Max Healthcare Institute Limited

Q3 FY23 Earnings Conference Call Transcript
February 03, 2023

Moderator Ladies and gentlemen, good day, and welcome to the Max Healthcare Institute Limited's Earnings Conference Call. 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 morning, everyone, and thank you for joining us on Max Healthcare's Q3 and 9M FY23 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'll have the forum open for an interactive question-and-answer session. Before we start, I would like to point out that some statements made in today's call may be forward-looking in nature and a disclaimer to this effect has been included in the earnings presentation shared with you already.

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

Abhay Soi: A very good morning to everyone. I am pleased to welcome you to Max Healthcare's Q3 Earnings Call.

Our performance for this quarter was on expected lines and reflected the continued focus on execution by the hospital teams while maintaining high levels of medical quality and patient satisfaction. Compared to Q3 last year, the occupancies, revenues, EBITDA and other operating and financial parameters have improved considerably. While compared to Q2, this quarter expectedly witnessed a slight dip in occupancy due to festive season and revenue was relatively flat. However, we yet again reported our highest-ever EBITDA – both in terms of absolute value and margins, EBITDA per bed, ARPOB and ROCE for the third consecutive quarter this financial year.

Our digital app 'Max MyHealth', which was soft launched at the end of September 2022, has already witnessed approximately 90,000 downloads. The app is now ready for a formal launch in the fourth quarter of the current year. Before I move on to the highlights of this quarter, please note that comparative numbers and percentages are

being reported on a like-to-like basis, excluding COVID-19 vaccinations and one-time tax gain in the previous quarter.

Key highlights of our Q3 performance are:

1) Occupancy for the quarter improved to 77% from 74% in Q3 last year. However, it was marginally lower than 78% for the previous quarter due to festival season.

2) Institutional bed share fell to 29% compared to 31% in Q3 last year. The bed share was 1% higher than the previous quarter due to relaxation owing to lower occupancy in festive season.

3) Network gross revenue was Rs. 1,559 crore compared to Rs. 1,385 crore in Q3 last year and Rs. 1,567 crore in the previous quarter. This reflects a growth of 13% year-on-year, while remaining flat quarter-on-quarter due to seasonality.

4) Revenue from International Patients grew by 62% year-on-year and reflected 110% of pre-COVID average. This accounts for around 9% of the revenues now.

5) Digital revenue grew to Rs. 272 crore and accounted for 17% of overall revenue.

6) ARPOB for the quarter rose to approximately Rs. 66,800, reflecting a growth of 10% year-on-year and 1% quarter-on-quarter.

7) We reported our highest-ever Network Operating EBITDA of Rs. 419 crore compared to Rs. 364 crore in Q3 last year and Rs. 410 crore in the previous quarter, reflecting a growth of 15% year-on-year and 2% quarter-on-quarter.

8) We are actively managing the costs, and there is a reduction in overheads quarter-on-quarter due to better collections and reduction in power costs.

9) The Network Operating EBITDA margin improved to 28.3% versus 27.8% in Q3 last year and 27.7% in the previous quarter. Annualized EBITDA per bed, most importantly, rose to Rs. 66.9 lakhs, yet again our highest ever, clocking a growth of 12% year-on-year and 4% quarter-on-quarter.

10) Profit after tax was Rs. 269 crore versus Rs. 252 crore in Q3 last year and Rs. 267 crore in the previous quarter.

11) Net Cash position stood at Rs. 372 crore at the end of December 2022 compared to Net Debt of Rs. 296 crore last year. This is after deployment of Rs. 102 crore towards the ongoing capacity expansion projects.

12) Continuing our efforts to give back to the community, we treated 38,344 OPD and 1,264 IPD patients from economically weaker section free of charge. In addition, we provided nutritional support to around 2,300 TB patients during the quarter.

13) Both our SBUs continued to report robust numbers.

    (a) Max@Home reported a top line of Rs. 36 crore, reflecting a growth of 30% year-on-year and 4% quarter-on-quarter. It started Immunization-at-home services and now has 14 service line offerings.

    (b) Max Lab reported a gross revenue of Rs. 28 crore. This reflects a growth of 46% year-on-year, while declining by 4% quarter-on-quarter due to

seasonality. The active network partners stood at over 900, spread across 34 cities and supported by a dedicated team of more than 700 personnel.

Now coming to the overview of the company's financial performance for the nine months ended December 31, 2022:

14) Network gross revenue stood at Rs. 4,597 crore, reflecting a growth of 16% on a like-to-like basis.

15) Network operating EBITDA stood at Rs. 1,199 crore, registering a growth of 20% on a like-to-like basis. ARPOB improved by 16% due to price, payor mix, case mix, etc., and led to margin expansion by 92 basis points. EBITDA per bed grew by 21% to Rs. 64.4 lakhs.

16) COVID-19 bed occupancy was negligible throughout. On average, COVID-19 patients occupied merely 5 beds in Q3 and 20 beds during the nine months.

17) On expansion projects, the current status of capacity coming on stream by FY '25 is as follows:

(a) 100 beds at Shalimar Bagh have been more or less handed over to operations team, and we are on schedule for starting the operations in the current quarter.

(b) 300 beds at Dwarka – The structure is complete and interior work is underway. We plan to file for occupancy certificate by May and operationalize in Q2 FY '24 as planned.

(c) 329 beds at Nanavati – The contract has been awarded to Larsen & Toubro on a turnkey basis in December for handing over the hospital on or before 24 months. L&T is fully mobilized and we expect to commission the facility by end of FY '25.

(d) 300 beds at Sector-56 Gurgaon (Phase 1) – Work has commenced. Excavation and D-wall work will be completed by Q1 FY '24 and by which time the civil contractor will also be mobilized.

(e) We would also like to point out that Sector-53 land cancellation has no impact on our bed additions plan until FY '28. It was not a part of our expansion rollout but will, if it all, impact bed potential post FY 2028 as we have put down in the investor presentation.

So, all in all, up to this stage, we are seeing no delays. We are focused on execution and it is going to be on the spot as planned.

(f) 350 beds at Max Smart – The project is delayed by around 3 months for lack of final tree cutting permission, which has been received in January this year now. The work will start in the current quarter, and we hope to recoup the time lost as we progress on the project.

