Max Healthcare Institute Limited

Q4 & FY22 Earnings Conference Call Transcript

May 26, 2022

Moderator: Ladies and gentlemen, good day and welcome to Q4 & FY22 Earnings Conference Call of Max Healthcare. Please note that this conference is being recorded.

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

Anoop Poojari: Thank you. Good afternoon, everyone. And thank you for joining us on Max Healthcare's Q4 and FY22 earnings conference call. We have with us Mr. Abhay Soi, Chairman and Managing Director; and Mr. Yogesh Sareen, Senior Director and Chief Financial Officer of the company. We will begin the call with opening remarks from the management following which we will have the forum open for interactive question and answer session.

Before we start, I would like to point out that some statements made in today's call maybe 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: Good afternoon, everyone, or good evening. A very warm welcome to all joining us for the fourth quarter earnings of financial year 2022. Let me provide key highlights of the past quarter before opening up the forum for question and answers.

Q4 performance was in line with our expectations. You would recall in our previous quarter's earnings call; we had highlighted the impact of Omicron wave on bed occupancies in the first half of the fourth quarter of FY '22. Subsequently, the occupancies bounced back sharply. Moreover, aided by resumption of international travel, international medical tourism recovered back to 90% of pre-COVID levels in March 2022.

The initial drop in occupancies was mainly due to the Omicron wave, this time characterized by high rate of infections, but low hospitalizations. Nevertheless, non-COVID elective work was impacted, as has been the case in the past. COVID admissions remained poor this time. The strong recovery in the second half mitigated the initial dip in occupancies to some extent, and thus the average occupancy for the quarter stood at 68% as against 60% in January. Fourth quarter EBITDA was Rs. 304 crore with operating EBITDA margin of around 25%. This is after one-time cost of Rs. 7 crore incurred in relation to the two inorganic transactions announced during the quarter.

The highlights for the fourth quarter performance were

- network gross revenue of Rs. 1,298 crore, a growth of 12% year-on-year, but degrowth of 7% quarter-on-quarter. Due to widespread Omicron infections a number of doctors were infected leading to disruption of work in some of the specialties in the first half of the quarter.
- The digital channel contributed 13% of the revenue.

- Network operating EBITDA stood at Rs. 304 crore in Q4 of FY '22, demonstrating a growth of 16% year-on-year and degrowth of 16% quarter-on-quarter. The EBITDA margin was 24.8% leading to a profit after tax of Rs. 172 crore. And like I mentioned, this included an Rs. 7 crore one-time transaction costs for the two inorganic transactions that we did.
- The absolute number of beds used for the institutional patients were lower than quarter three. However, due to overall drop in occupancies and occupied beds, relative share of such patients shows an increase from 31% to 33%.
- The ARPOB for this quarter was Rs. 63,500 implying a growth of 13% year-on-year and 4% quarter-on-quarter. This was assisted by the growth in international revenue as I mentioned.
- Cash generated from operations after interest, tax and replacement CAPEX was Rs. 179 crore during the fourth quarter. Rs. 328 crore was invested in growth initiative, which includes acquisition of stake in Eqova Healthcare for 400 bedded hospitals in East Delhi, operations, and management agreement for the under construction 300 beds hospital in Dwarka, purchase of transferable development rights for Gurgaon lands and other brownfield expansions at Shalimar bagh, Saket and Nanavati, Mumbai.
- Further, we onboarded 28 new senior clinicians in oncology, liver transplant, neuro, and cardiac surgeries.
- We also serve 34,000 indigent patients in IPDs and OPDs free of charge, the notional value of this treatment was Rs. 44 crore.
- Coming to the strategic business units,
    - MaxLab, which is a non-captive pathology business vertical added 60 channel partners during the fourth quarter FY '22. Taking the overall active clients to 760 spread across 25 cities now. Revenue grew by 40% year-on-year and 11% quarter-on-quarter. We continue to invest in this business and have augmented the operations, marketing and IT teams and increased our commitment to brand building.
    - Then comes Max@Home, our home healthcare vertical, we reported the gross revenue of Rs. 28 crore similar to the third quarter levels and representing a growth of 21% year-on-year. We have added around 70 people in the team during this quarter.

Coming to the overall fiscal FY '22, it has been an eventful year, to say the least. Where despite numerous challenges, there was a marked improvement in the performance. We closed FY '22 EBITDA at Rs. 1,390 crore, which is more than double of the Rs. 636 crore we achieved in the previous year.

In addition, as part of our inorganic growth strategy, we have announced four transactions, including purchase of two prime land parcels in Gurugram. These will have a combined potential to add 2,200 beds in the coming years, in addition to the ongoing brownfield expansions.

The key highlights for the year have been network gross revenue stood Rs. 5,509 crore as compared to Rs. 3,851 crore in FY '21, a growth of 42% year-on-year. Net work operating EBITDA stood at Rs. 1,390 crore as compared to Rs. 636 crore in FY '21, a growth of 118% year-on-year. EBITDA margin was 26.6% and the PAT was Rs. 837 crore.

