# Max Healthcare Institute Ltd (NSE: MAXHEALTH)

**BUY: INR 462.38 (+36.1%)**

Equity Research – Healthcare


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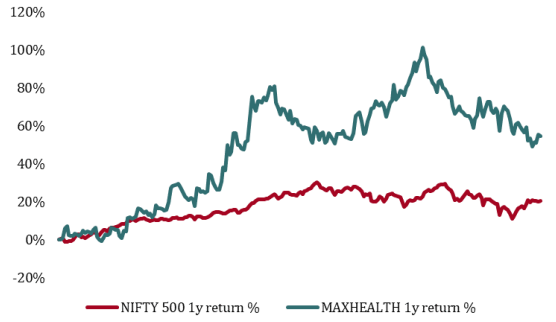
**Company Description**

| | |
|---|---|
| Ticker | MAXHEALTH |
| Last close (290322) | INR 339.70 |
| 12M Target Price | INR 462.38 |
| +/- Potential | +36.1% |
| GICS Sector | Healthcare |
| GICS Subindustry | HC Provider and Services |

**1Y Price Change vs. NIFTY 500**




**Company Description**

Max Healthcare Institute Ltd is one of the largest private healthcare providers in India, with some of the best operating metrics (ARPOB and BOR). It is helmed by Abhay Soi, a turnaround specialist, and is backed by private equity firm KKR. It owns over 3,400 beds with more than 17 healthcare facilities including hospitals, clinics and pathology labs. It was formed from the merger of Max Healthcare and Radiant Life Care in FY21.

**Key Financials**

| | |
|---|---|
| Market Cap | INR 32,200 cr |
| Basic Shares O/S | 97 cr |
| 52-Wk High-Low | INR 200.10 – INR 458.05 |
| Fiscal Year End | 31-Mar-2021 |

| (INR cr) | FY20A | FY21A | FY22E | FY23E |
|---|---|---|---|---|
| Revenue | 4023 | 3629 | 5323 | 6165 |
| Direct Costs | 1715 | 1508 | 2141 | 2556 |
| Other Exp | 1719 | 1485 | 1733 | 2007 |
| EBITDA | 589 | 636 | 1449 | 1601 |
| *EBITDA (%)* | *14.6* | *17.5* | *27.2* | *26.0* |
| EBIT | 381 | 420 | 1205 | 1282 |

**Key Executives**

| | |
|---|---|
| Abhay Soi | Chief Executive Officer |
| Yogesh K. Sareen | Chief Financial Officer |

We are initiating coverage of **Max Healthcare Institute Ltd ("MHIL")** with a BUY rating and a **INR 462.38** 12M price target, representing a 36.1% upside.

## 3Q22 Earnings Highlights

- Revenue expected to grow 47% y-o-y after stellar 3Q22 results, mainly led by hospital business.
- ARPOB grew 14% by 3Q22 to INR 57k/day, up from INR 50k/day in FY21.
- EBITDA grew from 18% in FY21 to 27% in 3Q22, while Bed Occupancy Rate (BOR) grew from 65% to 77%.

## Investment Thesis

- **MHIL's expansion strategy leverages existing hospital network which will edge out competitors and cement dominant status in Northern India** – growth of Delhi NCR to serve as a strong tailwind for MHIL.
- **Payer mix optimisation and increasing surgical specialisation to corner insurers and drive ARPOB to new highs** – Markets have not fully priced in the potential increase in bargaining power of saturated private insurer market.
- **New business verticals to leverage hub & spoke and allow greater continuum of care** – two new funnel strategies to increase MHIL brand loyalty due to existing network of hospitals in the North that can facilitate diagnostics and homecare.

## Catalysts

- Rebound of high margin medical tourism due to pent-up demand likely to drive higher ARPOB and bolster MHIL's outlook positively upwards.
- Promising expansion into new regions like Dwarka, Mohali and Mumbai highlights MHIL's intention to gain momentum and market share in the under-supplied Indian sub-markets.
- Complete optimisation of payer mix portfolio to drive strong EBITDA and allow MHIL to reach its true operating potential.

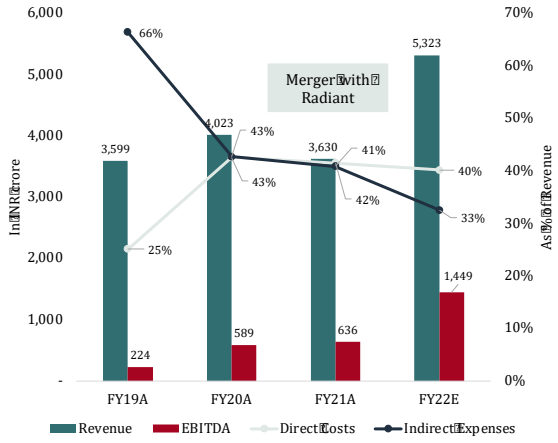
## Valuations

Our 12M price target at the date of coverage is **INR 462.38**, which was derived from a blended DCF and RV, where terminal value for DCF was derived using the Exit Multiple Method.

## Investment Risks

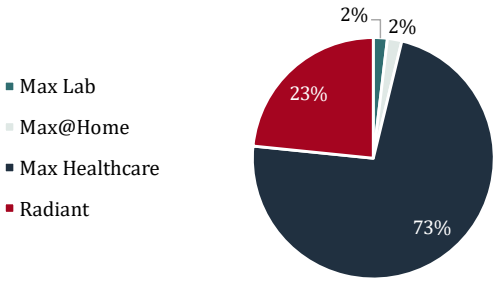
- Intense competition from other established players or new players might threaten MHIL's revenue growth and result in pricing pressures.
- Any unexpected delay in additional bed capacity production plans may induce bearish sentiments.
- MHIL remains prone to government policy changes and regulations which may affect cost margins negatively.

**Figure 1: Company Financials**



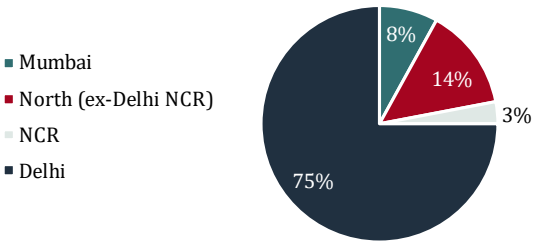

*Source: Company Filings, Team Estimates*

**Figure 2: Revenue Split**



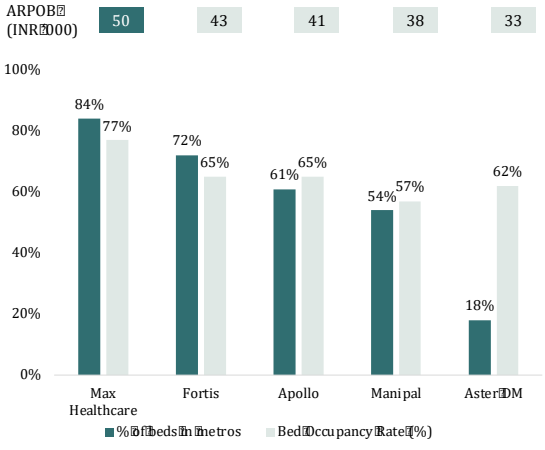

*Source: Company Data*

**Figure 3: Geographical Exposure**




*Source: Company Data*

**Figure 4: Key Industry Metrics**




*Source: Company Data, Peer Data*

## Company Overview

Max Healthcare Institute Ltd (MHIL) is a leading private healthcare provider in India. The entity was a result of a merger between Max Healthcare with Radiant Life Care in FY21, propelling MHIL to emerge as the second-largest hospital chain in India by revenue. It currently owns over 3,400 beds with 17 healthcare facilities including hospitals, clinics and pathology labs.

MHIL's strategy was centred on a National Capital Region (NCR) expansion strategy, which is in the Northern part of India. After the merger with Radiant Life Care, the company added its BLK and Nanavati hospital assets, allowing it to add to its NCR dominance and break into the Mumbai market respectively. Currently, about 92% of its revenue is derived from the North, whereas Mumbai contributes 8%.

MHIL operates largely in the NCR region with assets in Delhi and Gurugram. Saket, BLK and East Delhi Complex are its flagship facilities, and they were more affected by COVID due to their larger exposure to medical tourists. Some of their notable hospital profiles are described below:

- **Saket Complex** – the flagship hospital consists of Saket East Block, West Block and Saket Smart. The East Block and Max Smart are partnered health facilities (PHFs), and attract a higher proportion of international patients, given their higher-end tertiary and quaternary care. Moreover, all 3 hospitals are NABH accredited, with Max Saket (East and West) being JCI accredited, the highest accreditation that can be awarded and is recognised globally.

- **BLK-Max Super Speciality Hospital** – BLK was part of the erstwhile Radiant group, and the 650-bed quaternary care hospital is run by MHIL under an Operations & Management (O&M) model, where the trust owns the land, building and other assets but MHIL owns the "right-of-use". Being in a prime location in Delhi, this hospital is key to serving medical tourists.

- **East Delhi Complex** – the East Delhi Complex comprises Patparganj and Vaishali specialty hospitals, which are NABH accredited and offer a range of services across 28+ specialties, including cardiac, neurology, oncology, and OB-GYN. Both hospitals are situated near the Noida-Ghaziabad corridor, allowing them to be accessible to both locals and international patients.

In addition to its core hospital business, MHIL has two other business segments – Max Lab and Max@Home – driving its growth in diagnostic services and homecare respectively.

Max Lab, its pathology diagnostic business, is a non-captive business intended to serve as an asset-light adjacency to the hospitals. It was launched in FY17 and offers diagnostic services to patients outside hospitals directly and through a network of partners such as clinicians, hospitals and nursing homes, pathology laboratories and third-party hospital laboratory management. Max Lab currently has 92+ partner collection centres, 7 company-owned collection centres, more than 120 phlebotomists on site, and 250+

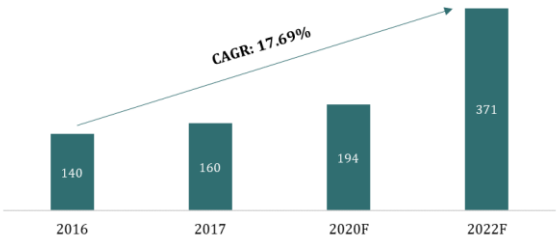
**Figure 5: All company facilities by location, capacity and care type**

| Facility | Location | Beds | Care type |
|---|---|---|---|
| Max Super Speciality Hospital, (West Block) Saket | Delhi | 201 | 3, 4 |
| Max Super Speciality Hospital, (East Block) Saket | Delhi | 320 | 3, 4 |
| Max Smart Super Speciality Hospital, Saket | Delhi | 250 | 3, 4 |
| BLK-Max Super Speciality Hospital, Rajendra Place | Delhi | 538 | 3, 4 |
| Nanavati Max Hospital, Mumbai | Mumbai | 328 | 3, 4 |
| Max Hospital, Gurugram | Gurugram | 72 | 2 |
| Max Super Speciality Hospital, Patparganj | Delhi | 402 | 3, 4 |
| Max Super Speciality Hospital, Vaishali | Ghaziabad | 378 | 3, 4 |
| Max Super Speciality Hospital, Shalimar Bagh | Delhi | 280 | 3, 4 |
| Max Super Speciality Hospital, Mohali | Mohali | 220 | 3, 4 |
| Max Super Speciality Hospital, Bhatinda | Bathinda | 200 | 3, 4 |
| Max Super Speciality Hospital, Dehradun | Dehradun | 182 | 3, 4 |
| Max Multi Speciality Centre, Panchsheel Park | Delhi | - | Clinic, OP |
| Max MedCentre, Lajpat Nagar – Immigration Department | Delhi | - | Clinic, OP |
| Max Institute of Cancer Care, Lajpat Nagar | Delhi | - | Clinic, OP |
| Max Multi Speciality Centre, Noida | Noida | - | Clinic, OP |

*1, 2, 3, 4 refer to primary, secondary, tertiary and quaternary care; OP – outpatient

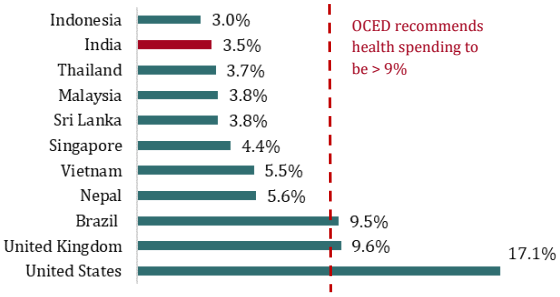
*Source: Company Data*

**Figure 6: India's healthcare sector growth trend (US$ billions)**




*Source: Frost & Sullivan, LSI Financial Services, Deloitte*

**Figure 7: Total Healthcare Expenditure as % of GDP across countries**




*Source: Global Health Expenditure Database, CRISIL Research*

pick-up points, with main operations in the NCR region, Chandigarh, Panchkula, Mohali and key cities in Punjab and Uttarakhand. It has 500+ active partner networks across both B2B and B2C channels with a wide test menu of more than 2,200 tests. Although it contributed to just 2% of revenue in FY21, it has grown at a staggering 91% CAGR over the past 4 years. The pathology services are offered by MHIL either directly through its own labs or by its partners, including third-party clinics, nursing homes, pathology labs, and franchisees.

Max@Home is the other non-captive, asset-light adjacency business of MHIL, which provides quality health and wellness teleconsultation services via an app. It covers more than 12 service offerings from preventive care to pre- and post-hospitalisation services, including critical care, ICU at home, X-ray and ECG at home, COVID-care at home, assistance-based services, physiotherapy, rehabilitation, sample collection, medicine delivery, doctor home visits, medical rooms, onsite wellness programs, onsite ambulance coverage and other such nursing procedures. MHIL also has omnichannel access for patients who can book services on the website, mobile app, WhatsApp and 24x7 helpline. In the 5 years since its inception, it has rapidly become one of the largest home healthcare service providers in the region. While it currently contributes only 2% of revenues, we forecast strong growth based on its differential offerings that will allow it to better serve as a funnel to its superior hospital network.