18) While we continue our focus on the growth levers articulated in the past, we have also been evaluating avenues for catering to demand for quality health care in the near term. We expect to add over 100 beds in the next 2 quarters at some of our hospitals through internal reconfigurations. Moreover, with our net cash surplus and deleveraged balance sheet, we are extremely well positioned and actively

evaluating inorganic growth opportunities. As of yesterday, our Board has given in-principle approval to raise finance of up to Rs. 4,200 crore of NCDs for any future M&A. However, we intend not to breach 2 to 2.5x Net debt to EBITDA, considering that any new acquisitions will also bring its own EBITDA into play.

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

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

Nikhil Mathur: My first question was to be on Net debt to EBITDA, I think you have kind of cleared it. But just at a slightly higher level, I wanted to understand with so much of organic bed expansions planned over the next 4 - 5 years, is there a pressing need to do an M&A or whatever M&A that you are seeking is going to be very, I mean very valuation conscious and there has to be some clear rationale for you to be looking for an M&A because I believe the bed CAPEX plan itself will kind of take care of the medium to long-term growth of the company.

Abhay Soi: I think we are not putting a cap on the long-term growth. If you look at the opportunity set, which is out there, it is significantly higher than what we are looking to tap through our brownfield or whatever we are expanding. One is that. secondly, also, given the fact that we have a completely unlevered balance sheet; we have got more than Rs. 1,000 crore of cash sitting; we have a net debt position of some Rs. 360-370 crore. Our entire expansion, which is at a cost of about Rs. 4,000 -4,500 crore over the next 4 years, is going to be conducted entirely through about 50% of our free cash flows. So, we have a totally unlevered balance sheet and we have the rest of our free cash flows to deploy. And given the opportunities set out there and again, if you've seen our history, it's been about buying assets at values which are intrinsically below what we believe we can eke out over there in EBITDA, okay? So, these will all be massively value accretive.

We are very, very conscious of ROCE. We are already operating at very, very high ROCEs, as I have said before also in my past calls. So, I think anything that we will be acquiring is going to be accretive. We're not acquiring it for the sake of it. I want to add one more thing, it also gives us presence in newer geographies.

Nikhil Mathur: And in terms of regional priorities, I think North looks pretty sorted for the company. There is obviously a media article of you venturing out in Kolkata, looking out for something there. But would it be safe to assume that, I mean, my understanding perhaps the Southern market is a bit more competitive. So, you might be looking more for West and East. Would that be a fair assumption?

Abhay Soi: Not really. I've in the past said, look, we won't go to uncharted territory. I will go to any territory where at least 2 or 3 of my competitors have proven viability, and we will do it better like we pretty much have done without exception, in every micro market that we are present. I mean, if you go by that list, I think the number of cities would be in the mid-20s where number of people have proven viability. I mean, we do operate a hospital in Mumbai, which is in Western India. It is the only asset that we have and it operates pretty well. And if we look at what we are doing in even outside the cluster of Delhi NCR in Tier-2 cities like Mohali or Dehradun, which are extremely high ROCE businesses for us.

So, I think even entry into the Southern markets, when you look at what their profitability, etc., are, I think so long as we have conviction that we can eke out and we can make it accretive, it becomes a sensible entry point for us.

Nikhil Mathur: One more question I had on the operations for this particular year. Now I think your investor presentation gives a clinical update on liver transplants, kidney transplants and bone marrow transplants done till date. But can you give some sense as to what is the number for these 3 categories of transplants looking like in FY '23 and what growth are we envisaging in the number of transplants that we'll be doing in the coming 2-3 years? I mean the clear question here is that these initiatives are ARPOB accretive. So, that could be an ARPOB driver for you in the coming 2-3 years.

Abhay Soi: I mean it doesn't really move the needle. I mean you have to look at it collectively. I think overall, this transplant business will be 5%-6%.

Yogesh Sareen: Nikhil, basically, if you come to the liver transplants, we do around 40 to 45 of them every month. Kidney transplants would be a bit higher than that, it will be around 60-65 every month. And BMT would be another 25 to 30. So, these are the ranges that we have. Obviously, the endeavor of the team is to start the program in more and more hospitals. For example, that's what we did in liver transplant. We started a program in Vaishali, we started a program in BLK, we are starting the program in Mohali and Dehradun now and we are waiting for the license. So, one is, obviously growing acuity for work, that's always the effort. So, now to put a projected number, I mean that's very tough for us. There is no order book that we have.

Abhay Soi: But moreover, what I'm saying is, this is going to be incremental because there is already a particular pace at which we add. So, this is going to be incremental. Even if I double this number, you're not going to see exponential change in EBITDA or margins because of it.

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

Damayanti Kerai: First, one clarification. Abhay, did you mention you would be able to add another 100 beds through internal reconfiguration, apart from the planned ongoing CAPEX?

Abhay Soi: Well, I said over 100 beds. So, it's a number which is higher than 100 beds, yes.

Damayanti Kerai: Okay. That's clear.

Abhay Soi: Let me make it clear. Through internal reconfigurations, okay, we will be adding this over the next few months.

Damayanti Kerai: Next few months, okay. My second question is how do you see your operating cost inching up as your planned beds come online over the next 2-3 years, both on a variable as well as fixed cost part?

Abhay Soi: I think the majority of the CAPEX that we're doing with the rollout we are doing it towards Brownfields, right? I mean 80%-85% of the total rollout is towards Brownfields. And Brownfields by their very virtue have higher operating leverage, because it doesn't necessarily have a fixed cost associated to it because the fixed cost, be it in terms of management or senior clinicians, etc., is already being incurred by the existing hospitals. So, when you add another tower next to it, it doesn't have that. So, technically you have a higher operating leverage. So, our operating cost overall should come down.

Damayanti Kerai: Because you would be able to expand existing resources to a higher number of beds, right?

Abhay Soi: That's right. And what you are actually putting over there are nurses or resident doctors, etc., your senior clinicians are already in place. And the reason you're doing these Brownfields in the first place is because your capacitied out, right, and we've got unsatiated demand at your doorstep, your doctors don't get OT time, they don't get beds for the patients and so on and so forth.

