Unihealth Hospitals

Operator: Good morning, everyone. This is the first day of the Bharat Connect Conference 2026 September edition. I welcome you all to the call of Unihealth Hospitals Ltd. Today, from the management team, we have Mr. Akshay Parmar, who is the founder and MD of the company. Before I hand over the call to management, I will lay out the flow of the event. We will start with the opening remarks by management and then move on to the Q&A round. Any participant who would like to ask questions can raise their hand or put them in the chat box. First, we will take questions from the participants who have raised their hands and then move on to the chat box if time permits. We will also take questions that I have received from clients who were not able to participate. I now hand over the call to management. Over to you, sir.

Akshay Parmar – MD: Good afternoon, and thank you for having me at this particular conference. I am Dr. Akshay Parmar, the co-founder and managing director of Unihealth Hospitals Ltd. I will give a quick brief on the company.

Unihealth Hospitals Ltd. was incorporated in 2010. We have completed more than 16 years, and we are present across multiple verticals of the healthcare sector, with the key focus being our medical centers and hospitals across East Africa and now in India.

As a quick update, we recently commissioned our second facility in India. It is a 200-bed, tertiary-care, multispecialty facility in Nashik. We commissioned it on September 1, 2026. With that, we now have 250 commissioned beds between Navi Mumbai and Nashik, in addition to our existing bed capacity in Uganda, which is about 150 beds. Therefore, we have 400 commissioned beds, and we will scale up further to achieve our target of 1,000 commissioned beds by the end of calendar year 2028.

This has been the major vertical for the group. In support of this, we have other verticals covering healthcare consultancy services; pharmaceutical and medical consumable exports and distribution; and medical value travel, commonly known as medical tourism.

In a nutshell, this is where the company is present. I will now leave it open for Q&A, and I can provide more details about the company, its operations, and its projections as we address the questions that come in.

Operator: The first question is from Shaurya Punyani. Please go ahead.

Shaurya Punyani: Hello, am I audible?

Akshay Parmar – MD: Yes, Shaurya.

Shaurya Punyani: First, we currently have 400 beds, if I am not mistaken. What is the occupancy?

Akshay Parmar – MD: In Uganda, which is a mature market for us right now, we are achieving occupancy in the range of about 68%–72% on a given day.

Navi Mumbai had a soft launch in October 2025, and we completed and commissioned all our services in February this year. Occupancy has been scaling up from the initial 15%–16% to what we have achieved right now, which is in the range of 35%–40%. We expect to cross the 50%

Report is AI-generated and may contain inaccuracies.

benchmark by the end of this calendar year.

We are awaiting our empanelment with several insurance companies and the GIC, which is the General Insurance Corporation, and we expect that process to be completed in the coming couple of months. Once that is done, occupancy is likely to increase significantly.

In Nashik, we have just commissioned our services on September 1. We started with our OPD services and diagnostics in the first couple of weeks, and we started taking in-patients from the last week onward. As we speak, we have in-patients, and we have successfully treated certain medical cases, including certain cases in the ICU. With respect to Nashik, I believe that the occupancy ramp-up will start sometime from November onward.

Shaurya Punyani: The ramp-up will start from November, okay.

Akshay Parmar – MD: We are already taking in-patients, but a significant number compared to the bed capacity will, I believe, start from November onward, once the entire marketing activity has been initiated across the catchment area. That will happen between now and the end of October. That is when we expect a significant number of in-patients to start coming in.

Shaurya Punyani: We are targeting 1,000 beds, so 600 more beds are coming. Where are they coming from? Will they be in Uganda or India?

Akshay Parmar – MD: The idea is to have a commissioned bed capacity of approximately 550-600 beds in India and 400-450 beds in East Africa.

The addition that is likely to happen will first be in the city of Pune, which is the next city in our target to complete the golden triangle of Maharashtra that we had initially conceived. We expect to add another 125-150 beds in Pune as the next step.

After that, we will expand our presence in Mumbai as well. We are already looking at possible opportunities to expand our network in different suburbs of Mumbai. This will be the expansion between Mumbai and Pune as the next phase of our expansion in India.

When it comes to Africa, we will work on expanding our presence in Tanzania and possibly look at Kenya as well between now and 2028 for a significant expansion in bed capacity.

Shaurya Punyani: I think last time you had debtors of approximately 120 crores. You had such a high number of debtors. What is the update regarding that? Have the payments been reco...?

