Healthcare Deck 1 – Sample ODA 1

DRAFT

BAIN & COMPANY

Summary | Early 'outside-in' perspectives on Target 1 and Target 2

What we like

1. **Offerings in specialized areas** – Target 1 has a clear focus on women and children healthcare providing services across 7 specializations spanning obstetric and gynecological health, women's health, and pediatric care; Target 2 focuses on providing affordable services in rural areas across focus segments such as orthopedics, medical rehab, neonatal intensive care etc.

2. **Presence across multiple locations** – Target 1 and Target 2 combined have 8 hospitals and 2 clinics (800+ beds total) across 3 prominent locations – DKI Jakarta, Banten and Jawa Barat

3. **Focus on infrastructure expansion** – Both hospital chains have steadily grown their presence over the years; Target 2 raised funds from Financial Institution 1 in 2021 via a senior term loan for business expansion

4. **Expanding services and facilities to a wider audience** –Target 1 positions itself as a premium offering & caters to upper middle class along with customers enrolled in the BPJS program, in addition to patients availing their private hospitalization services; it recently launched 'Target 1 Menstrual Center' to offer comprehensive care for women; also actively pursuing partnerships – *most recently partnered with 'Partner 1', a tele-health company, making it more accessible for patients to avail services & take medical tests*

5. **Sourcing patient referrals** – Target 1 has satellite clinics that help funnel patients to its hospitals through referrals

Satellite clinics

What gives us pause / what we need to test further

A. **Limited reporting** on historical financial performance; however, Target 2 is still in its growth phase with **single-digit million EBITDA** while Target 1 has a **revenue of only $xxM**

B. **Potential slowdown in future revenue** due to Indonesia's slow population growth & slowing birth rate could affect Target 1's revenue pools as it operates primarily in the maternity/childcare s

Birth rates & revenue

C. **Limited reporting on operational KPIs** such as bed occupancy rate, average length of stay etc.

D. **Operational improvement initiatives remains unclear**- With limited information around partnerships and efforts to improve operational efficiencies; for e.g., possible improvements in procurement practices (such as streamlining suppliers across sites), an integrated hospital management system, etc.

E. **Need for upgrading hospitals -** With more advanced treatment options available only at Target 1's selected hospitals, there is scope to upgrade to integrated equipment (e.g.: laboratory equipment) at all its hospitals to provide quick, efficient and quality diagnosis/treatment

Upgrading hospitals

Proposed scope *[Priority areas for deep-dive]*

- *Example priority questions*

Pressure test key assumptions of mgmt plan

How stable are Target 1 / Target 2's key catch-ments and operator business?

Private market demand/ growth prospects by catchment areas (Existing/New)

- *What are the primary/target catchment areas and their descriptions? What is the total patient market size in these catchment areas?*
- *What is the projected market size growth for each catchment area and its growth factors (based on background analysis of catchment areas using indicators such as population, GDP per capita, local initiatives, etc.)?*

Market share expectations, given competitive position in focus catchment areas

- *What is the competition like in each catchment area? This should be evaluated based on the number of beds, specialists, patient satisfaction, etc.*
- *What referral channels are in the target catchment areas, and how effectively does Target 1 / Target 2 maintain access to them?*

General assessment of owned/subsidiary hospitals (Regional Level)

- *What are the supply-demand dynamics, availability of public/private beds, types of hospital formats, doctor accessibility, pricing structures, and underrepresented specialties in each region where Target 1 / Target 2 has hospitals?*
- *How is each region ranked based on its attractiveness for establishing or expanding a presence?*
- *At a high level, how do Target 1 / Target 2 hospitals compare to competitors within the same catchment area?*

What can be the strategic priorities of Target 1 / Target 2 management

Feasibility of expansion of existing capacity, new hospitals, and operational efficiency initiatives

- *What are mgmt.'s expansion plans? How well are they placed compared to industry realities and what should be the practical performance expectations?*
- *What are the benefits of adopting industry trends such as integrated information systems etc. and do they outweigh the related threats such as employee resistance to change? How feasible is it to launch telemedicine in rural markets through Target 2? Is there merit in standardizing processes etc., across various hospitals to realize economies of scale?*

Drivers and sustainability of historical performance

- *What is the fair expectation for medical intensity growth of Target 1 speciality areas such as childcare, fertility etc.? What factors have contributed to the historical growth of the assets, and to what degree are these factors expected to persist?*
- *What growth should Target 2 expect in the rural markets and any emerging trends that it needs to focus on to expand its presence?*
- *How does the cost structure compare with local and regional counterparts? What are the reasons for this difference, and how does it impact the sustainability of profit margins?*

Current areas of improvement

- *What are various areas of improvement that need management attention basis the benchmark peer performance?*

Assess key risks or threats to plan

PENSTROKE RISK FROM BPJS

- *What is the current reliance on BPJS funding and how are patient referrals managed?*
- *What are the potential benefits and drawbacks from a regulatory perspective?*
- *Are there any potential challenges to patients' ability to afford healthcare due to population growth and increasing costs?*
- *What steps are being taken to mitigate the potential risks posed by changes to the BPJS program that could negatively impact Target 1 and Target 2?*
- *What steps are being taken to coordinate and standardize quality assurance standards for contracted hospitals?*
- *What is the profitability and payback profile like for hospitals of Types[1] A to D , and are there any factors limiting their profitability?*

UNIQUE COMPETITOR RISK (IN KEY CATCHMENTS)

- *How well does Target 2 perform in offering digital health solutions in rural areas compared to competitors?*
- *What consequences could be for Target 1 if competitors expand in its focus catchment area?*

LABOUR CHOKEPOINTS AND ABILITY TO NAVIGATE (ESP. DOCTORS)

- *Are there enough maternity specialists in Target 1 to fulfill the increasing demand in Indonesia? What are the different nuances of the country's medical labor market?*
- *Can Target 1 attract medical talent from competing hospitals to meet the demand for doctors with its expansion projects, and what retention strategies can be employed?*
- *Does Target 2 have sufficient staff at its facilities in rural areas?*

Note: (1) Hospital in Indonesia is categorized based on the minimum number of inpatient beds: Class A – 250, Class B – 200, Class C – 100, Class D – 250

AGENDA

Company overview

Market overview

Competitive positioning

Appendix

Bain credentials

Business overview | Target 1 specializes in women and child health care with ~200 employees; Target 2 aims at serving rural areas with ~100 employees

TARGET OVERVIEW

DRAFT

Business description

Foundation: Target 1 - 2006, Target 2 - 2018

Ownership: Target 1 – **Majority stake** owned by **PE Firm 1**; XYZ Investment Management and ABC Healthcare Partners hold minor stakes
Target 2 – **Majority stake** (>75%) **owned** by **PE Firm 1**

HQ: Jakarta

Description: Target 1 provides medical services through general hospitals offering services across 7 specializations with focus in obstetric and gynecological health, women's health, and pediatric care
Target 2 is a general hospital chain serving communities in rural areas by bringing in methodologies that are available in bigger cities and making them more affordable; focus areas include orthopedics, medical rehab, neonatal intensive care etc.

