February 14, 2024

Ref: - GHL/2023-24/EXCH/107

The General Manager
Dept. of Corporate Services
BSE Limited,
P J Towers, Dalal Street,
Mumbai - 400 001

The Manager
Listing Department
National Stock Exchange of India Limited
Exchange Plaza, C-1, Block G,
Bandra Kurla Complex,
Bandra (E), Mumbai - 400 051

Scrip Code: 543654

Symbol: MEDANTA

Sub: Disclosure under Regulation 30 of SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015 – Earnings Conference Call Transcript

Dear Sir(s),

Pursuant to Regulation 30 of the SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015, the transcript of the Earnings Conference Call held on Friday, February 9, 2024, hosted by Motilal Oswal, for the Third Quarter and Nine Months ended December 31, 2023 Results, is enclosed herewith.

The Transcript is also available at our website: https://www.medanta.org/investor-relation

This is for your information and record.

For Global Health Limited

RAHUL RANJAN
Digitally signed by RAHUL RANJAN
Date: 2024.02.14 14:46:54 +05'30'

Rahul Ranjan
Company Secretary & Compliance Officer
M. No. A17035

Encl: a/a

“Medanta – Global Health Limited

Q3 FY24 Earnings Conference Call”

February 09, 2024

MANAGEMENT: **DR. NARESH TREHAN – CHAIRMAN AND MANAGING DIRECTOR – MEDANTA – GLOBAL HEALTH LIMITED**

MR. PANKAJ SAHNI – GROUP CHIEF EXECUTIVE OFFICER AND DIRECTOR – MEDANTA – GLOBAL HEALTH LIMITED

MR. YOGESH KUMAR GUPTA - GROUP CHIEF FINANCIAL OFFICER – GLOBAL HEALTH LIMITED

MR. RAVI GOTHWAL – HEAD, INVESTOR RELATIONS – MEDANTA – GLOBAL HEALTH LIMITED

MODERATOR: **MR. TUSHAR MANUDHANE – MOTILAL OSWAL FINANCIAL SERVICES LIMTIED**

Moderator: Ladies and gentlemen, good day and welcome to Medanta Global Health 3Q-FY24 Earnings conference call. As a reminder, all participant lines will be in the listen-only mode and there will be an opportunity for you to ask questions after the presentation concludes. Should you need assistance during the conference call, please signal an operator by pressing star then zero on your touchtone phone. Please note that this conference is being recorded.

I now hand the conference over to Mr. Tushar Manudhane. Thank you and over to you, sir.

Tushar Manudhane: Thanks, Sagar. Good afternoon and a very warm welcome to all the participants on the Global Health Limited 3Q FY24 Earnings call hosted by Motilal Oswal. Joining with us today from the management side, we have Dr. Naresh Trehan, Chairman and Managing Director, Mr. Pankaj Sahni, Group CEO and Director, and Mr. Ravi Gothwal, Head, Investor Relations. Over to you, Naresh, sir.

Dr. Naresh Trehan: Good afternoon to all of you and welcome to Medanta's Q3, FY24 earnings call. I am also pleased to welcome Mr. Yogesh Kumar Gupta as our Group CFO and he is with us on this call. Now, coming to Q3 FY24 results, we have yet again delivered strong operational and financial performance.

More importantly, our clinical expertise, quality infrastructure, technology and compassionate approach are all aligned to ensure the best outcomes to our patients. The success of our strategy is visible in the growing patient footfalls across our facilities and also encourages us to serve more and more people in areas where these kind of facilities are required.

During the quarter, Medanta Group became the first hospital in India to use advanced AI-enabled Penumbra Lightning technology for treating patients who have suffered a very severe case of pulmonary embolism, which means that blood clots from the legs have gone into the lungs and are life-threatening. In the past, the patient in this condition will either have to be given very high doses of blood thinners, which led to many complications, or we would have to operate on them physically removing the clots. Now, this was all very high risk for the patient, but with the introduction of the AI-enabled Penumbra Lightning technology, we have been able to suck these clots out with the AI-monitored, assisted device which sucks out these clots, only the clots, not the blood. The patient suffers very minimum trauma to the body and is relieved immediately of the lack of oxygen that was happening because the pulmonary arteries were choked and lungs could not function. Overall, this has been a great advantage from the patient's point of view and a great technological movement forward.

Second, Medanta Lucknow has also launched advanced NICU ambulance and child development center amid growing demand for quality mother and child care health services. And this was much needed in the community because many newborns were losing their life because immediate care was not available to them. With the introduction of the NICU ambulance, we are now able to pick them up immediately and bring them to our NICU, that is the Neonatal Intensive Care Unit, which is a very large unit at our Lucknow facility and has been able to save many lives.

Medanta Patna has just launched a comprehensive cancer institute. Now, this cancer care program, which includes the most advanced radiation oncology machine, known as the Varian Edge, is the first of its kind in that part of the country. And Patna is now one of the most advanced facilities for cancer treatment because the precision with which the Varian Edge machine can deliver radiation to add a focus to where the cancer is without damaging the surrounding tissue is much more precise. With the introduction of this, I think the patients of all of Bihar will benefit hugely.

Overall, as a group, we continue to explore territories where we can make a difference in the standard of healthcare delivery. At Medanta, patient wellbeing is at the heart of our strategy and these values will continue to guide our decision making as we move forward in other locations.

I would now like to hand over the call to our group CEO, Mr. Pankaj Sahni, who will provide an update on quarterly results and walk you through them. Thank you.

