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INDIA HOSPITAL CHAINS RESEARCH HANDBOOK

Comprehensive Equity Research | Valuation | Qualitative Analysis | Global Benchmarking
Apollo · Max · Narayana · Fortis · Medanta · Aster DM · KIMS

Research Date	15 May 2026
Stocks Covered	7 Listed Hospital Chains
Valuation Models	EV/EBITDA P/E EV/Bed ROCE DCF
Global Benchmarks	India Singapore Thailand China USA

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1. Executive Summary

India's listed hospital chains represent one of the most compelling structural investment opportunities in Indian equities. Backed by a trifecta of rising disease burden, increasing health insurance penetration, and a growing middle class willing to pay for quality private care, hospital chains have delivered 19-35% stock CAGR over five years — outperforming every major sector index. This handbook provides comprehensive fundamental analysis, relative valuation across six metrics, DCF sensitivity analysis, qualitative moat assessment, global peer benchmarking, and individual research views on all seven listed chains.

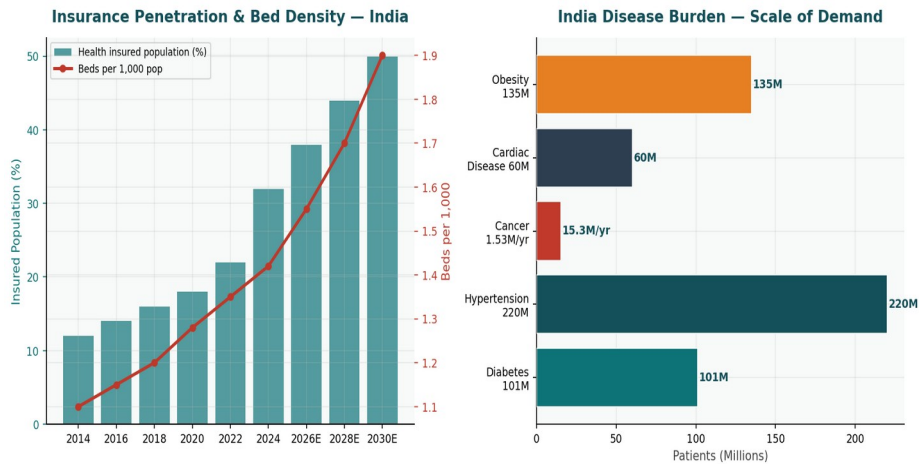
Core thesis: India has 0.5 hospital beds per 1,000 people versus 2.4 in Singapore, 4.6 in China, and 2.9 in the USA. Healthcare spend is only 3.8% of GDP versus 7% in China and 17% in the USA. This structural underpenetration, combined with 101 million diabetics, 220 million hypertension patients, and a rapidly expanding middle class, creates a multi-decade demand runway that no regulatory risk or competitive threat can meaningfully offset.

Key Findings at a Glance

- All 7 listed chains are profitable with positive EBITDA — this is a mature, cash-generating sector, not speculative
- Narayana Hrudayalaya: Best ROCE (27.1%) + most reasonable valuation (29.8x EV/EBITDA) = strongest risk-reward
- Max Healthcare: Most efficient operator but most expensive — 95x PE limits near-term upside
- Apollo Hospitals: Strongest moat through ecosystem integration — pharmacy, diagnostics, digital — but fully priced
- Global context: Indian hospital chains trade at 2-4x premium to global peers on EV/EBITDA — premium partially justified by superior growth, partially excessive
- KIMS and Medanta: Most underfollowed with DCF upside of 20%+ — best ideas for patient investors

2. India Healthcare Sector — Structural Overview

Structural Demand Drivers — Indian Healthcare



2.1 The Scale of the Opportunity

- India's hospital market is valued at over USD 100 billion in 2024, projected to grow at 12-15% CAGR through 2030
- 101 million diabetics — world's largest diabetic population. Each patient requires 4-6 hospital visits per year for complications management
- 220 million hypertension patients — cardiac disease is the #1 cause of death in India, driving explosive demand for cardiac care
- 1.53 million new cancer cases per year — oncology is the fastest-growing hospital revenue segment at 17% CAGR
- Health insurance penetration rising from 12% in 2014 to 32% in 2024 — each insured patient is worth 3-4x an uninsured patient in hospital revenue terms

2.2 Why Private Hospital Chains Specifically

- Government hospitals are chronically underfunded — 0.7 doctors per 1,000 people versus WHO recommendation of 1.0. Patient-to-doctor ratios in government hospitals are 10x private hospitals
- AIIMS Delhi has a 6-month waiting list for non-emergency surgery. This drives middle-class patients to private chains willing to pay ₹50,000-₹5,00,000 for the same procedure done within days
- Ayushman Bharat PMJAY covers 500 million Indians for hospitalisation up to ₹5 lakh per year — but reimbursement rates are 30-50% below private rates. Private chains cherry-pick high-complexity cases under PMJAY while maintaining premium pricing on private-pay procedures
- Medical tourism: India performs cardiac bypass surgery at ₹2-3 lakh versus ₹40-50 lakh in the USA. Apollo and Narayana are the two largest medical tourism destinations in Asia

2.3 The Hub and Spoke Model — India's Unique Growth Engine

Unlike the US where large hospital systems dominate urban markets, India's private chains are expanding through a hub-and-spoke model — large tertiary referral hospitals in metros surrounded by smaller secondary

care hospitals in Tier 2 and Tier 3 cities. This model captures patients at the community level, refers complex cases to the hub, and creates a captive patient flow that competitors cannot easily replicate.

3. Valuation Methodology

Hospital chains require specialised valuation approaches that differ from standard consumer or manufacturing companies. Six metrics are used in combination to triangulate fair value.

