"Narayana Hrudayalaya Limited Q1 FY20 Earnings Conference Call"

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Moderator: Ladies and gentlemen, good day and welcome to the Narayana Hrudayalaya Limited Q1 FY20 Earnings Conference Call. As a reminder, all participant lines will be in the listen-only mode. And there will be an opportunity for you to ask questions after the presentation concludes. Should you need assistance during the conference, please signal an operator by pressing '*' and then '0' on your touchtone telephone. Please note that this conference is being recorded. I now hand the conference over to Mr. Debangshu Sarkar. Thank you and over to you, sir.

Debangshu Sarkar: Thanks, Raymond. Good afternoon, ladies and gentlemen. Myself, Debangshu, and I run the Investor Relations and mergers and acquisition practices at Narayana Hrudayalaya. On behalf of the company, I welcome you all to our Q1 FY20 earnings call of the company.

To discuss our business and financial performance, outlook and to address your queries today, we have with us Dr. Emmanuel Rupert, our CEO and MD; Mr. Viren Shetty, our COO; Mr. Kesavan Venugopalan, our CFO; alongside Ashish Sukhija from the team.

I am sure you have gone through the investor collaterals, which have been uploaded on our website as well as on the stock exchanges. Before we proceed with this call, I would like to remind everyone that the call is being recorded and the transcript of the same shall be made available on our website. I would also like to remind you that everything that has been 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 the uncertainties and the risks that they face. These uncertainties and risks are included, but not limited to what we have already mentioned in our prospectus filed with SEBI and subsequent annual reports on our website.

After the end of this call, in case you have any further questions, do feel free to get in touch with us. With that, I would now like to hand over the call to Dr. Rupert.

Emmanuel Rupert: Building upon the momentum generated during the last fiscal, we are pleased to deliver 19.2% YoY growth in our consolidated revenues. Our India operations, continuing its growth trajectory, registered 15.8% YoY increase in revenues in Q1 FY20 as against 14.3% in Q4 FY19 and 10.7% in Q1 FY19.

The three newer centres at Mumbai and Delhi NCR are progressing well along the growth trajectory. As mentioned earlier that we are creating a Centre of Excellence for organ transplants program in Delhi NCR, Mumbai regions and we believe that the strategy is paying off well with SRCC, Mumbai having done 9 Bone Marrow Transplants (BMT) and the Gurugram unit having performed 8 liver transplants during the quarter. The ramp-up across these new facilities will set the stage for your company's growth trajectory in years to come. Other hospitals (excluding 3 flagship centres, Jammu and 3 new facilities) posted a robust uptick in their revenues with 18% YoY growth.

As you are aware, starting 1st April 2019, the financial results have been prepared as per the new accounting treatment for leases, IND AS 116. This resulted in INR 82.3 mn increase in EBITDA and decrease of INR 19.9 mn in PAT for Q1 FY 20 on a like-to-like basis (pre-IND AS 116).

You would be happy to note that our consolidated EBITDA more than doubled on YoY basis and grew by 11.2% QoQ in Q1 FY20. Adjusted for the losses of the three newer units across Delhi NCR and Mumbai, Indian operations posted an EBITDA margin of 16.4% during Q1 FY20 as against adjusted EBITDA margin of 11.8% in Q1 FY19 and 14.4% in Q4 FY19. Led ably by the three flagship facilities at Health City, Bengaluru and RTIICS, Kolkata, our matured set continues to deliver healthy EBITDAR margins at 23.3% for the quarter. Our facilities at Ahmedabad, Jamshedpur and Guwahati continue to move up the growth trajectory showing quarter-on-quarter improvement with the units combined together having registered an EBITDAR margin of 8.2% in Q1 FY20 as against being in the red in the corresponding period of the last year.

Moving on, our overseas operations at Cayman Islands posted YoY revenue growth of 39.4% in Q1 FY20 resulting into EBITDA margin of 22.3% sustaining the momentum generated over the last few quarters.

On the operational front, strategy formulated around attracting international patients to our newer hospitals at Delhi NCR and Mumbai is paying us the dividends with contribution of international patients to India business at 11%. Our focus on delivering high-end quaternary care, evolving case-mix along with increased share of international patients and reducing the average length of stay (ALOS) of patients has resulted in 12.5% annual increase in the ARPOB for the Indian operations.