**Earnings Review**

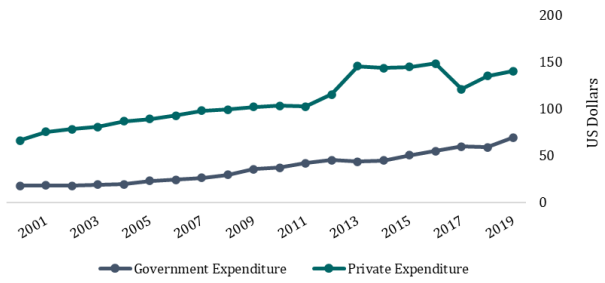
- Hospital assets made up 96% of revenues in FY21, with ARPOBs at INR 55k and a Bed Occupancy Rate (BOR) of 78%
- Shift in Payer Mix from 64% in FY21 to 67% in H1FY22, with a target of 15%, poised for 3-4% EBITDA margin expansion
- Max Lab revenues stood at INR 676m in FY21, posting 91% CAGR in 4 years
- Max@Home delivered INR 696m of revenues, having grown at 64% CAGR since inception in FY17

## Industry Outlook

India is the second most populous country in the world, with more than 1.4 billion inhabitants. It is growing steadily at an annual rate of 1.0% and is set to overtake China by 2027. The population is young with around 50% under 25 years of age, and life expectancies are 68.7 and 71.2 for men and women respectively. Non-communicable diseases are becoming a serious issue in India, with heart disease, cancer and diabetes being leading causes of the country's disease burden and mortality, accounting for about 60% of all deaths. The pandemic has also resulted in delays and reductions in cancer screening, diagnosis and treatments. As a result, the entire healthcare sector is projected to double in 2022 to US$371b (**Figure 6**).

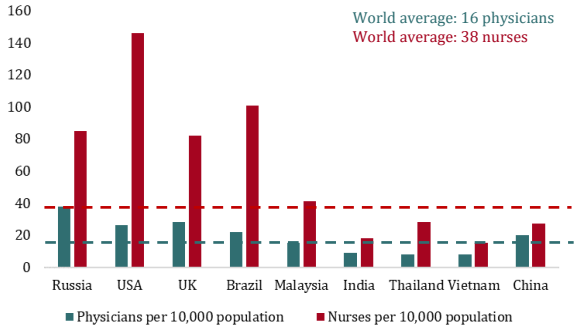
Healthcare in India is skewed in favour of private healthcare providers, with its share of healthcare provision covering ~80% of outpatient care and ~60% of inpatient care. It is estimated that 95%

**Figure 8: Expenditure per capital PPP in India**



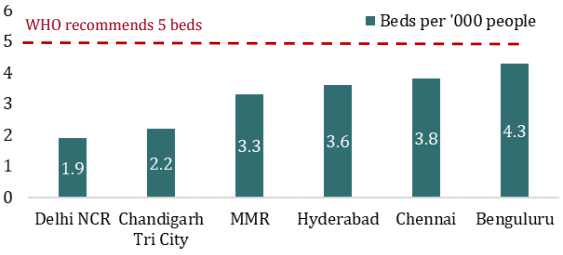

*Source: WHO Global Health Observatory*

**Figure 9: Medical practitioners India vs other countries**



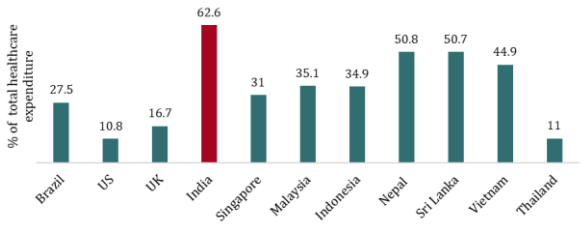

*Source: WHO World Health Statistics 2020*

**Figure 10: Low bed density in India even in major metro regions**




*Source: CRISIL Research*

**Figure 11: Out-of-pocket healthcare spend as a percentage of total healthcare expenditure**




*Source: Global Health Expenditure Database, World Health Organisation, CRISIL Research*

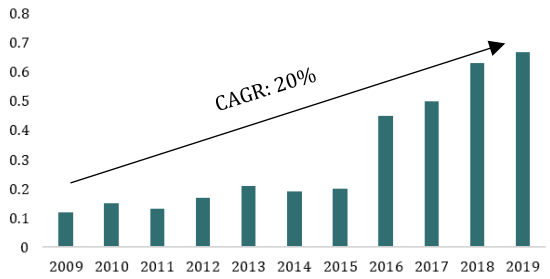
of all new hospital beds created in recent years were from the private sector. As a result, private hospitals occupy two-thirds of total hospitals, while owning only 37% of the country's beds. Its dominance, however, extends to medical education, training, medical technology, new hospital construction, pharmaceutical manufacture, and sales, with a strong concentration in the developed urban areas such as the metro and Tier 1 cities. Due to the huge demand supply gap between the metro and Tier 1 cities, and the Tier 2 and 3 cities, for healthcare, there have been policy calls to overhaul primary healthcare services in urban areas, such as through public-private partnerships for healthcare delivery. For secondary care, the goal is 1 hospital bed per 1000 people with the aim of delivering secondary care in 1 hour, while the typical government bed currently serves 1,845 people. The doctor-to-patient ratio in India is also low at 0.7 doctors per 1,000 people compared to the World Health Organisation (WHO) average of 2.5. In Delhi Non-Capital Region (NCR), where MHIL mainly operates in, bed density is higher at 1.9 and 3.3 per 1000 people respectively, still far short of the WHO's recommended 5 beds (**Figure 10**). Thus, patients from adjacent states including Uttar Pradesh and Punjab visit the NCR regions where the large hospital chains more commonly reside. As a result of this influx, the NCR typically enjoys higher average revenue per operating bed (ARPOB) margins.

**Figure 11** shows that the healthcare financing structure of India currently comprises of 62.6% of total health expenditure being out-of-pocket (OOP) versus the global average of 20.5%, with the remainder being accounted for by public health expenditure. This results in a high dependence on loans and savings. Key public insurance schemes include the Central Government Health Scheme (CGHS), the Employees' State Insurance (ESI), the Ex-Servicemen Contributory Health Scheme (ECHS) and the Pradhan Mantri Jan Arogya Yojana (PMJAY). Private insurance, while relatively small, is growing fast, with 86m covered in 2016. The main players in private healthcare include Apollo Hospitals, Fortis Healthcare, Cygnus Medicare, Narayana Health, Medanta, Aster DM Healthcare and Max Healthcare (MHIL), each with different geographical and business strategies. In Northern India, including the National Capital Region (NCR), MHIL competes for market share mainly with Fortis, where the market comprises of the wealthier Indian population.

Medical tourism has gained momentum over the years and India has fast emerged as a major medical tourist destination. According to the Ministry of Tourism, total foreign medical tourists in India have grown at a CAGR of 20% over the last decade, from around 100 thousand in 2009 to about 700 thousand in 2019 (**Figure 12**). Other than the increasing state-of-the-art infrastructure, growing reputation of India's private hospitals, and shorter wait times, India has a clear lead over the rest of the world in terms of affordability. A breakdown of the costs for key treatment procedures is illustrated in **Figure 14**.

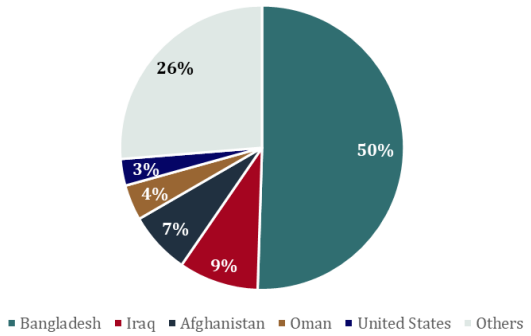
India sees medical tourist inflows come from neighbouring countries like Africa, West Asia and even developed nations like United Kingdom and Canada. The industry is also actively promoted by the Indian government. To encourage applications and ease the travel process for medical tourists, the government introduced special medical visas for multiple entries and longer stays.

**Figure 12: Growth in medical tourists**




*Source: Ministry of Tourism*

**Figure 13: Break-up of medical tourists by country of origin**



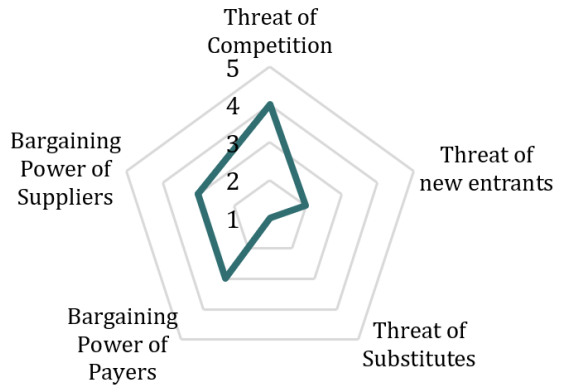

*Source: Ministry of Tourism*

**Figure 14: Treatment costs cheapest in India**

| Ailments (US$) | US | Korea | Singapore | Thailand | India |
|---|---|---|---|---|---|
| Hip replacement | 50,000 | 14,120 | 12,000 | 7,879 | 7,000 |
| Knee Replacement | 50,000 | 19,800 | 13,000 | 12,297 | 6,200 |
| Heart bypass | 144,000 | 28,900 | 18,500 | 15,121 | 5,200 |
| Angioplasty | 57,000 | 15,200 | 13,000 | 3,788 | 3,300 |
| Heart valve replacement | 170,000 | 43,500 | 12,500 | 21,212 | 5,500 |
| Dental implant | 2,800 | 4,200 | 1,500 | 3,636 | 1,000 |

*Source: CRISIL Research*

**Figure 15: Porter's Five Forces**




*Source: Team Estimates*

Accreditation of hospitals were also mandated to ensure high quality of care and to further boost India's positioning. India's government estimates medical tourism to be worth US$9b in 2020, garnering 20% of the global share.

## Porter's Five Forces

In summary, competition is high in the industry amongst the private hospital healthcare chains across all business including hospital, pathology and homecare. Many are taking more expansionary approaches as the country comes out of the pandemic, and to achieve scale sooner than later for new verticals. Private providers are driving the growth of the industry, as public healthcare lags in capacity and recruiting talent. (**Figure 15**)

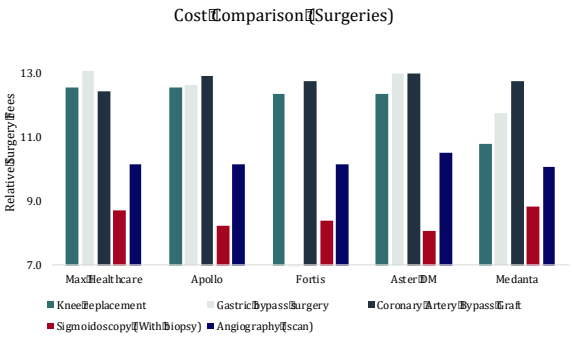
**Threat of competition – High**

Private hospitals drive the growth of the industry, and many have their own strategies in expanding across India. MHIL's main competitors in the North are Fortis and Apollo, through MHIL beats out on bed density. In terms of medical tourism, key competitors include Apollo and Medanta, where comparable services and first-in-class medical technology are also within their offerings. Fortis on the other hand, while not only having a strong presence in the North and South, runs a diagnostics vertical that has presence in the North. While MHIL preserves and is expanding its dominance more exclusively in the North and focusing on premium tertiary and quaternary healthcare, there is threat of competitors capturing a patient share from MHIL, as patients may begin to prefer more affordable treatment. (**Figure 16 & 17**) On the other hand, MHIL's pathology and homecare business units may be subject to various challenges, including developing logistics for collection centres and increased competition due to fragmentation of the respective industries. Management has factored that scaling these businesses would also entail expansion in underpenetrated areas, innovating and investing in technology for newer tests and technology.

**Threat of new entrants – Low**

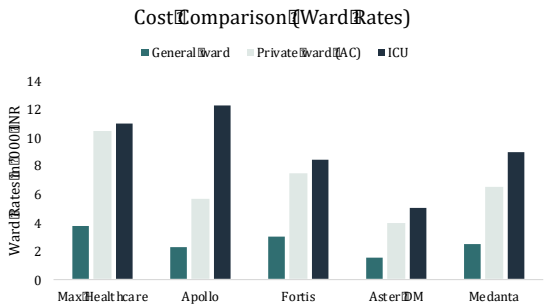
The threat of new entrants is relatively low due to the high barriers to entry. Firstly, access to resources, such as trained medical professionals, location and medical equipment is limited and highly sought after, especially for tertiary and quaternary care. India struggles with a paucity of medical professionals. The Economic Times reported in 2019 that the country faced a shortage of 600,000 doctors and 2 million nurses, and hospitals like MHIL and Apollo have recognised this in earnings calls. Business Insider (2019) reported that the sector average for clinician payout was more than INR 650 crore, creating a steep barrier to potential entrants. Over FY21, MHIL topped INR 940 crore in total for employee expenses. In addition, high capital costs and the difficulty in finding and building new hospitals in locations close to viable markets presents a formidable hurdle. Significant amount of resources and time would also be required for marketing and for gaining brand recognition.

**Figure 16: Surgery costs for private healthcare**



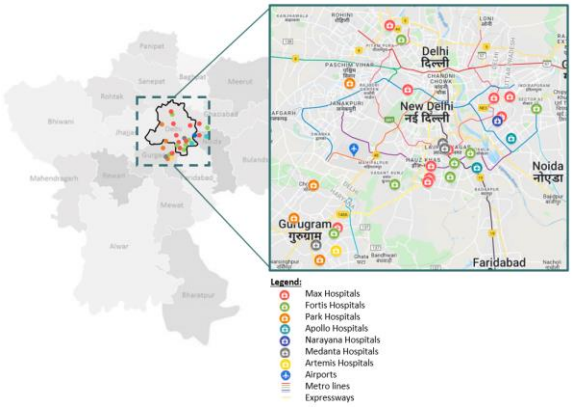

*Source: Medifee, Various Company Data*

**Figure 17: Ward rates for private healthcare**




*Source: Medifee, Various Company Data*

**Figure 18: Max locations have an accessibility advantage over its peers**




| Healthcare Provider | Number of hospitals in Delhi NCR |
|---|---|
| **Max Healthcare** | **11** |
| Fortis Healthcare | 7 |
| Park Hospitals | 4 |
| Medanta | 3 |
| Apollo Hospitals | 2 |
| Narayana Health | 1 |
| Artemis Hospitals | 1 |

*Source: Company Data*

**Threat of substitutes – Low**

Public healthcare services pale in comparison to quality of care that private healthcare provides. A survey by the National Sample Survey Office in India surveyed over 3.3 lakh households in 2015 revealed that the proportion of people visiting private institutions were at 79% and 72% for urban and rural areas, and most preferred private doctors for their quality, services and accountability. While the government struggles with keeping healthcare OOP affordable, private healthcare has and will continue to drive industry growth.