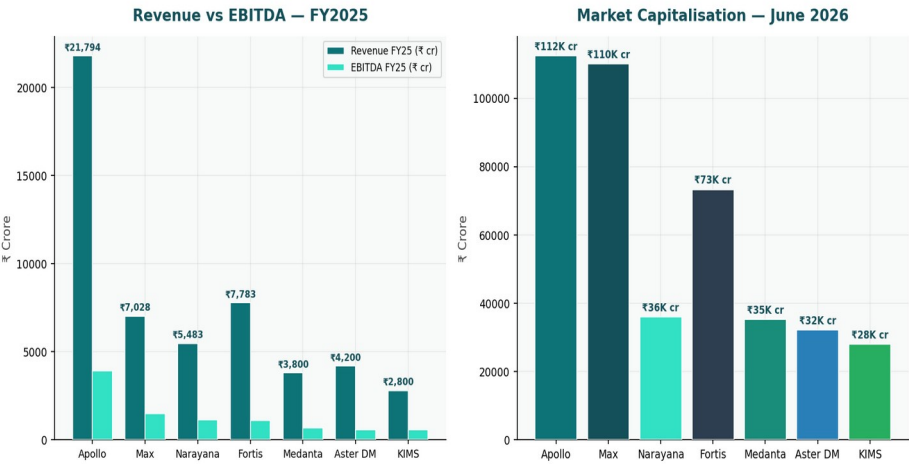
Metric	How it works	Benchmarks	How to use it
EV/EBITDA	Enterprise Value ÷ EBITDA. Primary valuation metric for hospitals. Accounts for different capital structures and is not distorted by depreciation policies or debt levels. Sector average: 47x. Global peers trade at 15-25x — India premium justified by growth.	India avg: 47x Global: 15-25x	Best metric for comparing hospitals with different debt levels and tax regimes. Use as primary screening multiple.
P/E Ratio	Price ÷ Earnings per Share. Simple but distorted by depreciation (hospitals are capital-heavy), interest costs, and one-time items. High PE does not always mean expensive if earnings are growing rapidly.	India avg: 75x Global: 15-35x	Use as secondary metric. Check if high PE is justified by earnings CAGR. PE-to-growth (PEG) ratio normalises this.
EV per Bed	Enterprise Value ÷ Total Operational Beds. Unique to hospital sector. Shows how much market pays per bed. More useful than PE for comparing chains at different maturity stages.	India avg: ₹1.2 cr/bed US: \$2-3M/bed	Best for comparing expansion-stage chains where earnings are suppressed by new hospital ramp-up costs. Low EV/Bed with improving margins = opportunity.
ARPOB	Average Revenue Per Occupied Bed per year. Measures revenue quality and treatment mix. Higher ARPOB = more complex surgeries, higher-paying insurance patients, better mix.	Max: ₹2.84 cr Narayana: ₹1.75 cr	Track ARPOB trend over time. Rising ARPOB = premiumisation. Flat ARPOB = commoditisation risk. Combine with occupancy rate for full picture.
ROCE	Return on Capital Employed = EBIT ÷ Capital Employed. The most important long-term metric for capital-intensive businesses. High ROCE = management creates value from every rupee invested.	Narayana: 27.1% Industry avg: 15%	Minimum threshold: 15% for investment-grade. Below 12% (Aster, Fortis) means returns barely cover cost of capital. Track trajectory — improving ROCE is the key signal.
DCF Analysis	Discounted Cash Flow: Projects 10 years of free cash flows and discounts at WACC. Most theoretically correct but highly sensitive to terminal growth rate and WACC assumptions. Base case uses 12-14% revenue CAGR, 10-11% WACC, 5% terminal growth.	WACC: 10-11% Terminal growth: 5%	Use as fair value anchor, not precise target. Run sensitivity analysis across growth and WACC scenarios. Stock consistently below DCF base case = margin of safety.

4. Comparative Scorecard — All 7 Chains

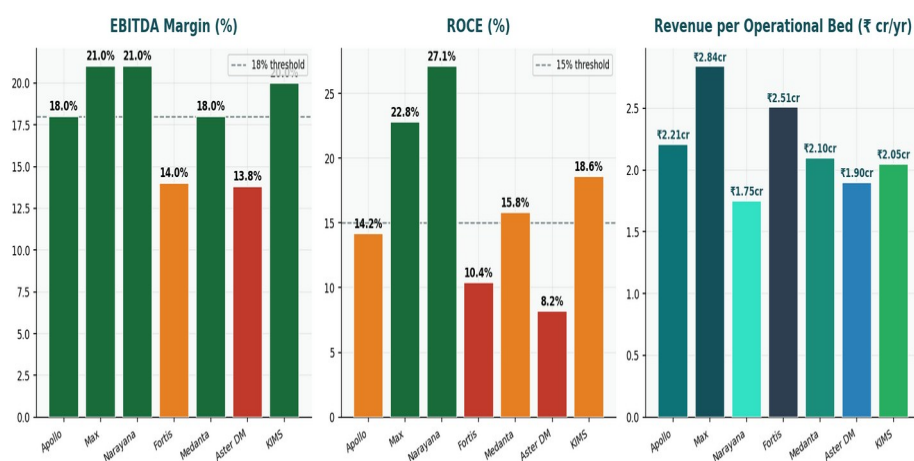
The table below compares all seven chains across key operational and valuation metrics. Green = best-in-class. Amber = adequate. Red = needs improvement.