Pankaj Sahni: Thank you, Dr. Trehan. Good afternoon and welcome to everyone for our Q3 FY24 earnings call. First of all, I would like to introduce our new CFO, Mr. Yogesh Gupta. He has joined us yesterday. He was appointed in our board meeting, as you would have heard. He is a highly experienced and accomplished chartered accountant with 27 years of experience in finance, accounting and commercial management across diverse industries, including pharmaceutical, manufacturing, retail and healthcare. He joins us from Sheares Healthcare. While during his career journey, he was also a vital part of various other organisations such as Maxh Healthcare, Fortis, TPG, Reliance Retail and Ranbaxy.

Now, coming to our quarterly financial performance, we have concluded yet another quarter with strong all-round operational and financial performance. Medanta reported consolidated total income of INR 8,545 million, a strong growth of 21% year-on-year. The growth was driven by higher patient volumes across our hospitals and ARPOB growth at our Gurugram facility.

EBITDA was INR 2,340 million, which is a growth of 36% year-on-year. EBITDA margins increased by 305 basis points from 24.3% in Q3 FY23 to 27.4% in Q3 FY24. Improvement in EBITDA margins is mainly because of higher operating leverage. Profit after tax was INR 1,235 million, a growth of 53% year-on-year. PAT margins improved by 304 basis points year-on-year to 14.5%.

As I have highlighted in earlier calls, our growth is led largely by patient volume growth, which is reflected in higher IPD volumes, which increased by 13% year-on-year. Average occupied bed days for the quarter increased by 15% year-on-year, representing an occupancy of 64% for the group.

As anticipated, there is seasonal dip in occupancy levels at matured hospitals on a sequential basis on account of various festivities in the quarter. However, this was offset by higher occupancy growth at Lucknow and Patna. ARPOB grew by 4% year-on-year to INR 60,571 in Q3 FY24, primarily driven by increases in tariffs and realisations at our Gurugram unit.

Developing hospitals, which comprise of Lucknow and Patna, registered strong growth of 33% year-on-year. Revenue share increased from 29% in Q3 FY23 to 32% in Q3 FY24, amounting to INR 2,742 million. Developing hospitals' EBITDA share increased from 37% in Q3 FY23 to 41% in Q3 FY24, amounting to INR 968 million.

Mature hospitals also registered strong revenue growth of 17% year-on-year and EBITDA growth of 37% year-on-year, amounting to INR 5,875 million and INR 1484 million respectively. During the quarter, international patient revenue increased by 6% year-on-year to INR 473 million, driven by increased volumes and realisation.

Our OPD pharmacy business continues to register consistent growth. Revenue increased by 28% year-on-year to INR 287 million in Q3 FY24.

We continue to strengthen our core and have on-boarded 253 doctors in the nine-month ended December '23 against the same period last year. Out of 253 doctors, 159 doctors were added in our mature facilities, while 94 doctors were added in developing hospitals.

We have incurred capex of approximately INR 1,770 million during nine-month-ended December '23, out of which 66%, which is INR 1,170 million, was incurred towards our Noida hospital project. Overall, our balance sheet remains well capitalised to fund future expansion and growth plans.

Coming to a few updates on our bed expansion. As you are aware, our Noida Hospital construction is underway, this is on-track, with about 82% of the superstructure completed. Mechanical, electrical and plumbing work is currently under progress, with the hospital expected to commence operations by the end of FY25. We expect to add another 140-150 beds in Lucknow and approximately 30-40 beds in Patna by the end of March 2024.

In Medanta Gurugram, we are in the process of converting one of the floors, which had approximately 60 beds to day care for our medical oncology chemotherapy procedures. In addition, we are adding approximately 50 beds more for our mother and child unit.

In Q3 FY24, Medanta and DLF Limited had incorporated a SPV company by the name of GHL Hospitals Limited to construct and operate our super-specialty Medanta Hospital in South Delhi.

With this, I am now happy to take any questions from the participants.

Moderator: Thank you very much. We will now begin the question and answer session. The first line of question would be from Tushar Manudhane. Please go ahead, Sir.

Tushar Manudhane: Yes, while the question queue assembles, just a couple of questions from my side. Sir, we have a good amount of cash available on the balance sheet, while we have grown organically, you know, since inception, so how to think about the usage of surplus cash?

Pankaj Sahni: Thank you, Tushar. So, there are two or three stated strategies which we have articulated over various conference calls. For the most part, these strategies remain consistent. The first one, as

I have mentioned many times, is of course to continue the various build-outs that have already been planned and disclosed.

Most immediate amongst them, of course is Noida, followed by the scale-up in our remaining hospitals, which are already constructed, as well as now the build-out of our facilities in Delhi as that project comes on board. We are, of course, also continuing to look at opportunities beyond these stated six or seven hospitals. And as those come on board and become definitive, we will be sharing them in due course with all of you.

The second aspect, when you think about the utilization of our cash, of course, we are looking at growth opportunities beyond our organic. And as we have mentioned in the past as well, that we are always open to looking at what potential opportunities may come in, provided they meet the criteria that we have very clearly laid out in many of our presentations, as well as our annual report, around ensuring that they are able to continue to create assets for us that deliver the highest quality of healthcare and provide healthcare in areas where we feel it makes a difference in the quality to serve in those communities.

We feel that the opportunities in healthcare delivery, as well as in its ancillary industries are quite strong and we continue to remain optimistic about them.

Tushar Manudhane: Sure. So, can you also update on Indore project?

Pankaj Sahni: Our Indore project, as we had articulated last time, is still undergoing various due-diligence processes. We need to make sure that everything that we do is 100% transparent, above board, and completely in line with our values and ethics. We do not want to rush into anything where the due-diligence and the legal processes of ensuring 100% compliance to the various real estate and construction approvals, etc are in place. And therefore, we continue to wait for our partners to obtain the necessary approvals before moving forward.