Damayanti Kerai: In most of these brownfield expansions, should we assume the breakeven should be achievable within 12 to 15 months of the commencement of the unit?

Abhay Soi: No. I've stated in the past, the brownfield should have a breakeven in the first quarter or two, if not the first quarter itself.

Damayanti Kerai: So, within 2 quarters, we can reasonably assume that?

Abhay Soi: Absolutely.

Yogesh Sareen: In a brownfield, you don't open the beds until such time you are able to fill it, right? So, there's no need for us to open all the beds.

Abhay Soi: I mean, not that we don't have the need. We have the need; I think the point that Yogesh is making is that you are holding the assets on your books, right? But there's no real fixed cost associated to it from the operating stand point.

Damayanti Kerai: My last question is, can you talk a bit about your ESOP programs? And right now, what percentage of Max employees are covered by your ESOPs? And what kind of annual expense do you expect for the stock option programs?

Abhay Soi: So, I think they're about 81 lakh shares, 271 employees, okay, are covered by the ESOP plan. I think the important thing is that the cliff for the ESOP plan, okay, is 20% IRR, which comes to a price of, I think.

Yogesh Sareen: To vest 100% of the ESOPs, the price is Rs.1.260 after 5 years.

Basically, the ESOP has 2 portions. So, one is the individual performance, the other is the company performance. So, the company performance part, which is mainly for the leadership team, will vest after 5 years provided there is a 25% CAGR in the share price from when we issued these ESOPs. So, at that point the rate, the price required for 100% to vest is Rs. 1,260 at the end of 5 years.

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

Amit Kadam: Sir, can you dwell a little bit more on the international patients, how that particular mix of segment is moving? In one of the presentation, in one of the slides, you mentioned that the sales are already at like 10% higher than pre-COVID. Just wanted to know that on the footfalls, how the things are looking? Where the traction is coming? How do you see the year going forward? Because last time when we spoke, you had mentioned about Afghanistan not present, but you are trying to cope with that particular thing with some other geographies. Just maybe 2-3 minutes brief on that particular segment.

Abhay Soi: We were not trying to cope up, we have coped up, right? So, in spite of Afghanistan which was 12% of our business being down to 0, we are at 110% of pre-COVID levels.

So, what that basically implies is that not only have we coped up for lack of Afghanistan, but we've sort of overcompensated for it, right? That's one.

Secondly, I mean, to have a discussion on present footfalls, you'll have to have a point of reference from past footfalls. I mean the fact that this number has been moving up, I mean, we are getting massive traction on this, it's over 60% compared to last year, it's over 110% compared to pre-COVID levels and in spite of 12% of Afghanistan not being there. Hopefully, in the next quarter or 2 quarters, depending on the geopolitics as and when Afghanistan does open, this will give us further push. But in the meantime, we'll be looking at other geographies as well. We've been opening offices in other places, and I guess, with also the support of the Indian government through Heal in India and Heal by India, there is focus on global medical tourism. So, I think we can have a step change over here.

I haven't given any guidance in terms of footfalls in future or revenue guidance in terms of international patients or any other sort of revenue guidance, I'm going to avoid that even at this stage.

Amit Kadam: So, when we say like revenue is like 10% higher, than even the footfalls are, I assume that if realization has been same, then those footfalls are higher than the pre-COVID?

Yogesh Sareen: Yes, more or less. But may not be 10%, maybe probably 4% to 5%.

Amit Kadam: Second is, in the presentation footnote, you have mentioned that there was a recovery in terms of bad debts, which you have put under indirect overheads. So, can you just help me with that particular number, please?

Yogesh Sareen: So, that number would be around Rs. 7 crore during the quarter. So, this is a charge during the quarter. So, there is obviously a running system that we have that at the end of each quarter whatever bill is not cleared within 365 days, they will get provisioned for.

Abhay Soi: We have a very stringent policy that anything which is over 365 days, okay, we provide for.

Amit Kadam: Because you had mentioned that why that OpEx is sequentially down. One of the line items you mentioned that one of this as the reason.

Yogesh Sareen: Yes, we did mention. That's right. So, there's impact. And there's always the impact . This obviously depends on when the collection comes. We have around 16%-17% of business, which is PSU revenue share and the payments from CGHS are tardy, they come in blocks.

Abhay Soi: Sometimes they come over 365 days, then we write it off at the end of 365 days, provide for it and then when it comes back, we have to write it back.

Amit Kadam: And just like I want to know further like because you had said that another 100 beds is what you are expecting in the next few months through the internal reconfiguration. Is it across the various hospitals? Or is it from one particular thing? Second is that, is it safe to build this particular increase in terms of like somewhere in quarter 1 or quarter 2 of FY '24.

Abhay Soi: Yes. I mean it should come in through by quarter 1 or quarter 2 of FY '24, right. These are in 4 or 5 separate hospitals, maybe 20 beds somewhere, 30 beds somewhere

and so on. So, collectively, it's over 100 beds. And clearly, you eke out this capacity in places where you're hitting thresholds. When you get to that stage, you find elasticity, you find reconfigurations and so on to be able to get by. I mean you don't do it in a place where you already have even a little bit of leeway as far as idle capacity is concerned.

You have to understand, as we are coming close to threshold capacities in places, what we earlier thought was threshold capacity, both in terms of operations and number of beds, we find there is elasticity at the end, right? It's like a manufacturing process, your rated capacity may be 75%. When you come to the 75%, you realize that you can operate at 80%. When you get to 80%, you'll realize you can get to 82%-83% and so on.

Moderator: The next question is from the line of Naman Bhansali from Perpetuity Ventures LLP.

Naman Bhansali: So, my first question relates to international patients. And I think it's around 8.5% contribution. But if you want to view it as a percentage of only Delhi Hospitals, so how much would that percentage be? And relating to the international patients, like what is the structure that we follow to attract these international patients, like do we pay some medical consultancy fees to any agencies? Or what sort of cost do we pay to attract these patients? And how is it versus the industry and Max? So this is my first question.

And my second question relates to the margin structure of brownfield expansion, which we are doing. So, with every incremental bed additions, how do we see the incremental margins which we get on the brownfield bed. Lastly, on the ARPOB difference, like what is the difference majorly in our business between the international and domestic ARPOB? And how would it boil down in terms of EBITDA per bed? So, these are my questions.

