Max Healthcare Institute Limited

Q2 & H1 FY27 Earnings Conference Call

November 03, 2026

Moderator: Ladies and gentlemen, good day, and welcome to the Max Healthcare Institute Limited Earnings Conference Call. Please note that this conference is being recorded. I now hand the conference over to Mr. Suraj Digawalekar from CDR India. Thank you, and over to you, Suraj.

Suraj Digawalekar: Thank you, Rayo. Good afternoon, everyone, and thank you for joining us on Max Healthcare's Q2 and H1 FY27 Earnings Conference Call. We have with us Mr. Abhay Soi, Chairman and Managing Director; Mr. Yogesh Sareen, Group Director and Chief Financial Officer; and Mr. Keshav Gupta, Group Director – Growth, M&A and Business Planning.

We will begin the call with opening remarks from the management, following which we will have the forum open for an interactive Q&A session. Before we start, I would like to point out that some statements made in today's call may be forward-looking in nature, and a disclaimer to this effect has been included in the earnings presentation shared with you earlier.

I would now like to invite Abhay to make his opening remarks. Thank you, and over to you, Abhay.

Abhay Soi: A very good morning and thank you for joining us today for Max Healthcare's second quarter and first half of FY27 Earnings Call.

We gained momentum in the second quarter, with revenue growing by 20%, operating EBITDA by 18% and PAT by 10%. Demand for quality healthcare remains strong across the hospital Network, with occupancy holding steady at 77%, despite a 14% year-on-year increase in operational bed capacity.

Occupancy and revenue across all 3 brownfield expansions, namely Max Nanavati in Mumbai, Max Mohali and Max Smart at Saket, Delhi, have ramped up very well and in line with our expectations. At Max Smart, the newly commissioned 260 beds achieved EBITDA breakeven within 3 months of operations and are now witnessing

high occupancy levels. However, the initial ramp-up of these beds did create a drag on EBITDA of Saket Complex during Q2. Excluding the Saket complex, revenue grew by 20% and EBITDA by 25%. We expect to commission the remaining 140 beds after Diwali puja.

Encouraged by these quick ramp-ups, we continue to explore opportunities to add capacity at our existing hospitals. In this regard, the Board has approved an investment of INR 415 crore towards addition of 209 brownfield beds at Max Noida, Max Vaishali and BLK-Max, along with a multi-level car park (MLCP) tower at BLK at the cost of approximately INR 85 crore. This is a part of the aforementioned INR 415 crore. Most of this capacity is expected to become available over the next 18 to 24 months.

During the quarter, 202 brownfield beds were added to the operational capacity, mainly at Max Smart, Max Lucknow, Max Noida and Max Dwarka. Services have also commenced at the new oncology block at Max Dwarka, which will enable addition of around 20 beds to the hospital in Q3 FY27.

Following the rights issue by Kalinga Hospital Limited, our shareholding has increased to 66%. A new leadership team has taken charge of Max Bhubaneswar and clinical teams have been added across gastroenterology, GI surgery, neurosurgery and orthopaedics. The hospital reported a revenue of INR 38 crore and EBITDA of INR 4 crore for the quarter. We have commenced renovation of this facility, and the first part will start rolling out towards the end of the year.

Now moving on to the Q2 performance highlights:

1) Average occupancy for the Network was 77%, similar to last year, despite a 14% increase in operational bed capacity.

2) Occupied bed days (OBDs) were up by 13% year-on-year and 7% quarter-on-quarter.

3) Average revenue per patient (IP ARPP) for the quarter stood at INR 2.31 lakhs, growing by 8% year-on-year. This growth was partly driven by a decline in institutional bed share to 29%, from 34% last year.

4) Network gross revenue stood at INR 3,219 crore compared to INR 2,692 crore in Q2 last year and INR 2,982 crore in the previous quarter. This reflects an increase of 20% year-on-year and 8% quarter-on-quarter.

Due to the discontinuation of select high-value chemotherapy drugs for institutional patients, as a result of CGHS rate revisions last year, the share of oncology for in-patient revenues dropped to 21%, from 26% in Q2 FY26.

Excluding oncology, gross revenue grew by 25% and ARPP grew by 11% year-on-year.

5) International patient revenue was INR 307 crore, registering significant growth of 33% year-on-year and now accounts for 10% of healthcare revenue from hospitals.

6) Digital revenue from online marketing activities, web-based appointments and digital lead management was INR 1,099 crore, accounting for approximately 34% of overall revenue. Website traffic crossed 1.14 crore sessions during the quarter, growing by 44% year-on-year.