Some of the key clinical highlights for the period are:

- Narayana Institute of Cardiac Sciences, Bengaluru successfully performed the world's first Patent Ductus Arteriosus (PDA) stenting and southern region's first thoracopagus surgery on a conjoined-twin with a single heart
- In a rare case, a 70-year-old patient suffering from a condition called medial sided knee degeneration was treated through unicondylar knee replacement at Narayana Superspecialty Hospital, Gurugram
- SRCC Children's Hospital, Mumbai performed 9 Bone Marrow Transplants (BMT) and Narayana Superspecialty Hospital, Gurugram successfully performed 8 liver transplants during the quarter
- A sickle cell patient having atrophic muscles, fixed joints in a contracted position and thus being bed-ridden for 11 years was successfully treated at Dharamshila Narayana Superspecialty Hospital, Delhi

- Mazumdar Shaw Medical Centre, Bengaluru successfully performed 7 adult liver transplants during the quarter, the highest number ever achieved by the unit in a quarter

Looking ahead, we continue to focus on further optimization of our operations across the network to maximize value for all stakeholders. With patient well-being at its core, we are committed to driving excellence across the clinical spectrum and continue to invest resources to reinforce our reputation to deliver quality affordable healthcare to all sections of society.

Debangshu Sarkar: Raymond, you can open up the question-and-answer session to all.

Moderator: Yes, sure. Thank you very much. We will now begin with the question-and-answer session. The first question is from the line of Harith Ahmed from Spark Capital. Please go ahead

Harith Ahmed: My first question is on the heart centers. It appears that we have done well this quarter; the margins are at 16% compared to 10% last year. And on a QoQ basis as well, we have seen a sharp improvement. Can you help us explain what is driving this improvement? And is this a new sustainable level at 16% margins for the segment? Whereas, I also noticed that there is some decline in the revenues for the segment, so can you explain that as well?

Viren Shetty: Yes. So, on the heart centers we have been able to increase the pricing gradually. These are mostly cardiology-focused centers and run basic cardiac procedures. Overall, we have not been expanding our heart centers, and we are looking at rationalizing a couple of them. We are close to exiting one in East India, Durgapur. But as long as we continue to have it, we will try and rationalize the operations, reduce the costs there, try and bring in the doctors from the main center and use the center for referral calling, but a lot of it is driven through tariff increase.

Harith Ahmed: So, these margin levels are sustainable, and we can assume this going forward?

Viren Shetty: Yes. Generally, the complexity of cases can go up as the doctors get more experience, they can put higher quality stents. But as it is, heart centers are in other people's hospitals, we don't have a lot of control over the sort of patients that come in. And the infrastructure is really not under our control. So, these are driven a lot for acting as a funnel for our patients. So, it will level off at some point where the high-value patients have actually been diverted to our larger hospitals.

Harith Ahmed: Okay. And on the new hospitals, you have given a revenue of Rs. 57 crores and EBITDA loss of around Rs. 17 crores, can you give a breakup of these units, each of the three new hospitals? We had those in the presentations till last quarter.

Debangshu Sarkar: Harith, the idea out there was to help you out with setting up the initial base case with all these hospitals individually, given that these were all new hospitals. As a practice, otherwise, we don't provide hospital-wise data. If there are any specific queries towards any particular

hospital, we can address that. But going forward, we will revert to our original bucket theory for hospitals wide information and we will continue to report it in the manner that you see in this deck.

Harith Ahmed: All right. But qualitatively, can you give some color on what is happening at each of these centers, the EBITDA number? The EBITDA loss figure seems to be flat on a QoQ basis whether there is an improvement in top-line. So, can you talk a bit about what exactly you are doing at these centers?

Viren Shetty: Yes, clinically we are adding more talent in all the three centers with focus on niche specialties and we are seeing a very good traction in the transplant department. We are seeing a good traction in that along with the oncology program which has started in Gurugram as well as we are seeing increased growth in the onco sector in the other units as well. The BMT programs are doing very well in Mumbai and Dharamshila facilities. So, we are focusing more on that, and the international patients are also gradually increasing in all the three units. We don't expect the EBITDA losses to come down significantly as the volumes ramp up, because we will ultimately be adding in a lot more cost as the new department gets set up, because doctors get these large payouts. But as mentioned in the previous conversations that once we reach a maturity cycle within three, four years, that's when the revenue growth will exceed that limit. And then we will come to normal losses and then start generating returns.

Debangshu Sarkar: Just to underline one particular thing, Harith, on this. We have commissioned our radiation oncology unit in the last quarter at Gurugram, which has meant that, like Viren was mentioning, we have onboarded certain resources and investment towards the clinical staff for that, which has impacted our EBITDA over there and shall continue for some time. The revenues from the service will be back-ended. So, without that, like-to-like, you probably would have seen some bit of improvement in EBITDA. But given, as Viren was saying, we will be commissioning slowly and steadily other departments, so this kind trend going forward shall continue.

Harith Ahmed: One additional question there. When you said you will be taking on more costs at these hospitals, what exactly are these costs going to be for, hiring new specialties or doctors? I mean, I was under the impression that we have almost set up almost all the necessary departments and the key doctors have been recruited. So, can you give more color on what exactly these costs are?

