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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
25th Floor,
Phiroze Jeejeebhoy Towers,
Dalal Street,
MUMBAI - 400 001
Scrip Code: 543220

Sub: Transcript of the earnings call on financial results of Q2 and H1 FY23 of Max Healthcare Institute Limited ("the Company") held on November 02, 2022

Dear Sir / Ma'am,

We refer to our intimation dated November 02, 2022, w.r.t. uploading of audio recording on the website of the Company, of the earnings call hosted on November 02, 2022 to discuss the financial results of the Company for Q2 and H1 FY23.

In this connection, pursuant to Regulation 30 of the SEBI (Listing Obligations and Disclosure Requirements) Regulations, 2015, please find enclosed the transcript of the said earnings call. The said transcript is also being uploaded on the website of the Company i.e. https://www.maxhealthcare.in/investors/investor-resources

You are requested to take the above on records

Thanking you

For Max Healthcare Institute Limited

RAKESH KUMAR KAUSHIK

Rakesh Kumar Kaushik
Interim Compliance Officer

Encl: as above

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Max Healthcare Institute Ltd
Q2 and H1 FY23 Earnings Conference Call Transcript
November 02, 2022

Moderator: Ladies and gentlemen, good day and welcome to the Max Healthcare's Earnings Conference Call. Please note that this conference is being recorded. I now hand the conference over to Mr. Suraj Digawalekar from CDR India. Thank you, and over to you, sir.

Suraj Digawalekar: Thank you. Good morning everyone, and thank you for joining us on Max Healthcare's Q2 and H1 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. We will begin the call with opening remarks from the management, following which we will have the forum open for interactive question and answer session.

Before we begin, I would like to point out that some statements made in today's discussion may be forward looking in nature, and a disclaimer to this effect has been included in the earnings presentation shared with you earlier.

I would now like to invite Abhay to make his opening remarks. Thank you and over to you Abhay.

Abhay Soi: Very good morning to everyone. We are pleased to welcome you to Max Healthcare's Q2 earnings call. Let me start by giving you updates about the company performance for the quarter.

Like the previous quarter, this was a normalized quarter. We witnessed a steady growth in occupancies driven by improved patient footfalls from international and insurance segments. There were concerted efforts to unlock value through previously articulated growth levers. Consequently, we delivered our best ever performance for the second consecutive quarter this financial year.

A significant development this quarter is that we are now a Net Cash Surplus company. Compared to a Net Debt of Rs. 217 crore at the end of Q1 FY '23, we have a Net Cash Surplus of Rs. 42 crore at the end of this quarter.

We are also happy to share that our digital app, Max MyHealth, has been successfully launched at the end of September 2022. The app has enhanced the experience of both patients and clinicians in our ecosystem. It provides a gamut of services including pathology, radiology, ambulance, home care, and facilitates physical and virtual consults among other things. It also provides access to patients' health records and trends at the click of a button.

Before I move on to the highlights of this quarter, please note that in Q2 last year we had a revenue of Rs. 91 crore and an EBITDA of Rs. 25 crore from COVID-19 vaccinations. Since this was a non-recurring revenue, the comparative numbers and percentages are thus being reported on a like-to-like basis.

Key highlights of our performance in Q2 are:

Occupancy for the quarter improved to 78% from 74% in Q1 FY '23 and 75% in Q2 FY '22. Institutional bed share has been brought down to 28% this quarter from 30% in Q1 FY '23 and 37% in Q2 FY '22, in line with our strategy. Consequently, the institutional revenue share dropped to 16% compared to 23% last year.

Revenue from international patients grew by 16% quarter-on-quarter and reflected 110% of pre-COVID average, despite negligible patient footfalls from Afghanistan, a key territory for us that contributed around 12% of the revenues previously.

Network gross revenue rose to Rs. 1,567 crore, our highest ever, reflecting a growth of 6% quarter-on-quarter and 17% year-on-year.

ARPOB for the quarter was Rs. 66,000, same as previous quarter, but grew 12% year-on-year. The mix of medical patients went up compared to last quarter due to seasonal infections, and this was reflected in the lower ARPOB. Increase in ARPOB over Q2 last year was led by improvement in the payor mix and case mix as well as annual price revisions.

Network operating EBITDA for Q2 FY '23 was Rs. 410 crore compared to Rs. 370 crore in the previous quarter and Rs. 337 crore in Q2 FY '22, reflecting a growth of 11% quarter on quarter and 22% year on year. Indirect overheads were up during the quarter due to relatively higher provisioning for CGHS bills outstanding beyond 365 days in line with our tight provisioning policy, seasonal cost increase for power and marketing expenses related to international patients.

EBITDA margins improved to 27.7% versus 26.6% in Q1 FY '23 and 26.7% in Q2 FY '22. Annualized EBITDA per bed, most importantly, rose to Rs. 64.3 lacs, our highest ever, clocking a growth of 4% quarter on quarter and 17% year on year.

Q2 FY '23 PAT was Rs. 267 crore versus Rs. 229 crore in Q1 FY '23 and Rs. 207 crore in Q2 FY '22. This excludes gain of Rs. 244 crore in tax expenses due to reversal of deferred tax liability relating to intangible assets transferred to MHIL pursued to voluntary liquidation of Saket City Hospital Limited.

During Q2, Rs. 28 crore was deployed towards ongoing capacity expansion projects. Construction of 100 beds at Shalimar Bagh and 300 beds at Dwarka is on track, and we expect them to be commissioned in last quarter of FY '23 and first half of FY '24 respectively, as indicated earlier. The outlay for some of the expansion projects has been deferred in view of ongoing discussions with some of the world's top contractors for faster build out.

Digital revenue grew to Rs. 242 crore and accounted for 15% of overall revenue.

Continuing our effort to give back to the community, we treated ~39,700 OPD and ~1300 IPD patients from economically weaker sections of society free of charge.

Both our strategic business units continued their growth momentum. Max Lab reported a gross revenue of Rs. 30 crore. This reflects a growth of 21% quarter-on-quarter and 65% year-on-year, on like-to-like basis. We added 65+ channel partners during this quarter, taking the overall active clients to 900+ and now offer our services across 34 cities. You may keep in mind that we have made huge investments towards Max Lab for the organic growth in the past quarters.