7) Operating EBITDA for the quarter stood at INR 820 crore versus INR 694 crore in Q2 FY26 and INR 704 crore in the previous quarter, reflecting growth of 18% year-on-year and a significant growth of 16% quarter-on-quarter. While EBITDA per bed grew by 4% year-on-year to INR 77 lakhs per annum.

8) Operating EBITDA margin was 26.8%, similar to Q2 FY26, despite 14% increase in operational bed capacity, and reflected an improvement of around 200 basis points over the trailing quarter.

9) Profit after tax (PAT) for the Network was INR 448 crore, against INR 406 crore in Q2 last year (normalized for one-time tax gain of INR 149 crore) and INR 357 crore in the previous quarter, reflecting a growth of 10% year-on-year and 26% quarter-on-quarter.

10) The Network generated free cash flow of INR 500 crore during the quarter, of which INR 292 crore was invested in ongoing capacity expansion in projects and INR 195 crore was disbursed towards dividend.

11) Net debt for the Network stood at INR 2,369 crore compared to INR 2,384 crore at the end of June 2026, while the net debt-to-EBITDA ratio continued to remain below 1.

12) Continuing our efforts to support local communities, we provided free treatment to over 57,000 patients from economically weaker sections of the society worth INR 90 crore at hospital tariff, reflecting growth of 47% year-on-year.

13) Both our strategic business units continued to deliver steady growth in revenue and profitability:
    - Max@Home reported revenue of INR 86 crore, reflecting robust year-on-year growth of 37%. It offers 16 specialized service lines across 15 cities, with over 56% repeat transactions.
    - Max Lab reported revenue of INR 66 crore, reflecting year-on-year growth of 24%. It provides services in over 60 cities and served over 7 lakh patients during the quarter.

14) Now moving on to the status of our expansion projects coming on stream over the next few years:

    - The balance 205 beds at Max Nanavati and Max Smart: will be opened post Diwali puja.
    - 100 beds at Max Lucknow: in the existing 468-bed facility will be commissioned over the next 2 quarters.
    - 500 beds at Sector-56, Gurgaon: We expect to start phase commissioning of this facility by the end of this financial year.
    - 250 beds at Max Bhubaneswar: renovation of existing facility is underway, and we expect phased completion over the next 12 to 15 months, with the first part of the renovation being delivered by the end of this current calendar year.
    - 85 beds at Max Noida: will be commissioned by December 2027.
    - 100 beds at Max Nagpur: Project work continues to be on track, and we expect commissioning by December 2027.
    - 400 beds at Zirakpur, Mohali: Project is on schedule, and we expect commissioning it by December 2027.
    - 200 beds at Pitampura: Project is on track, and we expect commissioning in FY29.
    - 400 beds at Patparganj: We expect commissioning by end of FY29.
    - 260 beds at Max Dwarka: We are putting up a new brownfield tower over there, which is the next phase, since Dwarka Hospital is running at full capacity. The new tower will be commissioned by FY30.
    - 271 beds at Nanavati-Max in Phase 2: Project work has started, and we will be commissioning it by FY30.

- 450 beds at Pune: We have received the IOD. Project is expected to be commissioned by FY30.
- 200 beds at Max Vaishali, Tower 3: which is a new brownfield tower being constructed over there. Project work is underway, and we expect commissioning again by FY 2030.
- 400 beds at Shaheed Path, Lucknow in Phase 1: We are awaiting formal environmental clearance (EC) and building plans to commence construction activity at the site. We expect to commission Phase 1 by FY30.

And finally, moving on to the overview of the company's performance for the first half of financial year 2027:

15) Total bed capacity was around 6,200, a growth of 20% year-on-year.

16) Network gross revenue stood at INR 6,200 crore, reflecting growth of 18% year-on-year.

17) Operating EBITDA stood at INR 1,524 crore, registering growth of 17% year-on-year. While operating EBITDA per bed grew by 4% year-on-year to INR 74 lakhs.

18) Operating EBITDA margin was 25.9%, similar to H1 FY26. This is despite total bed capacity increasing by 20% year-on-year.

19) Profit after tax (PAT) for the Network was INR 805 crore, against INR 750 crore last year (normalized for one-time tax gain of INR 149 crore), reflecting a growth of 7% year-on-year.