Viren Shetty: Yes, manpower costs, primarily. So, we started out with radiation therapy, but then we have to have physicists and very high-end consultants. And as the volume picks up, you need to hire additional consultants. So, for all the specialty areas, for Gurugram, especially, we have hired all the specialists that we have, except for radiation oncology, and that's what we added, it won't be that significant, but it definitely will be a negative for that hospital for profitability perspective. In Dharamshila and SRCC, more or less everyone has been added. But this is

primarily driven by Gurugram. And Gurugram, as you know, is a very high-cost location also so the salary is also on the higher side and with surgical oncology we are going with the model which is very similar to the Tata Memorial, having a region (body organ)-specific consultant. So, we are not going by one generalist surgical oncologist who does the onco program from the head to toe. We are going to have a region specific people who are very specialized in their sub areas of work. So, that will add up to the structure there and have more manpower.

Harit Ahmed: Okay. And last one from my side. On the Eastern Peripheral Cluster, we see a strong growth of 28% and margins have also picked up sharply, now at 10%. We reported, I think, 4% last year. So, can you talk a bit about the trends here? And how much more we can expect out of these couple of assets?

Viren Shetty: Yes. These refer primarily to Jamshedpur and Guwahati. These are two hospitals, which, infrastructure wise aren't much. The performance is quite good, I mean, in these places the footfalls, occupancy, we are quite happy with. It's just that these are very low ARPOB regions. And so for these two, for us it's always on a wait-and-watch, which is as long as the trends are good we will keep running there, but should anything serious happens, we would have to take a call on that.

Moderator: Thank you. The next question is from the line of Nitin Agarwal from IDFC. Please go ahead

Nitin Agarwal: Viren, in the annual report there is a lot of reference towards our digital strategies and investments that you are making towards there. So, two questions, A, what is the extent of investments you are making towards, any quantum that you can share? And B, strategically, in your assessment what are they due to the business, in terms of what implications it would have for the business in terms of the big digital strategies that we have been talking about here?

Viren Shetty: In terms of quantum it's not a huge amount, I mean the kind of spending within IT is not like making Uber or any of those Flipkart type companies. Essentially, what these are, are digital tools for our managers, our clinical administrators, our doctors. So, one of the big things we are doing is revamping our HIS (Hospital Information System). This is basically the platform for our EMR (Electronic Medical Records), our billing software, our supply chain software. So, what this is, if we get a good and stable platform, transactions become faster, error comes down, and we are able to have a lot more granular level tracking. So, for example, right now we have a lot of people doing the billing. With a much more intuitive software, we can reduce the manpower over there. The other one is, we do a lot of refunds and errors as part of the discharge, because the old software is riddled with a lot of bugs. That can come down. So, first we will see an uptick of a little bit on our realization. So, these are software that we do to get minor, minor tweaks here and there. But having said that, long-term, obviously, the software that we develop is built with the idea that this is fully scalable and at some point we might spin it off into product that other hospitals could make use of. And so while it's not anything we are talking about now and it's not significant, but as and when it stabilizes, which we expect

around two years, it's something we would start exploring. But even without that, the need for us to build a software was apparent, because just running our business with old software was proving to be next to impossible.

The other things that we are doing is on the analytics. In analytics, that we haven't invested a lot of money, it's just off-the-shelf software. I am sure you are familiar with tools like Power BI (Business Intelligence), Tableau and so on. This, we are utilizing for our doctors and for all our decision-makers in the hospital, which will pull out the data from the HIS and present it real-time to all the people who need to make decision. So, a doctor, for example, he will get to judge how good his consumption is, he will get to judge how the patient mortality is. Whereas for a hospital administrator, let's say, he can measure ALOS, he can measure how many people we are being giving discounts. We even implemented at the front line, so we have this thing called a Co-tracker. So, when patients come and they are bargaining with the front-office staff for some discount on the bill, the Co-tracker actually does, based on the risk assessment, it can tell how much actually we should be able to discount the price. So, it gives it a lot more of quantitative and not a very subjective payout.

So, these are things that are all part of the efficiency improvements that we have seen actually pay for themselves many times over. Just through the fact that we haven't added any more beds in the past 1.5 years. And even going forward for the next year, at least, we won't be adding significantly more beds. But to be able to continue delivering the revenue growth, these are the sort of efficient improvements we are relying on our software to deliver.

Debangshu Sarkar: Just to add on to what Viren said, and I am probably utilizing this opportunity to provide some guidance. A good portion of the investment that we have been making in our digitization efforts were actually capitalized till the last quarter, i.e. June 30th. Starting 1st of July, a portion of that will now get expensed for the rest of the period, and so that could be a new expense item that would appear in our P&L going forward.

Nitin Agarwal: Just following upon Viren, there was also at a high-level basis, the management commentary in the report alludes to the fact that we are sort of deprioritizing our intent to add beds, or to become like a bed-intense, to measure the success by the number of beds that we have. I mean, what is the thought process there? Incrementally, how does it change in terms of how we are looking to grow the business over the next five years?

