May 24, 2023

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

Symbol: MAXHEALTH

Listing Department,
BSE Limited
Phiroze Jeejeebhoy Towers,
Dalal Street,
Mumbai – 400 001

Scrip Code: 543220

Sub.: Transcript of Earnings Call held on May 17, 2023

Ref.: Regulation 30 of the SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015

Dear Sir / Madam,

Please find enclosed copy of transcript of earnings call, organized on May 17, 2023, on financial results of the Company for the quarter and financial year ended March 31, 2023.

The said transcript is also available on the website of the Company at www.maxhealthcare.in/investors/investor-resources.

Kindly take the same on record.

Thanking you

Yours truly,
For **Max Healthcare Institute Limited**

DHIRAJ ARORAA
Digitally signed by DHIRAJ ARORAA
Date: 2023.05.24 10:39:13 +05'30'

Dhiraj Aroraa
SVP - Company Secretary and Compliance Officer

Encl.: As above

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Max Healthcare Institute Limited

Q4 & FY23 Earnings Conference Call Transcript
May 17, 2023

Moderator Ladies and gentlemen, good day and welcome to the Max Healthcare Institute Limited Earnings Conference Call.

Please note that this conference is being recorded.

I now hand the conference over to Mr. Suraj from CDR India. Thank you, and over to you.

Suraj: Good morning, everyone and thank you for joining us on Max Healthcare Q4 FY'23 Earnings Conference Call. We have with us today Mr. Abhay Soi – Chairman and Managing Director; and Mr. Yogesh Sareen – Senior Director and Chief Financial Officer of the Company. We will begin the call with opening remarks from the Management, following which we will have the forum open for an interactive question and answer session.

Before we start, I would like to point out that some statements made in today's call may be forward-looking in nature and a disclaimer to this effect has been included in the Earnings Presentation shared with you already.

I would now like to invite Abhay to make his opening remarks.

Abhay Soi: A very good morning to everyone. I am pleased to welcome you to Max Healthcare's 4th Quarter Earnings Call.

At the outset, I would like to state that this has been a seminal year for Max Healthcare on many accounts and an important one of them being the overall translation of Rs. 1,636 crore of EBITDA to Rs. 1,281 crore of free cash flows. Consequently, in spite of a decadal opportunity for investment in the hospital sector, we have been encouraged to declare our maiden dividend.

Q4 was a robust quarter for us and exhibited the results of commendable execution of our strategy by teams on the ground. This quarter once again reflected our best ever performance across nearly all the financial and operating parameters recording significant growth year-on-year.

We commissioned and operationalized a 92-bed oncology block at Max Shalimar Bagh from 1st March. This contributed positively to both revenue and EBITDA in its very first month of launch. EBITDA margin on the incremental revenue was in the range of 35% to 40% due to operating leverage and overall occupancy at the hospital

was 83% in Q4. We expect this to contribute to improvement in EBITDA, both in absolute and margin terms in the ensuing quarter.

Key Highlights of Q4 Performance:

Occupancy for the quarter improved to 77% from 68% in Q4 last year and remained at the same level as in the previous quarter. However, it is pertinent to note that operating capacity moved up by 100 beds in March 2023 compared to December 2022.

Institutional bed share fell to 29% compared to 33% in Q4 last year and remained flat compared to the previous quarter. Again, there was higher capacity in the current quarter as well.

PSU tariffs for room rent and consults have been revised in mid-April. Further discussions are ongoing to increase tariffs for packages, diagnostics, etc. In view of these developments, we have not taken a hard call yet for some of the major accounts. At the same time, all our hospitals have been tasked with improving their operating occupancy thresholds to accommodate growth in the preferred channels.

Network gross revenue was Rs. 1,637 crore compared to Rs. 1,298 crore in Q4 last year and Rs. 1,559 crore in the previous quarter. This reflects a growth of 26% year-on-year and 5% quarter-on-quarter. The year-on-year increase was driven by growth in ARPOB and occupied bed days.

Revenue from international patients grew by 43% year-on-year and 10% quarter-on-quarter. This now accounts for around 9.1% of the revenue from hospitals and amounts to 120% of pre-COVID levels.

Digital revenue grew to Rs. 292 crore and accounted for 18% of overall revenue.

Led by improvement in channel mix and specialty mix, ARPOB for the quarter rose to approximately Rs. 70,700, reflecting a growth of 11% year-on-year and 6% quarter-on-quarter.

We reported our highest-ever network operating EBITDA of Rs. 437 crore compared to Rs. 304 crore in Q4 last year and Rs. 419 crore in the previous quarter, reflecting a growth of 44% year-on-year and 4% quarter-on-quarter.

The Network operating EBITDA margin stood at 28.2% versus 24.8% in Q4 last year and 28.3% in the previous quarter. Annualized EBITDA per bed, most importantly, rose to Rs. 70.3 lakhs, yet again our highest ever, clocking a growth of 25% year-on-year and 5% quarter-on-quarter.

Profit after tax was Rs. 320 crore versus Rs. 172 crore in Q4 last year and Rs. 269 crore in the previous quarter. The year-on-year growth of 85% was primarily attributable to improvement in operating metrics of all the hospitals and lower finance costs.

Free cash flow from operations stood at Rs. 425 crore, of which Rs. 65 crore was deployed towards ongoing capacity expansion projects. The Net Cash position improved to Rs. 733 crore at the end of March 2023 compared to Net Debt of Rs. 441 crore last year.

Continuing our efforts to give back to the community, we treated approximately 36,600 OPD and 1200 IPD patients from economically weaker sections of society free of charge.

Both our strategic business units continued to maintain their growth momentum.

1) Max@Home reported a top line of Rs. 37 crore, reflecting a growth of 26% year-on-year and 2% quarter-on-quarter.
2) Max Lab reported a gross revenue of Rs. 31 crore, reflecting a like-to-like growth of 57% year-on-year and 10% quarter-on-quarter.

Performance for the Full Year:

Network gross revenue stood at Rs. 6,234 crore, reflecting a growth of 18% on a like-to-like basis.

Network operating EBITDA stood at Rs. 1,636 crore, registering a growth of 25% on a like-to-like basis while ARPOB improved by 15% due to price and improvements in payor mix and case mix leading to margin expansion by 152 basis points.

EBITDA per bed grew by 22% year-on-year and touched a new high of Rs. 65.9 lakh.

Status of Expansion projects coming on stream by FY 2025 is as follows:

We have recently signed an ATS (Agreement to Sell) for purchase of land to enable expansion of Max Vaishali, which is consistently operating at more than 80% occupancy. If and when the deal is consummated, it has the potential to add 100 Brownfield beds to our network.