In line with our strategy to improve the payor mix in FY '22, the bed share of institutional patients has been reduced to 31% versus 34% in the previous year, FY '21 by way of dis-empanelment of few institutional accounts at some of our network facilities. This process could have been accelerated if it wasn't for intervening periods of low occupancy during COVID to non-COVID switchovers. ARPOB improved by 17% year-on-year to Rs. 58,500 in FY '22 and EBITDA per bed improved by 78% year-on-year to Rs. 53.9 lakh during the year in spite of lower earnings from COVID beds.

Cash generated from operations after interest, tax and replacement CAPEX was Rs. 770 crore. The routine CAPEX spent during the year was higher due to catch up for FY '21 replacements. The investment of Rs. 671 crore in the inorganic growth initiatives and brownfield expansions was totally funded by internal accruals. Overall, net debt including put option liability of Rs. 139 crore has come down by Rs. 103 crore to Rs. 441 crore as on March 31, 2022.

To recall the inorganic growth initiatives announced during the year were: one, acquisition of exclusive rights to aid development and provide medical services to an upcoming 500 bed hospital in Saket; two, acquisition of two land parcels in Gurugram admeasuring 11 acres with the capacity to add over 1,000 beds; three, asset light expansion through a 300 bed under construction hospital in Dwarka, Delhi; and four, acquisition of stake in Eqova Healthcare having the potential to add 400 beds in East Delhi. These transactions like as mentioned earlier, have a potential to add 2,200 beds to our network. Of these we plan to operationalize 1,500 within the next four to five years. In addition, we have four ongoing projects for brownfield expansions, which put together will add 1,300 beds over the same period. Hence collectively, we will be adding over 2,800 beds in the next five years with expected capital expenditures of Rs. 3,700 crore that is intended is to be funded through internal accruals alone.

During the year we also served 126,000 indigent patients in IPDs and OPDs free of charge. The notional value of this treatment overall was Rs. 160 crore. This year MaxLab added 370 new channel partners taking the active clients to 760 spread across 25 cities. The revenue grew from Rs. 68 crore in FY '21 to Rs. 104 crore in FY '22, resulting in a 53% growth year-over-year. But more importantly, non-COVID revenue grew by 85% in FY '22 as compared to FY '21. Max@Home reported gross revenue of Rs. 112 crore, representing a growth of 60% year-on-year. In addition, this team played a stellar role in COVID vaccinations during the year and took a lot of load off the hospitals.

Going forward, we see the following additional levers helping us in improving our performance in short to medium term. One, international medical tourism growth from both existing and new geographies; two, improvement in payor mix; three impact of senior clinicians onboarded and continued strengthening of medical programs; fourth inorganic expansion in both hospital and diagnostic space. Finally, we are also working on the digital front, which will not only help us engage with more patients and widen our reach, but also serve our customers better and provide improved experience.

On this note, I would like to open up the forum for question and answers. Thank you.

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

Nikhil Mathur: Hi, good evening. My first question is on EBITDA per bed that the company has recorded in 4Q. Now ARPOB has improved sequentially that would have added on to EBITDA per bed. But obviously there is operating deleverage because of occupancy going down substantially. Assuming let us say in 1H FY '23, the mix remains stable and basis the April occupancy trends that have been shown in the investor presentation, would it be safe to assume that the annualized EBITDA per bed in 1H FY '23 is looking much better than what you did in your best ever quarter in 3Q FY '22? This is taking into account any recent inflationary trends that you might have been witnessing, which were not present, let us say a few months back.

Abhay Soi: I think two things I think immediately we have not had any significant inflationary, pushes that were unanticipated at present, which may not be the case going forward, but it is hard to call right now. Having said that, you also know that we do not give forward-looking statements. But if you were to sort of look at what the trend has been

and what the occupancies are. Q4 is normally a strong quarter, but the first half of the quarter had pulled down the average and the second half of the quarter was significantly better. So, I mean, the second half if that sort of continues into the first this thing and from industry standpoint, there is no reason for that not to happen. I think things should continue in the manner that they are.

But as far as the EBITDA per bed is concerned, if I look at last quarter, Q3 were at Rs. 60 lakh. This quarter it is about Rs. 56 lakh. But if I were to sort of normalize for that one-time expenditure on the two transaction which has hit our EBITDA, we will come to about closer to Rs. 58 lakh. So I think there is a reduction of about Rs. 2 lakh in that, but some of it can also be -- or a lot of it can be attributed to the lower OPDs which we had in the first half of the quarter.

Nikhil Mathur: Okay , also, if I look at the direct costs as a percentage of sales, they seem to have gone up quarter-on-quarter by around 140 basis points. I mean, mix would have been better I believe, with more of international patients coming in. So any particular reasons why the direct costs would have gone up by 140 basis points on Q-on-Q basis?

Yogesh Sareen: So Nikhil, obviously, there were some beds being used for COVID patients, right. So average of 7% of the beds were used for COVID patients so that COVID ARPOB lower there and also the consumption of material is high, also when the COVID comes in, there is a lot of PPEs that we have used. So, then the store consumption goes up. Also, relatively, I think, Abhay mentioned this already in his speech that there were some -- because of the fact that the overall occupancy came down, the relative ratio of institutional business went up, right, and institutional business is a lower margin business for us. So that obviously comes in and plays into the direct cost.

