Date of submission: February 24, 2025

To, The Secretary Listing Department **BSE Limited** Department of Corporate Services Phiroze Jeejeebhoy Towers, Dalal Street, Mumbai – 400 001 Scrip Code: 539551 (EQ), 975516	To, The Secretary Listing Department **National Stock Exchange of India Limited** Exchange Plaza, Bandra Kurla Complex Mumbai – 400 051 Scrip Code- NH

Dear Sir / Madam,

Sub: Transcript of Earnings Call for the quarter ended December 31, 2024.

Further to our earlier letter dated Tuesday, February 18, 2025 in relation to uploading the Audio Recording of the Earnings Call of the Company held on Tuesday, February 18, 2025 for the quarter ended December 31, 2024, please find attached the transcript of the said Earnings Call.

We wish to inform you that the Earnings Call transcript is also available on the website of the Company at https://www.narayanahealth.org/stakeholder-relations/earnings-call-audio-and-transcripts

This is for your information and records.

Thanking you

Yours faithfully
For **Narayana Hrudayalaya Limited**

Sridhar S.
Group Company Secretary, Legal & Compliance Officer

Encl: as above

Narayana Hrudayalaya Limited
CIN: L85110KA2000PLC027497
Registered Office: 258/A, Bommasandra Industrial Area, Anekal Taluk, Bangalore 560099
Corporate Office: 261/A, 2nd Floor, Bommasandra Industrial Area, Anekal Taluk, Bangalore 560099
Tel +91 80 7122 2636 | Fax +91 80 2783 2648 | Email: info@narayanahealth.org | **www.narayanahealth.org**

Appointments
186-0208-0208

"Narayana Hrudayalaya Limited
Q3 FY25 Earnings Conference Call"

February 18, 2025

MANAGEMENT: **MR. VIREN SHETTY – VICE CHAIRMAN**

DR. EMMANUEL RUPERT – CHIEF EXECUTIVE OFFICER & MANAGING DIRECTOR

MS. SANDHYA J – GROUP CHIEF FINANCIAL OFFICER

MR. R. VENKATESH – GROUP CHIEF OPERATING OFFICER

DR. ANESH SHETTY – MANAGING DIRECTOR, OVERSEAS SUBSIDIARY HCCI

MR. NISHANT SINGH – VICE PRESIDENT - FINANCE, MERGERS & ACQUISITIONS & INVESTOR RELATIONS

MR. VIVEK AGARWAL - SENIOR MANAGER, INVESTOR RELATIONS

Nishant Singh: Good afternoon, everyone. My name is Nishant Singh, and I welcome you all to the Q3 FY25 Earnings Call for the company. To discuss our performance and address all your queries today, we also have with us Mr. Viren Shetty - Vice Chairman, Dr. Emmanuel Rupert - CEO and MD, Mrs. Sandhya Jayaraman - Group CFO, Mr. Venkatesh - Group COO, Dr. Anesh Shetty - MD of our Overseas Business HCCI, and Vivek - Senior Manager in the IR function.

Before we proceed with this call, we would like to remind everyone that the call is being recorded and the transcript of the call shall be made available on our website as well as on the stock exchange later. We 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.

With that now, we would like to start the Q&A session. I request everyone to now raise the 'raise hand' feature to start posing their questions. Yes, Prithvi, please go ahead.

Prithvi: Yeah. Obviously, the first couple of questions to Anesh on Cayman Business. Anesh, is it possible for you to provide some color on the scale-up of the new facility? Which departments have been commissioned, how is the response, etc.?

Anesh Shetty: Yeah, hi, Prithvi. Sure, happy to take that. So, we started the outpatient facility in the new hospital in the beginning of December. So, the results that you're seeing in Q3 only include the outpatient services, and that is also only from December, which is the last month of Q3. Prior to that, we were only bearing, I would say, a lot of the costs of the new facility, but we didn't have any revenue, incremental revenue, coming in. And the first few weeks of the new hospital have been fantastic. We've been very, very happy to see the positive response, and it really proves our investment thesis is in the right direction.

From the end of Q3 i.e. Jan 1st onwards, although those are not disclosed in the financials here, but just to give you some additional information, we commissioned a lot of other services such as the emergency room, inpatient surgeries, etc., as of January. The plan is in February i.e. mid-February onwards, to start obstetrics and neonatal care. So, hopefully by March or so, we'll commission all service lines. But the results you see only pertain to outpatient services being commissioned for the month of December. I hope that was helpful.

Prithvi: Yeah. Just a follow-up on this. If you look at Cayman margins this quarter, they have been quite exceptional with the kind of sequential improvement that we saw. I mean, I'm not asking for the specific guidance, but is it fair to assume that margins, going forward, will be sequentially better from now on?

Anesh Shetty: So, sequentially better is a tough bar to cross. But let's look at Q2, where we had about, I would say, 5% to 7% margin dilution. And that's because we were starting to bear a lot of costs for the new facility, but no revenue coming in. Whereas if you see now, you will see a good amount of recovery, almost very close to our usual run rate on an EBITDA basis. And that's only with the outpatient services being commissioned. But for Q3, in our estimate, we've been bearing about 85% of the costs, if not slightly more, for the new hospital. So, we're very happy to see that a lot of that was covered because of the revenue growth. And it's a fair assumption… no hard numbers to guide on, but it's a fair assumption to say that I think the worst is behind us, that was Q2, and let's see how things play out next quarter onwards.

Prithvi: Got it. Just on the India business bookkeeping question, can you give it a breakup of the new hospital's revenue and margins for the India business?

R. Venkatesh: I mean, if you take the new hospitals combined, the EBITDA, if you take Gurugram, Dharamshala and SRCC together, is around % for this quarter - Q3, which was around 3% in the Q3 FY24. So, there is a marked improvement. SRCC was marginally negative, but obviously Q3 is a weak quarter, but it will improve in Q4. Gurugram is marginally positive, and we consolidate in Q4, while Dharamshala, it continues to do well at higher double-digit EBITDA. Going into Q4, we expect all these units to perform better, with Gurugram likely to lead in the improvement metrics.

Prithvi: Can you give the revenue number for these new hospitals?

Viren Shetty: Sorry, we will be breaking out the revenue by cohort, I think, going forward. Going hospital by hospital for the new one, would not be a material thing.

Nishant Singh: Yes, the three put together, is roughly around INR 130 crores.

Prithvi: Okay. Thanks. That is all from my side.

Nishant Singh: Thank you. Thanks, Prithvi. May we have the next question, please?

Viren Shetty: Nishant, there is a question on the chat on occupancy of India business this year versus last year, and also EBITDA for Cayman.

