Max Healthcare Institute Limited

Q1 FY25 Earnings Conference Call
August 02, 2024

Moderator: Ladies and gentlemen, good day and welcome to Max Healthcare Institute Limited 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, Neerav. Good morning, everyone and thank you for joining us on Max Healthcare's Q1 FY'25 Earnings Conference Call.

We have with us Mr. Abhay Soi – Chairman and Managing Director, Mr. Yogesh Sareen – Senior Director and Chief Financial Officer and Mr. Keshav Gupta – Senior Director, Growth, M&A and Business Planning.

We will begin the call with opening remarks from the management following which we will have the forum open for an interactive Q&A 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 earlier.

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

Abhay Soi: A very good morning to all, and a warm welcome to Max Healthcare's Earnings Call for the Q1 FY25.

It's been a very promising start to this financial year. I am pleased to share that we have operationalized Max Super Speciality Hospital, Dwarka on July 2nd. Located in the heart of South Delhi, it is a 303-bed hospital equipped with the latest high-end technology and currently has 125 doctors and ~480 nurses, paramedics and support staff.

The hospital is seeing good traction since its launch. Presently, the hospital teams are engaged on various fronts including patient outreach, empanelment with insurance companies, clinical accreditations, etc.

Yesterday, we announced a built-to-suit transaction for setting up a 250-bed hospital in Mohali. This 2.75 lakh sft. building with attendant parking will be constructed by the developer as per our requirement and specifications. This is a long-term lease, extendable up to 50 years at our option, and we expect to commission the facility by FY28. The hospital will cater to surrounding areas of Himachal Pradesh, Punjab and Haryana. This is in line with our asset-light strategy, which allows us to expand while insulating against development risks.

Further, in a strong demonstration of our turnaround capabilities, both Lucknow and Nagpur hospitals that we acquired at end of Q4 last year are ramping up well, with an average occupancy hovering around 60%. For Q1, these hospitals contributed Rs. 99 crore to the revenue and Rs. 18 crore to the operating EBITDA, reflecting a year-on-year growth of 21% and 64% respectively. And more importantly, this was done within the first three months of us acquiring these facilities. Collectively, their ARPOB stood at Rs. 45,300 and annualized EBITDA per bed at approximately Rs. 30 lakhs. A large part of the post-merger integration activities has been completed now, the results of which will be more visible in the quarters to come and further augmented as new clinical teams join and infrastructure is upgraded there.

Now, coming to the Q1 performance. This is our 15th consecutive quarter of year-on-year growth.

Overall network gross revenue stood at Rs. 2,028 crore, registering a growth of 18% year-on-year and 7% quarter-on-quarter.

Network operating EBITDA was Rs. 499 crore, net of one-time charge of Rs. 6 crore towards pre-launch costs at Max Dwarka. This reflects a growth of 14% year-on-year and a marginal decline of 1% quarter-on-quarter.

Profit after tax (PAT) stood at Rs. 295 crore compared to Rs. 291 crore in Q1 last year and Rs. 311 crore in the previous quarter. While we expect substantial improvements during the course of this year, we are also infusing equity in the Lucknow subsidiary to bring down the finance costs.

All numbers from here on are going to be now shared for a like-to-like basis, excluding new hospitals.

1. Our average occupancy for the network increased to 77% from 74% in Q1 last year and 75% in the trailing quarter. While occupied bed days grew by around 5% year-on-year and 2% quarter-on-quarter.

2. Average Revenue Per Occupied Bed (ARPOB) for the quarter improved to Rs. 80,100, growing by 7% year-on-year and 3% quarter-on-quarter. Year-on-year improvement in ARPOB was largely due to growth in oncology, orthopedics and renal sciences as well as increased number of robotic procedures. This was coupled with tariff revisions for self-pay, insurance and institutional segments.

3. Network gross revenue was Rs. 1,929 crore compared to 1,719 crore in Q1 last year and Rs. 1,847 crore in the previous quarter. This reflects an increase of 12% year-on-year and 4% versus the trailing quarter.

4. The international patient revenue stood at Rs. 158 crore. There was a temporary impact on patient flows from some countries due to political situations and credit-risk management related actions taken by us, which accounted for the muted growth in this segment.

5. Network operating EBITDA stood at Rs. 487 crore, reflecting a growth of 12% year-on-year while declining by 2% quarter-on-quarter. Operating EBITDA margin stood at 26.5% for the quarter. Growth in EBITDA was impacted due to annual merit increase, GST on variable management fee and drop in footfalls for immigration health checks owing to change in visa regulations by some countries, particularly Canada and UK.

6. Annualized EBITDA per bed stood at Rs. 74.7 lakhs, clocking a growth of 6% year-on-year.

7. PAT was Rs. 316 crore versus Rs. 291 crore in Q1 last year and Rs. 322 crore in the previous quarter.

8. Free cash flow from operations was Rs. 258 crore. Of this, Rs. 213 crore was deployed towards the ongoing capacity expansion projects and upgradation of facilities at new hospitals. Consequently, net cash position stood at Rs. 66 crore at the end of June 2024.

9. Continuing our efforts to support the local communities, we treated approximately 36,800 out-patients and 1,150 in-patients from economically weaker sections of society entirely free of charge.

10. Both our strategic business units (SBUs) continued to report significant growth in the revenue and profitability:

    - Max@Home reported a top line of Rs. 49 crore, reflecting a strong growth of 23% year-on-year and 6% quarter-on-quarter. This SBU offers 14 service lines over 10 cities and continues to experience a very high rate of repeat transactions.