For 300 beds at Dwarka, interior work is in progress, lifts are under installation and external development has started. Medical equipment has been ordered. And as communicated earlier we expect to commission the hospital by end of Q2 FY24, subject to the developer obtaining occupation certificate by that time, of which we are quite certain.

For 329 beds at Nanavati the work is in full swing at the site. Foundation and column work have already begun. As you may be aware, Larsen & Toubro (L&T) is handling the project and we expect to commission the facility by the end of FY25.

For 300 beds at Sector 56 Gurgaon in Phase-I, D-wall work is complete and excavation is underway, while the civil contractor mobilizes for starting construction by end of June.

In order to obviate the delays at Max Smart caused due to tree transplantation issues, we are fast tracking the construction at Vikrant site, which is part of the same complex. We have received in-principle environmental clearance (EC) approval and are expecting other approvals over the next 6 to 8 weeks.

Lastly, we continue to actively, but prudently, evaluate inorganic growth opportunities for strategic deployment of our cash surplus from operations. With this, we open the floor for Q&A.

Moderator: Thank you very much. We have our first question from the line of Ashwin Agarwal from Akash Ganga Investments.

Ashwin Agarwal: Abhay, could you highlight what is your vision going beyond three to five years beyond what have you announced in terms of organic opportunities? And whether you would be looking at the South and the other regions in the country?

Secondly, you own around 24% stake now so would you like to increase your stake so that you can use the stock as an option in terms of acquisition, else you get diluted?

Abhay Soi: So, let me start with the last one first. Firstly, thank you for the compliment. The consequence of this performance has been that three years back when we were listing the company, one of the biggest critiques of the Indian Healthcare or the Hospital sector was that there are no free cash flows and you have to keep redeploying. I think with Rs. 1,281 crore of free cash flows translating from Rs. 1,636 crore of EBITDA which shows ~80% translation of EBITDA to free cash flows, I think we have answered that question. So, that is, as far as I am concerned, right up there as far as our achievements for the current year.

Now with respect to my vision over the next three to five years, I think there is a multi-decadal opportunity in the hospital sector. The kind of infrastructure, which is required to be created simply because you need to address that demand and we are seeing this every day. So all the cash flows that we are generating, we would be redeploying it into the sector and we have been looking at pretty much every part of India.

We have been very clear about two things that we will only look at places where at least a few of our competitors have proven viability. We will go there and we will do it better, like we do in each one of the micro-markets that we currently operate in. We have not been the first anywhere, but we are the top performer wherever we operate. So, I think that is the strategy that we want to employ. So, that doesn't preclude any place, but of course we like a 'cluster approach'. If I have to just do one hospital in Kerala or just one hospital in Chennai or something I would not do it, we prefer clusters so we will look at chains and we will look at clusters.

Ashwin Agarwal: Anything on your stake in terms of using the stock as an opportunity in terms of M&A?

Abhay Soi: So, look I think my stock, one of the consequences of our success is that it reflects on the market cap and the stock price. To buy anything meaningful, I would effectively have to leverage my current stock,which I am not interested in doing because I don't leverage my stock at all. You know 1% of the stock will cost me Rs. 500 crore, so pre-tax that money is about Rs. 800 crore. As my only form of employment is Max Healthcare, my salary does not permit me to buy more stock. But I would not be afraid of diluting if there is a great opportunity, let me just put it this way. When I say diluting, if there is an opportunity for a merger or an acquisition for the growth of the company, I would not shy away from the opportunity.

Ashwin Agarwal: Yes, that is what I was wanting to know.

Abhay Soi: There is no, and there has never been an issue as far as that is concerned.

Ashwin Agarwal: Would you be only city-centric in next three to five years in terms of opportunities or you would also look into Tier-II opportunities? And do you have opportunities like Nanavati which give you a gateway to any big city?

Abhay Soi: No, absolutely. I think, firstly, we are very happy doing Tier-II and Tier-III cities also. Our highest ROCE business is Mohali, second highest is Dehradun in Uttarakhand,

it is not Delhi and Bombay. Like I said, we will go to any city where two or three of our competitors have proven viability. We have a list of 21 such cities.

Moderator: Thank you. We have our next question from the line of Damayanti Kerai from HSBC.

Damayanti Kerai: Abhay, my first question is on your payor mix change plan. So, you mentioned we have seen upward revision in PSU tariffs etc., because of that is there any rethinking from your side to bring the institutional bed share to 15%-16%, which you highlighted earlier from 29% currently?

Abhay Soi: So, look, I think the trajectory is changing on account of two or three things. One is that we are finding marginally more capacity, we are operating at higher levels than what we were thinking of previously, so we are able to keep that business and be able to do more and you are seeing that in your margins month-on-month. The best thing is that if you can, we were pushing down that business because we wanted to accommodate our preferred channel of CTI. Now necessarily you are always going to find some elasticity towards the end, so you see the operating levers becoming higher.

Secondly, we have added 100 more beds, which is about 3% more capacity that has been added. Yet you see that the PSU number has still come down marginally.

The third thing is that there has been an increase in rates as far as PSU is concerned, an increase in tariffs, which will work well for us in the current year. That is about 20% or 30% of the total tariffs that they have revised. They have revised it quite significantly by about 70%. So, only four line items, but that amounts to about 20% of the total, 20%? --

Yogesh Sareen: The overall increase would be around 4% to 5% on the billing to the PSUs.

Abhay Soi: But the rest of the tariffs are looking to be revised in, they are saying by July. So, I think we have a little bit of a wait and watch here. Because if we have the same sort of increase by July, it has been proposed that rest of the packages and everything else is being revised. This is what we have been informed.

Damayanti Kerai: Just to clarify, this 4% to 5% tariff hike is for the PSU contracts so far and you are expecting…

Yogesh Sareen: So, what I am saying is that for the line items that they have raised prices on, the average price increase is around 70%, but in a way the contribution of those line items is around 10% to 12%, so that means the overall increase would be 4% to 5%.

Damayanti Kerai: Okay, and in July, another round of price hike?

Yogesh Sareen: Yes, we are expecting another round of price hike.

Abhay Soi: For the rest of the items.

Yogesh Sareen: They have not touched the diagnostics, they have not touched the packages, they have not touched the other elements of the blood bank etc. They have not touched that. They just touched four items: one is room rent for ICU beds, room rent for single room, and IP consults and OP consults. Only these four elements have been changed.