Akshay Parmar – MD: We have received significant payments from our largest debtor, the Uganda People's Defence Forces in Uganda. Simultaneously, our business with them has also been ongoing.

I do not have the exact amount on hand right now, but on a quarterly basis, compared to what we were receiving earlier, we have received payments in the range of 10-12 crores each quarter. We are expecting a payment anytime in the coming 5-10 days for this particular quarter as well.

In addition, there is a particular bonus being worked upon by the Ministry of Defence. As I mentioned in some of my earlier communications, the government of Uganda is working to bring down this particular debtor, meaning debtor days, to approximately 180 and then reduce it further.

Report is AI-generated and may contain inaccuracies.

The intent has been there, and they are working towards it. The payments that have come in reflect that intent, but it will take another 3–4 quarters for it to start coming down significantly below the 180-day mark.

What is also likely to happen as we move forward on a consolidated basis is that, with the addition of Navi Mumbai and Nashik, possibly by Q4 of this year and the first half of next year, that number will increase significantly. On a consolidated basis, the picture will be significantly different by the time we enter the next financial year.

Shaurya Punyani: What revenue are we targeting, and what are the margins for this year and next year?

Akshay Parmar – MD: This year, Uganda will grow at the standard pace at which we have been growing. We are making a lot of inroads into different super-specialties in Uganda. In a couple of quarters, we will start achieving the benefits of those initiatives.

As I mentioned, Navi Mumbai has started to pick up significantly. We expect that by Q4 we should cross the 50% occupancy mark. Navi Mumbai should contribute significantly from Q4 onward.

With respect to Nashik, the next 2 quarters will be important for establishing our presence. A meaningful addition to revenue is likely to start happening from Q4 of this financial year and Q1 of the next financial year onward. That is when we expect all the empanelments with the insurance companies to conclude for both our facilities.

In that particular sense, I would say that during this year, on average, for the 400 beds, we can look at a consolidated occupancy of about 40%–45%. The largest addition during this year is Nashik, which has 200 beds and has just been commissioned. Therefore, the occupancy levels for Nashik may touch approximately 15%–20% by the end of this financial year.

Keeping that in mind, on a consolidated basis, we can target a 40%–45% occupancy rate. The average revenue per occupied bed that we are currently generating is likely to be in the range of 30,000–32,000 rupees per bed per day, which translates to approximately 1.1–1.15 crores on an annual basis. That is the target for this financial year.

From the next financial year onward, the top line is likely to change significantly because Navi Mumbai will move towards becoming a mature facility, and Nashik will also start ramping up significantly. In addition, we are likely to have additions in Pune and East Africa. From that perspective, in the next financial year, we expect a significant jump in the top line compared with what we achieve this year.

Shaurya Punyani: At 40% occupancy for 400 beds, let us say we will have approximately 250 crores of revenue this year?

Akshay Parmar – MD: We should be approaching the 200-crore mark. I would not say 250 crores. It again depends on how Nashik ramps up between now and the start of Q4.

Shaurya Punyani: Okay, sir. That is all from my side. Thank you.

Report is AI-generated and may contain inaccuracies.

Operator: Thank you. The next question is from Tanish Vora. Please go ahead.

Tanish Vora: Hello, am I audible?

Akshay Parmar – MD: Yes, Tanish.

Tanish Vora: If I heard correctly, the guidance for this financial year is 200 crores, as you said just now. Is that correct?

Akshay Parmar – MD: That is what we are looking at based on our anticipated occupancy levels and ARPOB. ARPOB is something that we are presently achieving across all the facilities, based on the ARPOB that I mentioned.

Occupancy levels are an assumption right now. We are being conservative, and we do expect and hope to do better than that. That is how we are looking at it, unless there is something significant in terms of an addition in Pune.

In Pune, we are currently looking at a couple of facilities, including an existing hospital facility with which we are discussing an operational management takeover or some form of collaboration. If that is concluded within the particular timeline we have and we are able to receive the benefit of a portion of the existing revenue of that facility during this financial year, it may provide some addition. However, we are not factoring it in right now.

Tanish Vora: I believe we have reduced the guidance. Earlier, I think, we had been talking about approximately 300 crores. Is that correct?

Akshay Parmar – MD: No, we were looking at approximately 250 crores. The reduction is mainly because there has been a deferment in the timeline for the addition we are considering in Tanzania.