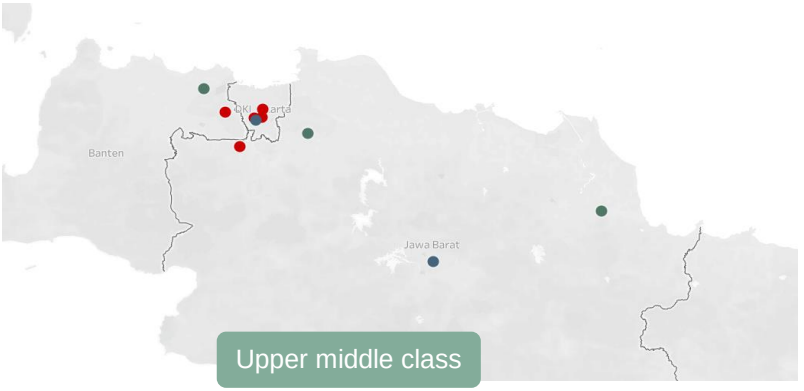
Financial performance:
- Target 1 reported a **revenue of ~$xxM**[1] and an **EBITDA margin of ~25%**, with capacity of existing sites to go upto $xxM
- Target 2, still in the growth phase, reported a **single digit million EBIDTA**

Capacity: **400+ beds each** across the Target 1 and Target 2 networks

Employees: ~300 (Target 1 - ~200; Target 2 - ~100)

Geographic footprint

	Target 1		Target 2	
Region	**# of hosp.**	**# of clinics**	**# of hosp.**	**# of clinics**
Banten	1	0	1	0
DKI Jakarta	3	1	0	0
Jawa Barat	1	1	2	0



Target 1 clinics
Target 1 hospitals
Focus on upper-middle class segment - provides services across specializations with focus on obstetric and gynecological health, women's health, and pediatric care

Target 2 hospitals
General hospital chain serving communities in rural area through modern settings

Segment overview

Legend: **Target 1 operations** | **Target 2 operations** | **Target 1 and Target 2 operations**

Care Continuum (Site of Care + Service)

Acute Care	Ambulatory	Post-Acute	Retail Healthcare		Wellness
Large Integrated Delivery Networks	Specialty care*	Home health	Dermatology	Optometry	Yoga
		Hospice	Diagnostic Imaging	Veterinary	Mindfulness
Community hospitals	Behavioral health clinics	Skilled nursing facility	Dental	Med Spa / Aesthetics	Guided meditation
		Inpatient rehabilitation facilities	Ear, Nose and Throat	Physical Therapy	Pet therapy
	Community health clinics	AL/IL/CCRC#	Fertility		Fitness^

Note: (*) Broadly defined – opportunity to deep-dive on specialties – e.g., Substance use disorder, ESRD and dialysis, oncology, cardiology, etc.; (#) CCRC = Continuing Care Retirement Community, AL = Assisted Living, IL = Independent Living; (^) Includes offerings catering to Slimming & health sport therapy, Sleep disorders, etc.; (1) BPJS healthcare program (BPJS Kesehatan) is a government-run universal health insurance program in Indonesia offering a range of healthcare services, including inpatient and outpatient care, maternity care, dental care, and emergency services; (1) Data for 5 sites of Target 1 Hospitals, revenue figures not available for Target 2 | Source: Company website, company reports, Lit. search, Bain analysis

Business overview | Since inception in 2006 and 2018 respectively, Target 1 and Target 2 have organically grown to ~10 hospitals/clinics by 2023

TARGET | BUSINESS HISTORY

DRAFT

Business Timeline

- Target 1 **2006** — Started operations as Target 1 Women & Children Hospital in Antasari South Jakarta
- Target 1 **2011** — Target 1 Hospital Tangerang commenced operations in Tangerang City and offers specialities such as minimum invasive surgery procedures, urology, fertility, trauma centre etc.
- Target 1 **2013** — Target 1 Clinic Kemang commenced operations in South Jakarta to offer physiotherapy, dental care, psychology etc.
- Target 2 **2018** — Target 2 was established as an entity to serve the rural population; currently op… RS Sumber Waras Cirebon, RS Target 2 Setu Bekasi, and RSIA Sepatan Mulia

BCN: Limited information available on the date of acquisition/opening of the three hospitals

- Target 1 **2019** — Target 1 Hospital Saharjo commenced operations to focus on specialities such as oncology, endoscopy etc.; a centre for heartlogy also opened in the hospital with investments from Attrui and TE Asia

Heartology — TE Healthcare Asia (investor in Target 1) opened a new center of cardiology called Heartology at Target 1 Saharjo Hospital- the first hybrid technology of cardiac surgery provided in Indonesia

- Target 2 **2021** — Financial Institution 1 signed senior term loan agreement with Target 2 Hospitals Group to fund hospital expansion and rehabilitation
- Target 1 **2022** — Target 1 Hospital Saharjo begins to support BPJS program; Target 1 Hospital Depok plans to expand into new offerings such as laparoscopy, endoscopy etc.; launched 'Integrated Menstrual Disorders and Endometriosis Service Center' in Antasari Hospital to offer menstrual care and treatment for women
- Target 1 **2023** — Target 1 Hospital Depok partnered with Partner 1, a tele-heath company, to offer telemedication services to its patients

Source: Company website, lit. search

List of Hospitals

Brand	Hospital	Year est.	Location
Target 1	Target 1 Clinic Kemang	2013	Jakarta
	Target 1 Hospital Antasari	2006	Jakarta
	Target 1 Hospital Duren Tiga	*Limited info.*	Jakarta
	Target 1 Clinic Bandung	*Limited info.*	Bandung
	Target 1 Hospital Depok	2018	Depok
	Ta… 1 Hospi…		Jakarta
	Target 1 H…		Tangerang
Target 2	Target 2 Hospi…		Bekasi
	Target 2 Hospi…		*Cirebon*
	Target 2 Hospital Sepatan	*info.*	*Tangerang*

- Target 1 currently clustered in and around Jakarta
  - Need to expand across Indonesia to garner awareness & incremental revenue
  - Further scope to target potential upper-middle class patients who currently have to get treated abroad

Jakarta cluster

Value creation | Opportunity to grow by focusing on payer approach, refer process, adjacency expansion, cost optimization, and digital innovation

BCN: Value creation levers marked basis outside-in perspective on target's on-going initiatives and examples from peers

VC LEVERS

Legend Core | Secondary

DIRECTIONAL -IN PER

Upgrade hospitals

Satellite clinics

Target 1, like peers, has a **diverse payer mix** including out-of-pocket, insurance payers and BPJS health & labor patients

Technology & efficient laboratory system influence patient preference for mode & place of treatment, indicating need for advanced & upgraded hospitals

Satellite clinics to help funnel patient referrals

Peers such as **Peer 1** are expanding through **partnerships with doctors** in local areas

Target 1, like peers, has **laboratory** offerings

Peers such as **Peer 2** are **standardizing consumables** to negotiate better deals with suppliers

Peers such as **Peer 2** are focusing on **supplier consolidation**

Target 1 partnered with **Partner 1**, a tele-heath company, to offer **tele-medication services** to its patients

Topline expansion	Top-line growth	Optimize payer approach and pricing (e.g., payer mix optimization, negotiation and contracting)	Expand and diversify service mix (e.g., focus on high value treatments)	Optimize referral intake (e.g., PCP[1] network and physician channel, high patient loyalty/advocacy)	Reduce capacity bottlenecks (e.g., ALOS and wait time reduction, alternative delivery models)	Enhance patient experience and quality of care	Marketing and branding
	Expansion	Adjacency expansion (e.g., specialty care, specialty hub, plan vs. one-time visits, primary/urgent care, take home products, OTC)	M&A/carve-outs (build scale through acq			hic expansion (expand footprint in regions with optimal density and demographics)	
	Asset/port-folio optimization	Optimize market footprint	Real estate investment strategy			Working capital optimization (e.g., balance sheet optimization, sales/leaseback)	
Cost optimization	Front end labor cost optimization	Physician labor optimization			Other/non-physician labor optimization		
	Materials cost optimization	Spend better (e.g., standardize consumables and pre/post procedure activities, optimize mix of physician preference items)			Buy better (e.g., supplier consolidation, volume purchasing of consumable and medical supplies)		
	Overhead cost optimization	Back-office optimization (e.g., optimize onshoring/offshoring mix, shared service model)			Service level rationalization (e.g., reduce frequency or number of services)		
	Enablers	Finance & portfolio analytics (enable asset/portfolio optimization and M&A)	Technology & digital innovation (enable better service delivery)	Data & advanced analytics (customer segmentation and identify OpEx improvement opportunities)	Management talent	Organizational structure (e.g., cross-functional teams, few layers, talent management and expertise)	Operating model (e.g., lean operations)	ESG (e.g., community services)

