UniHealth

Date: June 08, 2026

To,
The Manager,
Listing Department,
National Stock Exchange of India Ltd.,
Exchange Plaza,
Plot No. C-1, Block G,
Bandra Kurla Complex,
Bandra (E), Mumbai – 400 051

NSE Symbol: UNIHEALTH

Dear Sir/Madam,

Sub: Transcript of Results Earnings Call for Audited Financial Results for the half year and financial year ended March 31, 2026.

In continuance of our letters dated May 29, 2026, we hereby inform you that the transcript of the Company's Results Earnings Call to discuss the Audited Financial Results for the half year and financial year ended March 31, 2026 held on Wednesday, June 03, 2026 at 12.00 pm IST and concluded at 01.10 pm IST is available on the website of the Company at https://www.unihealthfinancials.com/.

We also enclose herewith a copy of the transcript and request you to kindly take the same on record.

Thanking you.
Yours faithfully,

For **Unihealth Hospitals Limited**
(Formerly Unihealth Consultancy Limited)

DESHNA JAIN
Digitally signed by DESHNA JAIN
Date: 2026.06.08 18:03:25 +05'30'

Deshna Jain
Company Secretary & Compliance Officer

UNIHEALTH HOSPITALS LIMITED MUMBAI

“Unihealth Hospitals Limited

H2 FY26 Earnings Conference Call”

June 03, 2026

MANAGEMENT: **DR. AKSHAY PARMAR – MANAGING DIRECTOR – UNIHEALTH CONSULTANCY LIMITED**

MODERATOR: **MS. SAKHI PANJIYARA – KIRIN ADVISORS PRIVATE LIMITED**

Moderator: Ladies and gentlemen, good day, and welcome to H2 FY26 Results Conference Call of Unihealth Hospitals Limited, hosted by Kirin Advisors Private Limited. This conference call may contain forward-looking statements about the company, which are based on the beliefs, opinions and expectations of the company as on date of this call. These statements are not the guarantees of future performance and involve risks and uncertainties that are difficult to predict.

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 this 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 Ms. Sakhi Panjiyara from Kirin Advisors. Thank you, and over to you, ma'am.

Sakhi Panjiyara: Good day, everyone. On behalf of Kirin Advisors, I welcome you all to the H2 FY26 Conference Call of Unihealth Hospitals Limited. From management team, we have Dr. Akshay Parmar, Founder and Managing Director. Now I hand over the call to Dr. Akshay Parmar for opening remarks. Over to you, sir.

Akshay Parmar: Thank you, Sakhi. Good day, everyone, and thank you for joining us today. FY '25-'26 has been a landmark year for Unihealth Hospitals and a significant step forward in our journey to build a leading integrated health care platform across India and East Africa. Throughout this year, we remain focused on expanding our health care footprint, strengthening our clinical capabilities, enhancing operational efficiencies and creating long-term value for all our stakeholders.

I'm pleased to share that we delivered another year of growth, which was strong and driven by healthy patient volumes, increasing demand for specialty health care services, improving utilization across all our facilities and continued the momentum across our hospital operations and allied health care businesses.

Our diversified model spanning hospital operations, health care consultancy, pharmaceutical exports, medical value travel and health care infrastructure development continue to demonstrate its scalability and resilience.

Looking specifically at second half of FY26, consolidated total income grew by 18.4% year-on-year to INR67.5 crores. The EBITDA increased to INR24.2 crores, while profit attributable to shareholders grew by 19% to INR10.7 crores. Despite investments towards expansion and integration initiatives, we maintained a healthy profitability and continue to generate strong operating performance across our businesses.

For the full year FY26, consolidated total income increased by 34.6% to INR137 crores. EBITDA grew by nearly 49% to INR58.8 crores and profit attributable to shareholders increased by approximately 83% to INR25.8 crores. Our EBITDA margin expanded by over 400 basis points to 42.9%, reflecting the strength of our operating model, better service mix, operating leverage benefits and disciplined execution across the organization.

Beyond financial performance, FY26 was transformational from an expansion perspective. During the year, we successfully commissioned our Navi Mumbai hospital, finalized the lease for our upcoming 200 Nashik facility and completed the acquisition and commissioning of UMC Hospital in Entebbe, Uganda.

These milestones have significantly strengthened the platform and doubled our overall bed capacity from approximately 200 beds at the beginning of FY26 to around 400 beds today. While Africa continues to be a key pillar of our growth strategy, our health care facilities in Uganda are witnessing increasing patient traction across specialties, supported by growing health care awareness and rising demand for quality medical services.

We also achieved an important clinical milestone during the year with the first successful IVF twin birth at UMC Victoria Hospital, highlighting the growing capabilities of our specialty health care programs and our commitment to delivering superior patient outcomes.

In India, we continue to lay a strong foundation for our next phase of growth. The commissioning of Navi Mumbai and the progress on the Nashik project reinforce our confidence in the long-term opportunity within India's health care sector.

Rising health care expenditure, expanding insurance penetration, demographic trends and the increasing need for quality health care infrastructure continue to create a favourable environment for sustainable growth.

As we move into FY27, our focus will be on accelerating utilization across our expanded network, integrate newly added facilities, strengthening specialty and tertiary care offerings and driving future operational efficiencies.

With a larger health care platform, a stronger balance sheet, expanding clinical capabilities and a clear road map for growth, we believe Unihealth is well-positioned to capitalize on the significant opportunities across both India and East Africa.

We remain committed to our mission of providing quality, affordable and accessible health care, while creating sustainable long-term value for patients, communities, employees and stakeholders. Thank you, and I will now be happy to take your questions.

Moderator: Thank you very much. First question is from the line of Niraj Thacker from Profit Tantra Financial. Please go ahead.

Niraj Thacker: Yes. Thank you for taking my question. Sir, I have a couple of questions. Like in last con call, you mentioned about the Tanzania second care facility, which will be operational by FY26 end. So -- and there was one more proposal for 100-bed facility, which was in advanced stages of takeover. So any update on that, sir?

Akshay Parmar: Sure. So the secondary care facility or the specialized hospital, 20-bedded facility, which is coming up in Mwanza, the infrastructure is completely ready. We have applied for the licenses with the regulatory authorities in Tanzania, and we are waiting for their feedback to come in

right now. We are expecting that license to come in any time in the next 3 to 4 weeks, following which we will be commissioning services.

There has been a delay of about a quarter. This was mainly because Tanzania had their general elections, the 5-year central government elections in November, December, I think it's early November, due to which, post mid-September, all the bureaucratic offices were nearly in a shutdown. They resumed only post the Christmas break in mid-Jan.

So there was a significant backlog at their end. Unfortunately, in Tanzania, the committee, which approves these licenses, they meet once in a quarter. So we had to lose out on 1 quarter before we could get the licenses. But now the application has been submitted, and we are just awaiting their approval.