Max@Home reported a top line of Rs. 35 crore reflecting a growth of 9% quarter-on-quarter and 26% year-on-year. Supported by a team of 800+ people, Max@Home offers services across 13 service lines and enjoys a high degree of customer loyalty.

Now, coming to the overall overview of the company financial performance in the first half of this financial year. Network gross revenue stood at Rs. 3,040 crore reflecting a growth of 17% year-on-year. Network operating EBITDA grew by 22% year-on-year to Rs. 780 crore. Increased OPD footfalls, improved case mix and reduction in institutional bed share resulted in margin expansion by 120 basis points to 27.2%, while EBITDA per bed grew by 26% to Rs. 63.2 lakhs per bed.

We continue to focus our efforts on the growth levers articulated earlier. That is, we are -- one, we are making significant investments to expand our bed capacity in the next three to four years, which is in line. Second, to complement Indian government's initiatives such as Heal in India, we continue to augment our international outreach initiatives and setting up offices across new geographies. We are also actively looking at inorganic expansion opportunities across existing and new markets, and we continue to improve our case mix through deployment of technology and hiring of new talent.

With this, we open the floor for Q&A. Thank you.

Moderator: Thank you very much. The first question is from the line of Kishan Amarchand Tosniwal from Polar Capital LLP.

Kishan Amarchand Tosniwal: Couple of questions. Firstly, how do you see the international business growth in the coming quarter?

Abhay Soi: We're very positive about it. It's been growing, like I mentioned, in the announcement that is already 110% of pre-COVID levels. This is in spite of the fact that 12% of our business, our key market was Afghanistan, where the Indian Government right now is not issuing visas. So once that opens up, you will see, and we hope it opens up shortly, because things seem to be normalizing over there, at least from, Government to Government perspective. And once that happens, you know, this will auger even better for us. It's a big thing to say that we've been able to sort of compensate and overcompensate this through other growth levers that we've invested in, in the international business. So that's done well and we are quite positive about it going forward. I think, you know, if you

couple this with the new Heal in India program of the Indian Government, you know, very similar to Make to India, which has been, sort of announced, by the Government, I think that will give us huge impetus, particularly because we have so much of our capacity in the metros.

Kishan Amarchand Tosniwal: Okay. The second part is that how is Nanavati doing after the VRS has been done?

Abhay Soi: It's been doing reasonably well. We are in mid-teens as far as EBITDA margins are concerned. Going forward, hopefully we can grow that to the rest of the portfolio as well. But like I mentioned in the past, the ROCE, it's the highest amongst the ROCEs. Although in terms of percentage, the EBITDA margins are lower than the rest of the pack.

Kishan Amarchand Tosniwal: The building that was coming up, which has been already dismantled and we started work, how is the progress on that?

Abhay Soi: Very well, I think we are well on schedule as far as that is concerned. The piling work has been completed. We are beginning excavation soon and you're going to see that online in the next two years.

Moderator: The next question is from the line of Nikhil Mathur from HDFC Mutual Fund.

Nikhil Mathur: My first question is on the CapEx plans of the company. If I look at first half, the CapEx incurred, I think is Rs. 41 crore, if I'm getting that number right.

Abhay Soi: That's right.

Nikhil Mathur: And I think the budget in the most recent investor presentation was around Rs. 657 crore for FY '23.

Abhay Soi: That's right.

Nikhil Mathur: So, any reason why this gap?

Abhay Soi: Yes, so a large amount of it was to be bunched up, towards the second half. It's a little difficult to sort of break it up. You're going to see a majority of that investment happening in the second half of the current year and first quarter of next financial year. Of course, you know, one is engaging contract engaging vendors and work starting, et cetera, but besides the mobilization advance, really the payments start happening, on delivery of certain milestones. I think as and when that happens, you will see that payout happen. It's a little -- when you're making five year plans for so many hospitals, a little difficult to sort of put it out quarter by quarter. So we put it out in a year. So you're going to see, significant investments will be complete. Invest the entire Rs. 640 crore in the second half of the year? Doubtful. But, you know, will it sort of bunch up in the first quarter, of the next year? Likely. But at this stage we are not seeing any delays on overall project schemes.

Nikhil Mathur: Right.

Abhay Soi: You know, I'll give you an example, because, when we were conceiving the projects you look at construction as usual, but then new technologies such as structural steel and hollow tubes, et cetera, which cuts down

timelines as far as the entire construction is concerned. But, it sort of takes you back a little bit into the planning stage about how to technically go about it. So that's why we don't see delays because we see benefits coming out of using, you know, alternate techniques. They may be marginally more expensive, but that's the new sort of way of doing things faster these days.

Nikhil Mathur: So it can be safe to assume that, CapEx running behind budget will not have any impact, at least on, Shalimar Bagh and Dwarka. Is that the right assumption?

Abhay Soi: Absolutely. As far as Dwarka is concerned, you know, we are hoping within the first quarter of next financial year for it to come on stream. And as far as, Shalimar Bagh is concerned it will be on stream early on in the last quarter of the current year. So Shalimar Bagh expenditure has been as per budget, as per plan, so there's no sort of delay over there. And Dwarka, as you're aware, there's actually somebody else who's constructing it and that's well on stream.

Nikhil Mathur: And second question I had on Max Lab. Now, there seems to be some pretty strong traction building up, from Max's perspective. There's quarter on quarter growth. There's YoY substantial growth in non-COVID revenues, and I think you have added quite a few partners as well, in two quarters, I think 150 partners have been added. So two questions here, I mean, A) obviously it would be very helpful if you can share the Max Lab outlook from a three-to-five years' horizon, and B) when you talk about partners, is it some sort of a franchise model or who exactly are these partner, some revenue sharing happens, if you can help us understand, a bit of construct there and how you're going about growing your business?