Abhay Soi: And whatever they have touched has gone up by 70% on average.

So, let us say there are 100 things and the revenue is 100, only 12% of the revenue has been touched by them. They have increased that 12% by about 70%, and for the balance 88%, we are expecting something to be done by July.

Damayanti Kerai: So, my second question is on your average revenue per occupied bed. Again, I think you have surprised positively quarter-after-quarter. In the last two years, we have seen around 15% increase. And I understand specialty mix change is the big driver of it. So, can you explain what has changed so significantly in last two-three years that you continue to see better and better specialty mix and how should we see this part moving ahead?

Abhay Soi: I think your ARPOB is being generated by payor mix and specialty mix. It is not only purely payor mix. We have also seen a massive increase in international business, which plays on the ARPOB. It is a combination of factors. During the last three years, you are looking at COVID in the middle, right. So I think your current ARPOB vis-à-vis a COVID year is going to be higher, and you need to compare it to pre-COVID years. Then you take up, perhaps, the cost increases over this latent period of COVID, because the disease burden has come back after COVID. In the middle, you are looking at COVID business, which was high occupancy but lower ARPOB. Now you have business, which is essentially high ARPOB, but your occupancy has moved up because there was not any capacity creation during the COVID years. So, I think you are going to see ARPOB move up, but obviously you can't do a comparison with the COVID year.

Damayanti Serai: Not even with COVID year, so if I look at the period of FY'19 before COVID, you were somewhere at Rs.46,000 to Rs.47,000 ARPOB, and now it has moved up to say, Rs.70,000 plus. So, I am asking from that perspective.

Abhay Soi: I will just let you know what the FY19 ARPOB was. But as you move up the occupancy curve, you are going to distill your payor mix. Now you are talking about a time when my PSU payor mix was 40% plus and now it's 29%, right. I think as you go up the curve, you start getting that operating leverage when you start getting that better quality of business. We still have hospitals in the portfolio that are doing Rs. 90,000+ ARPOB.

Yogesh Sareen: So, our FY'20 ARPOB was Rs. 50,300.

Abhay Soi: So Rs. 50,300 has gone up to Rs, 70,700 in three years now.

Yogesh Sareen: The average is Rs, 67,400 for FY'23. So, if you take year-to-year average, it will be 10% to 11% higher.

Abhay Soi: So, it's 10% to 11% increase right, from Rs. 50,300 to Rs. 67,400 you are saying.

Yogesh Sareen: Yes

Damayanti Serai: So, going ahead also say since we continue to see better mix both in payor and specialty part --

Abhay Soi: I think from distillation of payor mix itself, you should see an increase in ARPOB. For our clinical mix, of course like I said, there is always innovation going on. It's not only at Max Healthcare, but we have plenty of single hospitals in Mumbai, for example, which have been there for 20 odd years, which have no payor mix lever as it has sort

of saturated. There is no extra bed, not a square inch that they have been able to add, yet the clinical mix sort of drives ARPOB up. I mean, there are lovely examples of that – Hinduja Hospital, Breach Candy Hospital and so on and so forth.

Damayanti Kerai: So, comfortably, we should be seeing say high single digit to say double-digit growth in the ARPOB going ahead also?

Abhay Soi: I avoid giving any forward-looking guidance.

Damayanti Serai: And my last question is on your view on the competitive landscape in Delhi NCR market given we have seen many of your competitors trying to step up their presence. So, is there any possibility of bed oversupply in say foreseeable future, if not now?

Abhay Soi: I have not seen any new beds come up in Delhi NCR or even under construction.

Damayanti Serai: Actually, I think Apollo has a facility coming up in Gurugram so –

Yogesh Sareen: This facility was already there by the way; the first floor is already constructed. I think Apollo has just done an agreement; I mean it was not operating but I think this building has been there for quite some time. So, let us see when it starts to operate, it is not yet operational, right?

Damayanti Serai: Yes.

Moderator: Thank you. We have a next question from the line of Nikhil Mathur from HDFC Mutual Fund.

Nikhil Mathur: My first question is a kind of a clarification, when I look at the audited cash flow statement, the CAPEX incurred under the line item of purchase of property is around Rs. 335 crore whereas in the proforma numbers that we talked about in the executive summary, the company has given a CAPEX number of Rs. 208 crore. I guess there might be some technicality here. Can you please explain me why this difference in audited and executive summary?

Yogesh Sareen: So, just to clarify that point. When we report the Rs. 208 crore spend, that spend is on the capacity expansions, on the projects. So, whatever is the routine CAPEX in the cash flow, it comes in the property line, but eventually when we report numbers to investors we take it out from the free cash flows. When Abhay says that we have Rs. 1,281 crore of free cash flows against Rs. 1,636 crore of EBITDA, in that Rs. 1,281 crore whatever amount that is spent, the total network spend is around Rs. 211 crore on the routine CAPEX and that amount is taken out of the free cash flows. We only report the number of Rs. 208 crore, which is on the capacity expansion, basically on our ongoing projects. There are two type of CAPEX spends, one is the routine CAPEX, which is replacements happening in the running hospitals. And the other one is CAPEX for the capacity expansions. Rs. 208 crore is the number for the capacity expansion and whatever is the number for the routine replacement in the running hospitals, it is taken out from the operating cash flows.

When you say cash from operations, this number is already netted there, but in the audited financials this number, by virtue of the fact that if cash flow is as per a particular Ind-AS requirement, both numbers flow into that number.

Nikhil Mathur: So, Rs. 335 crore is the right number to look at, when we are looking at on a proforma basis?

Yogesh Sareen: No, that number will be around Rs. 419 crore vis-à-vis what you see is only consolidated financials, right. These consolidated financials don't have the the partner healthcare facilities (PHFs) number. The overall number, if I take the network cash flow, will be Rs. 419 crores of which Rs. 211 crore would be routine CAPEX and Rs. 208 crore will be capacity expansion.

Nikhil Mathur: In the cash balance, there is a difference of Rs. 100 crore again in the audited and the proforma balance sheet that you have given, some technicality here as well --?

Yogesh Sareen: So, if you read the very first page that we have put out there in our investor or earnings update, you will find what the difference is for. We have the PHFs where we control the medical operations through the Hospital Management Committee; we have a 3:2 ratio so we control the operations. Since it is a medical services agreement, we are not able to consolidate the PHF financials with the Group financials. So, what we do is we do a memorandum consolidation for the investors, get it certified and that's how we report the numbers to the investors. So, if you read the very first slide that would clarify this doubt that you have.