Nishant Singh: See, the occupancy is, we do not give the exact numbers, but it is roughly around the same between both the quarters of the two financial years. It is slightly below 60%.

Viren Shetty: For the Cayman, do you want to help them derive it?

Anesh Shetty: Yes, I think, I mean, you have the console and India. The difference between the two is more or less close. There will be some other minor things in between.

Nishant Singh: Yes, so if you just add up the two, the difference is not exactly HCCI, there is a bit of ICO, inter-company elimination. But the number which you get to see is INR 293 crores as per the press release, which is what we should consider the revenue for HCCI. And EBITDA also we have given the console and India. So, from that, you can deduct Cayman EBITDA.

Viren Shetty: Hi Yash, please go ahead.

Yash: Yeah, hi. Thanks for giving me the opportunity. So, what I wanted to understand is, all the cash proceeds that you get from your Cayman Islands business, what is going to be the utilization of the same? And do you see any sort of prospects in any other regions nearby or probably you want to enter the United States?

Anesh Shetty: Yeah, so we've recently just disclosed a small investment in the Bahamas. That's another Caribbean Island, which is a high priority market for us. We continue to be focused on finding an opportunity to grow in that market. We get a lot of medical tourism patients from there. So, that's a high priority market for us. Nothing in the US that we are looking at the moment or in the meaningful past.

Having said that, of course, as a console, as an organization, India is home and the highest priority market for us. But we'll continue to explore opportunities where we think we can make a significant value addition in other markets. And it's just good timing you asked the question because I think on Friday, we disclosed a small investment in the Bahamas, which is a market in the Caribbean. So, it's very close to where we are in Cayman, and a lot of synergies between what we do there and in Cayman.

Viren Shetty: With regards to the question on cash proceeds, the India dividends are funded out of Cayman.

Yash: Okay, fair enough. And another question that I had was on your Cayman Island business itself. So, if you could just give a split of all the patients that come to a Cayman Islands unit. So, how many of them would be residents of Cayman Islands versus how many of them are international tourists from other countries?

Anesh Shetty: Yeah, we don't give that split. It's a small market. And for competitive reasons, we prefer not to get into those details.

Yash: All right, fair. Thank you so much. I'll jump back in the queue.

Nishant Singh: Thanks, Yash. Yes, Damyanti, can we have a question, please? Damyanti, please go ahead.

Damyanti: Hello. Thanks for the opportunity. I want to understand your gross margin for the quarter. So, again, I guess very strong number, and this is even better than I think the Q2 numbers, which is sequentially better quarter for India business. So, can you explain this, what has led to such strong performance at the gross margin level?

Sadhya J: Yes. So, from, I think, gross margin, there is only consumption that kind of applies on gross margin. So, consumption has two factors that contribute. One is the mix effect. Depending on the type of procedure, the benefit in terms of the consumption mix. And second is the effect of efficiencies. Being a very lean quarter, so we've been very tight in terms of our execution and efficiency, and that is also reflected in the gross margin numbers.

Damyanti: Okay. So, although like India is seasonally weak, but because of efficiency, and as you mentioned, very tight control on consumables, etc., that actually led to better margins.

Sandhya J: Correct. Correct.

Damyanti: Okay. So, Sandhya, I think if you can also help me understand the other operating expense? As Anesh mentioned, we are incurring almost 85% of cost upfront for the new facility in Cayman. So, is Q3 mostly reflective of the base structure for operating cost, and we should be looking at this cost base going ahead?

Sandhya J: Yes. From a Cayman point of view, that is correct. Most of the costs that need to be baked in into the operating setup, has already been baked in. And therefore, this can be considered as a good extension.

As far as India is concerned, Q4 operating cost structures will be similar to Q3, except that the variable cost structures are variable to revenue and Q4 will be a higher revenue quarter.

As we hit Q1, we will obviously see the impact of increments that will come across the line, and therefore, the costs will see an escalation to that effect.

Damyanti: Understood. And one question for Anesh. Anesh, you mentioned by March, all the parts of new facility will be like… all services will be started by March. So, just want to understand, are you done with all the hirings in terms of doctors, nurses, etc., or that also will happen in a more phased manner?

Anesh Shetty: No, no. So, generally, the manpower and the other costs we have to incur, and there's about a one-month lag between when they are here and when… I mean, when they're on island and when we can actually start the services. So, as of December, like I said, about 85% of the manpower hiring will be and the costs would be complete. 100% of the fixed costs of the facility, about 85% of the manpower costs. By Jan, that's going to be almost 90% and by Feb it will be 100%. It is 100% as of now.

Damyanti: Okay, got it. That's helpful. Thank you.

Nishant Singh: Anesh, there's a question on the message.

Anesh Shetty: Let me just go ahead with it.

Viren Shetty: The question is, are we looking for a controlling stake in Spire Healthcare Group? We had already put out a disclosure. We are not looking to make acquisition of controlling stake in Spire Healthcare.

Anesh Shetty: Yeah, that's correct. So, essentially, there's a no-bid statement, which is a formal declaration to the takeover code under Rule 2.8, where we're restricted from making anything. And we said that was not our intention and we don't intend to do so.

Nishant Singh: Yeah. Thanks, Anesh. Can we have the next question, please? Yeah, Prithvi. Please go ahead.

Prithvi: I just have one follow-up question, Anesh, on the Bahamas stake acquisition. What is the rationale for 4% acquisition? I mean, what kind of value will we be in a position to add if we have only 4% stake? Is company looking to acquire majority stake going forward, or what exactly is the thinking here?

Anesh Shetty: Sure. So, Prithvi, in the Caribbean, there are only two private healthcare assets, which are 100 million plus scale. Anything below that doesn't make much sense for us to work with. That's one is us, one is a doctor’s hospital in Bahamas. It's also a publicly listed health system.

Now, the intention is, this is very much an initial step. It gives us the optionality to increase that, or to learn more about the market, or to just see whether there is a potential to expand into the Bahamas. Similar to what we've done in Cayman, which is a significant investment or it's something where we'll only get medical tourists coming in and grow our international business. It's an entry in the market that gives us a lot of optionality to explore various strategies.

And having said that, with the management and with the existing promoters, we have a very good relationship, where on an arm's length basis, we are providing them with various synergistic services around procurement, planning, strategy, etc. But yes, you are right. At a 4% level, we don't have the complete operational control, obviously. But this is an initial step and let's see how things proceed.

Prithvi: So, just one follow-up question on this. Cayman government has been quite business friendly with respect to the way approvals, etc. have been given. How do you rate Bahamas in that?