We are still working on the statutory approval. The bureaucracy in Tanzania moves somewhat slowly, and that is where the operational takeover of the 100 beds that we intend to undertake has been delayed. The discussions between both parties have been concluded, but there are certain statutory bottlenecks because the hospital facility that we intend to acquire operationally is currently under a trust. That complicates the matter somewhat further when it comes to statutory and taxation matters in Tanzania.

That delay is the reason for this reduction, which is what has been factored in at this moment. We were initially anticipating concluding this sometime by the end of Q2 or the middle of Q3 of this financial year. However, given the way things are right now, I am not sure whether it will happen within a month and a half from now or whether it might take longer than that.

Then December brings the Christmas period, so almost a month in Africa passes without any major work taking place. This facility already had, or already has, significant top-line revenue that it is currently generating. It is a fairly old hospital whose operations we were looking at acquiring.

When we last interacted on this particular platform, we had taken into consideration the addition of the top line of that facility for 2 quarters of this financial year. That is where this adjustment is likely to happen.

Report is AI-generated and may contain inaccuracies.

Tanish Vora: Two more questions. One is about receivables. In some of the last conference calls, you mentioned that we did not have any receivables beyond 2024. Is that correct?

What I see in the recent annual report for FY26 is that receivables outstanding for more than 2–3 years have increased from perhaps 2 crores to 6 crores. Is there any problem from the government side? From what I understand, we receive receivables within approximately 1 year. Within 1 year, we receive the past pending receivables. So is there any problem in this regard?

Management: No, that particular amount that you mentioned, which has increased from approximately 2 crores to about 6 crores, is a possibility, although I am not 100% sure of the numbers. However, that is not related to the receivables from the government department or the Ministry of Defence that we are discussing.

That amount was part of the receivables in some of the other verticals of the company, including consultancy services and part of the export and distribution business. The majority of it has been recovered between that period and now.

We have received or recovered considerable payments that were in process when we published our annual report. Based on that, I think that number will change and come down when we declare our half-year results.

That amount is not related to the medical services that we are extending to the government of Uganda, meaning the Ministry of Defence in Uganda. It is more related to some of the consultancy services. Part of it has been recovered, part of it is under discussion, and we expect that payment to come through anytime in the next 2–6 weeks.

Most of that old recovery from those debtors should be concluded before the end of Q3 of this financial year.

Tanish Vora: Understood. One more question regarding that. We started our operations in 2010, and from that time until now, until last year, we had only one hospital after the closure of Nigeria. Were there challenges in the African market?

The second question is, why the African market? I know you mentioned that it is a high-margin area where we can operate compared with India, but then you shifted to India, saying that growth is limited in those areas and scalability would be a problem in Africa. Why Africa in the first place? Why not India, given that you had an advantage in the African market?

Management: Why Africa in the first place? That was more of a natural progression for Unihealth when we were privately held.

The first vertical when we started the company in 2010 was medical tourism or medical value travel. We were bootstrapped, we were a small setup, and we started by bringing patients from the Middle East and Africa to different hospitals in India for treatment.

That allowed us to gain a strong foothold, create a substantial network, and establish partnerships in the African countries where we had a presence. That is how we saw opportunities there. Given the limited capital available to us at that point, we thought it would be better for us to invest in a

Report is AI-generated and may contain inaccuracies.

high-opportunity, high-growth market, which Africa was at that point, compared with India, which was also quite competitive at that time.

From that perspective, in 2015, when we decided to make investments, we thought Africa suited us better because there was a significant supply-demand gap. We understood that market quite well, with almost 5 years of experience in those geographies for medical tourism and an established local presence there.

That is what took us to Africa in the first place. We started with a small medical center in Tanzania, expanded our presence from there into Uganda, and later into Nigeria as well. We then graduated from medical centers into tertiary-care hospitals.

When we decided to go public in 2023 and after that, scalability also started becoming a consideration. With access to capital and the revised target of 1,000 beds in a 5-year period, we decided that Africa had its own benefits and limitations.

The benefits were that we were a sort of first mover, we had an understanding and an established presence, and the margins were significantly good.

The limitations were that scalability in each country was limited to anywhere between 200 and 300-350 beds. Beyond that, because the population size was smaller, the paying capacity and that matrix were quite different. We realized that we might not be able to scale beyond 250-350 beds in a particular country.