Abhay Soi: Yes, sure. I think, you know, the two things, one is, you know, we've been investing heavily in this business. When I say investing, both in terms of, I mean there's been -- mild investment towards marketing, but investment towards creating partners and partnerships with franchisees and so on and so forth. I think in the first half of the current year we had about 400 odd franchisees, to this, and it's a significant sort of this thing. So your EBITDA sort of gets depressed because of the investments that you're making in it. So I don't want you to kind of get misguided by looking at lower EBITDA margins or somebody actually mentioned to me, that -- from a loss making in the past quarter, that you've gone to -- marginally profitable, et cetera. But, this is on account of the new sort of, investments that you're making. I think overall, this business has always been profitable. There's no reason for it to not to be cetera. And if you were to sort of draw a line and not grow, immediately you'll see, this business coming to profitability. But that's not what the idea is. It's about, it's such an underpenetrated market and we have, such a strong sort of, brand and strategic advantage and comparative advantage compared to other players in this that we continue to invest in the business. Yogesh, do you want to sort of share light on what sort of arrangements that we have?

Yogesh Sareen: Yes, so we have obviously we have franchise model, we also have our own company owned centers. We then also have a model, which is phlebo at site (PAS). This is where we station a phlebotomist at the nursing home of a doctor et cetera, or a smaller hospital. We also have HLMs right? We do third party hospital lab management (HLM). There are more than 20 labs that we manage here, you know, big ones I would say. And then we also have pick up points (PUPs) where we -- where our

phlebo goes and picks up the samples from. So there are obviously various models. I would say the HLM is the deep discount model where we -- where we get probably 55% of the amount billed to the patient, but others would be at discount of 25% to 30%. So that's the model. And obviously company owned center, we bill at the retail price, so there's no discounting here.

Nikhil Mathur: Right. And in terms of the lab network, are only the hospital based labs being leveraged as of today, or, there are some, standalone labs as well. And, what's the lab network outlook over the next three to five years?

Yogesh Sareen: So as of now, we are leveraging the hospital lab, and not only our own hospitals, but also these HLMs that we have i.e. the third party hospital lab that we manage. So we pick up samples and try and get it tested in the nearest lab. The nearest lab well may be the lab, which is managed by us, but not owned by us. So that's the way it is, in a way they have their own labs in terms of the HLMs, but they don't have a reference lab of their own. They will certainly be looking forward to one, once the business shapes up to that level.

Abhay Soi: I mean, right now we have spare capacity in our labs, so we obviously use that, but as when there's a need for a centralized lab, I don't think there's a problem. In any case, the investment isn't too much, right? It's a very negligible sort of investment.

Nikhil Mathur: Right. So I mean, would you comment Abhay Sir, Max Lab now that it is crossing Rs. 100 crore kind of a revenue mark, if I annualize this quarter numbers, is as important a piece for the company as the hospitals? Can it be looked at that way?

Abhay Soi: Absolutely. It always has been. I think, you know, we started focusing more on it, and, in the past we also said we'd like to look at inorganic growth, but obviously, you know, sort of, numbers and valuations and, you know, the dynamics of the industry sort of changed. So we decided to kind of look at, focus on more on the organic growth as far as this is concerned. But this is always going to be a key focus area, and, you know, otherwise we wouldn't be in it, otherwise we won't be showing it as a separate segment. And similarly, I mean, you're saying this about Max Lab and similarly about Max@Home as well. And you've seen, I mean, that's a high number and it's a profitable business. It does mid-teen sort of EBITDA margins, it's the largest home care business in the country, and actually the only profitable one. And we are very excited about that as well. I mean, the traction that we are getting is essentially giving you a hospital in your, is extending a hospital to your home.

Moderator: The next question is from the line of Prakash Agarwal from Axis Capital.

Prakash Agarwal: Yes, so first question, trying to understand this occupancy run rate better. So we've been tracking very well and now touching 78%, I understand Saket and marquee ones would be one higher 85% plus. So what is the headroom here for us to -- you know, max out on the existing hospitals?

Abhay Soi: So look, I think there are two or three things that you need to look at this, in perspective. Okay? Pre-COVID level, we were at 70% to 73% compared to about 75% - 76% post COVID as a base. Now, certain quarters, and particularly quarter two every year is, that's the time when you have the rains, et cetera. So we have more viral diseases, more

dengue and so on and so forth. This quarter is typically characterized by higher occupancy, okay? Because of more medical patients coming. But also it's characterized by, because these patients you know, your earnings from these beds are lower, okay? You have a downward pressure on ARPOB. So although you see the 78% occupancy, it's basically, this peak has a little bit happened because of the viral load and the medical business, which has come, the dengue business and so on and so forth, which is the seasonal business. Having said that, you also have a secular increase, okay, in your business as usual, which is your surgical business, and your regular business, which is the non-seasonal business, which is further augmented by your international business reverting to even higher levels and growing, your insurance business growing, and so on and so forth. So what you're going to see in the subsequent quarter is because, and this business, okay, A) it will bring you higher, little higher occupancy, but also brings you B) higher ARPOB. Overall, when you look at let's say a 75% to 78% sort of range, of occupancy, your question being where do you sort of go from here? You have to keep in mind that even now, 28% of the total beds, which means of the 78% occupancy, 28% of the 78, so almost like one third of it, okay, is being consumed by institutional business, which is very low ARPOB business, and the ARPOB basically is close to half of what the ARPOB of the business as usual is.

Prakash Agarwal: No, I understand that. That was my second question anyways, but occupancy wise, what is a max we can get over?

Abhay Soi: So let me put it this way. In month of September, we were operating at 81% occupancy, right? I mean, if you ask me the same question, we have hospitals which are operating at 90% plus occupancy. The question is, can all hospitals operate at 90%? Theoretically, yes. Okay. You know, one year back, if somebody asked me that, look, on a sustainable basis, can you operate at 77%, 78%, I would have said difficult. Today, I'll say, yes, next year I'll say, you'll probably eke out two more percentage points here, and so on and so forth. But you are pretty much, look in my mind, 77%, 78% occupancy on a sustainable basis is where you should be. And then, you know, your patient services, et cetera, on the subjective areas start getting compromised a little bit.

Prakash Agarwal: Understood. So, second one is similar on the ARPOB side, as you already touched that you already declined to 28% in terms of institutional business versus 37% a year back. So here, I mean, do we have minimum threshold where we have to give minimum institutional services to central government employees? Or this can go to say 10%, 0%? What is the view here over the next four to eight quarters?