We are also continuing to evaluate opportunities in Indore, in our existing facility scale-up, as well as opportunities that remain with our partner who we have engaged with, as well as opportunities that may be above and beyond that. But we will not move forward until we have complete clarity and transparency on the appropriate regulatory requirements.

Tushar Manudhane: Thank you, sir. I will join back in the queue. Thank you, sir.

Moderator: Thank you. The next question is from the line of Bino Pathiparampil from Elara Capital. Please go ahead.

Bino Pathiparampil: Hi. Good afternoon and congrats on a good set of numbers. Just one question around ARPOB.

We are seeing that most of your peers, competitors are reporting very high ARPOB growth this year, in the range of 15% and above. As I understand, there has been quite a few revisions in insurance rates, CGHS rates, etc. this year, which is helping people, apart from, of course, maybe some case.

I was wondering why your ARPOB growth is much lower at around 4% levels.

Management: Is that the complete question?

Bino Pathiparampil: Yes, yes.

Management: Okay.

Pankaj Sahni: So, a couple of points. First of all, when you look at our growth across units, both developing as well as the mature unit, as well as the developing units, you will find that, unlike many in the industry, our growth has been driven mostly by volume growth. Dor the quarter, we see about 13% growth in inpatient footfalls, 15% growth in occupied bed days.

And the same applies for the nine-month period, about 17% growth in inpatient footfalls, and about 16% growth in occupied bed days. And when you look at this for our mature hospitals as well, it is not only the new hospitals that are showing volume growth, our mature hospitals are also growing very well on the volumes. So, we are very happy with the kind of volume growth that is coming.

And much of our revenue growth is actually driven by volumes. What this means is that we have not been forced to resort to tariff increases to drive the revenue growth. We've always maintained that the tariffs which we charge to the public should be as reasonable as possible, both in our newer facilities as well as our mature facility.

Just to give you a sense, we did take some tariff increases in our Gurgaon facility, starting in January 2023, and that was continuing out till about April 2023. We've also seen the tariff increases from the CGHS and some of the insurance renegotiations. But frankly speaking, these tariff increases are not really the largest driver of our revenues.

Also, to let everybody know, we've seen very strong growth in Lucknow and Patna. And Lucknow has not taken a tariff increase since it started four years ago. And Patna also has not taken a tariff increase since it started two years ago.Again, in these developing hospitals, we see very strong momentum. Therefore, we have felt that it makes sense to retain the tariffs at the rates they are, again, with the same philosophy that I articulated earlier. So, we continue to believe that our topline growth should be taken in a measured manner.

We are quite happy with the growth that we see in Gurgaon, the mature hospitals actually having grown a little bit higher than the 4% which you see at the consolidated level. So, that are the reasons. Some of these are intentional strategies, and some of them are because of the high growth in volume.

Bino Pathiparampil: Understood. So, it's a very good thing that your growth is primarily driven by volume. It shows the quality.

But at the same time, at an industry level, I was just asking for the purpose of understanding. When the insurance negotiations happen and all the other facilities around you take a 10% or 15% increase, wouldn't those kinds of increases apply to you as well from the same insurance companies or CGHS, etc.? I mean, how does the industry practice work?

Pankaj Sahni: Couple of points to clarify for your understanding. I think the first thing to understand is that there are actually different payer categories, and the tariffs apply differently to those payer categories across the industry. First of all, when it comes to payer categories like CGHS, ECHS, you will see from our presentation that our revenue mix for CGHS, ECHS, and these kind of scheme patients is quite low.

Only about 10%, 12% comes from CGHS patients, about 9%, in fact, actually, we'll see on the investor presentation. So, it is not a very big part of our overall sales mix. That being said, in the industry, when CGHS tariffs increase, they increase for the industry as a whole, although there are some small deviations in rates depending on which state you operate in. That is how the industry tariffs move for CGHS.

As far as the insurance companies go, both the nationalized insurance companies as well as the private insurance companies, these companies engage with commercial negotiations with each hospital or hospital group independently. In some cases, the hospital group may have the same negotiation rates across all of the units.

And in some cases, these may be different for different units depending on individual strategies of hospital groups. So, those are far more commercial negotiations. And very typically, they would take some form of a baseline with respect to the cash tariff, which is published by the hospital.

And then there is a discussion around how that moves with respect to the cash tariff. This is very often how the negotiations would move in the insurance. And then, of course, each hospital company or each hospital unit decides what its tariff strategy should be for the particular hospital in the market where they operate.

As we have said, again, many times, in our case, just because we can take tariff increases doesn't mean we should take tariff increases. And we continue to maintain this approach with all of our assets. So, we do take tariff increases from time to time to ensure that we are able to manage the inflation, manage the input cost as well. But we try to do it in as reasonable a manner not so as not to create excessive burden on the patient population that we serve. I don't know if that answers your question both on the industry as well as our philosophy.

Bino Pathiparampil: Yes, yes, that answers. Thank you. Thank you very much.

Moderator: The next question is from the line of Kunal Damesha from Macquarie. Please go ahead.

Kunal Damesha: Thank you for the opportunity. On this retrofitting of a floor for medical oncology, I'm sure rationale would be demand for that service. But is there any meaningful difference in terms of profitability, return on investment that we would be doing here versus some of the other specialties?

Pankaj Sahni: I think the important point to note first before we get into the return on investment or profitability is that the medical oncology, specifically the chemotherapy, typically functions in two types or maybe three types of care. The first, of course, is where a patient, because of their particular

disease or their particular medical condition, sometimes there may be multiple comorbidities, requires admission and overnight stay, whether for one day or multiple days, depending on the medical condition of the patient. So, that typically gets treated in the inpatient care and the patient stays overnight.