**Bargaining power of payers – Moderate**

The power of a payer diminishes when one moves from primary care to tertiary care. MHIL specialises in surgical procedures and critical care, of which demand is more inelastic. The majority of the insurance industry is still owned by the Life Insurance Corporation of India (LIC) while the more lucrative private insurer market is saturated. As the quality of private healthcare is significantly higher than public healthcare, the bargaining power of payers are moderate as hospitals like MHIL seek to differentiate themselves through developing specialties and creating stronger hospitals brands, amidst increasing competition.

**Bargaining power of suppliers – Moderate**

As mentioned earlier, the paucity of physicians and healthcare professionals in India allows private doctors to have greater leverage in negotiating their compensation. The Hindu reported in 2021 that private doctors and specialists are paid on average INR 6 lakh a month, close to 5x more than the average for public doctors. Since doctors constitute a major portion of the service offerings the private hospital can provide, physicians do possess high bargaining power.

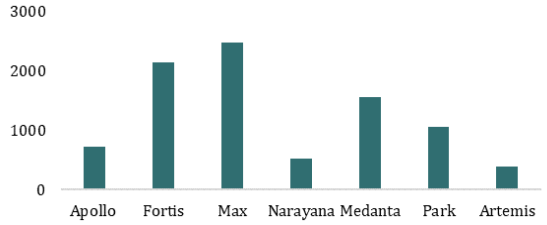
Another key area of concern is the cost of pharmaceutical drugs which hospitals procure for their pharmacies and treatments. India currently depends heavily on China for active pharmaceutical ingredients (70% of their API imports are from China) despite being a drug manufacturing powerhouse globally. This makes India vulnerable to price spikes if domestic API production is not strengthened.

## Investment Thesis

**1. MHIL's expansion strategy leverages existing hospital network which will edge out competitors and cement dominant status in affluent Indian regions**

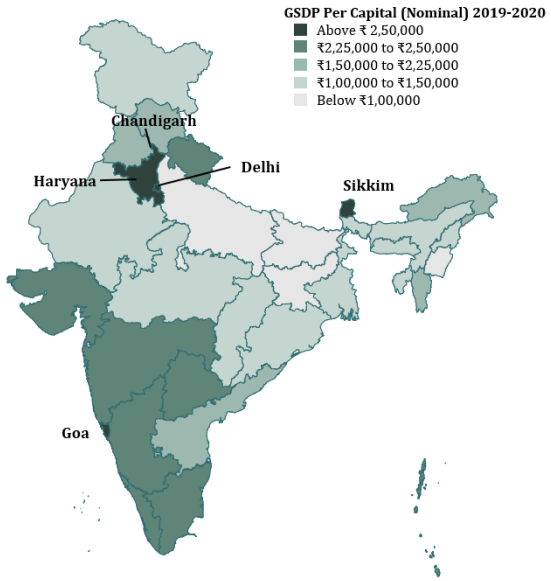
For hospitals to be competitive, its location and proximity to potential patients are considered crucial factors which ultimately determines its utility. We believe MHIL has done well concentrating its operations in Delhi NCR, carving out a large market share in the region. We delve into a further analysis of MHIL's regional strategy via the following sections:

**Figure 19: Top private players in Delhi NCR and their bed count**



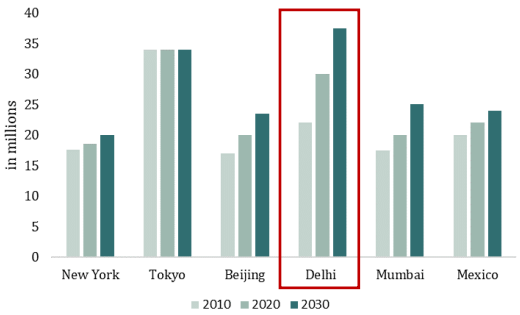

*Source: Company Data*

**Figure 20: Wealthiest states in India by Gross State Domestic Product per Capital**




*Source: Statistics Times*

**Figure 21: Delhi's population growth in relation to major global cities**




*Source: World Urbanisation Prospects 2018 by UN DESA*

*Clustered approach has made MHIL the largest private player in Delhi NCR*

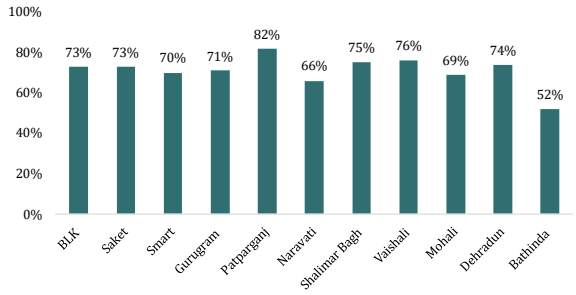
While MHIL's peers have expanded their geographical outreach into various cities all over India, MHIL Healthcare has instead focused on carving out a niche market it can dominate by clustering its operations in the National Capital Region (NCR) of India. MHIL Healthcare currently has a total of 3412 beds throughout India of which 77% is concentrated in the Delhi NCR region. Amongst the top private players with a presence in the Delhi NCR, MHIL has the highest bed capacity and the most locations. Max hospitals are also most conveniently located along the region's metro lines and in key residential areas, providing an accessibility advantage. Based on our research, we believe MHIL's closest competitor in NCR is Fortis Healthcare, which has the next largest sum of beds and locations (**Figure 18 & 19**).

*Growth in Delhi NCR serves as a strong tailwind*

Intense competition, market saturation and high land costs in Tier-I cities of India have led many competitors to tap into Tier-II markets instead. Comparatively, with MHIL's extensive presence in NCR, it benefits from economies of scale. We believe that management's decision to continue focusing on the Tier-I cities of NCR is strategic due to the target demographic available - those with a higher propensity to pay for MHIL's more premium healthcare services. Amongst all 33 Indian States and union territories, the NCR is one of the most affluent regions in India with the highest Gross State Domestic Product (GSDP) per capita. Financial Newspaper Mint estimates that the Delhi NCR region accounts for more than 11% of affluent individuals in India.

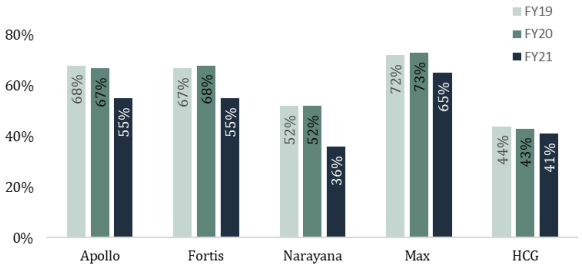
Furthermore, as the largest urban agglomeration in India, the population size of NCR has rapidly grown due to the region's higher standard of living. Great career progression opportunities, coupled with well-connectivity, eclectic mix of cultures, and rich history have resulted in large migration influxes every year. According to research firm Demographia, more than 32 million people currently live in and around Delhi, with 700,000 more estimated to migrate each year. This influx will drive Delhi NCR's bed density even lower and aggravate the undersupply issue that Delhi NCR is already facing. With the limited supply of quality healthcare, MHIL will enjoy higher occupancy rates as well as less seasonality in its hospital admissions. The above gives us a favourable outlook on the NCR strategy that MHIL adopts, which will keep their earnings growth robust. MHIL's expansion story is one that has been in sights for years given it was operating at an average of 73% occupancy level pre-COVID with no adequate excess capacity. While the pandemic has impeded them from acting, the under capacity demonstrated by their major hospitals served as good indicators of the unmet healthcare need that has only become more acute. At key locations, such as Saket, Patparganj, BLK, and Nanavati, it currently operates at ~95-100% of bed capacity. As quoted by management, this was unique to MHIL and its competitors did not experience such a bed crunch (**Figure 23**), possibly alluding to the differentiated standard of care that the Indian population had preferred in time of dire need. This means that MHIL needs to

**Figure 22: Max Hospitals enjoy an average of 73% occupancy pre-COVID**



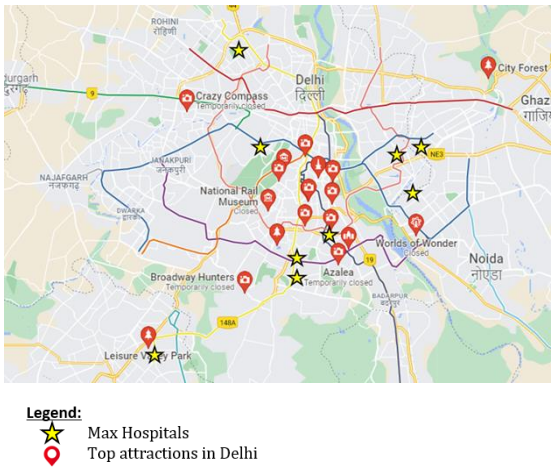

*Source: Company Data, HSIE Research*

**Figure 23: Max operates at significantly higher occupancy levels compared to peers**



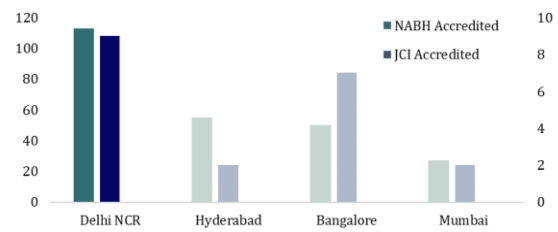

*Source: Company Data, HSIE Research*

**Figure 24: Max locations relative to the highlights of Delhi**




*Source: Google Maps*

**Figure 25: Regions in India with the most NABH-accredited and JCI-accredited hospitals**




*Source: NABH, JBI, Company Data, HSIE Research*

swiftly add new beds to cater to rising demand and capitalise on the potential growth opportunities.

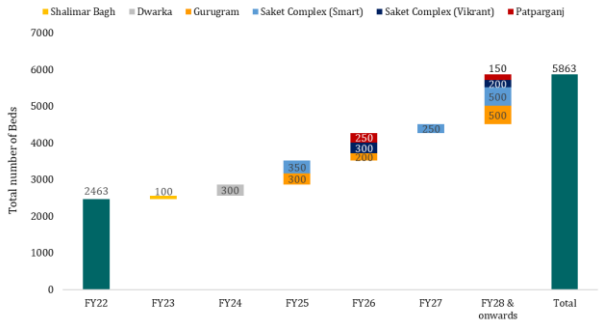
Lastly, MHIL's established services have placed it in a favourable position to capture a large portion of medical tourism. Based on pre-pandemic statistics, Delhi is the most preferred destination, attracting 45% of the medical tourists visiting India, according to CRISIL Research. The reason we are bullish on the effects of expected medical tourism is that it is not siloed, but instead under the umbrella of tourism (Heung et al., 2009). This means that medical tourists, while procuring medical services in a foreign country or city, also highly favour good infrastructure, shorter traveling distances and entertainment activities in a more conventional sense. Coincidently, as the capital region, Delhi NCR is a symbol of India's rich past and thriving present. The city is brimmed with innumerable attractions and monuments for people from all spheres of life to discover and enjoy. We plotted the top-rated attractions of Delhi on a map and found that MHIL hospitals are strategically clustered around Delhi Central, where most of the highlights of the city are found, making it ideal choices for medical tourists (**Figure 24**). Additionally, there have also been an abundance of literature stating that medical tourists are likely to look for JCI-accredited & NABH-accredited hospitals to seek specialist surgeons. In India, one will find the highest number of NABH-accredited and JCI-accredited hospitals in Delhi NCR. All 11 hospitals of MHIL in Delhi NCR are NABH-accredited. With three of its hospitals (Saket East, Saket West and BLK) being JCI-accredited, we are confident about MHIL's standard of care and it being the top choice for medical patients (**Figure 25**). We also found that oncology, orthopaedics, cardiac, transplants and neurology are the key therapies sought for in India, making up 65% of the overall medical tourism demand. MHIL has Centres of Excellence across all these therapies in the Delhi NCR region to complement the surgical mix, a testament to management's foresight. Taken in combination with the above-described sections, we strongly believe that MHIL will be able to capture much of the rebound in medical tourism and the expected growth in revenue stream will bolster MHIL's outlook positively upwards.

*Well thought out location choices and cost-effective ways of expanding signals strong management*

As mentioned above, borne out of MHIL's strategic need to expand its services and presence, MHIL Healthcare is entering a high-growth phase, with significant expansion plans at well-thought-out locations. Over the next 5-6 years, MHIL Healthcare will add another 4030 beds throughout India, effectively doubling their bed capacity through extensions, additional wings, and new locations (**Figure 27**). Expansions in NCR will form almost 84% of the pipeline, which will ramp up its capacities in the Delhi NCR region significantly, increasing the density of its hospitals and concentrating their strength regionally.

In particular, we see enormous potential in three of the cities selected:

**Figure 26: Indicative timeline for new MHIL beds in NCR**




*Source: Company Data*

**Figure 27: New MHIL bed capacity throughout India**

| Upcoming Expansion | Number of new beds |
|---|---|
| **Within NCR** | **No. of beds** |
| Shalimar Bagh | 100 |
| Dwarka* | 300 |
| Saket | 1600 |
| Gurugram | 1000 |
| Patparganj** | 400 |
| ***Total*** | ***3400*** |

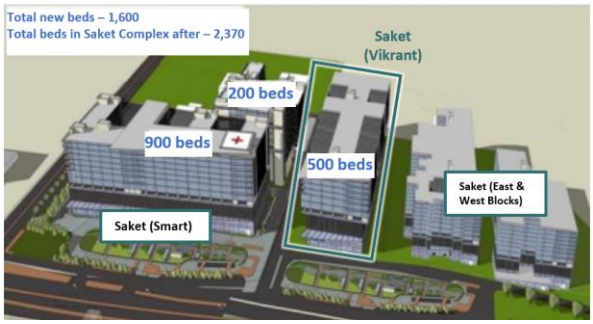
* New market in Southwest Delhi, entering with an O&M Agreement

** Based on 12 Feb 2022 announcement by MHIL Healthcare on acquisition of Eqova Healthcare

| Other parts of India | No. of beds |
|---|---|
| Mohali | 190 |
| Mumbai | 440 |
| ***Total*** | ***630*** |

*Source: Company Data*

**Figure 28: Brownfield development of Max Saket Complex**




*Source: Company Data*

Saket

Saket is a posh locality in Delhi and a prime retail destination, it is known as one of the best places to live in Delhi amongst the affluent. As such, we believe Max Saket is well-positioned to deliver larger earnings growth. Being the flagship hospital, the Saket Complex offers diverse treatments. Saket (East and West Blocks) has a complete spectrum of diagnostic and therapeutic technologies, across 38+ specialties like oncology, cardiac and neurology among others, while Saket Smart has a strong focus on critical care. The close proximity of the Saket Complex buildings allows hub-and-spoke connectivity, which has synergistically enhanced business performance and overall patient experience. In FY21, Max Saket operated at an EBITDA per bed of USD >110k, one of the highest in the country. The company plans to add 1,100 beds at Saket Smart in two phases over the next six years. Additionally, the land that previously separated Saket Smart from the other two units will see a new building, Vikrant, constructed to hold 500 beds as shown in **Figure 28**. We believe this keeps MHIL's earnings potential robust as upon completion, the connected complex (4 units – Smart, Vikrant, East Block and West Block) will form South Asia's largest private integrated healthcare complex with ~2370 beds in the heart of Delhi. This further extends MHIL's NCR dominance by raising barriers to entry.

