“Narayana Hrudayalaya Limited Q2 FY20 Earnings Conference Call”

November 11, 2019

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Moderator: Ladies and gentlemen, good day and welcome to the Narayana Hrudayalaya Limited Q2 FY20 earnings conference call.

As a reminder, all participants' 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 call, please signal an operator by pressing '*' then '0' on your touch-tone phone. Please note that this conference is being recorded.

I now hand the conference over to Mr. Debangshu Sarkar. Thank you, and over to you.

Debangshu Sarkar: Good evening 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 Q2 & H1 FY20 earnings call of the company.

To discuss our business and financial performance, outlook, and to address all your queries today, we have with us Dr. Emmanuel Rupert – our CEO; 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 collateral which has 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 at a subsequent 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 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. Post the 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.

Dr. Emmanuel Rupert: After having delivered healthy results in the first quarter of the fiscal year 2020, we are pleased to say that the second quarter was no exception. We registered a consolidated YoY revenue growth of 15.6% during the second quarter. At India business level, increased patients' footfall across the network helped us register a revenue growth of 14% on YoY basis during the quarter gone by.

The three flagship facilities at Bangalore and Kolkata continue to show decent traction and reported a YoY revenue growth of over 10% in Q2 FY20. The three newer centres at Mumbai and Delhi NCR are progressing well with Gurugram facility having registered a healthy occupancy ramp-up while Dharamshila unit losses having reduced substantially. SRCC Children's Hospital, Mumbai completed 1,000 paediatric cardiac surgeries since its inception

strengthening facility's reputation as a top-notch medical destination for paediatric treatment. Other hospitals (excluding 3 flagship centres, Jammu and 3 new facilities) posted a robust uptick in their revenues with over 16% YoY growth in this quarter.

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 80.6 mn increase in EBITDA and decrease of INR 25.4 mn in PAT for Q2 FY 20 on a like-to-like basis (pre-IND AS 116).

On the profitability front, our consolidated EBITDA grew by 68.3% on YoY basis and grew by 19.0% QoQ in Q2 FY20.

Adjusted for the losses of the three newer units across Delhi NCR and Mumbai, Indian operations posted an EBITDA margin of 17.8% during Q2 FY20 as against adjusted EBITDA margin of 13.7% in Q2 FY19 and 16.4% in Q1 FY20. The three flagship facilities at Health City, Bengaluru and RTIICS, Kolkata continue to deliver robust EBITDAR margins at 32.2% in Q2 FY20. Underlying the operating leverage, our other facilities (excluding 3 new hospitals and Jammu), as said earlier, grew by over 16% YoY, have registered a remarkable growth in EBITDAR with over 80% YoY growth in Q2 FY20 reflecting an EBITDAR margin of 18%. 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 13.1% in Q2 FY20 as against being in the red in the corresponding period of the last year.

Moving on, sustaining the momentum generated over the last few quarters, our overseas operations at Cayman Islands posted YoY revenue growth of 26.3% in Q2 FY20 resulting into EBITDA margin of 24.0% helping the facility more than double its EBITDA during the quarter as compared to the same period last year.

On the India operations, changing case mix coupled with focus on minimally invasive surgeries has helped us further lower our average length of stay to 3.5 days while allowing us to serve more patients with our discharges growing by over 15% YoY in Q2 FY20. This along with increased contribution coming in from international patients has resulted into a healthy 9.1% annual increase in the ARPOB for the Indian operations during the same period.

Some of the key clinical highlights for the period are:

- Narayana Multispeciality Hospital, Jaipur successfully performed cardiac surgery on a 2-year old child suffering from multiple congenital heart defects. VSD (hole in the heart) coupled with situs inversus (congenital condition in which major visceral organs are reversed from their normal positions) made this surgery quite complex and rare

- Narayana Multispecialty Hospital, Ahmedabad performed minimally invasive Transcatheter Mitral Valve Replacement - Mitral Valve in Valve Procedure (TMVR-Mitral VIV) thereby eliminating the need for conventional open-heart surgery
- In a rare case, gastrointestinal tumour which accounts for less than 1% of all tumour cases was removed at Narayana Superspeciality Hospital, Guwahati
- Sahyadri Narayana Multispecialty Hospital, Shimoga successfully treated a patient suffering from Osteochondritis dissecans, a rare bone-joint disorder, this is the first such case performed in central Karnataka

Looking ahead, we will continue to consolidate our hospital operations to maximize value for all our 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.

Moderator: Ladies and gentlemen, we will now begin the question & answer session. The first question is from the line of Pritesh Chheda from Lucky Investments. Please go ahead.

Pritesh Chheda: I have few questions. When I was referring to your presentation, we have given a breakup on slide #10 on maturity profile of 17 and 3 hospitals which is 20. This is only for our owned/operated hospitals which is 21 in number.

Debangshu Sarkar: Yes, it does not include Jammu.

Pritesh Chheda: Then, on the Bengaluru and Kolkata clusters of yours, what can be the upside from here to the ARPOB and the margin numbers because let's say Bengaluru operates at 34%, if you could give some thought here?

Viren Shetty: As we have stated several times in the past, it is not easy for us to give guidance on either the ARPOB or the revenue guidance but ultimately what we have done is demonstrate time and time again that we are able to maintain a consistency in ARPOB and revenue growth for Bengaluru atleast. So, we will be able to maintain the high single digit to low double-digit revenue growth for the Bengaluru cluster.

For Kolkata, we have attempted to do a couple of reorganizations within the existing structure but that is a capacity constrained unit. We are running short of beds in our flagship, Rabindranath Tagore Institute of Cardiac Sciences. So, there we may see a slight slowing down of the revenue growth but it can be maintained in the other hospitals we acquired in Kolkata which is our Westbank Hospital in Howrah and the one at Barasat.

Pritesh Chheda: So, the Bengaluru's growth rate directionally should be up is what we can assess direction-wise? Hence there is scope for growth there? And eastern, western, and Delhi, these three clusters should directionally eventually move towards the Kolkata type operating metrics?