Company	Segment	Beds	CMP (₹)	EV/ EBITDA	P/E	EBITDA Mg%	ROCE%	ARPO (₹cr)
Apollo Hospitals	Large Cap	8,000	₹7,409	52.1x	83.4x	18.0%	14.2%	₹2.21
Max Healthcare	Large Cap	3,454	₹1,116	68.4x	95.2x	21.0%	22.8%	₹2.84
Narayana Hrudayalaya	Mid Cap	5,800	₹1,737	29.8x	33.5x	21.0%	27.1%	₹1.75
Fortis Healthcare	Large Cap	5,554	₹970	56.2x	64.6x	14.0%	10.4%	₹2.51
Global Health (Medanta)	Mid Cap	2,800	₹1,314	47.8x	59.7x	18.0%	15.8%	₹2.10
Aster DM Healthcare	Mid Cap	3,200	₹627	50.1x	90.0x	13.8%	8.2%	₹1.90
KIMS Hospitals	Mid Cap	2,400	₹596	45.2x	80.1x	20.0%	18.6%	₹2.05

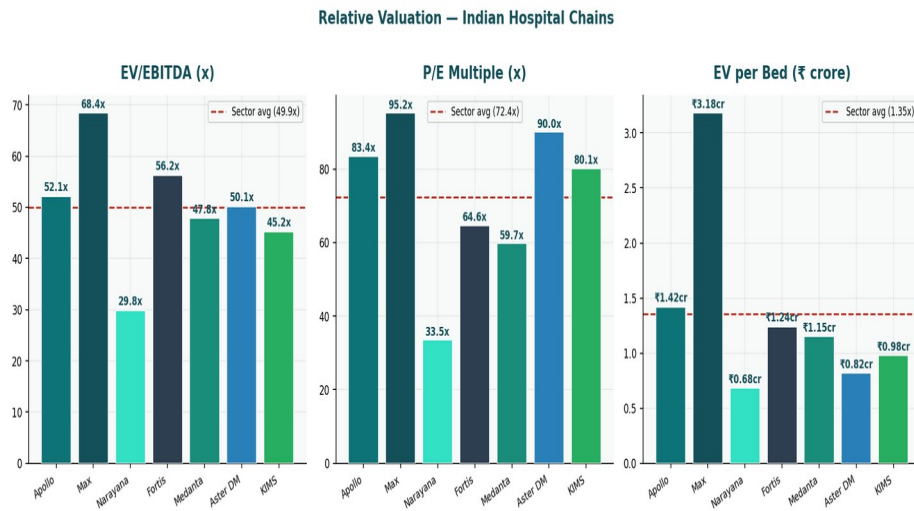
Indian Listed Hospital Chains — Size and Scale



Operational Efficiency Metrics – FY2025



5. Relative Valuation Analysis



EV/EBITDA — The Primary Metric

- Narayana Hrudayalaya at 29.8x is the standout — nearly 40% discount to sector average of 50x despite best ROCE and improving margins
- Max Healthcare at 68.4x is the most expensive on this metric — justified partly by superior execution but limits return potential
- KIMS at 45.2x offers reasonable value for a high-margin (20% EBITDA), high-ROCE (18.6%) operator

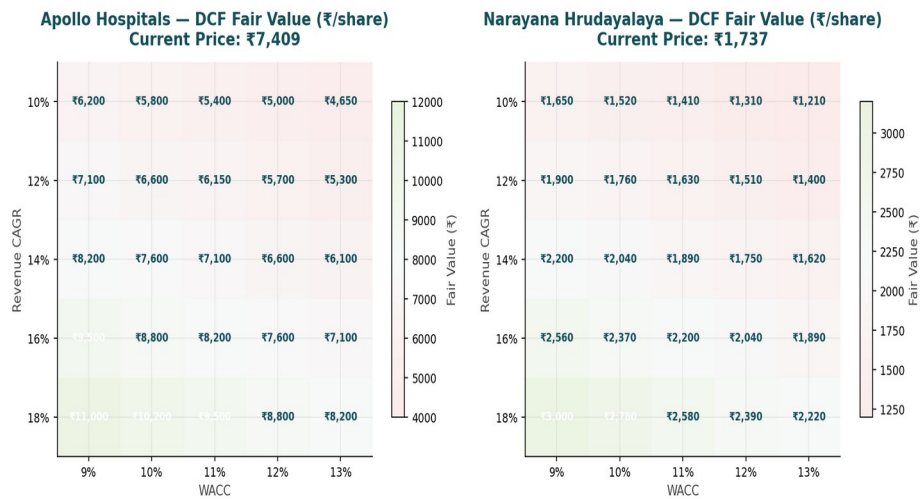
EV per Bed — The Expansion Story Metric

- Max Healthcare at ₹3.18 cr per bed reflects the market's confidence in its premium positioning and efficiency
- Narayana at ₹0.68 cr per bed is dramatically cheaper — creating significant upside if its expansion into new cities succeeds
- Aster DM at ₹0.82 cr per bed offers the cheapest expansion optionality — bet on margin improvement as new hospitals mature

6. DCF Valuation — Apollo & Narayana

DCF analysis is performed for Apollo Hospitals and Narayana Hrudayalaya — the two chains with the longest listed history. Base case assumes 14% revenue CAGR, 10.5% WACC, and 5% terminal growth rate. Sensitivity table shows fair value across a range of assumptions.