Abhay Soi: So I can give a 30-day notice today, and at the end of 30 days, bring this business down to zero. Keep in mind, we don't---

Prakash Agarwal: Don’t have any obligation.

Abhay Soi: None, none whatsoever.

Prakash Agarwal: So, what is our goal for the next four to eight quarters?

Abhay Soi: I do this business because I want to do this business, not because I have to do this business. We do this business because we don't want the bed idle. If I stop, bring this down to zero, today my occupancy comes down

to 55%, 57%. Right? The next question is, why aren't you filling those beds? Now, my goal, in the past also we have said, that five quarters later or six quarters later, this will be below 15%. And that goes down to 15% because that's when majority of my capacity starts kicking in as well. Now, I would say not five to six, let's say four to five quarters. And we have always sort of guided down to that. Then we comfortably come down to 15% or below. And the reason is that the new capacity comes in. Suppose the new capacity wasn't to come in or get delayed, this goes down even further. That's the advantage within this thing, these beds are built, they're sub optimally used right now. And you have this entire brownfield, etcetera, kicking in.

Prakash Agarwal: Okay, perfect. Great. And one more question was on the CCI probe, which came in on, you know, a few of the hospital companies including yours. So if you could give some color, is it to do with the annual price hike or is it due to that we came into limelight like because our ARPOB is highest in the industry today? And how are you tackling this? Because I heard in your opening comments that you've still taken price hike.

Abhay Soi: So I'm glad you asked this question. Okay. This is purely and simply relating to a case in 2015 where a person came to the hospital and said that, look, a syringe, you're delivering a medicine at, an injection at so and so price. Okay? Whereas I can get it from a pharmacy at so-and-so price, which is lower than that. So I should be able to bring my syringe in. And he went and complained regarding this. The sum total of this case is that they're saying that look, okay, I think firstly it's an investigation that they've done. Okay. They've asked us for a response on that investigation, okay? They haven't given us the basis of that investigation. So we went to Delhi High Court and we said please ask them to give us a basis for the investigation so we can give a response. Because as a hospital, what we do is we do not sell medicines and injections. We apply it, right? What we sell is at MRP. So, I mean, for the life of me, we can't understand where we are sort of, off track on this because we sell at MRP and we are not in the business of selling the medicines. And we sort of, when the nurse comes, gives the injection and so on and so forth. It's got nothing to do with any price hike. It's got nothing to do with pricing. It's got to do with, is a patient allowed to bring his medicine from outside? That's not even the jurisdiction of the CCI, frankly, because we can't have somebody bringing a spurious injection, okay, which may not be sterile or whatever from outside the hospital to inside the hospital.

Prakash Agarwal: Perfect. No, this is very helpful, thank you.

Abhay Soi: As narrow as that. And there's some comments made on the investigation. Okay. Which we don't know the basis of. Okay. Such as the hospital beds are, the rates for the hospital beds are more than four star hotels in the neighboring. Firstly, you know, nothing stops us from selling our beds at any price. That's one. Secondly, and it's definitely not within the jurisdiction of the CCI. Secondly, you know, we don't sell the rooms. There's a nurse, there's a doctor, you know, and there all of those services which comes with the beds. You can't make a like to like comparison, right? I mean, right now it's an investigation. Then, you know, if we will give our response, you know, if it's a litigation it will be litigation or it'll be killed by them at this stage.

Yogesh Sareen: Also the question is that when we have some 70% of the patients being treated on cashless basis, how can we ask patients to bring medicine from outside? Right? So they're saying that you allow patients to bring from

medicine from outside now, I mean, whole cashless falls off if that also happens. Right.

Prakash Agarwal: Okay. Got it. Okay. And my last question is on, your M&A and asset light strategy, given that, you know, you have a, you know, six-seven years' plan, you're doubling from internal accruals largely, but still net cash balance sheet. But you know, to propel growth or maybe, you know, add on to the growth, we've seen some companies like KIMS, you know, buying out, doctor owned models, hospitals which are not run properly. What is your thought there, or what are the M&A and asset light acquisition plans you have?

Abhay Soi: So, look we've written the playbook on it, right? I think essentially, as far as, buying hospital and unlocking value, but you have to maintain a certain critical mass and be able to do it, et cetera. Because KIMS or anybody else finds an opportunity does it, is not the sort of this thing. We at any given point of time are diligencing companies. We are very, very focused on inorganic growth. And like you rightly pointed out, we have an unlevered balance sheet, and we have excess cash on the books. We can easily sort of do that, but at the same time, you have to maintain, we have a ROCE of 33%, and whatever we do needs to be accretive to that, in the long run. And, I'm fairly certain in the next, you know, sooner than later we will be able to conclude another transaction. But do keep in mind, over the last 10, 12 years, our entire platform has been based on acquiring assets, unlocking value. So it doesn't sort of stop us from doing it. We just more, we just -- we have a stronger balance sheet, stronger team, stronger abilities to do that, to execute even better on this.

Prakash Agarwal: So, you would be still looking at it, but you're not talking about it, which way you're going. I mean, is it asset light? Is it KIMS model? Is it M&A?

Abhay Soi: No. So look, partnering with doctors, et cetera, doesn't excite us. If we like something, we want to own more of it than less of it, and we like to have control on it as well. And I think, sort of our EBITDA per bed, keep in mind, is 50% better than the next best player in the industry. So obviously our model is, sort of, works very well for us and for investors.

Moderator: The next question is from the line of Damayanti Kerai from HSBC.

Damayanti Kerai: Hi, my question is on, bed addition, new Bed addition, happening over next, nine to 12 months. So we have Shalimar Bagh and Dwarka adding around 400 new beds. So, currently you are operating at somewhere, 26% - 28% EBITDA margin. So after these new beds come in, should we expect some dilution in margin or, other way to ask you like how fast, you think these can achieve EBITDA breakeven after the launch?

