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June 14, 2018

The Secretary Listing Department, BSE Limited, 1st Floor, Phiroze Jeejeebhoy Towers Dalal Street, Mumbai 400001 Scrip Code: 540975	The Manager, Listing Department, The National Stock Exchange of India Ltd Exchange Plaza, C-1, Block G Bandra Kurla Complex Bandra (East), Mumbai 400051 Scrip Symbol: ASTERDM

Dear Sir/ Madam

RE: Disclosure under SEBI (listing Obligation and Disclosure Requirement) Regulations, 2015 – Transcript of Conference call

In continuation to our letter dated 14th May 2018 and pursuant to the Regulation 30 read with Part A of Schedule III of the SEBI (Listing Obligation and Disclosure Requirement) Regulations, 2015, please find enclosed herewith the Transcript of "FY 18 Results Conference Call" with analyst/ institutional investors on Tuesday the 22nd of May, 2018 at 11:30 A M IST.

Thank You,

For Aster DM Healthcare Limited

Thomas Joseph
Compliance Officer

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ASTER DM HEALTHCARE

FY18 Results Conference Call May 22, 2018

Moderator: Ladies and gentlemen, good day and welcome to the FY18 Earnings Conference Call of Aster DM Healthcare Limited. 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 '*' then '0' on your touchtone phone. Please note that this conference is being recorded. I now hand the conference over to Mr. Gavin Desa from CDR India. Thank you and over to you, sir.

Gavin Desa: Thank you. Good day, ladies and gentlemen, and a warm welcome to the Aster DM Healthcare Limited's First Conference Call for Investors and Analysts. This call is being hosted to discuss the Q4 & FY18 Financial Performance and share Operating Highlights of the Company with you.

With us on the call are Dr. Azad Moopen -- Chairman & Managing Director of the company; Alisha Moopen – Executive Director and CEO, Hospitals and Clinics, GCC; Sreenath P Reddy – Group CFO and Kartik Thakrar – Financial Controller, GCC.

We will commence the call with comments from the management team, post which we shall open the call for a Q&A Session where the management will be very glad to respond to any queries that you may have. At this point I would like to highlight that some of the statements that may be made or discussed on the conference call may be forward-looking statements, the actual results may vary significantly from the forward-looking statements made. A detailed statement in this regard is available in the Company's earnings presentation which has been circulated earlier.

I would like to invite Dr. Azad Moopen to commence by sharing his thoughts. Over to you, sir.

Dr. Azad Moopen: Good Morning, everyone and thank you for joining us on our very first interaction over this forum.

Aster DM Healthcare is a 30-year-old well integrated, comprehensive healthcare service organization with presence in 9 countries. Being the first such opportunity to address the shareholders, investors, analysts and media after our listing in BSE on 26th February 2018, I consider it appropriate to share with all of you briefly some basic facts of the company. Many didn't have the opportunity to understand us, as we are a new entrant and a brand in the Indian public market. Though our presence in India dates back to 2001, with a large 300 bed hospital in Kerala, we had just 2% of our assets and revenues coming from India at that time. Even now we have only 17% of revenues from India with 83% of revenues coming from the establishments outside India. We have the unique distinction of one among the very few companies listed in Indian

stock market with operating units, income and profits arising outside India. This has made it difficult for investors / analysts to understand our business model now. We hope that the market will better understand our business and appreciate our unique strengths and competitive advantages. We are glad that by market cap we are already today the 2nd largest healthcare company in India.

Before providing operational and strategic data about the company, I would like to share with you our financial performance for the FY 2017-18. I am extremely happy to announce that we have posted a growth of 13% for the whole year and we have delivered a 189 % growth in PAT during FY18. The Revenues (excluding finance and investment income) for the FY18 is Rs. 6,759.66 cr and EBITDA is Rs. 651.32 cr . My colleagues shall be providing you more details about the financial data.

Apart from the successful listing and good financial performance, FY2018 has been an eventful year for Aster DM Healthcare. We have commissioned 2 new hospitals, increased the number of beds from 4,651 to 4,762. The employee numbers are 17,335 as on 31 March 2018. We take pride in that we are a comprehensive service provider from Primary to Quaternary medical care in 9 countries through our 100 plus Clinics, 19 Hospitals and 200 plus Pharmacies. We also have the unique distinction of serving the customers by providing quality healthcare to all segments of the society regardless of their economic or social positioning. In line with this, we conceptualized the Company's three brands - Medcare for the high income, Aster for the middle-income and Access for low-income strata of the population. We have perfected these models in UAE over last 10 years and can roll it out in other geographies, as and when required. This gives us a unique strategic advantage to serve the full pyramid of human population.

More important to us than the number of establishments, is our achievements in the area of clinical quality and patient care. We are proud that all our hospitals in India are accredited by the NABH, in fact, way back in 2007, our MIMS hospital at Calicut became the first multi speciality hospital in India to be accredited by the NABH. The President of India Dr A P J Abdul Kalam handed over the certificate in person to me on that day, I still remember that. 6 of our hospitals, including one in India are accredited by Joint Commission International (JCI). Our highly specialized doctors are providing excellence in patient care, and doing many procedures first time in the country, some examples are the Paediatric live dual liver and kidney transplant, Robotic Trans vaginal Renal transplant, Minimally invasive multilevel cervical disc decompression etc. Recognition by way of awards were plenty, some of the important ones during the year were the Asia Healthcare Excellence Award, FICCI Award for Healthcare Innovation, Asian Hospital Management Association Award, Dubai Quality Appreciation Award, International Patient Safety Award etc. In this digital age, the best barometer of performance for any institution is the Google Rating. I am proud to share that you will see us at the top of the list in Google Rating and Facebook Likes in most places where our establishments are present.

Our greatest strengths are the soundness of our vision and philosophy and values rooted in ethical approach which is important for any industry, more so in healthcare sector. We envision a "Caring Mission

with Global Vision" with the philosophy that "Profit should be the by product and not the aim in health care", I repeat "Profit should be the by product and not the aim in health care". Our Six Core Values are Passion for the work we do, Respect for all stake holders, Integrity in our actions, Compassion to our patients, Excellence in what we do and Unity as a Team. We make it a reality through the team work of a seasoned and committed management and clinical team. We are proud that the retention of our senior management and top consultants have been over 90% in last 10 years. Focus on human capital and investments in state of the art equipment and fostering environment of innovation have helped us retain skilled talent reflected in our low attrition rate. The Company has 17,335 employees who we proudly call "Asterians" including 1,430 doctors and 7,926 nursing and paramedical personnel focused on delivering compassionate care through our brand promise to clientele: "We'll Treat You Well."

