“Narayana Hrudayalaya Limited
Q2 FY22 Earnings Conference Call”

November 12, 2021

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Debangshu Sarkar: Good afternoon, All. Myself Debangshu and as most of you are aware, I run the Investor Relations and Mergers & Acquisition practices at NH. On behalf of the company, I welcome you all to the Q2 FY 22 earnings call of the Company.

To discuss our performance and 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 Collaterals which have been uploaded on the stock exchanges as well as on our website.

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 before our Initial Public Offer in late 2015 and subsequent annual reports on our website.

Post the call, in case you have any further queries, 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: With the effects of the second wave of the pandemic subsiding, our Indian operations staged a decent recovery during the quarter gone by, after the significant impact as observed in Q1 FY 22. For the period Q2 FY 22, we are pleased to report record profitability with consolidated EBITDA of INR 1.81 bn and PAT of almost INR 1 bn. This has been possible on the back of recovery in Indian operations aided by our international ventures at Cayman Islands and hospital project management at St. Lucia. Overall, our balance sheet and liquidity profile remain strong with INR 5.6 bn of gross borrowings and consolidated cash & liquid investments of around INR 3.2 bn as on 30th September, 2021.

Our India business, adjusted for the Vaccine revenues, while growing 63% YoY due to the base effect translating into a 12% QoQ growth, registered an EBITDA margin of 13.1% during the period against 8% registered in the previous quarter. There was an all-round revival in business across the network with new Covid-19 cases waning across the country post the aftermath of the second wave which had significantly affected the operations in the previous quarter.

Our non-flagship hospitals continue to build upon its momentum of previous few quarters, with the group of Hospitals, excluding the 3 new hospitals and Jammu, registering an EBITDAR margin of 18.8% during the quarter thereby continually improving upon its profitability over the quarters. We are also encouraged by the improving profitability trends at our 3 newer hospitals across NCR and Mumbai with the

losses having reduced significantly despite the pandemic induced disruptions. Its indeed heartening to note that these hospitals across the network have not only held their ground during these uncertain times and have been leading the business revival across the group since the onset of the pandemic.

Recovery at our flagship hospitals have been slightly muted given the significant erosion in the international patient mix (1% of Indian business in Q2 FY 22) as well as high-end cardiac sciences based elective work (Around 31% of Indian business in Q2 FY 22) which were key footfall drivers at these Centres of excellence. Thus, profitability of this category, especially our Heath City Bengaluru hospitals remain affected as compared to the pre-Covid times. We continue to work on improving upon this over a period of time with the sentiments improving all around thus facilitating people's mobility across regions.

Moving on to our overseas operations, despite couple of hurricanes namely Grace and Ida impacting the region, our unit at Cayman Islands reported operating revenues of USD 19.7 mn in Q2 FY 22 resulting in EBITDA of USD 8.3 mn. Thus, for the 6 months period ending 30th Sept, 2021, the unit delivered a healthy USD 19.1 mn of EBITDA with PAT of USD 15.9 mn. Separately, our hospital management project at St. Lucia contributed INR 215 mn to the group's EBITDA during the quarter. We remain confident in this regional business emerging as a strong pillar of our future growth.

As regards our continuing focus on various digital initiatives, we have now integrated doctor's mobile application with ICU monitors for real-time remote patient assessment to enhance the clinical efficiency across the network. We have recently also launched a pilot project called "Enhanced Doctor's Bay Management System" for Outpatient queue management to ensure transparency and predictability in service delivery.

On the clinical front, we continue to deliver advanced super-speciality work as reflected in some of the highlights of this quarter as captured below.

- Mazumdar Shaw Medical Centre, Bengaluru performed a rare procedure of 'Selective Dorsal Rhizotomy' on a child with spasticity
- Narayana Superspeciality Hospital, Howrah successfully completed one of the most challenging procedure of Arterial Switch + VSD closure + Aortic Arch Repair under selective cerebral perfusion on a 1-month-old patient diagnosed with Taussig Bing Anomaly with hypoplastic arch
- Narayana Superspeciality Hospital, Gurugram performed a highly complex minimally invasive mitral valve replacement with tricuspid valve repair by right anterior mini thoracotomy of 2.5 inches
- Narayana Multispeciality Hospital, Guwahati treated a complex case of acute pancreatitis with GI bleed and shock. After stabilisation, patient underwent

CECT abdomen which showed gastroduodenal artery (GDA) pseudoaneurysm which was successfully managed by DSA+ Angio - Embolisation

Looking ahead, with the vaccination coverage expanding by the day, we are hopeful that business activity will resume its pre-covid growth trajectory. At the same time, we remain vigilant over the developments taking place globally with regards any fresh wave of infection to prepare ourselves accordingly in case of any further disruptions. Notwithstanding the near term Covid 19 related uncertainties, we remain confident about our business prospects by continuing to focus on delivering quality affordable healthcare to all.

With that, we now open the floor for the Q&A session.