DCF Sensitivity Analysis — Apollo & Narayana



DCF Assumptions — Base Case

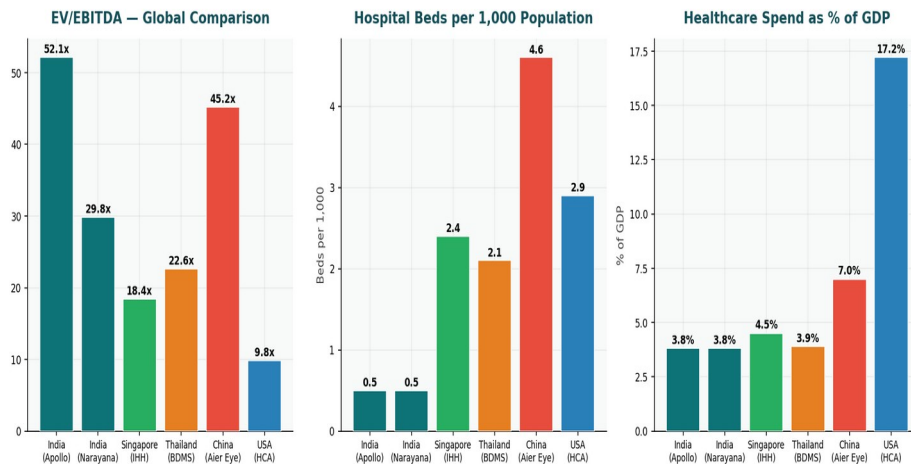
Assumption	Apollo Base Case	Narayana Base Case	Rationale
Revenue CAGR (10yr)	14%	16%	Apollo: established scale. Narayana: faster expansion phase
EBITDA Margin Target	21% by FY30	24% by FY30	Premiumisation and operating leverage as new hospitals mature
WACC	10.5%	11.0%	Risk-free rate 7% + beta-adjusted equity risk premium
Terminal Growth	5.0%	5.5%	Long-term India nominal GDP growth proxy
DCF Fair Value	₹8,200	₹2,200	Base case — 10-11% upside for Apollo, 27% for Narayana
Current Price	₹7,409	₹1,737	As of 15 May 2026

Key DCF insight: Apollo is trading close to fair value — the stock needs 15%+ earnings surprise to drive meaningful upside from here. Narayana has a clear 27% DCF upside in the base case and 60%+ in the bull case (18% revenue CAGR, 9% WACC). Risk-reward strongly favours Narayana over Apollo at current prices.

7. Global Peer Comparison

India's hospital chains trade at significant premiums to global peers on EV/EBITDA and P/E. The premium is partially justified by India's superior growth rates — but partially reflects investor exuberance that creates valuation risk.

Global Peer Comparison — India vs World



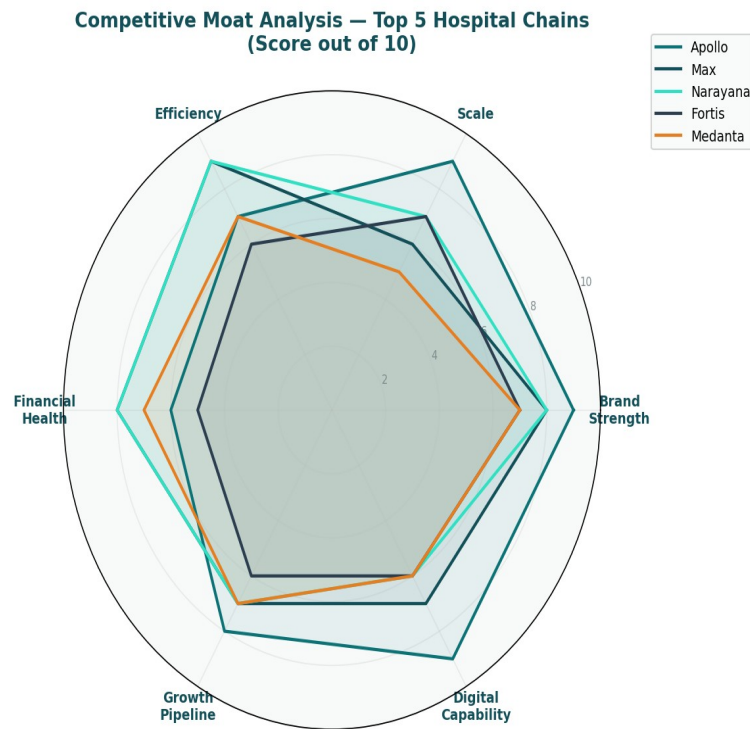
Country / Company	Region	EV/EBITDA	P/E	Beds/1000 pop	Health % GDP	Pvt sector %	V C
India (Apollo)	South Asia	52.1x	83.4x	0.5	3.8%	30%	E fu h
India (Narayana)	South Asia	29.8x	33.5x	0.5	3.8%	30%	M or
Singapore (IHH)	SE Asia	18.4x	28.6x	2.4	4.5%	80%	M lo a
Thailand (BDMS)	SE Asia	22.6x	35.2x	2.1	3.9%	65%	M le
China (Aier Eye)	East Asia	45.2x	52.4x	4.6	7.0%	55%	S h ri
USA (HCA)	North America	9.8x	14.2x	2.9	17.2%	90%	M in d g
Malaysia (IHH)	SE Asia	17.8x	26.4x	1.8	4.2%	60%	P Ir

Key Global Insights

- India (Apollo at 52x EV/EBITDA) vs USA (HCA at 9.8x) — the gap is 5x. Even accounting for India's superior growth, this premium is extreme. HCA grows at 7-8% annually; Apollo grows at 15-18%. The justified premium should be 2-2.5x, not 5x.

- India (Narayana at 29.8x) is actually reasonably priced relative to Singapore (IHH at 18.4x) when you adjust for growth differential. Narayana growing at 16% vs IHH at 8% justifies a 2x premium — and $29.8/18.4 = 1.6x$. This is the one Indian hospital stock that looks fair on global benchmarks.
 - China (Aier Eye at 45.2x) shows that specialty hospital chains in high-growth emerging markets can sustain premium multiples for years. This supports the bull case for Indian hospital multiples remaining elevated.
 - The beds-per-1,000 comparison is the most powerful argument: India at 0.5 vs China at 4.6 vs USA at 2.9. For India to reach China's level, the country needs to build 5 million additional hospital beds. At ₹1-2 cr per bed for construction and equipment, that is a ₹5-10 lakh crore capital investment opportunity for listed chains over the next 15-20 years.
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8. Competitive Moat Analysis



8.1 What Makes Hospital Chains Defensible

Brand and Doctor Trust — The Strongest Moat

In Indian healthcare, patients follow doctors, not hospitals. But doctors follow brand — they prefer to practice at hospitals that attract the right patient mix, have the right equipment, and offer the right research opportunities. Apollo's 30+ year brand and Narayana's Dr Devi Shetty association create doctor networks that take decades to build and cannot be bought or replicated.