Viren Shetty: It depends on which operating metric you are talking about. ARPOB-wise, Delhi is much ahead of Bengaluru. If you are going by sort of growth numbers, Delhi also will be much higher because that's a brand new hospital.

Pritesh Chheda: Margin-wise?

Viren Shetty: Margin-wise, in time, yes. The fact is there are 2 hospitals in Delhi. One is existing operation that we took over and the other one is a greenfield hospital. The greenfield hospital, generally, we expect 3 to 4 years for the breakeven, whereas the one that we acquired should break even by the end of this financial year. Post that, margin-wise, yes, in due course of time. Now, it is hard for us to actually foresee what will eventually lead it to achieving the Kolkata numbers because Kolkata has been around for 19 years.

Pritesh Chheda: We are looking for direction, sir.

Viren Shetty: Yeah, directionally, it should.

Pritesh Chheda: Lastly, I want to know what is the Ind-AS adjusted EBITDA for quarter 2 FY20 and H1 and what will be our debt repayment and CAPEX for FY20 and FY21?

Debangshu Sarkar: Ind-AS adjusted EBITDA, we have already disclosed in our results release as well as in the investor presentation. It is around 8 crores for the first 2 quarters each. So, it is just over 16 crores for the half year ended 30th September.

Your other question pertains to debt repayment and CAPEX for FY20 and FY21. Let me tell you what it has been for the H1 FY20 6 months' period. We have retired gross debt to the tune of around 75 crores in the 6-month period ended 30th September and we have incurred around 60 crores towards CAPEX in this 6-month period. If you have gone through our previous interactions and all the calls that we have been doing, we have maintained on that capital expenditure, we expect, on an annual basis, leaving aside any specific expansion projects, a number hovering around 120 to 150 crores with upward bias, given the increasing gross block for the group as a consistent annual number towards replacement/maintenance CAPEX. Any other specific expansion will be over and above that.

Pritesh Chheda: So, 120 to 150 crores is replacement CAPEX itself?

Debangshu Sarkar: Yes

Pritesh Chheda: Do we have any plans for a new facility addition as of now?

Viren Shetty: As of now, it is an incremental capacity addition. For example, in our hospital in Bengaluru, we will be looking at adding a new outpatient block. This won't add any beds, but what it will do is it will free up a lot of critical care and dialysis beds in the main hospital while moving the outpatient facilities outside.

Similarly, in Howrah hospital, we will be adding an additional floor of beds that adds another 100 beds to the existing hospital. Ahmedabad, we will be adding another 30 beds. Kolkata, we are desperately looking for something close by, a building that we can buy out to accommodate another 100 to 150 beds. So, it won't come within the 150 crores. This will be over and above that. But these are not massive expenditures.

Pritesh Chheda: Debt repayment, should we take annualization of 75 crores?

Debangshu Sarkar: That would be a difficult number for us to hazard a guess upon. If you have gone through our financials, you would have seen that there is robust cash accruals over the last 6 to 9 months and there is some amount of investment, which are currently lying in the form of current investments viz. mutual funds. We will take an appropriate call on that, considering prudent corporate finance norms and optimum capital allocation for the group.

Moderator: We move to the next question from the line of Chirag Patel from Adhiraj Shares. Please go ahead.

Chirag Patel: Congratulations for the excellent numbers. Sir, I have a question with respect to our U.S. operations of that subsidiary, which we created 6 months before. What is the status?

Viren Shetty: There has been no update on that. We continue to consult with a couple of U.S. hospitals on the operational improvements. But as of now, there are no revenues that have been booked on that. We have also indicated that it is something that we are just doing as a preliminary foray and was more from compliance with the regulatory standpoint, but that is not significant. But what we can disclose is that the digital consulting, we have managed to get 1 contract within India itself, but this will be done through the Indian entity. The revenue, again, is not a significantly large number. This is more on the lines of clinical intelligence and process consulting.

Chirag Patel: The last question is about capacity addition. Like Ahmedabad, which other location you mentioned?

Viren Shetty: The capacity addition is for Ahmedabad; for Westbank, this is our other Kolkata hospital; and for the main Kolkata hospital called RTIICS. These are the places we are looking at adding additional capacity. Bengaluru also we will be adding more rooms but this is for OPD, not for bed strength.

Chirag Patel: The total bed strength addition will be in numeric terms around, including Ahmedabad and Westbank?

Viren Shetty: If you just include Ahmedabad and Westbank, it will be around 120-odd beds. And we might also add around 50 beds in Raipur in the next couple of quarters. Yeah, but this is work that has already been going on and is more or less in the finishing stage of construction.

Chirag Patel: By what time this, around 200 beds, will be operationalized fully?

Viren Shetty: Construction time normally take about 18 months to 24 months. Because given that these are running hospitals, the construction tends to go a little slower.

Moderator: The next question is from the line of Raj Rishi, an individual investor.

Raj Rishi: Sir, can you comment on any plans for an asset-light model for growth?

Viren Shetty: At this point, we are not looking at adding any additional capacity which is outside of our network. A lot of the expansion that we spoke about was additions to the existing structure. These are buildings that are meant to go up 6 stories, but we will be just adding them 1 floor at a time.

In terms of the asset light, for example, there is an operation in Bangladesh that we are going to take up. It has been a little delayed, but we should start operations, possibly early next year. For this, there is no capital investment from our side. This is more of us bringing in the clinicians and running the cardiac setup in a greenfield hospital. That is the only one that we have spoken about in the past. Other things, we are looking at one in west India, but it is still a very sort of premature thing, and this, again, is more of a heart center model. It is not taking on a very large P&L.

Raj Rishi: Sir, if you could enlighten us about this particular concept like why aren't you going very aggressively for this asset-light model? Given the kind of funding, which is available and the expertise which you have, this match can be quite a fantastic thing for all the stakeholders, right? That's my understanding. Can you just comment on that?

