runs in the other direction if you have a preexisting disease. Large developing countries with low tax collection like ours cannot afford free universal health care on a fee for service model. So, as NH we would like to experiment with managed care where the interest of patients, payers and providers are fully aligned in an integrated manner. So, in this model care and coverage are seamlessly integrated and healthcare is delivered in a narrow network and the focus is on providing optimal levels of care and keeping your

customers healthy.

This is a logical next step in our journey to create an affordable, globally benchmarked, quality driven healthcare services model. At NH, we've always believed in getting closer to patients and bringing the promise of quality, affordable healthcare to the doorstep of the country's millions.

So, to this effect, we've incorporated a new company Narayana Health Integrated Care (NHIC) and have undertaken a slump sale to transfer our existing clinic assets. The value may not be that significant, about Rs.10 crores, but we will slowly build scale, competency and domain expertise in order to be a market leader in this space.

NHIC has a strong leader in Ravi Vishwanath who joins us with 25 years of experience across HDFC Argo, Apollo Munich, Tata AIA Life and Reliance General.

These are the early days of our journey but our initial results have been very promising. We strongly believe that an integrated care model based on whole person care, providing comprehensive coverage for all market segments is the need of the hour. We will share updates on the progress over the coming quarters.

We now open up the floor to your questions. Thank you. I would request everyone to now use the raise hand feature to start posing the questions and we try to address them in this forum.

Mr. Nishant Singh: Thank you, Viren. I would request everyone to now use the 'raise hand feature' to start posing their questions and we will try to address them in this forum.

Yes, Nirali, you may go ahead.

Ms. Nirali Shah: Yeah. Firstly, congratulations on a good set of numbers. My first question is, could you provide an update on the EBITDA margins for Mumbai in Q4 like in Q3, to be precise, in January Mumbai had had come to a breakeven. So, I would like to know EBITDA margins for Mumbai in Q4. Additionally, I'm also interested in understanding the current EBITDA margins for our relatively new hospitals in Gurugram and Dharamshila. And have we achieved a double digit margin in these two locations? I understand that Mumbai being a new one and we have just come across breakeven, so double digit is not possible for Mumbai but the other two, have we reached there? Have we achieved it?

Mr. R. Venkatesh: Yeah, I will take this call. I am Venkatesh. So, your question on Mumbai.

Ms. Nirali Shah: Yes, Mumbai.

Mr. R. Venkatesh: Yeah, the consolidated Q4 EBITDA for Mumbai is around INR 6 million which is around 2.3% in terms of EBITDA. This is the first time it has shown a positive EBITDA for the year at INR 6 million. If you look at the previous quarters, it was on a negative but gradually what has happened is the negativity has come down gradually and this is the fourth quarter where we've shown a positive EBITDA which shows positive direction in which we are moving and we hope to maintain this momentum for FY24 as well.

Now, in terms of Gurugram, the Q4 EBITDA margin is approximately at 2% on a base revenue of INR 35 crores. On the whole year, it has generated a revenue of around INR 133 crores with INR 3.7 crores EBITDA at around 3% margin.

When it comes to Dharamshila, the performances have been robust over the year. Our EBITDA margin is at around 16% at INR 8.5 crores on a revenue basis of INR 54 crores and for the full year the EBITDA margin is approximately 14% on INR 29 crores at a revenue base of INR 209 crores.

This is the status of all our New Hospitals at this stage.

Ms. Nirali Shah: Okay. So, ideally currently we are at a double digit only in Dharamshila, right?

Mr. R. Venkatesh: That's right. See all the new hospitals are in positive. Now, the most positive thing if you look at in this quarter is all the new hospitals are in positive at 8.6%. Dharmashila is double digit margin and we are confident that the other two will also reach the following figures in the next 3-5 years. But, of course, the stage is already set where we have started showing positive for all these new hospitals.

Ms. Nirali Shah: So, we can expect a healthy margin of 15%-17% in the near term perspective of say five years and this will be sustainable, right? Okay and my next question is about the Cayman Islands. Is the new Oncology Block in the Cayman Islands on track that was to commence operation as planned in the first quarter of FY 24?

Dr. Anesh Shetty: Yeah. Hi, Nirali. Anesh here. Thank you for your question. So, yes, the initial guidance we had given was Q1. We expected it to happen towards the end of April. However, we had some last minute glitches with the construction. We've actually started the operations about eight days ago and we've been treating the first batch of patients as we speak. In fact, just before the call started we were just playing a short video of the Radiotherapy Center for everyone's benefit.

Ms. Nirali Shah: Okay.

Mr. Nishant Singh: Thank you, Nirali. Next, we have Dhara.

Ms. Dhara Patwa: Yeah, thanks for the opportunity. So, I had two set of questions. One was for the ARPOB growth. So, this quarter we have seen ARPOB growth of 10% year over year and 5.5% sequentially. So, could you provide the breakup in terms of price hike and peer and specialty mix?

Mr. Viren Shetty: Nishant, do you want to take this?

Mr. Nishant Singh: Yeah, Dhara. See, our ARPOB numbers have gone up to INR 1.35 crores per bed. This number in a time spread will continue to grow but we will not expect this to grow very fast because our focus is not to have this revenue per bed at a very high level, at a very fast speed because we want to retain that affordable for all policy and hence we will see this growth but will not be the best in the industry. We will go steadily up but we don't have a clear guidance on this number.

Ms. Dhara Patwa: Okay. So, this 10% YoY growth like what we have achieved in this quarter, so how much was the price hike we have taken in the quarter? Because I understand CGHS has also increased their price and since we have 20% mix from the skin patients, so I guess there could be some element of price hike in the quarter.

Mr. Viren Shetty: This is Viren here. This won't be due to price hike because price hike is only taken once a year. This will be mostly due to change in the patient profile, the case mix, improving the throughput, reducing the occupancy. Those are things that drive. So, it's essentially the performance improvement that drive it rather than the increasing prices.

Furthermore on the price, it's not that everyone pays the price what we put as a rack rate. A significant amount of discounts are offered to the patients. Similarly, institutional payors like government do not renegotiate their contracts and even private insurance companies negotiate only in a three year cycle.