Participant 1: Good afternoon team. My first question is related to the potential oversupply of beds situation in the Cayman Islands. So Cayman, I think - I mean they do have already enough beds to fulfill the current needs and with our expansion coming up and we know that another listed peer also has a project in Cayman. So, would this lead to a potential oversupply of beds and would it decrease the prices and margins of procedure in Cayman?

Viren Shetty: I'll answer this one. If you just look, if you treat all beds the same on the raw number of beds that are available in Cayman, yes, you can call it as an oversupply, but that doesn't get to the truth. The fact is no two beds are the same. Essentially what you're talking about is the bed used for treating different kinds of treatment modalities. So, the expansion that we are looking into is not so much about adding beds as it is about adding clinical specialties that aren't being taken care of by our hospital and the other hospitals on the Island. So this is high-end cancer care, emergency care, neonatal care, very advanced surgeries with robotics, and so on. So when we have the new expansion, there will not be a single specialty barring some very advanced transplant and very advanced radiotherapy surgery like proton, which again very few people actually require.Barring that, for 99% of everything that a person from Cayman is most likely to experience in their lives, we will be able to cover with our expansion. As for what it would be if another hospital were to come with a similar set of offerings and the related impact. Yes, I mean obviously there would be the huge impact, but you have to also understand that logistical challenges of doing that in the first place so if you bring a cardiac surgeon on Island for example, they are also going to understand that there is an existing cardiac surgery program. If you bring an oncologist or a radiotherapist, they don't understand that the program is there. Their simply won't be enough work to split for the third and fourth person to come on the Island. So, just logistically, it becomes very challenging. But yes, if you were to overcome all of that and somehow run a duplicate facility if someone else were to set it up, there would be problem. But given that we have a significant legacy

on the Island, the brand that we have is extremely strong, and that patients have preferred our hospital over many, many years; it would definitely be margin erosive, but I would say much worse for someone else who's trying to start from scratch with the working capital loss that they would face and the fact that they would be starting on a much lower margin base for them to justify their investment.

Participant 1: Thanks for such a detailed explanation. The second question is relating to our onco therapy. So since last two, three quarters, our oncology mix has been around 13% of sales and now that we are adding onco blocks in most of our hospitals so two, three years down the line where do we see oncology as a therapy mix which is 13% currently? And I suppose onco is a higher margin and a higher ROCE than other therapies so is that true? Can you give more light on that?

Dr Rupert: We have seen the biggest growth in the oncology services as a service line after the cardiac services. It's growing very rapidly into a very prominent one and we feel that it will continue to grow like that because all we have to do is add the necessary comprehensiveness of the care that includes radiation in all our facilities. So once as we are doing that step-by-step, we will see this continuing to grow. And we have seen very good traction of not only medical oncology, but very high-end onco surgical work and radiation oncology wherever we have put up those things and for the comprehensiveness of that, we are adding the image-guided therapies as well becausethat is also one of another modalities which is there. So, we are well-equipped and we are equipping the centers for the sustained long-term growth of thesespecialties.

Participant 2: But do we have any targets in mind two, three years down the line what number as a percentage of sales mix you want to reach and is it more better on a unit economics levelonco compared to other therapies?

Dr Rupert: Because all the other specialties also are growing so I would see going closer to 20% or something will be what we are seeing.

Participant 3: Yes. Thank you for the opportunity. So, I have a couple of questions. Firstly, I would like to understand from you your outlook on international patients. How is the situation evolving particularly with respect to Bangladesh? So, that is my first question. And second question is with respect to your India P&L. So, the consumable expenses as a percentage of sales is now 28.1% instead of the long-term average of around 25%. Now I would have thought that since COVID is waning, this percentage would be 25% in the current quarter, but it has not been the case. So, what has been the issue and going forward in the subsequent two quarters and in FY '23, what would this percentage be? Thank you.

Viren Shetty: The outlook from Bangladesh I'll take. I'll address the consumable part a little bit and Dr. Rupert can address the COVID problem with that later. Yes, the flights continue to be restricted. The flights had opened up for a bit, then there were restrictions again. The Bangladesh traffic has been coming to Bangalore and Calcutta but not as much as it was before. There are many reasons for it. It's just generally now much, much more difficult for people to get the confidence that traveling is safe. So, the total international volume or rather revenue wise from 11% 12% has crashed down to 1-1.5%. The question you asked of when it will recover. it's very hard for us to predict. I will not be able to have any kind of confidence that we'll get back to previous levels unless there's no more COVID. But whether we reach some kind of accommodation, which is you will always have endemic levels of COVID and international travel will account for that.

But those who are going, it is very important for them to do so. So within that, we're still taking the time to do a lot of outreach, to work with clinics in Bangladesh, to do as much online consulting as we can to line up the patients. We've done all the work beforehand and so it's a much smoother experience than it was before. But honestly for when it will happen, it can only happen when there is almost no COVID in either India or Bangladesh and not surehow long that will take.