Viren Shetty: In theory, you are right. The understanding is absolutely correct. It is a very intelligent way to deploy capital. But the question is, being very selective about the areas that you would like to grow in. We did employ the asset-light strategy for growing in Dharamshila, which is our east Delhi hospital, and SRCC, Mumbai and for SRCC we raised funding from donors and trustees to set it up. So, it is just that this is a period of consolidation for us right now where we are able to deleverage a bit and work on our existing operations. But in time, you are right. Once we start to feel that the opportunities out there are priced well and we are running out of growth in the existing setup, then we would look at expanding again. But for right now, we see a lot more growth within our existing hospitals, which are a little capacity constrained. So, rather than running behind new geographies, I would rather turn around the existing operations and bring them to a much higher EBITDA level.

Raj Rishi: Any indication as to what extent the EBITDA can go up the margin? What do you have in mind if you can share with us, like from the present levels? What do you consider as optimum what you are talking about?

Debangshu Sarkar: That is a very difficult one to respond to. You need to be cognizant of the fact that individual hospitals have their own dynamics, consistent with the scale of operations, where exactly that hospital is geographically located. So, it is very difficult to equate all of this and come to a thumb rule based generalized response to this kind of an answer. All things remaining the same, just as an example, probably a 400-bedded hospital might have a completely different trajectory as well as fiscal lucrativeness vis-a-vis a 150-bedded or a 100-bedded hospital.

Similarly, hospitals of the same vintages and scales probably will have different economics basis just a metro or non-metro or Tier-3, Tier-4 kind of a location. Then vintage obviously plays a normal part in every hospital operation. So, it would be very difficult to come up with a generalized response to that.

Having said that, we believe anything over 15% to 20% of sustainable EBITDAR margin is a successful hospital. And obviously, there would be a difference between a metro, non-metro, scale of operations, all the things – caveats – that I put in all this.

Raj Rishi: About Ayushman Bharat, it seems to be a game changer for the health industry. How do you see it impacting your operations? To my mind, it should be like a game changer, right? For the positive. Can you just comment on this?

Viren Shetty: Not really a game changer. The fact that if you just look at the sheer amount of funds deployed for the entire country, while they are trying to cover 500 million people, they are planning to cover them with around 4000 crores as per my last recollection of the budget allocation. It is only a little bigger than the revenue of this group. If you have to spread this out across the millions of beds across the country, on a per hospital basis, it really doesn't add up too much.

But having said that, it is good for at least covering up that base level, at the bottom 10% to 15% of the beds that you have in the general ward. Those patients come under the Ayushman category and at least on a marginal cost basis, you can justify doing certain procedures. But by and large, doing procedure in Ayushman are margin depletive, and the government doesn't pay you anywhere close to what the true cost is nor do you get paid on time – even outside of Ayushman. When I speak of this, I speak of government schemes in general. This includes programs like CGHS, ESI, ECHS.

I would say, game changer is a strong word, but it is an indication of the way things are moving forward. The government will start to become more and more of a payer for large segments of the population. But it depends entirely on their allocation.

Moderator: We move to the next question from the line of Tapan P from Polo Capital.

Tapan P: What part of percentage of your revenue comes from Ayushman Bharat, if you could comment anything on that?

Viren Shetty: What we have disclosed in the past is that schemes overall are about 17% of the overall revenue that we get. But of the schemes, Ayushman is not the biggest component of that. That would actually be CGHS. 7 crores a month is what you can take as the Ayushman revenue that we do.

Tapan P: Just one quick follow-up. How long does the government or the insurance company take to settle the accounts?

Viren Shetty: I think there was a sort of a restructuring what was done last year in the insurance space for payments and clearance of payments by the TPA as well an agent. Earlier, it used to be very predictable of 45 to 60 days. Now, many of the payments are getting shunted between the administrator and the TPA. To that extent, the cycle has increased by around 15 to 20 days.

Moderator: The next question is from the line of Nitin Agarwal from IDFC Securities.

Nitin Agarwal: Viren, one big concern with the general hospital space has been the fairly aggressive expansion. The hospitals that were taken in the past, while right now most of the groups seem to be consolidating which pretty much seems to be the case for us also, going forward, whenever we are done with this consolidation process and we restart on an expansion sort of phase, what are the broad principles that we are going to follow? And how will this expansion phase, in your mind, be different than probably what you have done in the past?

Viren Shetty: I would guess the big difference between how you look at this going forward is to strengthen our hubs. A lot of the consolidation that we are doing also follows through on identifying the sort of winners among our hub hospitals and really doubling down on investing in them, both in terms of clinical manpower, the medical equipment technology that we are putting in there as well as the capacity that we bring in.

Prior, we did expand a large number through asset-light expansion, working with third party – other partners and other hospital groups. That we will be doing slightly less of, and in the cases where we do it, it will be more strategic, i.e., its value will only be immediately apparent to the hub hospitals that it is nearest to.

The other thing, I think, for the near term that we can be clear of is not taking up anything in a new geography. So a place where we currently don't have a presence, just to throw out an example, like Hyderabad or Chennai, we probably will not look at that in the near term.

Moderator: The next question is from the line of Chetan Seth from Sameeksha Capital.

Chetan Seth: On Whitefield, we mentioned 62 crore annual revenue, 91 beds. This will be included in our Bengaluru cluster, right? Bengaluru piece?

Debangshu Sarkar: Yes. The 63 crore revenue was for the last fiscal year.

Chetan Seth: Yeah, FY19. What kind of margin that the hospital was making earlier?

Debangshu Sarkar: I can tell you since we are now discussing about this particular hospital given the announcement that we have made, it was in that band of 15% to 20% EBITDA that I had mentioned previously that it clocked for this 6 months period ended 30th September 2019.