Anesh Shetty: I think we have a good working relationship with most governments. We do have to find a fit between the priorities of the government, the other doctors and the medical community in general and what our needs are. In Cayman, we've made a large upfront investment, and then we worked to make it possible. But over here, this is an initial step in the direction. We continue to interact with the government stakeholders. They're generally very, very supportive of what we've been doing. In fact, one of the largest payers for us from an international perspective is the government in Bahamas. So, we have a good relationship with them, and even with the existing promoters of the hospital and the management. And we're optimistic about the future.

Prithvi: Thanks, Anesh. Thanks a lot.

Anesh Shetty: I'd also add that the investment was made at a fairly attractive valuation, if you look at the performance of the asset, but that's just a side bonus.

Nishant Singh: Prashant, can we please have your question?

Prashant: Yeah, thanks. My question is about the expansion plan that you have highlighted in the presentation. So, this includes a lot of greenfield projects, and most of the projects are… I mean, all the projects are either fiscal '28 or beyond. So, how do we read this? Is there any additional, say, brownfield bed addition that you would be doing over the next couple of

years? Or are we to assume that the current bed capacity is what you will have for the next two years before these come on?

Viren Shetty: I'll answer this one. We are scouting for brownfield opportunities for buildings that already are there or hospitals that can be acquired or inorganics. It's just that those, while you can start the operations fast, are terribly hard to negotiate and the price has never been attractive for us. So, the ones where we either build the whole thing by the land, put up the construction, or partner with the developer, he puts up the building, we put up the equipment, those have long lead times, but those are the only deals that end up finally closing.

It doesn't mean that over the next 2-3 years, we won't try and get some half-billed building or a hospital for acquisition; those are out there. And one day, maybe God will be kind to us and we will be able to acquire one of those at a price that makes sense. But until that happens, it's one of those 'bird in the hand is worth two in the bush' situation. So, we will try.

And actually, that ties into one of the questions that's asked on the chat, which is, owning land versus leasing, which is the preferred strategy going forward? The preferred strategy is whatever is available to us at the right price. If in a certain part of Bangalore, the only opportunity that exists is to own it, then obviously, we would. That is the only choice there. Whereas if someone else is willing to build and lease to us, that's the one that we would prefer. Most priority is for acquisition at the right price, but those are very few and far between.

There's another quick question on pre-engineered buildings to build hospitals, given it saves time and cost. Yes, but so my background is in civil engineering, although I'm no means the expert on this. Pre-engineered buildings are better specked for housing developments. These are for large townships, apartments; things that are the same size, same dimension, same plate, that repeats again and again and again. Whereas hospitals are unique, because one is, the spec of everything is different and the way the way the land works and the way the specialties are developed, pre-engineered doesn't offer any great advantages in India, plus all that additional cost. That's one why it hasn't been so successful. Two, the only companies that got into this in a way, went bankrupt. So now there are a few companies still left doing pre-engineered prefab structures, but those are quite not as reputed.

So yes, there are prefabricated elements inside the hospital that we will try to put in, like precast labs and so on, but mostly it will be this long in-site pour that we will be doing.

Prashant: Just one more question from my side. So, acquisitions I understand are difficult to predict. Do you have scope to add beds in any of your existing hospitals?

Viren Shetty: Yeah. We have tremendous scope. But the question is whether the need is there. So in the Health City, for example, there's a lot of land and the scope for adding another 4,000 beds, but that part of Bangalore does not need 4,000 beds. In fact, we don't because we've been focused so much on reducing length of stay, improving efficiency, it's just easier for us to generate more revenue out of the same space than blindly go chasing after beds. But where we are losing out is that we don't have a presence in different parts of Bangalore. So we're spending a lot of money to be closer to where the patients are to improve the overall funnel of patients who will come to the Health City.

So yes, same for Jaipur, same for Ahmedabad, same for our Mumbai hospital, same for our Delhi hospital. All of them have the capacity to add more beds, but not the business case that requires it.

Prashant: Got it. Thanks. That's it from me. Thank you.

Viren Shetty: Yash, you still have a question?

Yash: Yeah. I just had another question. So, over the last 5-10 odd years, Narayana was little conservative in terms of adding more beds, doing some sort of brownfield or greenfield Capex in relation to other hospital chains. So, given that the cost of capital is a little lower than before, do you think this is the right time to get a little aggressive? I mean, this is beyond the addition of the beds that you have already planned.

Viren Shetty: It is evident from those who are paying attention to the Capex slides that, that has stepped up to another level. You can't time this in a perfect world. We should have gone in a more distributed fashion where there's, let's say, 1-2 hospitals coming up every year, spread out over 10 years. But now it is more of a lumpy distribution where a lot of hospitals are coming up at the same time. Historically, we were conservative. We will continue to be conservative. We will stay within our borrowing limits, and we'll try to fund with borrowing to the extent of our serviceability on repayments, as well as keeping in our dry powder for special situations as and when they occur. Rates coming down isn't the only determinant of whether we go complete gangbusters and build hospitals. It's a helpful determinant, but not the only one. Most is determined by what the business requirements are and the changing customer need.

Previously, people would travel from all over the country to come visit our places. Now, nobody does. I mean, very few people do that. So, we have to go to where the customers are. And so, that's why our hospitals need to be more spread out and across the city. And because we're committed to being an integrated care provider, we need to build clinics, we need to be much closer to customers so that they see value in buying our insurance plans. So, that is more the driver for the enhanced Capex allocation in our core cities i.e. Bangalore, Kolkata.

Anesh Shetty: Question on the chat Viren, on cash and bank balance available in Cayman. So, just a quick clarification. We disclose the consol cash and debt and we also disclose what percentage of the debt is foreign currency denominated, almost all of which is for Cayman. But we don't disclose the split between… investments between the two markets. Sandhya, you want to add something here.

Sandhya J: Yes, Anesh, that's what I was going to respond also. That part is not disclosed at the moment, yes. Obviously, in our financial results, which get declared at the end of the year, the breakup is readily available, because the standalone balance sheet, as well as the console balance sheet is available. So, I think that number can be computed.

Viren Shetty: Sorry for that. But we hope you'll understand why some things need to be calculated rather than put out there.

Nishant Singh: Okay. Deekshant, can we have your question, please?

Deekshant: Hi, management. Thank you so much for taking the question. The first one is that, I understand that it is expensive for us to buy a brownfield opportunity. But could you help us understand what kind of opportunity are we looking for? If you could just paint a word picture for us, how this opportunity would look like?