    - Max Lab, the non-captive pathology vertical, now offers its services in nearly 50 cities and has a network of over 1,100 collection centers & active partners. This SBU reported a gross revenue of Rs. 41 crore, reflecting a strong growth of 21% year-on-year and 6% quarter-on-quarter.

11. Now, coming to the status of expansion projects:

    - For 590 beds at Lucknow hospital, the work on refurbishing the existing facility is underway. Finishing work for operationalizing additional 140 beds has started. We have also received the environmental clearance (EC) approval for setting up a new 450-bed tower on this site and we expect to complete the development of the new tower within 24 months.

    - For 140 beds at Nagpur hospital, work has been initiated to add around 25 beds through internal reconfiguration by Q3 FY25 and environmental clearance (EC) application for adding 115 beds on two additional floors has been filed. We expect approval over the next 2-3 months and the project completion within 24 months.

    - For 241 beds in Nanavati (Phase I), the hospital structure will be up in this month and the project completion is expected by end of this fiscal year, as communicated earlier. The project continues to be on schedule.

    - For 375 beds at Max Smart (Saket Complex), the project was fast-tracked in Q4 and we expect its completion by Q1 FY26. This is a steel structure building and the installation of columns has already started. The site is fully mobilized and we don't expect any further delays.

- For 155 beds at Mohali, work on the 2nd floor slab is underway, while the work on ramp area side is reaching ground level. All high-side equipment has been ordered and the project is on schedule. We expect the completion by Q1 FY26.

- For 300 beds at Sector 56, Gurgaon (Phase I), basement slabs are nearing completion and the project is progressing as per plan. Orders for all high lead-time items have been placed. We expect completion of the first phase by Q2 FY26.

- For 250 beds at Patparganj (Phase I), post issuance of the no objection certificate (NOC) by the fire and water departments, we have submitted the drawings for approval and the tendering process for this project is on.

- For 415 beds at Max Vikrant (Saket Complex) (Phase I), the environmental clearance (EC) and consent to establish (CTE) have been received. The barricading and D-walls, etc. has started. We have applied for forest approval and are still awaiting the same. We expect some delay due to ongoing litigation involving DDA and Delhi Government regarding cutting out trees in the eco-sensitive zone near Asola Bhati Wildlife Sanctuary and the Ridge areas without approval.

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

Moderator: We will now begin the question-and-answer session. The first question is from the line of Amey Chalke from JM Financial.

Amey Chalke: The first question I have is in Lucknow Sahara unit. I understand that we have a plan to expand the unit to 550 beds and then there is another tower which could come up. But what is the near-term action plan for the existing units of the 250 bedded unit in terms of the speciality addition, etc. ARPOB, I believe, is substantially low, so what would be the drivers going ahead for this unit to improve the ARPOB?

Abhay Soi: Clinical programs is clearly one, adding doctors is the other and that's how you achieve growth in clinical programs, and improvement in infrastructure. We expect to refurbish the present infrastructure as well as add 140 beds by end of this calendar year. As far as clinical programs are concerned – oncology represents less than 2% of the total revenue in Max Lucknow. So, that's a major driver for us. As you know, it is a high ARPOB business and contributes more than 24-25% to our overall revenue. So, if you look at implying that to Max Lucknow, you will see a major fillip in ARPOB. Like I mentioned, we've seen that in the first three months literally. We acquired it in end of March, and in April, May, June compared to April, May, June last year, there's already been a ~58% increase in EBITDA, and this has largely come through all the low hanging fruits, etc., which were there.

The real changes that we may have made, you're going to have all of those pay dividends in the quarters to come. Also, typically we have a higher proportion of surgical business in our hospitals and a lower proportion of medical business, whereas in both Nagpur and Lucknow, the situation is the other way round. So, when your surgical mix moves up with respect to the medical mix, you see higher ARPOBs in any case. So, there are plenty of levers. We are not sort of concerned about that. And frankly, the kind of traction that we are getting and the early wins that we have been able to demonstrate over there, gives us a lot of confidence that we should be able to ramp up both ARPOB as well as profitability there.

Amey Chalke: So, this oncology addition, etc. should we expect it in the existing unit or it will happen once the expansion for the bed addition happens?

Abhay Soi: No, no. In the existing unit. We already have bunkers for radiation, etc., which are non-operational. We will just operationalize this. The 140 beds that we are adding as well as refurbishment that we are doing is going to happen by the end of the year. Actually, even the new tower that we are building is going to be done over the next 24 months because it is 27 acres of land and we don't have to build so many basements, similar to what we are doing at Max Smart. But yes, the oncology business should ramp up in the current year itself. It may not ramp up to 25%, but you will see ramp ups in the quarters to come immediately, as well as in the surgical business. Even after we take over these, when we start adding doctors, when we issue letter of intents and they sign up to join us, they still have 2-3 months' notice period. So, it takes them time to join us and as the infrastructure, the new equipment that has been ordered, etc. comes through, you will see more and more teams coming up. Right now, all the technology, all the equipment, etc. is being replaced, right?

Amey Chalke: The second question I have is on the Dwarka unit, which has been recently commissioned. If you can provide some timeline over there, how the ramp up will happen? And in terms of the Speciality, is it at par at present with the other units or do you think the improvement will happen over a period of time?

Abhay Soi: So, in terms of the infrastructure, it is at par. I think the bunker is not ready as yet. That is going to be ready in due course. But other than that, I think as far as the infrastructure and technology is concerned, not only it is at par, but it's also the new generation. I would say it's perhaps one or two steps ahead of the existing infrastructure. We have again seen very good traction over there. It is a massive facility. It's the best infrastructure of its kind in the region of Dwarka. There's a huge amount of population. Again, fantastic traction is what we have seen in the first month itself. And I think that should continue. We should have a break even within 6 to 9 months.