You raised a very good point on the consumable expenses. 28% is a very alarming figure for us. Now it's caused by several things. One is the fact is a lot of material prices have gone up. That is one part of it, but it's not the entire part of it. Post COVID, we did get a lot of high-end procedures, we did get a lot of high-end therapies and treatments from doctors, and they were preferring the original molecule. They were preferring the more expensive drugs in that case, which generally in times when we're not as preoccupied with other things were able to convince them on the benefits of using the generic and a lot of other options. But because a lot of our supply chain team and operation team are so occupied with the growing volume, they were not paying as much attention to the supply chain aspects which keep needing to be reinforced from time-to-time. But this is something that we have been analyzing and we are aware and we will be looking to address and reduce.

Dr Rupert: See, I mean COVID is not going away. We still have COVID cases in all our units though they might be in small numbers. So, we cannot let our guard down so COVID protocols though that has been revised still exist. So, lot of pre-existing testing and lot of protocols are still in place. And also, like Viren said, lot of high-end procedures. So, we have done almost close to 24, 25 percutaneous valve implantations and things like that. So, we know where the issues are, and we are working on it and hopefully we'll get it under control in the next couple of quarters.

Debangshu Sarkar: Shantanu, just to add on to what Dr. Rupert and Viren said and just for everybody's information, the number of 28.4% is a consolidated number, which includes the vaccine revenues and thereby the consumption towards vaccine. So excluding that simply and we have provided those numbers, the 28.1% actually becomes 26%, which is the lowest across the last three, four quarters. The other things -- the other points that Viren and Dr. Rupert highlighted remains very valid. But additionally, simply adjusting from the topline the INR 23 crores of vaccine revenues and from our consumption INR 20.5 crores towards the vaccine consumption, the consumption cost as a percentage of revenue actually becomes 26%, which is still a percentage higher than our long-term average, which point is well taken and the reasons Viren and Dr. Rupert have already elaborated.

Participant 3: Right. And okay, thanks for the explanation. That has been helpful. And on the international patients, any traction from other countries apart from Bangladesh or is it very low?

Viren Shetty: It's very low. We're getting patients coming from Africa and so on, but the travel between countries going -- usually Dubai is a big transit point. The difficulties with getting transit visa and coming through and getting Indian visas as well is causing it not to be as convenient as it was before.

Participant 4: Yes. Congrats on the good set of numbers. I have two questions. One about the Cayman EBITDA and PAT. And second in terms of the Bangalore cluster, the profitability has sequentially increased very sharply. What are the reasons for that?

Debangshu Sarkar: So I'll take the first one, Charu, that you have said. The profitability for Cayman unit for this quarter is the EBITDA is $8.3 million, which translates to an EBITDA for the six months ended September 30 of $19.1 million, which is close to 45% margin. And PAT for the H1 period is $15.9 million to be precise. There is a minimal other income of around $180,000 for each of these quarters. So for the half year ended September 30, the other income is around $360,000 which roughly translates to around INR 2.8 crores and for this particular quarter, it's around $180,000 which is roughly INR 1.4 crores.

Participant 4: About the Bangalore cluster profitability improvement sequentially?

Viren Shetty: That is essentially driven by the slowing number of COVID and the return to the normal operations. It could have been faster. We're doing a lot of work in outreach, in reaching out to patients to come and get their elective surgeries done.

But essentially this is more on the normalization trend. The big thing still missing is our international patients because our flagships in Bangalore and Calcutta get a huge percentage from international travel. But we've been able to bring a lot of the volume from the nearby regions and people from the corporates and so on to get treated. So, that's essentially what is driving it.

Participant 4: Okay. Do you think the profitability like 18% EBITDA margin (consolidated basis) is sustainable?

Viren Shetty: We are not seeing any large cost drivers that will take up a lot of the expansion and the business transformation work that we're doing is essentially being done with the goal of enhancing the yield without necessarily adding a lot of manpower cost associated with that. So rather than add greenfield capacity, a lot of what we're doing is changing the bed mix, getting more private, semi-private rooms, getting more high-end equipment, and doing high end surgeries; which increase yield without that correspond increase in the cost. So, it won't. There will be a seasonal effect no doubt because -- sojust to give an example. In this coming quarter as of this month, Cayman has an outbreak of COVID and so this was an Island that had not had much COVID at all. Now the Island is 80% vaccinated and not many people are requiring ventilation and so on and people are just mildly sick and there is a very large government hospital that is able to take care. So, we're not very alarmed as of now. Once you add this also to the fact that end of year most people in the Western hemisphere postpone their procedures till after New Year. So the time between Thanksgiving and end of Christmas, New Year, is when most people are on holiday and they don't really get any elective procedures done. Q3 is always a weak quarter for Cayman. So that combined with COVID will have a outsized impact for this one quarter, but then it usually recovers by Q4. But if you tell me just on a general basis going forward, I think it's more or less the same. I won't venture that it will go drastically down or drastically higher, but I wouldn't say that there's anything causing alarm other than of course more COVID in India and this one seasonal impact what will happen this month and next month.