The first site visit has happened. We are waiting for the second site visit, which is part of the entire process, following which the licenses should be received. So hopefully, in the coming 4 weeks or so, the licenses should be there with us, and we should be in a position to commission services.

With respect to the 100-bed tertiary care hospital that we had mentioned in the previous con calls, the commercial discussions and negotiations with the counterpart have completed and have concluded. The draft agreements have been shared between the 2 parties. We are now waiting on the legal and statutory approvals and the replies from the counterpart.

The entire process in Tanzania for this is likely to take another 2 to 3 months, following which we should be in a position to sign the dotted line and take over the operations. Since it is an existing facility, the moment we take over, there will be addition of revenue and a lot of other benefits for the Group.

We will be undertaking a significant expansion of the existing facility in the course of 2 to 4 quarters after we've taken it up. So that's the update on the Tanzanian front for both the 20-bed specialized hospital and the negotiations of the discussions for the 100-bed tertiary care hospital in Dar-es-Salaam.

Niraj Thacker: Thanks, sir. Sir, my second question is regarding that -- I was just going through the segment results actually, especially Uganda. There is a dip in revenue by around 17%, but PBT I see there is a drop by almost 46%, sir. So any light you can throw in that will be really helpful, sir?

Akshay Parmar: Yes. So one, there has been a dip in H2 in the Ugandan revenue. The main reason for that is twofold. One, again, there is a Christmas break, which comes in Uganda or practically almost entire Africa. There, from 10th of December till almost mid-Jan, there is a significant lean period that we experienced because people who can afford usually tend to travel out for holidays out of Africa.

People within the city, local Africans, local citizens, they also tend to go to their native place or the village out there to celebrate Christmas. No one wants to be in the hospital. So other than emergency cases, a lot of elective work gets pushed on to beyond the Christmas holiday. This year, just like Tanzania, even Uganda had their 5-year elections, which were held on 5th of Jan.

So practically, the Christmas break extended till almost the end of January. The results were, I think, a week post 15th of Jan, following which things started resuming and opening up. So from that perspective, we did lose about 1.5 months of good productive period because of which there has been a consolidated dip in the overall revenue for H2.

Now the decrease in PAT is more substantial. There are 2 reasons to this. One, after we have a particular breakeven revenue, anything beyond that usually contributes to 60%. That revenue contributes to 60% towards the profit margin. With the dip in the overall revenue, the erosion at the PAT level is significant because the fixed costs remain the same. So that is one reason.

Second reason is that we have undertaken significant infrastructural expansion in that project. So there's been a lot of expense towards maintenance, upgrading the patients rooms, upgrading the operating theatre rooms, which is an ongoing process. So a significant part of that expense was taken up during the second half of the year because we've upgraded the facility since it's been almost 10 years since we commissioned it initially.

So from that perspective also, there's been added-on expenditure towards the maintenance of the facility, which was recorded in H2 of this financial year, which also has increased the expenditure a little bit and contributed to the dip in the profit after tax.

Niraj Thacker: Thank you, sir. Sir, my last question is regarding this Nashik and Mumbai facility, sir. Sir, any -- like if you can just give a rough -- throw some light on like when these both will be like breakeven? And any, like, broad guidelines like next 2 years, how the growth will be going forward will be really helpful, sir.

Akshay Parmar: Surely, surely. So Navi Mumbai was commissioned as a soft launch in October 2025, but we received the critical licenses related to allowing us to operate our ICUs only by the middle of Feb. I think 15th or 16th of Feb was when we received the last license, which allowed us to open up our ICUs. So we have been fully operational since mid of Feb in terms of critical services.

In terms of the surgical load, we've been able to do significantly well. We've been able to ensure that significant critical procedures in the cardiac space, that is the cardiac bypass in the neurosurgical space, that is craniotomies, all these kind of procedures have now been successfully done. We recently did our first robotic total knee replacement also.

So from that perspective, the revenues have been growing. The occupancy at Navi Mumbai has been growing. And we expect to operationally breakeven in Navi Mumbai sometime by the end of quarter 2 of this particular financial year. That's by 30th of September. That's the internal target where we expect and anticipate operational breakeven for the Navi Mumbai facility.

Considering the numbers that are there right now, the initial average revenue per bed, per occupied bed that we were expecting in Navi Mumbai was in the late INR20,000, about INR27,500. But we've been able to achieve higher average revenue per occupied bed in Navi Mumbai at present as well.

So from that perspective, it has given the team significant confidence that going forward, we should be able to breakeven by the end of the second quarter here. In terms of Nashik, the update

is that we are expecting our hospital registration license to be received any time in the coming 5 to 10 days on the higher side.

Coupled with that, our FDA license for operating the pharmacy and the required licenses to operate the ultrasound and CT, MRI machines are also anticipated to be received by the end of this month. So we should be in a position to commission that facility for services by the start of the coming quarter. That's the first week of July is what we are targeting.

Once we do that, the targeted operational breakeven period for that facility will also be within 12 months. Once the facility has been commissioned and the first quarter has gone by, we'll be in a much better position to understand the dynamics on ground of how they are shaping up, how the occupancy is growing and how the average revenue per occupied bed is being realized by the company. But yes, this is what we are looking at and anticipating.

In terms of a basic guidance, Navi Mumbai facility for this financial year, we will be targeting an average occupancy between 55% and 62% of the strength. The average revenue per occupied bed that will be the target for it would be in the range of about INR32,000 to INR35,000. This is a revised target from the earlier INR27,500 to INR30,000 that we were looking at. And this is precisely based on the revenues that we are generating right now from the occupied beds at Navi Mumbai.

Niraj Thacker: And sir, like just broad guidance next 2 years, how we should look at the growth because they are, like, now we have -- we'll be adding Mwanza, Tanzania 100-bed, then Nashik will be operational. So next 2 years, how we should see the growth a broad one, if you can give us some -- throw some light on it?

Akshay Parmar: Surely, surely, surely. So the target is the same that we have been sharing with all the stakeholders since 2023 that in the next 2 years, that by the calendar year end 2028, we will be targeting 1,000 commissioned beds, of which we understand that by -- as of now, we've got 400 beds. By the end of this financial year, we will be inching towards roughly around 600 beds or so in terms of commissioned bed capacity.

So if I look at 2028, I would have 600 commissioned beds, which will be either -- which would have broken even operationally or would be towards the mature stage and another 200 to 400 beds, which would have been commissioned in that particular year. So on an average, if I'm looking at 60% occupancy on a consolidated basis for all those beds put together.

Maybe on a lower side, about 55%, I'll be looking at about 500 beds which have been occupied. The targeted average revenue per occupied bed again would be some around INR30,000 on a consolidated basis, which would amount to, say, about INR1 crores, INR1.1 crores on an annual basis. So that would be the target that the team has set in for the calendar end 2028, that's FY '28, '29 in terms of the top line.