Note: (1) Primary care provider | Source: Bain analysis, Company reports, Bain experience, Lit. search

AGENDA

Company overview

Market overview

Competitive positioning

Appendix

Bain credentials

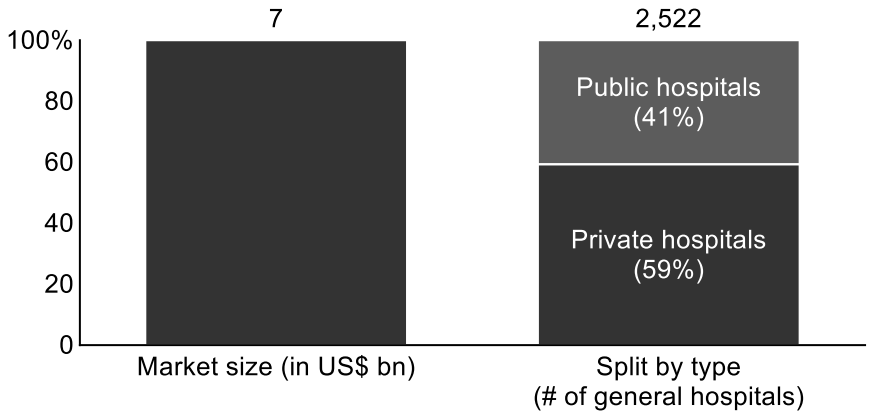
Market overview | ~$7B hospital market in Indonesia; ~85% population covered under National Health Insurance

MARKET SIZE AND LANDSCAPE

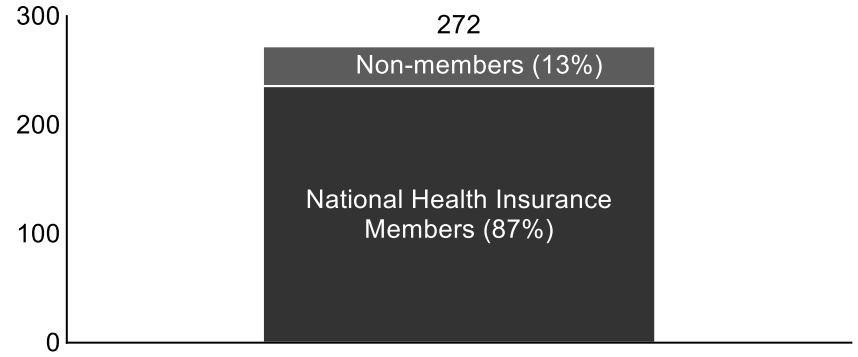
DRAFT

Healthcare market, 2021

General hospital market

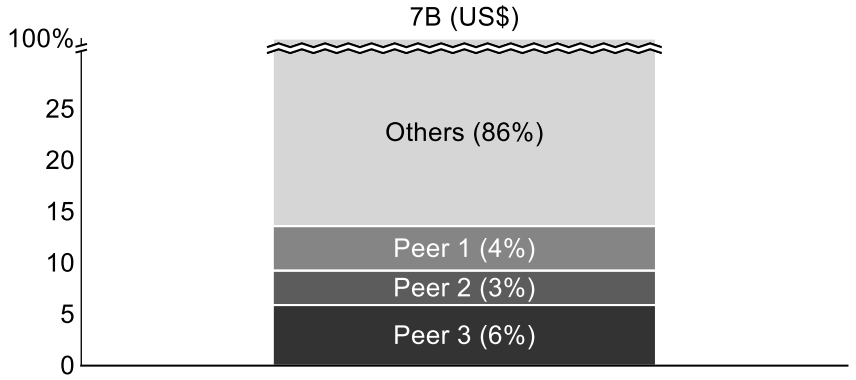


Population (in M) enrolled for National Health Insurance(BPJS), 2021

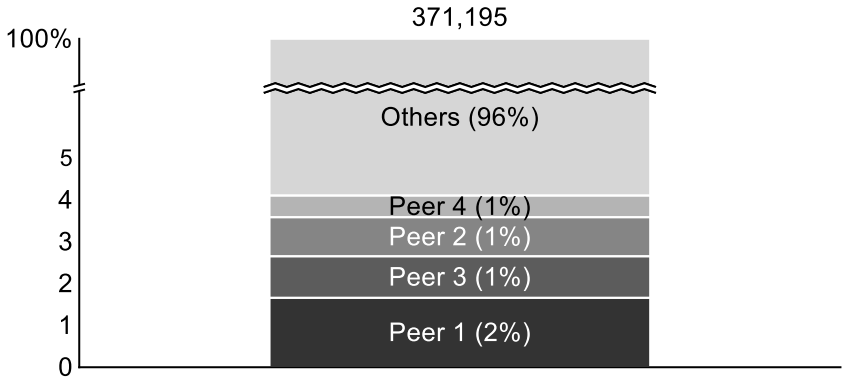


Healthcare market, 2020/21

Hospitals key players, 2020



Number of beds, 2021



Outlook

- **Indonesia:**
  - **Healthcare spending** in Indonesia accounted for **~3% of GDP** in 2022
  - The Hospitals market in Indonesia is poised to grow at **~12.5%** CAGR over 2020-25, due to **increasing government healthcare spending** and **growing population**
  - **Profitability** in the sector tends to be in the range of **10% to 25%**
  - The number of public & private hospitals is **growing** at a rate of **3%** and **6%** respectively
  - The Omnibus law in 2021 allowed 100% foreign investment in Indonesia's hospital sector
    - > Foreign medical specialists soon to be allowed to practice & be based in the country
  - As of 2021, there was a 6% YoY growth in members registered for the National Health Insurance (BPJS), from 2020
  - **PE/VC investors in the space** – GIC, CVC, Quadria Capital
  - Post COVID, with advent of new govt regulations, increased insurance coverage & increased life expectancy (73.5 yrs in 2021 from 70.2 in 2012), more Indonesians prefer to visit hospitals

Foreign docs

Covid effect

Note: (*) Calculated basis number of beds, average revenue per bed in public and private hospitals; (^) TMG revenue calculated basis geographic split in proportion of segment-wise split of overall revenue;
Source: Statista, Lit. search, Bain analysis

Market overview | BPJS is strengthening social and health security in Indonesia through universal healthcare

MARKET | REGULATION - BPJS

DRAFT

JKN[1] was launched in 2014 by BPJS[2] to implement universal health coverage in Indonesia

Year est.: 2014

Goal: To provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of Indonesia

Private providers: Hospitals allocate some of their capacity to BPJS patients and maintain available space for other private patients

Government is looking to replace the current 3 ward class system with KRIS[3]; trials in progress

Class	# of beds in shared room	Self-funded premium
I	2-3	~US$11 per month
II	3-6	~US$7 per month
III	>6	~US$3 per month

- By **2025**, the 3-tier system will be replaced by the **standard inpatient class (KRIS) scheme**
- KRIS aims to provide **equal health facilities and services** to BPJS patients
- With KRIS, maximum room capacity to be **4 patients**, with air-conditioning and at least one bathroom