Abhay Soi: Let me start by margins on brownfields. So, as far as margins on Brownfields are concerned, our typical brownfield will cost us about Rs. 1.30-1.40 lakh per bed. Our present EBITDA per bed is about Rs. 66 lakh last quarter. If you apply even a 75% occupancy rate to it, so that comes to about Rs. 66 lakhs into 75%, so maybe about Rs. 45-50 lakh I presume. So, you're looking at Rs. 50 lakh on top of Rs. 130 lakh. This is if you were doing business as usual. But like I mentioned, there is operating leverage in Brownfields, so EBITDA per bed should be northwards of that. And more importantly, over the next couple of years, by the time all of this comes on stream, you'll have some real and inflationary growth on top line as well.

So, it is massively accretive. Look, the most attractive thing we'll ever do, okay, more than M&A, more than greenfield, etc., is Brownfields, okay? Because A, you're building in a proven area where you are tapping into unsatiated demand, and then you have a huge amount of operating leverage coming out. So, that is exactly what we are doing. So, that's one. I hope that answers your question as far as margins are concerned.

Yogesh Sareen: So on the ARPOB question that you asked on the international side, typically, the ARR, the ticket size for the international patient is double of the domestic because of the fact that there are more acute patients. But the ALOS is also higher, right? So, the average length of stay of this patient is also 1.3x of the normal. So, typically, that means that the ARPOB will be one and a half times of the domestic patients. When I say domestic patients, they will be cash domestic patients. That's on the ARPOB. Yes, the EBITDA per bed is higher because of the fact that these are higher ARPOB. So, even if you maintain the same margin percentage, after payout on these HCFs or

facilitators, your EBITDA per bed would be around 20% higher than the domestic patients.

Abhay Soi: But having said that, our marketing is done through multiple channels. At the very least, there are walk-in patients, where there are no facilitators involved. Then you have patients and these people come through our digital platform, come through our office in overseas and so on and so forth. Then you have patients who come through international medical tourism companies. So, in those situations, we make a payment of facilitation fees to those international medical tourism companies.

The third is we have tie-ups with various ministries of health in various countries. We have tie ups in hospitals. At any given point of time, a number of our doctors are traveling overseas conducting OPD screenings. So, it's a fairly organic process. We also have doctors from these countries who come to our hospitals and work as observers, they go back and they campaign for us. But we conduct OPDs, we screen the patients, we do pre-consults, post consults over there and so on and that's the backbone of how we do medical tourism.

Yogesh Sareen: Also, on your question about the share of international patients in the NCR hospitals or Delhi hospitals, it ranges from 4% to 18%, right? So, the maximum is in BLK-Max Hospital and then followed with Saket and then you have other hospitals like Vaishali and Patparganj, etc. So, on an average, it will be probably 11% to 12% in the NCR hospitals.

Naman Bhansali: And what is the maximum on a consolidated basis, like we are currently at 8.5% in international contribution, and this can go up towards 10%-11%?

Abhay Soi: I mean it depends how much we are doing, right? Like I said, I'm going to avoid giving any sort of guidance in terms of how much of this business we are going to be shooting for over the next 4 to 5 years. But like I said, the potential is exponential, not incremental.

Moderator: The next question is from the line of Ashish Thavkar from IIFL AMC.

Ashish Thavkar: Sir, if you could spell out, is there a certain seasonality in our business because if we try to have a look at the occupancy rate, quarter 4 seems to be much lower than the earlier quarters. So, if you could just help us understand the nature of the business?

Abhay Soi: Absolutely. So, there is a seasonality in the business. So, even if you go back to our last quarter's investor call or the presentation, when we had the higher occupancy, we said in Q2 that the occupancy is higher because of seasonality, right? In the rainy season, you have waterborne diseases, airborne diseases, etc. So, in Q2, typically, all hospitals have higher occupancies, right?

I mean this is like I mentioned due to the seasonality and the flu season and so on and so forth. So, you'll have a lot of internal medicine patients, you have a lot of pediatric patients, etc. They come to the hospital for medical reasons, not for surgical reasons.

So, this quarter 2 is usually characterized by higher occupancy, but lower ARPOB. And if you look at Q3, it is typically a weaker quarter. Year-on-year, you will find it to be a weaker quarter, which is this present quarter, because it is characterized by the festive season. A lot of the New Year, Christmas holidays, etc., I think this year Diwali

was in October, so you will see patients postponing their surgeries or doctors postponing the surgeries, etc., by a few days or a few weeks or whatever.

So, typically, Q3 is a weaker quarter, which is characterized by lower sort of occupancies, but you have higher ARPOBs in this season because whoever is coming for surgery is somebody who can't really put it off. So, therefore, he is coming for more sort of acute and more Quaternary care surgeries, etc., which typically will have a higher amount of billing. Also, because Christmas and New Year, a lot of international patients don't sort of come in, they postpone their visits because look Christmas, New Year's also, etc. So, the way to compare health care this thing is quarter compared to the previous year quarter rather than sequentially the previous quarter because of the seasonality. Q4 is typically a stronger season, right, is the strongest sort of quarter in the year.

Ashish Thavkar: So, last one on the ARPOB, sir, we are already at 77%, 78%. Obviously, the concern remains as last time you had highlighted at peak, you can go to 80%-82% and the bed additions like you're trying to reconfigure or internalize. So, 100 plus beds over the next 2 quarters, where do you find comfort and do you feel that before we materially add a higher number of beds, can we still manage to do 10% to 12% top line growth which is 77% or say 80% kind of occupancy levels?

Abhay Soi: No. So, look, I think there are 2 or 3 separate things over here. Firstly, the number of beds we are coming out with over the next 6-7 months, I presume, is going to be 300 in Dwarka, 100 in Shalimar Bagh and 100 plus that we are doing. So, that's over 500 beds. That's one.

Secondly, last quarter, which is quarter 2, we were at I think 78% occupancy. We've done months of 81%-82% also and we've done quarters of 81%-82% as well. Some of our hospitals are operating at higher occupancies. And that's where, when you start, in those hospitals when you start hitting occupancy thresholds, we also have the lever of payor mix, right? I mean you start accommodating your preferred channel at the cost of the unpreferred channel. And that's why we had guided the unpreferred channel or the institutional business would come down accordingly. So, there's enough leeway in the system to accommodate any sort of growth that we have, while the new capacity comes in. And I have only given you 500 beds, which is estimated to come in over the next 6 to 7 months. And then in 2025, we have more beds coming and so on.