Accreditation and Regulatory Complexity

NABH accreditation is mandatory for insurance empanelment. JCI accreditation opens international patient flows. Achieving and maintaining both requires 2-3 years of operational preparation. This creates a significant entry barrier that even well-funded new entrants cannot shortcut.

Geographic Network Effects

A hospital's value increases with its referral network. Apollo's 73 hospitals create a network where a patient treated at Apollo Hyderabad can be referred to Apollo Delhi for a complex procedure, with all records on the same Apollo 24/7 system. This continuity of care is impossible to replicate without scale.

8.2 Apollo's Ecosystem — The Unique Differentiator

- Apollo Pharmacy: 6,000+ stores generating ₹8,000+ cr revenue — largest private pharmacy chain in India. Captures patients after discharge, creating lifelong revenue streams
- Apollo Diagnostics: 200+ labs — captures patients before hospitalisation with preventive health checkups

- Apollo 24/7: Digital health platform with 50 million+ registered users — India's largest connected healthcare ecosystem
 - Combined, these non-hospital businesses contribute 40%+ of Apollo's revenue and create switching costs that no single-segment hospital chain can match
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9. Qualitative Research — Indian Context

9.1 The Ayushman Bharat Paradox

The government's PMJAY scheme covers 500 million Indians for hospitalisation up to ₹5 lakh. On the surface this appears to threaten private hospital pricing. In practice it has been a net positive for listed chains for three reasons.

- Volume amplification: PMJAY brings millions of new patients into the formal healthcare system for the first time. Many are diagnosed with conditions requiring ongoing private care beyond PMJAY coverage
- Cherry-picking: Private chains accept PMJAY for procedures where the government reimbursement covers costs (simple cardiac procedures, orthopaedics) while maintaining premium pricing for complex oncology, transplants, and elective procedures
- Brand building: Treating PMJAY patients builds goodwill and creates patient relationships that later convert to private-pay when patients can afford it — particularly relevant in Tier 2 cities

9.2 Medical Tourism — The Dollar Revenue Opportunity

- India received 750,000+ medical tourists in FY24 generating USD 9 billion in revenue — up from USD 3 billion in 2015
- Average medical tourist spends 4-5x what a domestic private-pay patient spends on the same procedure
- Apollo and Narayana are the top two destinations, with significant patient inflows from Bangladesh, Sri Lanka, East Africa, and the Middle East
- The Cayman Islands Health City (Narayana's international flagship) performs cardiac surgery at 25% of US costs for American patients — a USD revenue stream that is dollar-denominated and immune to Indian healthcare pricing regulations

9.3 Digital Health Integration

- Apollo 24/7 has 50 million+ registered users — the largest health app in India. Revenue from telemedicine, medicine delivery, and diagnostic bookings is growing at 40%+ annually
- Max Healthcare's MyHealthcare app has 5 million+ users. The digital platform reduces patient acquisition cost from ₹2,000-3,000 per new patient to near-zero for digital-acquired patients
- The digital layer creates a virtuous cycle: better data enables better diagnostics, better diagnostics drives earlier intervention, earlier intervention reduces treatment cost, lower cost attracts more patients

9.4 The Affordability Paradox — Why Expensive Private Hospitals Keep Growing

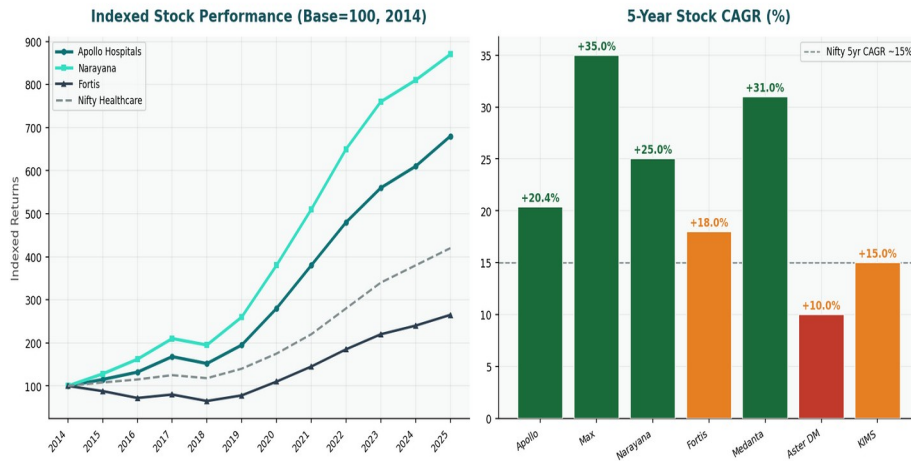
The most counterintuitive aspect of Indian healthcare: private hospitals are expensive by Indian standards but are growing fastest. The explanation is the rapid expansion of India's consuming class — households earning ₹5-15 lakh annually (250+ million people) who can afford private care for serious illness but would previously have used government hospitals for routine treatment. As household income crosses ₹8-10 lakh, the shift to private hospitals for secondary and tertiary care becomes near-universal.