Debangshu Sarkar: Okay. Viren, you may want to highlight that this number of this quarter actually includes a one-time windfall profit of INR21.5 crores from St. Lucia which is not recurring.

Viren Shetty: Yes. So, I mean that's essentially it and assuming you net off all the one-time things. So, we're doing a consultancy contract with the government of St. Lucia and the contract is nearly over. There's one last payment due.

Debangshu Sarkar: Charu, I hope you understood that from the consol number, you need to net that thing off to arrive at the recurring sustainable profitability margin.

Participant 5: Hi sir. Thanks for doing the call. So, just two questions. One is for in Cayman, could you probably highlight how many doctor clinics do we have now and what is the plan there going ahead?

Viren Shetty: Outside of the main thing that we have, we have one clinic in the center of the city, but that clinic itself we are expanding. So, we set up a separate chemotherapy area there and there is more space that we're looking at. So, we have one other. We would be opening up one more. This is in the Grand Cayman. We run another much smaller clinic in this place called Cayman Brac, but that is very small. It's in the government center. It's the Indian equivalent of a dispensary. But that's basically for doing follow-up for a lot of the patients. But we definitely have a much more aggressive clinic rollout program. As and when our existing clinics get to a very sustainable level and they max out, we will be adding more clinics and looking at opportunities in different parts of the Cayman Islands.

Participant 5: So theoretically speaking, how many clinics can you have up there? So, let's say if you have three right now; two big, one small.

Viren Shetty: Yes. To be honest, Manish, we're taking this more opportunistically. We haven't done a full study mapping of the whole Island to figure out. We have a good sense of which are the areas in which if you were to set up a clinic, where it would be because there are few locations in the Island where there is dense population, and it makes more sense to have a clinic located there. In terms of total number, it won't be a lot. Like it's a very small island and the mobility is pretty good over there and this is more about deciding where you want to -- it depends a lot also on the convenience of the doctors who are going to go there and the convenience of the patients who go. So, we're taking it -- every year we look at about one or two clinics like that until we get around four to five and then we'll take a call from there whether any more would make sense. Because the other thing is also learning as we go on the configuration. So, the clinic that we initially set up in this place called Camana Bay actually ended up three times the size of what we originally planned because as we started building it and as the response became really good, we just started growing bigger and bigger. So, just to give you an example. COVID testing, the RT-PCR testing unlike in India where you can get it done everywhere, in Cayman there are very few places where you can get the PCR test done and ours is one of the places. So, we've taken up dedicated space in our clinic just for doing the PCR test. And over there it's doing very well because a lot of people come in, but it means you -- this is the demand we did not foresee and the initial plan for that space was to use it for doctor offices. Now we have had to rent more space just to do doctor office so that the PCR thing can be in that part. So, we're taking it more opportunistically. It's not something we are preemptively near a plan to quote 20 clinics all over.

Participant 5: Got it. And my second question is I think for the last 2.5 years you've been putting a lot of effort on the digital front. So, is this largely to do with let's say productivity or improving the efficiency? Or if you could probably quantify let's say on a broad number, how much of savings does that really yield into versus the investment which you have done? Any broad sort of number let's say because now it's been 2.5 years so just wanted to understand if you have done a three-year project, what sort of Capex did that entail and what you do get in return from that? Thanks.

Viren Shetty: Manish, you asked some very good questions. Unfortunately, we don't have answers even internally. I mean even this is something that's the biggest pain of contention between us and the technology team. We're extremely excited by all the opportunities that are presented by the digitization of all our processes, but it's impossible for us to calculate whether the gains that we were able to get were digital related or whether they would have come anyway. Just to give you an example. We changed and revamped our entire contact center operations. So, we harmonized the multiple ways patients are able to reach out to us. Otherwise before what was happening, some people would call our doctors directly, some people call the secretaries directly, some people call the front office, some people would call the call center, some people would send emails or WhatsApp or make queries through the website; and there was absolutely no way for us to know and keep track of this.

So, we harmonized it and put it in a central contact center and now we have much better detail as to where the patients are all coming from. Now because it is easier to track and because we made it more convenient for the patients, we don't know if it led to a 10%, 20% or 30% increase in the number of inbound calls. We can tell you from now on, going forward and this is data we will start presenting as of this year. So from next financial year, we'll start giving you more data about how patients are actually reaching out to us. So, this is part of the overall disclosure that we're making where we are breakingup into the average revenue per patient, we talked about their clinical stay, ICU bed stay, and all of that rather than just getting stuck on occupancy numbers. So, we start getting the data out to you later. But the thing is attribution becomes very hard because the truth also is that this is table stakes by this point.