I would like to call to attention a unique aspect of seasonality of operations in our business which impacts our P&L. The seasonality is because of the decline in volumes across hospitals, pharmacies and segments during the summer months in the GCC countries from where we derive about 80% of our annual revenues. The H1 and H2 revenues in GCC are usually split 45%-55% but the EBITDA split can vary as much as 30% and 70% for H1 and H2. This is due to the high fixed cost with financial efficiencies kicking in with higher revenues in H2. This skews the picture significantly for the first and second half yearly results. For e.g., we had total revenues (excluding finance and investment income) of Rs. 3,137.81 cr in H1 and EBITDA of Rs. 193.39 cr, and total revenues (excluding finance and investment income) and EBITDA for H2 was Rs. 3,621.85 cr and Rs. 457.93 cr respectively. We have seen this seasonality variation for decades, in the past and foresee this continuing in future too. This will definitely be shown when you look at our financials in the H1, H2.

While we have done very well in the last 10 years in business growth and financial performance, we are aware about the challenges and risks in doing business in multiple geographies. One of the challenges for us with large portion of the revenues arising from GCC is the oil prices. We have faced the impact of this in Saudi Arabia couple of years back with receivables going up and have restructured the business to insulate against this as much as possible in the last two years. We have received most of the receivables during this period. You will see that we now only have 5% of our revenues from Saudi in this financial year. With the oil prices going up steeply, the overall business mood in the GCC has improved.

Another risk pointed out by many has been the legal ownership in GCC. As you may be aware, some of the GCC countries have this ownership structure and companies from the geography have listed in international markets like London with similar structure. This has been the case ever since our first private equity partner True North (then IVFA) joined in 2008 and suitable legal precautions were taken. We improved the diligence and protection further in 2012 when the US based PE partner Olympus Capital took a stake as this was looked at stringently while they invested. Last year, before filing DRHP, this was strengthened further by opting a structure protected by the Dubai International

Financial Center, which was vetted and approved by GCC, India and US lawyers and accepted by SEBI.

As an icing on the cake, I am very happy that there have been an announcement yesterday by the Prime Minister of UAE His Highness Sheikh Mohammed Bin Rashid Al Maktoum, that allowing 100% ownership rights in future in UAE which the details are yet to come but we are sure that this is going to help us because this will take out all the doubt in anybody's mind regarding the ownership in the GCC countries, because most of our assets are in UAE and Saudia Arabia anyway allows 100% ownership which covers large part of our address and there should not be any issue of any doubt in that.

There are other issues like getting good healthcare professionals for ever expanding need of our institutions. While this is a challenge for all healthcare companies, we are marginally in a better situation because of the access to the medical and paramedical graduates coming out of our own sister institutions in Kerala. There are challenges like increase in minimum wages of nursing and paramedical staff in some of the geographies like Kerala where we have significant presence, but we hope that we can manage this by market correction of tariff as we go forward.

Healthcare, as we all know is a sector with significant potential in geographies like India and GCC. At the macro level, the GDP spent on healthcare in India is very low and there is significant demand supply gap. Low affordability and insurance penetration are major reasons why healthcare hasn't taken off to the extent required. With the new National Health Protection Scheme announced by the Central Government covering half of the population in India, we expect significant improvement of capacity utilization in our Indian hospitals and scope for further expansion. Our strategy for India is to focus on large hospitals in Metros and Tier 1 & 2 cities with a very asset-like model. I want to stress that we would like to look at asset light model. We also foresee significant potential in bringing patients to our India hospitals for high end procedures due to our presence in GCC countries through medical value travel or health tourism. We already have 15-20% of revenue of some of our large hospitals like Kochi and Bengaluru coming from foreign patients. So we will definitely be having this advantage. The Indian healthcare companies have been struggling to make significant profits traditionally due to high capex and other challenges. Luckily, we have large part of our business in GCC with an asset-light model providing high ROCE. We hope that we will be able to have a good blended ROCE for GCC and India as major part of our profits are in dollar currency from abroad.

While we do not want to give any guidance, we are proud to share with you that we have grown exponentially in the last 10 years. In 2008, when True North (then IVFA) took stake in the company, our valuation was just US$ 100 million. When Olympus Capital took stake in the company in 2012, they invested at a valuation of US$ 400 million. As you can observe, our present market cap is four or five times of what it was in 2012.

While we cannot predict or promise about the future, we assure our stakeholders that we shall continue to work diligently to protect the

interest of all our stakeholders and provide decent return on investment to our investors.

I request Alisha Moopen -- the Executive Director to give further details.

Alisha Moopen: Thank you, Good morning everyone. It will be my endeavor to further bring out the strengths of our differentiated model, and impress upon you the strategic direction that the company is taking in order to deliver sustainable performance that is underlined by growth which is a testament of the quality of work that we are able to deliver in healthcare.

I would like to start talking about the lives that we have touched. The most important aspect for us as a healthcare organization is the impact that we are able to make and the number of lives we are able to heal. In 2017-18, it gives me great pride to disclose that we treated 17 million patients in total – 15 million visits in GCC and 2 million visits in India.

The focus area for us has been to enhance our reach slowly and steadily; and have a brand that you can trust that caters from the day to day incidents such as broken bones and routine vaccinations all the way to the cardiac transplants that require the most advanced and sophisticated care models and expertise.

Now, this comes from the people that we have with us. Our key strength of Aster is our doctors; we have 1,430 doctors within the group and am immensely proud to state that we have around 90% retention rate of senior consultants and specialists. Our retention of doctors is proof to the ethical practice and management which enables them to focus exclusively on patient care. We won the HBI Business Model Innovation Award as the best use of HR in Healthcare. We won the GCC Best Employer Brand Award and Dubai Human Development Award by the Government of Dubai.

Becoming a Healthcare brand of distinction can only come from quality clinical outcomes. Our Centres of Excellence which provides leadership in clinical practice, have to fulfill stringent criteria's from people, research, scope of work, clinical indicators to infrastructure to equipment. This ensures that we are able to attract the best of best talent with a very strong reputation for attracting referrals for the most complicated procedures for quaternary care to our Centres of Excellence namely Cardiac Sciences, Integrated Liver Care, Orthopaedic, Oncology , Neurosurgery, to name a few.

Our Indian unit boasts of having done the largest number of Robotic Renal Recipient Transplant Surgery in South India and we have a keen passion and dedication to make robotic surgery affordable. We also performed the Cardiac Robotic Surgery and Robotic Mini Gastric Bypass. Aster MIMS, Kerala, our oldest Indian hospital recently completed its 500th kidney transplant.

By way of training, Aster DM Healthcare is committed to enhancing the learning opportunities for our doctors. Core Medical Training was introduced at Aster Medcity in Kerala in partnership with London, Edinburgh and Glasgow Colleges of Physicians in the UK. Aster Medcity

will be the second in the world after Iceland to deliver CMT outside the UK. Aster DM Healthcare has been recognised by Royal College of Obstetrics and Gynaecologists (RCOG) for International programme accreditation for Core Medical Training as well.

As Chairman stressed upon the fact that a large portion of our business is in the GCC. What we have been actively trying to capitalize is on the opportunity of the mandatory insurance which came up in 2013 in the UAE. The last five years we have expanded our capacity in clinics, pharmacies and hospitals significantly in UAE to ensure that we are able to capture the increase insured population. UAE presently contributes to around 65% of our top line. Similarly, the increasing requirement in the Indian healthcare landscape was an area we were keen to aggressively participate and contribute to and this has been a driving factor for the last five years for us to create a brand which is synonymous with clinical quality of its national benchmark along with hospitality with strong service excellence focus where customer delight goes hand-in-hand with patient journey.