10. Risk Analysis

Risk Factor	Severity	Description	Mitigation Signal
NABH & Regulatory	HIGH	National Accreditation Board for Hospitals accreditation is mandatory for insurance empanelment. Any quality failures, adverse events, or loss of accreditation immediately cuts off insurance revenue which is 40-60% of a typical premium hospital's income.	<i>Monitor hospital accreditation status quarterly. Avoid chains with a history of adverse event reportage.</i>
Doctor Attrition	HIGH	Senior specialist physicians in India are highly mobile and carry patient loyalty with them. If a key cardiac surgeon or oncologist leaves for a competitor, 20-30% of that specialty's revenues can walk out in 6 months.	<i>Ask management about long-term doctor contracts, equity sharing programmes, and Revenue Per Doctor Employed trends.</i>
Insurance Pricing	MEDIUM	Government schemes like Ayushman Bharat (PMJAY) reimburse at rates 30-50% below private insurance rates. As government insurance pushes to cover more patients, hospitals face pressure to accept lower reimbursement rates.	<i>Track what % of revenue comes from government schemes vs private insurance vs self-pay. Higher self-pay and private insurance = better pricing power.</i>
Expansion Risk	MEDIUM	New hospitals take 5-7 years to reach breakeven occupancy. Chains expanding aggressively suppress current-year profitability. Debt rises and ROCE falls during expansion — market often over-penalises this.	<i>Look for chains where existing hospitals have mature occupancy (75%+) and new hospitals are well-funded without excessive leverage.</i>
Medical Negligence	MEDIUM	India's consumer courts and NCDRC are increasingly awarding large compensation in medical negligence cases. Reputational damage from a single high-profile adverse event can impact stock price significantly.	<i>Check for pending legal cases in annual reports. Monitor news flow on hospital-specific adverse events.</i>
Competition	LOW-MEDIUM	Barriers to entry are high — land, capital, accreditation, doctor recruitment all take years. But well-funded competition (new entrants in Tier 2 cities backed by PE) can gradually erode market share in specific geographies.	<i>Track new hospital announcements in key geographies. Geographic diversification reduces this risk.</i>

11. Stock Performance

Stock Performance — Hospital Chains vs Market



Performance Summary

- Narayana has delivered the highest absolute returns — ₹100 invested in 2016 at IPO has grown to ₹481 as of May 2026 — 4.8x in 10 years
- Apollo has delivered steady compounding — 5-year CAGR of 20.35%, remarkably consistent across both COVID and post-COVID periods
- Max Healthcare since 2020 relisting has delivered 35% CAGR — the highest among currently listed names but from a small base
- Fortis has underperformed due to legacy governance issues pre-IHH acquisition. The turnaround is underway but the multiple still carries a governance discount

12. Individual Stock Research Profiles

12.1 Apollo Hospitals (NSE: APOLLOHOSP | Large Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹7,409	—	ACCUMULATE
DCF Fair Value	₹8,200	+10.7%	Upside/Downside
Revenue FY25	₹21,794 cr	—	—
EBITDA Margin	18%	Sector avg 18%	At or above avg
EV/EBITDA	52.1x	Sector avg 50x	In line with peers
P/E Ratio	83.4x	Sector avg 75x	—
ROCE	14.2%	Sector avg 16.7%	Adequate
ARPOB	₹2.21cr	Sector avg ₹2.12cr	Adequate
5-yr Stock CAGR	+20.4%	Nifty 5yr ~15%	Significant outperformance
FII Holding	44.2%	Higher = better	Strong institutional confidence

Investment Thesis

India's largest hospital network with 73 hospitals and 8,000+ beds. Unique integrated model combining hospitals, pharmacy (Apollo Pharmacy — 6,000+ stores) and diagnostics (Apollo Diagnostics) creates a healthcare ecosystem with multiple revenue streams. Apollo 24/7 digital platform is building India's largest connected healthcare network. Premium positioning with strong international patient inflows particularly from Middle East and South Asia. The diversification reduces pure hospital cyclicality.

Key Risks

Highest valuation in sector at 83x PE — any earnings disappointment will be punished severely. Large debt from capacity expansion. Doctor attrition risk as star physicians command premium salaries. Pharmacy business faces e-pharmacy competition.

Research View: ACCUMULATE | DCF Upside: +10.7% | Accumulate on dips. Current price largely factors near-term growth. Better entry at 10-15% correction.

12.2 Max Healthcare (NSE: MAXHEALTH | Large Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹1,116	—	HOLD
DCF Fair Value	₹1,050	-5.9%	Upside/Downside
Revenue FY25	₹7,028 cr	—	—

Key Metric	Value	vs Sector	Research View
EBITDA Margin	21%	Sector avg 18%	At or above avg
EV/EBITDA	68.4x	Sector avg 50x	Expensive vs peers
P/E Ratio	95.2x	Sector avg 75x	—
ROCE	22.8%	Sector avg 16.7%	Best-in-class efficiency
ARPOB	₹2.84cr	Sector avg ₹2.12cr	Premium positioning
5-yr Stock CAGR	+35.0%	Nifty 5yr ~15%	Significant outperformance
FII Holding	51.8%	Higher = better	Strong institutional confidence

Investment Thesis

India's most efficient hospital chain by revenue per bed (₹2.84 cr — highest in sector). Despite having fewest beds among large caps, market cap matches Apollo — the market correctly rewards quality over quantity. Strong North India brand dominance. IFC and global PE backing adds governance credibility. Expanding into Tier 2 cities with asset-light model. Highest FII ownership at 51.8% — global institutional stamp of approval.

Key Risks

Extremely expensive at 95x PE — most expensive hospital stock globally on this metric. DCF suggests stock is at or above fair value at current prices. North India concentration risk. Limited geographic diversification. Any regulatory action on hospital pricing would disproportionately impact Max given premium positioning.

Research View: HOLD | DCF Upside: **-5.9%** | Hold existing positions. Avoid fresh buying at current valuations. Wait for 15-20% correction for better risk-reward.