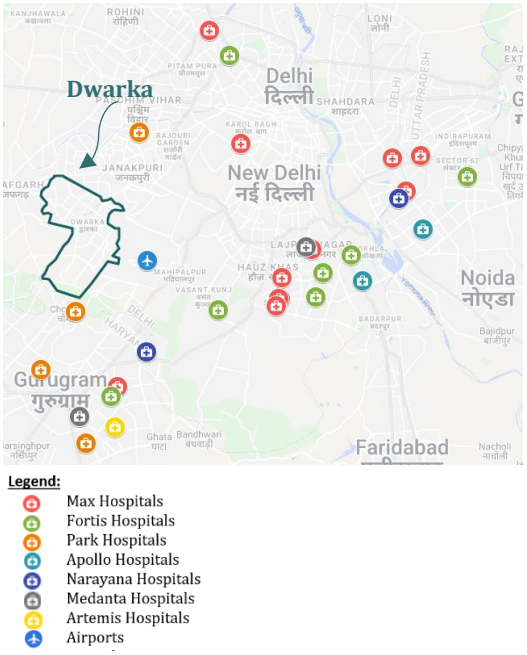
Dwarka

Another attractive micro-market in Southwest Delhi is Dwarka. Due to the area's rich history and pilgrimage to the Hindu religion, the Delhi Development Authority (DDA) has taken special interest over the years to establish the Dwarka sub-city as one of the best residential areas in Delhi. Spread across 22,840 hectares, the area is comparatively more developed than other parts of Delhi with popular entertainment hubs and well-maintained public infrastructure. Dwarka is a short distance from the Indira Gandhi International (IGI) Airport with great connectivity to other regions of Delhi NCR as well as other parts India. To provide last-mile connectivity, the Dwarka-Gurugram Metro Line project has also been underway since 2019. In addition, access to Gurugram via the Dwarka-Gurugram Expressway will be completed by 2023.

Despite the sub-city's large population of ~1.2m, healthcare providers have not caught up - the area is mainly sustained by a few public hospitals. While we note that there are smaller independent private players in Dwarka, none of MHIL's competitors have a presence in Dwarka (**Figure 29**).

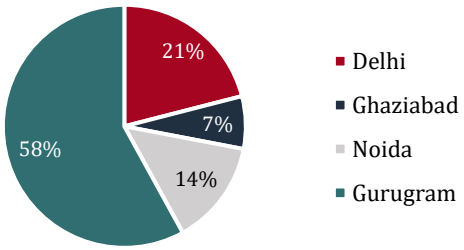
We believe that this presents a first-mover advantage for MHIL amidst the large demand and supply mismatch of quality private healthcare. MHIL will venture into Dwarka through an operations and management (O&M) contract. This strategy is carried out by partnering with a real estate developer who would build the hospital facility as per MHIL's specifications and MHIL would operate and manage the facility post-completion (right-of-use). The strategy allows MHIL to provide an additional 300 beds without requiring significant upfront capital and allows them to focus on its core healthcare operations with less drag on its financials. We think that the way MHIL has leveraged its brand and expertise to enable

**Figure 29: No large private players in Dwarka**




*Source: Google Maps*

**Figure 30: Supply of serviced apartments in Delhi NCR**




*Source: 99acres.com*

**Figure 31: Existing private players in Gurugram**


*Source: Google Maps*

it to venture into a new market with no development risk will play well for the company. We expect significantly higher RoCE from this strategy.

Gurugram

Gurugram is a prominent hub that enjoys large commercial establishments and sound connectivity to Delhi. In recent years, Gurugram has diverted some medical traffic away from Delhi and its successful emergence has Dr Abhay Soi recognizing it as one of the largest medical hubs for high-end care in north India.

One of the main drivers of patient flow to Gurugram is that in addition to many world-class hospitals, the city provides many serviced apartments for visitors to receive long-term care, something that is not as available in Delhi. Serviced apartments are a relatively new accommodation concept in India yet extremely convenient for medical patients and their families. Instead of living in hotels, medical patients or medical tourists can choose extended care in these apartments with their families, which provide comfortable stays for prolonged treatments. According to the listings available on 99acres.com, more than half of the inventory of serviced apartments in Delhi NCR is in Gurugram (**Figure 30**).

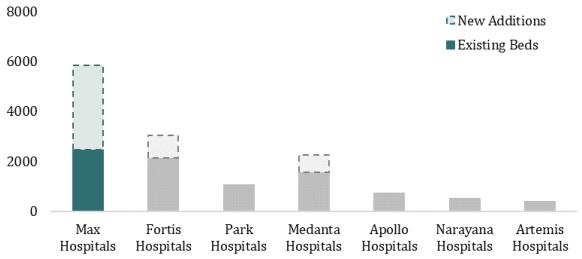
Gurugram is another location that represents MHIL's aggressive expansion within the NCR, and outside of Delhi. It currently has a small hospital with just 92 beds. We believe that this 92-bed project back in 2007 served as a litmus test for MHIL's management to assess demand and is consistent with the strong management foresight observed. Noting that this Gurugram hospital generates the highest EBITDA/bed in the entire Max network, it seems that timing is ripe for management to act on it via greenfield expansion, which will add 1000 beds in the city in three phases over the next six years. While building a new complex will require large amounts of capital, we think that the O&M contract revenues from Dwarka starting in FY24 can be used to offset the CAPEX needed to fund the development in Gurugram, ensuring cost margins remain within control.

Although competitors have already established much larger presences in Gurugram than MHIL, we note that they have not released any expansion plans in the city in the near future, likely because they have operations in the market and are looking to diversify into other geographies. As such, apart from MHIL, not much new capacity is expected. While Fortis and Medanta have significant presence in Gurugram, MHIL poses a threat to eroding their market share due to the overlaps in clinical specialties and comparable levels of medical technology. Given that Gurugram is a fast-growing market, we believe this expansion gives Max the ability to leverage on its clinical excellence to capture a large share of the up-and-coming demand.

*Conclusion of MHIL's expansion plan*

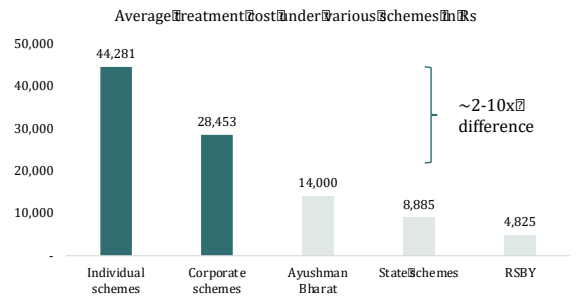
Considering the competition, we expect the expansion plans of MHIL Healthcare to help it sustain its leadership position in the premium markets of NCR. Apollo Hospitals currently has no plans to grow its hospital bed numbers in Delhi NCR possibly due to a series of expansions and a long capex cycle previously from FY14-

**Figure 32: Ambitious NCR expansion by MHIL dwarfs peers**



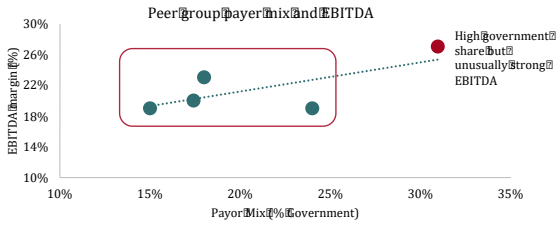

*Source: Company Data, Team Estimates*

**Figure 33: Treatment cost disparity under private and public payers**



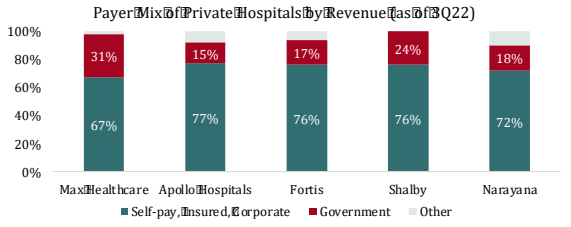

*Source: CRISIL Research*

**Figure 34: MHIL's outlier position (in red)**




*Source: Company Data, Peer Data (Fortis, Shalby, Apollo, Narayana)*

**Figure 35: Payer mix of private hospitals**




*Source: Company Data, Peer Data*

18. Recent announcements of Apollo see the company taking an international expansion approach. Fortis Healthcare has announced in its annual report an expansion plan to add 1300 beds throughout India. Nevertheless, Fortis's overall strategy has been more oriented toward Tier 2 city expansion, and hence the difference in corporate strategy will cede share to MHIL's expansion. This means that the bed capacity margins between MHIL and other players will widen drastically, allowing MHIL to cement a dominant status in the Delhi NCR region (**Figure 32**).

In addition, the avenue for growth that MHIL utilizes is less capital intensive and will have a quicker ramp-up time. The combination of mostly brownfield expansion as well as O&M would allow faster operationalization of beds and relatively lower start-up costs. These would help tackle slow growth and earnings drag. A study released by Edelweiss in 2021 stated that in general, capex of INR1-1.2crore/bed is required in premium metros like Delhi and Mumbai; noting these cities also generate higher ARPOB compared to other geographies. However, with the brownfield expansion potential, MHIL expects to incur capex of only INR40-50lakhs/bed. This will lead to higher return on equity in the future. MHIL also has the means to execute efficient greenfield capacity expansion in premium locations of Saket and Mumbai due to the valuable land bank they already have statutory approvals for. Unlike peers who would otherwise have to incur high land acquisition costs for expansion in Delhi NCR, MIHL's land banks require lower capital to be employed per bed and allows for a quicker breakeven with lower risk. This leads to high return on incremental capital employed with greater visibility.

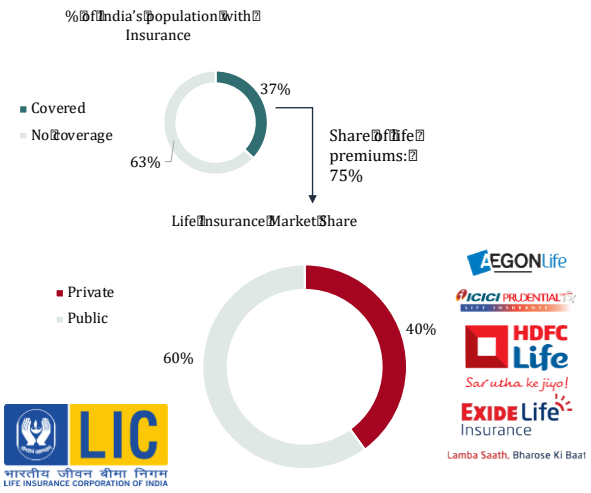
All in all, MHIL presents great opportunity to expand capacity in the country with minimal capex and without compromising its ROCE. We believe the main drivers for growth include the rising affluence of the region, compounded by the inelasticity of patients who seek premium quality care with private healthcare providers over public ones. We are confident that management will be able to deliver strong top-line growth and a more resilient business.

**2. Payer mix optimisation and surgical specialisation to corner insurers and drive ARPOB to new highs**

*Optimisation of payer mix*

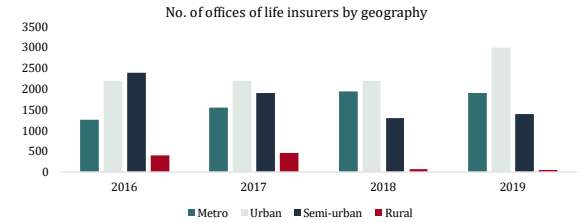
In addition to capacity expansion, MHIL will realise its full potential from its efforts in calibrating its current payer mix and increasing specialisation in non-communicable diseases. Typically, private hospitals prefer private and corporate payers such as private insurance schemes when they are reimbursed for treating patients and this is because of the greater profitability, as seen in **Figure 33** in comparison to the state-run insurance schemes. These government beds are often EBITDA negative, or around 40% lower in ARPOB, as reported by the company. MHIL is unique because despite the government accounting for a high proportion of its current payer mix, due to the increased COVID / government bed capacity from FY20-21, it has remained leagues above its peers in EBITDA, demonstrating the operating strength that the non-government beds have. (**Figure 34**) Hence, there is sufficient reason to believe that when MHIL reaches its target of just 15% of

**Figure 36: Market share of the Indian insurance market**



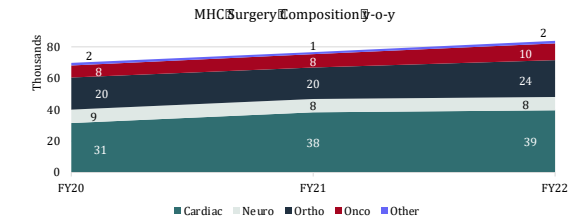

*Source: Arthur D. Little, Insurance Funda, CRISIL Research*

**Figure 37: Flight of private insurers to urban cities**



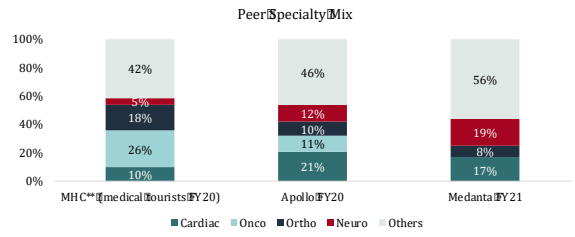

*Source: CRISIL Research*

**Figure 38: Surgical specialisation across time**




*Source: Company Data*

**Figure 39: Surgical specialisation amongst peers**




*Source: Company Data*

government mix in the next 3-4 years – half of its current 31% (**Figure 35**)– it will drive ARPOB up.