I would just like to talk a little bit about the growth in terms of number of units. This corresponds to expansion of operating facilities which now stands at 323 units which includes 19 hospitals with the total of 4,762 beds in FY18. This has ramped up significantly from the 149 operating units, 10 hospitals with the total of 1,419 beds in FY13. Further, the company has expanded to 90 clinics and 207 retail pharmacies in GCC, from just 41 clinics and 98 pharmacies in FY13.

Let me give you some of the key synergies between ours models as they all go hand-in-hand for creating the most convenient and comprehensive care for our patient.

Let me start with the clinics which is the nucleus for our GCC model. Aster's primary care clinics acts as initial touch point in the patients journey with the pharmacy complementing and completing the dispensing of prescribed medicines as needed. For more advanced care, the patient is referred to the hospital for the required surgical intervention to complete the care. We have the largest footprint of clinics in the UAE as an organized chain with our Aster Access and Medcare Clinics. OP is covered in insurance in UAE unlike the Indian market and the average visit per member is usually around 2-3 visits per annum.

Now, coming into Pharmacies, we have 207 retail pharmacies in the GCC space and the largest in UAE with 168 pharmacies. This lion share of the clinics network feeds directly into our pharmacy business. 60% of total revenues of Aster pharmacy comes from clinic attached pharmacies, 70-75% of our pharmacy EBITDA also comes from these clinics attached pharmacies. The gross margin for our pharma products are around 22-24% while our non-pharma products we get around 30-32% margin. The EBITDA margin from pharmacy has been rising from 9-9.4% over the last two years because of our increased focus on owned products with higher margin. We recently launched our Online Pharmacy which dispense a prescription to the homes of patients, single one solid step towards driving convenience with online pharmacy.

Now, moving over to Hospitals, in the UAE, we have approximately 17% of our hospitals business coming from our own clinics itself as they act as a funnel for the surgical workload. ROCE of our established hospitals in GCC stands at 27% approximately. This is the steady state ROCE for our clinics and pharmacies too in the GCC. We have nine hospitals in GCC presently and 10 hospitals in India. If you look at the ARPOB of our Indian hospital, it is Rs.23,700, which is quite similar to our peers. In comparison, if you look at the yields and the ARPOB of our GCC hospitals, our Aster GCC hospital will typically have an ARPOB of Rs. 120,000 and the ARPOB of our premium brand which is Medcare sits at around Rs.268,000. This is significant difference in the yield between the GCC and Indian unit. The Medcare hospital in itself are small exclusive facilities with very high yield and Aster hospital caters to the mainstream population and the bulk of the population pyramid.

We have opened five hospitals in the last three years, four of these have achieved breakeven between 9-months and 15-months, one is still under 12-months since commissioning and it is on course to operational breakeven shortly. This is really a testament to our brand strength and operational execution to make sure that the project ramps up quickly and swiftly.

We are moving towards developing more asset light models in India, similar to the model we have adopted in GCC which will help us to become more capital efficient and allow for quicker expansion too.

The expansion footprint continues to unfold in a calibrated manner which is aligned to our strategic and financial objective. In the GCC, we are anticipating the mandatory insurance to get rolled out in the near future across the other emirates and the GCC countries following suit from Abu Dhabi and Dubai. We have two planned hospitals in Dubai – one in Sharjah and expansion in Riyadh with the combined capacity of 307 beds in the pipeline. In India, we have two new hospitals coming up in Kerala, one each in Kurnool and Trivandrum, one in Chennai. This will augment the India capacity by a further 800 beds. So in total we have over 1,100 beds in the pipeline.

To conclude, the business momentum remains strong. Our operations are witnessing strong expansion on the back of these differentiated categories of healthcare and the superior service amongst other factors. The Aster DM Healthcare nameplate is gaining market share in key categories where we are present through multiple initiatives, partnerships and campaigns. Given the strength of our operations and opportunity available, the option to drive growth is truly attractive. As our initiatives gather traction and hospitals continue to mature, one will witness further significant improvement in the quality and sustainability of our growth model.

A challenge faced by nations across the globe, in both developing and devolved countries is the need for healthcare to be effective, efficient and sustainable. Aster is committed to contribute meaningfully to be part of this solution.

Thank you, all. I would like to pass it on to our CFO -- Sreenath Reddy, who will walk you through the financials.

Sreenath P. Reddy: Thank you, Alisha. Good morning everyone. I will start by recapping the financial highlights for the full year and then focus on providing you some flavour around the numbers and our journey forward.

Aster DM Healthcare has delivered strong financial performance with significant improvements in revenue, EBITDA and PAT.

In FY18, revenues excluding finance and investment income grew 30% YoY to Rs.6,759.66 crore, up from Rs.5,962.95 crore in FY17. In constant dollar currency the growth will be at 18%. This was backed by healthy growth in all segments.

In FY18, EBITDA increased to Rs.651.32 crore, up 79% YoY from Rs.363.78 crore in FY17. PAT increased to Rs.282 crore, up by 189% YoY from Rs.97.53 crore in FY17. Due to decrease in oil price, payments from government entities in Kingdom of Saudi Arabia were delayed in FY17. On a conservative basis, significant provisions were made in FY17 towards these delayed payments. Subsequently in FY18 the company was able to collect payments over and above the provision. Reversal of provision corresponding to prior period was Rs.85 crore which has been taken to exceptional cost in prior year, is now taken under the exceptional income in FY18. There is a significant scope of improvement at Sanad hospital to further improve the profitability. Further to this, we also have reversed Rs.45 crore of deferred consideration payable to RAR for the Sanad Hospital as exceptional income in FY18. So adding up both Rs.85 crore plus Rs.45 crore, it is Rs.130 crore which is shown as exceptional income in the current year. In FY18 the company has commenced operations of two new hospitals in GCC – Medcare Hospital in Sharjah, UAE and Aster Hospital, Doha, Qatar. The combined EBITDA loss for these two entities was Rs.93 crore in FY18; however, these units have ramped up over the year resulting in a relatively low combined EBITDA loss of Rs.9 crore in fourth quarter of the financial year FY18.

I am pleased to share the improvements in balance sheet. Our net debt-to-equity at 1.1 as on March 31st 2017, now stands at 0.6 as on March 31st 2018. Debt-to-EBITDA ratio have improved from 7.1 as on March 31st 2017 to 2.9 as on March 31st 2018. Our target debt-to-EBITDA ratio will be below 3.

We have a CAPEX outlay of Rs.650 crore; Rs.300 crore in India and Rs.350 crore in GCC for FY19 and another Rs.300 crore for FY20. The FY19 numbers include Rs. 70 crore of maintenance CAPEX. Also, the project at Trivandrum for the moment we are reconsidering it as this project involves high CAPEX, so we would like to look at an asset light model in case we are going ahead with the particular project.