Since we are a mix of some facilities which are now fairly old, have broken even, are operationally mature and are expanding the margins. On a consolidated basis, as a mixture of mature facilities and recently commissioned facilities, we do expect the EBITDA margins to be in the early 30s even at that stage.

Then we would have about 250, 300 mature beds, 200 beds which would have broken even and about 300-odd beds which would have been recently commissioned. So in that mix, we do expect the EBITDA margins to stay around the early 30s at least on a consolidated basis. So yes, that would be the approximate thought process for the company's management as we move towards 2028.

Niraj Thacker: Thank you so much.

Akshay Parmar: Thank you.

Moderator: Thank you. Next question is from the line of Deepak from Wealth with Wisdom. Please go ahead.

Deepak: Yes. Hi, Akshay. Congratulations on great set of numbers.

Akshay Parmar: Thank you, Deepak ji.

Deepak: Very, very elementary question, Akshay. So what is your rationale for building hospitals in India? You've been a leading player in Africa. Why are you not exploring African market instead, which has a big, huge gap? I understand India also has a big opportunity in terms of health care. But why India and why not go all out in Africa?

Akshay Parmar: Two or three important things. One, the tree stands strong where the roots are. So for Unihealth, the roots have been in India. So as we started growing, we realized that perhaps India is something where we would want our presence to be felt. But more importantly, I mean, that was on a lighter note.

More importantly, Africa is a very interesting space. But the challenge out there is we are talking about 54 countries in a continent, each country with diverse socioeconomic and geopolitical backgrounds and risk factors. So all in all, there are about 5 to 7 countries where investments are worth the money, majorly concentrated in East Africa, where our focus is.

So we are expanding rapidly in Africa, but the challenge arises in scalability. So while Africa has high margins, the scalability for the next 5 years is going to be limited in terms of bed capacity. We cannot look at a 5,000-bed strength in Africa alone because 2 challenges arise. One is the paying capacity. Second is the limited population in each country.

So if I'm looking at Uganda, it has got a population of about, say, 5.5 crore people, 55-odd million people, of which the paying capacity boils down to a very small percentage. And to cater to those requirements, then on the higher side, about 200, 250 beds will be good enough.

So each country that we go into, depending upon what the health care scenario in that country is, so Kenya, which has a national health insurance or Tanzania, which has a national health insurance, the bed capacity increases to, say, about 500-odd beds in that country, which can comfortably breakeven and give us very good returns.

But beyond that, in that country, we see a bottleneck arising. So from that perspective, if we are to look at a longer vision, a 5- to 10-year vision where we intend to have, say, 3,000, 4,000,

5,000 beds eventually as a group, then that scalability option is not there in Africa, which India has.

Second, if I am to expand rapidly in Africa, there are 2 important aspects that we need. One, we need to control and optimize our supply chain management. Second, we need access to very good bench strength of manpower at the technical and the nursing level. Doctors are fine in Africa. They are all trained in U.K., U.S., a lot of them in India as well.

So local African doctors are well trained. It's not a challenge. The challenge arises when it comes to technical manpower, nursing staff and the administrative or the management manpower. And to create that good bed strength -- I mean, sorry, bench strength so that we can expand rapidly in Africa, we thought strategically, India was a good base where we can have our hospitals. We can develop that manpower.

And eventually, we can position that manpower into Africa whenever new opportunity and the project comes up. because that's the tried and tested manpower, which would by then have absorbed the culture of Unihealth, and we would be very comfortable putting that manpower into Africa as compared to hiring someone very fresh and positioning them in a challenging environment in a relative term.

So, from those perspectives, we thought one was scalability. Second was the requirement on a strategic basis where India plays a pivotal role as we expand. Third, geopolitically, India being an Indian listed entity, the comfort zone that a lot of our stakeholders will also eventually have is going to be India.

Lastly, when I talk about larger funds, now health care is being dominated by a lot of private equity funds, a lot of impact funds, whether it's in India or in Africa. So Unihealth is uniquely positioned where we've got a strong bandwidth in Africa, which all the other peers in India, though they've got a much larger size in India, they do not have that African angle yet.

So while we are expanding from our existing capacity to 1,000 beds, the idea is in the first phase, we will be looking at an equal expansion, whereby the end of '28, we will be looking at 500 to 600 or 550-odd beds in India and a similar capacity in Africa, 400 to 500 beds so that we are able to ensure higher returns from Africa and the potential to scale up rapidly in India.

Deepak: Understood. Understood. Very well thought out strategy, Akshay, I must say. Just a related question to this. Since we don't enjoy that kind of brand equity, which, let's say, a Max or Apollo or, let's say, any other hospital in the West enjoys. How would we generate demand in terms of how would we ensure that patients keeps coming to us and what is the kind of sweet spot that we are kind of looking at between all these players, where do we want to play, which price point, which -- in terms of which particular specialty are we planning to play in this entire space…

Akshay Parmar So the approach that we have -- the approach that we are looking at on the strategy is multipronged and multi-fold. In India right now, as a first phase , what we've done is we rightly agree that the brand is not as well recognized or strong as the other players in the market, whether it's Apollo, Max, Medanta, Shalby or Fortis, that is a limiting factor, but that we are playing to

our advantage in the sense that, one, we are limiting ourselves to a bed capacity between 50 to 200 beds.

All these major players are right now targeting bed capacities which are 250, 300 and beyond. So, we want to be that big facility, which has the right mix of infrastructure. So, whether it's a 50-bed facility in Navi Mumbai or a 200-bed in Nashik or 125 bed that we intend to put up in Pune sometime later. So, all these facilities will be stand-alone, multi-specialty tertiary care, fully equipped with modular theatres, cath labs, the entire range of diagnostics, state-of-the-art ICU.

So, in terms of infrastructure, we are positioning ourselves at par with the [biggie players 0:23:37], ensuring that the doctors and the patients, the 2 important aspects of ensuring that the business is doing well are well catered to. In terms of doctors, we are able to give them the infrastructure that an Apollo or a Fortis has. We are better off in terms of providing them with agility and flexibility that a larger corporate setup sometimes is unable to do because of a variety of factors. So that is something that we are able to cater to.

We are able to allow them to thrive and prosper from a commercial perspective also in a better manner as compared to the larger corporates. There is a very big chunk of doctors in the age bracket of 35 to 50, which is stuck in the midrange. You go to an Apollo; you've got a head of unit or a head of department who is in the mid-50s. He's got another 15 years of active life.

So that seat is not going to be empty for another 10 or 15 years more or so. Now someone who's in the late 40s is very well equipped. So, at that point, he's doing well in terms of money. He's got a good patient base. But that fame and the name that he wants, that is something that he is not seeing in the coming future in Apollo or a Max or Medanta, that is where we are also positioning ourselves. So, we are able to give them that bandwidth.