Viren Shetty: Sure. See, it's not to say that we are going to stop adding beds, I think it's more of a shift of priorities. Dr. Shetty made a statement back when we were still a private company, he said I want to build 30,000 beds. Why 30,000 beds? Because the largest hospital group at the time, had around 30,000 beds. So, he said that's the goal we should achieve. But just adding more and more beds, it's like buying your revenue, right? When we do an acquisition, we just keep adding more capacity, given the nature of the return on capital being as low as it is, we just felt this wasn't the most adequate use of our resources. So, we found it to be a lot more efficient

that we take the existing beds that we have, we mine the data for all the patients that have visited us over the past 20 years, and those are the patients we can go back and say, look, you came to us 10 years back and we treated your condition, but is there anything else that we can help you with. So, these are the simpler ways we can leverage our existing infrastructure to drive growth. The bed addition what we get will be more additive, which is to say that when our hospital bed gets full, then we will add a wing there, or if we were to add onco centers to the existing infrastructure. So, now at least, that's the sort of role we feel more comfortable doing. But not to say that tomorrow, we are going to transition to like Uber, a completely fully asset-light digital model, because honestly they don't work. It doesn't work in the sense that the effort to deal with patients digitally. For us, we treat it just as a funnel. By itself, it's not a very profitable business. And there are a lot of startups that are trying to build those sorts of businesses. Well as for us, if we are able to connect with the patient, if we are able to treat his diabetes remotely, eventually, his kidney is going to fail. And the person who has been treating him will be in the best position to do the kidney transplant. As if a person has heart failure, and we just have to be on the phone with them once a week or once a month, and then generally give him advise on the app that we have made.

Nitin Agarwal: That's helpful. And if I can squeeze one more. In terms of future, if you take again a next two, three year view, are there any geographies or regions where you would incrementally be adding capacity, bed adding capacity to newer units? Are there spaces that you probably strategically would be targeting?

Viren Shetty: Well, that’s always a challenging question. I think we can definitively say, in a three year period it wouldn't be in any of the Tier 2 locations, and it would not be in any location where we do not already have a strong presence. The places that, reasonably we can say that we would add the infrastructures, the ones where our existing infrastructure is at the sort of breaking point, which is Kolkata. So, Kolkata is one place we already disclosed we will be adding some capacity in our Howrah Hospital. We really need to look for options for Rabindranath Tagore Hospital. So, anything around those areas, we will definitely need to add capacity there. Bangalore, actually, our Health City does have enough infrastructure, we are not too stressed over there. And Delhi, these are still new infrastructure, we really don't need to add. In Mumbai, if we were to add infrastructure, it would come from the trust. We don't need to actually spend on adding that. So, once we hit that sort of big occupancy, it may take a maybe a little more than two years, but roughly around that time. Then the trust would be adding the infrastructure for us. So, it wouldn't be an expenditure for us. The other one is in our Caribbean operations. There, we wouldn't add infrastructure, there's enough infrastructure on the respective islands. What we would just do there, go there and sign contracts with these governments to run the hospitals. So, we wouldn't, again, want to deploy a lot of capital towards doing that.

Moderator: Thank you. The next question is from the line of Charulatta Gaidhani from Dalal & Broacha. Please go ahead

Charulatta Gaidhani: My query was regarding, there is almost a 20% volume growth in India. What is driving this growth?

Viren Shetty: This growth is due to oncology that is pushing the volume growth there. And you will see in onco space, a lot of them can be done as day care work, mainly because it's the radiation and the medical oncology as far as the chemo and immunotherapy and all are done as a day-care or a short-stay work, that reduces the ALOS.

Charulatta Gaidhani: Okay. And this addition has been in which hospitals?

Viren Shetty: Apart from our well-established flagships three hospitals, it's also working well in some of our units in the East and West. So, Ahmedabad, Raipur, Jamshedpur, Guwahati, all these units will grow.

Debangshu Sarkar: Charu, just to highlight what everyone's noticed out there. And you rightly brought it out that there has been almost 20% increase in our discharges for this quarter year-on-year. But if we had gone by the previous convention of using occupied beds or occupancy as a parameter, you would have noticed that this 19% increase in discharges would have been completely wiped out by almost similar decrease in ALOS. And as far occupancy or occupied beds is concerned, it would have led to almost a flattish or a 1% growth. So, this just reinforces one of the points that probably Nitin was also trying to ask in terms of the redundancy of beds in terms of as a parameter or a criterion to track.

Moderator: We move to the next question. The next question is from the line of Sameer Baisiwala from Morgan Stanley. Please go ahead

Sameer Baisiwala: So, first question is on ARPOB. It's a pretty significant improvement and probably the first time that on a group-wide basis you are making to double digits, Rs. 10 million. So, are there any one-offs or do you think this is going to be sustainable going forward?