Cost discipline and focused CAPEX in asset light models very clearly remain focus area for us moving forward. We have reduced our India debt by Rs.564 crore. We believe a growing EBITDA profile, leaner balance sheet, improvement in utilization and margin expansion led by ramp up of recently set up units the stage is set for us to deliver incrementally free cash flows in ensuing year.

As a company, we are committed to report an enhanced journey profile in line with the strategy that Dr. Azad and Alisha have articulated earlier.

On that note, I conclude my opening remarks. We would be happy to give you our perspective on any questions that you may have. I would request the operator on this call to open the Question and Answer Session. Thank you.

Moderator: Thank you very much. We will now begin the Question-and-Answer Session. We will take the first question from the line of Sudarshan Padmanabhan from Sundaram Mutual Fund. Please go ahead.

S Padmanabhan: Sir, my question is on the cash generation and working capital. As you had alluded to the fact that 4Q is very heavy in terms of sales and EBITDA. I am trying to understand because if I am looking at the balance sheet, we have fair amount of increase in receivables, almost Rs.250 crore and inventories is about Rs.100 crore. So in terms of cash generation as probably moved towards the first quarter, should we actually see this entire cash percolating into further debt repayment?

Kartik Thakrar: This is Kartik here. I will just take this question since large part of the increase in receivables as well as inventory which you mentioned is in GCC and this is pertaining to the new units which we added in clinics as well as hospitals. We typically witness cash conversion from EBITDA to the tune of around 65% at an operational level. From there we fund all the projects combined with the debt. So you are right that there is a small increase in working capital. As a percentage it is not significant, but it is pertaining to this. Second thing, in terms of debt level increase in FY19, in FY19 we are looking at total debt increase of approximately Rs.200 crore additional net debt. We are using the proceeds for funding some of the projects, combined with the small amount of increase in debt.

S Padmanabhan: But I would assume that it can also be funded through internal accruals because if I am looking at probably as we move towards FY19, you definitely have a lot more cash generation as probably the GCC countries throw up more cash in India also, the loss-making entities throw up more cash out of the system, so we are already generating something like Rs.450 crore, so this should only improve from here. So why do we need additional debt in FY19?

Sreenath P. Reddy: To answer that question, in FY18, you are right, we generated cash from operations of Rs. 643 crore, and again there was an investment of Rs.535 crore. So definitely there will be significant cash flows in FY19. But as you are aware that our business in the GCC region is mainly insurance-driven, so because of which there is always around close to three months of receivables outstanding, so due to which there is a need for the working capital. Having said that, the requirement from here onwards on the debt side will be very minimal. So what we are estimating because we are coming up with these new projects in the pipeline and we are estimating just Rs.150 crore of additional debt from these levels.

S Padmanabhan: In terms of the working capital days, if I am looking at the 4Q versus the first half, would we assume that as we move towards the first half there will be more release of cash from working capital because I would assume that since third and fourth quarter is quite big for us, the working capital requirement will also be big?

Kartik Thakrar: No, it would be slightly different because the first half does not generate good EBITDA proportion to the total annual EBITDA because while the working capital will be more or less remaining same. So we normally witness good cash generation in Q3 and specifically Q4 which we have seen even in the quarter which we have published.

S Padmanabhan: If I am broadly looking at the GCC countries, the split between hospitals and clinics, how does the seasonality work between them because it looks like there is more seasonality in the clinics rather than the hospital. Is my assumption right?

Kartik Thakrar: Clinics definitely serve more of outpatients and it is a primary care model which affects the population which moves out during the summer season and the school vacation. In hospital, you see a slightly improved situation because of non-elective category of surgery which a person cannot postpone or delay. That is the reason you see small difference in that.

Dr. Azad Moopen: Answering that question, as you said clinics and hospitals will have larger seasonality but even in the hospital, what happens is it is not only the patients who move out, even the doctors take holidays and all during this period. So overall there is actually seasonality issue in the GCC countries. Any country you look at and this has been there traditionally. But there will be some variation between, clinics, pharmacies and hospitals.

Moderator: Thank you. We will take the next question from the line of Farzan Madon from Axis Capital. Please go ahead.

Farzan Madon: Congratulations on a wonderful set of numbers both operationally and financially. I was just analyzing a little bit. Would it be right to say that a clinic would typically make around 15-16% kind of EBITDA margin, mature clinic?

Kartik Thakrar: On the stable state clinics will be around 18-20% of EBITDA margin, with blended level the margin will be close to 15%.

Farzan Madon: The hospitals would be in the range of around 20% I would assume?

Kartik Thakrar: Yes, right.

Farzan Madon: Given that we have added capacity in clinics and hospitals in India and of clinics in GCC, would it be a fair amount to say that we have still underutilized and there is room for marginal expansion across both these segments?

Kartik Thakrar: Yes, we doubled our capacity in the last three years and most of the new units are at breakeven level or at single digit EBITDA margin. So

there is still capacity improvement which has to come in, in the years to come.

Farzan Madon: Your Pharmacy has been performing in line, 10% EBITDA margin very stable, so all in all I guess the GCC makes 30% kind of ROCE?

Kartik Thakrar: Yes, Pharmacy witnesses around 39% ROCE and the EBITDA margin of pharmacy have been stable at around 9.5-10% in the last two years and the growth has been double digit in the last two years.

Moderator: Thank you. We will take the next question from the line of Shyam Srinivasan from Goldman Sachs. Please go ahead.

Shyam Srinivasan: My first one is on the Sanad Hospital. I could not see it in the segmental breakout. I think Dr. Moopen said 5%, what is the revenue? Where are the margins on this one? What has happened to PF structure? I think MOH was like last I remember 35% in FY17. So where has that now trended towards and what is the receivable situation from the MOH at the Sanad Hospital?

Kartik Thakrar: Answering your question on the payer mix, now we are approximately 25% dependent on the government agency business which is MOH and the remaining is coming from insurance, cash and corporates. In terms of the margin and the ramp up which we are planning in FY18, there has been an annex building which is coming up in the same premise and project true-up was slightly delayed by six months, that is the reason we could not end the year with the profitability, ended at breakeven level. Though the last March month, the margin was approximately 8-10%, so we see that we will be able to complete that work as well as ramp up the facilities in FY19. In terms of the money which was recoverable from Ministry of Health and the government agency, everything has come in full and as my colleague mentioned in the start of the call, there is a small write back also which was exceptionally written off in the previous year and shown as exceptional income to the tune of Rs.85 crore. To add this, there was a normal provision which were provided in FY17 to the tune of Rs.54 crore which has also been reversed in FY18. That said, that is the down provision, it is not shown as exceptional.

Shyam Srinivasan: Karthik, just again, it is like doing US60 million revenues, would that be the right number?

Kartik Thakrar: Yes, we touched approximately US$55 million in FY18.

Shyam Srinivasan: Now, we should expect like normalized market kind of base growth rather because this has declined, right, from 100 million has gone to 50 million?

Kartik Thakrar: Revenue has to be high in the next two, three years because the additional beds will come in place, but you can see that earlier margins of 40%-odd would not be existing, it will be normalized margin which normally listed players in Saudi report.