Nikhil Mathur: On the bed expansion plans, I think in the last investor presentation there was the page that you share regularly now that Shalimar Bagh has come on stream, we should refer to that bed expansion plan in the previous investor presentation, that still holds or how should we look at the expansion plan?

Abhay Soi: That is right. Except for the Max Saket (Smart) site – as we said there is a little bit of delay there, everything else is going to be in line.

Nikhil Mathur: And what's the CAPEX plan for FY24 both routine as well as ongoing projects?

Abhay Soi: Routine would be Rs. 170 crore and ongoing projects would be Rs. 900 crore.

Nikhil Mathur: So, Rs. 900 crore plus Rs. 170 crore?

Yogesh Sareen: Rs. 900 crore would be for the capacity expansion, which is on the ongoing projects, and around Rs. 170 crore will be on the routine.

Nikhil Mathur: On the international footfalls, how should we look at growth in this business in the coming 2 to 3 years? Now FY23 has been pretty strong at 43% kind of growth. Do we expect to grow in FY24 as well on this particular base? And not just short term, what are your thoughts on the 2-to-3-year horizon as well in the growth of international business?

Abhay Soi: I think I have said on numerous occasions before that there is an exponential opportunity, and what we are seeing is only incremental. And now the Government has put its weight behind it. Hopefully, we will be able to tap it in the medium run, but in the short run we will still see incremental gain. I am going to avoid giving you any sort of guidance on the number, like I avoid on every other financial parameter as well. But we believe this is a space where we have not even hit the tip of the iceberg.

Nikhil Mathur: I also read somewhere, I don't know how true this is, that Delhi NCR accounts for almost 70% to 80% of international footfall that come into the country.

Abhay Soi: 40%.

Nikhil Mathur: And one final question, the tariff hikes whether on the PSU front or whatever you are contemplating on the packages side, is it a reflection of supply demand balance

being in favor of private hospitals at this point of time in Delhi NCR and do you think we foresee that this is likely to be an industry phenomenon not just specific to Max?

Abhay Soi: No, this is an industry phenomenon. CGHS rates are for the whole country.

Nikhil Mathur: This is in response to the news that had come in that government has allowed some price hikes on the CGHS side.

Yogesh Sareen: Yes, and by the way, the last price was fixed in 2014. It is a revision after 9 years, in a way.

Nikhil Mathur: But you are also considering revising prices for the packages, I mean, which is --?

Abhay Soi: No, that is also government.

Nikhil Mathur: That was on the government side.

Yogesh Sareen: Yes, so they just revised the prices for four elements. Other billing items for example, pathology, radiology, blood bank, packages, surgeon charges etc. all those things are under consideration –

Abhay Soi: Lot of things we do under package right? It is not itemized billing, say in case of CABG or C-section. They have not increased the C-section or the CABG package rates. They have increased the room rents, the doctor visit charges, etc.

Moderator: Thank you. We have our next question from the line of Lavanya Tottala from UBS.

Lavanya Tottala: I just wanted to get a clarification on these packages, so is the tariff hike only related to CGHS packages or is it something related to diagnostic business of Max also?

Abhay Soi: No, so right now they have not increased the diagnostics. Like Yogesh mentioned, out of only 12% of the revenues or line items that account for 12% of the revenues, price increase has happened over there and it is up to 70% increase. For balance 88%, which includes diagnostics, includes packages, and includes a lot of other things, has not happened. It is under consideration by the government and we have been told by July there may be some visibility on this.

Yogesh Sareen: Ma'am, do not mix the CGHS price increase with the other price increase. There is 29% bed share by PSU where the tariff is given to us by the state, Central Government actually. So, we are talking of that element of the business. For the other business, we do increase prices. We have increased pricing from 1st April. We also increase the prices with insurance companies as and when their contracts become due. So, just do not mix the two.

Lavanya Tottala: So, that's the reason I am just asking for clarification that this is everything the discussion is related to CGHS and nothing related to the Max --?

Yogesh Sareen: That's right.

Lavanya Tottala: So, Max Diagnostics are we planning to put any price increases for just diagnostic business -- in general Max diagnostic business?

Yogesh Sareen: There are two elements to the diagnostic business: one is in-hospital diagnostics and the other is outside retail business. For the in-hospital diagnostics, we do increase prices every April and we have done some bit of it this year as well. For the non-

captive pathology business or the retail business, we have not increased any prices there.

Lavanya Tottala: And on the ARPOB I understand that increase in ARPOB is supported by higher international contribution this quarter. So, do you expect an increase in international business in the coming year FY24 or do you think that we have reached the optimal level in Q4?

Abhay Soi: So, I think I have answered this question earlier. Like I said, there is an immense opportunity, exponential opportunity in the medium run. In the short run, it is still incremental. Nevertheless, I think it is clearly going to be incremental. It is nowhere near the peak. I mean with the comparative advantage that we have, there is no reason for it to slow down. It should only snowball and become much larger.

Lavanya Tottala: So, I just wanted to check because we have already crossed the pre-COVID level, so it should be incremental from here, but not a jump or significant jump that we have seen over last few quarters. So, I just wanted to check that.

Abhay Soi: It is a 10% growth quarter-on-quarter in international. Even pre-COVID you had a very good clip of growth. If you look at even pre-COVID levels, the growth rate was not slow. I mean actually 2 years later to go up 20% over pre-COVID levels means you still haven't caught up to the rate of growth.

Moderator: Thank you. We have our next question from the line of Andrey Purushottam from Cogito Advisors.

Andrey Purushottam: I just had a question on the 87% increase in PAT on Q4 '23 compared to '22. I can make out that there has been an increase in international business, I can make out that there has been a decrease in institutional business, I can make out that there is an increase in occupancy. Could you give some more granular insights as to what are the elements of the channel or payor mix that have contributed to this 87% increase?

And if you think that many of these profit drivers will remain in the future.

Abhay Soi: You want me to describe this 87% increase impact?

Andrey Purushottam: Yes.

Abhay Soi: Every line item before that?

Andrey Purushottam: No, not every line. I am just saying I have identified, as I said, 3 of those factors. Could you just give us a broad sense of which are the other specific factors when you channel mix and payor mix that have additionally contributed to this 87%?

Abhay Soi: It is payor mix, it is clinical mix, it is better cost management, lower consumption ratios, lower finance costs. I mean it is pretty much everything, but cost management other than payor mix and channel mix.

Andrey Purushottam: Anything specific in payor mix, apart from what I have outlined --?

Abhay Soi: In payor mix, there is a reduction in PSUs, while the cash, insurance and international business has grown. Effectively, it is not about reducing PSU, but it is about increasing these three other elements.