Moderator: Next question is from the line of Rishi Mody from Marcellus Investment Managers.

Rishi Mody: Abhay, just on the Mohali hospital that you are planning to add four years out, right, is this going to be firstly an O&M agreement the way we have with Devki Devi and those kinds of hospitals or is it an outright rental sort of a model that we see in retail where we don't incur any CAPEX, we have to just put in a security deposit, and we start operating on it?

Abhay Soi: It is the latter, we're leasing it. It's an outright rental / lease model where somebody else is putting the infrastructure and has invested in the land making a built-to-suit. It's a 50-year lease agreement. The only difference is normally you have commercial leases for 9 or 15 years, but here there's a 50-year lock in.

Rishi Mody: So, just from a broader conceptual point of view, right, are we seeing incremental interest from, say, the builder or real estate community towards having this sort of models or like if you could just share your observations from across north India or rest of the country?

Abhay Soi: It depends on the tenant. Today, say you tell a builder to make a built-to-suit and we will give you 8-8.5% yield, with 3-4% increment every year, which is what the market is, as far as commercial real estate is concerned. As far as the builders or developers are concerned, they are happy to do it for commercial real estate, for retail real estate or for hospitals. The question is how many hospital chains can offer this. Your own

ROCEs have to be significantly higher than what you are paying out over there. In our situation, we are able to take up these hospitals because our ROCEs are significantly higher. And so, this built-to-suit model works for us. And it certainly works for the developers. They are taking a punt on our balance sheet effectively and that is where they're getting the confidence that we will be around for 50 years, and they'll be able to, even after making that particular hospital, dedicate it to us for 50 years. Because do remember, this is a built-to-suit, so it's as per our design. If somebody is building something under certain specs and leasing it out to you for 50-years, he has to be very confident that you will be around for 50 years and your balance sheet will be able to hold it. I think that's the punt a developer needs to take because eventually you're a tenant, but here you're a tenant for 50 years. It's not as if you can move this hospital and you will start using it for a mall or give it for some other purpose or hotel or whatever else it is.

Rishi Mody: I think you went through the capacity addition plans and updates pretty quickly, but just on an overall basis versus Q4, any delays or any preponement, if you could highlight that piece?

Abhay Soi: Not really. So, we're not expecting any delays or preponements. I think, except for Vikrant, which is the last one in any case and is a 2027-28 generation hospital where we're expecting maybe a couple of quarters of delay. Other than that, we are not expecting any delays. So, you should have Mumbai, Mohali, as well as Smart up by Q4 FY25, Q1 FY26.

Rishi Mody: Yogesh, I had a question for you on the tax rate piece. So, I am seeing a tax rate for this quarter has come up to 26%. Just wanted to understand because I am under the impression that we have a tax benefit in the BLK and the Nanavati and now with both, the Dwarka unit. So, is my understanding correct and this is just a factor of the profitability for these two charitable hospitals, if you could just help me understand the tax piece for you all?

Yogesh Sareen: That's right. So, overall rate is 22.8%. The rate has gone up this quarter because we have losses in the new entities, mainly the Sahara hospital entity. Sahara hospital transaction was Rs. 993 crore. We funded this by Rs. 840 crore of loan into the entity. And as Abhay alluded to in his speech, we are changing the cost and capital structure in the company. So, since we have losses in the company, we don't do the DTA as per our policy till such time the company is profitable. That means that you have these losses, but you have tax on the other entities. That is the reason why the rate has gone up, but otherwise the rate was same as in Q4. Q4 was 21.8% and we do think that going forward it will be around 22%. Also, for BLK, the agreement is that whatever is the net profit, 98% of the profit comes to us. So, the moment we withdraw that money from there, there are two taxes on that: one is that there is GST and also other is that when the money comes on this side, then we have to pay tax on it, right? So, to that extent, BLK doesn't allow me any tax shields.

Yogesh Sareen: We don't trap money in trust. We take it and we pay full tax on it.

Rishi Mody: For example, now in BLK, there's no capacity expansion plan, so you are taking the money, repatriating it to the holding company, but Nanavati, we have a plan of expansion, hence we are not repatriating, but once that expansion is done, it will also become like BLK, is my understanding correct?

Yogesh Sareen: That's right, but also this formula is on cumulative basis. So, what happened is that BLK wiped out their losses on a cumulative basis in Q2 last year. So, the withdrawal has happened from Q3 onwards. Similar thing will happen for Nanavati, the

withdrawal will happen but that will happen once the cumulative profits are made in that trust.

Rishi Mody: So, maybe 1-2 years down the line, it will start paying off?

Yogesh Sareen: Yes.

Moderator: Next question is from the line of Damayanti Kerai from HSBC Securities and Capital Markets (India) Private Limited.

Damayanti Kerai: My first question is on the margin contraction which we have seen in 1st Quarter. Can we attribute most of that for the new facility cost or between 4Q and June quarter, have you seen any major change in the business mix say in terms of medical and surgical volumes which are coming to your facility?

Abhay Soi: We have clearly seen a change in the clinical mix. It's moved to a higher-end clinical mix. And like I've mentioned in the past, when you do higher-end surgeries, you do more robotics and more oncology, etc., they typically have lower margins in percentage terms, but higher margins in value terms. Whilst you see a flattening of EBITDA margins, you see an increase in EBITDA per bed on the existing hospitals as well. The takeaway should be that what is the increase in EBITDA per bed because eventually we have got two things - we have got inventory and we have got number of days in a year. You would rather do a 20% margin on a Rs. 10 lakhs surgery than do a 50% margin on a Rs. 2 lakhs surgery, right? So, the percentage is irrelevant. Other thing is that we had a reduction in OP footfalls, like I mentioned, in the current year and these OP footfalls were largely from immigration because of disruption in visa from Canada and from UK and a little bit in Australia. That has also had a couple of percentage points impact.