20) In the first half, we generated INR 897 crore of free cash flow from operations, after interest, tax, working capital changes and routine capex. INR 629 crore was deployed towards ongoing expansion projects and facility upgrades at new units, INR 386 crore was spent towards the acquisitions of Kalinga Hospital Limited (Bhubaneswar) and Yerawada Properties Private Limited (Pune), and INR 195 crore was distributed as dividend.

With this, we open the floor for any questions you may have.

Moderator: Thank you very much. We will now begin the question-and-answer session. The first question is from Tausif Shaikh from BNP Paribas Securities India Pvt Ltd.

Tausif Shaikh: Good afternoon and thanks for the opportunity. My first question is related to de-empanelment of hospitals mentioned in the footnote. Can you tell us how many

hospitals has been de-empanelled and which are the ones? And do you further plan to increase the numbers? And what is the rationale behind this?

Yogesh Sareen: So, we de-empanelled BLK in May for CGHS and then the Railways, etc., because they were not paying us. We also de-empanelled ECHS at Shalimar Bagh. But I think as we feel pressure on the CTI segments, so we will have to take the call at individual hospital level.

Abhay Soi: It is a normal trajectory. The more mature hospitals or older hospitals, you see them de-empanelling and distilling their payor mix, whilst the newer hospitals, you empanel them and you take on more institutional business.

Tausif Shaikh: Sir, just want to understand, are these decisions taken voluntarily overnight by any hospitals? And would you seek empanelment of the upcoming Gurugram hospitals of CGHS and ECHS?

Abhay Soi: Yes, we will seek empanelment for the new Gurugram hospital. And like I said, for the older hospitals, you de-empanel. For example, most of the hospitals, which are going for brownfields, they do close to no institutional business. And once the new brownfield capacity comes in, you start empanelling and you start doing institutional business there as well.

Tausif Shaikh: That is helpful. My second question is related to the doctor attrition rate and the dynamics of Gurugram market. With one of your competitors recently commissioning the new hospital, but we haven't seen a good attrition of star doctors in the market. Just wanted to check your thoughts. Have you started talking to doctors and what gives the confidence that once we commercialize Gurugram, we will be able to onboard good clinicians at a very quick time?

Abhay Soi: Clinician attrition happens up to maybe 1% of the clinicians per year, which may go up by a very slight amount or not. Do keep in mind, it is not as if too many hospitals are coming up. We have plenty of hospitals. Anybody who is the head of admin in a hospital wants to head a hospital in 4 to 5 years.

If you are a senior consultant, you want to head a program in a few years and so on and so forth. So, you have to provide career progression as well. The fact is, if you do not grow and if you do not set up more hospitals, then your next line will go and join competition.

I think the fact that we are putting up our own hospital in Gurugram and other places, expanding in Delhi NCR, allows us to sort of retain and give opportunities to the

second line as well. We have 14 facilities in Delhi NCR, and we have over 4,000 clinicians working for us on a full-time basis here.

Tausif Shaikh: Just the last one, if I may. What is the potential impact on sales and EBITDA on the recent trade margin cap imposed by the Government on non-scheduled drugs? Any broad number would be helpful.

Abhay Soi: We are still working it out.

Tausif Shaikh Thanks, I will get back in the queue.

Moderator: Thank you. The next question is from Neha Manpuria from BofA Securities India Limited.

Neha Manpuria: Thanks for taking my question, Abhay, you mentioned that the commissioning of Smart had some impact on the Saket complex. Based on your understanding, how long do you think it would take for Saket to normalize? And given that we have a fair bit of brownfield capacity that is coming up, do you think you could see some sort of disruption like these in our other facilities that we need to account for?

Abhay Soi: No. See, we have always guided to the fact that a greenfield may take 6 months to 1 year to break even. Typically, we guide to 1 year in a greenfield. A brownfield breaks even within the first quarter itself. And we have always guided to that fact, right? When you come up with expanded capacity anywhere, you will have a preoperative expense over there because firstly, you will hire employees. You may not be hiring senior management or perhaps very senior level consultants or clinicians, but you do hire everybody else.

So, before you commission, you are carrying a cost. And after you commission, first, your occupancy ramps up, then the quality of the revenue ramps up and then the EBITDA ramps up. In the first quarter, you break even within the brownfield. And we have seen that – Mohali was the first to open, and we broke even in the first quarter, and then it ramped up. Similar was the experience at Nanavati-Max in Mumbai.