From the patient's perspective, we are focusing more on the quality of care. So, I'm not debating whether an Apollo quality of care would be a substandard or a Fortis quality of care might be an issue. What we are looking at is with a smaller setup, we are able to optimize the protocols in a much better manner, ensure that the patient to attendant, patient to staff, patient-to-nurse ratio is better off so that their requirements are catered to in a faster manner because out here, unlike a hotel or a restaurant, a patient will never try again.

One bad experience is there for life. So, you had one bad experience, you do not come back or go back to that hospital. That is what we are trying to avoid at Unihealth and create that as a USP. So, these are some of the aspects on which we are playing. Obviously, the rates are an important factor in all of this because that's the entry point.

So yes, we are positioning ourselves significantly in a cost-effective manner as compared to an Apollo or a Fortis or the immediate geographic competitor that we have in the particular city that we are. So, depending upon what they are offering, we are better off. So, the patient is at an advantage. We are allowing the doctor some flexibility.

Now what happens in a corporate hospital is the doctors get a bunch of patients. There are doctors who are very famous, who get patients who are from the highest strata of the

socioeconomic ladder and who are also from the lowest strata of socioeconomic ladder. They are not able to cater to the lower half at that hospital because the corporate cannot provide that kind of a flexibility in terms of pricing, in terms of the commercial aspect. Plus, there is a fear in that particular patient that he goes and gets admitted to a large corporate setup, the bill is going to go out of his hand.

So that is again somewhere where we're able to successfully convince the doctor to give UMC that chance and get that patient, and we honour the commitment that we made to the doctor because our overhead is significantly lower. Our head of departments are, I would call them in an age bracket, which is at the senior managerial level at an Apollo today. So, from that perspective, my overhead cost, my admin costs are better off than Apollo. So, I'm able to play with the pricing a tad better without impacting my profitability long run.

Deepak: Thanks, Akshay. Great, great strategy. I'll join back in the queue.

Akshay Parmar: Thank you.

Moderator: Thank you. Next question is from the line of Priyam from Trinetra Asset Management. Please go ahead.

Priyam: Hi, sir. Thank you for the opportunity. So I just want to understand, so we had a plan to sort of decrease our receivable days over time in the assetting business. I just wanted to understand how is that working out and is there any sort of immediate result that we can see maybe in FY27 or so on?

Akshay Parmar: Right. So yes, the intent was there to reduce the receivable days. Now the strategy was twofold. One, definitely, we are banking on the revenues and the lower receivable days that are going to come in from the new ventures, whether it's Navi Mumbai Nashik or Tanzania at a later date. So, all these put together on a consolidated basis, the receivable days in these projects are going to be significantly lower than we are experiencing in Uganda.

So, on an overall basis, the balance sheet is -- and the cash flows are going to be much better as we inch towards the next 4 to 6 quarters. So that is one strategy that is getting played out because in 2023 post listing itself, the management was very clear in its thought process that in this 5-year period, while we're undertaking rapid expansion, the idea was also to limit our exposure in terms of the contribution to the total consolidated top line from any one geography outside India to less than one-third. So right now, though, Uganda is contributing almost 80%, 85%.

As we go forward into this financial year, the contribution from India is likely to increase significantly with Navi Mumbai, Nashik being functional. Hopefully, Tanzania will start joining in from Q3 or Q4, and all of that put together will ensure that the percentage contribution from Uganda comes down. So, despite the receivable days in Uganda being significantly higher, on a consolidated basis, the balance sheet start becoming stronger, the cash flows start becoming stronger. That was one, a 5-year vision that the company had charted out in 2023, and we are successfully moving towards that.

The second was over the last 2 or 3 quarters, this will be the fourth quarter, is that as the government, the [Inaudible 0:29:29] payments itself were being structured such that as compared to what they were paying earlier in a quarter they were trying to ensure that those payments get doubled or tripled up every quarter. So, over a period of 4 to 5 quarters, they're able to bring down the receivable days from 320 or to about somewhere around [200, 180 0:29:46]. That bracket, eventually, the target being 150 days. We achieved significant success still quarter 3.

Unfortunately, because of the general elections, obviously, a lot of stances was there when it came to quarter 4 of the financial year. The second half of quarter 3 and the quarter 4, and that is where, again, the payments were getting delayed a bit, but we've received a communication from the department that all that delay is likely to get covered up between Q1 and Q2 of this financial year.

So we are expecting a payment of about INR9 crores to INR10 crores in the coming week or so from the ministry. And post that, we are expecting a significantly larger chunk of payment to come somewhere in the month of July. That is what the communication has been to always put it across till the time the funds don't hit the bank. I don't want to start thinking out loud about it.

The first payment, as I've mentioned, is already in process, so that is likely to come any time soon. The second one that they've promised in July, that is something that we'll have to wait and watch, but the intent is there. The reason also being that Uganda, a few years back found oil, there's a very huge amount of investment coming in to develop that oil drilling and it's transferred from there to the port in Tanzania from where it's going to be shipped out.

So there's a lot of dollar inflow that is coming in from the Western Countries, and that comes with certain riders as always. And one of the riders out there is that they have to improvise on some of these metrics that are there, so payment for health care service is one of those key metrics that the government is mandated to improvise over a period of 2 to 3 years, which in terms of intent, they've initiated doing it. The practical application, we may be able to see it only by the, perhaps the end of this financial year.

Priyam: Sure. Okay. No, that's good for hear. And so for Navi Mumbai, what is the annual run rate that we're expecting as of today? I mean it's been roughly 2, 3 months. How is the occupancy at the ground level in?

Akshay Parmar: So the occupancy and the revenue at Navi Mumbai over the 3 months on an each month basis has increased by about 25% odd. Again, in India, there's a typical saying that the month of April and May or mid-March to May is a relatively leaner period in health care. Reason being that in March, you've got the school exams going on, so no one wants to get the elective surgeries done, then you want to go to your holidays or your uncle's house, is how we put it, and that's again where the elective surgeries tend to be fewer in number.

The numbers start picking up from the end of May, just before the school reopens, which we've actually witnessed in Navi Mumbai, and now with the monsoon start coming in, June, July and August is a period when there are likely to be significantly higher cases in the medical ICU or in terms of viral infections, dengue, malaria, all of that.

So all put together, the growth factor that we anticipate in the coming quarter is going to be somewhere around 30% to 40% because the base line is very small right now. But yes, the first 3 months, each month, we have grown significantly. For the financial year that we ended till 31st March, Navi Mumbai was able to contribute just upwards of INR3 crores revenue which we've generated over a period of, say, a couple of months that we were fully operational.

So we got the final license in mid-Feb, that is when we were able to open up our ICU. So typically, if I'm to say, it's just about 2 months, 2.5 months of proper services, we were able to generate a rough occupancy of about 10% and a revenue of about INR3 crores. The average revenue per occupied bed that we generated, we initially thought it would be something around INR27,000, INR28,000 but we've been able to generate in the early INR30,000. INR32,000, INR32,500 is what we've been able to generate.