Moving from one country to another changes the scenario completely. There is a different government, different rules, and different bureaucracy. That is when, with our presence on the listed exchanges and access to capital, we realized that India offered us the scalability option.

For the next phase of growth, we decided that we would also have a strategic presence in India. That is how the pivot from Africa to India took place as the company started to mature after the initial period of growth when we were privately held.

That is how we started from Africa, because we started with medical tourism, which allowed us to create a strong foothold in some of the African countries where we are present today.

Tanish Vora: Understood. On the margin side, I believe the margin this year should be on the lower side.

Operator: I request you to return to the queue, as there are other participants waiting for their turn. Thank you. The next question is from Shravan. Please go ahead.

Shravan: Thank you for the opportunity. I have a couple of questions. Forgive me if these are elementary; this is my first time looking at the company.

First, East Africa has very high margins, and now you are saying that you will focus on India. Is it reasonable to assume that margins will reduce going forward?

Management: Yes, there will be some correction in the overall margins. The margins in East Africa are higher, but the absolute numbers will increase significantly in comparison.

Report is AI-generated and may contain inaccuracies.

If it would take me, for example, 3 years to scale from 150 to 300 beds in East Africa, or from 150 to 500 beds in East Africa, and achieve those margins, the context in India is completely different.

The margins may correct somewhat from the EBITDA margins in the early 40s that we currently enjoy. They are likely to come down, especially because of the newer facilities that are being added and the operating expenditure losses that will occur initially during the setup period.

The EBITDA margins are likely to come down even as we mature. They may hover in the early to mid-30s compared with the early 40s that we have currently. However, the absolute numbers and the scale will increase significantly.

That is where the company is focused: moving from 150-200 or 400 beds in East Africa to 1,000 beds, and perhaps beyond that to 2,000-3,000 beds and beyond, over the next 7-8-year period or 5-7-year period. The absolute numbers are what we will focus on, while ensuring that we continue to have a healthy EBITDA margin in a peer-to-peer comparison.

Shravan: One question on the guidance. Could you reiterate the guidance on bed additions and FY27? I think you were looking at approximately 200 crores of revenue. Do you have any indication of the EBITDA margins and the number of bed additions in FY27 and FY28?

Management: In FY27, we have just commissioned Nashik, so we have added those 200 beds to our commissioned bed capacity and taken the commissioned bed capacity to 400 beds. We are exploring opportunities to add another 100-125 commissioned beds by the end of this financial year.

The target is to cross a commissioned bed capacity of 500 before FY26-27 ends. In FY27-28, we will be keen to add another 250-350 beds during that period. In the year after that, we will add the remaining beds to achieve the 1,000 commissioned-bed target by the end of calendar year 2028.

In terms of our revenue guidance, as you correctly mentioned and as I mentioned earlier in the call, we are looking at approximately the 200-crore mark during this financial year.

This is based on our current commissioned bed capacity and the stage at which the different projects are. Uganda is a mature facility. Navi Mumbai is now moving towards operational break-even and ramping up occupancy once we complete the empanelment with all the insurance companies.

Nashik was commissioned approximately 3 weeks ago. By Q4, it may achieve a position where we can have at least 15%-20%-22% occupancy. From that perspective, on a consolidated basis, we expect occupancy for this financial year for the 400 beds to be approximately 40%, plus or minus.

Going into next year, if I am talking about a commissioned bed capacity of 500 beds, from which I receive the benefit for the entire year, the target average occupancy for the 500-bed capacity would be in the mid-50s.

We will target approximately 275 occupied beds on a full-year basis. The ARPOB we are currently achieving is about 31,000-32,000 rupees per occupied bed per day. We would want to move towards the 35,000 mark in the coming financial year from the commissioned beds, meaning the

Report is AI-generated and may contain inaccuracies.

500 beds that I am referring to.

From that perspective, the top line will undergo a significant change as we enter the 2027-28 financial year.

Shravan: I think my questions are done. I have a few more questions, but I will return to the queue.

Management: Sure. Thank you.

Operator: Thank you. The next question is from Rohit. Please go ahead.

Management: I think I have lost Rohit.

Rohit: Yes, can you hear me?

Management: Yes.

Rohit: While coming to India, what prompted you to go to Navi Mumbai first, then Nashik, and now Pune and Mumbai? What similarities or differences do you see compared with your core market of Uganda while operating in these geographies? Do we target higher ARPOBs here?

Management: Why India first? I will answer that first.