12.3 Narayana Hrudayalaya (NSE: NH | Mid Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹1,737	—	BUY
DCF Fair Value	₹2,200	+26.8%	Upside/Downside
Revenue FY25	₹5,483 cr	—	—
EBITDA Margin	21%	Sector avg 18%	At or above avg
EV/EBITDA	29.8x	Sector avg 50x	Cheap vs peers
P/E Ratio	33.5x	Sector avg 75x	—
ROCE	27.1%	Sector avg 16.7%	Best-in-class efficiency
ARPOB	₹1.75cr	Sector avg ₹2.12cr	Volume-led model
5-yr Stock CAGR	+25.0%	Nifty 5yr ~15%	Significant outperformance
FII Holding	22.4%	Higher = better	Growing institutional interest

Investment Thesis

The single most compelling long-term compounder in India's hospital sector. Best ROCE at 27.1% — highest capital efficiency of any listed hospital chain. Dr Devi Shetty's factory model for cardiac surgery delivers world-class outcomes at one-fifth the US cost. Cayman Islands Health City generates high-margin dollar revenues from global medical tourists. Valuation at 29.8x EV/EBITDA is the most reasonable in the sector — significant discount to peers despite superior returns. Expanding to 25 cities by 2027.

Key Risks

Rural and semi-urban focus means lower ARPOB. Doctor dependency on Dr Devi Shetty brand — key man risk. Government pressure to keep cardiac surgery affordable may limit pricing power in domestic market. Relatively lower FII ownership suggests underfollowed — could be opportunity.

Research View: BUY | DCF Upside: **+26.8%** | *Best risk-reward in the sector. Buy with 2-3 year horizon. DCF suggests 27% upside from current price.*

12.4 Fortis Healthcare (NSE: FORTIS | Large Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹970	—	ACCUMULATE
DCF Fair Value	₹1,100	+13.4%	Upside/Downside
Revenue FY25	₹7,783 cr	—	—
EBITDA Margin	14%	Sector avg 18%	Below sector avg
EV/EBITDA	56.2x	Sector avg 50x	In line with peers
P/E Ratio	64.6x	Sector avg 75x	—
ROCE	10.4%	Sector avg 16.7%	Needs improvement
ARPOB	₹2.51cr	Sector avg ₹2.12cr	Premium positioning
5-yr Stock CAGR	+18.0%	Nifty 5yr ~15%	Moderate outperformance
FII Holding	35.6%	Higher = better	Growing institutional interest

Investment Thesis

IHH Healthcare (Malaysia) ownership since 2018 brought operational turnaround and governance improvement. Revenue per bed of ₹2.51 cr is second only to Max Healthcare — strong operational quality. Improving EBITDA margins from 12% in FY22 to 14% in FY25 — still expansion room to 18%+ which peers achieve. Strong brand in oncology and organ transplants. International patient business growing from Middle East and SAARC.

Key Risks

Lowest ROCE at 10.4% — still recovering from the pre-IHH era of poor capital allocation. EBITDA margins lag peers significantly. Historical governance issues under Singh family still overhang investor perception. High debt from legacy acquisitions being gradually paid down.

Research View: ACCUMULATE | DCF Upside: **+13.4%** | *Turnaround story with runway to margin improvement. Accumulate for 3-4 year margin expansion play.*

12.5 Global Health (Medanta) (NSE: MEDANTA | Mid Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹1,314	—	BUY
DCF Fair Value	₹1,580	+20.2%	Upside/Downside
Revenue FY25	₹3,800 cr	—	—
EBITDA Margin	18%	Sector avg 18%	At or above avg
EV/EBITDA	47.8x	Sector avg 50x	In line with peers
P/E Ratio	59.7x	Sector avg 75x	—
ROCE	15.8%	Sector avg 16.7%	Adequate
ARPOB	₹2.1cr	Sector avg ₹2.12cr	Adequate
5-yr Stock CAGR	+31.0%	Nifty 5yr ~15%	Significant outperformance
FII Holding	28.4%	Higher = better	Growing institutional interest

Investment Thesis

Premium super-specialty positioning with strong brand among high-income urban patients. Dr Naresh Trehan's brand equity is the strongest individual physician brand in India. Expanding beyond Gurugram base to Lucknow, Patna, Ranchi — underserved markets where Medanta premium is highly aspirational. EBITDA margins at 18% with room to expand as new hospitals mature. Relatively underfollowed — only 12 analyst estimates versus 25+ for Apollo.

Key Risks

Key man risk concentrated around Dr Naresh Trehan — any health issue would significantly impact brand and patient flows. Expansion into Tier 2 cities is untested for the Medanta premium model. Competition from Apollo and Max in NCR market intensifying.

Research View: BUY | DCF Upside: +20.2% | Buy for 3-year expansion story. DCF suggests 20% upside. Underfollowed status creates opportunity.

12.6 Aster DM Healthcare (NSE: ASTERDM | Mid Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹627	—	ACCUMULATE
DCF Fair Value	₹770	+22.8%	Upside/Downside
Revenue FY25	₹4,200 cr	—	—
EBITDA Margin	13.8%	Sector avg 18%	Below sector avg
EV/EBITDA	50.1x	Sector avg 50x	In line with peers
P/E Ratio	90.0x	Sector avg 75x	—
ROCE	8.2%	Sector avg 16.7%	Needs improvement

Key Metric	Value	vs Sector	Research View
ARPOB	₹1.9cr	Sector avg ₹2.12cr	Adequate
5-yr Stock CAGR	+10.0%	Nifty 5yr ~15%	Moderate outperformance
FII Holding	18.2%	Higher = better	Early-stage institutional discovery

Investment Thesis

Post GCC business sale (completed 2024), Aster is now a clean India-only hospital play focused on South India — Kerala, Karnataka, Andhra Pradesh. South India has highest healthcare awareness and willingness to pay in India. Proceeds from GCC sale being deployed in India capacity expansion. Lowest EBITDA margin in peer group at 13.8% — significant operating leverage potential as new hospitals ramp up. Most affordable valuation on EV per bed basis.