So that is again a promising factor for us internally that we can look at breaking even faster than what we initially thought because the revenue per patient or the revenue per occupied bed is going to be slightly higher than we anticipated in our forecast earlier.

Moderator: Thank you. Priyam, I will request you to come back for a follow up. Next question is from the line of Hitesh Randhawa from CaGR Quest Capital. Please go ahead.

Hitesh Randhawa: Yes hi. Am I audible?

Akshay Parmar: Yes.

Hitesh Randhawa: Right. So I have just 2 questions, actually. One is on the, I think in Pune, you are working on the PHRC hospital project as well, right? I think you're providing consultancy services over there. So my question was that, when is that getting completed and what is the probability of us getting the management of that hospital?

I'm assuming that they came off early, they might outsource the management of the hospital to kind of, is there a good chance that we might get that management contract? And I'm assuming that the Pune facility that you were talking about, that's a greenfield one, 125 beds. I think that's a greenfield, separate from this one.

And second question is around competition in terms of retaining the doctors actually because we have been hearing that there's a lot of competition and poaching of good doctors taking place. And kind of what are we doing to kind of maybe address that and in that situation, how do we get good doctors with us?

Akshay Parmar: Right. So PHRC, like you rightly mentioned is a consultancy project that we've taken up. At present, the total bed capacity for that project is roughly going to be about 750-odd beds. The project is broken up into two halves. One is a private wing, which is going to be about 150-odd beds and the other one is a teaching hospital, coupled with medical MBBS, the degree college.

So that is going to be somewhere around 600-odd beds. The ground breaking ceremony was done by Honourable Shri Amit Shah Home Minister earlier last year, and we expect construction

to begin, the excavation to begin now. So by the time the project actually comes up for commissioning, it's going to be a good five years from now is what I'm anticipating.

It may be sooner by about 6 months or it may get delayed by 6 months. In terms of management of that particular project, yes, there is a possibility because it's being spearheaded by a non-profit Section 8 company where the trustees or the directors do not come from the health care services background, and they are all in an honorary position. There is always a very strong possibility that they'll be looking at outsourcing the management.

Now whether we stand a good chance, we stand a fairly good chance, we have been associated with the projects since 2019 when it was conceptualized. So yes, it's a point of, I would say that we are 51% there to put in a strong proposal from our side. But yes, only time will tell whether we'll get that or no.

In terms of our bed capacity expansion plans, if that happens, that is definitely phase two for us. We are not considering that any time in phase one because that project will go live only somewhere around 2031 or '32. So from that perspective, we haven't considered any of the possibilities of that bed capacity coming under our fold right now in our projections or in our thought process or plans, so that's about the PHRC part.

Second is the part where you mentioned about retaining of doctors. So yes, the competition is tough. It's very strong. The challenge is there. So where we are working is one, giving, like I mentioned sometime earlier, flexibility to a lot of doctors. So a lot of doctors have come up with challenges where they got the patients but those patients are not able to pay for the services at a corporate hospital.

They are looking at a price bracket which is a little cheaper. They do not typically even belong to the charitable part of health care services. So they are better off than going to a government or a teaching hospital, but they are not at par with the services costs at larger corporate.

So that kind of patient base, the doctors need a playing area, which is where UMC is coming in. To ensure that the doctors have the comfort, we are investing heavily into infrastructure, so we are giving the, like they said, the big boys the toys that they need. So they are happy from the technological aspect part of it, they are happy from the infrastructure part of it. Then comes the commercial part where we've given them flexibility and we are coupling it up with a system where their dues are settled on a daily to a weekly basis.

So from a cash flow perspective, it is a little stressful on the company initially, but the doctors are very happy because now unlike a corporate, they are not running to the accounts department at the end of the month to cross-tally their dues and everything. The moment the patient is discharged the bill is settled, the payments reflect in the bank account of the doctor.

So that is also allowing a lot of doctors to develop a lot of comfort since we are an unknown entity when it comes to India. This is also a very valid thought process that the doctors have that we did one month of surgeries but after that will we get our payments on time, will we have to run around? So that is how we are navigating this. And one good feedback from one good doctor

pulls in another 10. So that is what we witnessed in Navi Mumbai where we've got more than 130 consultants on panel today.

What we are also doing for these consultants is giving them a very strong on-ground full-timer team. So whether it's Navi Mumbai or whether it's going to be Nashik, we've got round the clock, full-timer senior doctors in our internal medicine department, in our general surgery, orthopaedics, spine and cardiology, which covers almost everything in terms of critical care. We've got a very strong intensivist who is there associated with us at Navi Mumbai, and we're going to follow the same pattern in Nashik and all the other facilities.

So whenever a surgeon wants to admit a patient suppose perhaps perform a cardiac bypass surgery. His job is going to be for those 6 to 8 hours, post that for the next 5 days, it is the team in the hospital which the hospital is providing, which becomes critical to the outcome for that patient.

And that is again where UMC is heavily investing and ensuring that, that manpower is of the top quality, we end up paying a little more for that particular bracket, so that the consultants are comfortable bringing in critical patients, operating them and being rest assured that the post of care will not be compromised.

So these are the factors on which we are playing to ensure that the retained, the doctors are retained. But again, we are fairly new, so only after another period of, say, 12 to 18 months, these statistics will be absolutely clear on whether our strategy has been successful or we are looking at bottlenecks in this.

But we are quite positive about this. And last factor is that being doctors ourselves, I mean, Dr. Anurag and myself, we graduated 16 years back, so there's a lot of contemporaries, a lot of juniors, a lot of seniors who are now well established, and they are more friends and less of consultants in the typical commercial way. So for us, it's fairly easy to pick up a call, give them the assurance, give them the comfort because we've known each other since almost 20-plus years now.

And that is what pulls them in and then one good doctor pulls in 10 more. So that is how that entire chain has been created at UMC and that is how we're looking forward to banking upon it in terms of the differentiator between us and the competing corporate hospitals.

Hitesh Randhawa: Sure thank you.

Moderator: Thank you. Next question is from the line of Chaitanya Gadia from Value Prolific Investments. Please go ahead.

Chaitanya Gadia: Hi Akshay.

Akshay Parmar: Hi Chaitanya.

Chaitanya Gadia: So just one or two questions. One, I wanted to understand that the Nashik facility, what is the status on ground? Everything is ready, machinery installed and they are just waiting for approvals?

Akshay Parmar: The machines and everything is ready. The infrastructure is completely ready. The only three critical equipment, which is yet to be delivered is the MRI, CT scan and ultrasound because they need the PC-PNDT approval from the municipal corporation before these machines can even leave the premises of the selling company.

So from that perspective the moment those licenses come in, the machines are all ready, we will be getting them delivered, so we are looking at the first bunch of licenses to come in any time in the next 5 to 7 days, followed by the second round of licenses to come in before the end of this month. In that case, we will be equipped to start of our OPD services, basic diagnostic services and basic inpatient services.