Chetan Seth: These 91 beds are going out of the system and you already mentioned that we are trying to free up our Bengaluru flagship by putting up OPD, do we expect this will get replicated or replaced somewhere in the flagship center in terms of bed addition there once we construct our OPD and that 90 beds eventually we will see there?

Viren Shetty: Yes, it will, over a period of time. The one-to-one swap was not possible to time it that way. And not just in Bengaluru, there are some beds coming up in Raipur and Ahmedabad as well, which will more than make up for the bed loss out of Whitefield. But the sort of loss of beds in Bengaluru will be more than compensated through the flagship.

Chetan Seth: And we do have incremental space available at flagship, right? You mentioned earlier. So, we are hopeful to add more incremental beds over there instead of you buying out or doing acquisition in certain cluster?

Viren Shetty: Yeah, for Bengaluru at least, we don't need to do an acquisition, but we do need to build some infrastructure to move things around, because the existing building is full and we are changing the configuration of beds towards more critical care, operating room, cath labs, and so on. And moving out from our main building are lot of low-yielding rooms such as outpatients, diagnostics, physiotherapy, consulting, those sorts of rooms. And for that, we will be building an office-type building. It won't be like a hospital. And that will free up most space in the main hospital to increase our in-patient activities.

Chetan Seth: You mentioned earlier about reaching a scale and consolidating our existing network. Any ballpark number in terms of what kind of turnover you are looking at beyond which you need or the existing network will start facing growth issues? From that point onwards, we will kind of start looking on adding more capacities aggressively rather than right now very selectively and whatever is required, you are adding beds over there?

Viren Shetty: It is tough to give a group level ballpark number for us to tell when is the full stop on consolidating and then from tomorrow we start expanding. The truth is, both happen simultaneously. Even though we are saying that we are consolidating, there are also many offers that we look at. And even at times when we said we were expanding; we were looking at consolidation. So, in the end, it is about what really makes sense for the group as a whole.

To make a decision of when to expand beds in our Kolkata hospital, it is easy because there is a waiting line that goes out of our building and into the main road. That is a very obvious physical manifestation that we need to add more capacity there. For the past 5 years, actually, they have been reconfiguring space within the hospital, but they have reached their natural limits of how many more bricks and all the FSI consumption. So for that, they have to buy another building to expand, whereas in Bengaluru and in a few other places, it is easier just to add another bed or take out a dialysis unit and move it somewhere else. So, those can be configured within the existing setup. Ultimately, the goal is to keep demonstrating increase in growth, increase in margin, reducing ALOS, and improve the overall efficiencies of our operations.

Chetan Seth: In Jaipur Oncology, when do we expect?

Viren Shetty: That is still to be decided. There is no land to build a bunker within the existing setup. We have been working with the government to acquire some land to set up the Oncology there. But until that happens, it is still something that we are going to face a challenge in.

Moderator: The next question is from the line of Neha Manpuria from J.P.Morgan.

Neha Manpuria: As we are improving profitability, how do we look at improving ROCs for the business, especially since we have a couple of these Delhi hospitals which we have acquired, which need to ramp up. If you are looking at, let's say 2- to 3-year period, how are you looking at ramping up ROCE?

Debangshu Sarkar: While we understand where you are coming from, if you give us some credit, you will see that there has been an upswing in our ROCE over the last 8 to 12 months, if not more. While I agree with you that it was muted before, for probably a period of time which was stretched far more than what we would have hoped for, but there were a lot of things associated with external factors which were beyond our control.

Just to give you some indication of the same, what I just told you, for the period ended 6 months, this fiscal itself, if you just annualize our half-year figures, you will see that our book ROCE is hovering around 13% which if adjusted for the noncash elements towards the right to use assets as well as deferred government grant and the non-cash financial lease impact of the Dharamshila transaction, which have actually increased my capital invested by around 430 crores. Adjusted for that, that 13% actually bumps up to 16%.

Further to that, if I adjusted for the 3 new facilities, which you referred to the 2 hospitals at Delhi and the 50 crores worth of investment that I made in the SRCC Hospital in Mumbai, ROCE is actually north of 23% by just annualizing the number. And here, again, I have not averaged out the capital for the period. I have taken end of 30th September period.

While it would be very difficult for us to guide you specifically as to what specific measures would we need to do at one particular hospital to bump it up even further from these levels, it is

not lost out upon us that ROCE is a very crucial metric, and we are continuously striving towards improving it at all levels, and Delhi hospitals are no exception to that.

Viren Shetty: I will also just tell you, indicatively from the operations side what we are working on is that – obviously, the easiest way to improve ROCE is just by reducing the C (Capital Employed), but that will just be the shortsighted way of improving our numbers. Ultimately, we want to improve the returns that we get from this business. And what happens is, with a lot of investment-heavy growth and a lot of acquisition-driven growth, the organization just ends up buying revenue. And for that, the return on capital is much less than the cost of capital. And we have seen that in our own organization as well. With the efforts that Dr. Rupert and his team have been putting in on the medical side, they have been able to work with the clinical teams to improve their throughput, reduce infection, reduce the error rate, change the sort of mix of procedures that we are doing, use lesser antibiotics.

These are the sort of efforts that we are doing, at least, towards improving the return on capital from the operations side. But ultimately, there is a sort of diminishing rate of return from this. At some point, also we will have to start deploying capital to add more capacity. But at least for the next year or year and a half, it may not be that necessary.

Neha Manpuria: I understand that obviously it reflected that you have made a lot of improvement, but is it fair to assume that from where we are, the incremental improvement, given already operationally we have done quite a bit, incremental improvement would be dependent on Delhi and Mumbai improving from current levels? Is that the right way to understand?

Viren Shetty: Yes, overwhelmingly so, because while we can reduce the length of stay a little bit more across the network, but then the sheer size of our Delhi operations means that that will have much more of outsized impact.

Neha Manpuria: And that would probably take a couple of years as you mentioned in one of the previous questions.

Viren Shetty: Yeah.