Viren Shetty: We strongly believe this will sustain going forward. We have been saying that we have been making a lot of investments in really niche-focused specialties, getting the manpower we are able to do procedure in our hospitals that can't be done anywhere else. These all come at a very high realization. Other things, a lot of investments that we have made in process engineering and our software is paying off. So, we are better able to segregate the patients. The other thing we are doing is we are doing a lot more control over the schemes business. We are controlling the volumes of bed that we allocate towards government schemes. Another thing that's driving it is the new hospitals that we have in the tier 2 markets, as their results improve their ARPOB's improve there. And finally, international business, that is something that continues to grow since we moved into Delhi and Mumbai, which are the two most international-heavy markets in the country, there naturally the pricing is different, and we are able to get a good ARPOB.

Sameer Baisiwala: Yes. Great. Viren, when I look at your slide #5, which is specialty profile. At least on QoQ basis my guess is, on a YoY basis that profile doesn't change much. So, is it that within the same profile, you are doing more complicated cases?

Viren Shetty: Yes. So, the base specialty profile itself won't change. What happens is, within cardiac, let's say, so patients that comes with heart failure can be managed medically. And so for that instance, you will see him, you will give a few medicines, and then he will go up. But if you are able to target them with our software and run the test through a simple algorithm, it says, okay, this could be a good candidate for heart transplant. Then we are more actively alerted to the fact that this patient who came to us, while he can be medically managed, maybe we should present him with the option for getting enrolled in our heart transplant list. And so if he opts for that, he still counts for only one patient, I haven't turned one patient into two. But that one patient, if he is able to get converted, we will give a much higher yield. So, once we do that, we put them on a multi-disciplinary team, so that they evaluate and give the options of advanced therapies, which is available for a certain disease pattern. And then it goes forward in that direction. So, we are able to give the clinical team a different kind of an input, and they are able to act upon that. And we are working on this with the EMR team and the clinical data and the clinical analytical teams that we are constantly looking at various ways of different specialties of identifying patients right across the entire network. This is a work in progress, we have taken small steps forward, and we are refining it on a day-to-day basis.

Debangshu Sarkar: Sameer, just to clarify, I think we did not share the Q4, that is last quarter's ARPOB. We had shared the full fiscal year FY19's ARPOB, which is, as a point of reference, possibly, you are using as a benchmark to say that our ARPOB has risen dramatically. Our Q4 ARPOB was actually very close to the ARPOB that you see for Q1 out here. So, it's just that we are able to sustain that and continue to build upon that. Thus, it's not a one-off kind of a case that has happened only in this quarter that you are noticing.

Sameer Baisiwala: Okay. Thanks for this clarification. And just on this ARPOB, I am on slide #9, versus the new three hospitals having 12.4 mn ARPOB and for the existing 9.4 mn, it looks like they are counterintuitive, isn't it, I mean the new hospitals would be much lower, and then as time progresses it gets a better one, no?

Viren Shetty: Sameer, I mean the three hospitals in the new bucket are, firstly, they are lot of onco-focused hospital. Then one is in Gurugram, which is the highest ARPOB place actually in the whole country. And the other is are in Delhi, which also has a much higher ARPOB than the average. And Mumbai also, even South Mumbai, we try to make it as affordable, but affordable by South Mumbai standards for a hospital that are doing very high-end pediatric work. Whereas the existing hospital is averaged out by hospitals which do a lot of scheme, the hospitals in Mysore, Shimoga, Raipur, Jamshedpur, those sorts of places. So, it has sort of an averaging effect.

Sameer Baisiwala: Okay. I would have thought it's even higher for Bangalore, which is not part of these smaller cities.

Debangshu Sarkar: No, I mean just on that itself, like-to-like, the realization as Viren was mentioning, for a procedure in Gurugram would be much higher than even, let's say, Mazumdar Shaw at Bangalore, or for that matter even Rabindranath Tagore at Kolkata. I mean NCR as a region and within that Gurgaon as a specific location, has probably the highest ARPOB of all the regions or centers or cities in the country. So, that's just a reflection of the same.

Sameer Baisiwala: I see. So, for the same procedures as stent, or whatever, as a high-volume benchmark or onco, it would be at a significant premium in the pricing, right, that's what you are saying?

Debangshu Sarkar: Sameer, for any new unit, let's say, for Gurugram today, the ARPOB is very high and it settles down in some bit of time, because your OP to IP conversion is lower in the initial phase. And, by the nature of it, the OP procedures' ARPOB is infinite. So, as less proportion of it, relatively speaking, get converted into IP, the ARPOBs are higher than normal and eventually settles down lower over a period of time. You would have observed the same trend, let's say, at Cayman Island operations some time back. Though this time around, there is an exception on that account, I admit, and HCCI has actually seen an uptick in ARPOB. But you would have seen that progressively over the first three years, ARPOB of Cayman Island operations settled down from high ARPOB (low OP to IP conversion) to stable ARPOB (once hospital stabilizes with improved OP to IP conversion).