Ashish Thavkar: Sir, lastly, versus the volume growth. So, typically, the industry does around 8% to 10% volume growth. Any color on how the pricing trends are currently in the industry?

Abhay Soi: Year-on-year, you normally have a 2%-2.5% impact on revenue as far as pricing is concerned. And that's pretty much across the industry right?

Moderator: The next question is from the line of Lavanya Tottala from UBS.

Lavanya Tottala: So, I just wanted to understand how you look for breakeven time lines for the greenfield project? I understand for the brownfield, it's around 2 quarters, so for the greenfield project in Gurugram, how do you look at the breakeven time lines?

Abhay Soi: Yes. So, look, I think historically, greenfield used to be about a 2-year sort of breakeven. My belief is now it will be a 12 to 15 months sort of a breakeven in greenfield.

Lavanya Tottala: And the brownfield where the current occupancies are in the range of 75%, that should see somewhere like 3 quarters, high occupancy, something like 2 quarters and greenfield 2 years? Is it the right way of looking, sir?

Yogesh Sareen: No. we're not saying that. So, you take the example of Shalimar Bagh, now quarter 3, the occupancy was 85% in that hospital, right? So, at 85% occupancy, that means, obviously, you are not admitting all the patients. So, at that point of time when we open 100 beds, we think there should be EBITDA accretion in the first quarter itself, right? So, we are not going to wait for 3 quarters for us to get some EBITDA from those additional 100 beds. So, that should be immediate. Now it depends on where the occupancy is, but I would say, probably not more than 3 to 4 months for EBITDA accretion in a brownfield situation.

Lavanya Tottala: I just got disconnected in the earlier commentary time. So, if I understand right, like 100 beds with the existing capacity on the Shalimar Bagh, so these 200-250 beds should be available for the full year FY '24? And 300 beds from Dwarka should come in at what time line, sir?

Abhay Soi: We said Q2 FY '24.

Lavanya Tottala: So, around like for 2H it will be available, like the 300 beds of Dwarka.

Abhay Soi: That's right.

Lavanya Tottala: And so on the acquisitions, which you have highlighted, so what kind of efforts you will be looking at like the stand-alone hospitals or a chain? I just wanted to understand your view on what kind of assets would you be looking if you are trying to enter a new region or at least certain number of beds is the thing which you look at I mean consider an asset for this opportunity. So, how you will be looking at it?

Abhay Soi: So, the bigger the better. I mean that if you have a chain versus a single hospital, we prefer a larger sort of asset. But it doesn't mean that we don't look at single hospitals. We look at that as well. What is important for us is that it has to be accretive to ROCE, there is intrinsic value for us to unlock over there. And like I said, ultimately over the medium term, it needs to be value accretive and needs to be ROCE accretive.

I mean if I have to go to South India, I won't go with 1 hospital, but if I have to do it in adjacent to a cluster that we are, then we may do 1 hospital over there. So, I mean I just won't buy 1 random hospital, let's say, of 200 beds in Chennai. If I have to do Chennai it has to be a larger sort of this thing. If I have to do, Bangalore, it has to be a larger format. It just can't be a hospital for the sake of it because we are acquiring some EBITDA or something like that.

Lavanya Tottala: Yes. So, this is helpful, sir. So, that's what I wanted to check if you would be looking for a certain one asset in Chennai or a place like where other things are present, so that's what I wanted to check.

Moderator: The next question is from the line of Krishnendu Saha from Quantum Mutual Fund.

Krishnendu Saha: Sir, Just trying to understand the business as to why we have a higher ARPOB because of a lot of foreign clients or because of the mix ratio. Just trying to get a feel of the business.

Abhay Soi: We have a higher clinical mix. Firstly, I think if you look at the 2 things, which drive ARPOB, one is the payor mix, other is clinical mix, right? As far as payor mix is concerned, 7%-7.5% of our beds are totally free for the poor compared to 1% or 2% for most of our competitors. If you look at 29% of our beds are catering to institutional business compared to maybe 20% and 13% for some of our competitors, right?

So, the payor mix is clearly inferior, but our ARPOB is maybe 20%-25% better than the next best player in the industry. But more importantly, our EBITDA per bed is 55% better than the next best player in industry. Now EBITDA is better because on each and every, I think, line item, we outperform each of the hospitals where we compete in pretty much every micro market.

But as far as the revenue is concerned, we operate at a higher sort of more Quaternary care, higher end of clinical mix. So, it's also indicated in the fact that we have more beds, which are critical care beds, 35% of our beds are critical care beds. Most other people are between 25%-30%. So, it basically portrays that we are doing more high-end work as a proportion of the total work that we do. So it overcompensates for the lack of payor mix.

Krishnendu Saha: And a bit of high occupancy also compared to the peers?

Abhay Soi: Yes. There is no role in the ARPOB but the fact that we are present in the NCR that also helps us, right? And the stronger brand will be higher occupancy. The occupancy is not a function of ARPOB or this thing. Occupancy is a function of your brand strength.

Krishnendu Saha: So, just the expansion, which we will have, do you expect to maintain that 35% of the specialty types of the revenue stream, going ahead, because we'll be expanding at a faster click in the next 2-3 years? Just trying to get a feel that we will be able to maintain the 35% mix going ahead?

Abhay Soi: It would be higher. I mean there is no reason for it not to be. We're looking at the same mix of business going into the future as well.

Krishnendu Saha: All right. In the sense, more on understanding. Yes, there's an available market which you can definitely address to.

Abhay Soi: Available market is, it's where the crunch is, right? I mean 35% of our beds are critical care beds, yet where we don't have any beds available or the highest occupancy if we look at in our system is not in the ward bed, not in the rooms, etc., it is typically in the single room that more importantly in the ICUs, the critical care. So, as we are going forward, we are in fact intending to build more critical care beds because that's where the bottleneck is in our current system.

Moderator: The next question is from the line of Sachin Kasera from Svan Investments.