Also they were fixed component of clinicians costs, right. And that does not come down there is a one-month aberration here and there. So that all leads to a higher direct cost because of the fact that we cannot do much on that side.

Abhay Soi: I think, what you need to also focus on is EBITDA per bed, because what happens is the more medical programs that you do, okay, versus surgical medical programs have lower direct cost, while surgical programs will have higher typically, okay, but that's what you want to drive towards the surgical because eventually you also have a higher sort of flow through in terms of absolute numbers.

Nikhil Mathur: Okay, sure. And I just wanted to recheck on Nanavati here. So the bed addition of 330 beds that has to be done and 160 beds have to be demolished to achieve that. So basically the 288 beds, which are there currently operationalized that number will go down to 120 odd, and then obviously, plus the 320 or 330 addition that I am just rechecking sorry I might have forgotten from last earnings call.

Abhay Soi: So let me sequentially take you through it. We are doing in two phases. When we do phase one, we add 329 beds. Okay, we do not demolish anything. It is when I do phase two, that is when I have to demolish a part of the original structure. That is when I go down, but in a year so I am adding 650 and I am demolishing about 150 on an overall basis, so you would end up with I guess 650 plus 340 minus 150 or whatever eventually. It is not as if you reduce the number of beds and then you are doing phase one and phase two. Okay. So first the phase one comes up, then if we are doing phase two, which we are doing, okay, but let us say for some reason you decide not to do phase two, then you do not demolish the original structure.

Abhishek Agarwal: And Nikhil after both the phase completion, we will be having 760 beds in Nanavati after completion of both the phases.

Abhay Soi: That's census beds not total beds.

Nikhil Mathur: Okay, and another question on Nanavati, I don't know if it could be you would be comfortable sharing this or not, but have all the cost restructuring initiatives taken place in Nanavati and EBITDA margins would whatever you wanted to achieve whether at par with corporate or a few percentage points lower than the corporate has that been achieved, or is still an ongoing process and lot more can be achieved in '23 and '24?

Abhay Soi: So I think there is only one line item, which was the personnel items, the VRS you have to do in phases. We brought down the cost of employees over there, but it is still closer to the 30% mark rather than the 20% to 23%. So there is definitely 6% elbow room over there. Now, we are hoping to bring it down over the course of the year to that. But like I mentioned earlier, in any case it gets normalize when your phase one comes because then you have people get spread over a larger sort of -- you still need the people you will be reemploying them.

Nikhil Mathur: Sorry, does I hear it correctly that you are targeting 30% mark and you are 6 basis points lower than…

Abhay Soi: No, no, no. So where it is off Nanavati, the personnel cost is close to a 30% number rather than what we have everywhere else, because you have to do VRS, these are old unionized employee, so you have to do VRS over there. We did the first round of VRS, and the cost have come down because of this. Now we are doing subsequent rounds.

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

Damayanti Kerai: Hi, Abhay, just want to understand your thoughts on increased competition in diagnostics space entry of some large players having strong financial muscles. In such scenario, how should we look at prospects for MaxLab?

Abhay Soi: I think first and foremost, if you actually see the results of MaxLab versus a lot of other standalone laboratories etc., okay, we have had a healthier growth on the non-COVID businesses, relatively speaking, obviously, it is on a much, much smaller base. I keep sort of relating to that ad, which used to be the tires we race are the tires you buy, this used to be a MRF tires ad is pretty much the same with MaxLab as well. All of what Max does is predicated on the efficacy and the efficiency of our laboratories -- that is what all our senior clinicians and all everyone sort of rest their entire practice on. So it's very, very high end sort of work, the efficacy, the efficiencies of that are -- and eventually, remember one thing, the arbitrator of a result the doctor, your doctor is going to see a report, he is going to see your biopsy and say, look, so and so, company etc., it's showing positive, do you want to get a second opinion? Because you cannot necessarily rely on the new entrants, etc., you cannot discount or discard a MaxLab report it is coming from hospital, right?

So that is our modus operandi, that is our reason to survive in this business compared to everybody else. Therefore, whilst you would have competition and so on and so forth, the fact is, it is not like pharma you are not going to get yourself pricked twice, you are only going to do it once even if the first one is free. So all of these players coming and using discounting tactics etc., etc. works for some perhaps lower tests etc., but I do not think it kind of applies to hospitals and hospital labs. Pricing will in the short term, of course, will have pressure, but people who go to hospitals and hospitals still have a USP as far as this is concerned. I see that as a moat around our business.

Damayanti Kerai: Right. So I completely agree with brand equity associated brands like Max, but nonetheless say if new entrant is coming in offering this Rs. 100 test, so definitely, we will be seeing some shift in volume, maybe it is lower end, but part of volume can shift in there, right? So I just wanted to understand that part, how you think there?