The ultrasound machines will get delivered within a week of submitting the licenses. So there won't be much of a delay in that. It's only the CT and MRI, which post-delivery, installation and commissioning is likely to take a period of about 2.5, 3 weeks. So all in all, put together, by end of July, in terms of every single aspect of the facility, it will be fully operational and commissioned.

We've got a lot of learnings from Navi Mumbai, which we've implemented in Nashik in terms of the time line management. So we've been better when it comes to Nashik in time line management. Unfortunately, we lost out on about 2.5, 3 weeks because there's an ongoing census, which has been undertaken by the central government for which a lot of lower-level staff bureaucrats have been deputed and that resulted in a lot of clerical staff being absent in critical departments because of which the movement of file were getting staggered and delayed.

But yes, the inspections at the first level have all been completed earlier this week and we are expecting the license. So the official fee for the license has already been paid for 2 days back. Hopefully, in the next 5, 7 days, we should be handed over the registration license.

Chaitanya Gadia: Okay. Got it. Second question is basically, when we are setting up hospitals in India, we had a kind of a thought process that Africa being whatever market size it is, there are some machines which won't make any sense to deploy it there.

So our thought process was to get finally incoming medical tourism, whatever we are not able to treat there to get them to the Indian hospitals. So you think maybe it's an early stage or how successful we have been until now or will be in the future to catch this area?

Akshay Parmar: So we have been fairly successful owing to that being the first vertical for us. As a group, we started with medical value travel or medical tourism, and that's why we've got significantly deep inroads into that industry altogether when it comes to Middle East and Africa. I'd be happy to share that we've already assumed a fair number of international patients at Navi Mumbai over the last 30 days.

In fact, one of our international patients landed earlier today morning and as we speak, is getting his evaluation done at the hospital, there are more than 250 live inquiries that we are sitting on from a bunch of countries in Africa, whether it's Nigeria, Uganda, Tanzania, Kenya, so yes, the movement is there.

Definitely, once an inquiry comes in by the time the patient comes in, it can be anywhere between 30 days to 6 months, depending upon whether its documents are in place, whether we've got the funding in place, but yes, eventually, by the end of this financial year, we should be in a positioned where we'll have significant international patients coming into both our facilities, whether it's Navi Mumbai or Nashik, we do anticipate patient flows to come in for both these units.

Right now, we've successfully received patients from Uganda, we successfully received patients from Tanzania. So the two countries which we initially targeted, we've been able to turn them around. Right now, the focus is on Kenya and Nigeria as well. And then as we move ahead, we will be looking at Middle East once the overall travel situation in Middle East eases a bit post this entire war scenario, which is ongoing. So maybe at that point of time, we will start focusing more upon the Middle Eastern countries like Oman and Iraq and all of those from where there's a significant flow of patients that comes in.

Chaitanya Gadia: Got it. Sorry, just last question. I understood the bed forecast that you had given 800 to 1,000 beds, so on a conservative basis, our top line is 132. Can we look at that growing at 15%, 20%, 20%, 25%, under, what conservative estimate you can give us?

Akshay Parmar: I do agree with your estimate, it should be that or beyond. Twofold reason, one, there's going to be a basic amount of growth in the existing facilities. We are adding on some super specialties in countries like Uganda where we have a mature facility now like we did with IVF, now we are doing with a neurosurgical microscope and the cardiology setup, ophthalmology is already in place out there.

We expect the first bunch of cataract surgeries to happen sometime in the coming months. So from that perspective, there's going to be some amount of growth that happens in the existing facilities plus the addition of beds. So put together, yes, what you've mentioned is a likely forecast that we are going to witness. Hopefully, we'll be surpassing that.

Chaitanya Gadia: Okay. Thank you very much.

Akshay Parmar: Thank you.

Moderator: Thank you. Next question is from Sahil Garg from CCV Fund Managers. Please go ahead.

Sahil Garg: Hi sir, good afternoon. So my first question is on the operating margins. So like in FY25, the operating margins were in the range of 33% to 34%. In FY26 it like climbs to like 41% odd. And then you are targeting the operating margins like you were mentioning earlier to the participants on the call, the operating margins would be early 30s. Why there is so much volatility in our margins? And as investors, what minimum margin we should take like something which can be achieved?

Akshay Parmar: Right. So I'll first answer the volatility aspects. So right now, when we've grown from the mid to early, I mean, the mid to late 30s to early 40s, it is because right now, the contribution from newer beds is not there. So whatever contribution has come in has come in from facilities which were mature. So the moment the revenue in those facilities starts growing, like I mentioned to one of the earlier participants that 60% of that particular revenue gets added on to the margin.

So for example, if a breakeven point for a particular facility is INR1 crore, so till INR1 crore, I'm negative. Once I cross the INR1 crore, then I break even, the movement at touch INR2 crores, and I go beyond, then whatever I'm adding on the contribution towards margin is much higher because my fixed costs are stagnated, my utility costs are more or less similar.

The only variable that gets added on is the cost of goods sold. That's the cost of consumables and pharmacies, which does not on a consolidated basis and exceed 30%. So 30% is that cost, 10% to 15% is the escalation in utility and manpower. So about 40%, 45% is on the higher side. So that is one reason why we've seen the growth from the mid-30s to the early 40s.

Now coming back to the point where I mentioned that on a consolidated basis going forward, we will be looking at early 30s, that is because at that point of time, compared to the 200 mature beds that we are talking about, we're going to have a total bed capacity of roughly 800, of which 200 to 300 will be mature. Another 200 would be just about breaking even, and on remaining 200, 300 would have been just commissioned, where there are going to be significant operational challenges initially losses coming in.

So on a consolidated basis, the mature facilities will be able to take in the shock or absorb the negatives from the recently commissioned phases, or what we call facilities, and the ones which are breaking even will continue at 18%, 20%, 22% margin sort of a thing. So from that perspective, we are looking at not going below 30%. It can be early 30s or mid-30s, that will again depend upon how efficiently we operate these facilities.

Sahil Garg: So that means that every time there will be some expansion, the margins will be volatile in that nature because some hospitals will be in the mature stage, some hospitals will be in the early stage and might be going towards breakeven. So 30% is something you are like pretty sure that we will do every year.

Akshay Parmar: That's the baseline that is something that we've been working upon. So about 32%, 33% should be the baseline. Again, there's a contributing factor that we've got other verticals, medical tourism being one, health care consultancy being one, pharmaceutical distribution being one, where we are not taking those revenues or margins into consideration right now.

But consultancy does work on almost a 60%, 65% margin, distribution works from 30%, 35% margin. So all those put together also will ensure that we do not breach the 30% mark. Now whether we are at 32%, 33% of the late 30s, that is something which will be directly proportional to how soon we can break even and generate revenues from the newer facility.

Sahil Garg: Okay. And below the EBITDA level, what kind of PAT margin we can expect, something which can be achieved easily because...

