THE SCANNER

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The anatomy of **hospital valuations**

The hospital sector, a bedrock of India's healthcare infrastructure, is based on an essentially asset-intensive model. With high front-end investment needs in land, buildings, and advanced machinery, hospitals have long gestation periods before reaching maturity. Occupancy levels accumulate cumulatively, and hence the financial breakeven and profitability time frames span decades. For investors and analysts, this presents distinctive challenges in arriving at true value and risk.

Parallel to the changes in the industry's business mix, the sector has seen a shift in its operating models. Hospitals are reconsidering old ownership-based models, gravitating toward hybrid models that incorporate leases and asset-light structures. These changes have far-reaching implications—not merely for financial reporting but also for valuations.

The cost structures shaping hospitals

Land and construction expenses are at the heart of hospital economics, tending to account for 30–50% of all project expenses, subject to location. Such high capital intensity renders the industry particularly vulnerable to funding choices.

To counter this cost burden, next-generation hospitals are increasingly turning to combinations of owned and managed hospitals, some also taking the road to lease and freehold arrangements. This helps in phasing out conventional asset-intensive arrangements for relatively leaner models.

Leases and accounting standards – a new perspective

New accounting standards have made it mandatory to capitalise leases and freehold contracts on hospital accounts. The rationale is simple—leases are generally non-cancellable, and in extreme circumstances of cancellation, the penalties involved can be substantial. This, in effect, treats leases as similar to obligations with weight equivalent to owned assets.

Players such as Apollo Hospitals have made public their liking for long-term leases rather than outright purchases, a strategic decision. Likewise, Narayana Health (NH) has clarified that the hospitals are owned on a freehold basis with P&L responsibility retained, and Max Healthcare has opted for "built-to-suit" lease agreements.

Balance sheet realities – comparing players

The capitalised value of leases, right-of-use assets, and freehold properties offers interesting insights into how these models play out among major listed players:

Narayana Health (NH):
30.0% of assets come under leases, ROU, or freehold.

Apollo Hospitals:
45.2%—almost half of its assets—reflect such capitalisation.

Max Healthcare:
32.5% under these headings.

In numerical terms, this translates into INR 21,093 million in case of NH, INR 87,418 million in case of Apollo, and INR 29,812 million in case of Max. As a percentage of market capitalisation, these are at 5.6%, 7.8%, and 2.5%, respectively.

Valuation implications – Beyond P/E and EBITDA

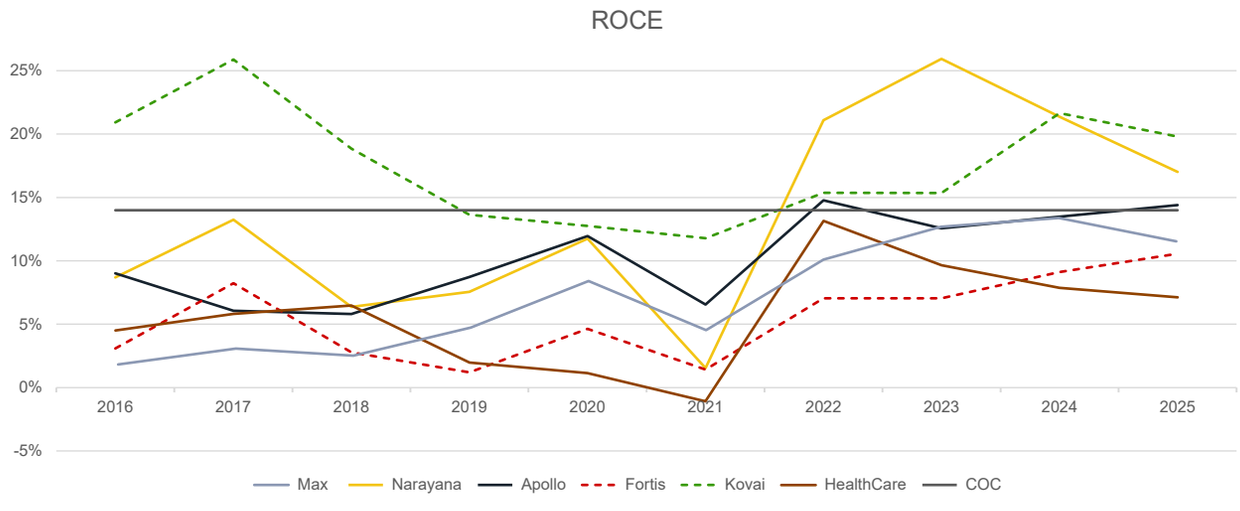
Historical valuation methods like Price-to-Earnings (P/E) or EV/EBITDA tend to miss the real value of hospitals. These techniques are unable to account for the value embedded in leases, freehold land, and right-to-use assets, thus giving an incomplete value.