Moderator: The next question is from the line of Arshad Mukadam from Vibrant Securities. Please go ahead.

Arshad Mukadam: Congratulations on a great set of numbers. I wanted to understand what you exactly mean by discharges? Does it include outpatients as well or is it only inpatients?

Viren Shetty: Only inpatients. Discharge means he has come in, he spent a night in the hospital, we did some procedure for him, and then he got discharged. We are actually trying very hard to arrive at much better metrics for growth rather than looking at occupancy because our business is not like the hotel business where occupancy is a good metric of performance. We do a multitude of procedures. We do many-many kinds of procedures on patients in our hospitals.

If you look, we made a little change to the investors' presentation on the operations side, and we have included ICU bed days, we have included discharges, length of stay, ARPOB, and just to give an indication of the things that we are really working on that we believe is more important than the overall bed count and occupancy of the same.

Arshad Mukadam: Yes. I have seen this has happened over the last 2 to 3 quarters, I think. And I think since, as you say, occupancy is becoming redundant as a metric, then shouldn't ARPOB also not be relevant because I think if you are giving discharges, then shouldn't we also look at a figure like revenue per patient? So, for that, I think, we will also need to understand the.…

Debangshu Sarkar: Theoretically, what you are saying is absolutely right. In fact, that is the way bottoms-up, any financial modeling for a hospital or a healthcare project is done. We actually call it ARPP, average revenue per patient or per procedure. We will possibly graduate onto that because there is a historical information which is out there in the market. If I do all the changes on day 1, it probably may not be easy for all of you to assimilate the same. So, we have been doing these changes as you recognize the same, but your point is valid on what you just highlighted. ARPOB as well as occupancies are actually derived figures.

Arshad Mukadam: That's fair enough. Could you just help me understand how does the revenue per inpatient versus outpatient look? Because I think oncology is mostly outpatient and that is actually increasing the revenues for outpatient, if I am not mistaken.

Debangshu Sarkar: If you look at the underlying factors or the things which are affecting ARPOB or ARPP are broadly the same. It has got to do with your payer mix, how much of your total payers are distributed across, let's say, the international business or the government scheme business which are low-yield versus a high-yield business. Then, as you rightly highlighted, what's the split of your business across case mix or specialty mix, how much of oncology business you are doing versus how much of probably ortho business you are doing. Within the cardiac, then it boils down possibly to the case mix as to how much of heart transplants you are doing vis-a-vis a plain vanilla CABG procedure. These indicators or the criteria which eventually decides upon or effects ARPP are similar to what impacts ARPOB.

Moderator: We move to the next question from the line of Charulata from Dalal & Broacha. Please go ahead.

Charulata Gaidhani: Congrats on the good set of numbers. I wanted to know what is the time frame that you see the new hospitals earning profits?

Viren Shetty: I think I mentioned this earlier on in the call. The Dharamshila Hospital, the one we have in East Delhi, is likely to break even by the end of this financial year whereas the other 2 hospitals will follow the normal trajectory that we have, which is, they can generally take 3 to 4 years to achieve that breakeven.

The Mumbai hospital could take a little longer than that given that it is a pediatric hospital and dependent a lot on very poor patients coming from the government programs or assistant programs.

Charulata Gaidhani: How much would be the revenue from heart centers?

Debangshu Sarkar: On an annual basis, we are on 100 to 120 crores run rate. 30 crores we did for this quarter, which is 120 crores run rate for the year.

Charulata Gaidhani: Majority of the traction that you are seeing in the EBITDA margin over the last few quarters, is it mainly because of heart centers or it is because of other operational efficiencies?

Viren Shetty: It is an even performance across the group. The heart centers just have a very low top line number. So, it doesn't add too much to the overall performance. The efficiencies that we have been working on both in terms of our digital transformation program as well as the clinical transformation, those, again, have an outsized impact across the main hospitals. So, the larger hospitals have been giving most of the returns, purely because they also have the largest revenue base.

But what it has done is that all the hospitals except our new hospitals are profitable, that also because we don't have any sort of negative EBITDA hospitals. It is what is, again, causing this kind of performance that you see, which was not the case last year or the year before that. So, a lot of the performance that you see is also driven by base effect, much lower base last year.

Kesavan Venugopalan: There is one other thing to add. Actually, quarter 2 is also generally a strong quarter for the healthcare in terms of seasonal volumes. So, those also have possibly contributed to, let's say, margin uptick.

Charulata Gaidhani: You think it will sustain over FY20 and FY21?

Viren Shetty: Q3 is generally a weaker quarter for us given the number of festivals and the winter season. Christmas being a time when a lot of patients tend not to get themselves admitted. But, yes, for the rest of FY20, we believe we should be able to sustain at least some elements of this growth.

FY21, again, hard to give guidance, but we remain confident.

Moderator: The next question is from the line of Chirag Patel from Adhiraj Shares. Please go ahead.

Chirag Patel: My question is on the Cayman Islands facility. We are posting a good set of numbers from that particular facility. Any targets we internally set that we achieve to more higher rate from here onwards?

Viren Shetty: We don't give targets to hospital per se. There is a budget performance that they need to hit and Cayman is more or less about 100% on its budgeted performance. What we will be doing going forward to drive the revenue and the EBITDA is Oncology. This is something we had disclosed earlier. We will be making roughly $8 million investment in adding an Onco block which includes linear accelerator for radiation therapy as well as certain outpatient rooms for oncology. That is a 1-year project. And post that, I would say, 15 to 18 months, we should start seeing Onco revenue come in for that hospital.

Chirag Patel: This $8 million investment is in pipeline or we will do after FY20?

Viren Shetty: No, it is in process right now. We started making advance payments to contractors, and the groundbreaking for this hospital will be happening at the end of this month and the construction will start by December.

Chirag Patel: Is it a kind of brownfield only?

Viren Shetty: It is just a bunker with a supporting complex around it. That is built within the existing facility. We won't have to acquire anything.