The second type of chemotherapy that is typically administered is what we call chemotherapy daycare, which happens across many hospitals around the world. And these are typical chemotherapy, which is medicine infusions into the patient, which has to be done in a hospital setting, but doesn't necessarily require the patient to stay overnight. Typically, we see these infusions are of two types.

Some are shorter in duration. So, the medicine is delivered over maybe a one hour, two hour or three hour period. And some of these infusions take a little bit longer, maybe four to six hours.

So, when it comes to how the medicine is administered, and of course, these are decisions which the doctors take individually based on each patient, you may find that a particular daycare bed may get utilized twice or thrice in a day, because if you're only required to administer the medicine over a course of, say, three hours, then that bed could, you know, in a nine hour period be utilized thrice or in an eight hour period be utilized twice.

So, it really depends on what kind of disease the patient has and how that bed gets utilized. What we have found, and again, in line with our stated strategy many times is that if you look at the way in which healthcare gets delivered, there is no reason to keep a patient in hospital if the same treatment can safely and effectively be delivered on daycare basis. So, when you look at our length of stay, which across the industry is quite low, this has been in part an active strategy to try to get patients back home as soon as possible. We realized that there was no real need to keep patients overnight in certain medical oncology procedures, and that is why we took the decision to actually convert a complete inpatient ward into a chemotherapy daycare ward. Does that address your question?

Kunal Damesha: Yes, on the business side, you know, how things operate here, but, some of you on the financial side, how kind of, you know, it helps us because I believe one of our peers has a very strong oncology contribution, you know, and that's been growing really fast as well as I think it also has a favorable profitability profile. So, is that the similar kind of trend that you are also witnessing?

Pankaj Sahni: Yes, so two points I think in your question, let me try to split them out. The first is with respect to the profitability or the financial economics on medical oncology. You know, obviously a large part of the treatment in medical oncology is the actual chemotherapy drugs that are administered, and of course the clinical inputs given by the medical oncologists and cancer experts towards that. Also important to understand that typically cancer doesn't appear as one disease. There may be multiple situations with the patient associated with various comorbidities, etc., associated. So, the large part of the patient's bill in medical oncology is driven by the cost of the pharmaceutical chemotherapy drugs that are administered, and therefore the room rent kind of component is much lower because the patient doesn't need to stay for a long period of time.

So, the economics is largely driven by the pharmaceutical consumables and the clinical input of the doctors. As far as your second question, which pertains to the contribution of cancer in general. See, it is important to understand each hospital looks at cancer slightly differently.

If you look at our sales mix and also what was articulated in our various investor presentations over the quarters, we view cancer as a disease management group basis. We don't actually record all of our cancer care under the cancer tagline which you are seeing in our sales mix which is presented in the investor presentation. We actually show much of our surgical oncology in the various different aspects.

For example, our uro-cancer, which is a prostate cancer and kidney cancer, that will be reflected in our kidney and urology institute. Our neuro-cancer, brain tumors, etc., would be reflected in our neurosciences institute. And our stomach cancer, GI cancer, colon cancer, pancreatic cancer, that will be reflected in our digestive institute.

And our lung cancer, etc., will be reflected in our chest surgery institute. So, when you see cancer, and it's also included in the footnote, it really only includes medical oncology, radiation oncology, head and neck surgery, and breast surgery. All other surgical cancers are actually split out.

So, if you look at our cancer contribution vis-a-vis most other big hospital groups as a percentage of the total revenue, it's more or less exactly the same. And that obviously makes sense because the incidence of disease occurred for all the hospitals the same way as in the country. So, I would assume most groups would have the same situation. It just depends on how you classify.

Kunal Damesha: Sure, Great. Thank you on that detailed answer. And second one on the payer mix, now we have shown pretty strong growth. Our occupancy levels are also around 64%. At any point in time, are we planning to refine payer mix? Maybe one year down the line, it could come into play for us. Is there any plan there?

Pankaj Sahni: I think two parts again to this question. The first is it's important to understand what's happening in the industry as a whole. We do see, especially post-COVID, some momentum towards increased insurance penetration on the healthcare insurance side across the country.

So, definitely our expectation is that over the next several years, I don't know whether that will be next year or next three years or next five years, but we do expect insurance penetration to increase. And therefore, the natural assumption would be that the insurance share of business for healthcare would increase. And maybe that would be at the expense of some of the cash patients.

Now, overall, we believe that this is a good thing for the industry. It's a good thing for the country and of course, a good thing for patients. We actively support the increasing insurance penetration and insurance coverage, because obviously we want patients to be secured from what could potentially be devastating financial consequences of you know, sudden illnesses.

So, I do believe that insurance sales mix will grow over time. As far as the other mix, whether it's our scheme business or some of the other mix that we have, we don't have any active strategy to move in one direction or the other. We believe that it's important to continue to serve as many sections of society as possible.

And that is why we do take patients at slightly lower scheme rates. And we believe that we will continue to support that segment of the society and that segment of our patients. But we do also feel that with the increasing focus of healthcare in India, with the government's focus on medical value added travel, we do believe that as an industry, international business will grow and medical value added travel will grow. And obviously, hospitals will benefit from that increase as well.

Kunal Damesha: Thank you.

Moderator: The next question is from the line of Nitin Agarwal from DAM Capital. Please go ahead.

Nitin Agarwal: Hi, on the new hospitals in Lucknow and Patna, we've had a very, very strong occupancy this quarter, about 71%. You talked about adding another 100-150 beds in Lucknow. Now, at the base where it is and with the occupancy that we've really got to, how do we see these two hospitals really moving ahead over the next two to three years?

Pankaj Sahni: Let me take both the units slightly separately. Let's first start with Lucknow. Our Lucknow unit has been doing very well and we've had very strong occupancy, especially this quarter. Some of it is also, of course, the hangover of Dengue, which extended quite long this year in Lucknow.