Viren Shetty: The number one determinant of the opportunity is it has to be in our core market. As I said earlier in the call, it could be a great asset in Nagpur, but we're not looking to expand in Nagpur right now. So, number one, it has to be in Bangalore or Kolkata, or second priority, Delhi or Raipur. If it meets that criteria, then is it in a good location? Is it the right size? Does it meet our business requirements? Meaning, is it in a place where we don't have a presence rather than being one more in a place where we already have a hospital? And the last determinant is the price, right? Do I generate a decent return on capital if I do acquire it? Or if there are some issues with how it has to be rebuilt to our purposes, because some buildings are very badly built, some will not be able to fit as many beds, some will not be compliant

with all the licenses and fire and occupancy certificate, all of it. If it meets all of that, then we would take it up.

Deekshant: Okay, makes sense. What kind of IRR are we targeting for a brownfield expansion? Just a ballpark figure.

Viren Shetty: Nishant, tell him our threshold.

Nishant Singh: So, the IRR we expect for many of these projects is upwards of 15%. Yeah, so that's that ballpark number which we target.

Deekshant: Okay, so that's like for us, that would be the bottom line, if it makes sense at 15%. Makes sense. Sir, if we are to do a brownfield expansion in the core market that we are looking at, what would be the general timeline it takes for us to make it operational? So, if the deal is signed today, how long would it take for us to make it fully operational as per our standards?

Viren Shetty: Three years.

Deekshant: Three years. And the sort of greenfield expansions that we are doing two years down the line, sir, that would be much more of an accelerant for us as a fundamental driver?

Viren Shetty: No, whatever it is, it's three years. It takes 2 to 2 ½ years for construction, half a year for all the license; just buffer zone for commissioning and whatever extra regulatory things we have to deal with.

Deekshant: Okay, so the announcements you have made right now, that would be first for construction and then another 6-9 months for all the other fitments and licenses. So, that would make three years. Is that the right way?

Viren Shetty: Yeah.

Deekshant: Sir, last question is on the sort of work that we are doing in Caymans. Sir, I know that stem cell is a very big part of the business when we are looking in places like Cayman. Is Narayana Hrudayalaya really looking at that one function of business?

Viren Shetty: No.

Anesh Shetty: No, I mean, there are legitimate uses of stem cell therapy and there's a lot of non-approved, non-FDA approved, non-CEA approved indications. So, we do not engage in any services that aren't FDA approved.

Deekshant: Sir, if I can just expand on a question a little bit here, there is a lot of great work that is being done by legitimate doctors in US part of the world on stem cells, which is in Panama's, which is for basically shoulder reconstruction, healing, hips and all that. But there is no such opportunity in India as well. And Narayana Hrudayalaya, having a facility in Cayman is an opportunity structure for us. Is that something that we have thought about internally, or is it something we are staying away from right now?

Anesh Shetty: Dr. Rupert, do you want to?

Viren Shetty: Yeah, Dr. Rupert is the best person to talk about this.

Dr. Emmanuel Rupert: Yeah. So, like Anesh mentioned, there are a lot of indications which are there, but it has not been having a great proven value for all these things. So, we would be slightly conservative before we embark on something like that. Yeah. So, the availability of also those things are also not easy, but we keep evaluating all these new age therapies. But we have a core clinical governance team, only when we think that it is the right approach for us to do, only then we will enter into something like that.

Deekshant: Makes sense. Sir, when you talk about value, is it a financial value or the treatment value.

Dr. Emmanuel Rupert: The treatment. It should make purely make sense for the patient. We would not like to do something which is not… It is there, but it gets constantly evaluated. From a stem cell perspective, the ones which we are doing is the CAR T therapy, which we have started. We have an in-house partnership with Immuneel to manufacture those things. So, we are constantly doing the CAR T therapy. But the new age… like what you mentioned indications for various other things for shoulders and various orthopedic applications, we are evaluating. And once we are fully convinced, only then we will be going.

Deekshant: Makes sense. Sir, just one last question if I am allowed to. Sir, we really like your Mumbai kids' clinic. Is there any sort of scope for a full-fledged Mumbai expansion as well?

Viren Shetty: In the existing hospital, we are in touch with the Trust to expand into the multi-specialty adult program. We are in discussion. We should hear positively from them over the next couple of months.

Deekshant: Okay, sir. Okay. Thank you so much for the clarity and transparency. Wish you the best.

Nishant Singh: Thank you. Can we have the next question from Nitin please?

Nitin: Hi, two questions. Viren, if you can, a) just give us an update on the primary health clinic business and on the insurance venture, in terms of how it has fared for the year? And what are milestones for the next few quarters for the business?

Viren Shetty: Yeah, we've taken a pretty aggressive target for next year. This year and the previous one, was the year when we were just building it out, getting the operating team in place and focusing just on Bangalore. Next year, we will move into Kolkata as well. I've given them a target of 50 clinics in a year. It doesn't seem like we'll be able to hit that, but at least optimistically, that's something that we want to go after.

The burn on clinics will start to increase. It was about INR 14.5 crores in Q3. It may be a little bit more in the year after i.e. the quarterly burn. We also launched Arya, which is the insurance plan that we actually wanted to build, which is full outpatient, full inpatient. And this is the one that's going to be our flagship product. It's just been out for a week or so, so it's not really showing much numbers and progress. And so, we're building out the sales team as well. Over the next year, you'll start to see both of them start to show. Still, it will pale in comparison to the hospital business, but this is something that we see really as an engine of growth for the integrated care business.

Nitin: On the clinics, what is the expansion that you have in mind? Where do you see the sort of peak losses really scaling up to?

Viren Shetty: We will not do what other competition has done, which is scale too fast. We will control the amount of burn to keep it manageable within the overall performance levels of the hospital. So, when I gave the team a target of 50 crores, if they come back and show me that I'm going to lose about INR 40-50 crores every quarter, then I'll say, “No way”. We'll try and keep it. Fortunately for us, the break-even period for these clinic cohorts is not that much. So if you're looking at 18 months of break-even for a lot of these clinics, then the profitable clinics will start subsidizing the newer loss-making ones. So, we've totally assumed about INR 400-500 crores worth of investment in this entire business. Now, that's roughly about how much we'd spend if I'm putting up a 250-bed hospital. So, it's one hospital's worth of spend to build a new business vertical. Now they have to prove that these guys can contribute, they can send patients, and they can sell policies. If they can, great. Then we'll look to scale up much more than that, but that will still be about 2-3 years away.

Nitin: And this INR 400-500 crore investment is over what time horizon?

Viren Shetty: Total. I mean, this is the amount that I mentally set aside that it's worth building a new business out of it.

Anesh Shetty: That also includes the insurance related…

Viren Shetty: Yeah, all of that. That includes whatever I need to put in for the insurance. The integrated care means clinics plus insurance. Sorry.