Damayanti Kerai: My second question is a couple of your hospitals are scheduled to start in another 6 to 12 months if I may say, Nanavati, Smart. So, just want to understand when you are about to start a new facility, when do you start your pre-launch activities and what kind of cost you are anticipating for these upcoming units?

Abhay Soi: Unlike Dwarka, which is a new facility and you need to actually have a minimum number of doctors and staff, i.e., you pretty much need to staff the entire hospital. In that case, before you apply for even a nursing home license, you are sitting fully staffed, then you make the application for the nursing home license and then you need to promote the facility by advertising it, etc. by onboarding doctors and getting all the insurance companies and TPAs onboarded, by getting institutional empanelment, by getting corporate tie-ups, etc. You are really starting from ground zero. All of the facilities that you have alluded to right now, be it Nanavati, Mohali as well as the Max Smart, they're all existing facilities. So, we don't need to promote the existing facilities. There are enough people waiting in the ER over there, waiting for beds. In fact, it's going to be very similar to what happened in Shalimar Bagh. In Shalimar Bagh, we didn't have to incur any pre-op expenses or promote the facility or even wait to get the contracts, etc. All of the contracts were already signed up at the existing facility. So, you won't see any pressure on margins over there. I think almost from day one you are good to go.

Damayanti Kerai: My last question is a clarity on your Mohali planned hospital. So, you said it's a 50-year long lease and it's a built to suit premise which you will be getting. So, there will be no CAPEX once you get the facility lead, just say, equipment and then people cost which will be going towards this?

Abhay Soi: That's right. We will be providing the medical equipment, the security deposit, which is interest bearing, and loose furniture. The entire project cost will be incurred by the developer, including the land and building, etc. More importantly, any delays, any cost and time overruns, everything will be on to their account. This is very similar to what we have done in Dwarka.

Damayanti Kerai: The way like Dwarka, it's O&M facility which you got into your network, but -

Abhay Soi: This is not an O&M; it is a lease. But the same arrangement like Dwarka, in the sense that developer will develop it and incur the project cost. We only bring in the equipment and fit-outs Whether you look at O&M or a lease, the commercials are pretty much the same and the arrangement is asset-light.

Moderator: Next question is from the line of Kunal Randeria from Axis Capital.

Kunal Randeria: Abhay, in the last few quarters, the number of your institutional bed is stagnant around 29%. Do you see headroom for some improvement over here?

Abhay Soi: We do see headroom for improvement here, but usually Q1 and Q3 are weaker quarters. So, compared to a Q4, you take your foot off the accelerator since that's not the time because your occupancy levels subdue at that point in time and you are not going to churn your patients. Typically, you will see churn happening in the Q2 and Q4.

Kunal Randeria: Because even I think in last quarter it was somewhere around 29%, right in the last five or six quarters somewhere in this range.

Abhay Soi: But that's a Q4, right, the fourth quarter is a strong quarter. So, if you see Q3 versus Q4, there may have been some change. But if you look at Q4 versus Q1, you won't have a change. So, typically now again from Q1 to Q2, you will see a change, but Q2 to Q3 you won't see a change.

Yogesh Sareen: I would also say there's a change that you don't see. That change is in the ARPOB of the business, right? We do the PSU business, but while you may see the same beds, but the throughput of those beds has gone up. If I see the improvement in the ARPOB year-on-year, it's a 10% improvement in the ARPOB of the PSU. This means that within those beds we are trying to do higher-end work

Kunal Randeria: Second question is on ARPOB. This quarter saw around 7% growth on your existing units. So, is this the new normal that we should expect going forward?

Abhay Soi: No, this is because of immigration and visas, that's had maybe a 2-3% impact on ARPOB. That is a business we had last year. But this year there's been some disruption because of Canada and UK not issuing immigration visas, and we have seen the same with Australia as well. We believe it's a temporary phenomenon and that business is a little subdued. But if it doesn't, then we kind of repurpose that space to put more dialysis beds, etc. We will catch that up. I think 7% would be a little muted compared to perhaps what we have had in the past.

Kunal Randeria: When you mention that your growth should be higher than 7%, does it include all the beds or just the existing units?

Abhay Soi: New units will be a significantly higher ARPOB growth. New units are starting at a low base. So, if you combine the two, then your growth should be more. You had a revenue growth of 21% in the new units.

Kunal Randeria: So, you are saying that maybe Lucknow and Nagpur whose ARPOBs are lower should grow at a much faster pace than your existing hospitals?

Abhay Soi: And Dwarka. It's the new hospital, right. Since your percentage growth, the absolute base is lower, they're starting on a lower ARPOB. If you add a 21% and 64% growth in Lucknow and Nagpur on revenue and EBITDA alone so you can imagine huge amount of growth coming from that.

Kunal Randeria: I think Lucknow seems to be like a go to spot for a lot of your peers also. Do you think that so many beds coming up in that area, there is enough medical talent available both from the doctors as well as from the nursing perspective?

Abhay Soi: Actually, I don't know of any other hospital coming up there. And besides Medanta, which has been there for a while and a smaller Apollo facility which has again been there for 5-6 years, and Max Lucknow (erstwhile Sahara hospital) was also an existing facility and other than that we have only bought the land in Shaheed Path. But I haven't heard of any other hospitals really coming up there.