But what we do see is over the last several years, I don't know if you've been party to those conversations around how our occupancies have grown. Last year, we had very high demand of critical care beds in Lucknow. So, we focused in on adding beds in the ICU. I think towards the end of financial year '23, we had added almost 50 or more beds in ICU because the ICUs were overflowing, and that demand continues to remain strong.

This year, what we realized is that while we were able to provide ICU capacity, the demand for the ward beds has increased as well. So, we are actually adding in about 150 beds of ward capacity. We also find that the demand for our mother and child services is growing, both on the critical care side in the NICU and PICU, as well as on the ward side.

So, you know we may be playing a little bit of catch up on demand. We had ICU demand, we built ICU beds, we have ward demand, we'll build ward beds. By the time we are done with this current build out, which we hope to conclude over the next couple of months, we will be almost at about 750 to 800 beds in Lucknow out of the total capacity of about 950 beds.

So, the bulk of the hospital will be complete. And then we will take some decisions based on how this plays out as to how we want to add out the additional beds. The important thing for us, you know, is that we are far more focused on the bed days and the IPD volumes, because occupancy by just very nature of the metric is a moving target. You add capacity, the percentage will fall. You know, you took the capacity, the percentage will increase. We really internally

manage this much more through absolute volumes than the percentage occupancy, which is frankly just a derived number. That's the story in Lucknow.

In Patna, what we've seen is that we continue to add the beds in Patna and we continue to roll that hospital out. We are at about 358 beds right now. There also we have a very strong need for additional ICU beds. We are actually currently in the middle of constructing two ICUs there, one of which we hope to come on board in the next few weeks and the other one probably in the first quarter of next year. And that should alleviate some of the burden because we are really choked on the ICU in Patna.

We also have already fully utilized our dialysis capabilities there. So, we are adding in some dialysis beds, because again, while it wasn't really planned, the demand has been very high. And we're also building out our chemotherapy ward there to be able to provide the same kind of chemotherapy daycare services as I articulated in one of the earlier questions.

As Dr. Trehan mentioned, we have inaugurated and launched our radiation oncology services in Patna this quarter, which is Q4, a few weeks ago actually. So, the complete suite of cancer services is now available and we do expect cancer work to grow across the board in Patna. So, this is how we are kind of building it out.

I think by the time we are done with this current build out towards, you know, maybe the first quarter of next year, Patna will hit almost about 450 beds or so. And then we will be able to complete one tower of the hospital and we'll have the second tower, which we will then again move towards building out as we move forward.

Moderator: Sorry to interrupt, sir. We have lost the audio from your side. Ladies and gentlemen, the line for the management has been dropped. Please stay connected while we connect them back. Ladies and gentlemen, we have the management line connected back. So, you can go ahead.

Pankaj Sahni: Hi, I'm sorry. I didn't realize. Where did you lose me? Did I complete the Lucknow story?

Nitin Agarwal: Lucknow was completed. You were talking about, you know, after the round of expansion, Patna is done. You'll be probably reaching about 450 odd beds there, 400 odd beds.

Pankaj Sahni: Okay, good. So, not too much you missed. So, you know, this round of expansion, which is currently already underway, we'll probably hit somewhere around 450 beds or so. It is possible we may add some specialties in Patna that is under discussion and we hope to be able to conclude on that by year end, which are not yet there.

And that may require some additional beds to be put into the system. But as you're aware, the capacity of the facility is about 650 beds. So, once we get to about 450, maybe even, you know, closer to 500 beds, we'll have a fairly big sized hospital there.

And then we look at the build out of the second tower, which typically will take about six to nine months because we have to put all the services into the second tower, etcetera. And then that will help us with the growth there.

The other thing that I was mentioning, I think when the call dropped is that while it started late, our PPP business from the government of Bihar has now started really only kicking off towards the start of Q3. Now we do see some increase in patients coming in from the government of Bihar. So, we're very happy that we're able to serve those.

So, depending on how that scales up, there may be additional demand for beds in Patna. But once again, as I mentioned earlier, we don't really worry too much about the occupancy percentage, as long as we are seeing good growth in the volumes and the bed days.

Nitin Agarwal: If I can just probably squeeze a little bit on that. On the Patna, obviously, it's a relatively new hospital, you are a relatively long way to go. In Lucknow, I mean, when you take say, three, five years of the business, you know, while I understand you, the focus on metrics like volumes and occupied bed days, but is there enough there, I mean, can the Lucknow with the pace of the demand that you see, can the hospital take on the next three to five years of growth, which you can see in the region for yourself?

Pankaj Sahni: Is your question oriented around do I have enough capacity to meet the growth? Or is the question around is there enough demand?

Nitin Agarwal: I think by the looks of it, capacity is a challenge, would be a challenge rather than demand

Pankaj Sahni: I mean, I would broadly agree with you before. Just if you sit back and reflect on the state of UP, it is a population of 250 million, and really no high quality healthcare, definitely nothing of the size and quality of Medanta. So, probably we need five, six Medantas to come up in UP and that also will not be sufficient to meet the demand there.

It's very interesting, obviously, because two, three years ago on investor calls and meetings, people used to ask us, why are you going to UP? I think those questions are well answered. And we had firm conviction in the need and our ability to deliver. And you're seeing that.

So, I would agree with you. I think the real issue in Lucknow and UP will be, can you continue to meet this supply? Because the demand for high quality healthcare there of the highest standard with the highest ethics is, of course, very high.

Nitin Agarwal: So, how are you thinking about leveraging this opportunity? Is it -- are you looking to get into more cities in Lucknow? And at what time period does it begin to happen?