Patients pay premiums to BPJS for a cashless patient journey

Patients (covered under BPJS)

- **Employees:** Premiums **mostly covered by employers** (5% of monthly salary, with a salary cap of IDR 12M)
  - **Private:** 4% by employer, 1% by employee
  - **Govt.:** 3% by govt., 2% by employee
- **Self-funded:** For workers who are self-employed or in the informal sector, **option to pay for their own BPJS**
- **Govt-sponsored:** For poorer demographics **completely covered by the government**

Seek treatment

Cashless patient journey

Providers

Primary care (i.e., clinics)

Puskesmas: Public clinics which **must refer patients to Class C/D** hospitals for further treatment

Private clinics: Can **also treat BPJS** patients and refer to Class C/D hospitals

Secondary/Tertiary care (i.e., hospitals)

Public hospitals

- All govt. owned hospitals **must serve BPJS patients**
- Patients must **first visit a Class C/D** hospital after being referred; patients are **only referred to Class B** hospitals **if treatment cannot be provided at Class C/D hospital**

Private hospitals

- **Opt-in** to serve BPJS patients, requiring a **lengthy application process** (up to 2 years) to receive BPJS accreditation
- **Similar referral pathway** as public hospitals

Submit claims for reimburse-ment

BPJS

Core functions:

- **Collect premiums** from employers, self-funded and portion covered by govt.
- **Manages BPJS budget** provided by the govt. to supplement premiums
- **Reviews providers** and **approve BPJS accreditation**
- **Adjudicates claims** by providers (both primary and secondary/tertiary care)
- **Reimburse hospitals** based on pre-agreed tariffs

Pay premiums

Note: (1) JKN – Jaminan Kesehatan Nasional; (2) BPJS – Badan Penyelenggara Jaminan Sosial Kesehatan; (3) KRIS - Kartu Indonesia Sehat; Class D – Min. 50 beds, Class C – Min. 100 beds, Class B – Min. 200 beds, Class A – Min. 400 beds | Source: Lit. search, Bain analysis

Market overview | The Indonesian healthcare system is witnessing a revamped universal health coverage, re-alignment of profit pools, and digital transformation

MARKET TRENDS

/DRAFT /NON-EXHAUSTIVE

Profit pools re-aligning

Trends

- As of 2022, private healthcare providers is a **$1-1.5B profit pool** in Indonesia – expected to double over the next decade, but value will shift towards **payer and provider ecosystem**:
  - **Top private hospital chains** expected to achieve **15-30% EBITDA margins** in **2030 from inpatients** (at a **CAGR of ~15%** over **'22-'30**) due to **player consolidation** and **price increases**, while **outpatient provider** segment profit pool expected to grow at a **CAGR of ~20%** over **'22-'30,** as hospital burden/cost will push for **shift to home/on-site care**

Opportunities

- **Care is moving away from the hospital** (e.g., via ambulatory care, telemedicine)
  - Peer 3 & Insurance company 1 – Partnership to launch a telemedicine feature called 'xyz' (2020)
  - Peer 7 – Introduced a teleconsultation platform during the pandemic; offers home care services for e.g., newborn care
- Providers already **consolidating** to create **larger health networks** with **economies of scale**
  - Peer 2 – xx largest private hospital network in Indonesia; expanded through a series of acquisitions

Threats

- **Traditional (hospital) profit engines facing competition** from independent outpatient groups (e.g., diagnostics)
  - Peer 8,9 – Competition from smaller healthcare providers focusing on lab tests, imaging services etc. which may attract patients seeking affordable or specialized care

Universal health coverage

Trends

- Indonesia is **shifting from private healthcare** to **universal coverage**, aiming to provide affordable, quality services for all
  - **~85% population** is now covered under the BPJS[3] National Health Insurance (launched in 2014)
- BPJS[3] plans to implement **standard classes** (subsidized and non-subsidized) instead of Class I, II and III patients

Opportunities

- By forming relationships with local clinics, hospitals can **increase patient volume** as these **clinics refer patients needing specialized care**
  - Peer 2 – The chain may benefit from Class I and II members (basis current BPJS classification) becoming private patients after merging of classes
- Hospitals can **influence patient flow** by working with primary care providers to **direct less-profitable patients/cases to other hospitals**

Threats

- Healthcare providers are paid by the government based on a package named INA-CBG[4] (typically at **a discount to a hospital's commercial rate)**, significantly affecting their **profit margins**
- Shift from out-of-pocket or corporate insurance to BPJS **complicates timely payments** due to red tape, potentially **delaying doctors' salaries** and discouraging them from joining hospitals with uncertain payment guarantees

Digital transformation

Trends

- Growing support for **digital health platforms, telemedicine**, **electronic medical records** (EMRs) and **mobile health apps**, especially post COVID-19
  - For e.g., MoH[1] **launched Indonesia Health Services platform** 'SATUSEHAT' to boost digital health transformation
- **Telehealth adoption rate** in Indonesia is expected to grow from ~25% in 2019 to **~70% in 2024**

Opportunities

- **Expanding reach** to remote areas, and increasing **patient engagement** using telemedicine
  - Peer 3 – An app 'xyz Mobile' for patients to schedule doctor appointments
  - BPJS Kesehatan – JKN[2] mobile app connected to 20K+ healthcare providers, making it easier to access healthcare services
- **Leveraging AI** (for e.g., EMRs, predictive analytics etc.) to manage and analyze data
  - Peer 7 – Investing in artificial intelligence and advanced hospital information systems to capture individual patient records

Threats

- **Risk of cyberattacks and data breaches** due to lack of robust system of checks and balances
  - In 2021, data of **~6M patients** in various Indonesian hospitals was breached and **traded on dark web**

Note: (1) Ministry of Health; (2) JKN – Jaminan Kesehatan Nasional; (3) BPJS healthcare program (BPJS Kesehatan) is a government-run universal health insurance program in Indonesia offering a range of healthcare services, including inpatient and outpatient care, maternity care, dental care, and emergency services; (4) Indonesia Case-Based Groups | Source: Statista, Lit. search, Bain analysis, Bain experience

AGENDA

Company overview

Market overview

Competitive positioning

Appendix

Bain credentials

Benchmarking | Target 1 is a private healthcare provider in Indonesia, offering a range of services across the value chain with limited reporting across KPIs (1/2)

PEER BENCHMARKING

/ NON-EXHAUSTIVE

	Target 1, Target 2	Peer 2	Peer 3	Peer 1	Peer 4
Headquarters					
Geographical focus					
Business description	• Target 1 specializes in obstetrics, gynecology, women's health, and pediatrics through general hospitals with 7 specializations • Target 2 offers affordable healthcare in rural areas, focusing on orthopedics, medical rehab, and neonatal intensive care	• Healthcare provider operating a network of hospitals & pharmacies, offering services for oncology, fertility, brain spine etc. • Manages 20 Peer 2 hospitals and 9 peer 10 hospitals	• Healthcare provider offering a range of medical services through its 40 hospitals • Specializes in various fields, including general surgery, pediatrics & neurology	• Healthcare provider focusing on the care of mothers and young children • Provides online consultations for patients' convenience	• Private hospital group catering to the middle and upper-class segments • Offers a range of specialized centers, including mother & child, sports clinic & orthopedic centers
Ownership type	Private	Public	Public	Public	Public
Revenue (USD M)	~xx[1]	~270	~740	~330	~100
EBITDA margin (%)	*25%[1]*	37.50%	26.84%	23.20%	14.00%
Funding details	• In 2021, Target 2 secured a senior term loan from Financial Institution 1 for business expansion	• Publicly listed since 2015	• Raised post IPO equity from CVC Capital Partners in 2016[2] • Publicly listed since 2013	• In 2021, minority stake acquired by Quadria Capital[2] • Publicly listed since 2018	• Released IPO in 2022
# employees	~xxx	~8.3K	~11.8K	~14.8K	~5.0K
M&A Activity *(last 3 years)*	*Limited info*	In 2020, acquired RSIA Panti Abdi for USD 2.3M	In 2021, participated in a USD 3M round of Prixa	In 2020 & 2021, acquired hospitals in Salatiga & Ciledug respectively[2]	*Limited info*