Ms. Dhara Patwa: Oh, okay. That's it from my side.

Mr. Viren Shetty: Thank you.

Mr. Nishant Singh: Next we have Yash.

Mr. Yash Tanna: Good afternoon and congratulations team on good set of numbers. Can you highlight a little bit more on the new subsidiary that you opened and you mentioned in the initial remarks? What is this about and how will this grow for us?

Mr. Viren Shetty: So, as highlighted, we want to get into creating a model for integrated care. So, essentially this will be housing all our clinics right now. We will be offering primary care services in these clinics. We will be being closer to where the patients are staying

and so in the periphery of our hospitals and close to the apartment societies, we will build up all these clinics. In the clinics, we will offer a combination of services both the services within the clinic as well as remote services such as homecare, online care and long term care plans.

Eventually, we will combine this with a comprehensive health insurance plan which would be able to cover not just the hospitalization in a narrow network but also the outpatient expenses within the clinic network that we have created.

Mr. Yash Tanna: Oh! All right, got it. So, the revenue generating model will be more on a subscription basis or something like that?

Mr. Viren Shetty: It will be a combination of both things. It will be a combination of subscriptions that we sell as well as the medicines, lab test, consulting fees, any diagnostics that happen in the clinic.

Mr. Yash Tanna: All right, got it. And how different will the unit economics be for this sort of a business versus setting up a hospital? Is it more a ROC affiliative or any calculations that we have done on that?

Mr. Viren Shetty: So, Capex wise these things are very light. They breakeven pretty fast. They may not be as high in EBITDA as the hospital business because the realizations are quite low and they can be spun up and spun down relatively quickly. So, it won't have too much of an impact on the overall consolidated ROC given that the quantum of investment at this stage as we are envisioning is not more than INR 50 crores. So, it won't have that much of an impact and we're doing it in a measured way. So, we won't plan on losing much money in running this clinic network but we want to test it out. We're trying it out in Bangalore. We'll eventually roll it out to Calcutta and see if people are more appreciative of this model of healthcare. So, where we have a thesis that a lot of healthcare should be delivered outside of hospital, we are yet to prove out that patients prefer this over coming to the hospital. Similarly, in anticipation of us offering these subscription plans whether they're fully compliant and whether there's something that has a lot of market acceptance. So, we're trying it out. We're very confident. The initial results are very good and we will start showing, you know, what we've been able to do from Q1 of this financial year onwards. But at this point, let's just say that it's not something you need to bake into your model. It's something we're also experimenting with and constantly changing it.

Mr. Yash Tanna: Right. This is very interesting, Viren, thanks for that. Just a question on the margins; India Business. So, as I see in the presentation, it's gone up from what 14% to 19%

year-on-year. So, now since our new hospitals are turning profitable and we are saying that we will maintain the momentum, what sort of peak margin potential does the India business have going forward?

Mr. Viren Shetty: Yeah. We won't really comment on this but, Venkatesh, if we can just give some color on generally how things stand in the short term.

Mr. R. Venkatesh: Yeah. Currently, when it comes to Q4 for India, also, we've done around 19.1%. Having said that, we believe there are headwinds against these numbers and therefore it may taper a bit. One is that, you know, this year there has been windfall growth in revenue whereas in the coming years we can see more of an organic growth. Secondly, there are also significant cost headwinds which only partially we've been able to pass on to the patients; we are not going to pass on the entire thing. Of course, we will try and maintain the same margins of growth through the throughputs which we've always spoken about, efficiency improvement and cost rationalization which we have been doing since the last few years and we'll continue to do that and make sure that we maintain the margin.

Mr. Yash Tanna: All right, got it. Thank you and I'll get back in queue and best of luck.

Mr. Nishant Singh: Can we have the next question from Dheeresh?

Mr. Dheeresh Pathak: Yeah, hi. Thank you for the opportunity. For the India Hospital assets, I want to understand the capacity that is available. So, I think the metric that you prefer is the IP discharges and not the occupancy. So, from that KPI point of view, if you can just help me understand how much capacity is there; Indian Hospital Business in aggregate?

Mr. Viren Shetty: I'll start and then I'll ask Dr. Rupert to join in. The thing is, it's not something where you are constrained in terms. So, there is a space constraint for a lot of our hospitals but the throughput can be increased relative to how much more investment you're willing to put into these buildings. So, the discharges by moving to things like daycare, for example, we've been able to improve, by changing the bed configuration we've been able to increase the realization, by investing in certain things like certain processes that discharge patients faster in the day we can fill up beds much better. But in terms of, you know, what they ultimately will be able to stop at, this is more of a moving target.

Mr. Dheeresh Pathak: That's fine but, I mean, is there a quantification to it because if you've seen at FY20 you had about 286,000 discharges, this full year you had 229,000 which is still below what you did some years back. And obviously compared to the beds and all, the number looks very low. I know that's not the right metric. So, how do we you sort of

get some sense in terms of where we are at least in the flagship assets, you know, Bangalore and the Calcutta one? Because, see, if you see a lot of your revenue growth and a lot of the EBITDA, so 80% of the India hospital EBITDA is itself is clustered. So, at least from those cluster point of view, if you can just help me understand how much capacity is available?

Mr. Viren Shetty: See, just off the top of my head, there is adequate capacity within all the hospitals we have, we just need to reconfigure to meet the requirements. As for us not reaching the pre-COVID numbers, there was a calculation error because back before when we were on the old system we were not making a distinction between the daycare discharges which don't end up as occupancy and the ones that do and the emergency visits also would not get counted whereas since we've reclassified all of that the absolute number of patients we're discharging has gone up and this is the highest it's ever been but can go higher.

If you would ask me exactly how much we can do, it depends on how much more of internal reconfiguration we are able to do for a lot of the hospitals that we have. We may not be able to double in the existing network that we have because that will require significant investment and a little bit of brownfield expansion, which we are doing also, but these two things will go in parallel.

Mr. Dheeresh Pathak: Okay. On slide 14 which talks about CapEx, so this INR 150 crores as greenfield inorganic for FY24, apart from the clinic's part is there something specific to the hospital business that you've identified? Any new land parcel? And new city? This INR 150 crores represents what?