Pankaj Sahni: Yes. So, we are definitely looking at opportunities in UP beyond Lucknow. Just to clarify, Noida also technically qualifies as UP, although it's part of NCR. We do believe that there is opportunities in Lucknow area, as well as in Eastern and Western UP both. And we are currently engaging in identifying and driving some opportunities in those regions. Obviously, as you're aware, we can't really disclose where we are until any of these things are definitive.

But looking at UP beyond Lucknow and Noida is very much part of the agenda. And that process is actually already underway. We will, of course, relay that information to you as and when it becomes definitive. But I think there's no doubt about the opportunity in this area.

Nitin Agarwal: Thanks so much. Best of luck.

Pankaj Sahni: Thank you.

Moderator: Thank you. The next question is from the line of Ankit Shah from Canara Robecco Asset Management Company. Please go ahead.

Ankit Shah: Hi. Thanks for the opportunity. I had a few questions related to Patna. Most of them have been answered. But firstly, I just want to get a sense, with the addition of ICU beds and radiation oncology block, would we see any ARPOB growth from current levels? Because as of now, developing hospitals, ARPOB has been flattish. So any improvement can be expected there?

Pankaj Sahni: So I think two things, right. One, as you very rightly pointed out, the ICU bed will have a higher average revenue per patient and a higher ARPOB just by nature of its services. And the other thing, when we look at ARPOB, which again, important to point out is a derived metric, radiation oncology revenue will be driven largely through daycare.

So the denominator is not getting added, but the numerator in terms of revenue is getting added. So yes, you could assume that ARPOB could come with radiation oncology and ICU beds increases. That being said, as I mentioned earlier, we also do hope to see an increase in the PPP patient volumes that we have committed to.

And given the tariffs of that are slightly lower than our listed tariffs, so that may have a slightly diluting effect. So it really depends on how this plays out in terms of the mix of all these specialties. And also to re-mention that we haven't taken any tariff increases in Patna at all. Same goes for Lucknow. So the reason your ARPOBs are flat in both those units, despite volume increases, is really because there's been no tariff increase in any of the developing hospitals.

Ankit Shah: And so as a mix of the mixed impact of both these factors, PPP patients plus ARPOB increase, should we expect the Patna margins to remain stable over here or can they increase further as occupancy goes up?

Pankaj Sahni: A I have mentioned in the past, we don't really give guidance on where the margins will go. But let me try to articulate it from this point of view. Obviously, as the hospital is still growing, and given the nature of our model, which I may have mentioned in the past, which is largely full-time doctors, fixed cost kind of a model, obviously, as the volumes grow, you get the benefits of operating leverage and those are margin accretive for the most part.

The second aspect, as you rightly pointed out, is that if you are able to generate revenues on businesses which have lower cost base, now obviously, radiation oncology at a P&L level doesn't have too much material costs and too much manpower cost to revenue, but obviously, there's a huge amount of capex that goes in. So if you look at it only at a P&L level, radiation oncology business is margin accretive. But again, there's obviously a huge amount of capex that has gone in towards the acquisition of the machine. So these are all things which are margin accretive.

As I mentioned, reduction in the payer mix towards PPP, although I don't anticipate it to be that drastic, you may be aware it's capped at 25% of the beds as per our contract, would have somewhat of a dilution effect on ARPOBs. But since it's volume at lower marginal cost, it may still be beneficial on the margin and the EBITDA. So we feel fairly confident. I think that if I look at the financial performance of Patna Hospital over the last several quarters, and we do anticipate this full year financial results.

Last year, I believe the EBITDA margin in the first year was about 8%. This year, we expect a significant improvement on that for the year. So overall, I would say in a second year of operations to deliver these kind of margins, which we are seeing in Patna, I think we are very, very happy with the performance of Patna.

Ankit Shah: Got it. My second question pertains to the Noida coming hospital, I understand that around 300 beds are expected to come by FY'25 end. So can you give some color on how this will be scaled up, or what period would EBITDA breakeven be achieved?

And also, considering that most of corporate costs are loaded in the Gurgaon Hospital, can we expect the margins over here to be much closer to the developing hospital versus the mature ones, as they are now at maturity?

Pankaj Sahni: So let me take that question also in two, three different buckets. Obviously, when you look at building out any hospital, especially of this size and scale and the quality that Medanta does, I think that the typical thought process is that hospital like 550 beds that's coming up in Noida, normally one would expect to breakeven in maybe three to four years. And that's typically how we internally also model it out.

That being said, we have proven that we are able to generate a breakeven in Lucknow in one year, in Patna also in the first year itself. Although, as I always tell people, please don't hold us to that just because we have achieved breakthrough performance in Lucknow and Patna doesn't mean that one should expect normally a hospital will breakeven in one year. It is not normal performance.

It is actually quite exceptional performance from that aspect. So we continue to model out our breakeven on a more rational basis. That being said, the Noida Hospital is a little bit different in its construction and layout as many of the other hospitals, which is most of our hospitals are built around two towers of inpatient beds. Noida is one tower. And therefore, our ability to scale up is a little bit faster because of the way in which the construction is done. So while we plan to start out with 300 beds, scaling up thereon is just a question of doing the interiors and fit-outs of one floor at a time.

So we hope that the scale up to 550 could be faster depending on what the demand is. As far as your question on corporate costs and margin profile goes, you're right. Currently, we load all the corporate costs on the margins of the stand-alone Gurgaon, Indore and Ranchi Hospital Company. Also, just to clarify from a financial point of view, the Noida facility will also be part of Global Health Limited, which is the same company as Gurgaon, Ranchi and Indore. So that will be part of that. So there's no real question of taking the corporate overheads, loading to a

new company. As you're aware, Lucknow and Patna are 100-percent subsidiaries. So that's one of the reasons for the difference.