Abhay Soi: I think the way to look at it is look at what our EBITDA per bed is. And then you say, look, if this our 400 beds coming, how long will it, get take me to get to let's say 75% occupancy. That's about, I guess, 300 beds and multiplied by EBITDA per bed. So yes, I think as far as Shalimar Bagh is concerned, it should be a matter of, you know, I mean, there's no dilution. In fact, day one, there should be accretion as far as this thing is concerned because it's a brownfield. There is no significant fixed cost or any fixed cost, which is being incurred. It is essentially variable costs as and when you open the bed, and, you know, my belief is that it's only a hundred beds in that location, which is, a hospital which is operating at 90% plus occupancy at present. So, you know, it's untapped demand. As

far as Dwarka is concerned, again, you know, I think, it's not really going to be dilutive because it's a very sort of, 300 beds on top of, this thing. But, I think, the kind of response we've got, the ramp up and the break even and everything else should be very, very quick over there. So I'm not seeing any real dilution on overall basis.

Damayanti Kerai: So, broadly the current level of margins can be maintained?

Abhay Soi: Absolutely. But you know, again, like I said, please focus on EBITDA per bed rather than EBITDA margins. I would rather do a $10,000 surgery with a 20% margin than a $2,000 surgery with a 50% margin.

Damayanti Kerai: Okay. My second question is on Nanavati hospital. So you mentioned, this facility is currently operating at mid teen margins. So, how like how long it can take further to reach near to the corporate average or how should we look at margin for this particular unit?

Abhay Soi: Well, you know, Mumbai by and large has a higher sort of doctor payout. Okay. So you typically have lower margins, but yes, there is room to increase the margins over there. Do keep in mind, you know, if one was to sort of increase the margins from, by 5% or 6% also from here, it means on a Rs. 400 odd crore top line, Rs. 450 top line, you're talking about Rs. 20 crore – Rs. 22 crore, you know, on an overall base of Rs. 1600 odd crore. So it doesn't really move the needle from that standpoint, but I think the big, big sort of swing will come over there, when the new capacity comes in, which is, you know, the construction is on. What it also does is, it will flatten out higher doctor cost as well as personnel cost.

Damayanti Kerai: Okay. So, operating cost will be spread over a larger bed network, and that will.

Abhay Soi: So actually, you know, there is, and as far as Nanavati is concerned there is a legacy personnel cost. Okay? Which is the worker's cost. Okay. That's the only single line item which is off. It is 30% - 31% compared to 22% - 23% for the rest of the group. And that, either through expansion of capacity, or through VRS is the two ways of tackling it. We tackled it partially through VRS. We may be looking at another VRS going forward, but more importantly, I think when the new capacity comes in, it gets taken care of by itself.

Damayanti Kerai: Okay. And my last question is on, seasonality in a hospital business. So, 2Q as you said, due to rainy season, we have higher cases of infections, etcetera. So, 3Q should we assume it could be a lower quarter due to like major festivals falling in and again, fourth quarter should be a better one? Or how does this seasonality vary across different quarters.

Abhay Soi: So let me put it this way. Usually your Q1 and Q3, are the sort of weaker quarters, right? But rather than timing it like this, because sometimes Diwali is here and there, so on and so forth, H2 is usually better than H1 historically for all hospital groups.

Damayanti Kerai: Okay. Very broadly second half performs better than the first half.

Abhay Soi: Always. I think if you see any hospital group typically, and historically our hospitals or any other hospitals, for them all H2 is better than H1.

Yogesh Sareen: Should see a 48:52 type in EBITDA. Revenue will be 49:51 types.

Abhay Soi: I mean, historically I'm just giving you based on experience or whatever, but I'm not giving you guidance. Usually at 48:52, first half versus the second half.

Damayanti Kerai: And final clarification, CapEx you maintain whatever, budget we have done, or we have disclosed earlier that remains on track and this lower CapEx during first half of this fiscal is just a matter of timing issue and eventually, as and when payments etc. start happening it should be in the budgeted lines?

Abhay Soi: Yes, so I mean, if I was to look at things which are going to come up in the next one year, okay. There is obviously certainty because we know where we are, we are in the fit outs etc. over there. As far as, you know, anything which is coming up really is bunching up towards the end of '24 – '25, and '26, I think there is strong visibility that we should be able to meet timelines over there.

Moderator: The next question is from the line of Praveen Sahay from Edelweiss Wealth Management.

Praveen Sahay: Yes, one clarification related to the bed addition. Beyond Shalimar Bagh and Dwarka, you have a – bed addition planned for FY '25. So is there any deferment in that 1170 bed odd?

Abhay Soi: Not really, no. Like I mentioned, the visibility is there and, works have started. At the same time, I just want to sort of also, layer it up that we -- like I mentioned, the reason I was going down to about 15%, institutional share is because I have visibility of this coming out at that time. Let's say hypothetically speaking, some project gets delayed at the end, and let's say it's not adjacent to a place which is at zero institutional, you still have that lever, by the way. Having said that, just squarely answering your question, we are not, right now as far as our visibility is concerned, we are not foreseeing any delays.

Praveen Sahay: Okay, and the second question is related to the ARPOB. For a sequential basis, if I look at your ARPOB is around Rs.66K, even after improvement in the payor mix like institution gone down to a 28%, and the international patient mix also improved. There also sequential improvement we have seen. So, what exactly, on the QoQ basis, relates to, the flat ARPOB.

Abhay Soi: Can you just repeat that question? Sorry.

Yogesh Sareen: So basically, this is because of the fact that the medical mix of the patients have gone up during this quarter. Abhay mentioned this earlier also, that, you know, this Q2, we had some dengue and viral fever patients. So the internal medicine has jumped by 26%. You know, you seen that comment in the earnings update also. Basically because of the, so if it was not to happen, generally you'll find that the ARPOB would drop in quarter 2 compared to quarter one, because of the medical patients going up, right. Medical patients, typically, you know, the Dengue patients would be 50% of the normal ARPOB that we have, right? So it should have dropped, but by the fact that we have this institutional share going down and the international patients going up, so it's been maintained at the same level.

Abhay Soi: Yes. But purely you can't look at it like, look, the occupancy went up, so, you know, there's a secular increase in occupancy also of your business as usual, right?

Praveen Sahay: Yes, I got the answer because of our internal medicine increased the contribution, maybe that is the reason why the ARPOB is maintained on the same level.