Mr. Viren Shetty: Venkatesh can take this up.

Mr. R. Venkatesh: Yes. So, when we were speaking about CapEx, of course, we are looking at replacements, capacity building, capability building. So, INR 150 crores, of course, is on plans to require a land parcel in Calcutta; for our plan in terms of Greenfield expansions. Calcutta; we've already spoken about expansions planned up for Calcutta and Bangalore. So, this is the first initiative or a step forward towards the Greenfield expansion to getting the land parcel in Calcutta has been factored in this INR 150 crores.

Mr. Dheeresh Pathak: Okay. Thank you for taking my questions.

Mr. Nishant Singh: Can we please have the next question from Prithvi?

Mr. Prithvi Earle: Viren, this question is on your CapEx. So, obviously this year the cash flow generation

has been very strong. Given this context for next year INR 1100 crores CapEx, can we assume that most of that can be funded by internal accrual and the debt number would be much lower than what we were guiding earlier?

Mr. Nishant Singh: Yeah. So, this is Nishant here. I'll take this question. See, we've added around INR 330 crores cash, net cash, in this year which has been very positive. And our plans for the next year in the CapEx of around INR 1,100 crores which we have highlighted, around INR 700 crores will be through the bank funding and the rest will be through our own internal accruals, which will take our Net Debt to around 0.62 of the overall EBITDA which is still very comfortable.

In terms of why we are not using the entire cash is because we have a lot of cash also at Cayman where we still continue to explore opportunities in the other islands and for India the cash balance is at around INR 200 crores plus. So, we'll have a judicial mix of both bank borrowing and the accruals in India to fund expansion in India. While the Cayman cash will stay there while we also add but we will also continue to look for opportunities at other islands around Cayman.

Mr. Viren Shetty: Provided we don't do any more expansion and acquisition and greenfield things. So, this is what we're giving the guidance for the next year and there is a lot. There's a huge opportunity that is presented to us in all the hospital that we run. So, it's something that we want to keep in mind. So, as it looks right now, there's a lot of work that can be done that we believe will really improve our realizations going forward and we'd like to continue that.

Mr. Prithvi Earle: And this question on Cayman's new Oncology Department, so has there been any markets or something of that sort you have done to just get a sense on number of people traveling to U.S. and, you know, what can be the potential from this block?

Dr. Anesh Shetty: Prithvi, sorry, could you repeat that question? This is Anesh here.

Mr. Prithvi Earle: On the new Oncology Block of the radiation, has there been any market survey that you people have done to get a sense on number of people traveling from Cayman to U.S. currently for this and then you know, who can now visit your block in Cayman?

Dr. Anesh Shetty: Sure. Thank you for the question. So, because the service we are primarily offering is radiotherapy, which is in general about a 6-8 weeks treatment regimen. What was earlier happening before our facility was up and running was that patients had to fly 95% mostly to Miami to some of the Centres over there and they would relocate there for a month to two months or more with their family and they would not be working, not be earning, significant logistics and inconvenience costs as well as the, you know,

high prices in that market that the insurers had to bear. So, what is happening is because we are offering a similar comparable treatment modality with the same machine, you know, treatment protocols more or less in line with what they would experience in Miami but with the convenience of having it down the road in a very convenient location at home for them where we don't foresee much resistance to converting people who need the service to use us because, A, we are at home and, B, we are the only linear accelerator on island.

To your second question about the market size in terms of number of patients etcetera, we have, you know, gathered some of this information through some payers which shared this publicly but others is, you know, collating various other sources of information. So, it's still an uncertain number that we continue to work with but there is a significant margin of safety built in when we planned this facility. So, we continue to remain very comfortable with the investment and its potential returns.

Dr. Emmanuel Rupert: And also we have a fair idea. We've been treating patients on medical oncology and surgical oncology and if you can extrapolate the clinical numbers from them, we have some uh fair idea as to the number of patients who will be requiring radiation from that.

Mr. Prithvi Earle: And can you give the Cayman EBITDA number for this quarter; absolute EBITDA in million dollars?

Mr. Nishant Singh: So, it can be derived from, you know, the statements, the difference between the consolidated and the standalone more or less but we generally don't disclose the specific numbers for that business unit.

Mr. Prithvi Earle: Okay. So, just final question. So, if that's the case even after the radiation Oncology Department can we maintain 40% plus EBITDA margin in Cayman?

Mr. Nishant Singh: So, the Radiation Oncology, we can confidently say will not be margin dilutive. So, this is a facility, you know, in any hospital, radiation, if you look from an EBITDA perspective is actually a very, very high EBITDA percentage business simply because the investment is significant in CapEx but not in operating expenses. So, definitely there will not be any margin dilution on account of radiotherapy at this stage.

Having said that, as we've discussed several times before as well, in Q1 of next financial year when we commission the larger hospital, which is the Camana Bay Hospital, which will also have cancer treatment among other specialties, at that time there will be a margin dilution simply because we will be bringing online a large chunk of fixed costs but for now with the radiotherapy Center there will be no margin

dilution.

Mr. Prithvi Earle: Thank you.

Mr. Nishant Singh: We have the next question from Mr. Dheeresh.

Mr. Dheeresh Pathak: Sorry, my question got answered. I'll go at the queue.

Mr. Nishant Singh: Okay, thank you.

Mr. Viren Shetty: So, anyone else?

Mr. Nishant Singh: Yes, Mr. Gagan. please go ahead with the question.

Mr. Gagan Thareja: Yeah, good afternoon. I hope I'm audible.

Mr. Nishant Singh: Yeah.

Mr. Gagan Thareja: Yeah. Sir, at the start of the call you mentioned, you know, there was a onetime contribution to the EBITDA for the quarter, if you could enumerate this contribution and also explain to what it pertains.

Mr. Nishant Singh: Yeah. So, we have also spelled it out in the deck. There's INR 28 crores EBITDA contribution from Saint Lucia which is part of India unit but there's also a lot of onetime expenses as well because of our brownfield expansion/transformation projects across India units. So, if you net off this one time gain from Saint Lucia and the onetime expenses which we incurred in this quarter, the net effect is minimal.