Key Risks

Lowest ROCE at 8.2% — highest capital intensity without commensurate returns yet. PE ratio of 90x is expensive given margin profile. Post-GCC sale integration of management focus is still settling. South India concentration — any state-level regulatory action impacts entire portfolio.

Research View: ACCUMULATE | DCF Upside: **+22.8%** | Accumulate for margin expansion story. 2-3 years for new hospitals to mature and EBITDA margins to reach 18%+.

12.7 KIMS Hospitals (NSE: KIMS | Mid Cap)

Key Metric	Value	vs Sector	Research View
CMP	₹596	—	ACCUMULATE
DCF Fair Value	₹720	+20.8%	Upside/Downside
Revenue FY25	₹2,800 cr	—	—
EBITDA Margin	20%	Sector avg 18%	At or above avg
EV/EBITDA	45.2x	Sector avg 50x	In line with peers
P/E Ratio	80.1x	Sector avg 75x	—
ROCE	18.6%	Sector avg 16.7%	Adequate
ARPOB	₹2.05cr	Sector avg ₹2.12cr	Adequate
5-yr Stock CAGR	+15.0%	Nifty 5yr ~15%	Moderate outperformance
FII Holding	12.6%	Higher = better	Early-stage institutional discovery

Investment Thesis

The hidden gem of the hospital sector — strong operational metrics with limited analyst coverage. EBITDA margin of 20% matches the best in sector. ROCE of 18.6% is third highest after Narayana and Max. Dominant position in Andhra Pradesh and Telangana — high-income southern markets. Expanding into Tier 2 cities in South India where competition from large chains is minimal. Low FII ownership at 12.6% — early stage institutional discovery.

Key Risks

Smallest scale among listed peers — limited bargaining power with insurers and suppliers. Geographic concentration in Andhra Pradesh and Telangana. Thin free float makes stock volatile. Limited management bandwidth for rapid expansion.

Research View: ACCUMULATE | DCF Upside: **+20.8%** | *Best undiscovered compounder in the sector. Accumulate systematically. DCF suggests 21% upside.*

13. Research View Summary

Research View Summary — Indian Hospital Chains
(For Educational Purposes Only — Not SEBI Registered Investment Advice)

Company	NSE	CMP	DCF Value	Segment	Research View	Thesis
Apollo Hospitals	APOLLOHOSP	₹7,409	₹8,200	Large Cap	ACCUMULATE	Diversified moat; pharmacy + diagnostics ecosystem; expe
Max Healthcare	MAXHEALTH	₹1,116	₹1,050	Large Cap	HOLD	Best-in-class efficiency; expensive at 95x PE; wait for better
Narayana Hrudayalaya	NH	₹1,737	₹2,200	Mid Cap	BUY	Best ROCE at 27%; affordable care model; Cayman Islands
Fortis Healthcare	FORTIS	₹970	₹1,100	Large Cap	ACCUMULATE	IHH parentage; improving margins; reasonable valuation vs
Global Health	MEDANTA	₹1,314	₹1,580	Mid Cap	BUY	Premium positioning; strong EBITDA margins; underfollower
Aster DM	ASTERDM	₹627	₹770	Mid Cap	ACCUMULATE	South India dominance; GCC hospital sale complete; clean
KIMS Hospitals	KIMS	₹596	₹720	Mid Cap	ACCUMULATE	South India Tier 2 play; strong ROCE; limited analyst covera

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How to Read the Research Views

- **BUY:** Stock offers >20% DCF upside with strong fundamental support. Suitable for 3-5 year horizon.
- **ACCUMULATE:** Stock offers 10-20% DCF upside. Buy in tranches on market dips rather than lump sum.
- **HOLD:** Stock at or near DCF fair value. Existing investors hold; new investors wait for better entry.
- **AVOID:** Stock above DCF fair value or fundamental deterioration underway. Not recommended at current prices.

14. Glossary of Hospital Sector Terms

- **EV/EBITDA:** Enterprise Value divided by Earnings Before Interest Tax Depreciation Amortisation. Primary valuation multiple for capital-intensive sectors like hospitals.

- ARPOB: Average Revenue Per Occupied Bed per year. Measures revenue quality — higher = more complex/premium procedures.
- ROCE: Return on Capital Employed. Measures how efficiently management uses capital. Above 20% = excellent for a hospital chain.
- NABH: National Accreditation Board for Hospitals. Indian accreditation body — mandatory for insurance empanelment.
- JCI: Joint Commission International. Global accreditation — required for attracting international medical tourists.
- ARPOB: Average Revenue Per Occupied Bed. Key operational KPI tracked by investors every quarter.
- Occupancy Rate: % of beds occupied on average. 70-75% is typically the EBITDA breakeven level. Above 80% = strong pricing power.
- PMJAY: Pradhan Mantri Jan Arogya Yojana. India's government health insurance scheme covering 500 million people.
- Medical Tourism: Patients travelling from abroad for treatment. India's medical tourism sector is valued at USD 9 billion.
- Hub and Spoke: Hospital network model where large tertiary hospitals (hubs) are surrounded by smaller secondary hospitals (spokes) that refer complex cases to the hub.
- DCF: Discounted Cash Flow. Valuation method that estimates fair value by discounting projected future free cash flows at the weighted average cost of capital (WACC).
- WACC: Weighted Average Cost of Capital. The discount rate used in DCF — reflects the blended cost of debt and equity financing.

— End of Research Handbook —

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