Nitin: Right. And in the initial experience that you've seen on these clinics so far, what are some of the benefits that you've seen coming to the network? If you can probably share some?

Viren Shetty: For now, we're not able to capitalize on it so much. So, the normal thing what people… even for us, when we used to build clinics before we took it more seriously, we thought, oh, a lot of patients will come to clinic and we can send them to the hospital. That's not been the experience so far. These are high frequency, low acuity, low value transactions. For us, we want to have a much closer relationship with our patients. It won't lead so much to referrals now because clinics are seeing relatively healthier patients. But we want Narayana to be top of their mind, so that tomorrow they will be more enticed into buying the plan, the insurance plan, the Arya plan, what we're offering. Or, even if they don't buy the insurance, if they ask, "Oh, you know, I have this serious problem or something's been diagnosed, who should I go to?" Our name will be top of mind. So, it'll take a while for those clearly defined referral pathways to emerge. But still, they benefit a lot from having a common earmark, from us being able to work with our specialists to come there and do evening OPDs or to come on weekends. So, it just gives us a larger surface area to expose patients to the kind of services we offer, rather than keep everything just stuck inside the hospital. But yeah, for now, the referral revenue may not be material.

Nitin: And just last one on this, so far in your experience a well-run clinic which sort of takes off well, establish itself well, what kind of profitability it can do?

Viren Shetty: Retail have as such the only comparables are, I think, AHLL, which is out there. It is low to mid-single digit EBITDA margins on a consol level. Clinic to clinic level, see, we are running 3 different business verticals inside the clinic. One is the Pharmacy; one is the Test and Diagnostics and then the consulting revenue but also we're adding the insurance and the subscription plan revenue in that. So, it does look to be quite healthy on the balance sheet at least. We will have a much better sense of what the EBITDA should look like, like I said, 2-3 years from now once everything is mature.

And we won't need to expand beyond a certain number of clinics because we're only going after the cities where we have a presence. We will not expand across the country; we will not build clinics in place we don't have a hospital and we'll only build it in our focus area. So, this is a build out that has a stop date. Post which, their only job then is to sell policies.

Nitin: Got it. Thanks. If I can just take the last one with Anesh. Anesh, on the overseas business, how do you overall think about this piece or what's the next 2-year perspective? I think in the Cayman bulk of the Capex is done. I mean, when do you see you hitting sort of optimal levels of revenues on Cayman? And what beyond Cayman from here on?

Anesh Shetty: Yeah, the next 2 years are going to be busy because we've just started the new hospital that gives us a lot to do at least for the next 12 months. From Jan 1st we've also started selling our Integrated Care, that is our insurance policies in Cayman. That's a completely tangential, I mean, it's a related business and very much feeds into what we're doing but it is a separate effort, separate build out as well. So, we have no shortage of opportunities to continue the trajectory we're on for the next 2 years. Now, what beyond that, obviously, we cannot time these things perfectly. We've been spending the better half of the past 5 years actively looking for opportunities in the region and beyond. And so far the only thing we have is the small investment in the Bahamas that we just talked about.

So, we continue to explore markets both in the Caribbean and elsewhere. But like we've always said, our focus is in India and which is at the moment the world's most attractive healthcare market for deployment of capital. So, whatever we look for has a very, very high barrier and high threshold to cross. That makes us very picky. But let's see, we'll keep trying.

Nitin: Okay, thank you so much.

Nishant Singh: Thanks, Nitin. Deven, hi.

Anesh Shetty: Sorry, before that, Viren, do you want to take the question on the chats.

Viren Shetty: Let's finish the ones on the call. Then we will go to the chats after that.

Anesh Shetty: Sure, sure. Yeah.

Deven: Okay, so should I ask?

Viren Shetty: Yes, Deven, please go ahead.

Deven: Yeah. Anesh, so for this quarter can you give, share the revenue from the new Cayman unit? And now that the hospital has started, can you share any sort of operating metrics for the new unit like IP, ARPP or OPARPP? What sort of ARPP should we expect?

Anesh Shetty: Sure, Deven. So, we briefly touched upon this the last quarter as well, but we'll repeat. I think it won't be possible for us, even internally, to differentiate revenue between the two units. We're running them as two campuses of the same hospital. So, almost all the doctors are common, we don't have separate clinical staff. Only maybe a few frontline executive staff are dedicated. But it's next to impossible for us even internally to differentiate revenue and cost between the two. So, we'd only be reporting it and even for our own reviews and our own analysis as well we look at the hospital businesses as one block. And that's just because of the way we are operationalizing it.

And it's a good thing we're doing it this year because we've not added significant costs to get the second hospital going but it also means that you lose that ability to have separate metrics and separate standalone analysis of these two. It's very overlapping, almost everything is overlapping.

Deven: Okay-okay, got it. And, secondly, coming to the Bahamas acquisition, the 4% stake, in the disclosure you have mentioned that it will also help you in referral access for tertiary care. So, is that going to be something material for us?

Anesh Shetty: So, the material part of our existing business comes from international markets because Cayman is a relatively small market. So, we do have a good portion of patients coming from elsewhere. In the international markets, Bahamas is in the top tier of its potential for us as well as its contribution potential more so. So, it already is part of the financials and the performance that you see, and we hope it will be a bigger part of it and this investment help to drive that.

Deven: Okay, understood. Thank you.

Anesh Shetty: Nitin, you want to go next?

Nitin: No, sorry, I'm done. Thank you so much.

Viren Shetty: You can take questions from the chat.

Nishant Singh: The first question is the long-term strategy for Gurgaon Hospital. Context being the location and the approach limiting the catchment area and in the context of Apollo and Max coming

up, that will probably capture the extended catchment area. So, long term strategy for Gurgaon market?

Viren Shetty: Venkatesh, Rupert, you want to talk about the domestic focus?

Dr. Emmanuel Rupert: Yeah, so we are focusing significantly on the domestic market with the radius of around 30 kilometers and, like Viren was mentioning, the clinics are also coming up. We are looking at coming up with a couple of clinics there in that region. And the specialties will be focused quite a bit on the secondary and the basic tertiary specialties as well in addition to all the other things which we've been doing. Together, it will become a comprehensive kind of an approach which we have been doing in many other locations and we feel that going forward we will see reasonable traction in the units.

Nishant Singh: Okay, thank you. The next question is, are there any change in the expansion plans of the insurance subsidiary for the next 2 years, next two quarters?

Viren Shetty: Any change in the?

Nishant Singh: Expansion plans of the insurance subsidiary for the next 2 quarters.