Andrey Purushottam: And you think that the operating margins of 28.2% or so are maintainable in the future?

Abhay Soi: I focus more on EBITDA per bed, not operating margin, because you would rather do a $10,000 surgery and have a 20% margin than do a $2,000 surgery and have a 50% margin, right. I think the question really is that the EBITDA per bed, even if it means lower margins tomorrow, going to increase tomorrow or not, because that is really what matters from EBITDA overall growth standpoint as well as ROCE standpoint. That, in my mind, will grow. We will continue growing.

Yogesh Sareen: We have the numbers Quarter 1 was 26.6%, Quarter 2 was 27.7%, Quarter 3 was 28.3%, and this quarter it is 28.2%. So, obviously that means it has been consistent, right?

Abhay Soi: Over last quarter, there has been an increase in EBITDA per bed, but if you see the margin, it is marginally lower. But we are happier about the fact that EBITDA per bed has increased. That is why your overall EBITDA has increased.

Moderator: Thank you. We have our next question from the line of Prakash Agarwal from Axis Capital.

Prakash Agarwal: Just trying to understand this 4% to 5% price increase is limited to the 17% to 20% of the total mix, is that right?

Yogesh Sareen: 29% of the beds are occupied by the PSUs, which constitute around 17.5% of the revenue right. Now out of this 17.5% --

Prakash Agarwal: 17.5% in value terms, which is about 4% to 5% in terms of pricing.

Yogesh Sareen: Yes, so I would say that if nothing else happens, then there is a 4% to 5% increase in the price. Now, we do expect price increases in the other elements because you cannot increase the room rent only for open surgery. You have to increase the packages as well. The moment you admit that the room rent has to go up that means it has to go up for the room rent component under packages as well.

Prakash Agarwal: So, the current increase is 4.5% on 17.5%?

Yogesh Sareen: Yes, that is what I am saying.

Prakash Agarwal: And you also mentioned that every year you take some price hike around April. So, that is more standard across the board in the hospital business?

Abhay Soi: That is right, yes.

Prakash Agarwal: So, that is 2% to 3% or it's like a high single digit kind of increase?

Abhay Soi: No, it is 2% to 2.5%.

Prakash Agarwal: So, what I am trying to understand, we had fairly good ARPOB increase last year and couple of years, just in terms of headroom of growth we do have international lever, we do have case mix, payor mix levers. So, then 10% to 12% is not way too off to model for this year as well, would that be right?

Abhay Soi: I am going to avoid giving you guidance on that Prakash, like I always have. But there is no reason for it to not climb.

Prakash Agarwal: And secondly on the volume side, occupancy side on a blended basis is 77% and we would be having few hospitals, which are 80% to 85%. So, I am just trying to understand the headroom in terms of, you mentioned that you have focus on growth in the preferred channels A, which is more on the pricing, but immediately how can we improve the occupancy or we are already operating at an optimal level of occupancy?

Abhay Soi: No, look I think that at certain places where you have absolutely hit the capacity, over there you will automatically start distilling. The levers that we have are the following: one is that at the very sort of end when you start pushing the envelope, there is some elasticity in terms of operations. We were earlier at 75% to 76% and now at 77% to 78%, but we also operate at 80% to 81%. So, each one of these facilities will have more efficient system of discharging and so on and so forth when it starts coming to the edge.

Second is, we have mentioned that about close to 100 odd beds internally that we are unlocking: 10 beds here, 20 beds here, 30 beds here, so on and so forth. 100 beds is about 3% of the total capacity. A couple of percentage points through occupancy and that gives you about 4% to 5%. On top of that, we also have the payor mix distillation that we can do as and where necessary.

Third, finally – but what you want to do is first you want to maximize on the first two, then you want to move to the payor mix distillation and – then finally you have another 300 beds coming in. Then by next year, nearly every hospital will have its own beds coming.

Prakash Agarwal: And this CARE Hyderabad one is finally not happening right?

Abhay Soi: Well, I will not say that because we have sued for specific performance and the matter is in arbitration, it is sub-judice so I will not delve into it. But, we have asked for specific Performance over there.

Prakash Agarwal: Okay, because I read Blackstone is getting into that so I was just checking on that, okay. Lastly, on the regulatory side off late there has been news flows on having reservations for the government as well as the poor and the needy. I mean there is too much unverified information. So, is it happening somewhere? Is it already happened? It had already happened, you know, in the past and it's just a rehash or if you could just --?

Abhay Soi: I think you rightly put it. Firstly, I think there is way too much being made out of something way too little. First and foremost, please understand that there is already a Right of Health across the country, through a Supreme Court direction. If a patient comes dying or a trauma patient comes into hospital you cannot say show me your wallet first. You have to take him in and stabilize him. That is Right to Health even as per Supreme Court. No hospital would ever even think of not doing that. I mean, really, if somebody was to do that you will read about it in the papers. That is how rare it is. And you have seen those situations before in the papers, etc. No proper hospital will you know deny a patient.

Let us say somebody comes to a hospital, it is an accident patient and a number of these patients come year on year. If we were to actually reject that patient – firstly, it is against our own policy. It is against the Supreme Court strictures. More importantly, if you do something like that, the media will string you, it will hang you. It is inconceivable to do any of these things.

Secondly, most states like Delhi NCR, Delhi, particularly, already for the last 10 years has the Delhi Arogya Kosh (DAK), which basically means that any accident victim comes over to your ER, DAK will pay you some money for it. Now the fact is in any case we were doing it free.

Now in Rajasthan, they pretty much rehashed the same thing and they said no, no Right to Health. Right to Health in emergency, which already exists.

Prakash Agarwal: So, this is limited to emergency and not routine surgery etc.?

Abhay Soi: No, only emergency. Even in Rajasthan, it is purely emergency. In fact, they have diluted it down by saying it is not applicable to the private sector, it is only applicable to hospitals, which have been funded or subsidized by the state government. That is the clarification given by the Rajasthan Government, which itself doesn't make sense because it is not as if at a private hospital when somebody goes, then you are going to reject the patient. You would still do it free.

Prakash Agarwal: Just one last one on the trust hospitals we also do a set reservation for the poor and the needy. Is that right?

Abhay Soi: That is right. Every quarter when you see our results, you will see those numbers being announced.

Yogesh Sareen: So, not only trust hospitals but also some of the hospitals where we have bought this land in auction, in the listed company, there we have some obligation to have 10% beds free and we do provide for them.