Note: Data for FY'22, unless specified otherwise; (1) Data for 5 sites of Target 1 Hospitals, revenue figures not available for Target 2; (2) Deal value undisclosed | Source: Lit. search; Company and competitor websites

Benchmarking | Target 1 is a private healthcare provider in Indonesia, offering a range of services across the value chain with limited reporting across KPIs (2/2)

PEER BENCHMARKING

Legend **Performance** Lagging Average Leading Best-in-class *n/a* Data not available

/ NON-EXHAUSTIVE

Key Performance Indicators	Target 1, Target 2	Peer 2	Peer 3	Peer 1	Peer 4
# of operational beds (K)	>0.8[1]	3.47	3.78	6.16	1.93
# of patients (M)	*n/a*	2.89	3.39	7.12	1.39
# of inpatients (M)	*n/a*	0.26	0.24	0.48	0.28
# of outpatients (M)	*n/a*	2.63	3.15	6.64	1.11
Average length of stay – ALOS (days)	*n/a*	3.45[2]	4.10[2]	2.80	3.40
Bed occupancy rate (%)	*n/a*	57%[2]	59%	62%	37%
Average revenue per inpatient day (USD)	*n/a*	242	436	139	228
Average revenue per outpatient visit (USD)	*n/a*	35	80	20	26
% of full-time female employees	*n/a*	85%	79%[2]	76%	76%
Average training hours per employee	*n/a*	195.63[2]	*n/a*	3.28	*n/a*
Number of workplace fatalities	*n/a*	2[2]	*n/a*	0	*n/a*
Lost-time incident rate (per 1M hours worked)	*n/a*	9.20[2]	*n/a*	2.76	*n/a*
Number of recordable work-related injuries	*n/a*	147[2]	*n/a*	153	*n/a*
Customer Satisfaction Rate (%)	*n/a*	92%[2]	*n/a*	96%	93%

Note: Data for FY'22, unless specified otherwise; (1) Data for sites of Target 1 and Target 2 combined; (2) Data for FY'21 | Source: Lit. search; Company and competitor websites

AGENDA

Company overview

Market overview

Competitive positioning

Appendix

Bain credentials

INDONESIA

Healthcare sector overview

Profile

Population

- ~271M (Jakarta: ~11M, Bandung: ~3M, Surabaya: ~3M, Bekasi: ~3M, Medan: ~2M)
- 34 provinces with unequal distribution of hospital beds across provinces e.g., majority beds are in Jakarta and Sulawesi

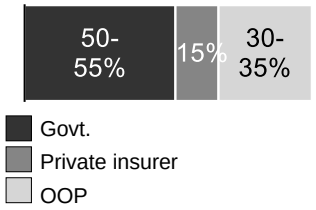
Universal Health Coverage

- Coverage
  - ~84% population covered
- Services
  - Comprehensive managed care plan, though evidence suggests healthcare providers still charged BPJS patients (e.g., forcing room upgrades)
- Costs
  - Limited cost sharing, except for patients who want to upgrade to higher class beds

Healthcare system

Payer

Healthcare spending (USD, Bn)

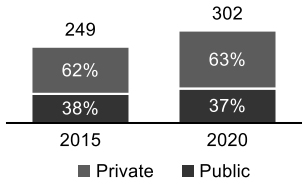


Jaminan Kesehatan Nasional (JKN)

- Roll-out date: 2014
- Funding: Government and members' contributions
- Success: Equity – Citizens/ residents felt strong sense of govt's responsibility for its citizens' health issues
- Challenge: Costs – Incurred high financial deficit due to impl. challenges, high util.

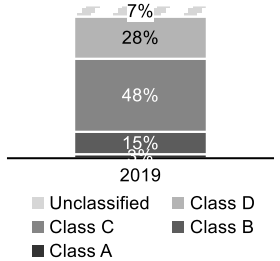
Provider

Public vs. Private hospitals (%)



Hospital classes

- Hospital classified based on sub-specialties, pre-2019



- Since 2019, MOH changed the classification system to bed-count based

Pharma

Prescription

- Doctor prescriptions required

Pharma dispensing

- In-hospital/clinic: Available to dispense drugs in hospital/ clinic's dispensary
- External pharmacy: Available to purchase prescription drug in pharmacy with doctor's prescription letter

Regulation-pricing

In-patient

- Reimbursement mostly on a fee-for-service basis (JKN based on capitation, fee-for-service or diagnosis-related groups)
- Reimbursement rates vary by degree of specialization of the hospital

Prescription medicines

- No formal price control mechanisms in place for private healthcare
- For public healthcare facilities, there are regulations on price of medicines

Doctor engagement

Employment

- Contract: Doctors are allowed to contract up to 3 hospitals
  - Younger doctors are choosing to contract with only one hospital
- Nationality: Most doctors are local
- Limited supply of specialist doctors outside large cities

Public/ private

- 4.7 physicians & 2.4 specialists per 10,000 pop. (2019)
- To specialize, need to practice in public hospitals for few years before qualified for private hospitals
- In general, specialists in private hospitals are more seasoned

Source: Fitch solution, BPJS Report 2019, Ministry of Health, Profil Kesehatan Indonesia 2019, WHO, Worldometer

INDONESIA

Regulation - BPJS: What you need to know

No.	Key questions	Summary
1	What is BPJS and the different tiers of BPJS?	BPJS is a **universal healthcare programme** under JKN (Indonesia National Health Insurance) to ensure coverage for all Indonesians. There are **currently 3 tiers of BPJS**: • **Class I** – Shared room with 2-3 patients, self-funded premiums ~US$10 per month • **Class II** – Shared room with 3-6 patients, self-funded premiums ~US$7 per month • **Class III** – Shared room with > 6 patients, self funded premiums ~$2 per month (with additional ~US$1 topped up by the govt.)
2	What are the different hospital tiers and criteria?	There are **4 classes of hospitals**, broadly **defined by number of beds**: • **Class D** – Min. 50 beds, **Class C** – Min. 100 beds, **Class B** – Min. 200 beds, **Class A** – Min. 400 beds • Previous, hospital classes were also defined by the number of specialties and sub-specialties
3	What is the referral pathway for BPJS patients?	• Patients must **initially visit a primary care clinic** (either Puskesmas or private clinic) and then be **referred to a class C/D hospital** • Only if treatment **cannot be managed** by the class C/D hospital, a patient gets **referred to a Class B** hospital
4	Can patients pay to upgrade?	• In the past, Class I patients were able to upgrade to VIP (i.e. single room) by paying out-of-pocket. Similarly, Class II patients were able to upgrade to Class I rooms • **However, since 2020, upgrading is no longer allowed for BPJS patients (i.e. no balance billing)**
5	What is the claims process for BPJS for a private hospital?	• A hospital will incur the cost upfront and **submit claims to BPJS for reimbursement** (every 3 months) • BPJS claims are **based on a tariff** (INA-CBGs list), typically at **a discount to a hospital's commercial rate** • BPJS tariffs are dependent on 3 **main factors:** (i) Location of hospital, (ii) Class of hospital and (iii) Class of BPJS patient
6	How can private hospitals 'control' the payer mix?	• **Supply-side:** – Hospitals will allocate a percentage of the hospital to BPJS patients and maintain available space for other private patients • **Demand-side:** – Hospitals form relationships with clinics in the region to drive patient volume to their facilities – Hospitals influence patient flow by working with primary care providers to direct less-profitable patients/cases to other hospitals,
7	What is CoB and the relationship with BPJS?	• A program whereby BPJS patients can **'top-up' their coverage with private insurance** to upgrade facilities, services or to have access to different treatments • This has been **discussed in Indonesia since 2014**, but has **never been fully implemented** (with the exception of InHealth) largely due to **hesitancy from private insurers on the reimbursement process, lack of clarity on what is covered and documentation/admin requirements**

