BUSINESS PLAN · INDIA

Sample-Collection Centre / Franchise

Where the franchisee controls the error and is paid for volume, the payment is the defect

DIAGNOSTIC LABS & IMAGING

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This document is confidential and prepared for planning purposes. All financial figures are illustrative model assumptions for an Indian MSME context and must be validated against live quotes, local rates and professional advice before any investment or borrowing decision.

1. Executive Summary

This plan sets out a **Sample-Collection Centre / Franchise** business in India — a franchisor operating a central laboratory and a network of 940 franchised collection points by Year 3, earning from testing on collected samples, franchise fees, consumables and cold-chain supply, phlebotomist training and certification, logistics, and a collection-point software subscription, handling roughly 2.94 million samples a year.

> This plan inherits the diagnostics anchor's rules from `pathology-lab` and the franchise rules from `pharmacy-chain-franchise`, and it applies them where the two collide. **The anchor established that 61% of all diagnostic error is pre-analytical and happens at the collection point. A franchise model hands that phase to somebody else.**

> □□ **THE FRANCHISEE IS PAID ON WHAT HE COLLECTS AND THE LABORATORY IS PAID ON WHAT IT RUNS — AND NEITHER IS PAID ON WHETHER THE SAMPLE WAS ANY GOOD. The phase that causes most diagnostic error sits in the hands of the party with the weakest incentive and the least capability to control it: a franchisee paid a percentage of test value, competing on convenience and location, frequently staffed by an attendant with no formal phlebotomy training, WITH NO LABORATORY OF HIS OWN AND THEREFORE NO WAY OF EVER LEARNING WHETHER HIS SAMPLES PRODUCED CORRECT RESULTS. He is not careless. HE IS BLIND AND HE IS PAID FOR SPEED, and those two facts together produce haemolysed tubes, wrong anticoagulants, delayed centrifugation and mislabelled samples that arrive at a laboratory looking perfectly acceptable. So this franchisor PAYS 30% OF FRANCHISEE EARNINGS ON SAMPLE ACCEPTANCE RATE AND PRE-ANALYTICAL COMPLIANCE RATHER THAN VOLUME ALONE, PUBLISHES REJECTION RATE PER CENTRE, and TERMINATES ON PRE-ANALYTICAL FAILURE — 66 in Year 3 — while terminating NIL FOR VOLUME SHORTFALL. WHERE THE FRANCHISEE CONTROLS THE PHASE THAT CAUSES MOST OF THE ERROR AND IS PAID ONLY FOR VOLUME, THE PAYMENT IS THE DEFECT.**

> □□ **AND THE MODEL P&L MUST CARRY A TRAINED PHLEBOTOMIST. Per the pharmacy-franchise rule, a brochure whose economics only work without one is selling a business that cannot be run properly. So a CERTIFIED PHLEBOTOMIST IS REQUIRED BEFORE A CENTRE OPENS and re-certified annually, NIL centres operate without one, the model P&L carries his full cost, and 28% OF PROSPECTS DECLINE after seeing it.**

> □□ **AND THE FULL OUTCOME DISTRIBUTION IS PUBLISHED. 1,108 centres opened cumulatively, 168 closed or exited, 940 trading, with MEDIAN franchisee monthly earnings of ₹24,800 rather than an average — and the WHOLE TAKE RATE published as one number at 59.6% of centre collection value, falling from 62.4%.**

This plan models an operator requiring **₹20.00 crore** (₹8.60 crore investor + ₹6.40 crore term loan + ₹3.20 crore promoter + ₹1.80 crore working capital), moving from **₹9.00 crore revenue and a ₹4.25 crore loss** to **₹58.00 crore revenue and ₹5.22 crore profit** by Year 3 — *a 9.0% net margin and 31.9% return on capital. (Collection-centre franchising — figures illustrative.)*

2. Business Description, Vision & Legal Structure

Concept: A collection network paid for samples that are good, not samples that are many.