Prakash Agarwal: Lastly, congratulations for Shalimar Bagh – turning it EBITDA positive in month one itself in March.

Abhay Soi: Yes, EBITDA positive in the first month and giving a 35% to 40% EBITDA margin on the incremental revenue. This is something that we have always spoken about – Brownfields do not suppress your EBITDA, in fact, they are accretive. We have always said that they will break even in the first quarter or two and obviously, we want to give you a more conservative estimate. Now you have seen the operating leverage come in.

Moderator: Thank you. We have our next question from the line of Tushar Manudhane from Motilal Oswal.

Tushar Manudhane: On PSU tariff revision, how much of a spread would get reduced in terms of EBITDA per bed with this price hike compared to say non-PSU or non-institutional patient EBITDA per bed?

Abhay Soi: It will actually rise per bed, because of the price hike.

Tushar Manudhane: No, the perspective here was that in the hospitals where we are already running up at a very high occupancy. That way we have a choice in terms of selecting the patient or distilling the patient as you pointed in the earlier commentary. So, just trying to understand is this sufficient enough to reduce that spread for EBITDA per bed through the patient payor mix?

Abhay Soi: No, it will not. But what happens is that if tomorrow I want to switch off 100 beds, yesterday I only needed to fill 40 out of those 100 PSU beds to breakeven and to make back the money that I am losing by switching off those 100 beds. So, I would

get 60 more beds to work with. Now that number from 40 has gone up to say 55, tomorrow that number will go up to 70 or 80. So what happens is that it becomes marginal, but does it get to the same amount? No. So yes, I think what you are going to see is that your trajectory sort of changes, but directionally you are going in the same direction. Albeit, you are doing it without impacting EBITDA, and well it's actually a more preferred approach since you are taking a fiscal call on the basis that it is going to be more accretive with these new numbers rather than less.

Tushar Manudhane: And if you could also clarify this tariff, the proportion of PSU patient pool is higher in which hospital or rather which cluster of hospitals of Max healthcare?

Yogesh Sareen: We do not give hospital wise data. You have to understand that the hospitals, which are fuller, there the proportion would be lower and where it is less full, they will be having more --

Abhay Soi: For higher occupancy, we have obviously moved away from that right. The lower occupancy places is, like Yogesh said, where you have higher amount of PSU. So, anywhere where your occupancy is getting higher, say to 80% to 85%, you start moving away from this business, you start distilling it over there. You do the business where you have idle beds.

Tushar Manudhane: Lastly on this Gurgaon thing is no more land coming up for auction.

Abhay Soi: No.

Tushar Manudhane: Because we have seen other hospitals also having some land parcel in this area. So, is there more area available for hospital expansion as such or this is more or less done from the government side?

Abhay Soi: Look, I think it is like Mumbai, right. I think you can have Central Bombay and you can have some place in Mulund. If you look at Gurgaon, the question is where in Gurgaon, Gurgaon extension, northern extension, etc., but where exactly. On the main Golf Course Road, there is no land available.

Tushar Manudhane: So, the intention to understand was within that particular area where the hospital space is supposed to be sort of premium so in that space, there is no land parcel available?

Yogesh Sareen: Not that we know of, yes.

Moderator: Thank you. We have a next question from the line of Raj Rishi from DCPL.

Raj Rishi: Just wanted to find out if presently obviously the situation is great for you guys. How long do you think this supply won't come in looking at the present fantastic scenario? Like, right now the demand supply gap is huge, which is why your occupancy is what it is. So, whenever the situation is so robust, obviously new supply is going to come in – in various geographies.

Abhay Soi: Not necessarily, I mean no new hospital has come up in Mumbai in 20 years, because there is no land available. No new hospitals have come up in Delhi for 12 years, maybe one, because no land is available. How do you get land in these metros and land at viable cost, right? If you want to buy land, you have to understand there is a height limit of 45 meters when you set up a hospital. If you want to set up a 400-bed hospital, you need 4 to 5 acres of land, contiguous land. Where do you get it in Delhi and Mumbai?

Raj Rishi: That's right.

Abhay Soi: One of the biggest plus points that we have is that we have this land in our network, in our system.

Raj Rishi: And Abhay you had mentioned medical tourism going up many times by 2030. So, how do you see it, like what is the size presently and where do you see it in 2030 for the sector I am asking?

Abhay Soi: You know, if you are saying 2030, there is such a massive comparative advantage that we have in India. I mean we are less than 5% of the cost of the U.S. We are less than 30% of Singapore. We are less than half of Thailand. I mean, look, it is not like rich people from the U.S. will start coming to India. But in my case that's the largest part of the world pyramid, where the bottom is all self-paid. And for them, affordability is an issue. This has the potential of surpassing the IT sector. That is the amount of comparative advantage that we have and no other country has such advantage.

I think because the comparative advantage that you hold in this space, no other country even comes close. Whilst in IT other countries may come close, here there is nothing. The sheer volumes and complexities our doctors handle, what they do in a year, the Western counterparts do not do in a decade. Our skill sets are right up there and our cost is fraction of the global cost. Aging population, rising costs, most government treasuries going bankrupt, this is going to be something else. This is not even the tip of the iceberg right now.

Raj Rishi: And Abhay another thing, just a thought, like generally when private equity guys are so heavy on sector it seems that it's sort of topping out when smart guys like Emami or Manipal dilute and private equity guys buy. It's just a thought, I mean what are your comments on that?

Abhay Soi: No, I do not disagree, I think you had hospitals and hospital chains change hands many times.For Manipal, I think this is the 6th or 7th private equity round that they have done in Manipal Hospitals over the last 10-12 years. If I look at, it is not as if Max was not up for sale, we bought Max. It is not as if other hospitals were not up for sale. Those transactions also happened in the past.

I do not think it is a question of tapping out. I think there is very clearly a multi-decadal opportunity to invest in this sector in India, which is much more true today, but it's not something which was lost in the past either. The only difference was the biggest critique and I remember when we were listing the company in 2020, now most of you will bear this out, right. The biggest critique of this sector was that the Indian Healthcare sector is a great investment but it is a mirage because there are no free cash flows. How do you invest? You have to keep raising money and keep reinvesting.

We have Rs. 1,281 crore free cash flows coming with Rs. 1,636 crore EBITDA. That is almost 80% throughput of the free cash flows. And you are seeing this, we are not raising any capital. My entire 2,900 beds is at a cost of Rs. 4,500 crore and that should not even be 50% of my free cash flows over next 4-5 years. And that's on a debt free balance sheet. Today this is the compounding. There is a massive multi-decadal opportunity to invest, I think, and to create infrastructure, so PE and all sorts of funds are going to be coming in.