Shyam Srinivasan: Second question is on cost. I think we have seen cost actually not grow as fast as revenues have grown in FY18. The big delta I could see was

employee cost which has actually grown much slower. Is there something that we need to keep in mind, is there any one-offs there? The second question related is on increase in minimum wages I think Dr. Moopen touched on. Is there a ripple effect, in the sense since Kerala gives the most number of supply of nurses throughout the country, is there a risk that this could now flow through for the rest of the businesses as well even GCC, would there be a ripple effect because of the minimum wage increase?

Sreenath P. Reddy: To answer your question on the manpower cost, as you are aware that most of our hospitals were new during the last two years and hospitals as well as clinics, started ramping up, and as the revenues starting to grow up, as a percentage of cost, the HR cost goes down and also consciously we have also decided not to add additional manpower and to be more efficient and that way where we have restricted the HR cost.

Now answering your second question on Kerala, yes, there has been an increase in wages in the current year and also there has been a retrospective kind of an impact of around Rs.14 crore which has been challenged in the court, for which we are not aware at this point of time because this is something which came up in the current year, this notification came in the month of April. However, the increase in wages cost is offset by increase in price because we passed on to the patients. There is a possibility that there could be some kind of implication in other states as well and India being the more of a cash market I think that most of the hospital groups including us will be able to pass it on to the patient.

Dr. Azad Moopen: One thing which I wanted to add to this. We know that efficiency and organization of HR is the big opportunity for us to improve our bottom line and we have now engaged consultants both in India and GCC; one is McKinsey and other is E&Y who are doing work on both the HR as well as the material to give us an insight into which are the areas where we could actually control cost further. So we hope that this will have some impact on our HR cost as well as our material cost.

Shyam Srinivasan: My third question is on that point, I think Alisha made on pharmacy. How much is the percentage of own products at this point of time? I think there was also a mention of the margins, I did not get that, the 25, 30% margins in some of the products for pharmacy?

Kartik Thakrar: Usually the pharmacy product mix will be the branded medicine, the generic medicine and the non-pharma. In the non-pharma which is OTC products and other supplements, there are some own products. Margin usually in generic medicine is +30%. In the non-pharma category, it can go even above 35-40% and for owned products it goes even further. So that is the reason you see overall blended gross margin in the pharmacy to the tune of around 28-29% and that results in EBITDA of around 9.5-10%.

Shyam Srinivasan: CAPEX you have said Rs.650 crore next year and Rs.300 crore after that. We have come up with a very high CAPEX cycle, but what gives us the confidence that CAPEX is going to trend down so much down and what is the FY18 number?

Sreenath P. Reddy: FY18 the total investments is Rs.535 crore as CAPEX and for FY19 we are looking at Rs.650 crore of CAPEX and this is mainly for the pipeline projects which are there and the year after that onwards it will start tapering down, for the year after that we are looking at just Rs.300 crore and after that it will get significantly reduced. So we are confident that we will be able to keep debt-EBITDA level at less than three.

Shyam Srinivasan: Sreenath, just the maintenance CAPEX is Rs.70 crore, that is like for revenue of around what you are doing, INR 67, 68 crore. Do you think it looks little too low, just curious?

Sreenath P. Reddy: You are right, the thing is that because many of our facilities are new, they are under warranty and these equipment do not need maintenance CAPEX. So therefore at least for the next few years, the maintenance CAPEX will be at lower levels.

Moderator: Thank you. We will take the next question from the line of Damayanti Kerai from HSBC. Please go ahead.

Damayanti Kerai: Sir, I have a general question regarding the outlook for Hospital business in India. As we have seen that some of the competitors have spoke about the intense competition, oversupply situation in metro and you mentioned that in India your CAPEX will be focused towards metros and tier-1 town. So how do you see the industry shaping up here, just your thoughts on the outlook?

Dr. Azad Moopen: That is a very good question. We have looked at various hospitals and we have found that the hospitals group they make their money in the large hospital in the large city whereas when they go into tier-3, 4 cities or even tier-2 cities with smaller hospitals, they lose money. That has been traditionally and even now the situation. Whenever you build 200-bed hospitals in tier-2 or 3 cities, you have to have the same set of equipment and it is very difficult to get doctors and also, the affordability of the people is low. So in spite of the competition, there is significant opportunity in the larger cities, because the population is growing and people are moving towards the metros and larger cities. So to give you an example, instead of just telling the theory, we started a 500-bed hospital at Bangalore and it broke even in less than one year, which gives us the confidence that a large hospital in a large city is better and that is why we are now looking at Chennai and Cochin is the largest city in Kerala, even though it is not a metro, our Cochin hospital broke even in 1.5-years. So we feel that larger hospital with better facilities will be better than going into the other cities. That is the reason why we are focusing on that.

Damayanti Kerai: But what about the competition scenario because we are seeing that multiple numbers of established players again targeting the metro, say in Chennai or Bangalore market. So how do you differentiate yourself against the competition?

Dr. Azad Moopen: As I was telling you, Bangalore will be a good example, there if you look at we have gone significantly higher when compared to many of the competition and we are quite up there in many of the cities. So the reason is service excellence. So if you look at the Google rating in Bangalore in our hospital, we will be at the top. Like that the service

excellence and also the clinical excellence helps us to go to that upper level. This has happened at Cochin also. Cochin, there were 10 hospitals and there are large hospitals which were doing well. But in spite of that, we went to the prime position of #1 because of the clinical excellence and people now have that confidence and if you go to Google or Facebook, you will see that. That is the one edge that we have. Our service offering, both clinical as well as service excellence, we hope that will take us to the top.

Damayanti Kerai: Again, one general question; compared to your GCC business, India despite having more number of hospitals and beds, so we are seeing that it just continued for around 17% to the revenues and around 15% to the EBITDA. So like why you need to focus in India if your GCC business is already doing so well?

Dr. Azad Moopen: This is again an excellent question which we ourselves many times are seeing that why should we be doing that, but there is a strategy behind it. We think that India if you look at the medium and long-term is the market where the affordability of people is increasing and there is a huge demand/supply gap and as a growth market we will see India is a place where we have to have presence. So we think that 25% of our asset, even though it may not be giving the same return on capital as in the GCC and we will be derisking ourselves, we do not want to put all the eggs in one basket and India is a place where we already have large establishments and we are very careful that we do not invest too much. So answering your question further, we are going for an asset light model. What has happened traditionally in India when we looked at most of the healthcare players is that they were all looking at building their own hospitals and spending huge amount on CAPEX. So our Bangalore hospital exists now and a second hospital which we are starting in Bangalore, work is already on, we do not own those hospitals, we are actually taking it on long-term lease or an O&M model where we pay a percentage of the revenue to the owner. So this model in India we think that will improve the ROCE. As well as, as I told earlier this large opportunity which is India which is our hope that in the next 10, 15-years going to be very much affordable population will be there with insurance penetration and the national health protection scheme. We think we have to be present there; at least 25% of our focus should be there.