*Cornering of private insurers raise pricing power over reimbursement rates*

According to the Insurance Regulatory and Development Authority report, health insurance penetration in the country stood at only 37% in 2018 while it has grown to nearly 50% in 2022. This is due to rising income levels, increasing awareness of lifestyle diseases, changing attitudes from prescriptive to preventive healthcare, and increasing government spending on healthcare.

However, markets have not fully priced in the potential increase in bargaining power over the increasingly saturated private insurer market.

The insurance sector of India consists of 59 insurance companies, of which 24 are in the life insurance business and 35 are non-life insurers (including re-insurers), where private insurers comprise of <40% and 56% of life and non-life insurance respectively.

Of those insured, 75% of the market are life insurance premiums where Life Insurance Corporation (LIC), being the only public-sector life insurance company in India, controls >60% of the market share in life insurance, leaving >20 private insurer companies vying for the remaining 40% market share as shown in **Figure 36**. More critically, private insurers have made transitions into more urban cities within the Northern region by shifting offices. (**Figure 37**) On the premium front, the post-pandemic expectations for health insurance premiums are also estimated to rise 5 – 25% according to online policy marketplace Policybazaar.com amidst the rising need for modern treatments like chemotherapy.

*Surgical specialisation for high demand areas further raise MHIL's bargaining power over private insurers*

MHIL's surgical portfolio has been increasingly calibrated to suit the high demand areas such as cardiac diseases and oncology. This can be seen across time and also amongst peers like Apollo and Medanta (**Figure 38, Figure 39**), while maintaining cutting edge medical technology in step as well (**Figure 40**). The shift is also led by its Saket, BLK, Mohali and Bathinda units, and will constrict the options for private insurers as described earlier because MHIL is pivoting to deliver care to high demand fields over its peers in the northern region.

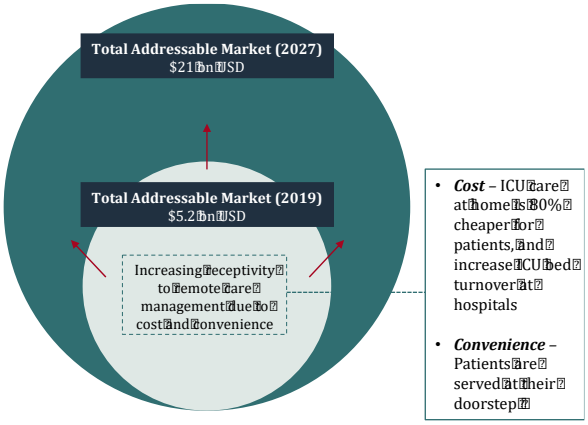
Against this backdrop, MHIL is in a highly advantageous position in terms of being able to leverage the optimisation of its payer mix, saturation of the private insurer market, and increasing specialisation will have a disproportionate effect on its topline because its hospital business comprises 50% of surgical revenues compared to 40% amongst peers, with the hospital allocating >30% of its beds to critical care beds (ICU beds) versus the benchmark of 21-22% by its competitors, indicating a stronger focus on tertiary care. As the dominant player in the metros (outlined in our first thesis), MHIL will be able to drive higher reimbursement rates from their services and procedures, as private insurers must strive to remain competitive in the urbanised areas by providing coverage at

**Figure 40: Medical technology across peers**

| Advanced Technology | MHC | Apollo | Fortis |
|---|---|---|---|
| Linac | Yes | Yes | Yes |
| Tomotherapy | Yes | Yes | Yes |
| Proton Therapy | No | Yes | No |
| Stereotactic Radiation | Yes | Yes | Yes |

*Source: Respective Company Data*

**Figure 41: Growing homecare market in India**



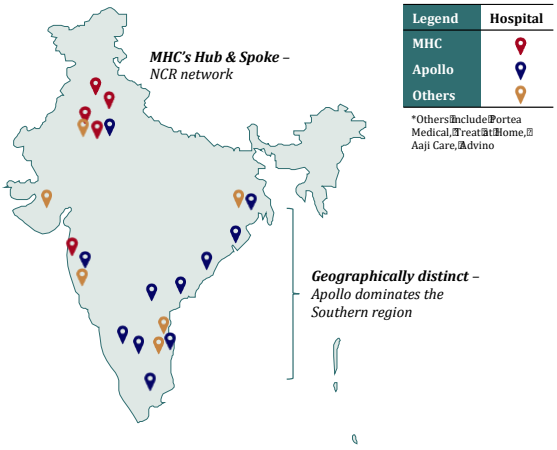

*Source: Grandview Research*

**Figure 42: Max@Home and Apollo 24/7 Homecare services**

| | Max@Home | Apollo 24/7 |
|---|---|---|
| Focus | **Critical care**, recent addition of diagnostics, radiation therapy | **Long term care** – surgery rehab, elder care |
| Geography | **Consolidation in North** – Mumbai, Delhi NCR, Dehradun, etc. | **Spread across region** – Delhi NCR, Chennai, Bangalore etc. |
| Other Services | Physicians, nurses, physio, diagnostics, teleconsultation | Physicians, nurses, physio, diagnostics, teleconsultation |
| Patient support | 24/7 | 24/7 |
| No. of employees | 550+ | 800+ |

*Source: Company Data*

**Figure 43: MHIL Homecare in the Northern stronghold**




*Source: Team Channel Checks*

premium hospitals, lest risk losing hospital business to the many other private insurers desperate for market share.

**3. New business verticals to leverage hub & spoke and allow greater continuum of care**

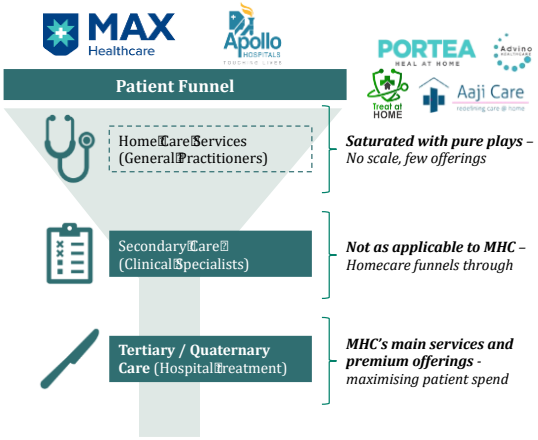
*Max@Home is easily scalable and has strong potential to shape the market for homecare as a first mover*

The homecare market is projected to grow on increasing patient demands for cost and convenience (**Figure 41**). According to CRISIL, it is 80% cheaper for patients who opt for ICU homecare over hospital ICU care. On the hospital end, CRISIL describes the attractiveness of homecare to derive additional income streams to circumvent declining revenue of ICU beds as time passes because patients commence post-op recovery. This means that more patients can be discharged for observation at home while freeing up patient turnover for beds as more complex procedures can be performed. Thus, there are clear incentives of this new business model for both parties, and we see it as an extension that complements core hospital revenues, while risks of overcrowding and hospital acquired infections are greatly mitigated as well.

The most offered services are currently: post-intensive care, rehabilitative care and services of skilled/unskilled nurses. But areas such as home therapeutic care for infusion and respiratory therapy, dialysis and convenience centred teleconsultation are growing. MHIL and Apollo are in fact the first movers amongst the large players. Both platforms provide similar services, but Apollo is more focused on long term rehab and concierge doctor services, while MHIL is more focused on critical care, with the recent addition of diagnostic services like X-ray and ECGs, and the first to bring radiation therapy to the doorstep. (**Figure 42**)

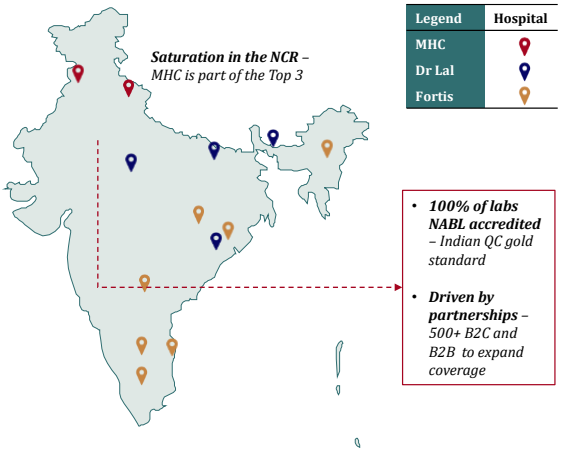
On the other hand, the home care landscape is occupied by many smaller pure play home care companies in the NCR, with some examples being Portea Medical, Aaji Care, Advino, Grand World Elder Care and Treat at Home. These smaller companies fall short in terms of scale and variety of offerings that tertiary hospitals like Apollo and MHIL can provide. Most have tiny geographical footprints scattered across various parts of India. Furthermore, a core advantage that larger hospital chains like MHIL and Apollo have would be the integration along the patient journey due to the ease of scalability that this new business vertical provides. For MHIL, Max@Home can function as an additional funnel to the broader spectrum of private offerings that the main hospitals offer, characterised by the hub & spoke model (**Figure 44**). Patient loyalty is also more easily forged given the nature of the funnel that can provide all tiers of healthcare, thereby increasing the potential healthcare spend for each patient with MHIL. Pure play companies often fail to capture this given their lack of resources, therefore focusing on more rehabilitation, diagnostics, or therapy-related care packages that involve less labour and technical expertise. To compensate for this, some partner with hospitals to create this integration, as in the case of Portea Medical. MHIL and Apollo bypass this through capitalising on their existing resources, saving on transactional partnership fees while widening their patient funnels within their hub & spoke model. And in line with its

**Figure 44: Large scale chains create greater continuum of care**



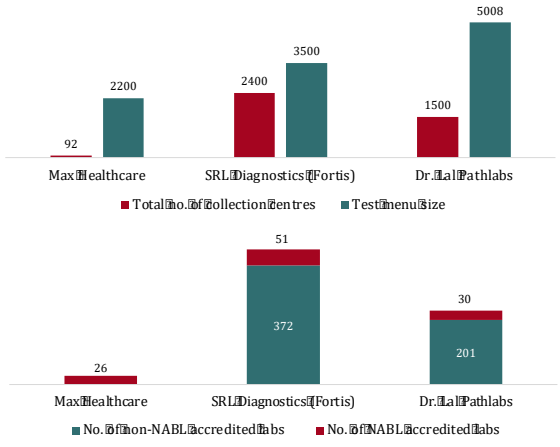

*Source: Various Company Websites, Team Estimates*

**Figure 45: Max Lab strategy**




*Source: Company Data*

**Figure 46: Max Lab offerings against peers**




*Source: Company investor presentations, websites, Business Today India*

overarching strategy, MHIL's geographical concentration in the North inherently taps into the hospital chain dominance it has, separate from Apollo that is farther stretched across India and mainly in the South. (**Figure 43**)

Max@Home has seen 70+% CAGR since inception in 2017 and its offerings will develop further and encompass more of hospitals, beyond its current presence in Mumbai, Delhi NCR (BLK Super Speciality Hospital), Dehradun (MHIL Super Speciality Hospital) and Chandigarh Tri-City. While still constituting a minute portion of revenues (<3%), we expect future revenue synergies will realise with the main hospital business through outpacing industry homecare growth, as well raise barriers to entry within the NCR as end-to-end care becomes more holistic with MHIL as a preferred single private provider for the affluent.

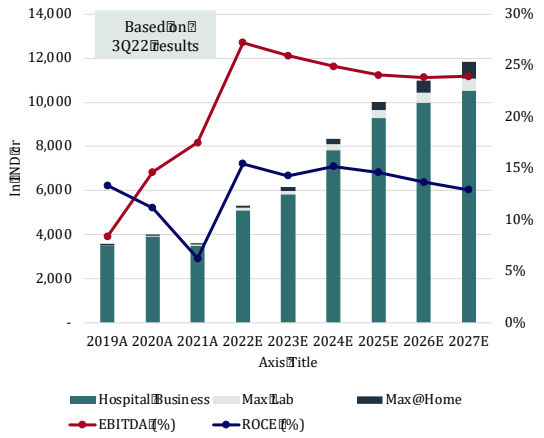
*Max Lab will employ a similar strategy as Max@Home and widen the patient funnel*

A similar strategy will be employed for its diagnostics vertical, though it is more competitive in the North. However, it has grown to be a Top 3 player in the North, rivalling Fortis and Dr Lal in just 4 years since inception (**Figure 45**, Fortis and Dr Lal are indicated by the yellow and blue halos on the map). Despite being a much smaller player in terms of the number of collection centres and tests selection (**Figure 46**), Max Lab compensates for this by having a wide range of partnerships in the B2B and B2C network, allowing it to render services to more patients. 100% of MHIL's labs are also NABL accredited, the gold standard in India, unlike peers with only a minority, indicating a strong alignment of the premium quality that the Max brand carries, beyond just in its hospital business.

**Catalysts**

- MHIL witnessed a sharp drop in international patient volume because of COVID-related restrictions on international travel. As border restrictions ease, medical tourism is starting to rebound and is even expected to grow beyond pre-pandemic levels. MHIL has seen a 68% increase in revenue quarter-on-quarter for the current fiscal Q3FY21, representing two-thirds of the pre-COVID run rate. We expect a full rebound of the profit-yielding segment by the end of 2022. This contributes to higher revenues per bed per day and increases MHIL's bottom-line profitability.
- The expansion into regions outside of NCR has shown promise. Further expansion in areas like Mohali and Mumbai highlights MHIL's intention to gain momentum in growing their position in the under-supplied Indian market.
- The realization of MHIL's ideal payer mix and revenue synergies with Max Lab & Max@Home would allow it to reach its true operating potential, catalysing ARPOB growth
- MHIL is driven by strong free cash flows and a debt free balance sheet. The outstanding performance turnaround of BLK and Narayana signals the strength of MHIL's management, who will ensure fast operationalization of the

**Figure 47: EBITDA normalisation to account for expansion with ROCE to remain above 12.5%**




*Source: Team Estimates*

bed pipeline. This keeps an adequate headroom for potential M&A activities in the next 1-2 years even with the existing development pipeline. Target acquisitions will be accretive to earnings by capturing synergies, leveraging economies of scale, and improving operating efficiency.