Yogesh Sareen: But nevertheless, we see an abundant supply of talent there. In fact, the doctors that we employ in Delhi, a lot of them are from SGPGIMS, Lucknow. So, to that extent, we haven't really –

Abhay Soi: Historically, Lucknow has been the place where we have got most doctors. Around 25-30% of our Delhi doctors are from Lucknow. Historically, Lucknow has had medical colleges and government medical hospitals, etc. and therefore a big base of doctors there.

Moderator: Next question is from Dheeresh Pathak from Whiteoak Capital Management.

Dheeresh Pathak: Sir, which quarter do we take the annual increments -- is it this quarter or -?

Abhay Soi: 1st of April.

Dheeresh Pathak: For the Mohali asset that we mentioned, would it be possible for you to share how much the real estate partner is investing in the land and building for the 250 beds?

Abhay Soi: I can't share that. He owns the land. We have given our specifications and our BOQs, but they don't share what they're spending. But the building alone will cost about 80% of the total project cost if we were to do it.

Moderator: Next question is from the line of Adrit Chaturvedi from Nomura.

Adrit Chaturvedi: So, my question is specifically regarding the inpatient business. So, you have reported this quarter around Rs. 1,600 crore of IP revenue. So, that's around 21% year-on-year growth. And also, the volumes have grown by roughly 17%. So, that translates to about like 3.5% growth in realization. Now, this 3.5% is sort of one of the lowest in the preceding quarters, but at the same time, the volumes are like highest in the preceding quarters. So, is this the sort of business profiling that we should come to expect as you grow and you expand that your realization per patient on the IP business is going to be around 3-4% but you are going to focus more on volumes?

Yogesh Sareen: I think you are looking at the overall number, which includes the new facilities. You should compare the number on year-on-year basis for the existing hospitals separately because the new hospitals' ARPOB is obviously lower. To that extent,

you will find a volume increase but not an increase in the revenues because of the ARPOB issue. As Abhay mentioned that as we change the mix of the business in those new hospitals, we also put in oncology there and have more talent there, the ARPOBs will start inching up slowly. So, there's a difference of Rs. 80,000 to Rs. 45,000. The new hospitals have ARPOB of Rs. 45,000 and our existing hospitals have an ARPOB of Rs. 80,000. We think that Rs. 45,000 will surely come up fast. So, it should be anything between Rs. 60,000-65,000 let's say in a year's time and that's how this will catch up. Then you will find that the volume increase and the overall revenue increase will start to have lesser differences.

Adrit Chaturvedi: So, the backdrop also on the levers for these realizations, right? So, like if we look at the sum of shares of oncology, cardiac sciences, orthopedics, neuroscience and renal, the share has come down this quarter on year-on-year basis and that's the first in a while and -?

Abhay Soi: Because you included the new hospitals, which has less than 2% oncology share.

Yogesh Sareen: Because the new hospitals share is very different from what we have in the existing hospitals.

Adrit Chaturvedi: When do you suspect like, as the expansion ramps up like we would have a sort of a resting rate where as you said ARPOB grows at roughly 9-10%. So, I guess the realization grow at 8%.

Abhay Soi: No, it doesn't work like that. Please understand what is it that we focus on? We focus on acquiring facilities, turning them around, and getting higher ROCEs over a period of time, but we look at it on an incremental basis, right? If we bought something with a lower ARPOB and we are demonstrating an increase in that ARPOB, it may or may not get to the same ARPOB levels as the Network average. For instance, Nagpur hospital will not have the same ARPOB, eventually, that the Delhi hospital does nor will it have the same EBITDA per bed. What you have to see is vis-à-vis what you paid for it, what is the sort of return you are going to get. What we are seeing is that levers for doing all of that is going to be better clinical mix, doing more surgical work, higher oncology business, etc. Now, you may get to that mix of 25% or 24% oncology, okay, but you may not get to the same ARPOB as Delhi because the rates in Nagpur are cheaper. I am not even chasing the Delhi ARPOB for it, right?

Adrit Chaturvedi: Lastly, so a lot of your peers have mentioned that they're sort of translating a lot of the lower ALOS businesses to like day care. And right now, your IP business is roughly 80% of overall. So, you don't give any separate numbers there. So, do you have like any kind of qualitative color regarding what's the OPD margin profiling versus daycare and how it helps your margins, if you sort of translate a lot of those lower ALOS to daycare and non-census beds?

Abhay Soi: Look, the lower ALOS business has its own sort of tenets with it, because currently insurance companies don't cover procedures where you don't spend the night in the hospital. So, you need to spend the night for insurance companies to settle the claim. Daycare may not be covered by the insurance companies. That itself is kind of a hindrance. The longer you stay in hospital, the hospital loses money since the surgical part is what makes money. So, if you can translate anything into a daycare, get a person in the morning, do the procedure and have him out by the evening, your yield is significantly higher. The question is, why is it that you can't do it, because for most of the procedures, you need to stay in the night in the hospital to get to claim insurance.

Adrit Chaturvedi: So, on the cash pay patients is there a targeted strategy there to like to move a lot of these lower ALOS to daycare or is it something that's not the focus right now in terms of your non-IP business?

Abhay Soi: So, we do that as hygiene, right? I'm not sure exactly what you are seeking. If you are able to articulate a little better, then perhaps I can answer your question.

Yogesh Sareen: For us, ARPOB is the one that we pursue. The daycare procedures will be all run-of-the-mill procedures. Our focus is to go up the value chain. So, we will be pursuing liver transplants, oncology, neuro, cardiology, cardiac surgeries, etc. I think those are the sort of procedures that we pursue. So, while obviously there'll be shift of some procedures that you do in one day stay to daycare. Yes, we can and we do, but that's not the focus of the hospital administration to really pursue.