Source: Market participant interviews

INDONESIA

Regulation - BPJS: Expanded coverage to >80% of the Indonesian population

JKN was launched in 2014 by BPJS to implement universal health coverage in Indonesia

Year established: 2014

Goal: To provide health insurance coverage and ensure affordable, acceptable, available and accessible health care services for all citizens of Indonesia

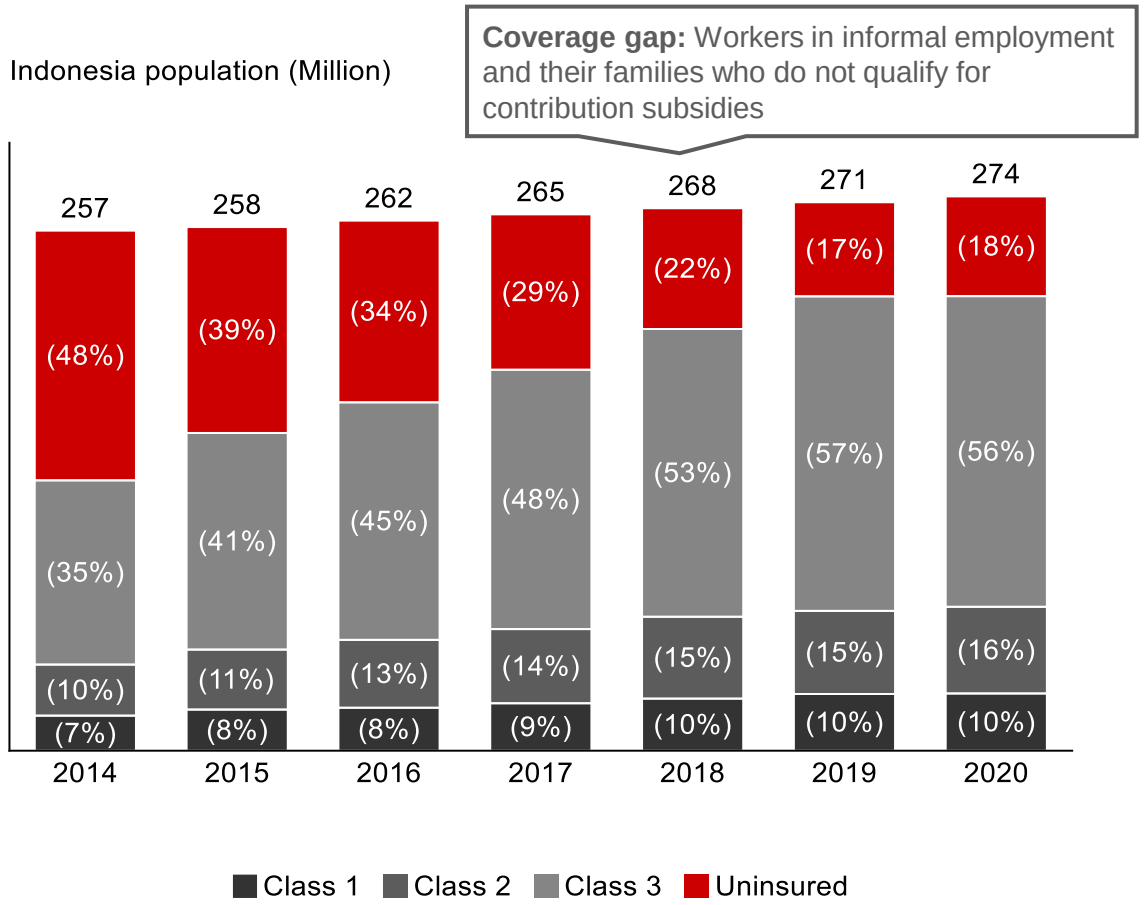
Classes: 3 class types;

- All classes have the same healthcare service
- Each class corresponds with different size and type of hospital room

Monthly Premiums: 3 categories of members

- Employees: 5% of monthly salary, contribution split with employer*
- Non-employees: Voluntary with fixed premiums per class
- Contribution assisted participants (PBI): Poor and disadvantaged's contributions are covered by government

Historical BPJS coverage % over time



Notes: BPJS – Badan Penyelenggara Jaminan Sosial Kesehatan, JKN – Jaminan Kesehatan Nasional | (*) Cap of RS120,000 salary, private sector: employers pay 4% while employees pay 1%, public sector employers pay 3% while employees pay 2%
Source: Lit Search, DJSN

INDONESIA

Regulation - BPJS: Patients pay premiums to BPJS for a cashless patient journey

Patients (covered under BPJS)

A Employees

- Premiums **mostly covered by employers** (5% of monthly salary, with a salary cap of IDR 12M)
  - **Private:** 4% by employer, 1% by employee
  - **Govt.:** 3% by government, 2% by employee

B Self-funded

- For workers who are self-employed or in the informal sector, **option to pay for their own BPJS**

C Govt-sponsored

- For poorer demographics **completely covered by the government**

Seek treatment

Cashless patient journey

Providers

Primary care (i.e. clinics)

A Puskesmas

- Public clinics which **must refer patients to Class C/D** hospitals for further treatment

B Private clinics

- Can **also treat BPJS** patients and refer to Class C/D hospitals

Note: Typically, BPJS patients are registered a single clinic. The clinic receives a monthly amount from BPJS for maintaining that patient, on-top of claims depending on treatment provided

Secondary/Tertiary care (i.e. hospitals)

A Public hospitals

- All govt. owned hospitals **must serve BPJS patients**
- Patients must **first visit a Class C/D** hospital after being referred
- Patients are **only referred to Class B** hospitals **if treatment cannot be provided at Class C/D hospital**

B Private hospitals

- **Opt-in** to serve BPJS patients
- Requires a **lengthy application process** (up to 2 years) to receive BPJS accreditation
- **Similar referral pathway** as public hospitals

Submit claims for reimburse-ment

BPJS

Core functions:

- **Collect premiums** from employers, self-funded and portion covered by govt.
- **Manages BPJS budget** provided by the govt. to supplement premiums
- **Reviews providers** and **approve BPJS accreditation**
- **Adjudicates claims** by providers (both primary and secondary/tertiary care)
- **Reimburse hospitals** based on pre-agreed tariffs