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

Sameer Baisiwala: The discharge growth has been pretty significant, I would say, not only YOY but also quarter on quarter at 75,000. Any color you can share? I can see that it is in existing as much as new, both. What is really driving it?

Viren Shetty: Seasonality is one part of it. Q2 is generally a strong quarter. But even if you look at the sort of broader trends, I would say that all the hospitals that we started outside of the flagships have also managed to establish quite a name for themselves in their respective geographies. And the longer we have been in the business, the more we invested in marketing and the brand, patients generally flock in disproportionate numbers towards larger brands that they can trust. And this is true not just for us, it is true of all the other listed hospitals as well.

This is coming at the expense of patients generally opting to get treated in nursing homes or unbranded single specialty or single doctor-owned hospitals or even government hospitals. So, the first point of call tends for them to be hospitals like ours.

Sameer Baisiwala: You are not sharing the number on occupancy, but just thinking about whatever is a practically achievable occupancy in your mind is across your network, what does it translate into number of discharges, if that's the right way to think about it? With this question, I am just trying to get to what kind of volume growth is possible within the network that you have at the moment?

Viren Shetty: The reason why we started moving away from occupancy is that you take any government hospital, they always claim 150% occupancy. But if you actually look at the number of

discharges they do, it is very less. So, they are essentially holding areas for patients to just come and get an IV drip and then either die or go somewhere else. So, why we moved towards the number of discharges and critical care bed days or ICU bed days, was because we felt this gives a better reflection of the actual performance of our hospital.

Now, what is the kind of ideal number of discharges is, that is extremely hard to come by because the more we reduce the length of stay, the more the discharge can happen. For example, if every procedure was daycare and you just came in and got it done the same day, then you can have infinite discharges. There is no limit to what you can do. And that we are starting to see. The length of stay for procedures does get lesser and lesser, but for hospitals to do that, they need to do a huge amount of investment upfront to invest in robotics, to invest in surgeons who can do those kind of procedures, to have a very good infection control team so patients don't catch any bugs in the hospital, to invest in good clinical practices so that you are able to discharge the patient more efficiently or even IT, for example, so that the bill can be generated on time.

These are a lot of things that we can do. And yeah, it is tough to say that there is no upper limit for discharges, but definitely, we believe there is still a lot more room to grow for discharges in our group.

Sameer Baisiwala: Just one final one on the pricing. Has there been any action by you in the recent past or going forward?

Viren Shetty: On the government scheme, there has been no change in the pricing. We have been trying very hard to work with other hospitals and negotiate with the government on price increase. That has really not been the case.

On our rack rates, we did a little bit of a revision at the beginning of 2019, where I think we had indicated this earlier in terms of moving away our margins from consumables and toward services. But that is more of a kind of reallocation here and there. Overall if you look on a like-to-like discharge basis, the patient charge hasn't really changed by more than 5% to 6% year on year.

Also, the other thing is these insurance companies, we have been renegotiating our contracts with them. These work either in a 1- and 2-year cycle. And those, we just bring them more in line with our annual statement of charges. In Karnataka, for example, we have been able to renegotiate the pricing with insurance companies. That took place in April of this year. So, there was a price increase for insured patients in Karnataka. Delhi, for example, we just have new contracts, so that can't be renegotiated for another year. It will happen in August next year. Similarly, Mumbai and Kolkata, again, sometime next year. These are all kind of continuum of price increases. Only half the patients (domestic walk-ins) that pay cash will see price increase every January. But for the rest of it, it is more on a rolling basis.

Sameer Baisiwala: For the walk-ins as well as the insured, a typical annual price increase is how much?

Kesavan Venugopalan: Sameer, actually for the insurance, the yearly rate revision doesn't apply because it is sort of a contract negotiated for 2 to 3 years, depending on the type of contract. As Viren said, all the annual price revisions will apply for the cash walk-ins, which typically in our network, we aspire to just cover the inflationary increase in the costs.

Moderator: The next question is from the line of Chetan Seth from Sameeksha Capital.

Chetan Seth: Sir, ALOS has declined from 3.6 to 3.5 this quarter sequentially. And if we look at the case mix as well, the movement is between Cardiac to Gastro; not much of the Onco coming up, still the same at 10% kind of number. What are the factors that led to drop in ALOS this quarter and how do we see going forward, in December?

Dr. Emmanuel Rupert: Yeah, we have concentrated a lot on the processing for mainly the procedures. We try and work up most of our elective procedures in the outpatient department and get them just in time for the procedures and optimize even the stays in the critical care units and in the wards and optimize that and put a lot of process changes so that we don't keep anybody inside the hospital unnecessarily for any length of stay. If clinically they deserve to be in the hospital, they will be there, but if they clinically are doing well, then we try and discharge them as quickly as possible.

Viren Shetty: GI growth has also been driven because we have a very skilled team based in Delhi that focuses a lot on kidney transplant, liver transplant, and other GI surgeries. And the other one also that this is driven a lot by advances in robotics and minimal access surgery. This is why we have spent a lot of money in building up the team. That also has seen the sort of increase there. Cardiac, what you are seeing is that cardiac is our biggest revenue line. And that's a number that can only go down as the other departments tend to pick up.

Chetan Seth: But direction-wise, do we expect further improvement on ALOS because that will free up our beds and we can see kind of more growth in discharges?

Viren Shetty: It is tough to say. I won't say it is unlikely to go below 3.5. We do a large number of procedures and we also get a large number of patients undergoing critical care and these are patients that will definitely stay beyond 3 days. So, while it can move by, let us say, 0.1 to 0.2 days here and there, at some level, you will start to flatline on the length of stay.

Chetan Seth: So, 3 to 3.5 in between will be the kind of sustainable number?

Dr. Emmanuel Rupert: It depends upon the mix of procedure and non-procedure patients. It will entirely depend on that.