And you are seeing the same happening at Max Smart, Saket. The last quarter was really the first full quarter of its operations. And although it ramped up beautifully by the end of the quarter, I mean, there was an EBITDA drag in that complex. So, it is just a one quarter impact that you have in a brownfield. Nevertheless, there is a drag. Now what is the extent of the drag that you have EBITDA growth overall of about 20%, but if I remove that complex, it is 25%. But by next quarter, it comes back to normalcy, right? Because whatever drag has to happen, the maximum burden you face is preoperative immediately upon operations.

Neha Manpuria: Okay. Understood. So basically, you mean that because this is still in ramp-up mode, that dragged down the profitability.

Abhay Soi: Yes, absolutely. So, what happens is, let us say, we open 250 beds. In the first month, you will occupy 50 beds, second month, you will occupy another maybe 100-150 beds and by the end of third or fourth month, you are already occupying 250 beds. I mean that is why we are doing Diwali puja and starting an additional 150 beds there, right? But all of the 150 beds then start giving to the bottom line, more and more. Your EBITDA trajectory surpasses your revenue trajectory and you even get operating leverage.

Neha Manpuria: Yes. So, to your point that the EBITDA margin ramp-up should happen, let us say, in second or third quarter post commissioning, so we should see this drag probably normalize by March. Would that be a fair understanding?

Abhay Soi: To a large extent, it is already normalized. But yes, you will see that. Like I said, you have a drag when your occupancy is 50 beds out of 400. When your occupancy is 250 beds plus out of the 400 additional beds that you have put up, then your drag is that much less. I mean we are already hitting very high numbers. What you are seeing is sigma of the entire quarter.

Neha Manpuria: Understood. Okay.

Abhay Soi: There is a hockey-stick growth curve.

Neha Manpuria: Okay. My second question, just on Mumbai, if I were to see the bed addition that you give by state in Maharashtra, is it fair to assume that the -- for the Phase 2, the block that needs to be taken down, that is been taken down. That is why the ramp-up that we are supposed to see in Nanavati, that is not reflected in Maharashtra's operational beds?

Abhay Soi: That is right. So those beds are discontinued and the balance 50 beds in new tower will start after the puja. Do keep in mind the quality of the beds, which have been brought down, are basically economy class. So, the quality of the beds is not very significant.

Abhay Soi: So, it is not an equivalent amount of drag. But yes, Mumbai has already passed that point of the revenue and EBITDA ramp up.

Neha Manpuria: Okay. My last question on the -- I know you said that you are still assessing the onco margin cap. But broadly, there has been a fair bit of noise around the drug devices, consumables, etc., and the margins made by hospitals. If you could give us any

comments on what you think is being misunderstood or how would you probably put forward your position on this, that would be very helpful.

Abhay Soi: I think the position of the sector has been put across in the court. The matter is sub judice. And I think it is quite clear what the position of the hospital providers is and so is the position of the Government. So, I think more than what you hear in the media, I would urge everybody to actually see what the Government is impleading and what statements were made, whether it is by the Government or the hospital sector.

I think the hospital sector pretty much stands by the fact that the median net profit of the entire sector, if I was to look at last quarter's numbers, is about 9%, if I am not mistaken, in a capital-intensive sector. But historically, it's been a product-based pricing industry rather than a services-based pricing industry. So, we will have to possibly recalibrate that going forward depending on the pulls and pushes. But I think this is where it is. But like I said, the matter is sub judice and I think many wise minds will be opining on it.

Neha Manpuria: Sure, sure. That is helpful. Thank you so much, Abhay.

Moderator: Thank you. Next question is from Damayanti Kerai from HSBC Securities and Capital Markets (India) Private Limited.

Damayanti Kerai: Thank you for the opportunity. My question is regarding your comment on the payor-mix change. So, as you said, you will keep on evaluating the mix exposure to CGHS channel, et cetera. And I think during the quarter, you reported the revenue contribution from this channel is around 18.5%, 300 bps lower than the previous year. So, will this be the level of revenue share which you intend to maintain? Or there will be volatility depending on how you see the change in payor mix part?

Abhay Soi: No, we are reacting to as and when new capacities come up. Those capacities will take on institutional business. And as some capacities mature, they will be moving away from institutional business. Some part of this revenue reduction is due to discontinuation of high-value oncology drugs following the CGHS rate revisions. So, this has also contributed to that percentage reduction.

Damayanti Kerai: Sure. And earlier, you mentioned that you would obviously like to bring down exposure to the institutional channel. So, any number you have in mind where you intend to move ahead?