First, the company is Indian-born and bred. We are based out of India, in Mumbai. Dr. Anurag relocated to Uganda in 2017, but when the company was started, both of us came from this particular region. That is certainly one aspect.

Second, we are listed on the Indian stock exchanges and have stakeholders from India, so there was an obligation and a consideration related to that as well.

Third, there was a two-fold strategy. One was scalability. As I mentioned, if I have to scale to 1,000 beds, 2,000 beds, and beyond, Africa would offer certain limitations and challenges. I would have to move from one country to another, and each country would have a completely different set of bureaucratic and political requirements, as well as a different understanding of the market.

Despite that, each country would limit me to approximately 300-400 beds at the higher end at this stage. From that perspective, India offers us scalability. It also offers us stability. Geopolitical risk factors, whether actual or perceived, do not exist to a large extent when we come to an Indian business for an Indian entity.

From that perspective, expanding into India became important.

The other point was a strategic decision. If we are to expand in a high-margin market like Africa and take our bed capacity from 120-150 to approximately 400-450 beds, the only bottleneck we identified would be technical and managerial manpower.

We have very good doctors in Africa. They are well trained in the US, the UK, and India as well. The limitation arises with nursing manpower, technicians, and managerial manpower at the administrative level.

Report is AI-generated and may contain inaccuracies.

A presence in India allows us to create a bench strength that we can train at our facilities in India and, at the appropriate time, during expansion, position in Africa for periods ranging from 1 year to 3 years. This gives us a strategic advantage to expand faster in Africa.

That was also a strategic initiative: a presence in India would allow us to expand rapidly and manage our African operations better. The manpower transitioning from India to Africa would also have India's support system, and they would know that at the end of their tenure in Africa, they would still return to the same company and perhaps work at a Navi Mumbai, Nashik, or Pune facility within the same group.

From that perspective as well, India was important.

Now, why Navi Mumbai, Nashik, and Pune? Primarily because the company is based out of Mumbai, so Mumbai and this particular region became important for our growth and initial presence.

When we look at the expanded geography of Maharashtra or western Maharashtra, the 3 key cities witnessing significant development are Mumbai, Pune, and Nashik. Geographically, they are very well connected. Travel time is between 2.5 hours and 4 hours at most, depending on which part of the city one is travelling from and to which part one is travelling. This also makes it relatively easy for the senior management.

Akshay Parmar – MD: It also helps us travel and ensure that the facilities are integrated at an operational level.

What these cities outside Mumbai—Pune and Nashik—also do is draw a substantial catchment from areas beyond them. In the case of Pune, there is a lot of catchment coming into Pune from tier-three and rural areas beyond Pune, including Satara, Ahmednagar, and areas beyond towards Kolhapur.

The same applies to Nashik, whether it is Malegaon, Dhulia, Jalgaon, or other areas that feed into Nashik. The catchments are large. These are important and developing cities, with substantial industrial activity coming in.

From that perspective, they complete the golden triangle for our first phase of growth. As we grow beyond the initial bed capacity of 500-600 beds, we will look at other geographies as well.

For the first phase, the selection of these 3 cities is based on the fact that the company is based here, so we have a very good understanding of the market. We also have a strong network, both at the establishment level and within the doctor fraternity. That gives us our own strengths in this market.

Rohit: Understood. Thank you.

Akshay Parmar – MD: Thank you, {? Rupak ?}.

Operator: Thank you. The next question is from Chaitanya. Please go ahead.

Chaitanya: Hi, Akshay.

Report is AI-generated and may contain inaccuracies.

Akshay Parmar – MD: Hi, Chaitanya.

Chaitanya: Can you brief us on the new shares or the transaction that you undertook with Victoria Hospital? What was this about?

Akshay Parmar – MD: Victoria Hospital Limited is a company that operates and owns the real estate and hospital business in Uganda. It currently operates our flagship facility, which has the 150 beds that we have there.

Before this particular event, the shareholding was 50-50. Unihealth Hospitals Ltd. held 50% of the equity, and the remaining 50% was held by our local partners, Mr. Bhaskar Kotecha and Dr. Chirag Kotecha, equally at 25% each.

That facility became debt-free on September 22, 2025. It has a good level of profitability, and it enjoys a corporate tax holiday extending until June 30, 2034.

Any cash flow coming in from the government's outstanding payments is also practically going to be used for expansion within the country or to fund expansion in the region. The operating expenditure is being taken care of by the regular cash business and insurance patients.