Sachin Kasera: I had just one question. As we bring this capacity to brownfield and some of these efficiencies, what is your thought in terms of being able to sustain or maybe improve the current payor mix and as well as sustain the current occupancy levels?

Abhay Soi: Like I said, the majority of the expansion is coming in our brownfields, right? The reason we are doing it, we're not doing it in order to tap the market, we are doing it because we've got unsatiated demand at our doorstep. So, I mean, the payor mix that we've got waiting of 6 hours to 2 days in a ER for the sort of bed that you may want.

If you want an ICU bed, even a single room is not available. I mean, if you go to Nanavati Hospital, if you go to Max Saket, if you go to Mohali, if you go to any of our hospitals that's where the challenge is. If you go to places like Gurugram and all, you don't have beds, right? So, there's no reason for that payor mix not to be sort of to be any differentiation over there.

Of course, we've guided in the past that our payor mix should be improving to a certain extent and then it will be plateauing out. It will be plateauing out because this new capacity is coming in by then.

Sachin Kasera: So, do you think the current payor mix is already plateaued out or you think there is still some improvement in the payor mix after which it will plateau out?

Abhay Soi: So, we have guided that it should be down to 15% in the next 4-5 quarters.

Sachin Kasera: And you remain confident on that number, sir?

Abhay Soi: That's right. You have to keep in mind, if you look at sequentially, in a weak quarter, you're going to be accommodative, right? I mean a weak quarter in the sense that in a festive quarter where you have lower occupancy, okay, why would you want to have idle beds? You're going to take more institutional or whatever else is at that point of time. And this was a weak quarter. I mean this is a seasonally weak quarter, not for us, but from an occupancy standpoint.

Sachin Kasera: And sir, any thoughts in terms of the revenue per operating bed.

Abhay Soi: I think what needs to be looked at, okay, is the fact that in spite of it being a seasonally weak quarter on an overall standpoint, right? We've navigated it to be the highest EBITDA quarter in margins, EBITDA per bed or absolute EBITDA in the history of the company. So, what happens in the stronger quarter?

Sachin Kasera: So, which would mean that even with this additional capacity coming in and with the leverage that we are talking about, actually, we could see improvement in ARPOB, EBITDA per bed and EBITDA margins over the next few quarters?

Abhay Soi: No doubt on that front. I mean I've repeatedly said that in the past that EBITDA per bed, it will be accretive.

Moderator: The next question is from the line of Ranvir Singh from Nuvama.

Ranvir Singh: My question was more about the macro situation here in healthcare or hospital industry. I see in this budget, the Government has allocated some, I think, Rs. 6,000 crore to Rs. 7,000 crore for setting up AIIMS in different locations. Just I wanted to understand going forward because the Government thrust has been to improve infrastructure, mostly in public sector. So, do you see that the public sector is emerging strongly here and that could give the private sector a bit of competition in the next 3-4 years. So, how is your view on it?

Abhay Soi: I think anybody who's been to a public sector hospital should be able to answer that question. And even during COVID when health care was in focus and everybody was looking at it, you saw while there was no beds in private hospitals, there were idle capacities, okay, in Government hospitals across the board. And I think if this public sector supersedes, then probably in my memory, it will be the first time and first

country where the public sector sort of outperformed the private sector. I don't think it's ever happened anywhere else. So, I really don't see that coming as a threat.

I think public sector hospitals are free hospitals. They are free to the poor and to the rich and everybody else. When it is free, your idea is to provide health care coverage to more and more people, not necessarily to provide creature comforts. It's not as if your room may have a TV over there or you have AC in the room and so on and so forth, I mean it'd be a very basic sort of thing. And you may not be aware, no government hospital even has a stream, which is called 'critical care'.

I mean there is nightingale wards and so on and so forth. I think the whole push of the government is very, very different from that standpoint. I mean after that the next stage will be hospitals which are doing PMJAY, we are not even doing PMJAY. We don't even cater to that sort of subject.

Yogesh Sareen: For us, a hospital like AIIMS is basically a source of medical talent, right? So, typically, doctors working in AIIMS after 20 years, they take voluntary retirement and they try and work in the private sectors. I think that to us is a good thing, right?

Abhay Soi: I mean, that's massive because the sort of range of skill sets that they develop in public hospitals is immense simply because the volume and the complexities they see over there. So, typically, you'll see a doctor having worked in any of the Government hospital after a while leaves and joins the private sector.

Ranvir Singh: Thanks for your view. And specific to the company, I guess I missed a number, that what was the contribution of international patients during this quarter in revenue?

Abhay Soi: 9%.

Ranvir Singh: And what was it in Q2?

Abhay Soi: Same.

Ranvir Singh: Same. Okay. And ARPOB is normally much, much higher in international. So, what would be the average ARPOB in international patients?

Abhay Soi: I think Yogesh mentioned in the previous this thing, it's 50% higher ARPOB.

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

Prakash Agarwal: Just trying to understand the margin outlook better for the next 4 to 6 quarters. I understand the bed additions of Shalimar Bagh, Dwarka and others you mentioned, they could have a little lower EBITDA per bed and the ARPOBs than the average. Would that understanding be correct? And would it have any impact on the margins?

Yogesh Sareen: Not in the brownfield hospitals, but Dwarka, yes. It will take time for Dwarka to start generating EBITDA. So, as I think, as Abhay mentioned, 12 to 15 months is when we see the breakeven in terms of EBITDA in Dwarka, that's the greenfield site. But other than that, it should be all better EBITDA per bed, etc., and better margin because these are all brownfields. And as I mentioned, Shalimar Bagh had 85% occupancy in quarter 3, right? So, in that hospital when I add 100 beds, you can understand how soon the uptake in the occupancy will be.

Abhay Soi: And the 100-plus beds actually which we are eking out of the present capacity, right? I mean their EBITDA is again, we'll be swinging for the fences over there, literally with the EBITDA margins. So, that 200-plus bed, 200 to 250 beds should give you a higher EBITDA on day 1 sort of thing. And Dwarka will take 12 months to sort of get there and thereafter.

Prakash Agarwal: But the 200 addition is higher than the average that the company is clocking?

Abhay Soi: Very much. No doubt about that.