But we feel very confident in the market in Noida. We feel very excited about the expectations of the community there. A lot of positive demand from the clinical community to get associated with Medanta Group and Medanta Noida specifically. So all the indications are positive for our opening and build-up. How the margins play out, I think time will tell. And once again, we don't really crystal ball gaze into that. But we feel confident on the broad success of Noida as an institution.

Ankit Shah: Thank you.

Moderator: Thank you. The next question is from the line of Jainil Shah from JM Financial. Please go ahead.

Jainil Shah: Hi. Thank you for the opportunity. Just trying to understand the developing hospital performance better. So we've reported 70% occupancy and flatter sharp ups. Is it fair to assume that Patna's occupancy is somewhere around 60% plus and its margins are, you know, have reached 20% and above?

Pankaj Sahni: So to your question, is it fair to assume? Yes, I think it's fair to assume. Obviously, full results we will declare in the year-end when we publish the independent accounts for both entities. But yes, things are going quite well in Patna, both as far as occupancy goes as well as the margin profile.

But again, just one word of caution on both the units is that, as we add beds, occupancy percentage tends to be a little volatile because obviously you are changing the denominator on a constant basis. So I think slightly more holistically, because again, this business is not run quarterly when you look at it over the course of the full year.

I think we will see good occupancy numbers, good inflation volumes, good bed days, as well as the kind of margin profiles that, you know, you're talking about, which, frankly speaking, is much better than what we would have originally anticipated just in a short two-year period.

Jainil Shah: And we have reported, you know, margins of 25% plus over the last two quarters. So just want to know your thoughts. Is this sustainable? Are we planning any more price hikes next year? Because we have a few bed additions and we have Noida coming up. So just want to understand the trajectory going forward?

Pankaj Sahni: Look, like I mentioned earlier, I don't want to be giving out what the EBITDA guidance will be, and especially not quarter-on- quarter. So I think the margins are an outcome of the efforts we put into the work that we do. That being said, I think the smarter way to think about this is to lay out what are the potential accretive and dilutive impacts.

As I mentioned already, with respect to the developing hospitals, the incremental volumes on a largely fixed cost base will provide disproportionate profitability because the marginal cost is lower. Frankly speaking, if you look at our volume growth over the last nine months or so, in

even our mature facilities, you see good amount of volume growth coming in. And that, of course, again, is getting delivered on an asset base and a cost base that is fully mature and also fixed to a large part.

So obviously that also flows towards the bottom line. So that all ends up being margin accretive. We are conservative as far as tariff increases go. So to the extent that we maintain that conservatism, there may be some input cost increases as we think about doctor costs, as you think about the tendency in the industry for the various elements of input cost to increase.

Obviously, there's always this question which people ask us around, how do you think the regulation may impact the pricing? So regulation will obviously have a margin dilution effect. So I think that none of these impacts are very different from what we would have seen last quarter or even the few quarters before that.

So if you step back and look at this slightly more holistically on an annualized basis, I think the trends are very positive as far as the Medanta Group goes. Just because we see good volume growth, we see increased utilization of the hospitals that are built out in Patna and Lucknow. We are seeing very strong volume growth even in a hospital like Gurgaon, which has already been operational for 12-13 years.

So I think these are all positive. Definitely there will be some initial margin reduction with the ongoing operational costs of Noida as that unit becomes operational. But of course, that will be determined whether it's capitalized as part of pre-operating expenses or whether it gets into the operational expenses.

So I think once the finance accounting of all that is sorted out, you'll be able to see where those numbers fall. But these are, I would say, the levers that will drive the profitability of our group.

Jainil Shah: Sure, that's helpful. Thank you so much.

Moderator: The next question is from the line of Lakshminarayanan KG from Tunga Investments. Please go ahead.

Lakshminarayanan KG: Thank you. I have a couple of questions. The first question is, conceptually, how to think about ARPOB in NCR? Because what puzzles me is that all the leading hospitals continue to add beds and the ARPOB is the highest in India. And despite the city having the highest number of beds, including leading providers, AIMS, etc. I just want to understand that question?

Pankaj Sahni: I think various different elements there. One, of course, let me first just touch upon my perspective on the NCR area as a whole. Obviously, you're aware that the demand and the population is still growing in NCR and is still hugely short of the supply and capacity required from a bed to population ratio point of view, including vis-a-vis some of the other major cities in the country.

So from that point of view, Delhi NCR is still significantly undersupplied for from a hospital bed point of view. The city is continuing to grow and therefore, that problem is only likely to

get worse. And also Delhi, just because of its nature, drains a lot of patients, not only from other parts of the country, but also internationally. So I think that when you look at the demand supply mismatch in Delhi, as far as infrastructure capacity goes, of course, not to mention doctors is still fairly large. So I don't see any concerns with additional capacity coming on board. I think that will continue to be needed.

Now, as far as the ARPOBs and tariffs go, look, Medanta as a group has always maintained that we do not want to be the most expensive in town. We want to maintain a reasonable level of tariffs to be as affordable as possible, given the context of the quality of healthcare, the cost of infrastructure and the cost of the inputs that we provide. So we don't aspire to charge more just because it's possible to charge more. We try to charge as reasonably as possible. That may or may not be the approach of others in the industry. That's our approach.

And therefore, we always view our tariffs in these lines. The other thing that I mentioned earlier is look, ARPOB a derived metric. If your average length of stay will fall, your ARPOBs will rise. If your average length of stay will increase, your ARPOBs will fall. So we really much more view this on average revenue per patient basis than ARPOB, because depending on your sales mix, depending on your patient mix and the complexity, the length of stay, etc, ARPOB's tends to move around. So we don't obsess on ARPOBs growth.