Raj Rishi: Just one last question, how do you see this asset-light model? How heavy can it be for you guys?

Abhay Soi: Sorry, just understand one thing. A PE puts in money at valuations and they need to underwrite 20% to 25% IRR in dollar terms. So, only because they are seeing this opportunity and I believe Manipal for example was probably done at 29 to 30 times 2024 EBITDA. Those guys are expecting to do 25% CAGR from there on dollar. On the contrary, I think when PEs come in they see opportunity.

Raj Rishi: One last question about the asset-light model, how heavy can it be for you guys? Like are you thinking of increasing that part of the business?

Abhay Soi: Well, I think quite heavy from that standpoint. I think over the next couple of quarters you will be coming across some announcements from us on this front. This is really the way for us to grow particularly where we are looking at any form of Greenfields. We do not like to build on our own. We like to collaborate because it decreases the construction and development risk, particularly in geographies that we are not currently present in. So, I think you are going to see some of those come through now, because that's going to be a big focus area for us. We have a 36% cash-on-cash ROCE, so we can afford 8% yield to developers.

Moderator: Thank you. We have a next question from the line of Neha Manpuria from Bank of America.

Neha Manpuria: Abhay, you mentioned improvement in specialty mix quite a few times. And if I were to look at the chart maybe through the profile obviously there is improvement in oncology, a little bit in Neuro, Cardiac. So, are the beds that we are adding essentially focusing on doing more higher ARPOB work like adding more Onco beds etc. or are we seeing the kind of work that we do within Cardiac, within Neuro itself increase that is improving this specialty mix. So, how do I differentiate between the two?

Abhay Soi: I think it is a combination of the two. First and foremost, if you look at capacity spread and you look at overall ARPOB, the ARPOB that you see of Rs. 70,700 is a summation of ARPOBs. When you see our occupancy is 77%, it is a weighted average. It means there may be some hospital, which is operating at 70% occupancy. There may be another one, which is operating at 90% occupancy.

Similarly, in ARPOB you will have certain departments that are low ARPOB. You will have a certain payor mix that is lower ARPOB. Yet, you are hitting the capacity thresholds. Firstly, if you are hitting capacity thresholds, then you are going to look at expanding over there. What you would seek is that if today I am creating more capacity and I was to take my lowest payor mix and my lowest ARPOB specialty there, that is really what I am creating it for. Any expansion that you are doing is serving the lowest common factor because that is what you are doing it for. Otherwise, if you were not to do that brownfield field expansion, what you are going to do is you are going to distil your payor mix and you are going to distil your clinical mix.

Neha Manpuria: But it could also be I am asking this one is let's say I am adding more Onco beds or I am adding more OT or ICU beds because of the improvement in the clinical --

Abhay Soi: What is an Onco bed? You know a lot of our beds are fungible, except for some daycare beds etc., but the beds are all similar. I mean in Cardiac, for example, there may be a Cath lab, but the OTs are similar. It's sort of quite fungible within the hospital, you have to understand that. We may segregate it and we may do some clinical programs there. But the way I will value it, please understand this, is that say I have 100 beds, of which say 50% beds are very high ARPOB and 50% beds are low ARPOB, and they are fully occupied. Then when I look at creating another 50 beds, the way I will calculate it is to take my lowest ARPOB of 50 beds and to put it

over there. Alternatively, my opportunity is to just play the lower ARPOB out and occupy my current facility.

Neha Manpuria: So, essentially that would mean you either add a new specialty or add doctors, which will allow you to remove that lower ARPOB work, right?

Abhay Soi: No, even if you don' do that and a lot of that stuff could be aspirational, right. Today when you have a waiting list of two or three days in your ER for patients, you know there is unsatiated demand at your doorstep. I mean take Shalimar Bagh's case-in-point. We put up an Onco block over there, so what happens immediately is that the oncology patients from our current facility or the pre-existing facility move into the new Onco block. So, what happens to the old block? Our high ARPOB business may have gone out but the lower ARPOB business has started climbing up over there.

When I evaluate setting up 100 beds in the new block, I have to evaluate vis-à-vis the low ARPOB business and not the high ARPOB business, even though I may be doing it for the high ARPOB business. Yet what you see is that even without adding much doctors, etc., within the first month we broke even and hit a 40% EBITDA margin. We have overall an occupancy, now this is what matters, of this incremental facility as well as the existing facility, of the entire hospital of 83%. I mean, I am not saying it is 83% of the new 100 beds, I am saying it is 83% of 300 beds.

Neha Manpuria: The reason why I am asking this is for example we added the new Onco block, so that's not necessarily increasing my entire Onco contribution quarter-on-quarter. It could just be moving patients to the new block to unlock sort of free capacity to move on.

Abhay Soi: There is some increase, but really it is not a jump increase that happens because you have opened a new block. Of course, the new Onco block will have a disproportionate increase in Oncology, but it is not as if other services are not increasing.

Let me put it this way, let's say a hospital of mine has 50% PSU business and 50% other business and is running at full capacity. When the question comes about expanding over there, when a note is put up to expand, my first question is whom are you expanding for? Are you expanding for PSU? Because alternatively you could be distilling the PSU. So, for that expansion, whatever specialty that goes there is irrelevant. You obviously put up the specialty with the highest ARPOB, which will be more accretive etc., but it has to be evaluated looking at the lowest opportunity.

Yogesh Sareen: Neha, the hospitals are passed on both fronts: one is that within this specialty they have to work on increasing the quantum of procedures, which are high teen procedures. Then they are also supposed to allocate more beds and fill up more beds for high ARPOB specialty. So both things play into it and that's what the hospital's job is.

Neha Manpuria: And is there any way for us to sort of segregate as to how much of our ARPOB increases come, let's say from an improvement in specialty --?

Yogesh Sareen: So, I can tell you that say the Quarter 4 increase is 5%. Around 2% of this is because of the procedures within the specialty, which means that with the same number of beds for each specialty, the specialty ARPOB has gone up. Around 2% of this is because of relative change in the Occupied Bed Days (OBDs) to the specialty. The Occupied Bed Days of Oncology and Cardiology, etc. have gone up, and they are high ARPOB specialty. The mix has changed of the beds - that is 2% impact and 2%

impact is that within the specialty the ARPOB has gone up. I am talking about overall increase.

Neha Manpuria: The entire quarter-on-quarter increase.

Abhay Soi: Yes, I am saying 5% increase, 2% is from here, 2% from there.