Pay premiums

AGENDA

Company overview

Market overview

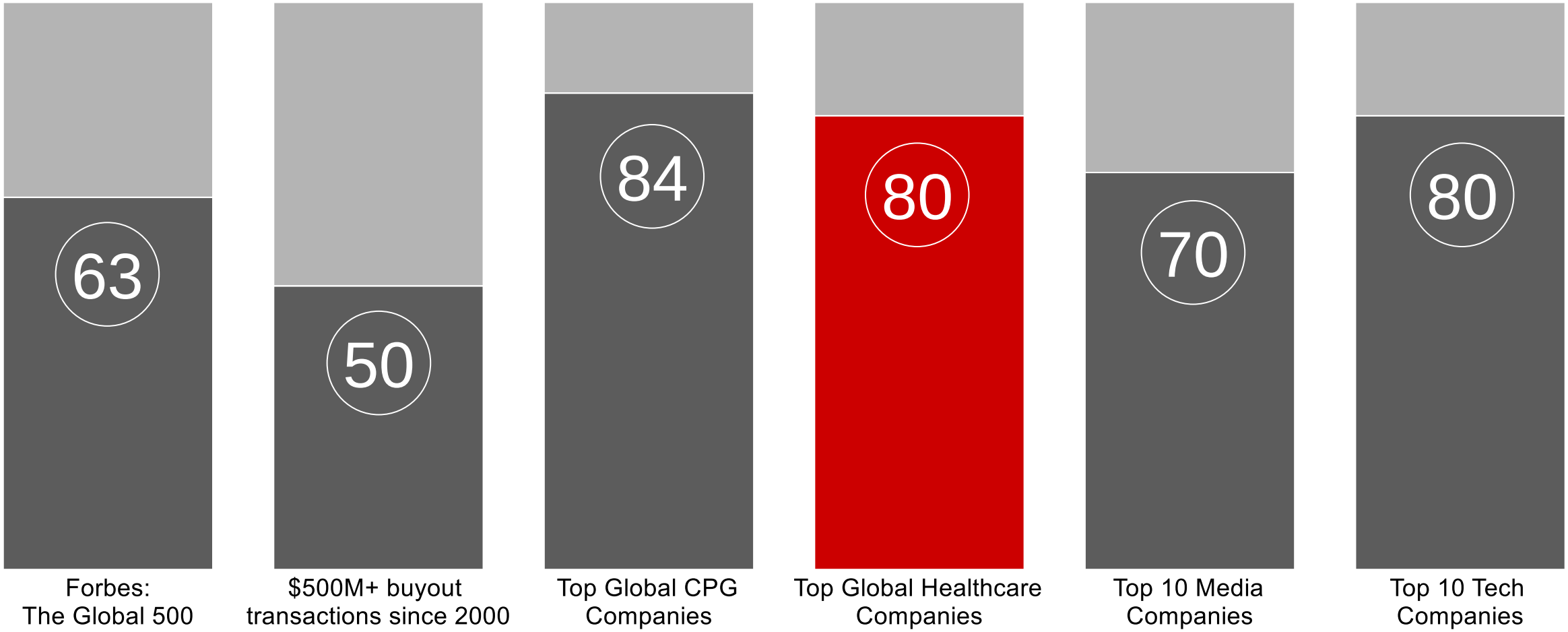
Competitive positioning

Appendix

Bain credentials

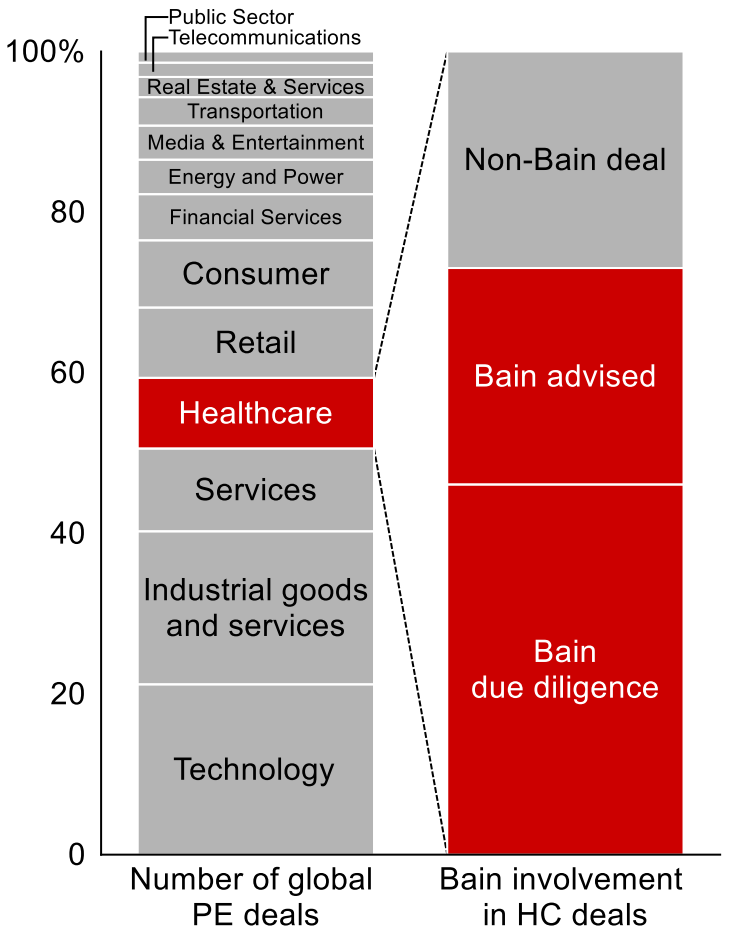
80% of the top healthcare companies globally **choose Bain as their partner**

Bain clients (%)



Bain is a leader in the Healthcare private equity space globally: we serve ~75% of scale deals globally

Bain serves ~75% of all SCALE healthcare deals…



- Drugs (primary and specialty care)
- Reagents
- Genomics
- Generics
- Contract research
- Contract manufacturing
- Animal pharma

- Regional Payers
- Regional and national payer systems
- Third-party administrators
- Disease management

- Cardiac devices
- Aesthetic lasers
- Imaging equipment and media
- Medical appliances and supplies
- Outsourcers
- Contract manufacturers
- Diagnostics

- Hospitals
- Imaging Centers
- Eye Surgery
- Healthcare/physician practice mgmt.
- Dental physician management
- Counseling services
- Urgent care centers
- Ambulatory surgery centers
- Post acute care centers

- Travel nursing
- Out-sources blood testing
- I/T hardware, software, PACS, etc.
- Lab services
- Infusion
- Personal hygiene services
- Radiology services
- Dental products and distribution

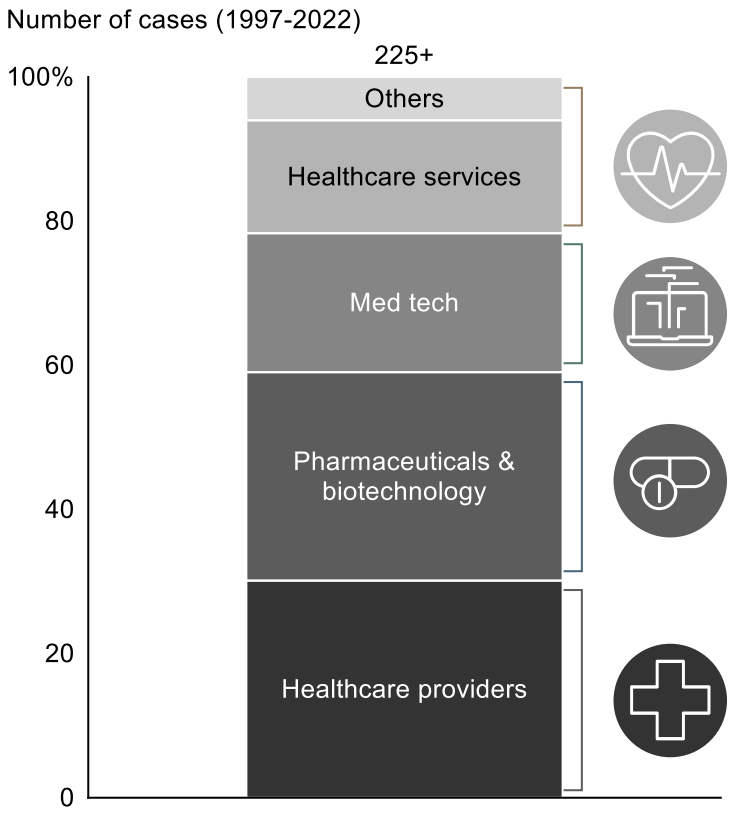
- Eye glass lenses
- Hearing aids
- Vitamin supplements
- Personal care products
- Nutritional supplements
- OTC pharmaceuticals
- Health food