Viren Shetty: Insurance. Okay, if it's just insurance, no. I mean, they are scaling up moderately, so I think it's adequately capitalized. We don't need to infuse too much capital just for the insurance part. The only ramp up in spend would be mostly on the clinic side, which is a separate vertical called NHIC.

Nishant Singh: Okay. There's another question on the expansion plans on the west side.

Viren Shetty: Yes. I assume they mean the western part of India.

Nishant Singh: Yeah.

Viren Shetty: So, the hospital we have in Western India are Mumbai and Ahmedabad. At this point, the only thing we're looking at is if the SRCC Hospital in Mumbai, if we can turn that into an adult program as well. So, it'll run as a children's hospital plus also have the adult program. Outside of that, it is not an immediate thing that we're looking at. It's something once we've finished the buildout for Bangalore, Kolkata, we may look at that.

Nishant Singh: Okay. There's a question on the same U.K. thing, which you already clarified. The next is on the expected ARPP growth and revenue growth which we're targeting.

Sandhya J: Let me take that. From ARPP growth point of view, as you are aware that our price strategy is not a very aggressive price strategy. So, the growth will be similar to what you've been seeing so far in the past. It'll grow reasonably but over a period of time. As far as revenue growth is concerned, I think our organic growth trajectory is already established and, therefore, we will be able to sustain this kind of organic growth trajectory. As and when we have some opportunities to inorganically augment this, we will see the benefit of that. We will obviously see the benefit of Cayman growth in the near quarters because at the moment not much of the revenue of the new hospital is on the baseline. So, that uplift we will see in the coming quarters. Similarly, we will see some amount of uplift coming in from the growth of the capacity that we've added in our MMRHL hospital and a little bit of capacities that we will add in across different hospitals. But broadly, it will be in line with the trends you have seen so far from our organic growth point of view.

Nishant Singh: Yeah, so we'll go back to Deekshant.

Deekshant: Hi. Just a question on the insurance category. So, I'll just ask some ballpark numbers. We have talked about having the product in such a manner which aids in regular treatment plus the recovery of individual if something major has to happen, do we also cover senior citizens in this category as a floater policy?

Viren Shetty: Yes, but there will be some loading on senior citizens because of the comorbidities and the things that work with that. There is a thing, we're still in the early stages of formulating, which is a senior citizen specific policy, but that would be quite expensive but also very comprehensive. We don't know how well that would sell but it's something we think the market does require. But for this one, yes, with some amount of loading, we can add senior citizens but not in all cases.

Deekshant: Would that senior citizen policy would also have if somebody has existential diseases because most senior citizens in India do.

Viren Shetty: Yeah, it depends on that. So, I mean, if you're looking for your parents, I'll share my number and after this we can sit and talk to you. But, yeah, it is something that comes as a frequent request. There are some things that we know are quantifiable and manageable because we're in the healthcare business, we know there's certain risks that you face and at the various ages where most insurance companies will just say, 'No, I don't want the hassle, forget about it'. But for us, we can make very customizable solutions to offer to our customers. But a senior citizen specific one, that's something definitely we are working on and would like to have a rollout sometime next year.

Deekshant: Thank you so much, Sir. I mean, I'm also looking at it from actually a business standpoint for us. Of course, personal standpoint would be helpful for all of us. I'm just assuming here, if we are looking for a plan where it's wife and husband plus family, is that some sort of product that is being created or being sold right now? And what is the revenue leader product for us right now in the insurance category?

Viren Shetty: Right now it's still very early. So, we have two products, which is family of 4 or family of 5. There is the inpatient only product, that one is called ADITI, then there's the inpatient plus outpatient product called Arya, that we believe will be the flagship product because that is the fully integrated thing that we're offering. Sandhya, any extra things you want to add on that, on pricing and so on?

Sandhya J: Yeah. So, ADITI is a missing middle product and, therefore, it is priced in a very affordable way because ADITI is like an entry level for people who are not able to access insurance today. And Arya is for people who are actually having insurance or are able to afford insurance but are not happy with the experience of insurance. So, Arya is an end-to-end seamless experience that is available right from outpatient to management of clinical services that are needed as well as if there is an inpatient event that happens, then management of that as well.

Like Viren was saying, we're still working with these products in a very controlled way so that we are able to manage the overall thing. So, it will take some time for us to be able to share numbers on these products. Though from a customer feedback and people who have experienced the product point of view, we are getting very, very positive traction. The biggest advantage that you have in both these products is a complete walk-in, walk-out experience. So, when a patient is in our network and they walk in, there is no pre-approval and pre-auth and clearance and then waiting for insurance clearance and no deductions, no co-pays. So, it's a very clean walk-in, walk-out, 100% trustable kind of product and that's what we see the people who are now buying the product or understanding the product like about them. But like we've said, these are still in very early stages and as these products build up we'll be able to share more information.

Deekshant: Just two small follow ups here is on the Arya product that you have mentioned, Ma'am. Ma'am, this would, I assume, only be viable at Narayana Hrudayalaya.

Sandhya J: For elective, yes. For emergency, we are covering in all hospitals.

Deekshant: Oh! Okay. Got it, got it. So, if it's a pre-planned surgery…Okay, got it, got it. Another part is if we are doing so end-to-end of a product, which is amazing for the customer and really revolutionary product in the industry as well, does it not lead us to more risk in terms of our net ROI of the product?

Sandhya J: So, we have a very strong underwriting process that we are following as well as a mathematical model by which we are managing the risk. Obviously, only with scale the risk balancing will happen and as we build scale, we'll be able to balance out the risks. But whatever the norms are available and whatever our judgment on those are, we have considered the risk in the pricing of the product. Viren, you want to add to this?

Viren Shetty: Yeah. See, the biggest risk we face are the thousands of crores of Capex we're putting up for the hospitals and people are complaining a lot in the market that healthcare is becoming very unaffordable, and I don't blame them. The sort of price increases what you're seeing is ridiculous and the sort of price increase in insurance also what you're seeing is ridiculous. So, for us, all this capacity what we're making, we want people to utilize healthcare more because that is what the natural order of things is. Your great grandparents never went to a hospital, your grandparents with some reluctance went, your parents would have gone once or twice, you will go quite often, your children, for every cough and cold you're taking them to ICU. That's just how it is worldwide. You can't stop that and insurance is the one that removes the barriers.

So, the ROI, it's something we'll dynamically adjust. We are not insurance experts, we don't know it but we know healthcare and we know you need to access more healthcare and we know that once you make an offering that works with the patient and does not look to extract as much value as you can, your patients pay over long periods of time and they are loyal and you can lose money upfront but eventually you make it back.

Dikshant: Agreed, agreed, agreed. Thank you so much, Sir. Thank you so much.