Abhay Soi: So again, like I said, the arbitrator of the test is a doctor. Eventually, he has to decide if somebody does you Rs. 100 test, you take it to a doctor, and the doctor looks at it and says, I am not sure why don't you get a second opinion, because this does not relate to your previous test. Even if the first test will INR 100 or free for that matter, you do not want to get yourself pricked the second time. And this is invasive somebody is doing a blood test, it is not like a medicine. Having said that -- somebody else is purely playing on price, because the same brand you are giving at a cheaper price. But having said that, I do completely agree with you that with all of these players coming, you will have a lot of volume moving towards that as well. But do remember 70% of the business is sort of disorganized, 30% of it is amongst some of the larger players, we still continue to be a very solid but small player, you're going to see a lot of movement happening with the big players in my mind, because, I think the larger players are something to worry about with all this discounting, but this discounting is please understand this discounting is the old strategy of discounting is you do it for a few years, you take market share, then you raise prices, we've seen it in telecom and same in others.

I am not getting impacted right now, perhaps we will to some degree, but not too much. But we will stand the course, we will stay the course because look, eventually people will come to us for higher end test and so on and so forth. That market is increasing, and they will keep coming to MaxLab. And by the end of the day proof of the pudding is eating, and you see our number and you see everybody else's. Again, like I said, it is a very small base.

Damayanti Kerai: Okay, that is helpful, I think to understand the scenario. My second question is on ARPOB. So we ended fourth quarter at Rs. 63,500. So that is around 12% growth on previous year's base. So, again, I think, if you can just try to make us understand like how far we can go in terms of our ARPOB growth, and what will be the key driver from here on, because in this fiscal, we definitely had some benefit from COVID-related test, vaccination, etc. So excluding all these, what will be the key drivers for ARPOB going forward?

Abhay Soi: So if you do not look at it on an annualized basis, so like this quarter, we had no vaccinations and really hardly any COVID-related tests. Similarly, in the previous quarter as well, I do not think that argument holds that the higher COVID sort of -- and every quarter that you have seen, we have shown ARPOB, and we have shown EBITDA per bed minus the COVID vaccination and COVID-related test in each one of our quarterly results. So the ARPOB that we have been speaking about, do not include vaccinations.

Yogesh Sareen: That is right, the ARPOB calculation doesn't include any vaccination and Max lab

Abhay Soi: That's right. So it does not have these two things. Like I said that argument does not hold. That is one. And I think, again, I'll just go back to what I've been sort of saying and underline the same fact, the two drivers of ARPOB or three drivers, one will be a clinical mix, which is incremental, it's not exponential, I see a major push coming from payor mix change, because moving away from institutional business that you've seen, I've called it even a year ago. And what you are seeing right now is the results of that. And the third is, the international business coming back, again it has been something that I have said by the end of the financial year, we should be getting close to 100% or we will be 100%. We had the Omicron wave so that got delayed a little bit, we got back to 90% by March. But in my mind, you will get to that number very soon. And you will probably exceed that if you have not already done that. So all of that international business is high ARPOB business. The minute we are moving institutional beds down and replacing with CTI that gives me 40%, 45% more revenue. That means my ARPOB on those beds is 45% higher, it is a mathematical exercise. So I would not get worried about or concerned about seeing high ARPOBs over here. I mean, international ARPOBs significantly higher than this. I mean,

theoretically speaking, if you have a hospital only does international business, we will have ARPOB upwards of Rs.90,000-Rs.100,000.

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

Praveen Sahay: So just to take it forward is there a further room for improvement in clinical mix? Because in the last couple of quarters, we had observed that the clinical mix has improved significantly after COVID? So is there further room for improvement there as well?

Abhay Soi: So look, I think, one is movement from COVID to non-COVID. I think, in movement from COVID to non-COVID, there is an exponential -- there is a step change in clinical mix, because the minute you are moving from medical programs, which are capped in pricing to non-medical, surgical programs, which are not capped, they have higher ARPOBs, they have higher EBITDA per beds and so on and so forth. Having said that, the two big like I said on the clinical side, okay, if I look at business as usual, so let us say what I'm doing this month or whatever when there is no COVID on normal high occupancy when I'm operating at 73%, 74% occupancy levels, the sort of ARPOBs that I'm doing, what is going to drive that? I am talking about times when there is not much COVID happening or any COVID happening. In those situations, our clinical mix is already superior. We already do a lot more of that. So I am not saying there will not be increase, there will be, but it will be incremental increase. And again, relatively speaking, ARPOB is driven by three things and three things alone, it is driven by your pricing, which every year you are going to have that 2%, 3% impact on pricing on your overall revenue. It is impacted by your payor mix, where we are going to see a step change, or there's opportunity for a step change simply because we have 30 odd percent beds, which are still doing business at 45% lower rates or 40% lower rates. And the third is the clinical mix. The clinical mix is already superior, it is not as if we are not adding clinician, we will see further increase over here, but you are not going to see a step change because of which you will see it because of other things. So I hope that answers the question.

Moderator: The next question is from the line of Hemal Shah from NR Shah Associates.

Hemal Shah: Sir my question is running a hospital involves very high management of labor and is extremely service oriented. We have grown very nicely in past and also planning to grow very nicely in future, does it act as a constraint as we go and our size increases?