Mr. Gagan Thareja: Okay. And the Oncology Center at Cayman, if you could enumerate the fixed cost associated…Sorry, in terms of OpEx, the cost associated with that facility. I understand that, you know, in an aggregate over the year or thereafter, you know, it might reflect its optimal margins but as it scales up the margin profile would be different. Therefore, just to understand, you know, what could be the incremental fixed cost associated with this one.

Mr. Viren Shetty: Gagan, we run that Radiotherapy Center similar to how any hospital would or how we do it in India as well. You know, in terms of fixed costs, aside from the manpower cost to run the facility, which is not much because there are few people, expensive but few people, and the infrastructure cost which is the facility costs in terms of the utilities that fit out et cetera, the ongoing cost for those things. There isn't much of a fixed cost compared to the traditional, you know, your regular medicine, surgery, cardiology, orthopedic service lines. While we are not in a position to disclose specific numbers in terms of absolute value but it's not much as long as we stick to Radiotherapy.

Mr. Gagan Thareja: And in terms of utilization, you know, obviously this is not going to be like on a bed count basis but any idea you could give us as to what sort of average utilization you could see for the first year of operations and when could it reach a mature optimal sort of utilization?

Mr. Viren Shetty: Yeah, Gagan. So, you know, I'll start and Dr. Rupert can continue. When we look at mature optimal utilization for a linear accelerator of the kind that we have, you know, this is a true beam facility. Some of our other centers in India are treating in the range of, Dr. Rupert said, 70-80 patients.

Dr. Emmanuel Rupert: Yeah, 70-80 patients.

Mr. Viren Shetty: 70-80 patients a day in this kind of a machine. Now, when we planned this Centre, we obviously knew that those kind of volumes will never happen but unfortunately, you know, we can't buy half a linear accelerator. So, we understand that the volumes will be significantly less. However, given the exponentially higher realization compared to what we see in our home market in India, as mentioned before, we're very comfortable with our returns from this investment, accounting for a very healthy margin of safety.

Mr. Gagan Thareja: And this could be achieved by when? I mean, I understand, you know, these are estimates but just to understand given your assessment of the market and the fact that you are the only one on the island, at least so far, do you see this sort of hitting that mature utilization fairly soon? Maybe a year or 18 months or is it too optimistic?

Mr. Viren Shetty: No, so there will be two phases to the utilization, Gagan. So, the first phase is the local business. So, local business, you know, like we elaborated in the previous question, simply because of the value proposition of convenience and logistics costs and the overall, you know, benefits of being treated at home, the local on island business will ramp up. We don't expect to have much of a delay beyond a couple of quarters to get all the local business that needs radiotherapy unless there are some patients who for a very, very specific reason will still travel to the U.S. and they'll do so no matter what. So, that's phase one, which will happen fairly soon. But what we're really counting on in the longer term, which is a little much more uncertain, is the demand for radiotherapy services from the broader Caribbean region, which is in line with our overall medical tourism play for all our services. So, if you look at the region as well although there are a few handful of Linux, you know, all over in a few markets, they're not really run well, they're not commissioned, in many cases they have maintenance problems, they don't have manpower shortages. So, in terms of having a modern true

beam line linear accelerator, which is 24/7 available online with comprehensive medical, surgical, oncology, and an entire hospital setting similar to what you get in Miami this is definitely a one-of-a-kind facility in the region, but selling this and you know to other markets to payers there will we'll take some time. You know we obviously won't be in a position to answer even we ourselves don't know how many quarters it will take, but I think that will be the second phase of volume expansion where after the local business is done, the overseas medical tourism will start kicking in.

Mr. Gagan Thareja: Is there a cost proposition for that because you know as you said people from Cayman go to Miami, so probably you know from the other islands they as of today go to Miami, is the travel cost or inconvenience and you know the treatment cost differential substantial enough for people from the other islands to shift to this?

Mr. Viren Shetty: Yeah, that's actually a good question. So, when we thought about this and did some research into this, what we realized is since most patients who will be going to the US are coming - potentially coming to us and came in from other islands. There are basically two categories; there would be the insured patients and they would be the self-pay patients. So, if they're self-pay, there is definitely a cost advantage to coming to us, it does get slightly dampened by the although for the clinical service you would spend a lot less than you would spend in the US, but staying in Cayman, which is one of the most expensive jurisdictions in the world actually to live in you know it does dampen some of that compared to you know some of the East Coast - US East Coast markets, but there still is a value proposition, however, the larger market which is the insured patients you know the patients are insulated from the treatment costs largely. They feel that they've paid their premiums, so they're entitled to whatever the maximum benefits are offered and they feel that you know why wouldn't I go to you know a world class center in the US, why would I go to a new place in Cayman. So, there is that's selling to the payer, selling to the one who's paying in some many cases the governments as well that we'll have to work through, but we've been doing this for other specialties for some time now, so it's no different just because it's radiotherapy. So, there is a value proposition, there is a cost saving, but it's a question of communicating it to the person who is able to influence the direction the patient moves in that can take some time.

Mr. Gagan Thareja: In terms of realization you know you indicated that while volumes would be lower as compared to what you've seen in India, but realizations are substantially higher, any numbers we could work with in terms of realization per patient or ARPOB, if one could

boil it down of that? So that was a question on this one if there's no data possible on that, I have two more questions. One you know the second unit that came in whenever it comes on stream you indicate that it'll come with substantial fixed cost and therefore initially you know have some sort of an impact on your margins, point well taken, but I presume that one of the reasons for doing that facility was that you know daycare patients I think you indicated in some of the previous calls don't want to come to the current facility because it's from a travel perspective not the most optimal location and therefore you want to you know to capture that bit you want to do something in the heart of the city. If that is the reason or the focus for that facility, then ideally the fixed cost there should be lower than you know a full-fledged inpatient sort of a facility, so just trying to understand how does the fixed cost on that facility compare with your existing facility and also you know the proposed bed count there?