Vision: To make the rejection rate the number a collection centre is judged on.

Mission: Pay the franchisee for quality as well as volume; put a certified phlebotomist in every centre before it opens; publish the rejection rate and terminate on it; show the honest model economics including his cost; and never interpret a result at a collection counter.

Legal structure

- **Private Limited** — recommended. Laboratory registration, franchise agreements across states, and outside capital all assume it.
- **Franchisee as an independent establishment — the collection centre operates under its own registration where state rules require it, and the sample becomes our responsibility at handover, which is precisely why the handover conditions must be contracted rather than assumed.**
- **Network audit function reporting to the board, independent of franchise development — because the team that signs a franchisee must not be the team that terminates him.**

> **Regulatory anchor:** the Clinical Establishments Act 2010 and state rules where adopted, under which **a collection centre may itself require registration and, in several states, must be linked to a registered laboratory with the linkage documented**; state Clinical Establishment and Nursing Home Acts elsewhere; the National Medical Commission's conduct regulations on referral commissions, **binding on the doctor who receives and not on the franchisor or franchisee who pays**; NABL accreditation under ISO 15189, which covers **the laboratory and its pre-examination processes — including collection performed on its behalf, which is the formal reason a franchisor cannot treat pre-analytical failure as somebody else's problem**; the PCPNDT Act where any prenatal-related sample handling arises; Bio-Medical Waste Rules, which apply at every centre generating sharps; the Drugs and Cosmetics Act for collection consumables; the Digital Personal Data Protection Act 2023, under which patient identity and results at a collection point are sensitive personal data held by a party with minimal infrastructure; franchise contracting under general contract law, since **India has no franchise disclosure statute**; GST; and shops and establishments, EPF/ESI and POSH. **The decisive structural fact is that accreditation makes the laboratory answerable for collection it does not perform, while nothing obliges it to pay the collector for doing it well.**

3. Promoter & Ownership

Led by a promoter with diagnostics network, laboratory operations or franchising background. Three competences decide outcomes. *Pre-analytical engineering*, because a network's entire quality position is decided by what happens in nine hundred rooms the laboratory has never seen. *Franchisee selection and economics*, since the survival curve is set at signing and median earnings drive churn. And *the willingness to terminate on quality rather than volume*, which is where this plan's proposition sits and which removes revenue from the network's own books. Ownership, equity & investor terms are editable inputs; **the network audit function reports to the board independently of franchise development, and no employee's pay is affected by terminations or by any individual centre's volume.**

4. Market Analysis — India

The fastest-growing layer of Indian diagnostics, and the weakest link in its quality chain.

Demand drivers

- **Convenience** — patients will travel two kilometres, not twenty, for a blood test.
- **Laboratory consolidation** requiring reach without capital.
- **Low entry cost** making collection centres an accessible small business.
- **Chronic-disease monitoring** generating predictable repeat collection.
- **Corporate and institutional screening** needing local collection points.
- **Tier-2 and tier-3 expansion** where a full laboratory is not viable.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian laboratory collection network capacity	Very large; expanding fast and largely unregulated in practice
SAM	**Prospects who can fund a certified phlebotomist from day one**	**28% smaller than the brochure market**
SOM (Yr 1–3)	Trading centres and samples	₹9cr → ₹58cr; 940 centres; 2.94m samples

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and who bears the quality risk
Testing revenue on franchise-collected samples	**55.0%**	**58.0% — and every rejected sample is a cost here**
Consumables, kits & cold-chain supply to centres	14.0%	22.0% — deliberately thin; the right tube matters
Franchise fees, territory & setup	10.0%	78.0% — one-off; not a business by itself
Logistics & sample transport services	9.0%	28.0% — where time-to-centrifuge is won or lost
Phlebotomist training, certification & audit	**6.0%**	**64.0% — the capability sold, not absorbed**
Software subscription — LIS-lite, rejection tracking, records	6.0%	72.0% — carries the rejection feedback to the centre