Moderator: The next question is from the line of Shaleen Kumar from UBS.

Shaleen Kumar: Thank you. So more of an understanding thing. See, I understand your institutional patients are coming down, but is it right way, to think that they generally take, general ward, right? So you will be replacing them with a patient in general ward, right? So probably my improvement in ARPOB when I replace institutional patient will not be the same level of my average ARPOB.

Abhay Soi: See, that's not true. Okay. Let's say you are working in Northern Railways, right? Who are these people effectively, these are public sector undertakings? They're Delhi Jal board, they're various central government, etc. It could be anybody from income tax to let's say from irrigation department, right? All IAS officers, Rajya Sabha members, Lok Sabha members, former members, et cetera, et cetera. All judges, all Supreme Court judges, high court judges, and so on and so forth. Now, each one of them, if you're a lower tiered officer, or you are a let's say a class three employee or whatever, then your allocation or your entitlement, like in insurance, may be general ward, but if you're a judge or IAS officer or whatever else it is, it will be single room or deluxe room, well, single room, okay? So what you're replacing it by is not that. The other thing you need to keep in mind is my Rs. 66,000 ARPOB is a weighted average, which includes the Rs. 35,000 - Rs. 36,000 of CGHS as well. What actually replaces it is a higher ARPOB.

Shaleen Kumar: No, it replaces, but will it replace by hospital average? And I think what you said is it's possible.

Abhay Soi: Right. But the other point I want to make is that yes, you know, although we are talking about reduction in institutional business, right? I think the right way to, and the best way to think about it is increase in the non-institutional business. Because if you can increase occupancy, all right, that's what I sit with the teams on. I'm saying, look, rather than pushing your best case scenarios where you can find ways increasing occupancy, retaining this, as well as increasing your, and finding ways to accommodate your, preferred channels.

Shaleen Kumar: But you said that beyond 80% like service compromise can happen, so difficult to, I mean, I don't know.

Abhay Soi: Today, yes. Like I said, you know, three years, two years back, somebody asked me a 75%, I would've said, no, you compromise. The fact is, and I'll give you example of Breach Candy hospital in Bombay. I mean, your service is not compromised. It operates a 90 plus percent occupancy. It's just that over a period of time, they found ways to do it. You become more efficient. If you look at Hinduja hospital over there in Bombay, I mean, they've got 27 ICU beds. They've got the lowest ALOS because they've got it down to a T. Because they've been living with this situation or saturation where they can't expand it even by a square inch for so many years. I mean, everything is down to just-in-time and so on and so forth. But yes, those are all incremental efficiencies. But I still want to sort of put that down.

Shaleen Kumar: But that's important, right? Because as a modeling perspective when we model, we start doubting that whether the hospital can hit beyond 80%. But if you, if you see there is a possibility and there are models and you can kind of build in, then it's very interesting and it's very important for us.

Abhay Soi: I have hospitals right now operating 90% plus, and without compromising anything. Because that's one place we put our foot down as far as you know, because what you don't want is, and immediately you'll see a sort of a pushback in the next couple of quarters. Your doctors will have a problem, your patients have a problem, and so on and so forth. Our PSAT scores, all of that, on a daily basis, which we look at has been increasing and improving.

Shaleen Kumar: So do you have a score like NPS score kind of thing as well here? Do patients satisfaction score, you track something like that?

Abhay Soi: Oh, absolutely. Multiple things, including, and we do it through, you know, even SMS et cetera, where it's voluntary for you to sort of, respond to it. So although you only have 4% or 5% people responding to it but those are very true sort of these things, right? -- It's not as if you are sitting in a hospital where the management or the nurse is coming up to you and saying, sir, please sign this.

Shaleen Kumar: You also mentioned, about, moving away from probably a traditional way of construction. Are you going with the hollow structured tubes for the construction instead of RCC?

Abhay Soi: No. So look, we evaluate hollow tubes versus structural steel frames. Or, let's say composite. So you do your basements, we still have to do it in concrete. We are still finding ways of, doing that mostly in steel as well, but the rest of it you do on steel frames, which is, which is very, very promising. You see, unlike, you know, the cost of construction is maybe higher by 15% or 20%, but if you can save 20% of the time, okay, in our case, you can get to market that much sooner. Because for me, every day is a loss of profit, right? So unlike a residential real estate where the cost of construction matters because the delay is to, let's say, the consumer's account. Here, it's actually, I have a positive incentive for me to get it up and running sooner than later.

Shaleen Kumar: True, true. So, ballpark, have you looked at the IRR? Basically it's all about IRR at end of day, right? So it's positive, it's accretive?

Abhay Soi: I mean, each day, I mean, when you have a cost of construction or a brownfield of let's say Rs.130 - Rs.150 lakhs or whatever and your EBITDA per bed, okay, is Rs.60 odd lakhs, you may as well get that sooner. You have 50% ROCE. I mean, the question is how soon do you get to that 70%, 60%, whatever that occupancy is, and largely these are brownfields, right? And like I said, there is unsatiated demand at my doorstep. I have no fixed cost. I mean, there is absolutely no benefit on any Excel sheet for even a day's delay on this.

Yogesh Sareen: Shaleen, it is also about the patients' convenience because when you have the traditional construction, you have more disturbance to the patients who are in the hospital, right? So there is obviously noise around etc. So by doing this structure, you are also able to reduce the inconvenience to the ongoing operations.

Shaleen Kumar: Very much agree.

Yogesh Sareen: Let's say you're doing it in Nanavati, right? So you already have a running hospital there, right? If you have all this digging out going there and a lot of construction activity going on there, this obviously disturbs people staying in the hospital. And you can't do 24x7 construction in that case. So I think this also allows us to, you know, fabricate this stuff outside and bring it in and, it's a faster construction and also lower disturbance on the site, especially where you're running the hospitals.

Shaleen Kumar: Fair enough. That's about from my side, thank you so much

Moderator: The next question is from the line of Dheeresh Pathak from White Oak Capital Management.

Dheeresh Pathak: Yes, thank you for taking my question. Can you give the CapEx outlay for the Dwarka project and as well as for the Shalimar Bagh?