Abhay Soi: It really depends on what your proportion is. For everybody, the ALOS is different because the clinical programs are different. Now, if you do a liver transplant, your ARPOB is higher, your EBITDA per bed is higher. But the fact of the matter is that the patient stays much longer. Now, would I replace that with a dengue patient, which has maybe a lower ALOS and higher percentage margin but lower sort of EBITDA per bed and ARPOB? No.

Moderator: Next question is from the line of Prashant Nair from Ambit Capital.

Prashant Nair: As your new projects now start coming onstream over the next few years, if you take some of your larger brownfield projects like say in Saket or Nanavati, when the new beds come online, do they have similar case mix, payor mix, ARPOB, etc., as the older base, or would we start at slightly different levels and then match up to how the existing hospital beds does?

Abhay Soi: So, you are going to have a different mix to start with, because first and foremost you try to ramp up occupancy over there in the new beds. And when you do that, then you are not kind of very strict on the payor mix as well as the clinical mix. People who may not be getting priority today because that's a lower end payor mix or a lower end clinical mix, you open your doors to it. So, your ARPOB from the incremental beds is lower. Having said that, the EBITDA per bed is higher. So, your profitability is higher because you get huge amount of operating leverage over there. Your main costs, associated costs, etc. are already being incurred by the existing hospital.

Prashant Nair: Second question is in these projects, would the investment in the beds follow a similar pattern for say a new Greenfield project where you front load everything, right? So, in brownfield beds, is there a period maybe after the first year, second year when you have to step up either investment in people or equipment for a ramp up, or are they all done at the beginning?

Abhay Soi: This is all done in the beginning. So, you don't have to step up anything. For brownfield, you are operating with the same set of people, the same majority of the equipment is already there.

Moderator: Next question is from the line of Tushar Manudhane from Motilal Oswal.

Tushar Manudhane: So, on international patient ARPOB if you could just help us understand like how much decline in the ARPOB that has happened because of these issues related to visa's over there year-over-year or quarter-on-quarter?

Abhay Soi: International business has got nothing to do with immigration business. These are two separate streams altogether. The immigration business is where people come for visas, they have to get themselves tested, etc. in our immigration departments. International business is the incoming business that you have. I mean, immigration business is if you have to relocate to Canada, then you have to get your medical tests and all done. It's outpatient business. The international medical tourism is people who are coming to India. So, these are two separate business streams.

Tushar Manudhane: So, as far as international business, just to understand what kind of ARPOB growth we have seen in the last two or three quarters?

Yogesh Sareen: Typically, the ARPOB in the international business is one and half times of the overall ARPOB. International business growth on ARPOB would be 7% to 10% if you see last year. But it also changes from quarter to quarter, depending on what is the procedure configuration that you are getting. So, it will be overall growth. These tariffs are linked to the self-pay tariff.

Tushar Manudhane: So, largely similar to that of the domestic patient in terms of growth, not in terms of value, but in terms of growth, we are largely similar in both international as well as domestic patient, is that the right way to look at?

Yogesh Sareen: Pricing is linked to the self-pay tariff, right? We charge a premium on that, but it's linked to self-pay.

Tushar Manudhane: How much is the OPEX at Dwarka like operational costs when you say break even within six to eight months, so if you could share how much OPEX and how much of that is already into the P&L? You said that we need to get the licenses and also you need to have doctors and nurses already onboard. So, does it mean that it is already in 1Q?

Yogesh Sareen: In this quarter, we have Rs. 6 crore of pre-launch costs. These are the costs of the doctors and the staff that we had hired. Before you get the nursing home license, you are supposed to have people on your payroll. You need to demonstrate to the Delhi Health Department that we have so many people available for treating patients. So, this is that cost. We haven't had any revenue from the hospital in Q1. This cost will obviously build up. This is the cost which is for the quarter. But obviously if you take June month, the cost will be higher than the average. Rs. 6 crore is not for the full quarter. If I take July, you will have further increase in the cost because we are adding more people. So, we opened 94 beds at this point of time and I can't give you a P&L statement in terms of what the cost would be, but we do think that by the 8th to 9th month we should be in a breakeven state, which means that in Q4, we should start to see breakeven numbers at EBITDA level for Dwarka hospital.

Tushar Manudhane: Trying to understand till that time how much drag will be there on the existing EBITDA of say 500 crore, so from that perspective just wanted to understand?

Yogesh Sareen: We said Q4 will breakeven, right? So, that means the drag will happen till Q4. So, in Q4 you will see that loss becoming kind of breakeven for Dwarka.

Tushar Manudhane: And how much further investment would be required in Lucknow for these 450 beds once the EC approval is there?

Yogesh Sareen: So, I think this will be around Rs. 700 crore plus for the beds.

Moderator: Next question is from the line of Amit Kadam from Canara Robeco Mutual Fund.

Amit Kadam: Sir, my question is like I am just reading the Slide #10 and I am trying to refer the outpatient growth what we have seen, the fourth chart, where it shows that 4.5% has been the growth for the like-to-like the existing hospital. Whereas when I compare it for the Q1 FY'24 a year back, this run rate was like almost 13%, 14% growth rate. How do I read this particular thing 14% versus 4.5% right now?

Yogesh Sareen: OP consults have come down and Abhay alluded to it in his speech as well. We have immigration business, which is down by around 48%. We have three centers for immigration: two in Punjab and one in Delhi. Now, the footfalls have come down by 48% there. So, obviously that has an impact on these numbers because that's OP business. So, we do think that this impact will go on till Q3. Q4 was the normal quarter because we have this change in the visa regulations from 1st of January this year. So, there will be some impact that you will have.