Prakash Agarwal: So, on a blended basis, you are okay with the margin trajectory or maybe see an improvement also?

Abhay Soi: That's right.

Prakash Agarwal: And how about M&A? I mean, clearly, with the fundraise plans and the cash. I mean we are sitting in Delhi NCR, which is the best micro market as such. But if we expand in the gaps maybe in Mumbai or even other Tier-1 metros, this kind of ARPOBs are unheard off. So, when we look into this M&A, would it be fair to say that we would be okay with the lower ARPOB to start with and with case mix, etc., we would be improving? Or how should we think about it in terms of M&A going into that particular micro market selection with respect to our margin stability and ARPOB stability?

Abhay Soi: So, I think Prakash, firstly, our highest ROCE businesses are not Delhi, it's the Tier-2, Tier-3 cities, okay? Secondly, my ARPOB in Mumbai is comparable, if not, I mean, higher than any of the Delhi hospitals.

Prakash Agarwal: Yes. Barring Mumbai and Delhi, we would be looking at M&A outside also, right?

Abhay Soi: So, I'm saying outside Delhi and Mumbai, like I said, even if I look at Tier-2, Tier-3 cities, my ROCE over there is much higher than Delhi.

Prakash Agarwal: Yes, understand ROCE concept. But from the ARPOB and margin perspective, would we be open for lower ARPOB and lower margin business?

Abhay Soi: Of course, I'll be very open to lower. The only thing I'm concerned about is ROCE. I am okay with lower ARPOB and I am okay with lower margins so long as whatever in absolute terms is EBITDA per bed vis-a-vis what we put in over there is accretive to us on a return on capital basis.

Prakash Agarwal: And just one more clarification. So, during COVID times, there was a higher cash patient mix. So, has that normalized now post COVID? And how is cash versus insurance? I mean insurance would have gone up, right?

Yogesh Sareen: Prakash, so yes, insurance has gone up once the COVID set in and there was more policy being sold and that trend is continuing, right? So, it's not that it was one-off and the share of the insurance business has come down. It's been maintained at the same level now.

Prakash Agarwal: And cash would have gone down.

Yogesh Sareen: Yes, it did. Yes.

Prakash Agarwal: And typically as per you would be about, what, 20% in pricing, 20%-25%?

Prakash Agarwal: So, in terms of insurance are obviously contracted rates. I mean, that is about 20%-25% lower than the cash patient billing.

Yogesh Sareen: 7% to 8%.

Prakash Agarwal: Oh, that's it?

Abhay Soi: And it actually works out better because when you have insurance policy, and yes, there's been a step change in the frequency of people buying insurance, health insurance being more. But the trend has been on for the last 10 odd years in some manner or the other. It works out well for the quaternary hospitals because as and when you have insurance policy, you're paying the same amount of premium, whether you go to Max or you go to ABC Nursing Home. And what we see is people don't window shop at that stage. You're less price sensitive, you go to the better brand, better hospital because eventually you pay the same premium.

Moderator: The next question is from the line of Kunal Dhamesha from Macquarie.

Kunal Dhamesha: So, the first one was on the 100 beds that we are adding in our existing capacity, would that be more kind of the deluxe beds or the private rooms, et cetera? Or would it be a mix of everything?

Abhay Soi: No. So, it will be more critical care beds than more single rooms, etc., which is more of what we need.

Kunal Dhamesha: So, probably more ARPOB basically if those gets filled, right, because of a single room or deluxe room, critical care beds, et cetera.

Abhay Soi: We make more out of doing a liver transplant in a general ward than we do from doing a delivery in the suite.

Kunal Dhamesha: But over a longer period of time, that's not in your hand, right? Like, over a longer period of time, the private rooms would obviously be better assuming that the mix over a long period across beds remains same.

Abhay Soi: That's right. So, I would actually take the current mix and project it. It won't be lower than that because it's a general ward or whatever else it is. Like I said, most of our hospitals are suffering from a bottleneck at the critical care.

Kunal Dhamesha: And as far, I believe that those critical care bed addition, etc., requires permission or something like. So, all those are in place for us?

Abhay Soi: Yes, I mean no permission required within the existing capacities.

Kunal Dhamesha: In terms of government being able to operationalize AIIMS, etc., which they are kind of opening up now or investing in now because their operational cost or operational cost structure is very different from private players, right? Maybe around the nursing expenses or nursing salaries around maybe 2x-2.5x than what they get in the private hospitals. So, at any point, is there any talks between Government and a player like you to hand over the operations and management of such apex institute to a company like Max, given we are also kind of providing similar kind of care?

Abhay Soi: It's a different profile. But what we are seeing is a lot of state Governments, be it Haryana, be it UP and so on and so forth, are inviting private players from and they've been some RFPs for public-private partnerships, okay, on creating newer facilities. I mean the government has its own way of working. You would have seen even the total outlay has been increased by about 13% towards the health care sector. And whatever the economics of the government are the economics of the Government facilities.

Their viability, I'm not going to sit and question. The fact is they are trying to cater to perhaps an audience, which is an unaffordable audience, right, which can't even afford PMJAY sort of, etc. That's for free health care effectively. And irrespective of viability, I don't think a private player is going to be catering to anybody who can't afford to pay at all.

Moderator: The next question is from the line of Sumit Gupta from Motilal Oswal.

Sumit Gupta: I just have few questions regarding international patients. So, I just want get a gist on the overall pricing. So, I presume that international ARPOB is more than Rs. 1 lakh. So, it is gross or net of discounts and every other thing that you pay to the overall medical tourism agents and all?

Yogesh Sareen: ARPOB is always Gross, right? It's based on the revenue that you book. There may be some expense linked to that revenue. So, we don't net that. That comes on the expense side.

Abhay Soi: No matter how you look at it, EBITDA is 20% higher like what Yogesh said, per bed.

Sumit Gupta: And one more thing regarding, like sequentially, if I see that payor mix for international patient it is nearly like 9%, so consistently. So, going forward, do you see it at 9% or like moving it to 10%-11% also with like new geographies opening up?