Sameer Baisiwala: Okay. That is very helpful, Debangshu. And just one final question, with your permission. For the two largest buckets that was Bangalore and Kolkata, which is 58% of total revenues, what is the outlook going forward?

Debangshu Sarkar: We would say is that Health City, which is Mazumdar Shaw and NICS in Bangalore still has room to grow. We have enough infrastructure capacity, so there wouldn't be any restriction on the sort of growth in either the revenue or the EBITDA over there. RTIICS, on the other hand, has capacity constraint. So, there we are trying to do a little bit of reshuffling of departments moving some out. We are desperately looking for some space over there.

Moderator: Thank you. The next question is from the line of Tanush Mehta of Dalal & Broacha. Please go ahead

Tanush Mehta: Yes. Sir, my basic understanding was that from the earlier questions that were taken by you that this growth is kind of the sustainable and now since we are shifting our focus towards operational efficiency in the last two, three quarters. We had a PAT positive, and we are showing tremendous growth. So, the revenue, the share of treatment that is your gastro or onco and all, can see the same profitability jump every quarter?

Viren Shetty: I would say, maybe only in oncology you will see that kind of growth, because it's a growing field and barring the sort of one-off things that happen, such as price control which happened, we feel that onco is the one field that will deliver a continuous growth. Cardiac, nephro, neuro are more matured fields, there isn't that much going on with them. But essentially, our ability to do very advanced work in that keeps going up as we mature. So, once the hospital reaches maturity, they can start doing transplants, they can do robotic surgeries, mini-invasive surgery, they can start doing onco surgeries in that specific department.

So, I would say that, yes, the headroom for growth does exist, but a lot depends on the maturity of the hospital, and how much we are able to invest in that place, both in terms of infrastructure as well as getting the best clinical team there. So, places that do not shape up, if a unit is either constrained in infrastructure or if the location aren't good and we are not able to attract world-class talent there, then we have to take a call on that.

Tanush Mehta: It requires more of infrastructure development from your point of view because different hospitals at different locations and different ARPOBs and different segment specifically?

Viren Shetty: So, yes, you are right. So, for example, places like Jaipur and Delhi you may have the same profile of disease burden. But if you are trying to attract someone who is an excellent surgeon for heart transplant or a very advanced onco surgeon or a radiotherapist, obviously, these people would prefer to be in Delhi. It's not that the demand wouldn't be there in Jaipur, it absolutely will, and in Jaipur we will start making those investments. It's just that it will happen in Delhi first. And that's where we would focus on it, because our ability to attract talent and also find the right number of patients who can pay for it is much better in certain geographies than others. But it doesn't mean that the need is not there. As the economy improves, as paying capacity goes up and even the smaller towns can start seeing the sort of yield that the larger towns would have. For now, at least, we will be mostly restricted to our large centers in the big towns.

Tanush Mehta: Okay. And the last question. Overall, if you go to see the ARPOB slowly, slowly, earlier like a few quarters back we had hospitals that were in mature hospitals, and now we will be seeing any one of the hospitals coming into the existing one as compared to the new one? As in, coming into the existing bucket instead of the new bucket? Right now we have three hospitals in our new hospitals and 17 in the existing. So, by what time any of our new would shift into the existing one?

Debangshu Sarkar: Tanush, I guess your question is two folds, one is, previously there were other buckets like 3-5 yr, which you would understand had gotten merged into the existing bucket, given that those hospitals have completed 5 years of operation. The 3 new hospitals, as we have been very clearly outlining all this while, I mean, you have the timelines for all the three hospitals separately, Gurugram has just completed 15 months, Dharamshila, we took over almost two

years back and similarly, SRCC operations are just over two years. All the other hospitals that you see in the existing buckets are all greater than five years' vintage of operation.

Moderator: Thank you. The next question is from the line of Nitin Agarwal from IDFC. Please go ahead

Nitin Agarwal: Viren, any thoughts on the Caribbean operation? I mean, how should we look at this business going forward? In a sense, what is the current occupancy level at this hospital? And then is there enough scope to grow this particular unit there for the primary driver for growth, as you mentioned, is just going to be just probably opportunities in sort of the more Caribbean islands?

Viren Shetty: Yes. Room for growth is definitely there, we were 36 occupied beds in the last quarter with 95 census beds available currently which is less than 40% occupancy. This is primarily driven by daycare. Unfortunately, we built this hospital as per Indian specification. We didn't westernize the design enough. And from our understanding now, in western hospital, the amount of daycare procedures, consulting rooms and the walk-in, walk-outs sort of visits vastly outnumbers the inpatients. Whereas, we built it based on the model where people get all those basic things done somewhere else, and they come to us for procedures.