You cannot run any modern corporation not just in healthcare. You cannot run any modern corporation unless you have a robust digital strategy, unless you have a CRM, unless you have very good lead management software, unless your doctors as in your workforce is able to access all their tools digitally. This is the bare minimum that anyone has to be doing. So, we are really playing catch up to be honest. Compare us not with the other hospitals, but to all the other firms and other industries that are digitally forward, I would say we are far far behind. So, there is tremendous scope and it will start to show in the numbers. But unless I do something what Apollo does where I create a separate digital vertical, which we're not yet in

the phase of doing, it will be difficult for us to get digitally attributed revenue. But for results, having good the responses out there as in with the OPD footfalls just to give you an example.

Our OPD footfalls today are still not at pre-COVID levels, which is the number of people coming in physically visiting us in the hospital. But by and large nearly all the hospitals, except two that we have, have reached their pre-COVID revenue numbers on a monthly basis. So, we can -- at least I can attribute very clearly to the fact that patients now have different ways of reaching our doctors and getting the thing that they want from us without having to physically visit us. So that has decongested the OPD, it has done a lot of good work, and I can see at least that much is concrete proof that this whole thing is working.

Participant 3: Viren, just one small data point if I can. So, let's say annually what is that one number - if you're spending on the tech side, what would be let's say the percentage of sales? Would it be INR15 crores, INR20 crores? Just rough number, that will be helpful. Thank you.

Viren Shetty: Good question. If I include tech, including all of that, it will be more than 20 cr - yes, it will be around INR 15 crores to INR 20 crores if I include the contacts and operations, the spend on the IP, all the ERP licenses, everything else we're doing

Debangshu Sarkar: Manish, just to give you a ball-park sense, till last fiscal year cumulative we had spent around INR 50 crores and it was almost equally split between Opex as well as the Capex part of it, the network software and everything part of it. The impact assessment obviously is going on, is a work in progress and once we have robustness of data and confidence around the data, we'll surely come back to you and share with you everything as Viren highlighted.

Participant 3: Sorry. I'm really sorry to harp on this. But you would have spent let's say INR15 crores over three years, but you have spent INR50 crores for this. So, the incremental INR35 crores is what you're saying?

Debangshu Sarkar: No, I said INR50 crores was the cumulative number till the last fiscal, just as a ballpark sense.

Participant 3: Hi. Thanks and good afternoon, everyone. A very good quarter. How are you thinking about the volume recovery going forward? I'm comparing your total discharges now I think you're roughly about 49,000 plus versus pre-COVID what used to be 70,000, 75,000 just for India business.

Dr Rupert: Yes. I mean if we look at the trends in the last month or so, the volumes are continuously going up. What we are seeing is the routine, elective work for straightforward work have started to come in wherever there is confidence in the system where there is no COVID and other things have started to come into the system. So as we move forward, we will keep seeing this rise in this number of discharges as well. And also you would have seen that the day care procedures have also started.

Participant 3: I guess my question is that how far are we from the full-blown recovery in the domestic business? And if I can combine here not only the volumes, but also say the mix. Cardiac used to be earlier 40%, we have improved but we are still at 30%. If I look at your ALOS pre-COVID used to be 3.5%, now at 4.6%. So, just how do you see the pace of recovery and what timeframe do you think we are going to get back?

Dr Rupert: See, the ALOS will start settling down once certain COVID specific protocols will be toned down significantly because we do want to make sure that the patients are not -- even though we test them prior to surgery -- prior to admission and prior to surgery, we don't want to -- for any major work, we don't want them to land up having COVID after we have done the procedure because that leads to a sure shot death. So, the ALOS will start coming down once the confidence in the system and the COVID and all those things factors are negative, then these things will start moving down. So, that is not an issue. I mean that will start settling down.

Viren Shetty: COVID being one, the other is also we are seeing the nature of the work has changed as well. And so it could be that the number of discharges was very standard procedures that in basic cardiology, angioplasty, and so on will take a longer time to recover but will be made up on the fact that we're doing a lot more high-end procedures. But we still want to get back to the old discharge numbers because that's what our infrastructure is built for, but we'll have to do very different things to get to those numbers again.

Participant 3: Okay. Viren, not very clear. But let me just try once more. The economy is normalizing, cases are a lot lower. If you exclude Kerala actually, we are having very low cases, vaccination is very high. But our volumes are still I would say 30% 35% below pre-COVID. So, do you think it's realistic to expect that within the next couple of quarters going backup there? That's the question.

Viren Shetty: I think we would be very different from what it was pre-COVID and I think every sector as the economy is normalizing, there are definitely more winners than losers, right, and there are certain behaviors that are irrevocably changed. Certain behaviors people have learned during COVID, which is let's say ordering stuff online. I think it will never go back to a pre-COVID level of ordering things online. If it is more now, it will continue to be more. So from our business, it would be that a lot of the things that we became known for; which is the emergency response, the vaccination, the intensive care, the very high end procedures; I think that will grow and continue to develop.