Akshay Parmar: Considering our rapid expansion phase, there's going to be some amount of finance cost which is going to come in. Depreciation is going to be significant because we're going to rapidly be adding on newer equipment and since some of these subsidies on a leasehold basis, and we are in the India's accounting standard, there's the depreciation on those facilities as well.

So put all these together, we can comfortably look at somewhere around early -- I mean, 10%, 12% PAT margin is what my anticipation would be, but it will hover between 8% to 12%, depending upon the number of beds that we've added on that particular period of time. So, whether it's a quarter or half year, or the financial year, the number of beds that we add on, that 2%, 3% will depend upon that variation.

Sahil Garg: So basically, FY26 was the exceptional year for you, in terms of margin because I guess, in context, you did close to 35% of our PAT margins, and now we are expecting 10% to 12-odd percent PAT margins, so like it's a huge decline in the margins and obviously they kind of...

Akshay Parmar: No. So, if we look at about INR20 crores, INR25-odd crores in PAT on a INR137 crores consolidated top line, we are again talking of about 20%, which I'm seeing, as we grow will come down to about 12-odd percent. So that 8% dip is more so towards part of depreciation, which is going come in because of the heavy investment in equipment's and some part of the finance cost.

Because right now, in Uganda, we are debt free, we became debt free in the – on 30th of September. But as we grow, we're going to have some amount of bank funding coming for the equipment that we buy. So, a bit of that finance cost, and a significant portion of the depreciation, which is going to get factored in as we grow. So that 6% to 8% variation is likely to be, because of these two factors more than anything else.

Sahil Garg: Okay. And sir, my second question is considering the Tanzania facility is delayed due to election and everything, so what kind of growth we can expect in FY27?

Akshay Parmar: So, FY27, we are looking at 150 beds in Uganda, which are fully mature. We are looking at 50 beds of Navi Mumbai, which should break even, addition of 200 beds in Nashik, which will be in the early phase. So about, say, 400 beds which are about to break even or which would have broken even. And then another 100, 150 beds which are likely to be added on in Tanzania, 120 beds out there, and maybe another 30 beds in East Africa, either in Uganda or Tanzania as a secondary care.

So, all put together, we are talking of about 600-odd beds by the end of the financial year. Consolidated basis because Tanzania 100 beds is an operational facility, it already has a baseline occupancy, it all has a baseline revenue, so we are now going to go through the early stages of pain when we take that facility over.

So, whether it's Q3 or Q4, it's going to be a straight addition of some amount of that top line to the book, so on an occupancy basis of these 500-plus beds, we can expect an occupancy of somewhere around 60%, which will translate to about 300 beds, and the targeted average revenue per occupied bed on an annual basis. It would be in the range of INR75 lakh to INR1 crores. So more so, we are looking at or targeting -- doubling up the revenue.

But yes, the next 2 quarters will be important in terms of closing in on the Tanzania bed and ensuring that Nashik takes off in the manner that we intend to. So based on that, the -- post the first half of the year, we'll be in a much better position to understand, which way the revenues are going for this particular year because there's always the possibility of a delay of about a quarter in what we plan and intend to do, and what is executed.

Sahil Garg: And margins would be again same like 30% EBITDA margins and 10%, 12% in the PAT margin, right?

Akshay Parmar: That is the bare minimum that we'll be targeting. The EBITDA margins may go to the mid-30s also because this year, we are talking about Uganda, which is a mature facility, Navi Mumbai, which would have broken even, Tanzania, which already has some bit of EBITDA associated with it, so it's not going to give us operational losses at the moment we take over. So, from that perspective, it might be in the mid-30s, that is what we are targeting, we are anticipating. But yes, I mean, there are multiple factors associated with all of this.

Moderator: Next question is from Shubham Gupta from Prospera Wealth. Please go ahead.

Shubham Gupta: So, sir, I just wanted to check, like this year, how many beds will be operational, and what is the revenue we can expect this year?

Akshay Parmar: So, in terms of operational bed capacity, we will be upwards of 420 beds for sure. This is taking into consideration 150 beds in Uganda, 50 in Navi Mumbai, 200 in Nashik, and 20 beds in Tanzania, which is a specialized hospital. Another 100 beds in Tanzania are in the last stage of discussion in terms of the agreement stage.

So, if that we are able to conclude and get the statutory approvals in time, then another 100 beds will get added on to this bed. So yes, we should -- we are aiming to cross 500 beds in terms of commissioned and operational bed capacity by the end of this financial year.

Shubham Gupta: Okay, sir. And like out of these beds, like what is the top line we can expect like average?

Akshay Parmar: The average occupancy that we are targeting is about 60% on a consolidated basis for these, so we are talking of about 300 beds occupied. Right now, based on the present run rate of average revenue per bed and the addition, we will still target around INR27,500 on a consolidated basis as the ARPOB, which translates to about INR1 crores of revenue on an annual basis. So roughly around 300 occupied beds at that ARPOB is the target that we have. As we proceed in the coming few months, the picture is going to be clearer.

Shubham Gupta: So, it will be around like -- on a conservative basis, it will be around INR250 crores to INR300 crores of top line that we are targeting, right?

Akshay Parmar: That's what we are targeting, yes.

Shubham Gupta: Okay. Thank you sir.

Moderator: Next follow-up question is from the line of Deepak from Wealth and Wisdom. Please go ahead.

Deepak: Hi Akshay. Yes, just wanted to understand in terms of hospital start-up costs and revenue trajectory, so let's say, on the cost side, what are the key operating costs that begin accruing before the hospital is even open to patients? Could you walk us through cost buildup, which costs kick in from day one of construction or fit out, which ones come closer to commissioning, and which ones are triggered only when the patient operations begin?

Akshay Parmar: Right, right, right. So about 2 months, 2.5 months prior. So, the moment we conceptualize the project, there's a team of about 7 to 10 people that gets added on, on ground in the first 3 to 6 months of that project being conceptualized, and that is the unit head, the head of nursing, the head of diagnostics, the head of pharmacy. So those heads come in to picture because the other ones are going to be executing the project on ground from the concept to the commissioning stage.

Then in the last 2, 2.5 months, we add on significant number of team members because we are training staff, and they are also needed from a statutory perspective when we apply for the licenses. As a thumb rule for each bed that we put in, we -- on a fully occupied basis, we are looking at about 4 people employed around the clock, sort of a thing. So, for a, say, 50 beds, we'll be looking at a team strength of 200 beds around the clock, which includes right from the CEO to the security guard for that facility.

First year, we will be looking at about 60% of this. Pre-operating, we will be looking at about 40% of the strength. So, by the time we operate 50 beds, we would have about, say, 40% of 200 people, 80-odd people on the payroll. The average expenditure on a consolidated basis for all of these would be about INR30,000-odd per month. We are talking about roughly around INR22 lakh to INR25 lakh in terms of manpower cost for a couple of months for a 50 bed.