Debangshu Sarkar: Chetan, just bear in mind that we have a disproportionately higher contribution by cardiac sciences to the overall pie. To that extent, our ALOS will tend to be a little higher than probably any other comparable figure that you might be observing over there, notwithstanding the point that Dr. Rupert made. And you also need to take into view the fact that there has been a significant improvement of our group ALOS number over the last 12 to 18 to 24 months.

From these levels, like Viren and Dr. Rupert said, significant improvement may not be the case, notwithstanding, obviously, the actual proportion of procedures versus non-procedures and the case mix that we operate upon.

Chetan Seth: On ICU bed days, that was a new number we are looking at. How do we read that and what is the utility there?

Viren Shetty: Our belief is that going forward, patients will end up coming to hospital for 1 or 2 kinds of procedures. One is a very sort of short-stay, invasive or minimal access procedure where he just gets the surgery done, spend as little time in the hospital and goes out. That will be one business line.

The other that, we believe, will happen is patient on chronic care, which is older patients who will require either being on ECMO. So, those are long-stay patients who the longer they stay, the more sort of services you are required to do for them.

That is why we want to start separately showing the kind of ICU bed discharges. This shows the kind of conflicted sort of business that we are in where on the one hand we are trying also to get patients out of the hospital as fast as possible, but on the other hand, we have this much larger business growing, which is of patients staying here for long periods of time.

Chetan Seth: So, from there, what should we kind of derive in a sense that this portion of the beds are higher ALOS number, generating revenue nonetheless, but these are the bed occupied for slightly higher compared to what we are giving on a blended basis?

Viren Shetty: Exactly.

Moderator: The next question is from the line of the Vivek Agarwal from Citigroup. Please go ahead.

Vivek Agarwal: Sir, the margins of heart centers have improved sharply this quarter. What explains this?

Viren Shetty: This is essentially a provision reversal and curtailment of operations at the loss-making Durgapur centre. As you know, heart centers were the ones that were most exposed to the sort of price control action. Those are the ones that carried the most amount of risks from regulatory point because these things only have one specialty to fall back on. So, we have made a lot of provisions in these centers and have been quite conservative on our pricing and very conservative on what we felt that the performance of these units will be, but it turned out that we were being overly sort of conservative, and this is a sort of number that we were able to demonstrate for that.

But still, having said that, it is not a business that we will go too aggressively on given that individually, these things never get to be extremely large or profitable in their own rights. Their purpose is more towards driving more cardiac volume to the main hospitals.

Vivek Agarwal: Can you put some more light on the shutting down of Whitefield unit?

Viren Shetty: Actually, probably, we should have started with this. The Whitefield unit was an experiment from our side. This was the first time a group like ours wanted to try something that was a little more high end, a little more of a boutique hospital that was located deep within a neighborhood rather than being far away. It started out as a 120-bed hospital that would do more daycare-focused surgeries, orthopedic, luxury birthing, and it was priced very differently. And it worked quite well up to a certain point. We included cardiac surgery and we included very advanced orthopedic surgery, but that drove up the costs, and once the cost discipline went out of the way, then we just had to go for volume. And so, we thought we might convert this into one of our regular hospitals. Rather than being a 120-bed boutique hospital, we thought we can make it into a 300-bed, very large multi-specialty hospital that will have everything in it. And this is one of the earliest of our asset-light hospitals.

So, we tasked the landlord to construct an additional wing for us. Unfortunately, the landlord neither was able to give it to us on time nor he was able to build it according to the specifications what we required. He ended up constructing it smaller than what we wanted. And he built it in such a way that it would not get a host of clearances because of setback, sewage treatment plant, and so on. We didn't want to take the risk of taking up a hospital that was not compliant fully with all the norms.

The other part, a little unfortunate, was that our commercial negotiation with the landlord also broke down. While we had agreed on a certain price for taking up the building, the final price turned out to be something else. So, rather than sort of continue with the operations as a 120-bed hospital which would only stagnate and would eventually start to decline, we thought it would be better that we exit the business.

We tried for a while to find a buyer for the business, but we were not able to do that. Meanwhile, word got out in the market that this was happening, and a lot of doctors started leaving. So, rather than try to flog the asset to someone else and to see it slowly diminish over time, we decided to, at one shot, just pull the plug on it, take all the medical equipment as much salvageable infrastructure that is there and redeploy them in the existing network in Bengaluru. And whatever else that we are not able to do, we just leave it there and shut down the operations entirely.

That will be starting this month and should finish by the end of December, where we would be able to salvage most of the operation there. The decision of this was driven partly by strategy, partly by sort of difficulty in dealing with the landlord that we had, partly also kind of geographical consideration, given that the time that the landlord took to build the building, a lot of other hospitals came up in close proximity, which started poaching our doctors and making life difficult there. It was a sort of perfect storm under the circumstances. We could have continued it going the way it was, but we just felt that it made more sense for us to focus on the larger, better run hospitals of ours.

Moderator: The next question is from the line of Arshad Mukadam from Vibrant Securities. Please go ahead.

Arshad Mukadam: I just wanted to understand one thing about the new hospital. If I just look at the quarterly run rate that we have been doing, the revenues have been increasing steadily and so has the OPEX. And we are still in losses, I see. And if I am not mistaken, I think it is because we have just been increasing the beds, the operational beds at each of the units. Is that the reason for this? Because I think 2 years have been completed at SRCC and Dharamshila and they still have not broken even, I think. Could you give some light on this?

Viren Shetty: I will start with Dharamshila. Dharamshila was a cancer hospital that only had a single specialty, and we took it up in a greatly diminished sort of mode. One of the first things we did upon taking it over was to add all the other specialties there, which included cardiac, ortho, GI, neuro, the specialties that hadn't existed. For everything outside of cancer, it was like building a greenfield business from scratch. And so that led to the sort of long gestation period for that.

The occupied beds also kept going up because we weren't utilizing the full capacity of the hospital. The hospital is built as a 300-bed hospital that can go up to 600 at some point in the future. But we shall operationalize them only when we start to run out of space in the existing beds.