Abhay Soi: So, as far as Dwarka is concerned, we are not incurring the CapEx. We are incurring will be about Rs. 130 odd crore, Yogesh can give the precise figure as far as the medical equipment is concerned. CapEx is being -- entire CapEx is being incurred by the developer. We have a fixed rental that we are going to be paying him, which, -- which is Rs. 20 odd crore.

Yogesh Sareen: Shalimar would be roughly a cost of Rs. 150 crore, including the equipment and on the – Dwarka one, that will be around Rs. 170 crore because we are expecting the LINAC also there. Now this Rs. 170 crore, in addition, we've given some deposits for these guys, to start with, as -- when we signed the contract.

Dheeresh Pathak: And what is the rental in Dwarka? Rs.20 crore?

Yogesh Sareen: The rental in Dwarka would be Rs. 22 crore a year.

Dheeresh Pathak: So on the labs business, can you give like the share of revenue from B2B and B2C?

Yogesh Sareen: Yes, so I would say it'll be a 50-50 type. So 50% will come via B2B. When I say B2B, this also includes franchisees, right? And balance will be B2C.

Dheeresh Pathak: But franchisee in true terms, it is B2C, right? But the HLM business would be typically B2B?

Yogesh Sareen: HLM will be around 20% of the business will be HLM. And 25% will be coming via the franchisees. So another 5% through the phlebo at site, etcetera. Balance will be all direct including pick up points, home pickups and wellness, etc.

Dheeresh Pathak: Okay. So one last question for Nanavati what would be the EBITDA per bed?

Yogesh Sareen: We don't share the hospital level EBITDA per bed.

Dheeresh Pathak: Okay. Because the number you said is double digit EBITDA margin, and if I do the math, Rs.450 crore revenue you said, and 15% margin.

Yogesh Sareen: Yes, it's around 15% margin. Yes. So I would say actually in quarter two it's around 16% margin, right? And you have the -- you have the revenue from Maharashtra already in Earnings Update -- so you can compute it.

Dheeresh Pathak: Yes. So then also it'll look lower and primary reason, like Sir explained, is it because the legacy doctor cost, which is 10 percentage point?

Abhay Soi: No, personnel cost.

Dheeresh Pathak: There's a union there, is it?

Abhay Soi: But I mean, it's a benign union. That's not -- the issue is not that. The issue is that look, when you do a VRS, right, typically you pay let's say six months of salary for every, year of service left or nine months of salary for every year of service left. So we did the first –VRS at six months of salary for every year of service left. Now the ask is one year of salary for every year of service left, you know, so rather than paying that out, I'm saying, look, the new capacity comes in, this gets defrayed over a larger this thing in any case, the excess manpower. We also have to do a cost benefit.

Dheeresh Pathak: Okay. So even outside of that, also the EBITDA per bed, I don't know, based on the numbers we are sharing, even adjusted for that would look lower. So is there something else also in Nanavati? Like is it lower occupancy, is it lower ARPOB apart from that?

Abhay Soi: Higher number of general ward beds at present. The configuration has fewer single rooms, fewer double rooms with attached bathrooms because these are older sort of buildings. So the big, big thing over there is, for single rooms. If you are from Bombay you'll know that you won't get a single room in these hospitals, right? I mean, you typically get admission in lower category than move up, move up.

Moderator: The next question is from the line of Tushar Manudhane from Motilal Oswal Financial Services.

Tushar Manudhane: So just firstly on the international patients, like historically if -- does the patient from Afghanistan have better realization than compared to what you are having from the current international patients? Or will that be just driving the volume, if at all the Afghanistan patient starts coming into India.

Yogesh Sareen: No, Afghanistan won't have any better, you know, ARR et cetera. So it'll be all the same. It'll be in the same range.

Tushar Manudhane: Okay. So it will drive the volume basically not the realization.

Yogesh Sareen: Yes, yes. Nevertheless, with international patient, the ARR is generally double of the domestic, right? Because we get more acute patients there and that obviously helps us and it is more complex work that we get on international side. And so obviously that helps us in terms of the ARPOBs and the EBITDA per bed et cetera.

Abhay Soi: Your average bill is twice. It's not about the pricing, the average bill is twice.

Tushar Manudhane: But resource as well as the service aspect also will be the typically much superior compared to?

Abhay Soi: No, but understand, in spite of that, I mean, if you -- if today I have a patient for a fracture and I have a patient for a liver transplant, right? I make a lot more absolute margin as well as the overall billing on a liver transplant. Of course the resources are higher, but my margins are much higher. So when a person comes, nobody's going to have a fracture and come from Afghanistan to get it sort of sorted over here, but you come for a lifesaving liver transplant or transplant or a lifesaving procedure or whatever, where the average billing is much higher.

Tushar Manudhane: So just to understand, approximately what would be the margin from the international patients compared to the company level?

Abhay Soi: No. See, again, you're talking margins in percentage, which is the wrong sort of cadence to look at. Well, like I said, you'd rather do a 20% margin on a $10,000 surgery than do a 50% margin on a $2,000 surgery. So what I'm telling you is the average billing is twice.

Tushar Manudhane: And secondly, on the case mix side, the cardiac sciences seem to be improving nicely over past couple of quarters. And oncology remaining pretty stable. So while the payor mix change can definitely drive the ARPOB, but from a case mix perspective, typically cardiac is little lower compared to oncology. So will that have certain impact on the overall ARPOB?

Abhay Soi: No. And you've seen it, like you said, yourself, right? You've seen it increase yet you've seen overall increase in ARPOB, correct?

Tushar Manudhane: Okay. And just lastly, just to understand the mix of, so while this quarter had a viral load on account of dengue, so the typical mix of, surgery and the medical business for the quarter or for the first half, and how probably that can change in the coming when there is no viral infection per se. So any broad color on that?

Yogesh Sareen: So Tushar this is -- the medical mix was up by 2% this time. So let's say this is, you know, generally if 43:57 this time it was 45:55, 45 is the medical. So in quarter one it was 43:57. So I think as we get into quarter three, this will normalize to the old levels.

Tushar Manudhane: So effectively resulting into, let's say a ballpark, what kind of increase in ARPOB, is it like in the meaningful range of Rs. 1000, INR 2000 or much more than that because of change in this portion?