Abhay Soi: No. So look, I think there are two things, one is you are absolutely right, it is the service industry its extremely people oriented, we have over 25,000 people who work for us at MaxHealthcare but do keep in mind that we have a huge amount of unemployment in the country, we have a massive demographic dividend. We have such a large population below the age of 25, who are looking for jobs. So although overseas, you are seeing this right now that you are seeing a shortage of trained manpower. But we are the largest exporters and providers of medical technicians, doctors, nurses to the world. And do keep in mind, all of it sort of reflects in the price, doesn't it? I mean, today, the cost of a nurse or even a resident doctor in India, about Rs. 40,000, Rs. 45,000 a month, I mean, compared to any of their western counterparts, I mean, it is nothing.

Hemal Shah: Sir my question is, our management bandwidth to manage it.

Abhay Soi: No, we have no issues on the management bandwidth, a lot of expansion are happening through brownfield. So, brownfield what happens is in the same hospitals that you sort of expand. So, I mean, if you look at Mumbai example, is like Hinduja puts up another wing, you are not going to put up new management, you need more sort of people at the bottom end. Having said that, you are going to increase teams

such as projects, digital and so on and so forth, because these are to sort of focus on growth opportunities.

Also I think it is not as if what you are saying is not valid, it is a valid question. That is a challenge that all top management across all successful organizations face today. How to sort of reward, retain their top managers, senior managers and attract new talent from the markets, I mean, that is a constant.

Hemal Shah: Right. And so my next question, the second question is can you give me some color on scope of inorganic growth opportunities available?

Abhay Soi: I think there are plenty of inorganic growth opportunities available because there are lots of PE-owned hospital chains up for sale, there are lots of standalone ones up for sale. So I cannot give you color beyond that. But I think there is quite a bit available, it is not as if it is not. You are seeing some sensibility around valuations. Those hectic periods are -- so it is getting back to serious business. I think all of the stuff that we were seeing in the equity markets and in transaction values, etc., there is seems to be some semblance at least right now.

Moderator: The next question is a follow up from the line of Praveen Sahay from Edelweiss Wealth.

Praveen Sahay: Yes, so next question is as you had mentioned in the presentation that the central Government health services have some delay in the payment. So can you give some details from which facility, which location you got impact of that and how much is outstanding?

Abhay Soi: So I think Yogesh will give you exact outstanding. But typically what happens is that the Government has -- if I look at previous history or last 20 years, they have a habit of sort of intermittent delays, and you will see bunching up of payments and suddenly for months, you do not get payments, suddenly you get into for this thing, etc. So they kind of accumulate, and they get released. That is one. Having said that, the central Government this is the payment is made through a portal, or the system works through a central government health scheme, which is moving to the NHA now. So moving to different system. To the delay, which is happening right now is because of that they are moving to an NHA, whilst hand over is happening, and it is not just us, I think everybody in the industry, everybody sort of impacted. We are perhaps a little more so because we do more, like you see, we do higher proportion of institutional business at our hospitals. Yogesh?

Yogesh Sareen: Yes, our outstanding as at end of April, it was around Rs. 270 crore So we have been talking to NHA for quite some time, we have been told every month that, they are paying some money and we also had a meeting with health ministers, etc. But then eventually, we have taken a call to stop the OPD business, that means we are not going to be OPD that we treated, the rate of which were Rs. 156 per consult. So we stopped that and that is the news item that you would have seen in the front page in Times of India. But I think we are getting a signal that they are now getting their house in order, and we should be getting some payments in the course of next two weeks.

Abhay Soi: So I mean frankly, I am not concerned about -- I am not perturbed about this. I mean, when it accumulates, we also come up with media stories and write letters and so on and so forth. But that is all part of the game with the government.

Praveen Sahay: Okay, and the second question related to the outpatient, so I can understand for this quarter, because of Omicron, but in the last continuously from second quarter, third quarter, there is a down and then from third to fourth quarter, there is a bounce. So, do you see this trend to change, and you are seeing this currently, because April, May already is done?

Abhay Soi: No, I think we only see it down OPD business only lower in COVID quarters or COVID month. Otherwise, we see sharp bounce back in non-COVID months.

Yogesh Sareen: So, basically on this OPD football typically in quarter three is generally soft quarter because of this festivals etc. And also in quarter three, as you would have -- we would have mentioned this earlier also that we have dis-empaneled ourselves for some of the state schemes where it was highly OPD football, but low IPDs. So for example, DGHS etc., we had dis-empaneled ourselves. So there was a, I would say, degrowth in quarter three results quarter two in terms of the OPD footfalls and that was by design. So it was not something that we did not anticipated. So, it is because of the fact that we wanted to bring down the institutional business. So we picked up those decisions where it was high OPD and low IPD because we were also facing a lot of constraints on the OPD side. So I would say in quarter as we see April onwards the numbers are getting normalized.

Praveen Sahay: Right, got it. And on the occupancy side, can you give any color on the normal high level of occupancy, you can reach to a hospital wise? How much of the maximum any hospital can go up to in the occupancy?

Abhay Soi: It can go to 77%, 78% on a sustainable basis. I mean, we have done 81% 82% some of our hospitals consistently for years, I mean doing an 80% Plus, but to do it on a sustainable basis at that level, it does compromise, I would not say outcomes, but definitely your discharge time, your admission time and so on and so forth. So patients' services. So 77%, 78% is what I would put it to at the network level.