We are adding our oncology unit over there. We have got planning permission, and we are identifying the contractors and the architect for that. The constructions, we should start in about two months' time. Oncology, we believe will be a huge driver for this, and take it even beyond the sort of performance that it has because of the huge cancer burden on the island. And the other big thing is the massive discrepancy that exists between the cost of treatment between what we are planning to offer and what is available to these patients in the US. So, we believe that the oncology investment that we make will be a huge driver there.

The other thing what we are doing is, other islands. We are not only focused on just Cayman Island itself. Our doctors are starting to see cases in Bahamas, we are in discussions with other governments in Trinidad and St. Lucia. So, there is infrastructure there, but it's like any government infrastructure in India. Someone came and built the hospital at some point, and now it's just lying empty or very underutilized. So, we are in talks with the government and might make an offer, under which we will send our doctors there. In one of the islands, for example, we have an onco physician who is posted there, full time. And whenever he lines up cases, whatever case needs be done, our orthopedic surgeons from HCCI will go there, operate and come back. And in time, once we get more confident in these countries and sort of the law gets worked out, we will take over those infrastructures. So, these are the couple of things that we are doing to drive the growth in the Caribbean.

Nitin Agarwal: Okay. Perfect. And secondly, you talked about the outlook for newer hospitals as well as the older ones, the more mature ones. I mean the middle bracket which is there, what has been

your experience in terms of the scale up that some of these hospitals have had over the last say, couple of years or so? I mean are you more optimistic on the prospects of hospitals?

Viren Shetty: There were few hospitals within that, Raipur in particular. So, that one really did well. And so we have been investing a lot in that. We have a very good clinical team. It's in a great location. Infrastructure is good. So, we are adding a lot more investment there. We have recently commissioned a large onco center. With the exception to that, the rest have not really been able to deliver the sort of performance that we expect. They are still doing very well. The success of Health City isn't just because Health City doctors are sitting in Bangalore and they are doing great things. A lot of it depends on the hard work put in by doctors in Shimoga, Bellary, Dharward, Kolar, Kuppam. While those guys are sitting there and struggling, what they are doing is getting the name out and giving people in far flung areas the taste of what it means to get treated at Narayana location. These guys may not do the full range of procedures, they may not be very profitable by themselves, but being there they are is important and assets for us, both in terms of brand as well as, I think, the company call it experience tools. Maybe that's not the right analogy. So, it's always a sort of tough question for us when we decide to pull out of a small hospital that's not doing well, because we always worry that we now measure the patient flow, so we know exactly how much each hospital is sending to the main hospital. So, worry is that it may start to impact the numbers of patients coming to the hub. If there is a place which is extremely hard to do business or if there are serious issues with the land, or infrastructure, the promoters, or we are not able to get clinical talent, those are the places we will always exit. I mean there, it becomes very obvious.

Nitin Agarwal: And lastly, there has been a significant amount of consolidation which was underway in this sector across the country. Have you seen it sort impact your business, positively, negatively in any ways, are you seeing any signs of it?

Viren Shetty: Impact on our business? I wouldn't say. Yes, you are right. See, in terms of moving money from left bucket or right. What will start to happen, we feel, is that the ones that are just not able to get acquired will start to close down. Once that happens, that will suck-up a little bit of capacity from the market, and that should then have a good rationalizing effect on prices as well as the salary expectations. So, that is something we expect to happen as things start to get a little tougher, both in economy as well as in the health sector.

Nitin Agarwal: And on this salary cost, do you see any impact of it? What is that inflation trend that you have seen with doctor costs in the previous year, in general, have you seen some softening on that aspect over the last few this quarter?

Viren Shetty: Yes. Not really. It gets worse, actually. The thing is also, there is a lot of action from government on increasing minimum wage, which really devastates the private sector. But anyway, so what it does is create a sort of pressure on salary. I would say the salaries really haven't gone down, but at least once we have invested in new tools, we are able to hold our

doctors and the people who work with us a lot more accountable. And that is something, at least, we have a distinct advantage compared to a lot of the other hospitals. So, that value rationalization, it should happen. But a lot of things are happening on the policy front, something Dr. Shetty works on quite a lot, on increasing the overall pool of doctors. So, that, being there, I would say, in five to seven-year scenario, once all these doctors start to graduate, then it should come down a lot more. But for the next couple of years, I would say, not really.

Moderator: Thank you. The next question is from the line of Aadesh Mehta from AMBIT Capital. Please go ahead

Aadesh Mehta: So, I just wanted to know, you are talking a lot about upgrading the kind of procedures you offer in your hospitals, like more transplants, more complex procedures. If I were to see your revenue mix, how much would these procedures be contributing currently versus say a year back?