Mr. Viren Shetty: Yeah. So, the first question on the fixed cost and should it be lesser so, you know you are right in that you know the distance is a significant barrier to many patients even though it's just a 40 minute drive from the City Center to where we are, but in that market that's perceived to be a lot. So, the primary reason for this hospital was a location advantage and you know like we mentioned before when we decided to solve it, we decided to solve it with the best possible land. So, the land parcel we own, the location we have is the most premier land in the country and it's just at the roundabout by which half the country passes by every day. So, we've definitely neutralized that location disadvantage. Having said that because we've neutralized that we obviously would be for better more attractive to patients who require daycare surgeries, but also just you know outpatient visits, diagnostics, even some light inpatient work as well whatever the reason may be, so the way we are thinking of this is to make maximum utilization of our facility and our of our investment, we will not be restricting any services, so essentially whatever we perform in the main campus in East End will also be performed in Camana Bay because it doesn't make sense to not offer it when patients have a need for it especially since we have the most expensive fixed cost which is the human resources, the doctors already in the same island. So, to your question the difference in fixed cost, yes it will be lower than what we currently have, but that's only because we will not be hiring the second or third cardiac surgeon or the second or third neurosurgeon etc. You know a very large chunk of our costs are our clinical manpower and at the clinician level, at the doctor level they all have a good amount of redundancy or excess capacity to still be unlocked, so we will be using that so because of that you know the fixed cost of the facility will be lower. Added to that,

the main campus is about 110,000 square foot facility whereas what we're building is about 64,000 square feet facility. So, to that extent you know the facilities cost will be proportionately lesser than that and I think your last question was on the bed count of that building. I think we've mentioned it before. We'll have inpatient beds, we'll have emergency, we'll have chemotherapy, we'll have a large obstetrics neonatal presence as well. I think I don't want to give a number that's materially different from what we've earlier disclosed, but Nishant if we could follow up with that, I think what we said was in the 50 to 54 beds I think, so it's about 50 to 54 beds here.

Mr. Gagan Thareja: Right and just to follow up on that, when this facility come in would it mean that you know some of the revenue that you're currently generating in your existing facility would get sort of in a way cannibalized and shifted to the new one possibly to start with and then you know as the cases ramp up here that effect might go away and also final one you mentioned at the start of the call that you foresee some headwinds on the margins and there was some windfall gains if you could elaborate there as well? Thanks.

Mr. Viren Shetty: Yeah, absolutely. So, to your first question and I'll hand it back to Nishant for your second question because I think that was a comment on NH India, the margins there, yeah but to the first question, yes so there will absolutely be a sort of transfer, you know cannibalization is a harsh word, but yes a transfer of patients and revenue from one facility to another, but at the same time there will also be a transfer or sharing of costs you know like I mentioned we won't be hiring any incremental patient facing clinicians to do this which is a very significant fixed cost because they all have you know spare capacity and you know the same goes for other senior resources as well. So, yes you are absolutely right that in the initial ramp up phase there will be a large amount of you know transfer of business revenue and cost until you know things settle in and then we will see you through incremental gain of revenue, hopefully without any incremental gain in costs and that's what we're really hoping for. So, back to – Gagan if that answers your question, can we move pass it along to Nishant.

Mr. Gagan Thareja: Yeah, sure. Thanks.

Mr. Viren Shetty: Thanks. This was a question, Nishant on the one time, the headwinds on the margin?

Mr. Nishant Singh: Yeah, I think this was already answered earlier?

Mr. Gagan Thareja: No, sorry to interrupt - this is not for the one time. I think there was a comment made that for FY24 you see some margin headwinds

Mr. Nishant Singh: Oh, sure, Venkatesh, yeah.

Mr. Gagan Thareja: Yeah, yeah, and

Mr. R. Venkatesh: I'll summarize that, so the margin headwinds mostly around the fact we're entering an election year and so generally what happens is if you're exposed to a lot of government business, you'll be a little cautious because of the growing receivables. The other is the usual global macro scenarios what we expect with the war and so on and the deteriorating currency situation in a lot of the Asian countries likeBangladesh, Nepal, lot of places that traditionally send patients around; other than that there was a low base effect that led to a large gain between last year and this year, whereas now of a high base it may not be easy to replicate the same sort of revenue growth in this year and lastly a lot of the work we are still doing, a lot of the room reconfiguration, doing up the Cath labs, adding bone marrow transplant units or robots doing up the Cath lab OT all of that is still very much under progress and will be for the next three to four years. So, as and when these units are being built, it does lead to a lot of loss in productivity because of the areas you are shutting down. So, those are the headwinds that we expect over this year which is why we'd be a little muted in our optimism for being able to continue growing at the very high pace.

Mr. Gagan Thareja: Yeah one of your peers indicated that CGHS rates partially have been revised and expected to revise you know for the packages as well and by I think a reasonably substantial amount since it's happening after a gap would that not in some way help you, I mean I'm trying to understand your CGHS exposure here and secondly how has been the international patient flow for you and is the momentum there growing for you or you believe that in the coming year it might temper down?

Mr. Viren Shetty: I'll address the CHS and Venkatesh will address the Bangladesh. CGHS, they had announced a revision in the rates for a lot of outpatient consultation, so ₹100 they were paying a doctor, now they're going to pay ₹150. This is a doctor who charges ₹700 to ₹3,000 for a consultation. So, the enthusiasm that would have would be adjusted accordingly for this patient, similarly the daily room rate went from ₹1,000 to ₹3,000 on rooms that cost ₹15,000 for patients paying cash. So, similarly everyone's enthusiasm on the increase in the prices would be temporary. Now, they have said that some rate increase would happen over the CGHS rates we're to expect it in July. We don't know what that's going to be, we can speculate and obviously our fingers across that it will be substantial, but then again no one never knows with this thing, whether you're talking about 5%-10%, 50%-70% price increase. This is a rate that hasn't been revised since 2014 and if I'm a payer, why let a good thing you know why not let's let it continue going on. Venkatesh will address the Bangladesh

Mr. R. Venkatesh: What I was trying to say is that post the migration into from NHL to CGHS affiliated claims have also not been processed, there are significant outstandings. So, there has also been a delay to clear the bills, so we also need to keep a watch on how effectively the payments also happen along with trying to see what values the rate revisions will give us. So, that's what I wanted to say as an add on. Now, when we come into international patients, international patient volumes have been improving gradually from 6.5% in Q1 FY23 to about 8.5% in Q4. We're focusing on more market of Bangladesh, but with more of a direct outreach, but still what we feel is that we may not - we don't believe that we will still reach our pre-COVID numbers in near term because one is we have cut all the referral arrangements and we are getting directly into the market, we are also restricting our activities to pure key markets in direct engagement model and our strategy also would be to shift the marketing expense into digital and domestic activities which actually will be less impacted by travel disruption if anything happens in future, so it's a backup or a standby arrangement so that the flow of patients have no it's continues to be a seamless flow of patients irrespective whether we have an international sector opened or not, but the focus is Bangladesh patients keep coming, international patients keep flowing in, but we would of course as I say restrict the early key markets and focus more on digital and domestic activities.