Abhay Soi: Our focus is always on the occupied bed days increasing, right? I mean if it remains 9% and other business is also increasing, so be it, right? So, as long as the operating bed days on an absolute or a stand-alone basis for medical is increasing. So, we don't necessarily look at it as a percentage of the overall pie. We look at it as a separate segment altogether. So, we look at, look, is international number of bed days occupancy increasing or not? Is the total revenue in absolute terms increasing or not? And then separately we look at the same way for upcountry business, we look at the same way for cash business, we look at the same way for other business, right?

My focus or our focus is on this thing. The 9% being flat on 2 quarters is also because, like I said, it's seasonality. People don't travel during the festive season. Doctors themselves put off surgeries, etc., because they are on holidays. I mean the better way to look at it is at the same time last year. Unfortunately, last year being a little bit of COVID year, you have a kind of an uneven comparison, and we're all forced to look at pre-COVID levels. But sequentially, one should avoid. You'll typically see the first quarter and third quarter are weak quarters. And for these very reasons they'll be.

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

Amit Kadam: Just one small question, can you help me with the tax rate for maybe how do we look at it going forward, may be FY '24?

Yogesh Sareen: I think for tax rate. I said this earlier also, the ETR should be in the range of 18% to 20%, right? So, this quarter was 18% plus, right? But I would say it will peak at 20%, on the Network basis. But you will note that this quarter, the CTR has come down, i.e the current tax rate has come down. It's by virtue of the fact that last quarter, we did some voluntary liquidation and there are some benefits of that liquidation in terms of depreciation on intangibles. So, I would say 2 things. One, the rate will be 18%-20%. Secondly, I would say watch out the CTR rate, that's better parameter because that's where the cash outflows are linked to, right? And that's improved over quarter 1 and quarter 2.

Amit Kadam: So, 18% would be a fair assumption to consider somewhere between 18% to 20%?

Yogesh Sareen: I would say go towards the higher range of 18% to 20%.

Moderator: The next question is a follow-up question from the line of Ashish Thavkar from IIFL AMC.

Ashish Thavkar: Yes. So, if you get an opportunity in future, would you also be willing to consider stand-alone hospitals, which are specialized in oncology, pure play oncology or say something like pure play child care?

Abhay Soi: We will evaluate everything; we have no issues evaluating anything. When the opportunity arises, we will evaluate.

Ashish Thavkar: Sir, lastly on this digital app-based model, if you could just give some color on the potential of this model. And would there also be a cash burn?

Abhay Soi: On the app, there is no cash burn. It's not an agnostic platform. It is a platform for our patients to interact with our doctors and our doctors to interact with the patients and for the hospital to provide services to the patients, right? Be it diagnostics at home or home care business or video consults and so on and so forth. I mean, I encourage you to actually look at the app, please download and look at it. So, I think all your reports, everything is sort of stored over there. So, it's effectively a platform between the hospital and the patients to interact. And for us to deliver those services to the patients.

Ashish Thavkar: Okay. Perfect. That was it, sir.

Abhay Soi: We are not a platform for third-party players, etc. So, I mean it's very, very different. I mean it's not 24/7 or anything like that. I mean it is 24/7, but it's for us, so we're not marketing it as a third-party platform. I mean the cash burn itself essentially what it is for technology and a little bit of marketing that we will be doing within the Delhi NCR or whatever reason through the hospitals, etc. I'm not looking at any significant cash burn or anything which will even move the needle over here.

Ashish Thavkar: Okay. And your diagnostic offerings would also be clubbed with this app?

Abhay Soi: Absolutely. So, we will be providing diagnostics through the app as well.

Ashish Thavkar: Okay. Sounds good.

Abhay Soi: So, on our app at the top, okay, there's a red button, which can get you an ambulance in Delhi anywhere, anytime within 20 minutes. That's one, which will take you to a

Max Hospital. Then diagnostics, then nurses, then all your medical records, then any video consultations that you want, any scheduling of appointment that you may want to do and so on. Physiotherapy at home, anything, so anything that of. So, the entire suite of services that the hospital provides can be provided to you at your doorstep effectively or without you entering the hospital premises. That's what the app does.

Yogesh Sareen: It will also review trends of your diagnostics, reports. So, in a way, it's there to improve the experience. It's there to improve the, I would say, the interaction of the patient with the hospital and vice versa.

Abhay Soi: But check it out, it's out there. I think that's the most important thing.

Ashish Thavkar: Yes, sure. I will.

Moderator: The next question is the follow-up question from Krishnendu Saha from Quantum Mutual Fund.

Krishnendu Saha: Just clarifying our average length of stay at 4.2 days, is there higher or it probably could go down a little bit more. Just trying to understand it is high because of the critical care being a larger portion is it? And can it go down further?

Abhay Soi: And higher services. And eventually, we need to look at average revenue per occupied bed because your inventory in hand effectively is number of beds days that you have. So, it's higher ALOS but which leads to higher ARPOB growth for you, that's because you're doing more higher end. I mean, so look, if a place has more medical patients, your ALOS is lower but if you have more transplants patients it is longer. But transplant patients will pay you more. I mean the more BMT transplants, lung transplants, heart transplants you do, people tend to stay longer. And billing is more, ARPOB is more, the length of stay is more. You can't really compare A particular chain with B and C.

Krishnendu Saha: Yes. So, some metrics if you look at ALOS in all these days, occupancy and all, so just trying to figure out as to why because we are a little bit higher as of that sir.

Abhay Soi: You can't compare. That's what I'm saying. Within my chain, I can't compare two hospitals because they may be leading 2 different medical programs. I have to really compare program to program or I have to compare with the same hospital to its absolute in the previous year.

Yogesh Sareen: It will actually be procedure-to-procedure, right? So, that will compare the ALOS. And average revenue per occupied bed is the better metric, but that will have ALOS play in to it already, right? If that metric is growing and it's better than others, that to my mind, means ALOS should not be even looked at.

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

Abhay Soi: So, thank you. I appreciate everybody coming online. And I just want to reiterate that the 2 pillars of the foundation that our organization rests on is firstly, execution. So, we are very, very focused on execution, not only in operations but on projects as well to see that they are rolled out in time. And second is fiscal discipline, so you would see that any leverage, if at all, we use for inorganic growth, we would be within what

our declared norms or prudent norms for leveraging the company are, which is not more than 2-2.5x Net debt to EBITDA. So, thank you for the opportunity. Good bye.