From all these perspectives, we found that the company was positioned in such a way that it would make sense for Unihealth and its stakeholders to own a majority of that company.

That would allow us, first, to utilize its assets and cash flows for the expansion of the entire group. Second, it would allow the profits earned by that company to be reflected entirely in Unihealth.

We entered into discussions with the other partners, and what we offered them was a no-cash deal in which we entered into an equity swap. Against the 49.81% stake that they transferred to Unihealth Hospitals Ltd., Unihealth Hospitals Ltd. issued fresh equity in exchange, which will now be held by them.

Thus, under a share-swap arrangement, we issued fresh equity to Mr. Bhaskar Kotecha and Dr. Chirag Kotecha in exchange for acquiring 49.81% of their stake in Victoria Hospital Limited.

As we speak, Victoria Hospital Limited, effective September 2, 2026, is a subsidiary of Unihealth Hospitals Ltd., in which Unihealth owns a 99.81% equity stake. Therefore, almost the entire profit of that company will be added to Unihealth's profitability.

The minority interest that was reflected until the last financial year, which was a significant amount, will no longer be reduced from PAT. That will benefit all Unihealth stakeholders.

Second, Victoria Hospital Limited's cash flow can now be accessed by Unihealth as a group without limitations and used for expansion either in East Africa or in India, as we choose.

As we speak, we have some unsecured debt that was extended by the parent, Unihealth Hospitals Ltd., to this company in Uganda over a period of years. This shareholder debt is now being repaid.

A significant amount of cash flow is therefore coming from Uganda into India and into the parent company. It will be utilized for expansion either between Mumbai, Pune, and Nashik or reinvested

Report is AI-generated and may contain inaccuracies.

into the expansion we intend to undertake in other parts of East Africa.

Chaitanya: I have just one or two final questions. Are you planning to take on any other debt? That is the first question. Second, are we looking at any fundraises in the future?

Akshay Parmar – MD: Regarding debt, we currently have a 22-crore term loan that we took in November 2025 to expand between Navi Mumbai and Nashik, primarily for the Nashik facility and its equipment. That is the only term loan we currently have.

As we move forward, it will depend on the structure in which we expand. Certain opportunities coming to us are purely operations and management opportunities, which will require limited capital investment from our end.

There are other opportunities where the real estate is also attractive and available, and we are still evaluating the benefits and the possibility of the company pursuing them.

Depending on how we proceed, if required, the company is well positioned and the balance sheet is sufficiently strong to access some debt. We will be open to obtaining banking facilities either to acquire equipment or to acquire an asset for the company's long-term growth.

We will therefore be open to debt.

Regarding a fresh equity round, we are also open to that depending on the requirement for funds. We anticipate that the company will require significant funds over the coming 9-12 months as we embark on this growth and expansion from the existing 400 beds towards the 1,000-bed capacity.

For the addition of 600 beds, we will require a significant amount of funding. This will be met partly through internal accruals, mainly from cash flows in Uganda; partly through bank debt; and then, for the remaining gap, we will explore or remain open to some form of QIP or preferential allotment.

As management, we may start working on that in Q3 and Q4.

Chaitanya: Thank you. All the best.

Akshay Parmar – MD: Thank you, Chaitanya.

Operator: Thank you. The next question is from Neeraj. Please go ahead.

Neeraj: Hello. Yes, am I audible?

Akshay Parmar – MD: You are audible now.

Neeraj: Most of my questions have been answered. If we extrapolate or fast-forward to when all the facilities are commissioned, by the end of FY28, or FY27-28, what revenue can we expect as a company as a whole, including India and Africa?

Akshay Parmar – MD: In FY27-28, we expect to benefit from at least 500 commissioned beds that will have passed through the initial setup period. This includes the current 400 beds and at least another 100-125 beds.

Report is AI-generated and may contain inaccuracies.

Those 500 beds should provide occupancy of approximately 55%-60%-62% on a consolidated basis. We may also add another 150-200 beds during that particular financial year, providing another approximately 10% occupancy.

It would be fair to assume that we are talking about approximately 325 occupied beds on a consolidated basis across the group, including all facilities in India and Africa.

For these 325 beds, the ARPOB we would target at that point would be in the early 30,000s per day. It would be somewhere between 33,000 and 35,000 because Uganda is achieving a significantly higher ARPOB. By that time, Navi Mumbai and Nashik will also be achieving significantly higher ARPOBs, while the newer facilities will be on the lower side.