Mr. Gagan Thareja: Sir, just one final comment I mean the three hospitals that you earlier talked about Gurugram, Bombay, and Dharamshila, they are on their way to relatively better margins as their utilizations improve your international patient flow you know maintains momentum, these are positive for you, and yet you're talking about net-net there being headwinds on margins, I am unable to reconcile if you could elaborate a little more?

Mr. R. Venkatesh: Headwinds is something which is a little different in terms of the cost aspect we're talking about and also these are key headwinds we were talking about is on the major units which we have already spoken about in terms of transmission activities, terms of the elections, and also certain cost increase which is there. We talk about the newer hospitals which is Gurugram, Dharamshila, and Mumbai, of course there is a - when we are looking at international marketing and getting into this on a direct engagement model there is a good scope for these units also, but at the same time the alternate in terms of digital and domestic and neighborhood activities is just as an addon in terms of trying to see how we can add more volumes into the system and also as a standby just in case of any unforeseen circumstances come up in future just like what we've experienced in the earlier a couple of years. So, this is this is an alternate while we

keep focused on international marketing, we also need to make sure that we have alternate sources of patients for generation like this.

Mr. Gagan Thareja: Right. Thanks, and what would be the cost for debt for you, the 700 crores that you intend to raise?

Mr. R. Venkatesh: Sorry, can you please

Mr. Gagan Thareja: Cost to debt.

Mr. Nishant Singh See it varies, now it's actually high for everyone so it should be in the range of 8% to 8.5%.

Mr. Gagan Thareja: Thank you.

Mr. R. Venkatesh: And we also have to include this tax on that so effectively should be around 6½%.

Mr. Nishant Singh: Sure. We can move on to Nitin.

Mr. Nitin Agarwal: Hi, thanks. I have two things, one is A - on the India business with all the CapEx that you've outlined can you give us a rough sense on a number of incremental beds you looking to add across various locations over the say next two to three years?

Mr. R. Venkatesh: The next one year, no incremental beds. Over the next two to three years, we'll start disclosing it when we put up the CapEx list for FY25, but right now a lot of the things that we're doing now is more on OPD Plazas and parking areas, internal refurbishment, and in fact some of our bed count may actually come down because a lot of that is going to existing hospitals. Some will be operational like Howrah for example we're adding more beds, but the net effect is not significant. FY25 onwards, there may be bed addition, but we'll start putting that out from the Q1 slides onwards.

Mr. Nitin Agarwal: And you your Calcutta hospital was running to capacity the RTIICS Hospital, how do you sort of manage to work around that for now?

Mr. R. Venkatesh: As we have been always saying about throughput occupancy or capacity you can't view it in isolation especially in high throughput centers, even Calcutta is also one of the high throughput centers, we focus on very high throughputs perform cardiac surgeries or robotic procedures which has a morning-evening admission discharge. We're also working on efficiencies and improving discharge time especially in insurance and scheme discharges happening, we are trying to make sure that we get it done before 12, so that there is more admissions happening during the day, we're also trying to improve the throughput in the ICU's, trying to change the bed mix. We're also developing efficient communication tools between the doctors and nurses to

coordinate care and discharge patients faster and we've said we are significantly investing in technology to improve our thruput, faster discharges, lab results, seamless appointments, and also increasing throughput through process transformation, and also working on the ALOS coming down, we've got some targets and we're confident of achieving it in the next eight quarters. If the space we saved with all these measures, we try to focus on infrastructure enhancement like to address these patient bottlenecks like OTs, adding OTs or adding ICUs, Diagnostics, Lab Billing, which will you know enable us to increase revenues at the same costs and same capacity really come with Greenfield expansions.

Dr. Emmanuel Rupert: Yeah, Dr. Rupert here. We've been working with the clinical teams across the network and part of the thing is to change clinical pathways so that we are able to do the same procedure in a much more shorter period of time and get the same predictable outcomes as well and this is what we've been doing apart from all the things Venkatesh has mentioned. So, this is yielded very good you know results. If you see the cardiac hospital with less capacity in terms of actual beds and other things, we have been able to do more work, so somewhere around the pre-pandemic we used to do around 500 cardiac surgical procedures, we are able to do around 770 that was the number in the month of March. So, we have been able to do much more with the same number of beds and all because of many things which all work In Sync to enable us to do these things and this is being replicated across the entire network as far as the clinical work is, whether we have beds or not we are just working heavily on the process transformations as well as the clinical pathways to enable the procedures to become - for them the patients to use as less time as possible in the hospital.

Mr. Nitin Agarwal: And secondly on the Sparsh Hospital because it has been about six months since we integrated or merged at closer transaction, so any updates on our experience with that?

Dr. Emmanuel Rupert: Yeah, it's been going on track as per our expectations. We are continuously doing more than 200 procedures per month and we have a subspecialty work in orthopedics and spine in that hospital. So, we have specialists who do only joint replacements, some who do only sports medicine, some who do only spine, some do the pediatric orthopedics and things like that, but it's been doing very well and because of the neuroscience department which is very well established here, our work on the traumatic brain injuries as also been excellent results and things have been moving in the right direction and we are also investing in the new age technologies as far as the robotic programs for both the joints as well as for the spine, our equipments are

expected to land in sometime in the next quarter and we should be in a position to take this in a much in the right direction as what we want to do.