Viren Shetty: We don't disclose that separately, but it is definitely a lot more. So, for example, while we were, I would say, five years back we were virtually doing no heart transplants across the network. Whereas now we do a few dozen. Yes, the sort of materiality of that is not something that we are reporting yet, but it's just to give you a sense of directionality. Because even if you don't do a lot of transplants, the fact that you can do it, it raises your profile. And so when a patient is there to choose, he will choose the hospital that's able to do the best, even if he doesn't need it. Because from the sort of consumer choice assumption, okay, if they can do that, that means they must be the best. So, even the sort of standard procedures starts to go up, and you are able to rationalize the pricing on that.

Aadesh Mehta: Right. So, it basically also helps build your brand apart from obviously getting you more money.

Viren Shetty: Yes.

Aadesh Mehta: Okay. And on this Cayman facility, we understand that we are also trying to scale up the oncology business over there. So, by what time should we expect onco starting to contribute revenues over there? And what could be your expected CAPEX?

Viren Shetty: It takes a little longer just there because in the Western world there is a lot more adherence to the standards and norms. So**,** in India it may have taken six months, over there it will be more like 8 to 10 months. Plus, you add like all the permissions and so on, so it will take like 12 months from when we start, which is two months from now. So, it won't be adding materially to that number. And we have onco services now but for radiotherapy, we do chemotherapy and we see some onco patients. So, the sort of ramp-up will happen very quickly after that because we start to prepare our waitlist for all these patients.

Aadesh Mehta: Okay. And the expected CAPEX?

Kesavan Venugopalan: So, I would say, overall, around $6 million to $8 million.

Aadesh Mehta: Okay. And last question from my side. Viren, you mentioned that Dr. Shetty is very much involved on the regulatory side, and there is a lot of action going on in increasing the overall pool of doctors. So, I just wanted your sense that in terms of number of specialists how should we see that evolving over the next five to eight years? If you can give some more color to it?

Viren Shetty: It will take a long time. See, just the statistics from our annual report. There are 100 diabetologists. 600 diabetologists have to treat 72 million diabetics in India. So, to get to the sort of optimal level, you need a 100x increase. But even so, with all the bill on NMC and with things that we are doing, we are still talking about maybe 20%, 30% year-on-year increase, which will take a long time to sort of reach the developed world numbers for the kind of doctors that we need. The other thing also is that, there is a tremendous shortfall in the number of professionals in the developed world, and a lot of them are aging out. And so what happens is that we need to actually be training twice the India requirement, because you have to assume that half of them will leave. And the only ones who don't leave are the ones who don't get absorbed by the US, UK, Japan, those sorts of places. So, we will start to face almost some kind of crisis situation, unless we do something, definitely to increase the number of doctors. So, that's why a lot of things are being done, we are investing in technology, we are trying to increase the reach of our doctors. Because without that then just having access to doctors would be like, you are the only provider of lithium or cobalt or some kind of a rare metal in the world because there's so little of that.

Moderator: Thank you. The next question is from the line of Tushar Sarda from Athena Investments. Please go ahead

Tushar Sarda: My question is, how do you ensure that the doctors' quality of treatment is uniform when you are managing so many hospitals, so many different specialties and doctors?

Viren Shetty: We have typically the hub-and-spoke model, and the level of the protocol, clinical protocols and evidence medicine is very standardized. The issues will come up only in tertiary and quaternary level care. And then once you are having a hub-and-spoke model with one of the leading clinicians acting as a mentor, who not only looks into it and reduce all the clinical work that is being done, then we have a much standardized way of doing that. We cannot exactly pinpoint and say, this is the only way to do things, and that does not work. But as long as the clinical pathway for standard treatments, and that is standardized across, then you are able to ensure that there is uniformity of care. And science also keeps on helping. So, what this clinical group actually does is, make sure that we are up-to-date as much as possible. So, we have the zonal clinical directors, and we also have the clinical governing councils which look into the clinical care and we measure outcomes. This is available to the mentors as well as the

clinical directors, and we make sure that in case there is any deviations from what is expected out of them, then there is a clinical group which addresses it on a case-to-case basis.

Moderator: That was the last question. I would now like to hand the conference back to the management team for closing comments.

Debangshu Sarkar: Thanks, Raymond. Thanks, everyone, for your active participation on the call. We acknowledge that this being a weekend, you guys took out special time for participating in our call. Should you guys have any further queries, do feel free to reach out to us, we would be trying our utmost to help you out in addressing the same. Thanks, once again, for your active participation.

Moderator: Thank you very much. On behalf of Narayana Hrudayalaya Limited, that concludes the conference. Thank you for joining us, ladies and gentlemen. You may now disconnect your lines.