On a consolidated basis, taking into consideration the mix of commissioned bed capacity—some facilities being completely mature, some having achieved a particular level of occupancy and ARPOB, and some having just been commissioned—achieving an ARPOB of more than 34,000-35,000 rupees per day appears possible at that point.

That would translate to approximately 1.2 crores in annual revenue per occupied bed. Therefore, we would target approximately 340-350 crores in top-line revenue.

What is also likely to happen during this period is that, if we secure certain opportunities in the O&M space and acquire the operations of existing hospitals, the top line is likely to increase accordingly. In those cases, we would not be looking at the entire commissioning period and revenue build-up. We would instead enter at a point where that particular phase had already been completed and would be looking at incremental growth from there.

For example, regarding the Tanzania opportunity that we are discussing, despite the delays, both parties have agreed on the overall structure of the deal, and it is now mainly with the government authorities.

We had anticipated a 6-month period for the statutory approval, but it is likely to take somewhat longer. If that approval comes through, perhaps by the end of this financial year, we would receive the benefit of that revenue from the next financial year onward. That would be the immediate addition of significant revenue.

If something of that nature happens, and even 2 projects of that nature are concluded during the period we are discussing, this amount is likely to increase accordingly. However, I am not factoring anything in right now.

On a conservative estimate, I am sharing the occupancy and ARPOB targets that I mentioned.

Neeraj: On that approximately 350-crore top line, what would our margins be? In the best-case scenario, what would the gross margins be?

Akshay Parmar – MD: On a consolidated basis, we would expect EBITDA to be in the early 30s. Uganda may continue to enjoy much higher EBITDA, which will allow us to offset the initial operating expenditure losses at some of the newly commissioned facilities.

Report is AI-generated and may contain inaccuracies.

As a result, the overall EBITDA margin on the total consolidated top line is likely to be just above the 30% mark.

Neeraj: What about the O&M space? In that case, I think the margin would be somewhat lower because it is O&M.

Akshay Parmar – MD: For the O&M space we are considering in India, if we take up an existing facility, the margin initially is likely to be in the early to mid-20s. That is where I mentioned that the higher EBITDA margins from Uganda will be important.

Uganda is currently generating a significant amount of our revenue. Therefore, whatever revenue build-up we have, the contribution from Uganda, despite declining on a percentage basis, will still be significant.

For the period we are discussing, a more than 40% EBITDA margin in Uganda and an EBITDA margin in the early 20s from the Indian business would still allow us to cross the 30% mark.

What I have also not factored in is our small but significantly important consultancy services business, where EBITDA margins are usually above the 55%-60% mark.

If we are able to improve that business in terms of revenue even by a couple of crore rupees, that will also add significantly to EBITDA because operating expenditure in the consultancy business does not increase in the same proportion as the business.

We are in the process of registering many of the products that we export into Africa. Some registrations have been completed, and some are expected to be completed during this financial year.

Hopefully, from the next financial year, we will see an upswing in trading volume as well. That business will also enjoy an EBITDA margin in the early to mid-30s.

Taken together, on a consolidated basis, we are quite positive that at that level we should touch and cross the 30% mark.

Neeraj: Thank you for that. One last question. In the last conference call, you mentioned a very good opportunity and potential in the maternity segment in Africa. Are there any thoughts of expanding in that segment? That is a cash-flow business for us, and it does not directly operate like the military business, where cash flow gets stuck.

Akshay Parmar – MD: Basic maternity is part of almost all our units that we are considering. What is mainly adding to revenue and margins is the IVF and fertility setup that we commissioned in Uganda in January 2025, which is doing very well.

IVF as a subspecialty is something we intend to continue across every major tertiary-care hospital that we establish, whether in Tanzania or Kenya. As we expand and commission facilities in other countries in East Africa, we will continue to add IVF from the initial days itself.

Akshay Parmar – MD: In Uganda, it took us almost 9 years to set up IVF because that was our first facility. However, we now have the support of our teams in Uganda and the support of teams in

Report is AI-generated and may contain inaccuracies.

India at the different facilities that we are commissioning.

Whatever facilities we take up and commission in East Africa going forward, IVF will be one of the important and critical subspecialties that we will look at commissioning from the initial days itself. It will continue to remain an important focal point for us.