Moderator: Thank you. We will take the next question from the line of Rohan Dalal from B&K Securities. Please go ahead.

Rohan Dalal: I just had one or two questions; the first one being about your sales in GCC Pharmacies and GCC Clinics. So if I see, it is about 10% and 13% sales growth if I am correct from your presentation. I just wanted to understand, is that a function of lower pricing or is it lower volumes because the mandatory insurance should have increased volumes to the clinics and pharmacies in the GCC?

Kartik Thakrar: Just to address the question, constant currency growth is 18% and INR growth is what you see is 13%. That is because of the year where rupee strengthened unlike the previous year and the current position. That should address your question. But you are right that there is an increasing footfall and revenue which we expect from the insurance coverage which is coming in but it is a gradual process, because

people do try to get enrolled on the insurance plan and it is a gradual process. So we expect the growth to continue for the next two to three years. Whenever mandatory insurance come out in the past in the UAE, we have seen that the market has grown for at least three to four years because it is a gradual process of addition of population.

Rohan Dalal: Right sir, but in terms of the growth in GCC Pharmacies and Clinics, even if you regularize it let us say 15% for Pharmacies and 18% for Clinics based on currency, peers are growing at about 20, 21%-odd, so I was just wondering why is the revenue growth been lower in the Pharmacies especially?

Kartik Thakrar: We would not call it a low because if you see most of the insurance additions which have happened from the population, most of them have come in the low segment and the mid segment of the population where the spending will be more towards generic and non-branded products. So these products may not generate the high revenue in Pharmacy but give around 35% plus margin. So I think even on a low growth if you see our gross margin has improved from the earlier years, in fact, the last three years we were at 25, 26% in gross margin which has gone to almost like 28%, 30% and that is purely because of the product mix change from the branded to generic and non-branded products. I think we concentrate more on the quality of the margin rather than making a big top line and then making a gross margin, which is 25%. So we feel that we will continue growing with this generic and non-branded markets.

Rohan Dalal: My second question is relating to the unallocated and eliminations. What is that concerning regarding your EBITDA?

Kartik Thakrar: If you see the presentation around Rs.139 crore standing as unallocated expense.

Rohan Dalal: What exactly is the unallocated?

Kartik Thakrar: It is the corporate cost which is for India and GCC which is not allocated to a particular thing.

Rohan Dalal: My third and last question is relating to the Indian operations. Regarding the established units, the EBITDA margin came in at 13%. I was just wondering the facilities have already reached close to about five years. So what is the road forward – do you see the EBITDA margins growing further to about 20, 25% to the pure average or do you think 15% is the regularized for Aster DM?

Sreenath P. Reddy: Some of our hospitals in the past were in tier-2, tier-3 and is not contributing to that kind of margin but hospitals which are in the bigger cities are contributing higher margins and we expect this 13% EBITDA margin to move closer to the peers in the coming year.

Moderator: Thank you. We will take the next question from the line of Neha Manpuria from JP Morgan. Please go ahead.

Neha Manpuria: Sir, if I look at the ROCE of our India business, obviously, currently because we are still ramping up our operations, it looks slow. But in your

view, what could be a sustainable return profile for the India business when you look at expansion?

Sreenath P. Reddy: Hospitals in steady state do make around 18% ROCE in India and we are hopeful that we should be reaching those levels in coming years.

Neha Manpuria: How much time would that take based on our ramp up for profitability?

Sreenath P. Reddy: So on a consolidated basis, there will always be one or two hospitals which are new but any hospital which was not to be steady state mode and when I say steady state, going beyond five years from the date of initial operations, they should be able to reach those levels.

Neha Manpuria: The fact that a lot of our expansion is O&M, would the O&M allow us to improve ROCEs to more than 18% to a time?

Sreenath P. Reddy: Yes, definitely the ROCE we see in the GCC region is high because in the GCC region we are very asset light, so therefore capital is efficient. Going forward even in India we would like to follow similar model and if you see that the new hospital that we are coming up at Chennai as well is on an asset light model and therefore we expect the ROCEs to improve further.

Neha Manpuria: The second question is on the India businesses. Would we have a breakup of what proportion of the India business is international patients versus domestic patients? How does the payer profile change?

Sreenath P. Reddy: Some of our hospitals in the bigger cities, mainly the Bangalore and the Kochi hospital, 13-15% of the revenue are through medical value travel and because of our presence in GCC we have got that advantage for the national flow happen from the GCC region to India and we expect this percentage to go up significantly higher in the coming year and that too this will also fetch us higher average revenue per bed per day.

Neha Manpuria: What would be the rough ballpark percentage number would be in terms of ARPOB for an international patient versus domestic patient?

Sreenath P. Reddy: Our average ARPOB is around Rs.23,000 plus per day, for an international patient it would be around Rs.60,000 per day.

Moderator: Thank you. We will take the next question from the line of Harith Ahmed from Spark Capital. Please go ahead.

Harith Ahmed: Can you talk a little bit about your doctor engagement model especially in the Middle East hospitals? Your Indian peers have professional fee to doctors at roughly 20% of their revenues while yours is at around 10% and I understand the difference is because of the strong presence in the Middle East. So consultants or full time employees, what percentage of revenue will be the payouts to doctors in the Middle East Hospitals?

Alisha Moopen: In the Middle East, what we have are fixed term contracts with the doctors, so majority of our doctors are own and the only other model we have are small proportion of visiting doctors that come to do the surgeries. So for the visiting doctors, we have two parts; one is that fixed

part and then the variable part, so the fixed is quite basic, so we incentivize on the total revenue that they are able to generate, typically in clinics the average payout will be between 30-33%, in the hospitals it is lower; it goes from 15% to 25% for the doctors as a payout.

Harith Ahmed: Your Indian hospitals will be broadly in line with peers, is that a right assumption?

Alisha Moopen: Yes, that is right; it is quite similar.

Harith Ahmed: My second question is on Aster Medcity. Given that this hospital is very important to your India P&L, what occupancy and EBITDA margin levels are we at now and is there an improvement that we can expect going forward, and if yes what would be the drivers for the same?

Sreenath P. Reddy: Medcity at this point of time is around 65% occupancy, the capacity still exists, so definitely this occupancy will go up in the coming years. But rather than just increasing the occupancy, our thrust is more to see that we get quality kind of top line. So we are not doing much of schemes and other things, because if we do, lot of government schemes and others we can fill up the bed, but we do not want to do that, in fact, we have reduced these components. In fact after reducing we have got a healthy margin and going forward, yes, occupancy will definitely go up with a much more healthy margin.

Harith Ahmed: Is there a broad indication that you can give on the current margins at the facility level?

Sreenath P. Reddy: No, we do not want to give single hospital specific margin but we can see as to or how we do the broad kind of a thing, maybe offline we could look at that.

Moderator: Thank you. We will take the next question from the line of Chintan Sheth from Sameeksha Capital. Please go ahead.