Moderator: Thank you. We have a next question from the line of Amit Thawani, an individual investor.

Amit Thawani: My first question is can you tell me what the price increase that we have got in by the PSUs?

Yogesh Sareen: So, Amit there are four elements where the prices have increased: one is on the ICU beds charge; second is the normal ward bed charge; third is the IP consults and fourth is the OPD consults. OPD consult has gone up from Rs.150 to Rs.350, IPD from Rs.300 to Rs.350. These are the prices changes. So, overall average if I take, it's a 70% price hike we have got. This is after nine years; the last one was in 2014.

Now the point is, this is only a small quantum of the line items that get billed to the patients in the PSU. So, we do expect that there will be further price increases by the government because if the room rent prices increase, that means that the room rent, which is part of packages will also go up, right. Let us say cardiac surgery, there is 12 days stay and there is a package charge that we charge to the PSU patient, that should also go up. The CGHS authorities have put up a note to Finance Ministry, etc. so we expect that there should be a decision on that by July.

Amit Thawani: So, just trying to understand the institutional business is 20% of our sales. So, how much of that could….

Abhay Soi: In bed share, understand that bed share is 29% and revenue is 17%. Now for 17% of revenue, 12% of that 17% will go up by 70%. That is a net impact of 4% to 5% on the institutional part.

Amit Thawani: My second question is the digital revenue is about 18% of our overall sales. Just trying to get a sense of what the margins on that digital revenue are. Is it higher than the overall margin of the company or is it lower?

Abhay Soi: No, it is just a channel. People used to call up earlier. People would come to hospital as walk-ins. Then they used to call up call centers. Now they will do it through digital platform. They are booking appointments, so your margin does not change. You can go into customer acquisition costs, advertising, etc. but that is meaningless here.

Amit Thawani: So, the press release said digital revenue from online marketing activities.

Abhay Soi: That is right, digital revenues means it is digital booking. If you book a liver transplant through our website, then that is digital revenue.

Yogesh Sareen: If you come on the website, we track the patient footfalls on the website and then we see conversion from there. So, if there is conversion from the website that is accounted as digital revenue.

Amit Thawani: My last question is on the contribution of ALOS to ARPOB, we saw the ALOS go up this quarter.

Abhay Soi: Look, ALOS is meaningless, right. A hospital that does more complex surgeries will have a longer ALOS. If I do a bone marrow transplant, the ALOS is 20 days. If I have a liver transplant, and this is the business you want actually, the ALOS is longer than doing non-surgical work. When you do more surgeries, you have more ALOS, but all of it plays out in ARPOB. Eventually what is it that you have, you have inventory and you want to earn the maximum in a day from there. So, it is all based on the ARPOB. No point having a very short ALOS and having a lower ARPOB. You would rather have a high ARPOB. You have beds into days in a year, so what you want is higher amount of revenue from each of the days.

Moderator: Thank you. We have a next question from the line of Alankar Garude from Kotak.

Alankar Garude: Abhay assuming the CARE acquisition does not go through, can you help us understand whether there are any meaningful acquisition opportunities of hospital chains left in India which fit your criteria?

Abhay Soi: Yes, plenty.

Alankar Garude: And we do not have any preference on geography, right. It is just the criteria, which you have of two players being successful and you preferring a cluster approach.

Abhay Soi: That is right. I mean our approach is a little more less casual than just that. We have worked out a list over 20-21 cities, but that is an important criteria. What we find is that at the umbrella level, these are the places that typically will have the demand, supply, doctors, etc. and so we will be comfortable over there. I am putting it very simplistically by saying that at least two or three of my competitors have proven viability. In each one of these cases, this is what I find common. You read the profiles that we want to take. We are not pioneers; we do not like to go to uncharted territories.

Alankar Garude: And the other thing is, would it be fair to assume that most of these would be standalone assets now or if at all just two, three hospitals per chain or there are still say chains operating five to 10 facilities across India, which are on the block right now.

Abhay Soi: I think there are plenty of conversations happening and you are going to see consolidation. Firstly, consolidation happens because there is a requirement for those conversations, right. I mean in the case of Max Healthcare, you have seen Rs. 1,636 crore of EBITDA translating into Rs. 1,281 crore of free cash flows. Now typically for some companies and most mid-sized players that you will see, will have a Rs. 500 crore to Rs. 600 crore EBITDA and their EBITDA translates to a Rs. 200 crore to Rs. 300 crore free cash flow at best. This is pre-Ind AS, post maintenance CAPEX, post any increase in working capital and taxes. Now this is a capital-intensive sector, so if you have Rs. 200 crore to Rs. 250 crore, you can build one 500-bed hospital every four years. That is all you can do, one hospital every four years. If you are a listed company or unlisted, where do you go from there?

Alankar Garude: So, my question was more from some of our peers especially the unlisted peers being quite aggressive on the M&A front and also private equity interest in the space continues to remain quite high.

Abhay Soi: Look, I will tell you something that there always be some people trying to outbid you. What is it that we look at? Our criteria is very simple, I want to look at a 20% ROCE three or four years down the line or four or five years down the line. If we have a clear line of sight and visibility of that ROCE, we will come in. Now a PE fund. Typically, will be getting excited at the multiples that they are paying. But our ability

to underwrite an EBITDA or a business case, four-five years down the line is much more pronounced than a PE. I mean, for us to underwrite, let us say, in situations where we believe where 2x or 3x or 3.5x of EBITDA, is very possible three or four years down the line. For a PE to underwrite that gets very difficult. So with the amount we are willing to pay at the outset is a derivative of that, of where I believe I can take the business four years down the line. Do keep in mind, our EBITDA per bed is the highest in the industry, you know that, by 50% to 55%. A PE cannot underwrite my case. He has to underwrite the industry case.

Alankar Garude: And the second one is more of a quick clarification. So, is it now fair to assume that we may not reach that 15% institutional volume mix number by March '24? But given that we are operating at high occupancies, the institutional volume mix will still gradually keep on coming down.

Abhay Soi: No, it will come down. We have done a bit of a pause, like I said, because we are expecting some increment, although it is still coming down. We have also found more capacity. We have more elasticity in operations. The price is moving up. It is not going to reach 15% immediately but your trend is going to keep reducing over there because eventually, it is finite, right. I can suffer that higher price for some time, but it is still not the same as my CTI business.

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

Abhay Soi: Thank you so much for being on the call. I think this has been a seminal year for us on many counts and we are happy to have most of you as our investors and the rest of you, we look forward to them joining our cap table. So, thank you very much.