> **The consumables line is deliberately the thinnest margin in the business at 22%, and the reason is a quality decision rather than a commercial one: a franchisor taking a wide margin on tubes and needles gives every centre a standing incentive to buy them elsewhere, and the wrong tube is one of the commonest pre-analytical failures there is. Cheap correct consumables supplied centrally cost us margin and remove an entire failure mode. The training line at 64% is the mirror image — the capability that makes the network work is SOLD as revenue rather than absorbed as overhead, because a training function funded out of goodwill is the first thing cut in a bad quarter. And the software line matters more than its 6% suggests: it is the mechanism by which a rejection reaches the centre that caused it, WITHIN THE SAME DAY, which is the only way a franchisee who has never seen a laboratory can learn anything at all.**

Constraints

- **Certified phlebotomist availability**, which limits how fast centres can open honestly.
- **Franchisee economics**, since median earnings drive churn and churn destroys networks.
- **Transport time and temperature** from nine hundred points to one laboratory.
- **Competitor networks** that open faster because they require nothing.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
National diagnostics chains' franchise networks	Brand, test menu, aggressive expansion, capital	**Franchisee paid on volume alone; rejection rate never published**

Local laboratory collection tie-ups	Personal relationships, flexibility, low cost	No training standard; no rejection feedback at all
Standalone laboratories opening own centres	Full control of pre-analytical process	Capital-intensive; slow; limited reach
Home-collection platforms	Convenience, no premises cost, direct patient reach	Phlebotomist utilisation and transport time harder still
This plan	**30% of earnings on quality, rejection published per centre, certified phlebotomist required, honest model P&L**	28% of prospects decline; slower network growth

The positioning speaks to two audiences with a single fact. To a prospective franchisee: your earnings depend partly on whether your samples are usable, which is unusual and initially unwelcome, and it is also the only version of this business in which you find out whether you are any good at it. To a referring physician or a patient: the rejection rate of the centre you are standing in is published, which no competitor discloses because no competitor measures it in a way that could be published. The commercial handicap is straightforward — a rival network can open a centre in a week with a trained attendant and a fridge, and we take six because somebody must be certified first — and there is no way to present that as speed.

The cost of the honest position is stated in rupees rather than implied. Requiring a certified phlebotomist before a centre opens, and publishing a model P&L that carries his full cost, cost ₹2.32 crore of Year-3 margin through the 28% of prospects who decline — the largest item. Paying 30% of franchisee earnings on acceptance rate and pre-analytical compliance rather than on volume cost ₹1.86 crore. Terminating 66 franchisees on pre-analytical failure while terminating none for volume shortfall cost ₹1.24 crore in lost collection and empty territory. Publishing the full outcome distribution including closures cost ₹64 lakh in prospects who saw the closure record and went elsewhere. Total ₹6.06 crore against ₹5.22 crore of profit — so a franchisor running trade-standard practice with the same central laboratory would earn ₹11.28 crore.

6. Paid for Volume, Blind to Quality

This is the finding, and it is an incentive design rather than a failing.

What the franchisee controls	What he is paid for	What he can observe
Tube selection and order of draw	Nothing	**Nothing**
Venepuncture technique and haemolysis	Nothing	**Nothing**
Labelling at the point of draw	Nothing	**Nothing**
Time to centrifuge and separation	Nothing	**Nothing**
Storage and transport temperature	Nothing	**Nothing**
Number of samples collected	**Everything**	**Everything**

The right-hand column is the part that is usually missed. A franchisee is not merely unrewarded for pre-analytical quality — HE CANNOT SEE IT. He has no laboratory, no analyser, no result he can trace back to a tube he filled, and no mechanism by which a haemolysed sample he drew on Tuesday ever becomes information he receives. The report goes to the patient and the physician; the rejection, if it is recorded at all,

goes into a laboratory system he has no access to; and the wrong result, if the sample was run anyway, goes to a doctor who acts on it. So the franchisee operates for years in a perfect informational vacuum about the one thing he most affects, WHILE RECEIVING A CLEAR DAILY SIGNAL ABOUT THE ONE THING HE CONTROLS LEAST INTERESTINGLY — how many people walked in. This is the commissary problem again and worse: there, the producer at least received a price signal; here the collector receives a volume signal that is actively misleading, because the fastest draw is often the worst one. NOBODY IN THE NETWORK IS BEHAVING BADLY. THE INFORMATION AND THE MONEY BOTH POINT THE WRONG WAY.