## Financial Analysis

| | 2019A | 2020A | 2021A | 2022E | 2023E | 2024E | 2025E | 2026E | 2027E |
|---|---|---|---|---|---|---|---|---|---|
| **Revenue (INR cr)** | 2671 | 4023 | 3629 | 5323 | 6165 | 8353 | 10030 | 10991 | 11840 |
| **Revenue Growth** | *-2%* | *51%* | *-10%* | *47%* | *16%* | *35%* | *20%* | *10%* | *8%* |
| **EBITDA Margin (%)** | 8% | 15% | 18% | 27% | 26% | 25% | 24% | 24% | 24% |
| **EBIT Margin (%)** | 8% | 9% | 12% | 23% | 21% | 19% | 18% | 17% | 16% |
| **D/E Ratio** | 0.50 | 0.46 | 0.33 | 0.37 | 0.54 | 0.73 | 0.86 | 0.94 | 1.01 |
| **ROCE (%)** | 13% | 11% | 6% | 15% | 14% | 15% | 15% | 14% | 13% |

**EBITDA normalisation to account for expansion with ROCE to remain above 12.5%**

EBITDA has remained historically strong over time (pushing INR 50k/day in FY19) even through the pandemic, which is essential for a premium healthcare provider like MHIL. Pre-pandemic EBITDA margins were in the 15-18% region and ROCE ~12%, with a more palpable dip in FY 21 attributed to COVID. 3Q22 posted strong BOR, after normalising downwards to 75% from pandemic highs of 85%, while ARPOB posed a 24.6% jump in 3Q22 from FY21, a strong bounce back from the pandemic period. Through FY27, EBITDA is expected to remain elevated, albeit slightly lower to account for bed expansion in the North. The 2 new business verticals will aim to constitute 10% of total revenues, up from current 4%. (**Figure 47**)

**Average cash flow generation and cash financing capabilities for organic growth**

MHIL's FCF generation has weakened in FY21, not just due to the dip in BOR but also from the immense CAPEX (net block up 7.68x from FY20 to INR 6,537 lakh in FY21) to fund its brownfield and greenfield expansion developments that commenced over FY21. However, it has maintained a relatively stable 1.77 – 2.25x interest-coverage ratio, with cash and cash equivalents (INR 655 lakh) just about covering its current liabilities less provisions (INR 672 lakh), which is expected of the company's preference towards internal accruals to funding its expansions over debt.

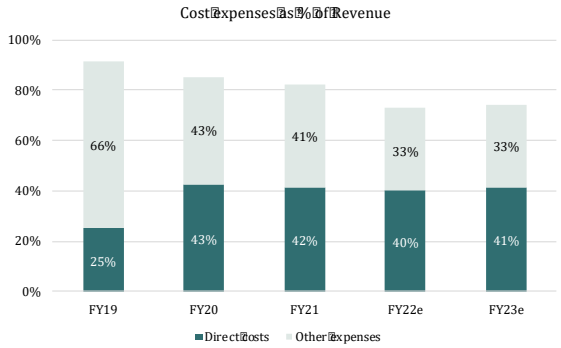
Towards FY27, interest coverage is expected to expand well into the mid-5.00x range, due to the increasing operational strength as demonstrated from 3Q22 results. We expect debt to remain 10% of revenues through FY27 given management guidance on the company's preference to depend on internal accruals as well as greater reliance on their various credit facilities to fund their riskier site expansion. This is demonstrated in the negative free cash flows that will see the company through till FY27, mainly weighed down by the CAPEX in effectively doubling bed capacity.

## Valuation

Valuation Price Target: **INR 462.38**

We project a 12-month blended price target of INR 462.38, representing an upside potential of 36.1%. This was derived using a 50:50 weighted bottom-up unlevered DCF and relative valuation

**Figure 48: Cost expenses for MHIL**




*Source: Company Data*

**Figure 49: WACC Parameters**

| | |
|---|---|
| **Cost of Equity** | **Risk-free rate**: 6.83% (India 10-year Government Bond Yield)<br>**ERP**: 6.42% (Damodaran)<br>**CRP**: 2.18% (Damodaran)<br>**Levered beta**: 0.53 (Re-levered beta of peer median beta)<br>**Cost of Equity: 11.36%** |
| **Cost of Debt** | **Risk-free rate**: 6.83% (India 10-year Government Bond Yield)<br>**Company default spread**: 2.25 (Damodaran, Synthetic BB Rating)<br>**Effective tax rate**: 22.0% (India Tax Rate)<br>**Cost of Debt: 7.94%** |
| **WACC** | **11.25% (97% Equity, 3% Debt)** |

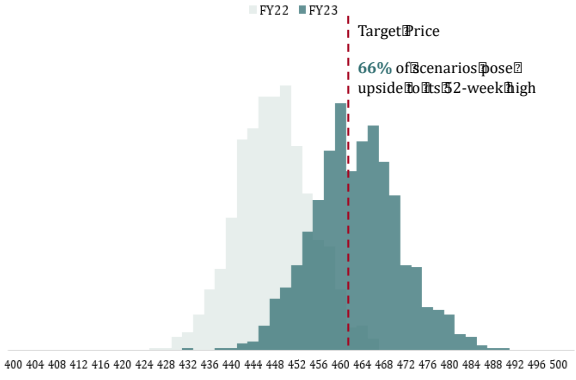
*Source: Damodaran, Company Data*

**Figure 50: Peer group used for RV and EMM**

| Company | Market Cap (INR bn) | P/E | EV/EBITDA |
|---|---|---|---|
| Fortis Healthcare | 198.14 | 42.70x | 18.30x |
| Apollo Hospitals | 697.95 | 52.90x | 28.50x |
| Aster DM Healthcare | 86.41 | 17.70x | 8.50x |
| Narayana Hrudayalaya Ltd | 142.52 | 44.00x | 20.90x |
| Dr. Lal PathLabs Ltd | 218.26 | 59.60x | 33.30x |
| Shalby Hospitals | 14.07 | 30.30x | 12.50x |
| Krishna Institute | 110.79 | 31.20x | 18.80x |
| Metropolis Healthcare | 97.02 | 40.60x | 23.40x |
| Thryocare Technologies | 42.53 | 24.10x | 16.50x |

*Source: Koyfin, Yahoo Finance*

**Figure 51: Monte Carlo Simulation**




*Source: Team Estimates*

approach. Terminal value for DCF was derived using an Exit Multiple method (EMM).

**Valuation Inputs and Assumptions**

*Revenue Projections*

We broke down MHIL's revenue by the three business segments.

Hospital Business: Revenue from this segment was calculated by multiplying ARPOB by Operating Bed Days. It was projected in line to our thesis of a growing ARPOB due to the highly advantageous position MHIL has established for itself. The upcoming new MHIL beds were also accounted for based on management's timeline for the expansion.

Max Lab: In FY21, revenue from Max Lab was about INR 70 cr, contributing about 2% of total revenue. Based on management's vision to be amongst the top 5 diagnostics players in five years, we stepped up this segment to ~INR 550 cr by FY27 after comparing to its peer group.

Max@Home: A report by Redseer Consulting projected India's homecare market to grow at a CAGR of 19% for the next five years. Since MHIL has leveraged its hub & spoke model to emerge as one of the leaders in homecare, we believe the revenue growth in this segment will outpace the market and reach INR 760 cr by FY27.

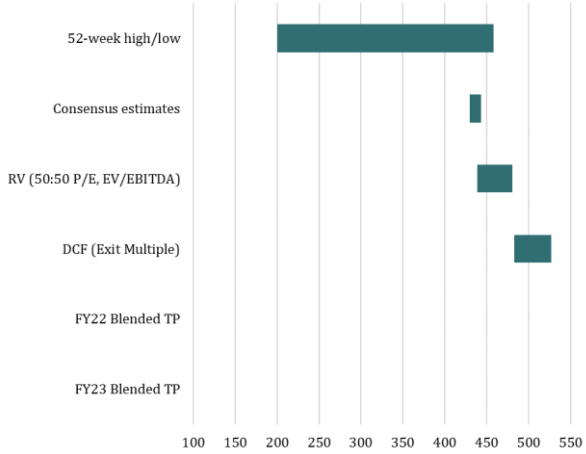
*Operating Expenses*

MHIL's cost cutting initiatives since FY20 have also begun to reap rewards, with OPEX coming down to the low 70% range. The major items accounted for are the procurement of pharmaceutical drugs, equipment for direct expenses, and employee wages under other expenses. Moving forward, we expect direct expenses to remain stable while other expenses decrease as % of revenue to 35% in FY27 given their cost initiatives to reduce physician costs, while accounting for their bed expansion. (**Figure 48**)

*Discount Rates*

Our DCF model discounts the unlevered free cash flow by the weighted average cost of capital (WACC) from FY22 to FY27. (**Figure 49**) Using CAPM, the cost of equity obtained was 11.36%. The risk-free rate was taken to be the India 10-year government bond yield at the time of projection; market risk premium was taken to be the implied equity risk premium and country risk premium from Damodaran; beta was the levered beta from the average of unlevered trading peer beta with private healthcare providers as screening criteria; effective tax rate was taken to be 22% using the statutory tax rate for India as proxy; and cost of debt was derived synthetically using an implied spread of 3.50% from the historical average risk-free rate based on its expected interest coverage ratio of 2.25x. The FY27 terminal value was taken using the 75$^{th}$ percentile P/E and EV/EBITDA multiples of MHIL's peer group to justify its superior prospects. The reason why the Exit Multiple Method was conducted over a Perpetuity Methods is to justify the

**Figure 52: Football Field**



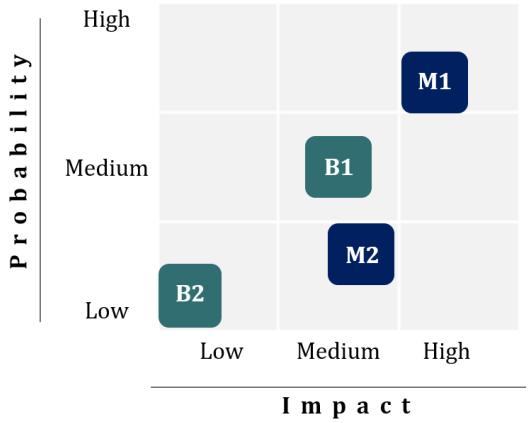

*Source: Team Estimates*

**Figure 53: Parameters for Monte Carlo Simulation**

| Probability distributions | | | | |
|---|---|---|---|---|
| **Probability** | **BOR** | **FY23 ARPOB Gr** | **FY23 Home Growth** | **WACC** |
| 1st percentile | 73% | 3% | 54% | 10.25% |
| Median | 75% | 5% | 56% | 11.25% |
| 99th percentile | 77% | 7% | 58% | 12.25% |
| Implied standard deviation | 0.9% | 0.9% | 0.9% | 0.4% |

*Source: Team Estimates*

**Figure 54: Risk Matrix**




*Source: Team Estimates*

high growth phase that MHIL is entering, where cash flow risks will become elevated.

Our RV model screened for private healthcare providers in India, with peers shown in **Figure 50**. Similarly, 75th percentile multiples were used for forward P/E and EV/EBITDA.

**Sensitivity Analysis**

Monte Carlo analysis was performed over 1,000 iterations, where BOR (%), homecare growth, ARPOB growth and WACC were varied, resulting in a distribution resembling that of a normal distribution. (**Figure 53**) FY22 results were extrapolated from 3Q22 results and used as a sense check for the FY23 implied share price.

The 50th percentile estimate of INR 462.38 arising from the simulation was taken to be the target price. In addition, there is an asymmetric risk-reward opportunity – 2/3 of the distribution pose an upside to its 52-week high. Based on these assumptions, FY23 was used as the 12M TP horizon, as represented in the football field (**Figure 52**) overall slightly more bullish than consensus estimates.

## Investment Risks

Market Risk 1 (M1)

**Hospital business remains affected by the pandemic:** (**Figure 54**) Although the healthcare sector has been at the forefront of treating COVID-19 patients, hospital businesses have been substantially impacted due to increases in cost of operations, in part from increased admission in inpatient flow but reduced outpatient footfalls, as well as little to no revenue from international patients. Given the waves of COVID variants, hospitals are also impacted when state governments announce restrictions and lockdowns to control the spread of the virus. Some of the procedures performed in MHIL facilities are elective in nature and there has been a decline in patients undergoing treatment, with many choosing to postpone for fear of contracting the virus during hospital visits or due to periods of financial difficulties. The future impact of the pandemic depends on the nature and severity of the virus, and the sticky situation described will be one faced by the entire industry.

Market Risk 2 (M2)

**Exposure to regulatory risk faced by the healthcare industry:** MHIL operates in a regulated industry that has witnessed continuous regulatory intervention during the past couple of years. Healthcare costs in India have increased significantly over the past decade, and there have been interventions by legislators and regulators in the past couple of years to limit the rate of increase, cap margins, fix the price of procedures and diagnostics, to lower healthcare costs in India.

For example, in FY17, National Pharmaceutical Pricing Authority (NPPA) introduced regulations such as capping of drug-eluting stent prices and knee implant prices. The stricter compliance norms had an adverse impact on MHIL's operating margins. During the COVID-19 pandemic, the Indian government also imposed a cap on private hospital treatment costs in certain regions, such as

Maharashtra and Delhi, to ensure the affordability of healthcare. Such regulations impose adverse impacts on the prices that MHIL can charge and increases their cost margin, which would render an impact on the company's profitability. However, we find this risk inherent in the healthcare industry and is not unique to MHIL. Changes in any pricing policies are foreseeably difficult and arduous to enact fairly.

Business Risk 1 (B1)

**Delay in proposed expansion and delay in improvement in payer mix:** MHIL is dependent on third party developers and contractors for the construction and development of new hospital buildings. Any delay in sourcing building materials, receiving requisite approvals, or issues with funding could delay its projects. However, we believe that MHIL has taken the necessary actions to sufficiently prepare itself for the expansions. For example, MHIL has already acquired the necessary approvals from state government for construction on its land banks, as well as completed a NCD issue to ensure funding. While no further information has been disclosed, we think that the strong management of Max Healthcare will carry out its expansion plans efficiently.