It is better to apply asset-based valuation using Replacement Cost of Assets (RCA) in order to eliminate such a distortion. By adding the value of right-to-use assets and the related debt adjustments, the method of valuation makes the valuations represent actual capital commitments.

When we use the cost-per-bed replacement approach, we account for only those beds where land is owned or include leases only when relevant lease adjustments have been made after the cost has been paid upfront, thereby providing a realistic proxy for replication expenses.

Hospitals illustrate the difficulties of valuing asset-intensive businesses in a changing healthcare environment. The migration to lease models and hybrid asset strategies reflects the industry's flexibility but also makes the investor's job more difficult. By venturing away from conventional earnings multiples and using asset-based valuation techniques, a better and more complete picture ensues - one that reflects both the burdens and opportunities inherent within hospital operations.

Exhibit: Trend in Return on Capital Employed (ROCE) across select hospitals



ROCE is cluttered below the Cost of Capital (COC)* line. Barely 1-2 players earn above cost of capital returns.

*Cost of Capital (COC) is defined as the minimum rate of return a company must earn on its investments to justify the cost of the funds it has raised from investors (debt holders, shareholders, etc.).

Exhibit: Debt Equity (D/E) ratio and years to repay debt for select hospitals

Hospital (FY2025)	Years	D/E
Apollo Hospital	9.2	0.6
Max Healthcare	11.2	0.4
Fortis Health Care	9.3	0.3
Aster DM Healthcare	1.2	0.2
Kovai Medical	2.19	0.2
Narayana Hrudayalaya	4.5	0.2

Exhibit: Price trend of Max Healthcare (as on September 30, 2025)

Source: Factset

Exhibit: Price trend of Apollo Hospitals (as on September 30, 2025)

Source: Factset

Exhibit: Price trend of Narayana Hrudayalaya (as on September 30, 2025)

Source: Factset

Q&A

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How do hospitals balance the trade-off between asset-light strategies (like leases) and long-term control over critical infrastructure such as land and buildings?

Land and buildings lie at the core of the operations of a hospital. Thus, companies try to incorporate an element of control by obtaining the leases for a very long time (generally 30 years+). The longer duration periods could reflect the fact that companies want to act as owners of the property, while limiting the capital needs associated with such property. The trade-off earlier was that non-capitalised leases provided off balance sheet funding to hospitals. On the other hand, the asset light model is adopted to show that capital employed is lower, while the fruits from leasing are seen in profitability. However, despite using asset light models, hospitals barely earn cost of capital returns.

What risks do investors need to be mindful of when valuing hospitals that rely heavily on lease agreements?

Almost all listed hospitals in India have a debt-equity ratio in the range of 0.5-1, with the exception of Shalby. Investors need to ensure that lease obligations are a part of the debt related ratios that are computed. At Multi-Act, we use a very specific 'years to repay debt' ratio wherein we divide the total debt (including the leases) by the average of the company's last 5 years operating cash flow. This ratio helps us understand the number of years it would take the company to ordinarily meet its total debt obligations.

Beyond accounting treatment, how do capitalised leases and right-to-use assets impact hospitals' operational flexibility and expansion plans?

Ideally, operational flexibility and expansion plans could be slower when using own funds as compared to leases. In some cases, we have observed that where assets were on leases, there have been instances of lawsuits concerning non-fulfilment of certain conditions. For example, in the current ongoing case of Apollo Hospitals, one of its hospitals was in breach of one of the conditions of lease requiring free treatment to a pre-decided number of patients. While still under trial, new sources stated that the Court was considering handing over the hospital to the government, in case investigations reveal lapses in compliance. Such cases can add an additional layer of risk and impact operational flexibility.

Statutory Disclosure and Disclaimer:

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Multi-Act Trade and Investments Private Limited ("MATI") (SEBI Registered Investment Adviser – Registration No. INA000008589 and BASL Membership ID:- 1398)

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