So both are redirected. 30% OF FRANCHISEE EARNINGS ARE PAID ON SAMPLE ACCEPTANCE RATE AND PRE-ANALYTICAL COMPLIANCE — time-to-centrifuge, temperature, labelling and tube selection — rather than on volume alone, rising from 22% as the measurement matured. EVERY REJECTION IS PUSHED BACK TO THE CENTRE THAT CAUSED IT THE SAME DAY, with the reason, through the software subscription, so a franchisee can finally observe his own work. REJECTION RATE IS PUBLISHED PER CENTRE, and a CENTRE REPORTING A ZERO REJECTION RATE IS INVESTIGATED per the vertical anchor rule — because at a collection point a zero reading means samples are being accepted that should not be. 66 FRANCHISEES WERE TERMINATED ON PRE-ANALYTICAL FAILURE and NIL FOR VOLUME SHORTFALL, which per the pharmacy-franchise rule is the pair of numbers that proves what a network actually values. WHERE THE FRANCHISEE CONTROLS THE PHASE THAT CAUSES MOST OF THE ERROR AND IS PAID ONLY FOR VOLUME, THE PAYMENT IS THE DEFECT.

7. The Phlebotomist, the Denominator and the Counter

Three further rules, two inherited from the franchise plans and one specific to a collection point.

□□ THE MODEL P&L MUST CARRY A TRAINED PHLEBOTOMIST. Per the pharmacy-chain-franchise rule, a brochure whose economics only balance without one is selling a business that cannot be operated properly — and in this trade the omission is easier to hide, because a collection centre visibly requires only a room, a chair and a refrigerator, and a family member can be shown how to draw blood in an afternoon. So A CERTIFIED PHLEBOTOMIST IS REQUIRED BEFORE A CENTRE OPENS, re-certified annually, with NIL centres operating without one; the model P&L carries his full cost, which reduces the advertised owner earnings materially; and 28% OF PROSPECTS DECLINE after seeing it, at ₹2.32 crore. Training is delivered by our own academy and sold as a revenue line rather than absorbed, because a training function funded out of goodwill is the first thing cut in a bad quarter.

□□ AND THE OUTCOME DISTRIBUTION IS PUBLISHED, CLOSURES INCLUDED. Per the food-franchise rule, an average computed across surviving centres removes exactly the outcomes a prospect is trying to price, and India has no franchise disclosure statute requiring otherwise. So 1,108 CENTRES OPENED CUMULATIVELY, 168 CLOSED OR EXITED, 940 TRADING, with MEDIAN franchisee monthly earnings of ₹24,800 rather than an average and the survival curve shown by signing cohort — and NIL average-only figures published anywhere. THE WHOLE TAKE RATE is published as one number — laboratory share plus consumables plus logistics plus software, 59.6% of centre collection value, falling from 62.4% — because a franchisee told only the laboratory share is being told a fraction.

□□ AND NOTHING IS INTERPRETED AT THE COUNTER. A patient collecting a report will ask what it means, and the person handing it over is a franchisee or an attendant with no clinical qualification, standing in a room with a medical-looking sign on it — so the answer he gives carries an authority it has not earned, and the patient cannot tell the difference. So NIL RESULTS ARE INTERPRETED OR COUNSELLED AT A COLLECTION CENTRE, reports carry the laboratory's pathologist contact for queries, and staff are trained in how to decline

the question warmly rather than answer it badly.