Whereas a lot of the other hospitals may see their volumes increase in the most basic work say the other smaller hospitals, the nursing homes, and so on. They may see a permanently higher number of the regular standard procedures what they are good in doing. Very much we're working overtime to it getting back to pre-COVID demographics of the patient also, but there is an equal argument to be made about the situation that we may have permanently lost the lower end of the market; which is the low margin, low yielding procedures; and gained in more complex procedures and people coming and staying longer and going for high treatment. Now that is a theory of course. I mean this is just me planning for the absolute worst-case scenario in that. But it could very much be that things do revert back to a pre-COVID state and we get back to doing the more standard procedure and the hospital OPDs get crowded once more and so on. In which case, yes, I think you can revert back to your model from 2019, but it still may be that we need a year or so to get a good sense of what the future for us looks like.

Participant 3: Okay, great. Very clear. My second question, Viren, is on the pricing environment and now things have stabilized. Can you just share your thoughts what's going on for the cash patients and for the insurance patients?

Viren Shetty: Pricing has always been tough. It's one of the most competitive markets in the world for healthcare because there's such a large private sector. For the cash, what we do is we take annual price increases to account for all the inflationary costs that we've to bear. And since our salary cost especially for nurses and frontline workers have gone up as a response to the sheer amount of risk that we made them take during the pandemic, a lot of those costs had to be passed on to the patients and we're trying to do that while still remaining competitive. It's been difficult, but we'll make up the difference in volumes. With insurance companies, these are two-year contracts and those discussions are always beset with a lot of tension.

So cash, we pass on. We revise the rates every year in January. Insurance contracts are negotiated for two-year term, but insurance contract discussions are always very difficult and prolonged negotiations. So, these things end up stretching beyond the two years, as and when they expire -- so we have four major insurance companies whose contracts have expired, we are in discussions with them. Hopefully we'll close this in two to three weeks. If not, there are alternatives available in which case customers pay the hospital and they collect the reimbursement later from the insurance company. So, that does give the pricing power in that instance. But some major things where we -- not just we, all hospitals lose out on is in the government insured patients; CGHS, ESI, Ayushman, all the state and government schemes; where rates just never get revised and I don't know if it will ever happen any time soon. But that's one thing that continues to be absolute margin erosion and gets worse every year when the wage inflation, consumable cost inflation goes up 7%, 8%, 9%, 10% and this thing still stays basically the same.

Participant 3: Yes. Thanks for this, Viren. So if I exclude the scheme patients, for the other two which

is cash and insurance, all the pluses and minuses and difficulties taken into account; I mean is it fair to put 4% to 5% annual inflation and how much have you effected already for the cash patients?

Viren Shetty: We still haven't closed November, we'll know only by January once the prices come in. The price increase again it's not a flat number, it's something that -- so certain procedures we want to stay competitive on such as our cardiac procedures so those, the price increase will be very nominal say 4% to 5% what you said. There are other things that have been accompanied by huge amounts of increase in the price of the input material so a lot of onco treatments, chemotherapy drugs, and so on; the price have gone up a lot so those have price increases more in the 10% to 12% range. So, it's a mixed bag so it's difficult for us to pin down what the total number would be. But yes, we are able to cover the at least the wage increase, cost increase, input price increase. We're able to cover that.

Participant 3: Okay, great. With your permission if I can ask one last question. And that is, Viren, there is so much of funding which is now available for healthtech platforms and many things which are happening. Some of them are actually sticking, some may not, who knows. So the question here is for your hospital business, do you see any form of disruption that may happen to your inpatient and outpatient businesses and that makes you vulnerable to these healthtech platforms?

Viren Shetty: Yes, 100%. I mean we are vulnerable to everything; we are vulnerable to other competitors, vulnerable to the start-ups. So, couple of the models that I find quite interesting are models that are getting funded now. So, the previous generation was all telemedicine. There was a lot of that going on five, six years ago and we adopted it and it took up with some success during the pandemic, but it wasn't as game changing as the VCs made you believe because lot of patients and doctors still prefer to do things face to face. It's a good introductory call for us to do these things just like we're speaking now, you and I. But you very much like to meet me and the only thing stopping us is you having to wake up early to come to Bangalore or me flying to Bombay. So, telemedicine is a good intro to what digital disruption in this business will be. Things are a lot more interesting now. Companies that are getting wholeheartedly into actually doing the surgery and so what they started doing is aggregating different doctors, working with different small hospitals, advertising very aggressively online, and saying we'll do your piles, we'll do your gallbladder surgery at some price and Hrithik Roshan will come and say it's super stay, it's a very good experience. And a lot of patients are choosing to get operated that way, which is very different. I have never imagined that you could consumerize these procedures in the way that they've proven it can be done. Not that we would end up doing any of those things or getting Hrithik Roshan to advertise for our surgeries, but the lessons that we learn are essentially how they're reaching out to patients, how they keep those engagement models, how they deal with a lot of the inconveniences that we really have taken

patients for granted.