Praveen Sahay: Lastly, on the pricing set, is there any you know, increase in the pricing happened in the past quarter or you are expecting increase in the prices in the coming quarters?

Yogesh Sareen: So yes, there is a price increase which has happened from first quarter. And also there is one or two major TPA where the price has been revised. And so this is a normal yearly ritual that we do. So yes, there is some price increase.

Praveen Sahay: How much is that sir, if possible?

Yogesh Sareen: So I think Abhay alluded it, but typically it is 2.5% to 3% depending on how much TPA prices were hit, the TPA prices does not happen every year, it can only happen after 18 months or 24 months depending on what the contract is. So I think major TPA agreements revised last year. So this will be obviously lower compared to last year, but I think still on the cash side and some of the big TPAs, there will be some of the price increase, I cannot give you a value. But I think it is in the lower side of that range that we mentioned.

Moderator: The next question is from the line of Bharat Sheth from Quest Investments.

Bharat Sheth: Hi, sir. So thanks for the opportunity. Sir, you said that our 40% of the occupancy is -- I mean, our contribution is coming from the lower realization that is a government kind of a tie up, is that correct understanding?

Abhay Soi: 30%, let us say 30%, 31%.

Bharat Sheth: Okay. And earlier you had given us some indication that over a time it will come down. So can you give some color over where do we expect in next three-year time? Or how do we see this gradually decreasing every year?

Abhay Soi: So it was 37%, it has come down to 30%, 31%. Over the next two years, it will come down to about 15%.

Bharat Sheth: And that will help us to improve over ARPOB, correct?

Abhay Soi: Absolutely.

Bharat Sheth: Okay. Sir, on this diagnostics, you say that we are also looking for inorganic opportunity. So can you give some color that what kind of a criteria that you have in mind while acquiring geography or specialty kind of or what kind of IRR we expect when taking over any new opportunity?

Abhay Soi: Let me put it this way, we have a ROCE of closer to 30% across the board, so anything that we do over a period of time has to be accretive, there is no point to anything which is non-accretive to our ROCE. That is one. Secondly, if I look at the laboratory or the pathology business, where the pricing are right now, and my expectation is perhaps in this industry, both margins and multiples will be under stress, and my mind it is highly valued. So, if I have to do any acquisitions in this business, I will only use my stock to do it, I will not use cash to do any sort of this thing. But again, we have to be able to be convinced about the turn up of opportunities over there.

Bharat Sheth: Apart from this financial, qualitative, what kind of geographic expansion…

Abhay Soi: So, North is something I would like to do, West is something I would like to do, but not beyond that, I do not want to go East. I definitely do not want to go South right now. Please understand, I mean, out of Rs. 5,500 crore my current business in about Rs. 120 crore, Rs. 130 crore. So we are talking off a very small base to start with.

Bharat Sheth: And do we have some kind of new capability, are we evaluating?

Abhay Soi: There are plenty of initiatives on that site to move up the value chain, we are already focusing on the more high-end stuff etc., to do the one-off tests and so on. But again, the path from Rs. 100 crore onwards is pretty long to get to a meaningful level. Is there any big bank initiative, we are looking at investing in, which will 3x this thing in the next year or two? The answer to that is no.

Bharat Sheth: Sir, while doing brownfield expansion, what are the capability, I mean, additional manpower on which side we require how much if you -- per bed or if you can say some color?

Abhay Soi: So typically we have a five and a half to six employees per bed ratio. And brownfield essentially requires that you do not acquire management, existing management already in place in the subsisting facility as well as the semi-clinicians already in place. So you do not require the high end for brownfields. First and foremost, the question is why do you do a brownfield? You do a brownfield because you run out of space in our hospitals, we ran out of space.

In most of our hospitals right now, you cannot get beds, waiting in emergencies, is anything from six hours to one and a half day to get a bed of your choice. Second, I am finding it difficult to onboard more doctors. Simply because I do not have operation theatres to give them, I do not have OPD chambers to give them and I have no beds for the patients. The third is, I actually had to take up my entire management in the hospital now sit outside the hospitals, because we've cannibalized those spaces, and we have taken up this thing.

So therefore, I would say we need to do a brownfield. It is like Breach Candy Hospital in Mumbai, right? I mean, it is run out of space, they are making a tarp, how long will it take to fill that up? And what do you require for it? The doctor is already there, the management is already there, you will make another tarp in the same which is in the contiguous land, therefore a brownfield. So it is a low hanging fruit.

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

Nikhil Mathur: Can you help me with the gross block number associated with the 3,300 beds that are today operational for the entire group, including the partner facilities?

Yogesh Sareen: Yes, so net tangible asset is Rs. 3,227 crore, you would have seen that it includes the land and everything else.

Nikhil Mathur: Yes, so plus depreciation, what would be the number?

Yogesh Sareen: So gross block would be in the range of Rs. 4,200 crore.

Nikhil Mathur: Okay, that is helpful. And sir, on the institutional business, of the 31% of the beds, do you mind sharing what percentage of this 31% is towards Government beds? And what percentage is usually occupied by the NGO or private sort of entities?