It is not only IVF; there are many other subspecialties that we are focusing on. For example, ophthalmology is something that we have now commissioned in Uganda. We have started performing cataract surgeries, and we are expanding that footprint to include phacoemulsification and retinal surgeries as well.

Certain subspecialties that we did not have a presence in when it came to Africa, but that we are adding now, will be part of all the expansion we undertake in that region. With a team now in Uganda, it is quite easy for us to duplicate that setup and extend the initial services from Uganda to the facilities that we intend to establish in the neighboring countries.

Neeraj: Thank you so much. As always, you answer all the questions so patiently. Thank you.

Akshay Parmar – MD: Thank you.

Operator: Thank you. Please note that we will take the last question, as there are only 5 minutes left for the session. The next question is from Nikhil. Please go ahead.

Nikhil: Hello, Dr. Akshay. I hope you are doing well.

Akshay Parmar – MD: Thank you, Nikhil.

Nikhil: I wanted to understand how the other businesses are doing, such as medical value travel. Have we received any other order apart from the 500-bed hospital contract in the consultancy business?

Akshay Parmar – MD: In medical value travel, we are witnessing significant interest. A good number of inquiries are active for both our facilities in Navi Mumbai and Nashik.

We have also completed the interlinking of our teams between Uganda and India to ensure that referrals generated from our facility in Uganda for the Indian entity are properly handled.

We have already catered to more than 15 international patients in the last 4-5 months, and we are keen to streamline and increase that as we move forward.

There is significant focus on this vertical over the coming 2 quarters and beyond. We expect it to become streamlined to the point where, from the next financial year onward, we will hopefully have a significant contribution from international business across all our facilities in India.

Medical value travel is therefore an important pillar of the next level of growth that the company is pursuing. We have our own strengths and network in this area, since it was the first vertical with which Unihealth started. We are streamlining the entire process as we speak.

Report is AI-generated and may contain inaccuracies.

In terms of consultancy services, we are in active discussions to add more projects. I am quite hopeful that during Q3 of this financial year, we should be able to conclude a couple of additional agreements in the consultancy services space. These will allow us to generate revenue over the coming 2-4 quarters.

Nikhil: What kind of revenue would that generate? Can you provide any financial indication?

Akshay Parmar - MD: In consultancy services, many of these projects tend to extend anywhere from 3 months to almost a couple of years because we are providing services to establish clinics and hospitals.

A significant portion of the revenue generation is either milestone-linked or structured as a monthly retainer with bonus payments when we achieve certain milestones.

Whether the entire revenue is recorded in the books during this financial year, or whether part is recorded this year and part goes into the next year, is something we will know as we progress with discussions with the client and factor in the timelines.

What we are considering is adding approximately 250-350 beds under the consultancy services business. Part of this will be comprehensive consultancy or project management, while part is being considered only for the design aspect of the project under consideration.

Nikhil: Understood. I also wanted to understand how the doctors are structured. Are they on a minimum-guarantee model, or is there another type of model?

Akshay Parmar - MD: It is a mix. We have certain doctors who are full-time with us, some who are purely visiting consultants on a revenue-share basis, and a mixed model in which certain super-specialists come in with a minimum guarantee and contribute a certain amount of time to us.

There is also a revenue share for the business they generate beyond a particular threshold. It is a complete mix depending on the specialty we are discussing.

As a standard policy, we try to ensure that general medicine, general surgery, orthopedics, spine, cardiology, and intensive care—these 6 critical faculties—have around-the-clock coverage at all our facilities.

We have full-time doctors and doctors who are available around the clock to ensure that any patient who walks into a UMC facility is catered to in terms of emergency requirements.

Nikhil: Thank you so much. That is all. I will return to the queue.

Operator: Thank you. Due to time constraints, we will have to close this call. I request Dr. Akshay to give the closing remarks.

Akshay Parmar - MD: I would like to thank everyone for participating. It has been a pleasure to interact with you. If there are any unanswered queries, we will be happy to interact over email or schedule another call to address them.

Please feel free to get in touch with us if any stakeholders or investors have queries. Thank you.

Report is AI-generated and may contain inaccuracies.

Operator: I would like to thank the management and the participants on behalf of Arihant Capital for sparing their time and sharing insights about the company. Thank you very much.

Note: {? ... ?} indicates a figure or name where audio clarity was insufficient for confident transcription. Verify against the source audio or the company's published filings.

Report is AI-generated and may contain inaccuracies.