Yogesh Sareen: No, I can't obviously reveal the figure. But I think you can see that, you know, 2% change in the mix of the PSU patient and an increase in the international patient, the level which has come in the quarter two compared to quarter one, if that increase was not to happen, then obviously as I said, the ARPOB is only one and a half times for the international one and for the PSU it is double. So if you compute that, you'll get to a number.

Moderator: The next question is from the line of Bharat Sheth from Quest Investment Advisors Private Limited.

Bharat Sheth: You said typically in Mumbai, doctor payout is higher than the rest part of the world. Is that correct understanding and if that is there, what exactly are we doing to retain this kind of talent? I mean, for our hospital and in future then would you like to go for Mumbai?

Abhay Soi: So my Mumbai hospital does not compete for doctors against hospitals in other parts of the country. They compete with hospitals in Mumbai. So it's a secular trend that the doctor payout in all hospitals across the Mumbai are similar, which is higher than compared to the rest of the country.

Bharat Sheth: But then ARPOB in Mumbai is much higher than the rest of the country, because the payout is higher?

Abhay Soi: Not necessarily. The doctor payout has nothing to do with ARPOB. Doctor payout is a cost line. Your ARPOB is a revenue line.

Bharat Sheth: Can you share some kind of, I mean, broader statistics say apart from in these -- all these metro city, how these international tourists, which city attracts more international and which is less?

Abhay Soi: Number one place in India is Delhi NCR. 40% of all medical tourists come to Delhi NCR. The rest is distributed; Mumbai's share is the least.

Bharat Sheth: Second, now since we are -- currently next two years, we will be expanding brownfield. But once we go for our brownfield opportunities over and if we go for a greenfield, then it'll be taking a little hit on the margins. Is that understanding correct?

Abhay Soi: When you do greenfields, which are sizeable in nature compared to the rest of your portfolio, it will have, sort of temporary in towards your margins. It does not mean that you give up that opportunity, when you have -- that opportunity. So if I get opportunity to do, let's say three greenfields right in the middle of Mumbai, not that I'll get the land for it, but if I was to, I'd do it. But having said that, we have a large base of, you know, Rs. 1500 crore - Rs. 1600 crore of EBITDA, about Rs. 6,000 odd crore top line. So how much will be impacted by it is the question.

Bharat Sheth: Okay. Fair. Last question, sir. We have several levers for expanding the margin. So when we are talking currently, we have around annualized, Rs. 65,000 to Rs. 67,000 per bed EBITDA. So with all this levers, where do, what is our aspiration? And of course, occupancy is also increasing.

Abhay Soi: Like I said, you know, we cannot give you, forward looking guidance on EBITDA on this thing. Our EBITDA is Rs. 64 lakhs, not thousand per bed. As far as the levers are concerned, all of them should auger better and improve this going forward. Some sort of calculations you can do, like I said, um, you know, I'm reducing institutional bed share by 13%, in absolute terms. So that means that 13% should be able to generate at least 50% more revenue, 85% of that will flow to EBITDA. So that has, some impact on your EBITDA numbers, your international patients increasing, your insurance patients increasing, et cetera, et cetera. So I think overall we are in a good space, exactly where it will lead you to, which quarter is something for you to estimate. But, like I said, you know, I think, you know, as a sector, as a company, we are in a good space. We are generating significant amount of free cash flow, and we have very good land banks right in the middle of the metros. From 85% capacity, we move to 93% capacity post expansion. And we already have these land where work has started most importantly. And there's an opportunity set in the rest of the country, and I've always gone out to say that look, any location which is viable, where at least two of my competitors have proven viability, we'd be more than happy to sort of enter those places. And of course, you know, M&A is another big lever for us and you know, that will

throw out further geographies and opportunities for us. And we certainly have the balance sheet and the cash flows to support those expansions.

Bharat Sheth: Okay. So what are the -- I mean, while criteria for M&A I mean, do we still, I mean, would like to have an evaluating any 33% kind of ROCE would like to generate?

Abhay Soi: Of course, in the long run, of course. I mean, it may not be immediately available that sort of ROCE, but yes, over a period of time, through those assets, through further expansions over there, brownfield, et cetera, we can unlock value. Do keep in mind, brownfield expansions allow you a significantly higher ROCE than your present set of operations because your EBITDA per bed is much higher in a brownfield and there is no stress on your -- even your short term sort of EBITDA margins.

Moderator: The next question is from the line of Harith Ahamed from Spark Capital.

Harith Ahamed: Hi, so looking at our bed addition plans, we have roughly 1,500 new beds getting commissioned in FY '25 and I believe a higher number, probably by FY '26. So how should we think of the payor mix specifically at these new beds? Will we stick to our targeted 15% share from institutional patients, or will we prioritize occupancies and probably accommodate a higher share at these new beds?

Abhay Soi: So look, 15% is a derived number, right? Essentially what we believe is that the reduction in institutional business will stop when this new sort of capacity comes in. It's beneficial that majority of this capacity or almost all of this capacity in '25, '26 is all brownfields. So it will not disturb the payor mix at that time, but at the same time, you know, any further acceleration will stop towards non-institutional. So I mean, I don't, and then again, coupled with the fact that look, you've got lot more operating levers for almost all of this capacity because it's brownfield. It will not disturb your payor mix or your margins at that stage.

Harith Ahamed: And then in terms of M&A priorities, are we open to assets outside metros and tier one cities, which is our current market?

Abhay Soi: Absolutely.

Harith Ahamed: And also assets outside the north region of the country, which is again, our core market today.

Abhay Soi: Look, we have capabilities of executing anywhere in the country, you know, on similar sort of models that we understand. My only criterion has been that, in a new geography I don't want to do a greenfield and B, I don't want to go to uncharted territory where, you know, I only want to go to places where at least one or two of my -- two of my competitors at least have proven viability. We will do it better like we do in each and every micro market that we compete in, without exception. And you are witness to that over quarters. Right?

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

Abhay Soi: So thank you so much for your time, for logging onto the call. And we look forward to connecting with you in the next quarter with good news again. Thank you.