Mr. Nitin Agarwal: And when just to sort of sum it up across the various measures you guys are taking to not really with the focus not being on adding specific amount of beds, but across increasing the you know the clinical complexity and the overall patient experience from an output perspective, I meant where is it reflecting, it reflects in higher EBITDA margins for us, higher ARFOBs or what are the outcomes that one that you really working towards out here?

Dr. Emmanuel Rupert: All of the above men, on the higher utilization, higher OC, higher ARFOB. See, the thing is we can run around the country blindly chasing beds, making expensive acquisitions provided we run out of pennies that are found under the couch and that's the easiest sort of you know gains that you can make because it's sitting right there you don't need to look too far, you don't need to run around the whole countryside to find it, and there is so much about our business that can be improved which is you know patients simply sitting around waiting hours and hours for lab test. We implemented the Atma Lab System, we were able to get the lab results in the time it took for them to walk from the lab to get there - this one the bills collected, the results had already come. So, this kind of throughput is phenomenal. No other hospital in the country is able to achieve that and that it's not - it sounds easy to do, it's not just a question of putting money and put one software, everyone had to work together. We had to put one very expensive auto track system, we had to work with all the lab people to do auto certification and work with the companies to integrate their software into our Atma, we had to iron out all the kinks, we had to get the doctors all lined up to say that you know these are the tests that will be done with a very low tab, so it's a lot of hard work, but when it's done it makes you so much more efficient, improves the patient experience so much, reduces your cost, and allows us to be more competitive in a field which as you know there's it's not always that you can keep on raising your prices year after year and significant challenges coming in the future where you have you know a lot of people and maybe rightly so saying that there are things that the healthcare cost should not keep rising up so much, there should be - there may be things coming to cap the price a lot of services which we're worried about and so a lot of things we're doing to address is the you know the fixed cost and we don't want to take for granted. Now, I'm not saying we're going to give up on adding beds, of course we want to add beds, why wouldn't we? We want to go all over the country, but going all over the country with the way in which we operate

makes us extremely inefficient, has a very low return on capital, and it's not the best way to deploy our capital. So, a lot of money in the way which we operate become the most efficient then we can run around the whole countryside buying up hospitals.

Mr. Nitin Agarwal: And the last one on the St. Lucia income that we booked for the year, what is the nature of this contract and how should we sort of look at this share of income on a going forward basis?

Dr. Anesh Shetty: Yeah, Nitin, Anesh here, I'll take that. So, essentially you know when we continue to explore opportunities in the Caribbean region outside Cayman, what we are very clear on is that we will not put our money or our boots firmly on the ground as a first step unless there's a very, very compelling reason to do so. So, we will explore these markets in various ways. Now, given our almost decade of brand equity in the region and the fact that we've been able to demonstrate a very robust track record, our governments, private players, and you know everybody in between are actively keen and you know very actively pursue us to try and see if we can replicate what we've done in Cayman in those markets. We'd love to do that, the challenge is we need to understand the economics of the healthcare business on these islands, the certainty of rule of law, repatriation of profits, the general business environment etc. and of course the local medical conditions and the doctor's lobby which can always be a problem, so St. Lucia was one of the early market - the earliest markets outside came in which we explored and the way we explored it is essentially through a consultancy contract for the government of Saint Lucia to help them Commission their National Hospital and the intention was to you know help them do this and have an option to be the operator if we so desired. We did that, the contract is over, we've completed our work, and we've taken our call that you know the market is not favorable for us to make an investment. So, we no longer participate in that market, but the contract is terminated and the revenue has been booked and it was a onetime consultancy contract.

Mr. Nitin Agarwal: Oh. So, there is no more incremental cash flows from the St. Lucia business?

Dr. Anesh Shetty: Yeah not from St. Lucia.

Mr. Nitin Agarwal: And are there any other such contracts which could be meaningful I mean not meaningful, but which you're pursuing which can start accruing to our earnings on a going forward basis?

Dr. Anesh Shetty: Yes, there are a few that we are in discussions with. We will keep you updated as and when we are close to finalizing them.

Mr. Nitin Agarwal: Thank you.

Mr. Nishant Singh: Thanks, Nitin. Can you move to Dheeresh?

Mr. Dheeresh Pathak: Yeah, thank you again. So, just to understand this better, so the IP realization per patient in India last two years it's up only 9%, not sure if my numbers are correct and my understanding is that you are trying to minimize some of your assets by you know changing the ward threads into single room and other things, so I have expected slightly better you know although the ARPOB is better, but that is also largely driven by outpatient gets you know calculated in the ARPOB as well, but if I just look at the inpatient realization that has not increased that much despite the feminization effort that we would have undertaken, so please help me understand that little bit better?

Mr. R. Venkatesh: So, short answer is, it takes time. The long answer Dr. Rupert can talk about the challenges in increasing the per patient realization.

Dr. Emmanuel Rupert: Again, it depends upon the kind of procedures that we do and the complexities of the procedure so we do need to keep a work on the margins because some of this is extremely high catenary work do have a little bit on the higher side on the medicine consumables pattern, but that is something which when I mentioned upon the clinical pathways, these are some of the things that we look to standardize across the network to keep this under a very tight control and this is not something that from an administrative point of view we drive, but we have key clinicians and the mentors who drive the pathways to keep these things under complete control and the tech enables us to keep and seeing which are the outliers and from a clinical standpoint and see whether these things are justifiable or not so that we are able to keep this under close track.

Dr. Anesh Shetty: But price wise we always aimed to be the most competitive priced in the marketplace, so our you know realization for patient what they end up paying in our place will not grow in line with what everyone else is able to do because we just want to maintain our mass market appeal.

Mr. Dheeresh Pathak: But is that a fair impression that I have that you wanted to premiumize by changing the bed configurations and all those things, so that mix effect that should show up right despite you not taking price increase on like to like basis let's say for the general ward patient.