Chintan Sheth: I just wanted to understand maintenance part which you explained that we have a long-term warranty which will keep the maintenance CAPEX lower in foreseeable future. Just wanted to understand whether this is a unique for you or it is the industry wide practice and medical equipment are being under the warranty for a prolonged period, can you help us in understanding that part?

Kartik Thakrar: It is not that we are having anything significantly different than other players, we do get higher amount instead of market scenario what we might be getting, is few years extra, but I would try to bring your attention to the model itself. It is a primary and secondary care model where the equipment base itself is not high, if you see the capital assets which we have, large part of it is interior decoration and the fit out which we do and then the balance is equipment. The interior fit out typically does not require any large maintenance CAPEX. Once we do the interior fit out, it is only a very small amount which we spend on that and most of them are leased or some of them are even covered by landlord. Second thing is most of the equipment which are there, because the in-house team medical team is quite capable, we do not rely on the outside parties to do AMC and our in-house team is able to

take care of those needs internally. That is the reason you do not see a large CAPEX being spent. But yes, all the costs which I am talking would be AMCs and in-house team is captured in the EBITDA.

Dr. Azad Moopen: Just wanted to clarify, if you look at the total revenues and taking it as a percentage of that, it will look smaller, but if you look at as a group having just half of that than its growth whereas more than 50% of our revenue come from clinics and pharmacies where there is not much of any capital employed. So what we are talking about is half of that or even less than that is coming as revenue and of which you are keeping this maintenance CAPEX. So that is one of the important reasons why we have a low maintenance CAPEX.

Chintan Sheth: No, I am not comparing it with revenue part, but in terms of your gross block, is it a fixed kind of percentage we maintain, or we require to spend on the maintenance on the gross block part, or it is more of the newer assets require lower maintenance, but the older assets require higher maintenance as the equipment age, so on a gross block basis, how do we look at maintenance CAPEX?

Kartik Thakrar: As Dr. Moopen also mentioned, the gross block consists of a large part of fit outs and that goes into pharmacy and clinic. It is there irrespective of new or old we do not require CAPEX for that. Now equipment is a category, yes, you are right that initially it will be low and at a later age of the equipment it will be high. But typically, we take AMC even after five years; at the time of buying the equipment itself, we normally negotiate the AMCs also for the post-warranty period. So those are factored in the EBITDA. That is the reason the CAPEX is not required for any of these categories.

Sreenath P. Reddy: So only some few surgical instruments and other things which need, but most of the large equipment don't need any kind of replacement for a long time. As my colleague, Kartik said, any maintenance related to these equipment is part of our regular maintenance which goes as part of our EBITDA, it is a regular exercise.

Chintan Sheth: In terms of larger equipment, what is the typical lifecycle – does technology also impact, or you have to replace the older technology because the newer one has additional cost associated to it, how do we see those replacements of equipment, is it regular?

Sreenath P. Reddy: Most of these large equipment, the life is anywhere around 13-years. So it is not required for a regular replacement, it is only the instruments that are being switched, other than that most of these large equipment do not need it. Suppose if a new technology comes and even if you want to bring in that new equipment this equipment we will use it in one of our other sectors.

Chintan Sheth: Second question I have in terms of the CAPEX, of the Rs.650-odd crore, we are planning around Rs.1,100 crore new, right, that is the capacity which you talked about, Rs.300 crore in GCC and Rs.800 crore around India. So, what is the cost difference between the GCC versus India… how much additional cost required in GCC?

Sreenath P. Reddy: The cost of setting up a bed in India is approximately around Rs.80 lakhs per bed if it is will be land and building. But if you eliminate the land and building and if we are going on an asset light model, it will be Rs.40 lakhs per bed, that is the CAPEX. In GCC, it is all asset light, we do not own the land and building, in GCC it will be two times; Rs.40 lakhs on an asset light model in India will be Rs.80 lakhs in the GCC.

Moderator: Thank you. We will take the next question from the line of Charulata Gaidhani from Dalal & Broacha. Please go ahead.

Charulata Gaidhani: My question pertains to the differences between the ARPOB in the matured hospitals and not-matured hospitals, why is the differential so high?

Sreenath P. Reddy: So this is mainly in India. The reason is that because the newer hospitals which are coming up, as a strategy we have decided to be in the large cities with large formats. In metros and tier-1 cities, the realizations are much higher compared to the smaller cities. In the past, we have certain facilities in smaller cities in India but as a strategy going forward we have decided to be in large cities with large formats and which will give us higher realizations as well as better margins.

Kartik Thakrar: In the GCC, you might see a difference between the established one which is to the tune of around Rs.1,50,000 and the new one is giving approximately Rs.2,00,000. That is mainly the reason that new one has got one of the large facility of Medcare hospital and typically the Medcare brand commands a higher ARPOB than the Aster brand. So on an average the Medcare brand ARPOB will be approximately Rs.2,70,000-3,00,000 while on Aster brand it will be like below Rs.1,20,000-1,40,000 or 1,50,000 level. That is the reason you see the new facility which is a Medcare facility of 124-beds commanding a higher ARPOB. Second thing is these started hardly six to eight months back, so the occupancy level is very low. Because of that the outpatient revenue which the hospital generates gets apportioned to the low occupied beds giving high ARPOB. So this is stabilized to the normal level once they cross the three year range.

Dr. Azad Moopen: Just to add to that, as Sreenath was mentioning in our hospitals which are there for a longer period, you will be at lower ARPOB whereas our newly started hospitals you will have a higher ARPOB. This is because we have started most of the new hospitals like Cochin, Bangalore and larger hospitals in the larger cities. So that is one of the reasons why we were thinking that we should focus on that.

Charulata Gaidhani: How have been reflected in the profitability of the newer units?

Sreenath P. Reddy: So the profitability also will be better compared to the smaller towns as it was told some few minutes back, because in smaller towns there is the issue of affordability, it is a big challenge, doctors is a challenge, but however in larger cities at least 30% is covered by the insurance so therefore affordability is there. In fact even the breakeven it is much faster in the bigger cities and the margins also will be higher in bigger cities compared to the smaller towns.

Charulata Gaidhani: What kind of breakeven period would you look at for the newer hospitals?

Sreenath P. Reddy: The hospital generally breakeven in 2.5-years' time but as my Chairman was saying that in Bangalore in fact the EBITDA break even happened in one year's time. So that is why we are confident that we do not need that 2.5-years kind of standard time to break even, we will be able to break even much earlier.

Moderator: Thank you. We will take the next question from the line of Krishna Sundaram, who is an individual investor. Please go ahead.

Krishna Sundaram: My main question would be, like it is partially already covered but it was on the Sanad Hospital in GCC, so whether all the entire amount which was outstanding it has been received and going forward the higher oil prices whether it is expected to contribute to further revenue per patient?

Sreenath P. Reddy: At Sanad Hospital, we have received all the amount that was outstanding, so there is nothing outstanding on the past. But in the normal course there are some outstanding, we are still continuing to do the business with the government but however what was 80% in the earlier year, that has been significantly reduced to 30% now. So there is a high probability that the realizations will start looking up now with the increase in oil price. Also what we have done is that not to depend only upon the government business, we are catering to insurance as well as cash patients for that and the cash patients definitely will give higher margins, no doubt at this point of time the insurance is a little bit lower, but we are also looking at changing the mix. Now that the oil price has stabilized, and it has gone up. We may look at some small contracts from other government agencies which can push up the realization forward.