Another crucial problem would be if MHIL fails to reduce the government portion of its payer mix significantly. Since government schemes lag private insurers in terms of reimbursement, they are generally less profitable and may even cause EBIDTA negative bed margins.

Business Risk 2 (B2)

**Intense competition from other established players or new players:** Given the new wave of opportunities created by COVID-19 pandemic, the healthcare sector is one that is attracting a lot of new entrants. New players might offer lower rates and compete with MHIL for doctors and other medical professionals. We think that the risk posed by new entrants is low as MHIL's strong brand salience would help it retain its reputed doctors. Furthermore, comfort is drawn from the market power of MHIL. Going forward, MHIL's prospects would depend upon its ability to improve its profitability, scale-up its operations, and to manage the competitive pressures in the sector by diversifying into other geographies or build up on its asset light adjacencies.

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# Appendix A: Financial Model

## Financial Statements

| Income Statement | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Figures in INR cr** | **Historical** | | | | | **Projected** | | | | | |
| | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** |
| **Revenues** | | | 2,671 | 4,023 | 3,629 | 5,323 | 6,165 | 8,353 | 10,030 | 10,991 | 11,840 |
| *Growth(%)* | | | *-2.3%* | *50.6%* | *-9.8%* | *46.7%* | *15.8%* | *35.5%* | *20.1%* | *9.6%* | *7.7%* |
| Direct costs | | | (672) | (1,715) | (1,508) | (2,141) | (2,556) | (3,431) | (4,105) | (4,524) | (4,861) |
| Other expenses | | | (1,775) | (1,719) | (1,485) | (1,733) | (2,007) | (2,840) | (3,511) | (3,847) | (4,144) |
| Employee costs | | | (746) | (997) | (941) | | | | | | |
| **Total operating expenses** | | | (2,447) | (3,434) | (2,993) | (3,874) | (4,563) | (6,271) | (7,616) | (8,370) | (9,005) |
| **EBITDA** | | | **224** | **589** | **636** | **1,449** | **1,601** | **2,081** | **2,415** | **2,620** | **2,835** |
| *As % of Revenue* | | | *8.4%* | *14.6%* | *17.5%* | *27.2%* | *26.0%* | *24.9%* | *24.1%* | *23.8%* | *23.9%* |
| D&A | | | - | (208) | (216) | (244) | (320) | (483) | (641) | (768) | (899) |
| **EBIT** | | | 224 | 381 | 420 | 1,205 | 1,282 | 1,598 | 1,774 | 1,852 | 1,936 |
| *As % of Revenue* | | | *8.4%* | *9.5%* | *11.6%* | *22.6%* | *20.8%* | *19.1%* | *17.7%* | *16.9%* | *16.4%* |
| Interest | | | - | (215) | (187) | (187) | (220) | (269) | (318) | (362) | (405) |
| **EBT** | | | 224 | 166 | 233 | 1,018 | 1,062 | 1,329 | 1,456 | 1,490 | 1,531 |
| Provision for Tax | | | - | (3) | 50 | 224 | 234 | 292 | 320 | 328 | 337 |
| Effective Tax Rate (%) | | | 0% | -2% | 21% | 22% | 22% | 22% | 22% | 22% | 22% |
| **Net Profit** | | | **224** | **169** | **183** | **794** | **828** | **1,037** | **1,136** | **1,162** | **1,194** |
| excl. Extraordinary items | | | - | **(40)** | **(277)** | - | - | - | - | - | - |
| **Profit after Tax** | | | **224** | **209** | **459** | **794** | **828** | **1,037** | **1,136** | **1,162** | **1,194** |
| *As % of Revenue* | | | *8%* | *5%* | *13%* | *15%* | *13%* | *12%* | *11%* | *11%* | *10%* |

| Balance Sheet | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Figures in INR cr** | **Historical** | | | | | **Projected** | | | | | |
| | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** |
| **Assets** | | | **1,931** | **3,724** | **7,489** | **8,841** | **11,201** | **14,358** | **17,536** | **20,531** | **23,639** |
| **Current assets:** | | | **360** | **700** | **1,557** | **1,716** | **2,361** | **3,496** | **4,607** | **5,622** | **6,669** |
| Cash & bank balance | | | 4 | 122 | 655 | 421 | 857 | 1,448 | 2,158 | 2,936 | 3,774 |
| Inventories | | | 15 | 27 | 54 | 53 | 65 | 98 | 108 | 121 | 132 |
| Sundry Debtors | | | 285 | 96 | 485 | 711 | 824 | 1,116 | 1,341 | 1,469 | 1,582 |
| Loans and advances | | | 55 | 456 | 362 | 531 | 615 | 833 | 1,001 | 1,096 | 1,181 |
| Other current assets | | | - | - | - | - | - | - | - | - | - |
| **Non-current assets:** | | | **1,571** | **3,024** | **5,932** | **7,125** | **8,840** | **10,862** | **12,930** | **14,909** | **16,970** |
| Net Block | | | 479 | 851 | 6,537 | 7,730 | 9,445 | 11,467 | 13,535 | 15,514 | 17,575 |
| Other non-current assets | | | | | | (605) | (605) | (605) | (605) | (605) | (605) |
| Capital Works in Progress | | | 10 | 28 | 27 | | | | | | |
| Investments | | | 770 | 2,182 | 1 | | | | | | |
| Misc Expenditure | | | 312 | (37) | (51) | | | | | | |
| Net deferred tax | | | - | - | (582) | | | | | | |
| **Liabilities** | | | **644** | **1,171** | **1,850** | **2,409** | **3,940** | **6,061** | **8,104** | **9,936** | **11,850** |
| **Current liabilites** | | | **254** | **318** | **772** | **1,054** | **2,240** | **3,846** | **5,391** | **6,993** | **8,664** |
| Reolver Facility/ST Debt | | | | | | - | 1,001 | 2,217 | 3,461 | 4,877 | 6,398 |
| Sundry Creditors and Others | | | 242 | 270 | 672 | 954 | 1,139 | 1,529 | 1,829 | 2,016 | 2,166 |
| Provisions | | | 12 | 48 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| **Non-current liabilties** | | | **390** | **853** | **1,078** | **1,355** | **1,700** | **2,215** | **2,713** | **2,944** | **3,187** |
| Borrowings | | | 390 | 853 | 1,078 | 1,355 | 1,700 | 2,215 | 2,713 | 2,944 | 3,187 |
| Secured loans | | | 390 | 853 | 1,078 | 1,355 | 1,700 | 2,215 | 2,713 | 2,944 | 3,187 |
| Unsecured loans | | | - | - | - | | | | | | |
| **Stockholders' equity** | | | **1,287** | **2,553** | **5,639** | **6,433** | **7,261** | **8,298** | **9,434** | **10,596** | **11,790** |
| Equity capital | | | 537 | 537 | 966 | 966 | 966 | 966 | 966 | 966 | 966 |
| Reserves and surplus | | | 749 | 2,016 | 4,673 | 5,467 | 6,295 | 7,332 | 8,468 | 9,630 | 10,824 |
| Minority Interest | | | - | - | - | | | | | | |

## Cash Flow Consolidation

| Figures in INR cr | Historical | | | | | Projected | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
| **Cash Flow Statement** | | | | | | | | | | | |
| Profit for the year | | | 224 | 209 | 459 | 794 | 828 | 1,037 | 1,136 | 1,162 | 1,194 |
| Add: Depreciation | | | - | 208 | 216 | 244 | 320 | 483 | 641 | 768 | 899 |
| Add: Misc Expenditure Write-Offs | | | 71 | 349 | 15 | | | | | | |
| Add: Deferred Tax | | | 5 | - | 581 | | | | | | |
| Add: Others | | | - | - | - | | | | | | |
| Gross cash flow | | | 299 | 766 | 1,271 | 1,038 | 1,148 | 1,520 | 1,777 | 1,931 | 2,093 |
| Less: Changes in WC | | | 106 | 159 | (131) | 112 | 24 | 154 | 101 | 51 | 59 |
| **Operating Cash Flow** | | | **193** | **607** | **1,402** | **926** | **1,124** | **1,366** | **1,676** | **1,880** | **2,034** |
| Less: CAPEX | | | (20) | 598 | 5,901 | 1,437 | 2,034 | 2,506 | 2,708 | 2,748 | 2,960 |
| **Investing Cash Flow** | | | **(20)** | **598** | **5,901** | **1,437** | **2,034** | **2,506** | **2,708** | **2,748** | **2,960** |
| Revolver Payments | | | | | | - | - | (1,001) | (2,217) | (3,461) | (4,877) |
| Revolver Proceeds | | | | | | - | 1,001 | 2,217 | 3,461 | 4,877 | 6,398 |
| Secured loan additions | | | | | | 277 | 345 | 515 | 498 | 231 | 243 |
| Proceeds from Equity Issuance | | | | | | - | - | - | - | - | - |
| **Financing Cash Flow** | | | | | | **277** | **1,346** | **1,731** | **1,742** | **1,646** | **1,764** |
| **Free Cash Flow** | | | **213** | **10** | **(4,500)** | **(234)** | **436** | **591** | **710** | **778** | **838** |

# Revenue Projections

| | Historical | | | | | Projected | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Figures in INR cr** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** |
| **Revenue** | | | 2,671 | 4,023 | 3,629 | 5,323 | 6,165 | 8,353 | 10,030 | 10,991 | 11,840 |
| *yoy change (%)* | | | *0%* | *51%* | *-10%* | *47%* | *16%* | *35%* | *20%* | *10%* | *8%* |
| Max Healthcare | | | 2,584 | 2,841 | 2,643 | | | | | | |
| | | | | 11% | -11% | 46% | 14% | 35% | 19% | 7% | 5% |
| **Hospital Business** | | | 3,512 | 3,905 | 3,492 | 5,109 | 5,823 | 7,837 | 9,287 | 9,971 | 10,517 |
| ARPOB | | | 50 | 50 | 57 | 71 | 75 | 77 | 79 | 80 | 81 |
| yoy change (%) | | | | *0%* | *14%* | *25%* | *5%* | *3%* | *3%* | *1%* | *1%* |
| No. of Operating Beds | | | 2,376 | 2,256 | 2,248 | 2,634 | 2,859 | 3,736 | 4,298 | 4,569 | 4,772 |
| Operating capacity change (%) | | | | -5% | 0% | 17% | 9% | 31% | 15% | 6% | 4% |
| Total Bed Capacity | | | 3,202 | 3,177 | 3,412 | 3,512 | 3,812 | 4,981 | 5,731 | 6,092 | 6,362 |
| Capacity yoy change (%) | | | | *-1%* | *7%* | *3%* | *9%* | *31%* | *15%* | *6%* | *4%* |
| Bed Occupancy (%) | | | *74%* | *71%* | *65%* | *75%* | *75%* | *75%* | *75%* | *75%* | *75%* |
| Operating bed days ('0,000) | | | *70 days* | *78 days* | *61 days* | *72 days* | *78 days* | *102 days* | *117 days* | *125 days* | *130 days* |
| **Adjacencies** | | | | | | | | | | | |
| **Max Lab** | | | 24 | 41 | 68 | 105 | 172 | 258 | 361 | 469 | 563 |
| *yoy change (%)* | | | *0%* | *71%* | *66%* | *54%* | *64%* | *50%* | *40%* | *30%* | *20%* |
| *As % of Revenue* | | | *1%* | *1%* | *2%* | *2%* | *3%* | *3%* | *4%* | *4%* | *5%* |
| **Max@Home** | | | 63 | 77 | 70 | 109 | 170 | 258 | 383 | 551 | 760 |
| *yoy change (%)* | | | *0%* | *22%* | *-9%* | *56%* | *56%* | *52%* | *48%* | *44%* | *38%* |
| *As % of Revenue* | | | *2%* | *2%* | *2%* | *2%* | *3%* | *3%* | *4%* | *5%* | *6%* |

# Cost and Working Capital Projections

| Figures in INR cr | Historical 2017 | 2018 | 2019 | 2020 | 2021 | Projected 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Revenue | | | 2,671 | 4,023 | 3,629 | 5,323 | 6,165 | 8,353 | 10,030 | 10,991 | 11,840 |
| EBIT | | | 224 | 381 | 420 | 1,205 | 1,282 | 1,598 | 1,774 | 1,852 | 1,936 |
| EBT | | | 224 | 166 | 233 | 1,018 | 1,062 | 1,329 | 1,456 | 1,490 | 1,531 |
| **Cost Build** | | | | | | | | | | | |
| Direct Costs | | | (672) | (1,715) | (1,508) | (2,141) | (2,556) | (3,431) | (4,105) | (4,524) | (4,861) |
| As % of Revenue | | | *25%* | *43%* | *42%* | *40%* | *41%* | *41%* | *41%* | *41%* | *41%* |
| Other Expenses | | | (1,775) | (1,719) | (1,485) | (1,733) | (2,007) | (2,840) | (3,511) | (3,847) | (4,144) |
| As % of Revenue | | | *66%* | *43%* | *41%* | *33%* | *33%* | *34%* | *35%* | *35%* | *35%* |
| Total costs as % of Revenue | | | *92%* | *85%* | *82%* | *73%* | *74%* | *75%* | *76%* | *76%* | *76%* |
| Income Tax (Provision) | | | - | (3) | 50 | 224 | 234 | 292 | 320 | 328 | 337 |
| Effective tax rate (%) | | | *0%* | *-2%* | *21%* | *22%* | *22%* | *22%* | *22%* | *22%* | *22%* |
| Extraordinary items | | | - | (40) | (277) | - | - | - | - | - | - |
| As % of Revenue | | | *0%* | *-1%* | *-8%* | *0%* | *0%* | *0%* | *0%* | *0%* | *0%* |
| **Net Working Capital** | | | | | | | | | | | |
| Inventory | | | 15 | 27 | 54 | 53 | 65 | 98 | 108 | 121 | 132 |
| *As % of COGS* | | | *2%* | *2%* | *4%* | *2%* | *3%* | *3%* | *3%* | *3%* | *3%* |
| *DIO* | | | *2 days* | *2 days* | *5 days* | *4 days* | *4 days* | *4 days* | *4 days* | *4 days* | *4 days* |
| Sundry Debtors (AR) | | | 285 | 96 | 485 | 711 | 824 | 1,116 | 1,341 | 1,469 | 1,582 |
| *As % of Revenue* | | | *11%* | *2%* | *13%* | *13%* | *13%* | *13%* | *13%* | *13%* | *13%* |
| *DSO* | | | *39 days* | *9 days* | *49 days* | *49 days* | *49 days* | *49 days* | *49 days* | *49 days* | *49 days* |
| Loans and advances | | | 55 | 456 | 362 | 531 | 615 | 833 | 1,001 | 1,096 | 1,181 |
| *As % of Revenue* | | | *2%* | *11%* | *10%* | *10%* | *10%* | *10%* | *10%* | *10%* | *10%* |
| Other current assets | | | - | - | - | - | - | - | - | - | - |
| *As % of Revenues* | | | | | | | | | | | |
| Sundary Creditors (AP) | | | 242 | 270 | 672 | 954 | 1,139 | 1,529 | 1,829 | 2,016 | 2,166 |
| *As % of COGS* | | | *36%* | *16%* | *45%* | *45%* | *45%* | *45%* | *45%* | *45%* | *45%* |
| *DPO* | | | *131 days* | *57 days* | *163 days* | *163 days* | *163 days* | *163 days* | *163 days* | *163 days* | *163 days* |
| Provisions | | | 12 | 48 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| *As % of Revenues* | | | | | | | | | | | |
| Total current assets | | | 355 | 579 | 901 | 1,295 | 1,504 | 2,048 | 2,449 | 2,686 | 2,896 |
| Total current liabilites | | | 254 | 318 | 772 | 1,054 | 1,239 | 1,629 | 1,929 | 2,116 | 2,266 |
| Net working capital | | | 101 | 261 | 129 | 241 | 265 | 419 | 519 | 570 | 629 |
| **Change in net working capital** | | | | **160** | **(132)** | **112** | **24** | **154** | **101** | **51** | **59** |