AND THE SAMPLE BECOMES OURS AT HANDOVER, WHICH IS WHY THE HANDOVER IS CONTRACTED. Accreditation makes the laboratory answerable for pre-examination processes carried out on its behalf, so time-to-centrifuge within limit at 93% and temperature-logged transport are our obligations discharged in somebody else's premises — measured, not assumed.

8. Operations Plan (certify, collect, reject, feed back)

Franchisee economics

- **30% of earnings on acceptance rate and pre-analytical compliance**, not volume alone.
- **Whole take rate published** — laboratory share, consumables, logistics and software as one number.
- **Median franchisee monthly earnings published**, never an average.
- **Full outcome distribution published** — opened, closed, trading, by signing cohort.

Capability

- **Certified phlebotomist required before a centre opens**; re-certified annually.
- **Model P&L carries his full cost**; nil versions shown without it.
- **Training delivered by our academy and sold as a revenue line.**
- **Consumables supplied centrally at a deliberately thin margin**, so the right tube is the cheap tube.

Quality feedback

- **Every rejection pushed back to the causing centre the same day**, with the reason.
- **Rejection rate published per centre**; a zero reading investigated.
- **Time-to-centrifuge and transport temperature logged** per consignment.
- **Termination on pre-analytical failure**; nil terminations for volume shortfall.

At the counter

- **Nil results interpreted or counselled** at a collection centre, ever.
- **Pathologist contact printed on every report** for clinical queries.
- **Nil referral commission** paid by the network or by any franchisee, per the vertical anchor.
- **Patient identity and results handled under DPDP** at premises with minimal infrastructure.

The operational hinge is a franchisee doing forty per cent above the network median in a good catchment, popular, punctual, and paying his fees on time — whose acceptance rate has sat at 91% for two quarters against a network figure of 96.6%, which means roughly one sample in eleven from his centre is unusable. He is the network's best commercial relationship and its clearest quality failure, and the two facts are connected: a fast draw and a full waiting room are what produce both. So the AUDIT FUNCTION REPORTS TO THE BOARD, SITS OUTSIDE FRANCHISE DEVELOPMENT, and NO AUDIT STAFF MEMBER'S PAY IS AFFECTED BY NETWORK REVENUE, TERMINATIONS OR SIGNINGS. The system refuses rather than warns: two consecutive quarters below the acceptance threshold trigger mandatory re-certification, and a third triggers automatic termination with no commercial override available to anybody — because a discretion that exists will be exercised in favour of the high-volume centre every single time.

9. Registration, Accreditation & Operating Compliance (India)

- **Clinical Establishments Act 2010 and state rules — a collection centre may itself require registration and, in several states, must be linked to a registered laboratory with the linkage documented.**
- **NABL accreditation under ISO 15189** — covers **the laboratory and its pre-examination processes INCLUDING COLLECTION PERFORMED ON ITS BEHALF, which is the formal reason a franchisor cannot treat pre-analytical failure as somebody else's problem.**
- **NMC conduct regulations** on referral commissions — binding on the doctor who receives, not on the franchisor or franchisee who pays.
- **Bio-Medical Waste Rules**, which apply at **every centre generating sharps** — nine hundred small waste generators is a compliance problem in itself.
- **Drugs and Cosmetics Act** for collection consumables; PCPNDT where prenatal-related sample handling arises.
- **Digital Personal Data Protection Act 2023** — patient identity and results at a collection point are sensitive personal data **held by a party with minimal infrastructure.**
- **Franchise contracting under general contract law — India has no franchise disclosure statute, so whatever is disclosed is disclosed voluntarily.**
- **GST, shops and establishments, EPF/ESI and POSH. Accreditation makes the laboratory answerable for collection it does not perform, while nothing obliges it to pay the collector for doing it well.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owns the quality-linked payment rule
Central laboratory staff	42	118	Runs 2.94m samples; records every rejection
Logistics & cold-chain transport	22	68	Time-to-centrifuge is won here
Network audit — pre-analytical & rejection	12	46	**Reports to board; pay unaffected by terminations**
Franchise development & support	14	38	Structurally separate from audit
Training academy & certification	8	24	**Sold as revenue, not absorbed as overhead**
Technology & systems	6	16	Same-day rejection feedback to the centre
Finance, legal, compliance & admin	10	27	Publishes rejection rates and outcome distribution
Total	**115**	**338**	Audit and training at 21% of headcount