Yogesh Sareen: Most of this 31% will be the CGHS tariffs entities, so will be all state governments or the central government, or ECHS type schemes. So it is all CGHS dependent tariffs I would say.

Nikhil Mathur: So my question on this would be if majority of these are Government associated relationships, aren't these riders set in stones when that facility would have been built would not these have been part of the term agreements of the land or the facility that this percent of beds have to be reserved for institutional patients?

Yogesh Sareen: No, I think that is different that we have some communication on the EWS side, this is economically weaker section that is a treatment free of cost. You do not get any money for that. And as Abhay alluded to that, the money that is spent around Rs 14 crore, Rs. 15 crore every month on that treatment. So that's not part of that 31%.

Nikhil Mathur: And final question, I think I heard the number 13% of revenues came from digital channels. Please correct me if this number is not right. And the question on this is that, are there any significant investments that have been taken in FY '22, FY23, FY '24? Do you envision a lot more spent towards building the digital footprint?

Yogesh Sareen: Yes, we do. I think we already spend; I would say I cannot give you a number now. I mean we have spent a lot of money there. And in fact, going forward you would see increase in spend on this particular line item. So we have a separate team for digital marketing. So there is an outbound call center, there is a bot out there bot on the website. So there is a lead management team out there so there is a full-fledged department on the digital marketing side. And yes, the budget is going up for them for next year. But it's a significant increase in their budget.

Nikhil Mathur: So, I mean, I am fine if you are not comfortable sharing the exact numbers. But is this spending likely to be accelerated in '23 like the same in levels with FY '22? Is it a long-drawn process I mean, three four years our business have to be done or one or two years and you will be done whatever level you want to reach there?

Yogesh Sareen: I would say, this will be a permanent change in the line items in terms of where the money we have spent. And also there will be higher allocation to them for all times to come as I see it, because some of it is also manpower costs. So putting more people on it, so we cannot do off and on type there. So I would say, to give you a proportion then probably 60% increase in the budget.

Moderator: The next question is from the line of Bhavya Gandhi from Dalal & Broacha.

Bhavya Gandhi: Thank you for taking my questions. So I just wanted to understand is it so flexible to change the institutional mix to maybe cash or insurance because, we go for institutional mix when our occupancies do not get filled right. So is it so flexible to switch?

Abhay Soi: You're right I mean, that is why we do it right now, instead of keeping the beds idle we do it, but please understand two thirds of our business which is non-institutional has a particular rate of growth. It is growing at let us say 8%, 9% per year for the last how many years. Now, as you have seen we are operating in the 74%, 75% occupancy level, maximum we can get to 77%, 78%, which I mentioned. So, what do I do about the rest? So, let us say I have 2,000 odd beds or 2,200 beds will grow by about 8%, 9% every year. I need to 200 more beds every year. Now I got to a stage when I have 60% occupancy yes, your point holds, but when I am capacity is out right now, what do I do, I have to displace this business. So it becomes -- it is not so much about this thing. Insurance business is growing at a certain rate, international is growing at a certain rate and so is cash. Now, when that segment of the business is growing in an environment where we have no capacity then automatically that distilling will happen.

Bhavya Gandhi: Right. And another question is with respect to diagnostics, for example, if you are doing a capital deployment out of Rs 100, the larger chunk is into still -- the entire hospital spend is into normal hospitals business itself right? So, why are for a small pie of 15% and that right now the margins are attractive, but with competition kicking in the margins will also start dipping. So why are we looking at maybe acquisition is the diagnostic space because from a capital deployment angle is it viable enough in the longer run because our normal hospital business also gives us 25% margin today?

Abhay Soi: No, no it is viable on multiple fronts, please understand our brand is a lot more than our reach right now as far as diagnostics is concerned. I mean, we get patients from, Max is an aspirational brand not only for people in Delhi NCR but also for upcountry in smaller places and so on and so forth both for doctors and patients. If somebody wants to get a major surgery, he will go to Max Hospital. So imagine if Max Hospital providing you pathology in your town, in your small district etc., that is the opportunity. My problem is that the brand is there, my reach is not.

And secondly, look, it is not as if why are people getting into business, they are getting into it because of the fact it is underpenetrated. And everything is in its favor. But yes, right now it is getting crowded, and you are going to have -- you have venture capital money coming in, business discounting and so on and so forth. Very similar to what happened for us in the telecom space, but you got to have a shakeout over here. So you want to have some of the players in the sector who will go out of business, you will have some players who are got to be established, etc. And eventually everybody will raise prices back to -- everybody is going to earn for money. The fact of the matter is, do I have more of a right to survive in this business and thrive in this business than others. My belief is yes. And simply because I have a hospital brand to back it.

Bhavya Gandhi: So overall, from a margin perspective, will it be more dilutive, because will we be able to generate 25% EBITDA margin when it comes to diagnostic? I understand from a brand perspective it will be helpful.

Abhay Soi: No, see please understand EBITDA margin means nothing. You have to look at from ROCE standpoint, it is a service business. It does not require so much this thing it is all variable costs. So even on a percentage standpoint, it goes down it does not matter. I mean, I would rather have higher ROCE. Okay. Look at that.