Abhay Soi: No. I do not think there is any intention to reduce the exposure to the institutional channel. The best case for us, I mean, is that if we increase capacity in a particular place, then we are able to serve both the businesses. But what happens is that as

capacity comes under pressure, automatically lower ARPOB business starts getting filtered or the lower ARPP business starts getting distilled. But the best-case scenario is if we can keep increasing capacity over there to cater to both.

I will give you a very specific example of our hospital in Mumbai, where there was no institutional business. But because we had capacity expansion there, we were able to put up more capacity, and now we were able to accommodate both. Whereas in another hospital, let's take BLK, where there is capacity pressure, we have to de-empanel it. So that sort of shift will continue.

Damayanti Kerai: And this empanelment-de-empanelment, whether that will be, again, a case-on-case basis, right? And I just want to understand, say, you have dis-empanelled CGHS at BLK hospital. So, in the future, if you want to re-empanel, will that be a possibility? Or how that goes then?

Abhay Soi: We have not de-empanelled them. We have got ourselves de-empanelled. You are empanelled, and later when you choose not to, then you apply to them and you get yourself de-empanelled from it. And yes, I mean, if as and when we expand that particular facility, we may, at that stage, re-empanel ourselves. But let us say, in the case of BLK, we are only adding about 64 beds. So, we may not do that since it is not a large capacity that is getting added.

Damayanti Kerai: Understood. My second question is on the regulatory headwinds, which we are seeing for oncology drug specifically, I think in last year as well as the recent development. So, while the matter is under the court, what do you think like which other segments can really help you to offset the impact of these regulatory headwinds in oncology, whether like you will be preferring some other sector over oncology as your key driver?

Abhay Soi: We react to the burden of diseases in the market. And you have seen that it is not as if other diseases are not growing. They have all grown by around 20% year-on-year, right? Eventually, we have inventory over there. Although we have a loss in revenue, it is not as if we have a reduction in occupied bed days to that same extent, right? I mean, we do not see that as something that is going to have an adverse impact.

Damayanti Kerai: Okay. So, the top 4 or 5 segments, generally we call CONGO-R. So that proportion should continue to increase, some part getting offset by others…

Abhay Soi: No, you need to put this in perspective. We have inventory. We have various specialties and patients. When a patient comes to the ER or a comes for elective surgery, we do not ask him "Are you for oncology or are you for cardiac?" We dot not

ask the cardiac patient to wait an and tell the oncology patient that he gets an accelerated sort of admission path. It does not work like that. At the point, it depends on whichever bed is available. We have not seen a reduction in occupied bed days of any particular specialty.

Damayanti Kerai: Sure. Okay. Thanks. Thank you for your response. That is helpful. I will get back in the queue.

Moderator: Thank you. The next question is from Karan Vora from Goldman Sachs.

Karan Vora: Thank you for taking my question. My first question is with respect to the Gurgaon greenfield, which is expected to come online by the end of the year. So just wanted to get a sense on how many -- like are we expected to like in the Phase 1, do all the 500 beds? Or will it be split? And what could be the EBITDA impact from the same? Any breakeven timelines, etcetera, you would like to highlight?

Abhay Soi: Yes. So, we typically start with 150-200 beds, ramp them up, hit breakeven, and then we try to open more beds. And you have seen a similar trajectory in Dwarka as well. There is no benefit in opening all 500 beds if we do not have occupancy on day one. And we cannot have day one occupancy of 500 beds; it does not operate like that. There is still a ramp-up period.

When we opened 300 beds in Dwarka, we had an EBITDA loss of INR 30 crore. You can estimate based on that. If I was to draw a line in the sand, it would be around INR 40-50 crore. We are still working that number, but it should not be more than that.

Karan Vora: Got it. And the second question is with respect to CGHS. So, you mentioned that we have successfully done this strategy of kind of taking in CGHS patients in new beds. So just wanted to get a sense on in such instances, how do you ensure that the patient perception of the premium-ness of hospital does not get impacted when a lot of CGHS kind of patients come through?

Or even for that matter, in some of the hospitals where we have like north of 75%, 80% occupancy, how do you ensure all the -- like because it means that the hospitals are completely full, right? So how do you ensure that the service levels as well as the patient perception not get impacted because of such high occupancy?

Abhay Soi: When you open a new hospital, if we had occupancy of 500 beds, we would probably open all 500 beds. But when you do open a new hospital, you do not immediately have occupancy for 500 beds, right? So, I mean, first and foremost, what you do is you take business – lower ARPOB business, lower clinical mix, whatever else it is.