> **Forty-six auditors for 940 centres is one per twenty, which is far heavier than a network needs to check signage and stock — and again the point is that pre-analytical compliance cannot be assessed from a purchase ledger or a photograph. It requires unannounced visits, observed draws and consignment inspection. The function reports to the board, sits outside franchise development, and NO AUDIT STAFF MEMBER'S PAY IS AFFECTED BY NETWORK REVENUE, BY TERMINATIONS OR BY SIGNINGS — the terminations clause matters as much as the revenue one, because an auditor incentivised on terminations is corrupted in the opposite direction. The training academy at twenty-four staff is funded as a revenue line precisely so that it survives a bad quarter, which a cost centre would not.**

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & central laboratory	Month 0–8	Incorporation, laboratory commissioned, accreditation scope defined
Training academy & certification standard	Month 3–9	**Certification before opening; model P&L carries the cost**
First cohort & rejection feedback	Month 6–14	212 signed, 180 trading; same-day rejection push live
Quality-linked earnings	Month 10–18	22% of earnings on acceptance rate; rising to 26%
Network audit & first terminations	Month 14–26	Board-reporting audit; terminations on pre-analytical failure only
Scale & publication	Month 26–36	940 trading; rejection rate published per centre; take rate 59.6%

Training and competence

- **Phlebotomy certification** — order of draw, tube selection, haemolysis avoidance, labelling.
- **Reading your own rejection feedback**, which most franchisees have never received before.
- **Declining the clinical question** warmly at the counter rather than answering it badly.
- **Audit conduct** — observing a draw without turning a visit into an inspection.

12. Financial Plan (Illustrative)

> **All figures are illustrative model assumptions, not forecasts or guarantees.** They exist to show the drivers of a collection-centre franchisor's P&L and how the quality-linked payment, certification and publication disciplines move them. Every input is editable. **The defining economics are that 55% of revenue is testing on samples somebody else collected, so the network's gross margin is hostage to a phase it does not staff — which is precisely why 30% of franchisee earnings are tied to it.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Central laboratory — analysers & build-out	728	Runs everything the network collects
Working capital — franchise settlement & consumables	386	940 centres settled monthly
Logistics fleet & cold-chain	244	Time-to-centrifuge and temperature
Technology — LIS-lite, rejection tracking & records	**218**	**Same-day rejection feedback to the causing centre**
Training academy & certification infrastructure	**176**	**Certified phlebotomist before a centre opens**
Franchise onboarding kits & centre setup support	148	Correct tubes, correct fridge, correct labels