Abhay Soi: But the good part is this is not the OP business which leads to in-patient admissions, right? I mean, for immigration business, OP patients come do the consult and go out the same day. So, they don't get translated. Normally reduction in OP business or in outpatient footfalls would be concerning because what that means is you are going to have lower inpatients going forward, but this is not the category of people which convert to inpatients. Also, last year, I think we opened Shalimar Bagh and so 3% of that was because of the capacity expansion, as Keshav pointed out. It was new capacity, which had opened in this quarter last year.

Amit Kadam: So, like the kind of capacities what we are going to see in next one odd year, what is the metrics or what number you would like to see because for a kind of a run rate in terms of volume what we want to see and partly driven by ARPOB, but partly driven by volume, this number should be high single digit, that's what could be a number for maybe a steady state growth?

Abhay Soi: Are you talking about the existing hospitals or the new hospitals or combined?

Amit Kadam: Existing, sir, because combined may not be correct reference but like when I just see that inpatient and outpatient both and you say that partly would be the international but then I am just like little confused that international patient coming off may not have a so much -

Abhay Soi: So, the material part is the inpatient.

Amit Kadam: Yes, so inpatient is 5.5%. That's what is the second part of the question is then what is the run rate I need to see in this particular number to maintain our steady state growth rate as a tracking point?

Yogesh Sareen: So, I will just give you an example of what happened in Shalimar Bagh. This is the hospital where we added 43% bed capacity, and the moment you had the capacity available, the capacity got filled up, the inpatient volumes and the occupancies went up by 34-35%. That means the outpatient and inpatient footfalls went up by 34-35%. That's the same thing we expect here to the extent that if there is a brownfield expansion and let's say in a 300-bed hospital, we are adding 150 beds, and we plan to open all those 150 beds in one go, so to that extent you will find that the volume will expand and within 2-3 quarters we should be reach normal occupancy levels as well –

Abhay Soi: If you want to do apples-to-apples, like you added Shalimar Bagh capacity last year same time, this year you will add Lucknow and Nagpur and then see what the overall growth is. That's why I asked you the specific question, because you are not doing

apples-to-apples, right. If you are looking in existing hospitals last year, then you have to look at existing hospitals without the Shalimar Bagh expansion.

Amit Kadam: But sir, this is a volume count, right? So, it is irrespective of what hospitals I am trying to count because even I give that benefit of Shalimar Bagh also now part where in the existing part, and if it is 5.5.

Abhay Soi: I just look at it differently. So, let's say last year, you had 3,400 beds and then you add let's say 200 beds to it because you have done a brownfield. Now, you have moved to 3,600 beds. You are not comparing the 3,400 to the existing beds today, you are comparing the 3,600 beds to the existing today, but you had that jump of 200 beds last year. Likewise, if you take a jump of 900 beds this year, then you need to look at overall footfalls.

Yogesh Sareen: Let me convey it the other way around and explain this. So, basically, we have the highest occupancy among our peer group, which means that we cannot have more in-patients. So, what needs to come first? You need to have capacity to have more in-patients. So, to that extent we are limited by the number of beds that we have. And the example that I gave to you was Shalimar Bagh. The moment we added beds there, the volumes went up. So, as the capacities will get added, we do think the growth in the volume will materially change because we don't have beds right now.

Abhay Soi: If you don't come up with brownfield, if you don't come up with capacity addition, we're already operating at 77% occupancy. I don't have room for my beds' occupancy to go up. It can only be marginal.

Amit Kadam: This explains that particular thing because maybe on the flip side, I was maybe trying to see is there a shortfall in terms of whatever the demand expectation is.

Abhay Soi: No. I mean, there's a shortfall of supply and that's why we are doing all these brownfields.

Yogesh Sareen: And that's where the Shalimar Bagh fitted.

Amit Kadam: And you mentioned that inpatient and outpatient doesn't have a high correlation with that particular thing?

Abhay Soi: No, it has a very high correlation, but the outpatient business that has reduced is the visa immigration business. So, let's say if you immigrate to Canada, you will come to our hospital and get the medical certificate from us because we were accredited with the Canadian Embassy. Now that person was not going into inpatient, he was not getting admitted for a procedure. Since Canadian government is not issuing visas right now, so people are not coming for that medical certificate.

Amit Kadam: If you would have added that missing part, what run rate this number 4.5 would have been?

Abhay Soi: My inpatient would be the same.

Amit Kadam: Not inpatient. Outpatient, then, sir. That 4.5 would have jumped up?

Abhay Soi: Yes. Then that would have gone up.

Moderator: Next question is from the line of Sumit Gupta from Centrum Broking.

Sumit Gupta: So, just want to understand on the bed share mix. So, basically from the existing universe bed share has remained majorly between 29% to 30% for the institutional segment, however overall institutional bed share mix has come down to 27%. So, how do you see it going forward over the next two to three years, once all the facilities get integrated and they are in full stream?

Abhay Soi: There are two aspects. Like we said that Q1 is a weaker quarter, so you have less demand. Therefore, you don't put your foot on the accelerator and start driving out institutional business, you accept and accommodate because you want to fill your beds. Normally, you see this happening in Q2 and Q4 where you have reduction in institutional business. Having said that, like I mentioned, when you come up with new brownfield capacity, then occupancy is the criteria, not the caliber of clinical mix as well as the payor mix. So, at that stage, we will be taking more institutional. But having said that, even for institutional business, the EBITDA per bed which we're able to eke out is significantly higher than what it is for existing beds, and that has been our experience in Shalimar Bagh also. So, when we opened the new beds there, we saw the incremental ARPOB of the new beds come down because you were taking institutional as well as lower payor mix, etc. but the EBITDA per bed pertaining to those incremental beds was higher than the EBITDA per bed of the existing hospital.