Viren Shetty: Thank you, Deekshant, for allowing us to advertise our insurance products for the 15 minutes of this call.

Nishant Singh Yes, Deven, please go ahead.

Deven: Yeah. So, in your slide, on the Capex slide, at the start of the year we had budgeted a Brownfield Capex of INR 1350 Mn but we have ended up spending only INR 240 odd Mn, so there is a significant deviation from what we had planned at the start of the year. So, if you

can just explain this difference? What happened throughout the year that we could not spend or did not want to spend the budgeted amount?

Viren: For one, these things to take longer. Sandhya, please go ahead.

Sandhya J: No, go ahead. Go ahead, Viren. Sorry.

Viren Shetty: It just took us much longer, the negotiating time, it took for us to expand in India. The time it takes to negotiate contracts to work on the licensing, just generally we haven't been able to execute fast. It's not for want. We want to spend; we want to add capacity.

Deven: Okay. No, but this will be largely in our existing hospitals, right, the Brownfield capacity addition budget that we give in the slides?

Sandhya J: Yeah, I'll just add to what Viren was answering for the Greenfield part where we budgeted quite a bit and we have not completely caught up to it. But there are projects in pipeline and we do believe that we will bridge some of it in the current year. Otherwise, we'll just flow over by a quarter. As far as the Brownfield and capacity addition part of it is concerned, roughly half of it is just the CWIP in different stages which we need to capitalize because as we keep doing these projects, a lot of the bills, etc. come for settlement and then we have to take them through capitalization and that process has taken some time for us. We will bridge most of that Brownfield capacity addition; we will bridge. Some of it will flow over to next quarter.

Brownfield; there was one more aspect in Brownfield, which kind of we had anticipated. Sorry, one more aspect in Brownfield which we anticipated, which was the entire Health City expansion Capex. If you remember, at the beginning of the year we were looking at commissioning an extra tower inside Health City because we were looking at that as a growth of beds but then we pivoted to more capacity creation across the city and that is why we have projects now - the HSR project, the Central Bangalore Project, the South Bangalore Project. And, therefore, we have for the time being reprioritized a little bit on the Health City expansion plan and we have to the expansion across the city. So, that also is some part that will not get bridged on that line, but it will get bridged on the Greenfield line.

Deven: Okay-okay, understood. And whatever Brownfield Capex that, let's say, we will do in this year, where are we adding the beds? In which regions are we adding these beds?

Sandhya J: So, one is, we have done the expansion in Howrah. That is one place. We are also doing a little bit more expansion in our Barasat unit. In addition, we have 5 beds, 10 beds, expansion

across different, different units where different types of capacity bottlenecking initiatives are there. Within Health City campus itself we are completing some amount of remodeling and restructuring. We did a lot of it last year, this year there is still some flow over and capacity re-shifting. So, moving more beds from General Ward beds to Critical Care beds where are seeing greater traction. So, those kind of work also is currently happening. So, that's where the Brownfield and capacity addition is happening.

Deven: Okay, understood.

Viren Shetty: It won't be a material addition of beds, most of this is just a reallocation to target and improve the yield.

Deven: Okay, understood. Thank you.

Viren Shetty: There was a question and that's related to what he asked about the new HSR hospital. There's a question on the chat about why we're spending so much more than peers. So, the peer spend is 1.5 crores per bed, ours works out to little less than 2.5 crores per bed. For those who are familiar with Bangalore, HSR is where all the startups are. It is nearly impossible to get large parcels of land and the fact that we found this at all, we had to pay through the nose to get the land. And, so, the increased cost is a reflection of the cost of running the only tertiary care hospital in HSR Layout, which otherwise does not have any.

I can maybe do the other chat questions. We're looking at Group Insurance policy for faster rollout of the insurance business. Group, yes, you get faster rollout, you also get to lose money faster. We're targeting small employers, SME employers, smaller companies because they tend to find these things a lot more attractive. Large employers will not find a restricted narrow network plan very attractive, whereas smaller companies in the vicinity of our hospital network will say that the value is much worth to them. So, those are the targets we go after. The discussions have started and that also will be an important channel, but we don't want to lose too much money chasing volumes.

Anesh, can you answer this question on the doctor attrition in Cayman? And how do you replace them in case anyone goes back home?

Anesh Shetty: Sure. So, attrition for doctors in Cayman is very, very low. They've made a big commitment personally and career-wise to relocate there. So, attrition is not the problem. But it is difficult to hire new people and the rare occasion that they leave to replace because not just professionally but a lot of things from a personal standpoint have to fall into place with

children, parents, family, spouse, etc. So, it is tough. But that's how it is in many markets, I guess.

Viren Shetty: There's one more question on the chat. Last time someone brought up the bonus shares and we had a big philosophical argument on our side on what does that really do on a per share price because essentially nothing is changing on the equity side, you're just issuing more shares and so you're dividing it by a larger number. Philosophy aside, we don't think now is the right time to look at bonus shares. I think there are much more higher priority things we're working on in our company and much better performance to be expected from a lot of the investments we made in technology in our clinics in Cayman that will drive the performance of this company.

Sandhya J: Also, to add to what Viren said, we will continue to be consistent in our dividend strategy. What we've done for the past few years, we'll continue to maintain that and that way we will also be ensuring that we are giving a reasonable cash return to the shareholders subject to approve approval of the shareholders, of course.

Nishant Singh: Are there any more questions, please, because we're done with the questions on the chat? Yeah, there's one more question now.

Viren Shetty: Yeah, Nishant, this is your question. How do you find Capex?

Nishant Singh: Yeah. So, funding for the Capex will happen through a mix of debt and internal accrual. So, for all the projects we have closed so far, we are closing the project finance with the banks for long term loans, say, between 10 years and 20 years. 80% odd is going to be funded by the bank and the rest is going to be funded by the internal accruals.

Any more raise of hands for asking any questions? So, if there are no more questions we would like to end this session.

Nishant Singh: Yeah, sorry.

Viren Shetty: This one is for Venkatesh or Dr. Rupert. How do you measure throughput in OPD? What are the benchmarks we look at? Maybe you want to talk about all the kiosk work and the TAT and the lab test results.

R. Venkatesh: Yeah, I mean, we are working very aggressively on the apps which we have where you have clear cut appointments worked out through the app before the patient comes into the OPD. So, from the time you book the appointments and the time you visit a doctor, the benchmark

is, if you look at 6 months back the benchmark was around less than 30 minutes, now the benchmark is less than 15 minutes; how fast you can process the patient from the time he enters the hospital.