Dr. Anesh Shetty: Correct, but that takes time and it's not that we converted all the hospitals into only private rooms and even in the hospitals it's just a couple of wards that were reconfigured to meet the existing patient demand where we had not much demand

for the general wards and more demand for the semi-private and private. So, we're not going too far ahead of what the market is telling us they want to be treated and yes to very much a place where people struggle to meet their expenses where they sell assets to pay for healthcare and so yes we can pad up our numbers by going all private and refusing care to everyone else and you can get away with that for a short time, but you want to build something that lasts for a century, you have to give the customers what they're willing to pay for and make them very happy for it.

Mr. Dheeresh Pathak: So, because the number that I have not been restated for the change in the you know methodology that you would have done for ARPP and discharges, so can you just help us understand that over the kind of pre-COVID period let's say FY19 what kind of CAGR or how much higher are we in terms of IP discharge because the number that I'm seeing they're still lower, but you're saying that you earlier to my question you said that there's a change in methodology in the way you calculate.

Dr. Anesh Shetty: Yeah, it's hard for us to reconcile the sets of numbers because we were on an older system, we haven't moved to all the billing systems to our Atma yet. So, it's tough for us to do a pre-analysis to what it was post-COVID. Once we get caught up

Mr. Dheeresh Pathak: When did you change this methodology of measuring this?

Dr. Anesh Shetty: Over 2019 to 2020. Now, Atma itself has been ongoing since 2018, but there are certain modules that were put in, but that's not an excuse. I would say that the larger issue is that every year there's a moderate increase in the per patient realization, but the larger increase is due to volumes, thruput, discharges, and looking at the case mix. So, it's not just the plain price increase that leads to the year-on-year revenue or margin increase for us.

Mr. Dheeresh Pathak: So, that I understood, but I'm seeing the throughput increase I'm not able to see it, because the numbers tell me that it is still lower?

Dr. Anesh Shetty: Yeah, that's the problem yeah because they're on different - the numbers are different in that the previous one was counting everything, so the baseline is there, so what will give you clear numbers is from 2021 onwards, but of course 2021 would have been a COVID year.

Mr. Dheeresh Pathak: But how much are the understated current IP discharges number just

Dr. Anesh Shetty: Yeah, it's not been understated or anything, it's just that it's a very different methodology of calculation.

Mr. Dheeresh Pathak: Yeah, yeah, okay. So, that we don't have, okay. So, next question is this Greenfield

CapEx which you're saying land in Calcutta, this would be I think if I understand correctly after many years that you are buying land for a hospital, so probably the last one would have been in Gurgaon, I think if I understand correctly, so what have you like you know internally at what IRR, whatever payback, whatever measure that you have used how you under return this CapEx Greenfield land?

Dr. Anesh Shetty: Sorry, can you just say the last part of your question again?

Mr. Dheeresh Pathak: So, as per my understanding this will be after many years for a Greenfield hospital, so in internally when you're underwriting this CapEx what measures have you know what is the hurdle rate that you have taken?

Dr. Anesh Shetty: All our investments go between a 16% to 18% hurdle rate and of course a lot of this is excel fiction, but this was after exhausting all options, so going for Greenfield either acquisition or doing construction wasn't our first port of call. We looked at adding something to the existing structure, but that meant demolishing an existing building, we looked at finding something nearby that was not available to us, so this is after exhausting all the other things. So, it definitely returns do come on the lower end given that on a 10-year horizon, the returns won't manifest themselves as well it will be more back ended from there, but we feel more confident about making this investment in Calcutta because it houses our flagship asset, we can leverage a lot of the existing clinical manpower and not have to double invest in a lot of that and we have a tremendous brand and patient flow that we can leverage for this. So, we're confident about making this investment, but it definitely will be just like in Cayman margin dilutive it will cause you know huge amount of upfront investments in the manpower and running expenses over there, which will dilute our numbers for a bit, but it will still take time. This construction is 2½ to 3-year project, so we have time for that to just.

Mr. Dheeresh Pathak: One last question, is their FSI available in Bangalore and Calcutta understand is not, but is there FSI available apart from reconfiguration, is there actual FSI available for you our existing assets?

Dr. Anesh Shetty: Yeah, in the Health City in Bangalore, there is, I mean we can add as much as we want, we're on the absolute outskirts of the city, there's a lot of land available that we won't have a problem. In Bangalore, we're adding an expansion to our cardiac building, we're adding an OPD Plaza, we're adding a park near and we'll eventually add an inpatient area as well and that will come up in phases over the next five years.

Mr. Dheeresh Pathak: Okay, so in Bangalore when you expand you don't have to invest in land, it's only in

Calcutta that you have to invest in land?

Dr. Anesh Shetty: We may need to invest a little bit of land, but it doesn't come at a significant of cost as it would be in Calcutta.

Mr. Dheeresh Pathak: Okay. Thank you.

Dr. Anesh Shetty: Any other questions?

Mr. Nishant Singh: Yeah, we have Madhu Gupta on line.

Ms. Madhu Gupta: Thanks for taking my question. I have a question regarding the Jammu facility which has turned around and has reported very good margins in FY23. So, what was the kind of I mean what is the growth trajectory going ahead do you foresee any growth potential over there or it's going to remain at the same level?

Dr. Anesh Shetty: The Jammu Hospital is more of a management contract that we run on behalf of the Mata Vaishno Devi Shrine Board, just for purposes of the way in which it's structured, it comes on our balance sheet, but we don't take any money, we don't make any money off it. It is something that's part of our *seva* to the government over there. So, it'll do well you know those numbers show up on our balance sheet, but it doesn't come at any margin and going forward we would also like to move away from the current system, which is as a limited company and move towards putting this into a trust because the Shrine Board has its own ambition, they want to create a Medical College, they want to take this to another level, and we're just there as management support to help them you know achieve that vision.

Mr. Nishant Singh: Dheeresh, do you still have any questions?

Mr. Dheeresh Pathak: No, sorry. Sorry, I don't have questions.

Mr. Nishant Singh: Yeah, so if we don't have any further questions, we would like to conclude this session.

Dr. Anesh Shetty: Any further questions?

Mr. Nishant Singh: No. So, thank you everyone for your active participation as always. Please do feel free to reach out to us in case of any follow-on queries that you might have and thank you all once again.

End of Transcript