Yogesh Sareen: I mean that is the reason that we mentioned, -- it is precisely the reason that we mentioned we moved out of suburban -- we were trying to do the transaction with Suburban. But beyond a point, we cannot go further and obviously Dr Lal spent more money than we thought we would be spending on it. So yes, we are very cognizant of the fact that this should be ROCE accretive.

Bhavya Gandhi: Right, right. And from an expense standpoint, normal expenses, so we talk about expenses, is there any room for any of the expenses, where we can control and maybe do some sort of margin, because our employee costs cannot be adjusted, doctor consultation fees, because that is the key in the entire business. So whatever adjustments we were about to do, we have done one by changing the clinical mix almost at optimum level. And you are trying to change the payor mix, but from another expenses standpoint, is there any room wherein we can sort of adjust our expenses, and there is a lever to maybe increase our margins?

Abhay Soi: So three years ago, our margin was 8.8%. And we gave a plan, and the total EBITDA of the company was Rs. 340 crore and we gave a plan for Rs. 220 crore in the first year another Rs. 120 crore in the second year, the Rs. 340 crore is equivalent to the entire EBITDA of the company, and we actually implemented it.

So the point I am making is, all of the stuff you are talking about on the expense side etc., we have done this, I mean, by the end of the day, anything further, you have to sort of maintain a balance, you do not want to compromise on outcomes or the patient services. Max being a metro brand Metro in Delhi and Mumbai, and stuff like that, our patients generally tend to ask for more. So we have to ask for more of ourselves as well,. So I do not see any incremental this thing in our understanding there is -- and the two things that we sort of pride ourselves about is very tight cost management. And the second is very disciplined as far as capital allocation is concerned. So these have been our two main sort of stays as operators.

Moderator: We'll take one last question, which is from the line of Naysar Parikh from Native Community Capital.

Naysar Parikh: My question is, how do you look at your geography expansion with few new acquisitions also you made is in Delhi. So, at what point do you think that you have reached an optimum capacity in Delhi NCR, and you would like to make this a bit more geographically diverse by maybe entering a bit more into West or South?

Abhay Soi: Look, I think, first and foremost, you obviously, always look at low hanging fruit in your backyard before you go further and so on. We have done that. And we will look at other geographies, we are looking at other geographies. It is not as if we are not there in Uttarakhand our highest ROCE businesses over there, which is not as if we are not in Mohali, we have a fantastic business over there. So my highest ROCE in fact not only Delhi and Mumbai, but they are also the other towns, and we will see our focus over there. But also understand our focus over there will be perhaps through M&A and not through buildouts.

Naysar Parikh: So I am just trying to understand three, four, five years out Delhi say 70%, 75%, Delhi NCR, where do we see that mix going? And do we see mix of like you said metro Tier one towns actually increasing? So how do you see that mix for the next three to five years?

Abhay Soi: It is tough to sort of answer that question, I mean, if let us say I get an opportunity to buy Medanta tomorrow, I mean, it is already making money. For example, if I do a transaction like that, I will have to allot them more beds in Delhi, you are going to ask me that, look, you have further concentration. The problem is it is not concentration you have to play it on merit. Its existing business, which already I perhaps will not do

a greenfield in Delhi. But if I get the opportunity to buy something, which I believe I can turn up even further, okay, why would not I do it. So, although we are proactive, we are also reactive, in M&A you have to be reactive as well. So it's really hard to sort of define, look what our geography will be. If I get opportunities in Bengaluru, I will go to Bengaluru tomorrow. I must get it.

Naysar Parikh: And my second question is the medical inflation, what are you seeing on medical inflation? Are you seeing that picking up more than average given things around? And do you see any kind of regulatory risk on price caps, etc.? Government has been coming out with slew of regulations to kind of curb inflation. So what is the sense on regulatory impact on the healthcare sector to kind of curb any medical inflation, which might be an access?

Abhay Soi: Which has to be input right? At the end of the day, if there is inflation on input costs of medicines for consumers, it is essentially a pass through for us we essentially pass it on to the patient, any inflation increasing in MRP that is just passed on to, we are basically only making a margin out of that. There has never been an output price cap. There has always been a price cap for inputs. And we had that conversation I had already provided my views on why the stent and the implants is etc., and probably it was a welcome thing.

But overall, you have to understand one thing, if there is one sector, which is counter cyclical, is anti-inflationary, is insulated from inflation is perhaps the medical sector. I mean, not India globally, not only us I think that is the nature of the business. It is a defensive. In India it is so offensive, simply because of the huge under penetration.

Naysar Parikh: Got it. Thank you. And just one data point question if you can, given Q4 has been impacted by Omicron, can you provide March ‘22 month’s ARPOB and occupancy?

Yogesh Sareen: No, we will not be able to share you that data.

Abhay Soi: But I think I think coming to the last one, but look, keep in mind one thing, what is being disclosed. So I think the occupancy in January was 60. The average occupancy for the quarter was 68. So I am sure most of you guys can work out, perhaps or closer to where we were in March.

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

Abhay Soi: So thank you, everybody for joining late in the day today, but we will try not to make it a habit and next time we will make it a more convenient time for everyone. Thank you so much.