Again, if you are looking at the 200 beds, this will become into 3, roughly, so that is the pre-operative cost. So effectively, for a 50 bed, we plan for a INR1.25 crores pre-operative cost, for 125 beds, we plan this to be around INR2 crores. And for 200 beds, we plan this to be around INR3 crores, INR3.5 crores, so that is the pre-op cost that we are likely to incur. Part of it is considered as capex because we've not yet commissioned the facility.

First 6 months, more also, the revenues for 3 months are really small. The opex remains very similar. The only added factors would be utility expenses, and some amount of expenditure towards the upkeep of the facility; that's housekeeping and patient attendance care. So that would add on depending upon the size of facility anywhere between INR10 lakh to INR15 lakh, or somewhere around INR7 lakh to INR15 lakh, I would put in a 50-bed would be around INR7 lakh. So that is the cost that gets added on.

To a large extent, the initial revenue start offsetting part of this, part of the employee costs and everything. So, this is the basic opex breakup. In terms of capex breakup of 50 beds, because we are on an asset-light model, we don't look at buying the land and building for now. So, from that perspective, of a 50-bed we plan to put up anywhere between INR15 crores to INR17 crores of capex, 125 would be in the range of INR23 crores to INR25 crores, and 200 beds would be in the range of INR28 crores to INR30 crores.

Deepak: Understand. Understand. And similarly, Akshay, on the revenue and demand side ramp-up. How does the hospital typically go about activity services? Like does OPD really start before IPD and within OPD...

Akshay Parmar: Right. So OPD, IPD pharmacy, diagnostics, we've started everything concurrently. We've not phased out. But yes, IPD starts with very basic cases, something which is purely -- just what you call malaria, dengue treatment or basic appendectomy or a very basic hernia surgery. The first couple of months going back because there are teething issues, there are issues when there's a new team of doctors and a new team of paramedical team -- staff.

They are gelling in their alignment with each other, takes a few procedures to be done. So even we encourage the doctors only to get straightforward simple cases for the first month, and then start stepping it up like in Navi Mumbai, like I mentioned, October, we started we did our first cardiac bypass in March, so there's about 3 to 5 months of period during which we do, the ironing out of all challenges internally by doing simple cases. And then by the 6 months, we start entering into a phase where we are ready to accept all sorts of critical cases.

So that's how the overall revenue start ramping up, the occupancy would be barely 2%, 3% in the first month. It is likely to go to about 7%, 8% or 6%, 7% the second month, cross 10% by the fourth month or so and then witness a significant upswing. This is also a period when a lot of our empanelments with corporate, with insurance companies, with a lot of charitable foundations, all that takes place. So, once we have the license in place, that is when we can start approaching all of these.

And the standard processes that they have, ensure that a timeline of, what, 3 to 6 months goes in, getting ourselves empaneled with some of these. For example, in Navi Mumbai now, we are empaneled with Konkan Railways, we are empaneled with a few other corporates, Rashtriya Chemicals and Fertilizer. So that process can take anywhere between 3 to 6 months. But once that empanelments happens, then there's a significant upswing in the numbers that we witnessed.

Deepak: Understand. And if you could quantify in terms of revenue ramp up what percentage of optimal or peak revenue doesn't mean hospital typically generate in its first 3 months of operation and where does it stand by the end of year 1? And at what point, maybe from the data, let's say, first patient you typically reach optimal utilization and peak revenue run rate?

Akshay Parmar: Right. So, I would put it in a slightly different context. The breakeven point for us is usually about 50% of occupancy, which we intend to target and reach by the end of the first year on a pro data basis. Initial 3 months like I mentioned, it can be between 2% to 6%, 8%. It depends upon the geography and a lot of other variable factors, but between the 6 to 12 months, we start gaining significant upswing where the revenues start coming in at between 30% to 40%, and eventually, the target is 50%, which is what we intend to achieve anytime between the ninth and the 12th month. That is our breakeven point.

For a 50-bed, I would say the breakeven point comes at about INR2 crores of revenue. The peak revenue that we can target is somewhere around INR3.5 crores, INR4 crores eventually. But that's not purely a mathematics of occupancy, it is also super specialization that eventually kicks

in. So, in terms of occupancy at 50%, we would target a INR2 crore-odd revenue to break even, and then the upswing in occupancy and addition of international patients or addition of super specialty will allow it to further go up.

So, from that perspective, that is how we pan out that yes, the 50% occupancy or the breakeven point for a facility should be around 12 months, anywhere between 9 to 12 months, then that growth starts, and somewhere by the time we tend to reach the 24th month, it should be in a position where we are achieving 62%, 64% of [inaudible 01:04:02] EBTIDA.

Moderator: So sorry to interrupt, we lost you again in between. Can you repeat the last few sentences, please?

Akshay Parmar: Yes. I'm just saying that from a trajectory perspective, it is the first 12 months and we try to break even between the ninth and the 12th month by achieving roughly around the 50% occupancy. Post that, between the 13th and the 24th month is when the upswing starts. By the end of the 24th month, the target is to achieve occupancy of about 62%, 64%, which will allow us to have an EBITDA margin in the mid-20s.

Deepak: Understand. And is there a difference between, let's say, a trajectory of the brownfield health care facility vis-a-vis, let's say, a greenfield or let's say, acquisition?

Akshay Parmar: No, definitely. See, when you're looking at a brownfield or an acquisition, there's a baseline revenue already in place. There is some amount of EBITDA, albeit it might be really small. But you've got the patient load, you've got a lot of things already in place for you to capitalize. So that's where the operational expertise comes in, that is where you're able to move things faster. So, what I would achieve in a greenfield in 12 months or a brownfield, it might be 6 months. What I would achieve in a greenfield in 24 months, for brownfield, it might be 12 or 13 months.

So -- but then for a brownfield or an acquisition, you are also paying a higher fee upfront. I mean if I am to set up a 50-bed I'm going to spend INR15 crores or INR17 crores, but if I'm to acquire only the operations, I'm negating the real estate.

But if I'm going to acquire the operations, it may be somewhere around INR25 crores, INR30 crores or more, depending upon at what stage that facility is, what are the revenues that they are generating. So from that perspective, the capex is higher, and that is also the reason why you are to break even or generate profits significantly earlier.

Moderator: Thank you very much. Ladies and gentlemen, we will take that as the last question. I'll now hand the conference over to Sakhi Panjiyara for closing comments. Sakhi, may I request you to unmute your line and proceed with the closing remarks.

Sakhi Panjiyara: Thank you, everyone, for joining the conference call of Unihealth Hospitals Limited. If you have any further queries, you can write to us at resource@kirinadvisors.com. Once again, thank you, everyone, for joining the conference call. Thank you Akshay, sir. Have a good day.

Akshay Parmar: Thank you.

Moderator: Thank you very much. On behalf of Kirin Advisors Private Limited, that concludes this conference. Thank you for joining us, and you may now disconnect your lines. Thank you.