Source: Bain global experience center

We are the partner of choice for leading financial investors as they look to deploy capital in healthcare in APAC

/NOT EXHAUSTIVE

Healthcare sector due diligences in APAC



Examples of Bain PE diligences in Healthcare in APAC

We have supported over 225+ transactions across healthcare in APAC

Note: Includes DDs only, excludes Deal Gen, Sector Screen, VDDs, Firm Strategy etc. Others include overall Healthcare
Source: Bain PE Experience Database

Our perspectives are informed by our unrivalled depth and breadth of experience across the healthcare ecosystem

NOT EXHAUSTIVE

Healthcare providers and payers

APAC

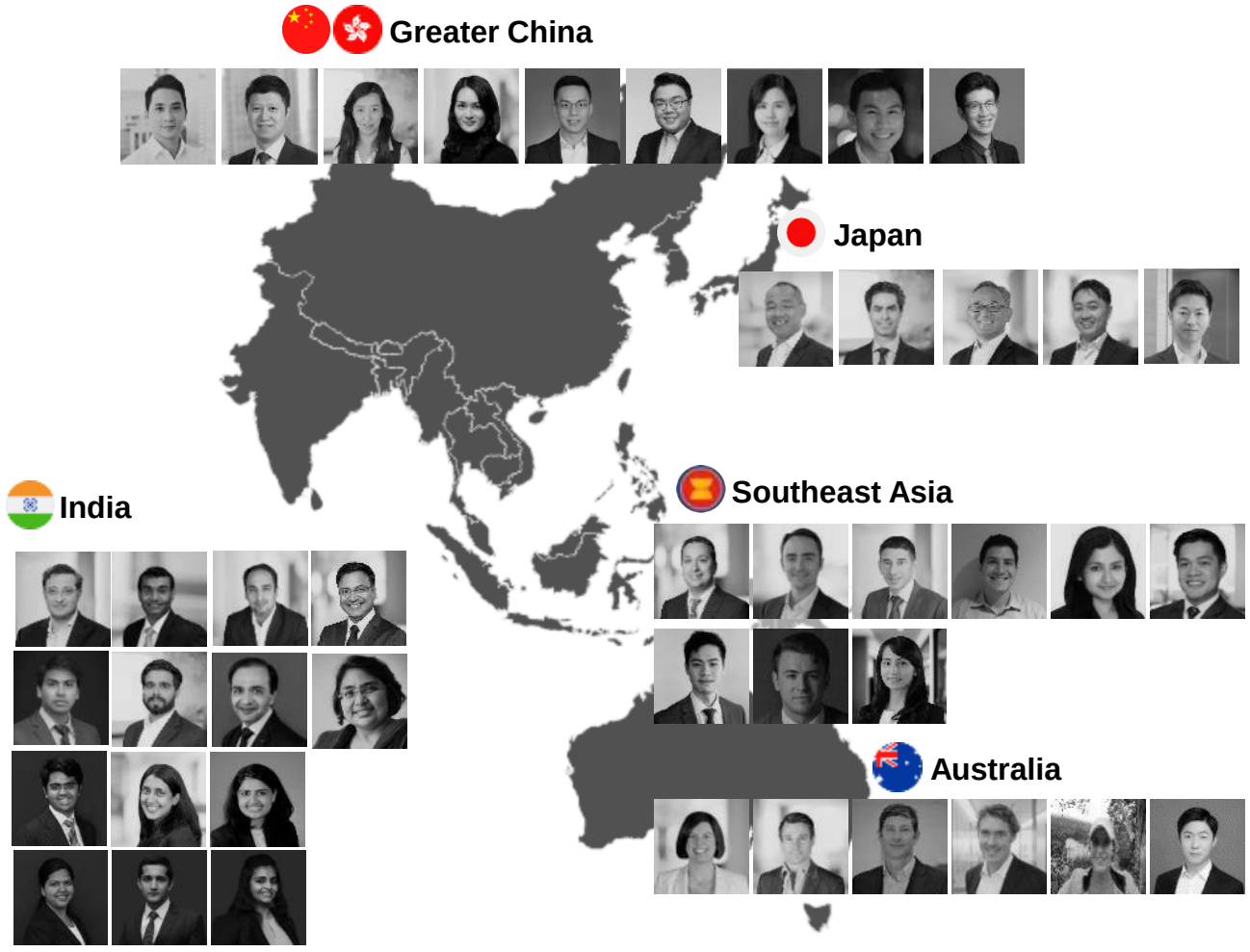
USA

Europe

Digital health natives

We have an extensive network of healthcare experts across all major APAC geographies and deep bench of healthcare PE experts globally

Network of healthcare experts across all major APAC markets



North/South America

Europe/Middle East

Source: Bain & Company

From the Front Line of Health: We have proprietary and recent research on health systems and digital needs of patients and doctors *(longitudinal)*

EXAMPLE

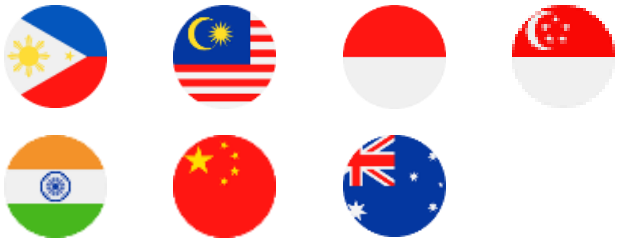
APAC Front Line of Health Survey 2021

1,750

Consumers & Patients surveyed

210

Physicians & Doctors surveyed

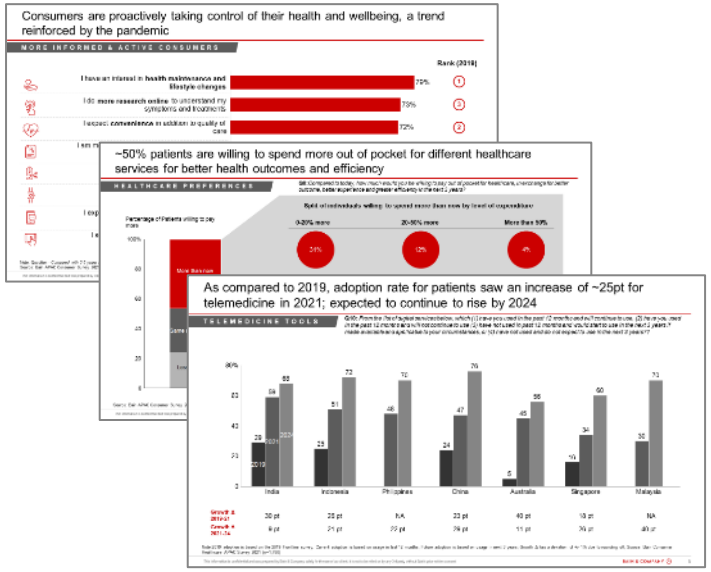


Comprehensive APAC view

Deep-dives on attitudes toward digital health platforms

Proprietary point-of-view
based on deep expertise in Digital Health / Insurance, with multi year insights (2019 and 2021 surveys)

Deep APAC consumer understanding *vis-à-vis Digital Health*



BAIN & COMPANY