Krishna Sundaram: Continuing with the same question, since the oil prices gone up, whether we would relook on our strategy of not dealing with the government, like as you said, maybe now it may be worthwhile looking at government because of the oil prices it may be having more income?

Sreenath P. Reddy: We do not want to take again major exposure to the government. But having said that there are certain government departments which pay very promptly, so we could look at increasing exposure towards them.

Dr. Azad Moopen: Expanding that answer, traditionally when we look at our peer group hospitals in Saudi Arabia, they were having say 25-30% exposure to government and rest was insurance and cash payments. They all did well even while we struggled actually. Our issue was that our business at that point of time which we bought was having 75-80% of the business coming from government. When the government defaulted or delayed, this was a big issue for us. So we do not want to go to such situation even though temporarily as you rightly mentioned there maybe some benefit. So we thought there should be a mix of all these together -- government plus the private as well as the insurance. That is why we stopped to concentrate too much on the government and have more

business. In fact, there is more business available from the government, they want us to do that, but we have restricted it to 25-30%.

Moderator: Thank you. We will take the next question from the line of Rahul Agarwal from VEC Investments. Please go ahead.

Rahul Agarwal: I had two questions for Mr. Moopen. Firstly, anything on the risk assessment. Just to frame it rightly, so if I am looking at next three years or your business with the growth plant you have framed here, in terms of risk assessment in your view, what might actually derail or hamper the growth plan you have across the businesses including GCC and India, majorly because Dubai is about 65% of our business today?

Dr. Azad Moopen: If you had asked me this question three days back, the answer would have been different. But as I told in my initial remarks, there has been a significant change in the last two days where there has been an announcement that the ownership now is guaranteed by the government, earlier it was all structural and we got confidence that this was there and this was approved by all the legal and all. So that is out of our mind now which was always there in the back of the mind. Now, looking forward, one risk that I should highlight is always the availability of the professionals of doctors or the lack of availability of that. So what is happening is that we were getting traditionally these professionals from countries like India and other countries like Philippines, in India especially with the salaries and all going up, we are finding it difficult unlike earlier times to get good quality medical professionals coming to India. So we have to look at this pipeline of healthcare professionals. So that actually is a problem for everybody but even for us that is an issue. Now, challenges that were there even one year back was partially mitigated, this is from oil price because the business here is dependent on oil price, even though Dubai to some extent insulated, it has gone up now and it is in a very good position at $75-80/barrel, but it had gone down even to $30. So we have gone through that cycle and we have experienced. So answer to your question is risk in GCC will be mainly the availability of HR professionals, second will be the oil prices. In India, the risk that I see is the capping of prices by the government. This has happened recently where there has been capping of stents and some of the implantables and all where there have been issues for some of the hospitals who were focusing on that particular area. For us it is slightly better because we are multi-specialty and we do not focus on a single specialty. But the salary increase and risk like that are there. It will all get mitigated by increasing tariff because as the price in India is not fixed and we have increased the price and if the market is accepting that, so we will be able to mitigate that. So these are broadly some of the things which do not keep me awake in the night now but at least these are that I should tell you.

Rahul Agarwal: My second question was related to pricing. Obviously, you have explained into India how is that moving because of capping and stuff. But do you view pricing in GCC markets for over next two to three years because it is more mandatory insurance-driven market as well as business there for Aster?

Dr. Azad Moopen: That is an excellent question and we are getting used to that. Whenever insurance comes there is an opportunity as well as risk. The opportunity is that we can get volume of business and the risk is that there will be

control by the insurance companies or they will ask for capping of the price even if the government does not bring in cap. So we have now learned or we are learning as you will see from our earnings this year, we are looking at the efficiencies and how to manage at lowering the HR cost, lowering the cost of inputs and all. So yes, there is a risk that insurance gains more coverage that will be more of restriction on top line but we hope that market will have some value for whatever business we are doing and we will be able to maintain our existing margins.

Alisha Moopen: Just to add to that, typically, the government here also has inflation related increases which are approved. So it is not like it is completely capped by insurance, so there is involvement by the regulators to ensure that it does not restrict providers from increasing the tariff.

Rahul Agarwal: Since you are the market leader in Dubai market, does that give you some kind of pricing power there as in could you increase more than the inflation increase allowed by the government?

Dr. Azad Moopen: No-no, the rates cannot be increased in Dubai. Actually as Alisha was telling, government has fixed rate and they give for the inflation. What happens is that the insurance companies ask for a discount on your price. So you have a price, if 100 is your price, insurance companies can ask you about a discount of Rs.5, 10, 15, 20, 25, 30 or even more than that depending on your bargaining capacity. Because of this price, that advantage of bargaining with the insurance companies because they cannot write a policy without us because we are there in all the sectors like pharmacy, hospital and clinic and we are into all the three segments of the population that is upper, middle and lower income. So we have some clout under which I think will help us to claim lower discounts from the insurance company.

Rahul Agarwal: Just coming back on to the risk part, oil prices you mentioned, so is it the right way to look at it now obviously last 10-years growth has been phenomenal, right, for you, as you said, the first time the PE investor invested $100 million you are almost trading like Rs.9,000 crore market capital markets today. So does it mean that oil prices going up is a positive/negative in the sense that the oil price can behave as it wants but how do we look at your business in terms of oil prices behaving, does that actually benefit you in the GCC market, or should we look at it negatively when goes down, how do we assess that?

Dr. Azad Moopen: This is something I want to tell you that Dubai as you know is not having major oil income, it is very minimal. We have majority of our business in Dubai. To some extent it is insulated. But going to the wider level, even Dubai will be affected if there is an issue in the GCC where oil prices come down, so we have seen this. As I told you earlier, oil prices going down to 30 and coming up to 120 and now it is at 80. But if you look at our growth as well as more CAGR for the top line/bottom line, the rate is 25-30% over the last 10-years which were not significantly affected by what happened to the oil, it will go up in two months or come down. The CAGR has been maintained and we have sort of perfected that art of living whatever the circumstances and are relatively I think insulated against the oil fluctuation.

Moderator: Thank you. Ladies and gentlemen, that was the last question. I now hand over the conference to the management for closing comments.

Dr. Azad Moopen: Thank you very much. It has been a very good interaction. Being the first conference like this we were little generous on our initial opening remarks and we will make sure that we would not bore you that much in the future quarterly calls and all because we know that this has been long, but we will concentrate more on the QnA. Thank you very much for all the support. We are now three months into the stock market and you know why and as we go forward we hope that the investors as well as the analysts and the shareholders will understand the company better and we will be viewed with that advantage of being in a market which is having better return on capital employed. Thanks a lot.

Moderator: Thank you. On behalf of Aster DM Healthcare Limited, that concludes this conference. Thank you for joining us and you may now disconnect your lines.