The perception does not get affected by institutional business or whatever else it is. I think 40% of our business is still upcountry.

Keshav Gupta: Karan, there is no specific intent to have a different perception for the different patient pools. The system is neutral to which sponsorship category the patient comes from.

Abhay Soi: They start distilling automatically.

Karan Vora: Got it. And just one follow-up here. So, the empanelment when we de-empanel, but the empanelment in itself will also be of a certain period, right? So maybe a 1-year or a 2-year empanelment. So, once we empanel ourselves to any particular hospital to that CGHS scheme, what is the minimum time frame for which we have to abide by it?

Abhay Soi: It is a 6-month ever-greening process. We sign an agreement and we keep ever-greening it every 6 months.

Yogesh Sareen: And you can give a 1-month notice if you want to de-empanel. Either side can give the notice.

Karan Vora: Got it. Helpful. Thank you.

Moderator: Thank you. The next question is from Rahul Jeewani from IIFL Capital Services Limited.

Rahul Jeewani: Thanks sir, for taking my question. With respect to the 2 greenfields which is Sector 56 Gurgaon and Zirakpur, Mohali. For 56 Gurgaon, you talked about INR 40 crore to INR 50 crore kind of an EBITDA loss. So, would that loss be just in the initial few quarters or you would expect this drag for the full year of FY28? And similarly, if you can also talk about what kind of EBITDA drag we should build in from Mohali in FY29?

Abhay Soi: Normally, we guide to a one-year breakeven. We broke even in 6 months in Dwarka. So, I guess the answer will be somewhere around that. At Dwarka, we had 300 beds in Delhi. It had, like I said, around INR 30-35 crore EBITDA loss. This was cumulative peak EBITDA loss.

Rahul Jeewani: Okay. Sure, Abhay. And Zirakpur, Mohali should also have a similar kind of a loss in FY29? Or would you expect that number to be slightly lower?

Abhay Soi: Lower, much lower. Around INR 30 crore. We will work out the numbers and provide more precise figures later, but roughly around that. We will have a better idea when we start onboarding teams of clinicians, etc. That is the time we will know what the

trough is, what the pre-operating expenses are and what our day one expenditure is going to be.

Rahul Jeewani: Sure. And just on, let us say, this impact of the...

Abhay Soi: If we are opening something in December next year, 12 months down the line, we have not started onboarding the teams yet. So, we do not know what the cost of the team will be. Therefore, we are not trying to be evasive, but we can only give you a line-in-the-sand answer at this stage.

Rahul Jeewani: Sure. So, the second question is with respect to the impact from the discontinuation of chemotherapy drugs. So that impact started from third quarter of last year. So, with the impact anniversarizing in third quarter of this year, would you expect this top line growth, which we delivered of around 20%, to accelerate further going into third quarter and fourth quarter?

Abhay Soi: Yes, that should be the case because you are coming off a lower base.

Rahul Jeewani: And that would also be aided by the fact that you would have some of these incremental brownfield and greenfield expansions coming and helping in too?

Abhay Soi: That is true.

Rahul Jeewani: That's it from my side.

Moderator: Thank you. The next question is from Dhara Ganatra from UTI Pension Fund.

Dhara Ganatra: Thank you for taking my question. My question is largely on this trade margin cap that has come out. What is the share of pharmacy in your revenues and EBITDA? And within that, if you can also highlight how much would be the medical oncology part of it? So, excluding the surgeries and all on the oncology part, how much would be the pharmacy share?

Yogesh Sareen: Actually, chemotherapy generally accounts for 30% of the overall oncology revenues. Now, within that, you know there is a mix of some ORC and monopoly drugs for which there is no impact of this price cap. So, once we get the new revised MRPs, we will be able to assess what the impact is on that proportion. But that is what the story is.

Yogesh Sareen: CGHS is already baked in here.

Abhay Soi: The CGHS impact on oncology we mean...

Yogesh Sareen: Yes. That is already baked in here.

Dhara Ganatra: Right. So still what is the kind of impact that you all have internally assessed as management? Anything that you would like to put out as an estimate?

Abhay Soi: We have not. We are working it out. Like I said, only part we know is that the CGHS impact won't be there because that impact already happened last year.

Dhara Ganatra: Sure, sir. That is all from our side. Thank you.

Abhay Soi: Thank you.

Moderator: Thank you. The next question is from Bino Pathiparampil from Elara Securities (India) Private Limited.