Like one thing one of these companies does is they send the car to pick up the patients. It's so convenient. It's just astonishing that I didn't think about that because when they're paying INR 2 lakh for a procedure, just a INR 300 pickup to bring them to the hospital would be such a convenience and we're thinking of something on those lines. Similarly, the amount of follow-up that we get has driven us to invest in CRM. So, to give you an example, the heart hospital in Bangalore gets 50 calls per day only for Dr.Shetty and this goes to his assistant and he's not able to take all the calls and so he's able to call back some of them, he's not able call back some of them. So, 40% of those calls get lost and each of those is a potential revenue source. And multiply that by all the doctors in our network and we're losing a huge amount of business just by virtue of the fact that we don't keep track of who wants to come to our hospital and get treated and so it's driving us to put in a good something like Salesforce that will allow us to much more be able to follow through with patients who indicated that they would like to get treated in our hospital. So to the question you asked about healthtech and all the things,like I don't think we have the DNA to be a healthtech startup-ish sort of company, but there are fundamental lessons that they do and they have much better insights about what consumers want. That we can easily copy and adapt into our models and do it with much more success because we don't need to lose money doing that. Whereas they have to spend a lot of money acquiring customers, building a brand, paying for Hrithik Roshan, and those sorts of things which we won't need to do.

Participant 4: Yes. So, this is the first question particularly to the north region. It is in line with the previous questions that are we on the pre-COVID level particularly to two hospitals, one at Dharamshila and Gurugram. Can you please explain how these two hospitals are doing?

Viren Shetty: We have exceeded our pre-COVID numbers for both hospitals.

Participant 4: And what about the Gurugram hospital, how do we see the outlook for that business?

Debangshu Sarkar: So Viren, he wants to ask the Gurugram losses and what's the outlook for that. I mean as Viren mentioned, Shailesh, the revenues for I mean these two hospitals particularly have far exceeded the pre-COVID revenues as well as the business traction in terms of both occupancies and discharges and all. And as far as the financials are concerned while Gurugram is on the brink of breaking even, but still short of that while Dharamshila for few quarters now as you guys are aware is in the black. So put together, these two hospitals from the NCR region is actually in the black for a couple of quarters now as you would have seen in our deck. Outlook wise we remain fairly positive given that these are newer hospitals in a key geography and we do see potential for further runway in terms of the growth potential of these two hospitals.

Participant 4: Yes, thanks. Just one last question little bit on the accounting side. When I look your consol number, it's INR100 crore higher than -- on the EBITDA side I'm taking than the standalone. So I understand the INR50 crores, INR55 crores out of that is from that the Cayman Island and what is the remaining INR40 crore, INR45 crore out of that?

Debangshu Sarkar: So our consol EBITDA number for this quarter is INR181 crore, out of which India is INR 100 crore and the balance INR 80 crores is accounted by INR 60 odd crores from the Cayman operations and INR 21 odd crores from St. Lucia project, which is a one-time gain that we already referred to earlier in the call and there is also a loss of around INR 1.9 odd crores from Chittagong heart centre separately, which is also accounted for in the INR 181 crores consol number.

Participant 4: So when you're saying India number is INR100 crores, standalone is along INR70 crores EBITDA. I'm just excluding the other income.

Debangshu Sarkar: Okay. Because there are other businesses which are not part of the standalone NHL entity, which also operates hospitals namely Mysore, Dharamshila as well as our West bank hospitals in the Kolkata region, which are not part of the main NHL standalone entity; but are separate subsidiaries of the standalone NHL entity namely NHSHPL and MMRHL respectively.

Participant 5: Thanks. This question is for Viren. So Viren, it's really good to see the progress that you've made on the automation and digital initiatives over the last few years, I have been listening to your quarterly calls as well as the AGM discussions. So question there is and I had asked a similar question in last quarter's call as well. We've done a lot of work in terms of internal automation and digitization for workflows. But on the patient facing side, we haven't seen much progress and you had said that there are some initiatives underway which should help us get there. So, could you share the progress on that? So, the reason I ask is so you're on the right track in that there is a certain amount of CRM that we need to do to make sure there's no linkage in terms of potential customers. But if you extend that thought and think of it as more of a patient lifecycle management, a lot of our patients are essentially patients for life. So, people who undergo cardiac or diabetes treatments unfortunately are going to have some kind of extended care for months or years. So, how are we thinking of addressing those patients to a, try to improve the productivity from our end and also reduce the visit friction in terms of their needing to come to hospital and soon?