## Other Accounts

| | Historical | | | | | Projected | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Figures in INR cr** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026** | **2027** |
| Revenue | | | 2,671 | 4,023 | 3,629 | 5,323 | 6,165 | 8,353 | 10,030 | 10,991 | 11,840 |
| EBIT | | | 224 | 381 | 420 | 1,205 | 1,282 | 1,598 | 1,774 | 1,852 | 1,936 |
| EBT | | | 224 | 166 | 233 | 1,018 | 1,062 | 1,329 | 1,456 | 1,490 | 1,531 |
| **Non-Current Accounts** | | | | | | | | | | | |
| Total Non-current assets | | | 1,571 | 3,024 | 5,932 | 7,125 | 8,840 | 10,862 | 12,930 | 14,909 | 16,970 |
| Other Non-current assets | | | 1,092 | 2,173 | (605) | (605) | (605) | (605) | (605) | (605) | (605) |
| Capital Works in Progress | | | 10 | 28 | 27 | 27 | 27 | 27 | 27 | 27 | 27 |
| Investments | | | 770 | 2,182 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Misc Expenditure | | | 312 | (37) | (51) | (51) | (51) | (51) | (51) | (51) | (51) |
| Net deferred tax | | | - | - | (582) | (582) | (582) | (582) | (582) | (582) | (582) |
| Proceeds from issuance of shares | | | | | | - | - | - | - | - | - |
| Equity capital | | | 537 | 537 | 966 | 966 | 966 | 966 | 966 | 966 | 966 |
| Increase in share capital (%) | | | | | 34% | 0% | 0% | 0% | 0% | 0% | 0% |
| Minority Interest | | | - | - | - | - | - | - | - | - | - |
| **PPE Build** | | | | | | | | | | | |
| Gross block | | | 653 | 1,234 | 7,136 | 8,573 | 10,608 | 13,113 | 15,822 | 18,569 | 21,529 |
| Accumulated depreciation | | | 174 | 383 | 599 | 843 | 1,163 | 1,646 | 2,287 | 3,055 | 3,954 |
| Depreciation | | | - | 208 | 216 | 244 | 320 | 483 | 641 | 768 | 899 |
| *As % of Sales* | | | *0%* | *5%* | *6%* | *5%* | *5%* | *6%* | *6%* | *7%* | *8%* |
| CAPEX | | | (20) | 598 | 5,901 | 1,437 | 2,034 | 2,506 | 2,708 | 2,748 | 2,960 |
| *As % of Revenue* | | | | *15%* | *163%* | 27% | 33% | 30% | 27% | 25% | 25% |
| | | | | | | | 42% | 23% | 8% | 1% | 8% |
| Net block | | | 479 | 851 | 6,537 | 7,730 | 9,445 | 11,467 | 13,535 | 15,514 | 17,575 |
| **Debt Schedule & Cash** | | | | | | | | | | | |
| **Cash & cash equivalents** | | | 4 | 122 | 655 | | | | | | |
| *As % of Revenue* | | | *0%* | *3%* | *18%* | | | | | | |
| Minimum target cash balance | | | | | | 377 | 436 | 591 | 710 | 778 | 838 |
| *As % of Revenue* | | | | | | 7% | 7% | 7% | 7% | 7% | 7% |
| **Revolver** | | | | | | | | | | | |
| Cash at BOP | | | | | | 655 | - | - | - | - | - |
| Cash generated at EOP | | | | | | (234) | (565) | (625) | (534) | (638) | (683) |
| Minimum cash desired | | | | | | 377 | 436 | 591 | 710 | 778 | 838 |
| Cash surplus (deficit) | | | | | | 44 | (1,001) | (1,216) | (1,244) | (1,415) | (1,521) |
| **Interest Repayment Schedule** | | | | | | | | | | | |
| Interest expense | | | - | (215) | (187) | (187) | (220) | (269) | (318) | (362) | (405) |
| Interest on ST debt | | | | | | 3% | 3% | 3% | 3% | 3% | 3% |
| Interest paid | | | | | | - | - | (30) | (67) | (104) | (146) |
| *(Unused)* | | | | | | | | | | | |
| *As % of EBIT* | | | *0%* | *56%* | *45%* | *16%* | *17%* | *17%* | *18%* | *20%* | *21%* |
| Interest Coverage Ratio | | | | 1.77x | 2.25x | 2.01x | 2.13x | 2.07x | 2.10x | 2.08x | 2.09x |
| Secured Loans | | | 390 | 853 | 1,078 | 1,355 | 1,700 | 2,215 | 2,713 | 2,944 | 3,187 |
| *As % of Revenue* | | | 15% | 21% | 30% | 25% | 28% | 27% | 27% | 27% | 27% |
| Debt additions | | | | | | 277 | 345 | 515 | 498 | 231 | 243 |

## Capital structure

| | |
|---|---|
| Total Debt (in cr) | 1,078 |
| Market capitalisation (in cr) | 32,200 |
| Debt as proportion of capital strucutre | 3% |
| Equity as proportion of capital structure | 97% |

| | |
|---|---|
| **Derived WACC** | **11.25%** |
| **Monte Carlo WACC** | **11.25%** |

| | | |
|---|---|---|
| **Cost of Equity** | **11.36%** | |
| Risk free rate | 6.83% | India 10Y Government Bond |
| Equity Risk Premium | 6.42% | Damodaran |
| Country Risk Premium | 2.18% | Damodaran |
| Beta | 0.53 | Peer group |
| **Cost of Debt (Synthetic)** | **7.94%** | |
| Risk free rate | 6.68% | India 10Y Government Bond |
| Interest Coverage Ratio | 2.25x | Company |
| Coverage spread | 3.50% | Damodaran |
| Tax rate | 22% | |
| **Beta Calculation** | | |
| Peer Group Unlevered Beta | 0.51 | Based on RV peer group |
| Company D/E | 0.03 | |
| **Company Relevered Beta** | **0.53** | |

| *Interest Coverage Ratio* | *Rating* | *Spread* |
|---|---|---|
| > 8.5 | AAA | 0.75% |
| 6.5-8.5 | AA | 1.00% |
| 5.5 6.5 | A+ | 1.50% |
| 4.25- 5.5 | A | 1.80% |
| 3- 4.25 | A- | 2.00% |
| 2.5-3 | BBB | 2.25% |
| 2- 2.5 | BB | 3.50% |
| 1.75-2 | B+ | 4.75% |
| 1.5-1.75 | B | 6.50% |
| 1.25-1.5 | B- | 8.00% |
| 0.8-1.25 | CCC | 10.00% |
| 0.65-0.8 | CC | 11.50% |
| 0.2-0.65 | C | 12.70% |
| <0.2 | D | 14.00% |

## Unlevered Free Cash Flow Calculations

| | Historical | | | | | Projected | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
| Revenue | | | 2,671 | 4,023 | 3,629 | 5,323 | 6,165 | 8,353 | 10,030 | 10,991 | 11,840 |
| EBITDA | | | 224 | 589 | 636 | 1,449 | 1,601 | 2,081 | 2,415 | 2,620 | 2,835 |
| EBIT | | | 224 | 381 | 420 | 1,205 | 1,282 | 1,598 | 1,774 | 1,852 | 1,936 |
| Tax (Provision) | | | - | (3) | 50 | 224 | 234 | 292 | 320 | 328 | 337 |
| Tax rate (%) | | | *0%* | *-2%* | *21%* | *22%* | *22%* | *22%* | *22%* | *22%* | *22%* |
| Tax shield on Net interest | | | - | 4 | (40) | (41) | (48) | (59) | (70) | (80) | (89) |
| **Operating Cash Flow** | | | **224** | **388** | **330** | **940** | **1,000** | **1,246** | **1,384** | **1,445** | **1,510** |
| Add: Depreciation and Amortisation | | | - | 208 | 216 | 244 | 320 | 483 | 641 | 768 | 899 |
| Less: CAPEX | | | 20 | (598) | (5,901) | (1,437) | (2,034) | (2,506) | (2,708) | (2,748) | (2,960) |
| Less: Changes in NOWC | | | (106) | (159) | 131 | (112) | (24) | (154) | (101) | (51) | (59) |
| **Unlevered Free Cash Flow** | | | **138** | **(161)** | **(5,224)** | **(365)** | **(739)** | **(930)** | **(784)** | **(586)** | **(610)** |

| Period | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 |
|---|---|---|---|---|---|---|
| Year Frac | 0.708 | 1.708 | 2.708 | 3.708 | 4.708 | 5.708 |
| Discount factor | 0.927 | 0.833 | 0.749 | 0.673 | 0.605 | 0.544 |
| **Present Value of FCFF** | **(339)** | **(616)** | **(697)** | **(528)** | **(354)** | **(332)** |

## Terminal Value Calculations

| **Exit Multiple** | |
|---|---|
| Exit EV/EBITDA Multiple | 33.30x |
| Terminal year EBITDA | 2,835 *FY27* |
| Terminal value | 94,411 |
| PV of Terminal value | 51,366 |

| Model Output | |
|---|---|
| | **Exit Multiple** |
| PV of cumulative FCFF | (1,905) |
| PV of terminal value | 51,366 |
| Implied Enterprise Value | 49,462 |
| Terminal value as % of EV | 104% |
| | |
| Less: Debt | 1,078 |
| Add: Cash | 655 |
| Less: Minority Interest | - |
| Less: Preferred shares | - |
| **Implied Equity Value** | 49,039 |
| **Implied Share Price** | $505.76 |
| Upside / Downside (%) | *49%* |

| | | +1FY | | | | |
|---|---|---|---|---|---|---|
| **Company** | **Market Cap (INR bn)** | **P/E** | **EV/EBITDA** | **Beta** | **D/E** | **Unlevered Beta** |
| Fortis Healthcare | 198.14 | 42.70x | 18.30x | 0.38 | 0.22x | 0.32x |
| Apollo Hospitals | 697.95 | 52.90x | 28.50x | 0.47 | 0.77x | 0.29x |
| Aster DM Healthcare | 86.41 | 17.70x | 8.50x | 0.99 | 1.19x | 0.51x |
| Narayana Hrudayalaya Ltd | 142.52 | 44.00x | 20.90x | 0.57 | 0.58x | 0.39x |
| Dr. Lal PathLabs Ltd | 218.26 | 59.60x | 33.30x | 0.43 | 0.11x | 0.40x |
| Shalby | 14.07 | 30.30x | 12.50x | 1.37 | 0.20x | 1.18x |
| Krishna Institute | 110.79 | 31.20x | 18.80x | 0.59 | 0.08x | 0.56x |
| Metropolis Healthcare | 97.02 | 40.60x | 23.40x | 0.68 | 0.14x | 0.61x |
| Thryocare Technologies | 42.53 | 24.10x | 16.50x | 0.68 | 0.04x | 0.66x |

Screening Critera **Indian Private Healthcare**

| **Range** | **P/E** | **EV/EBITDA** | **Unlevered Beta** |
|---|---|---|---|
| 25th Percentile | 27.20x | 14.50x | 0.36x |
| Median | 40.60x | 18.80x | 0.51x |
| 75th Percentile | 48.45x | 25.95x | 0.64x |
| 90th Percentile | 59.60x | 33.30x | 1.18x |
| Max | 59.60x | 33.30x | 1.18x |

| **Relative Valuation P/E** | FY22 | Historical P/E | **FY23 (Forward)** |
|---|---|---|---|
| 75th percentile | 48.45x | 60.90x | 48.45x |
| +1FY EPS | 8.19 | 8.19 | 8.54 |
| **Implied Share Value** | **396.77** | 498.73 | **413.82** |

| **Relative Valuation EV/EBITDA** | FY22 | Historical EV/EBITDA | **FY23 (Forward)** |
|---|---|---|---|
| 75th percentile | 25.95x | 36.10x | 25.95x |
| +1FY EBITDA | 1,449 | 1,449 | 1,601 |
| Enterprise Value | 37,602 | 52,309 | 41,552 |
| Less: Debt | 1,078 | 1,078 | 1,078 |
| Add: Cash | 655 | 655 | 655 |
| Less: Minority Interest | - | - | - |
| Less: Preferred Shares | - | - | - |
| Implied Equity Value | 37,179 | 51,886 | 41,129 |
| **Implied Share Value** | **383.44** | 535.13 | 424.19 |
| | | | - |
| **Blended Share Price** | **390.11** | **516.93** | **419.00** |

| | | | |
|---|---|---|---|
| **Overall blended TP with forward multiples** | | | **462.38** |
| Implied Upside | | | ***36.1%*** |