Bino Pathiparampil: Hi. Good afternoon. Sorry, just a follow-up on the previous question. How much did you say is the contribution of pharmacy to the overall revenue, all pharmacy together, not just oncology?

Abhay Soi: I did not give you a number.

Bino Pathiparampil: Okay. But in a general sense, could it be 15%, 25%, 35%?

Abhay Soi: These are bundled services. For example, you have chemotherapy, but then you also have the mixing charges, etc., bundled with it. So, it is a little difficult to find out what the pharmacy part is because, in packages, you would have to split it out. How do you work it out?

Bino Pathiparampil: Understood. And what part of the total revenue will be package services and what would be like as you pay as you go kind of service?

Yogesh Sareen: It depends on which segment you are talking about, whether self-pay or insurance. But it would be anywhere between 20% to 30%, because CGHS also has some packages.

Bino Pathiparampil: Sorry, 20% to 30% would be packed services?

Yogesh Sareen: Yes, depending on who the customer is.

Bino Pathiparampil: Okay. So, for the remaining 70%, you would be able to give some sort of contribution of revenue, right, contribution of pharmacy to the revenue, right?

Yogesh Sareen: We would not be able to tell you. We know the overall pharmacy numbers, but we would not be able to tell you what the balance is, what is the pharmacy component is, etc. That is not the way we look at the numbers.

Bino Pathiparampil: Okay. But we are looking for roughly a rough estimate of the 70% where we...

Abhay Soi: You would have to unbundle services, which is not possible. I mean, you know the overall net profit.

Bino Pathiparampil: Understood. Thank you.

Abhay Soi: Thank you.

Moderator: Thank you. The next question is from Sidharth Negandhi from CWC Advisors.

Sidharth Negandhi: Thank you for taking my question. You mentioned that the ex-oncology growth is 25% in revenue. Could you help me understand what would that also mean in terms of EBITDA growth? And second, while you alluded earlier in the call to not really having a particular set patient mix, there has also been a decrease in the cardiology salience, which means cardiology would have grown slower than the overall revenue. While we do not see that in the allied space in pharma of any slowdown in the cardio growth. Is there anything that may be happening there due to increasing competitive intensity? Or what is your read on the cardiology growth being slower? Yes, those are the 2 questions.

Abhay Soi: Cardiology is typically a seasonal business. So, during winter season, you have higher incidence of cardiology cases and you know that's the time there is lower incidence of orthopaedic cases. So, are you looking at quarter-on-quarter or year-on-year?

Sidharth Negandhi: Year-on-year.

Yogesh Sareen: I am not sure what your question is. I think you are saying the oncology impact is because of the chemotherapy drugs discontinuation, right? So, as a result, if we take oncology out, then the revenue growth is obviously higher because last year, you had those chemotherapy drugs and this year, you do not have. And that is the reason you find that the oncology's share is also down as a percentage of the total revenue, right?

Sidharth Negandhi: Correct. So, sir, what I wanted to understand is revenue ex-oncology is higher by 25%. Could you help us also understand what that has meant on EBITDA growth? Is EBITDA growth also significantly higher because of the same oncology impact? That was question one. On cardiology, just to clarify, I was looking at it year-on-year, not quarter-on-quarter, and that is where the question was?

Abhay Soi: The EBITDA growth would be higher, right? Therefore, your EBITDA margin is the same as last year in spite of that revenue going out of the books.

Yogesh Sareen: No, we cannot impute a value which is not there in the P&L. We cannot just say that this would have been the value. So, obviously, the drop in chemotherapy drugs had an impact on the margin. We said last time that the overall impact of chemotherapy drugs being discontinued is roughly around INR 100 crore in a year. But nevertheless, we had a net gain of INR 200 crore from the CGHS price revisions. This is the number that we have given earlier.

Abhay Soi: So, you cannot take one without the other. I mean, net-net, there was a gain because of price revision of CGHS. One part of it was oncology, where we had a loss.

Sidharth Negandhi: Thank you.

Abhay Soi: We had 16% growth in cardiology as well.

Moderator: The next question is from Prashant Kshirsagar from Unived Corporate Research Private Ltd.

Prashant Kshirsagar: Good afternoon, sir. My question is on Noida Super Specialty Hospital. Can you share the occupancy level in Q1 and Q2 numbers, if you can?

Abhay Soi: On Noida?

Prashant Kshirsagar: Yes.

Abhay Soi: We do not share specific hospital level occupancy numbers.