Viren Shetty: Yes. Parag, I mean all really good points. So, our thinking on this is not finalized yet. So I'll say a couple of things, but this is not the final word on the matter on how we've evolved. I had mentioned earlier about the DNA that certain companies have and I said that we cannot be like a start-up because we are built very differently. The kind of people we have and the kind of people we hire, the way we're oriented is very different. We have built an app - a patient facing app called NH Care and we worked very hard to get a lot of people to download it. We hired a lot of iOS and Android

developers to build on that. But the sheer amount of effort and developer's time and as you know that would be really hard to hire good developers now and the ones we have we're holding on to and everytime someone starts hinting that they're getting another offer, we start panicking. Hiring a software developer right now is an extremely difficult job. The sheer amount of time involved in building, developing, and maintaining these patient facing apps for us is always a question of trade-offs. It's time that we could have spent improving something else in the operation. It's time that could have been spent in improving the e-prescription module or time that is desperately required to rollout the software developed in Cayman which is such a huge component - so we rolled out the NH Care, we tried to get people to download it. There's a huge amount of reluctance from anyone to download the app and the app that we made was a substandard experience because it's not on par with anything that you could download from 1MG or Pharmeasy because those guys have been at it for years. We've only been at it for a couple of months. So, we decided that at this point at least we will strengthen our focus on the things that we're really good at and things that will lead to immediate yield. So rather than us putting more developer time into building a whole suite of apps that patients can use to book tests and so on, they can easily piggyback off things that other people have already built.

Rather than building the ecommerce infrastructure for sending medicines around, we will partner with other companies who are doing it anyway and get on a revenue share arrangement with them rather than build a patient facing app that they would have on their phone for us to remind them to take their medicines and in order to buy things, we can just do a WhatsApp integration with that. So, the core pieces of all of that, we're building out. So, that means we may from a patient side at this point have a very light presence and there isn't much that you as a patient would be able to download from NH whereas a lot of the focus we would have are on things that are used by the hospital, used by the doctors.

It doesn't mean we're not abandoning this space entirely. It just means that right now given the shortage we have in resources and by resource, I mean developer, there is no amount of money we wouldn't spend in doing this. But because it's very difficult for us to get developers, right now we've decided to focus our efforts on finishing up all the products that we currently have, making sure it's used by the hospital, by the doctors, by all of them. And for all the patient facing things, we'll rely a bit on third-party applications either through other startups, we can work with or by implementing Salesforce everywhere so it will allow us to at least track where the patients are coming from and be able to improve our lead conversion, improve the throughput, address queries much faster, and be able to drive revenue in a more conventional way rather than go after digital revenue, which will take a lot of time.

Participant 5: Fair enough. So, I think that's a great way to think about it. So I'm not asking sort of in terms of building a slick app that will compete with the best in class health-tech apps out there. So, I was thinking more in terms of I mean just the whole thought process of digitizing that whole patient lifecycle management. Right now, it's essentially how we

are thinking about tapping the entire set of contact points with the patient and being sort of proactive in guiding the patient towards what needs to be online and what can be offline. Is there some kind of thought process around that?

Viren Shetty: Most of those are online, but they are given in a very different manner right now. At least with the CRM, we can integrate all of that into one place. So why we were interested in an app strategy was because we could combine all the different ways that patients are reaching out to us; through website, through the phone, through WhatsApp, through email, through directly contacting us into this one central place where all of these would happen and then it will be relatively easy for them to reach us and for us to reach them. So, that was the fundamental premise of the app and the app is still there and people are still downloading it, it's just that it's taking much longer than we thought and it needs a lot more resources for us to popularize it and developers to build on that. So, that's why our focus is decided at least we'll build up a lot of the smaller integrations.

So for example, integrating online payment options. So it took developers rather than building more UI features to the app, they worked on integrating with RazorPay so that you can use at different parts of the hospital RazorPay through the UPI, pay through RazorPay, pay online and they can have a completely contactless experience in the hospital. So, that is convenience in the hospital. But we can extend that right now to them being able to pay for services at home in advance for some like sending medicines at home. That we won't be able to attract right now. But the things that we are already good at doing and the things that patients are experiencing, we made it much more convenient for them. But your larger point is true that we definitely are aware that a lot more of these things have to be more patient facing and there's a whole realm of digital health that should be unlocked and for that we're running a separate program with our clinics rather than with the hospitals because the clinics are a lot smaller and more focused and we will be able to spend a lot more time understanding the consumer behavior there. But from a hospital perspective, there's just so much more. So just I don't have any real facts to back this up, but I would posit that there is an entire other NH worth of revenue sitting already in our existing system that we're not able to tackle because of our relative inefficiencies - medicine fulfillment that we're not able to do because the pharmacies are crowded, through all the calls who come to our call center who are not able to get, through every patient in our neighborhood who would like to come to our ER but doesn't know the number of the ambulance or is not able to reach out to us, every doctor who does two surgeries a day but could do one additional surgery or two additional surgeries if only they were able to line up for patients on the same day. These are all these inefficiencies within our system that are much cheaper to do, much faster to do, easier to rollout, which would lead to tremendous gains without us going after new things. Not that we wouldn't do it, we absolutely are doing that. But these are things that are right there, it's in our grasp.

Sure. Thank you very much. So, I look forward to hearing about those initiatives in the

coming quarters.

Debangshu Sarkar: I guess that concludes our session for the day. Thanks everyone for your active participation just like every time. Like I highlighted right at the outset, should you have any further query, do reach out to us, would be happy to address it to the best of our abilities. Thanks once again.