I think for us, the real focus is, are we able to serve the patients that come in and are we able to continue to see growth in that dimension?

Lakshminarayanan KG: Got it. And second, your inpatient revenues, does it include the inpatient pharmacy charges also?

Pankaj Sahni: Yes, it does. So all the charges that the patient incurs while admitted in the hospital are part of inpatient revenue. The outpatient pharmacy business that I mentioned in the earlier remarks is purely the OPD pharmacies, which are the retail pharmacies. For the most part, they are the ones which are in the various hospital lobbies, etc, and one or two outside hospitals as well.

Lakshminarayanan KG: No. What kind of profit margin for the gross profit you make on either inpatient or outpatient pharma?

Pankaj Sahni: We don't disclose gross profit by category of revenue stream. And frankly, neither do we disclose gross profit across the board. I think it's important for you to understand also that healthcare delivery is not about just giving medicines or just having a doctor or just doing a surgery.

It's far more complex than that and it consists of a very complicated, integrated level of care. In Medanta, we also believe that care is not delivered by one doctor alone. It is the team that delivers care. And that team comes together comprehensively to deliver care. So neither do we worry too much about individual line items in the bill, and neither do we report out the economics in that front.

Lakshminarayanan KG: And the last question from my side is, when you said profitability, do you actually have every hospital is taken as a different PnL? And because you mentioned some of that earlier, that the corporate overheads get slowed, and I just want to understand that part.

Pankaj Sahni: Go ahead.

Lakshminarayanan KG: Yes. So, and also I just want to understand, how do you drive procurement efficiency as you increase the footprint?

Pankaj Sahni: Okay. So two different questions, I think. The first one is that, as mentioned in our, right from our IPO days, the Medanta group is structured as the Global Health Limited, which is the hospital, which is the listed entity, as well as the company which houses Indore, Ranchi and Gurgaon. And our accounts are disclosed as such. And that includes all the corporate overheads that you were mentioning. Lucknow is 100% subsidiary in the company called MHPL.

And Patna is 100% subsidiary in a company called GHPPL. So, at the end of the year, you will see three sets of accounts being filed with the ROC. And that is how we disclose our financials on across the board.

So, we of course have many different ways that we manage the company internally. But this is what we disclose out across the board to the public as well as to the authorities and the exchanges. As far as procurement efficiencies, I think that's a far deeper question.

But obviously, there are all the basics, which is economies of scale, ensuring that you are actually able to optimize your procurement across the group rather than looking at it individually, which is how I think most hospital groups would do it. And also ensuring that you are able to use that to get the best possible rates from the suppliers. That being said, it is not the cheapest only.

Medanta has a very, very high bar on quality. And so, there are certain inputs and certain manufacturers that would not qualify for procurement in us, even though they may be cheaper as far as the rates go. So, we take a very high focus on quality of inputs that we utilize.

Lakshminarayanan KG: Sorry, I just want to squeeze in one more question if it's possible. May I?

Pankaj Sahni: Yes.

Lakshminarayanan KG: Yes. So, what I understand is Q3 is slightly lower in terms of utilization for the industry, given the festival period coming in. So, I want to understand at an overall level, where does your hospital utilization gets?

It's very difficult. That is, you cannot inch beyond 75% or 80%. What's the band you actually look at it? if you just look at utilization over a period of time, and what kind of de-bottlenecking you normally do?

Pankaj Sahni: Look, we don't run this company or view the business optimization quarterly. It just so happens that we are required to report our quarterly results. So, absolutely nothing that we do in the company runs the business on a quarterly basis.

We are far more long term in our orientation, and far more focused on ensuring that we deliver a high standard of care. And we believe that if you do that, the numbers will kind of speak for

themselves. So, this is not the kind of organization or in our opinion, the kind of industry, where you're optimizing things on a quarterly basis, trying to produce good results, quarter on quarter.

So, the numbers are what they are based on how we run the business. And our personal belief is that at a minimum, you should be looking at this on an annualized basis, if not even on a longer term period. And that's how we think about the business.

Obviously, on a daily basis, we look at where the inefficiencies are that can be kicked out. And what are the improvement opportunities that we can bring in. But like I said, none of this is at the cost of the quality baseline and benchmarks that we have.

Lakshminarayanan KG: And actually, the quality goes down with what point in utilization, it actually...

Pankaj Sahni: It doesn't work like that, actually. Because when you look at utilization, again, at a very macro level, it's too difficult to say. Quality differs in daycare, quality differs in OPD, quality differs in the IPD. So, to really understand this, I don't think a one hour conference call will be sufficient, you really have to get into how a hospital functions.

So, quality utilization, I can't tell you that there's a particular number where quality will fall, totally differs depending on what's the nature of the specialty and the nature of the institution. And frankly speaking, what your baseline and benchmark is for you to define quality. So, I don't think there's an answer I'll be able to give you on that front.

Lakshminarayanan KG: Thank you so much. This is very helpful.

Pankaj Sahni: Thak you.

Moderator: Thank you. Thank you. As there are no further questions, I would now like to hand the conference over to the management for closing comments. Sir, you have any closing remarks?

Pankaj Sahni: Thank you everybody for participation in this call. And just to reiterate, we remain committed to our outline strategy. And I hope you will agree that we have been consistently reverting back to you that we are working on the outlined strategy, which we laid out several quarters ago. And we will continue to maintain that focus on delivering the highest standard of care with the highest standard of ethics and values. And we thank you for your support and participation.

Moderator: Thank you. On behalf of Medanta Global Health, that concludes this conference. Thank you for joining us. You may now disconnect your line.

Notes:

1. This transcript has been edited for readability and does not purport to be a verbatim record of the proceedings