Prashant Kshirsagar: Okay. And secondly, the 85 beds, which will become operational in brownfield expansion in Noida, that would be above the 504 beds you have? Or will it be 377 beds plus?

Keshav Gupta: It is part of the 500-bed complex. Currently, 400 beds are operational and we will be adding 85 beds to that activated bed capacity.

Abhay Soi: Somewhere there is the answer when you do a brownfield because your capacity utilization is high. Otherwise, we would not be adding 85 beds.

Prashant Kshirsagar: Yes. So, it will be basically towards the 700-bed hospital, which will be...

Abhay Soi: No, no. That is additional.

Keshav Gupta: Just to clarify, the entire site is 18 acres. The current structure has a 500-bed capacity, of which 400 beds are active. We will be activating another 85 beds in the same complex. The residual 11 acres remain unused, where we can add 700 beds. That is a separate phase that we have mentioned in our earlier communications.

Prashant Kshirsagar: Okay. Fine. And my second question is on the Greater Noida. In the earlier presentations, you had mentioned that there is a land parcel for 400 beds. So, do you have an existing hospital in Greater Noida or you do not have?

Abhay Soi: No, we do not have.

Yogesh Sareen: We only have a piece of land there.

Prashant Kshirsagar: So, you only have a piece of land there. Okay. That clarifies my question. Thanks a lot.

Moderator: The next question is from Divya Makwana from Ajcon Global Services.

Divya Makwana: Hi. Thank you for taking my question. And most of my other questions have already been addressed. So, I will just ask one about Max Lab and Max@Home. We have seen healthy year-on-year growth of around 24% and 37%, respectively, this quarter. However, their contribution to the overall business is relatively small.

So, what are the key growth drivers for these two businesses going forward? And over the next 3 to 5 years, do you see them becoming meaningful contributors to the group's overall growth and profitability?

Abhay Soi: I think the key drivers of these businesses continue to be what they have been in the past. I think there is a need, and our patients and our brand help. We have seen the same level of healthy growth in the past as well. I mean it is always plus or minus 4-5 percentage points, but it has been around 20-25% CAGR over many years.

And I mean they have been growing at a good pace. We are happy to see that percentage contribution of these businesses of the overall revenue remain the same, so long as our other businesses also keep growing at this pace. And as you are aware, our other business has also been growing at about 20% over the last 5 years.

So, I mean that is the only reason, similar to international business, that they remain a smaller percentage of revenue, or their share of revenue remains static, even though they have been growing on a standalone basis. And of course, we see these businesses becoming meaningful over the years to come.

Otherwise, we would not be doing these businesses. We do not do businesses just because they are short-term cash cows. We see them as cars of the future, and we continue to invest in these businesses. They are already quite profitable.

Divya Makwana: Okay, that is helpful. Thank you.

Moderator: We will be able to take one last question. We take the last question from Prince Goenka from Narnolia Financial Services Ltd.

Prince Goenka: Thank you, for taking my question. I have 2 questions. That is first one, in Bhubaneswar, 80 beds currently shut for renovation. So, what is the timeline for making them operational? And what occupancy and EBITDA levels do we expect over next 2 to 3 years?

And the second one is, how are employees and doctors related costs trending as a percentage of revenue? Do we expect operating leverage to improve as newly added capacity mature? Or will manpower costs continue to put pressure on margins?

Keshav Gupta: The first one, the renovation phase should last about 12 months. In the first phase, we expect to get delivery of few OTs and beds in about 3 months' time. Over the next 2 to 3 years, we will add another tower with 250 beds on that site. What was your question on manpower and operating leverage?

Prince Goenka: Do you expect any operating leverage to improve as newly added capacities mature or will manpower costs continue to put pressure on margins?

Keshav Gupta: For the new brownfield facilities that have been commissioned, there will obviously be operating leverage. That is what we mentioned at the beginning of the conversation. As the capacity fills up, operating leverage gets triggered. And the same thing will happen for Bhubaneswar as well.

Prince Goenka: Okay. And one more question. Of the 20% revenue growth in Q2 how much came from higher patient volumes versus improved average bill realization per patient?

Keshav Gupta: We have mentioned this earlier. The ARPP and the IP volume growth figures have been disclosed in our presentation. In-patient volume growth was about 12%, while ARPP growth was 8%.

Moderator: Thank you very much. We will take that as the last question. I would now like to hand the conference over to the management team for closing comments.

Abhay Soi: Thank you, everyone, for joining us today. We appreciate your time and look forward to interacting once again with you next quarter. Thank you.

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