Sumit Gupta: And for the international patients also, you see bed share mix going upwards or remaining at the same level and like how do you see this international business going forward?

Abhay Soi: The growth in that business has been outstripping growth in other segments, so percentage share is incrementally going up.

Yogesh Sareen: So, I think Q1 is an aberration there, but growth has come back as we speak and there was some temporary blip because of situation in Bangladesh, Yemen, Somalia, etc. –

Abhay Soi: Nevertheless, as long as your growth in international business is more than growth in your other business, you will see the bed share only go up.

Moderator: Next question is from the line of Alankar Garude from Kotak Institutional Equities.

Alankar Garude: We have added two new cities to our network in the past six months. Other than these two, our focus seems to be on growing in the existing market at least over the next four to five years. The question is beyond what we have already announced so far on the expansion front, is it fair to expect a relatively higher expansion announcement coming through towards the newer markets?

Abhay Soi: I think growth in our existing hospitals is not a focus, growth in our existing hospitals is a necessity, because we have run out of capacity. We are already operating at 77% and we need to increase bed strength in our existing hospitals. That's why you are seeing this incremental expansion happening and this is something we embarked on 2-3 years ago. So, they've been under construction and maybe between the next 8 to 15, 20 months you are going to see a lot of that capacity come through. Now, having said that, we still have our balance sheet. You know all the expansion is being incurred through internal accruals. So, we are intending to go to other markets. They are high ROCE markets, high opportunity markets, and frankly, you can imagine whatever multiple we have paid for these two hospitals, has already come down by 60-odd% simply because we have moved the EBITDA up in the first three months. So, we see opportunities in other markets as well and we are focusing on them. That's where the focus is going to be. This doesn't mean that we don't look

at metros. The point is that in metros, it's going to be that much more difficult to be able to acquire hospitals or to acquire land because it's not available.

Alankar Garude: So, maybe a link to that one, how are you looking at this expansion from an operational standpoint, I mean any need to beef up the senior management team, can senior management bandwidth be increasingly an issue going forward?

Abhay Soi: On the contrary, I think if you actually see the number of locations that we have added in the last 5-6 years, is essentially three; one is Dwarka, which is opened, one is Lucknow and one is Nagpur. So, from maybe 17 hospitals, we have gone to 20. Everybody wants career progression, right? We have got close to 30,000 people working for us, and if it's one unit head, he also wants, over 5-6 years, his area of influence to increase. He's handling one hospital, now he wants to handle two, the person who is handling two, wants to handle three or four. So, I think providing that growth, providing that segue for people's career path, is a necessity today. And essentially, a lot of our expansion is brownfield. Now if I increase 800 beds by another 400 beds in Saket, it's the same location, you are not really operating another facility. So, from 200 beds in Mohali, you go to 355 beds, you don't require management bandwidth for it. I mean, you are just doing more of the same effectively. And 85% of our growth coming through going forward is coming through brownfield. So, it's your existing capacity that you are increasing. From a leadership standpoint or down the line, with three locations getting added on top of 17, there is not much of a bandwidth issue. On the projects side, of course we have augmented the teams, because when we embarked upon all of these expansions, we needed to fortify those teams. So, that we focused on. Other than that, not really. And of course, we have strengthened the teams, etc. but that happens through due course. I don't see bandwidth issues because frankly the expansion hasn't been that much in terms of locations.

Alankar Garude: So, maybe that question becomes more relevant as we go beyond these 20 locations. So, the second one then, Abhay is we have been increasingly hearing about resistance from insurance companies on rising healthcare tariffs. Over a period of time, do you expect any change in the balance of power when it comes to negotiations between corporate hospital chains like us and the insurance companies?

Abhay Soi: Insurance companies by the end of the day piggyback on what your schedule of charges is, what your rate list is for cash paying patients. And frankly, I think you have the most democratic system over here because no hospital has a monopoly. Patients are choosing to go where they want basis the value proposition that they are able to get. It's not as if people are not kind of reducing their prices to get more patients. Everybody does that. None of the big chains are price makers, we are all price takers. Eventually, 90% of all healthcare is provided by smaller nursing homes, etc. Every year they know what the inflation is, they come up with a particular price, and when we seek price data, that is the basis on which we increase our rates. From our standpoint, do keep in mind that our EBITDA per bed is still 55% better than the second-best player in the industry. Our ARPOBs are maybe 20% better than the second-best player in the industry. So even if there is price negotiation, that sort of comes down for us. I frankly think that the insurance companies are a lot more fragmented.

Moderator: Next question is from the line of Shubham Dugad from Purnartha Investments.

Shubham Dugad: I want to know how many nursing seats you have across hospitals?

Abhay Soi: You mean nursing colleges?

Shubham Dugad: You have some nursing facility in Lucknow, I think.

Abhay Soi: We have one nursing college in Lucknow and that's around 100 seats.

Shubham Dugad: And do you want to increase that or something like planning there?

Abhay Soi: No, we have tie-ups with many nursing colleges.

Shubham Dugad: How many beds being operationalized in Dwarka?

Yogesh Sareen: So, it's a 303-bedded hospital, and so far, 94 beds are operational.

Moderator: Ladies and gentlemen, I now hand the conference over to the management for closing comments.

Abhay Soi: So, thank you everyone for joining us for the Q1 FY25 Earnings Call. We look forward to catching up again next quarter. Thank you.