And, also, what we're working on is the kiosks across all the major hospitals where we've installed all the kiosks over the last two quarters. Here, what happens is, the entire queuing systems are going to be discontinued. The patients do all the registrations through the kiosks and there'll be only one counter there in every hospital where all the cashless or the credit systems will be addressed but that will also disappear over a period of time. So, it's all going to be automated where the patient just comes in, gets the consultation and the investigation billing done through the kiosks and then gets a doctor consultation, gets the investigation again done through the kiosk and then gets the report on the app and moves ahead without any files.

So, it's all going to be digital, it's all going to be paperless, and the benchmarking obviously is that the consultation time should be within 15-20 minutes from the time he reaches the hospital and the routine laboratory and the investigation reports should come to him within 30-40 minutes from the time the samples are taken from the patient. That's a benchmark which we're following and we're also working towards gradually trying to improve even those benchmarks going forward in the quarters to come.

Dr. Emmanuel Rupert: Broadly if you look, from the time they enter into the consultation area they should be out with the labs and diagnostics and other things, with the reports, go back to the doctor, get a clear clinical plan and move out of the hospital within a 2-hour period in most cases.

Viren Shetty: See, why that is important is we are investing in a significant amount of money in a footprint in the city and in the cities we don't have the luxury of having very large spaces and thus we're not able to accommodate too many people waiting for test reports, waiting for the doctor, just waiting for information that can be conveyed. So, we want to be able to build a 200-250 bed hospital but essentially have it function like a 500-bed hospital.

So, the limitation for us being the physical infra and the way we address that and increase the throughput by investing in all of this is to ensure that a lot of it happens on the app and doesn't require any sort of counter skewing of that. And so, this will really, really be useful for us when the next lot of expansion comes in.

Nishant Singh: There's another question on the chat. Why Cayman Islands as a location is important for Narayana?

Viren Shetty: Anesh, your favorite question.

Anesh Shetty: Yeah, Viren, go ahead. You want to take it?

Viren Shetty: Okay. See, Cayman, as we've gone through in the past, it has a history behind it. This was an area we chose because we wanted to make a very large scale medical tourism. We wanted to go after the largest medical tourist market in the world, which is the United States, the largest healthcare market in the world, but we didn't want to build in the U.S. itself. We thought we'll come to Cayman, we'll be able to attract large numbers of medical tourists from the U.S., we tie up with the U.S. healthcare hospital operator and they will send their patients over there, large employers in the US who have very high expenses will send their patients over there. Large employers in the U.S. who have very high expenses will send their patient. It made sense on spreadsheet; reality was the medical tourism from U.S. never materialized but there's much more of a Caribbean and a local Cayman business that was there.

And, so, why it is important for us is to show that our model, which delivers good performance in India, but it's very Capex heavy, it takes a long time to breakeven, it's operationally very complex. You apply the same model in the Western environment where the reimbursements are much better, the hospital also performs much better. So, why it is important for us is because it does well. We've run a pretty good business, we'd like to say, and we want to see if we can replicate. So, it is for us to use that as a place to show that our model is far superior to a lot of the Western healthcare operators and to use that as a place to see if we can try any other things overseas in the Caribbean or other, you know, U.K. jurisdiction type countries.

And there's a reverse flow as well because the things that we learned in Cayman, because it's a small country, manpower is very expensive we learnt how to be much more efficient and a lot of those lessons also flow back to India as much as India provides a template for Cayman.

Nishant, there's a question for you on Debt to EBITDA ratio. How are we looking at it?

Nishant Singh: Yeah. See, it is true that there will be a lot of debt for this project finance. We are comfortable with the Debt-EBITDA levels up to a level of around 3, so we will be conscious of that number and we will probably reach there if you do all the projects we have planned for, say, by the end of the 4th year. But then what will happen is that as the new hospitals start to accrue cash and be positive on the EBITDA, those numbers will rapidly come down. So, when those numbers start to come back down then that's the time when we start to have the next phase

of expansion. But around 3 is the number which where we have with this internal discipline, which we'll try not to breach.

Viren Shetty: Anesh, what are the reasons for Americans not leaving their country to go overseas for treatment?

Anesh Shetty: We can have an hours long discussion on this but a quick 2-minute version. It's very complicated but patients in the U.S., as far as we've learnt, they don't even cross State borders for healthcare unless it's to a center of excellence like the Mayo Clinic, Cleveland Clinic, etc. And patients are in the U.S. are not making consumer choices. There are a lot of intermediaries, principally the insurance company and others. So, unlike India where patients make a consumer choice, they're really customers and not patients. In the U.S. there are a lot of channels, preset pathways, discount arrangements, networks and so patients are not fungible from one location to one another and especially this is within the U.S. from State to State or from hospital to hospital. And if you're talking international borders, it's several orders of complexity more challenging.

Viren Shetty: Having said that we are seeing that in India as well. A lot of the bets and assumptions we made on medical tourists coming to India from. We used to get a lot of patients from Indonesia, we've got patients from Malaysia, we used to get from Iraq; those don't last very long. There's certain habits and given a choice people want to just get treated in their own city, forget about their own country. And even within India, there's a lot of cross-State, across the city travel that has nearly stopped.

In Bangalore we're located in one corner of the city all the way in the South and we know that we don't get patients from North Bangalore there. So, we want to attract those patients, we have to be there physically. So, this is a behavior that we see in the U.S. and is very fast catching up in India as well. And so, we can't just accept that things will change and if we make it more attractive, people will travel in India. We have to go and make the investment and go to where the customers are.

Next question is, how do you look at your organic, inorganic expansion plans in medium term, 5-7 years? 5 to 7 years, with confidence I can see that it will still only be what we're currently doing. Stick to our focus markets, just look at building smaller sized hospitals in Bangalore, Calcutta and a little bit of expansion in Raipur. Have only one large Health City per city, the rest Health City means a flagship hospital that's 1000 beds plus. Every other hospital, 200-250 beds is sufficient. Just make sure that you are located dotted around the city so that patients will not need to travel more than half an hour to get to one of your setups and all

the gaps you fill up with clinics and have an insurance plan to tie it all together. So, 5-7 years, this is more than enough to work for us to be able to achieve within these 2-3 cities. We prove it works then we'll see if we can roll it out to the other major cities.

Nishant, anything on the chat on your side?

Nishant Singh: No, there are no new questions. We'll just wait for a minute to see if there are more questions on the chat.

Viren Shetty: Okay. Yeah, I guess we are done.

Nishant Singh: Yeah. Yeah, so I think as there are no more questions we would like to conclude this session. Thanks everyone for the active participation as usual. If you have any more questions, please feel free to reach out to us. Thank you.

END OF TRANSCRIPTION