SRCC was a greenfield hospital and that, again, in pediatrics. It did not grow as fast as we had envisioned because it had a sort of limited universe. It is a sub-sub specialty which is only pediatrics and high-end pediatrics. We don't have birthing. We don't have sort of very basic procedures nor do we have any adult programs there. So, the uptake for this depends entirely on driving large number of volumes, which does take its time because people need to know who you are and they need to trust the results that you are able to give.

And that, again, was built for 200 beds, but we started out operationalizing with only 50 beds at a time. As and when we reach capacity, then we add more beds, we add more nurses, add more manpower to do it up. And that's why you start to see the OPEX also start to increase, but the quantum of losses has been decreasing quarter on quarter.

Arshad Mukadam: But could you just help us understand in terms of where the current operational beds out of the total bed capacity stand and when do we plan on moving towards, say, full capacity?

Viren Shetty: For Dharamshila, for example, we have occupied about 100 beds out of 250 beds that is in total. But then, again, the total occupancy as such doesn't cross more than 60% to 70% – 65% at best – in a cancer-focused hospital just because we have a large number of discharges and patients doing daycare procedures.

SRCC, we have occupied around 70 beds. This is, again, on a capacity of 200 beds, I believe. But that also has room to grow in 2 ways because our trustees have committed that they will keep going up until it reaches 400 beds. That's the sort of goal that they have for their institution.

And they have indicated that they are going to support us through the CAPEX as well as through patient support programs.

The question for us is, we want to chase top line growth for SRCC. We just want to minimize the losses and we will keep working towards doing there, but the sort of breakeven will get stretched out given the sort of limitation that we have in the specialty that we run plus also the need for us to keep adding more infrastructure to take in more volume.

Gurugram, that is the newest hospital of the lot. There are only about 40 beds so far that are occupied. It is a 200-bed setup. But that, again, will follow the normal trajectory. It will take around 3 years. Breakeven occupancy for these kinds of hospitals generally 45% to 50% (of the capacity) is what we have seen.

Arshad Mukadam: When you say breakeven occupancy, is this on the capacity or is this on the current operational beds?

Viren Shetty: On the capacity.

Moderator: We move to the next question from the line of Dhruv Jain from Ambit Capital.

Aadesh Mehta: Congrats on a great set of numbers. I just wanted to understand the revenue per discharge a bit right. How is it spread out across specialties? Which of your specialties would have the highest revenue per discharge and which would have the least?

Viren Shetty: It is tough because if you look at GI, it can be something as simple as gallbladder, but it can also have liver transplant. And liver transplant is like 15 to 20 lakhs. Gallbladder is 30,000 to 40,000. And that it just varies across the spectrum. But if you look at on average, on a per discharge basis, probably it will be a tie with cardiac.

Aadesh Mehta: Onco would be higher than cardiac?

Viren Shetty: Yes, onco surgery generally gets roped in with GI surgery. Or if it is head & neck, it goes with faciomaxillary surgery. But those are generally dependent on schemes. Reimbursements are quite poor in that.

Aadesh Mehta: Are we implying that the revenue per discharge would not be much different across different specialties?

Viren Shetty: No, it is quite different. But every specialty also has a large spectrum.

Dr. Emmanuel Rupert: You can have a very routine procedure to a very complex procedure. So, it all depends on the number of the complex procedures you do in a particular.

Moderator: The next question is from the line of Samir Aggarwal from Consortium Securities.

Samir Aggarwal: Do you guys track readmission rates? And if so, how have they been trending?

Dr. Emmanuel Rupert: As part of all the quality parameters, we track all the readmission rates. We try to keep it as minimal as possible. That is all within the accepted norms. So, there are no issues on that. Where we have issues are the chronic patients with the elderly population who keep coming back with the end-stage diseases. Ideally, they should be into some kind of a palliation, but since lack of such kind of facilities across many of these cities, most of them land up in our own hospitals. But if you look at routine procedures, it is barely anything which we have as part of the readmission.

Samir Aggarwal: Could you share that figure? Is it in percentage?

Viren Shetty: We haven't yet started publishing our clinical data, but it is something we are going to start doing separately. This is essentially what we are able to disclose.

Samir Aggarwal: You can't disclose that?

Viren Shetty: Not can't. It is just that we haven't done a good enough job of cleaning up the data and being able to sort of commit to those numbers yet, but it is something that we are working on.

Moderator: The next question is from the line of Chirag Patel from Adhiraj Shares. Please go ahead.

Chirag Patel: As we are going to shut the operation of Whitefield hospital, how many number of beds currently operating there in daycare specifically?

Debangshu Sarkar: 100-odd beds, Chirag.

Chirag Patel: We are going to expand around 200 fresh beds at Ahmedabad and Bengaluru and West Bengal across. So, is there any plan to interchange these beds to those facilities? Like, we are shutting the operations of the 120 beds, right? Of Whitefield hospital I am talking about.

Debangshu Sarkar: Chirag, I think you mean that can that technically offset beds that will be there in toto in the system. You are right, but it will not be like-to-like and it will take some bit of more time. These beds, as we have mentioned in the disclosure, will go from my overall count from 31st December night, while the other beds that we have mentioned across to you, across the network, will probably take some bit of time to come online.

But yes, over a period of time, we will be more than able to recoup the number of beds that we will lose in the system because of Whitefield closure.

Moderator: Ladies and gentlemen, this was the last question for today. I now hand the conference over to Mr. Sarkar for his closing comments. Over to you, sir.

Debangshu Sarkar: Thanks for your active participation. Please feel free to reach out to us in case of any further queries. We will be more than happy to address each one of your queries.

Moderator: Thank you very much members of the management. Ladies and gentlemen, on behalf of Narayana Hrudayalaya Limited, that concludes this conference call. Thank you for joining us, and you may now disconnect your lines.