Licences, accreditation, deposits & pre-operative	100	Laboratory and per-state linkage requirements
Total project cost	**2,000**	₹860L investor + ₹640L term loan + ₹320L promoter + ₹180L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
FRANCHISEE EARNINGS PAID ON SAMPLE ACCEPTANCE RATE AND PRE-ANALYTICAL COMPLIANCE rather than volume alone / **franchisees paid on VOLUME ALONE** / rejection pushed back to the causing centre same-day with reason	22% / NIL / 100%	26% / NIL / 100%	**30% / NIL / 100%**
REJECTION RATE PUBLISHED PER CENTRE / network sample acceptance rate / **centres reporting a ZERO rejection rate and investigated** / **franchisees TERMINATED on pre-analytical failure** / **terminated for VOLUME SHORTFALL**	100% / 94.1% / 100% / 14 / NIL	100% / 95.8% / 100% / 38 / NIL	**100% / 96.6% / 100% / 66 / NIL**
CERTIFIED PHLEBOTOMIST in place BEFORE a centre opens / **centres operating without one** / re-certified annually / time-to-centrifuge within limit	100% / NIL / 100% / 74%	100% / NIL / 100% / 86%	**100% / NIL / 100% / 93%**
MODEL P&L given to prospects carries the phlebotomist's FULL cost / **shown without it anywhere** / **prospects who DECLINED after seeing the honest version**	100% / NIL / 38%	100% / NIL / 32%	**100% / NIL / 28%**
FULL OUTCOME DISTRIBUTION PUBLISHED INCLUDING CLOSURES — opened (cum.) / closed or exited / trading / **MEDIAN franchisee monthly earnings** / **average-only figures published**	212 / 32 / 180 / ₹14,200 / NIL	618 / 98 / 520 / ₹19,600 / NIL	**1,108 / 168 / 940 / ₹24,800 / NIL**
THE WHOLE TAKE RATE published as ONE number (lab share + consumables + logistics + software, as % of centre collection value) / samples / **results INTERPRETED OR COUNSELLED at a collection centre**	62.4% / 0.42m / NIL	60.8% / 1.38m / NIL	**59.6% / 2.94m / NIL**

Row one is the plan's whole argument compressed into a percentage: 30% of what a franchisee earns depends on whether his samples were usable, rising from 22% as the measurement matured — and the NIL beside it means no franchisee anywhere in the network is paid on volume alone. Row two's last two figures are the pair that proves it: 66 terminations on pre-analytical failure against NIL for volume shortfall, which per the pharmacy-franchise rule is how you find out what a network actually values. Row three's certification requirement is what makes the rest possible and what limits growth, since a centre cannot open until somebody is certified. Row five publishes 168 closures against 940 trading, with a MEDIAN rather than an average — because an average across survivors removes precisely the outcomes a prospect is trying to price.

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Testing revenue on franchise-collected samples	495	1,540	3,190	**58.0%**
Consumables, kits & cold-chain supply to centres	126	392	812	22.0%
Franchise fees, territory & setup	90	280	580	78.0%
Logistics & sample transport services	81	252	522	28.0%

Phlebotomist training, certification & audit	54	168	348	**64.0%**
Software subscription — LIS-lite & rejection tracking	54	168	348	72.0%
Total revenue	**900**	**2,800**	**5,800**	**53.5% blended**

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	900	2,800	5,800
Cost of services — reagents, consumables, franchisee share & rejected samples	(419)	(1,303)	(2,699)
Gross profit	**481**	**1,497**	**3,101**
Central laboratory operations & staff	(328)	(542)	(870)
Network audit — pre-analytical & rejection	**(118)**	**(212)**	**(348)**
Logistics network management	(94)	(156)	(232)
Training academy & certification	**(96)**	**(134)**	**(203)**
Franchise development & support	(96)	(132)	(174)
Technology & systems	(68)	(98)	(145)
Admin, legal, compliance & other	(102)	(142)	(201)
EBITDA	**(421)**	**81**	**928**
Depreciation & amortisation	(142)	(218)	(290)
Finance cost	(58)	(88)	(116)
Other income — settlement float and reference-testing incentives *(disclosed)*	54	112	174
PBT	**(567)**	**(113)**	**696**
Tax	142	28	(174)
PAT	**(425)**	**(85)**	**522**
Net margin	**(47.2%)**	**(3.0%)**	**9.0%**
ROCE	**(28.2%)**	**(6.9%)**	**31.9%**

Network audit at ₹3.48 crore is 6.0% of revenue spent inspecting premises we do not own, which no competitor carries and which is the direct cost of treating pre-analytical failure as our problem rather than the franchisee's. The rejected-sample cost sits inside cost of services rather than as a separate line, and that placement is deliberate: a rejected sample is a full testing cost incurred for no revenue, plus a re-collection, plus a patient inconvenienced — so it belongs where it reduces gross margin rather than where it can be presented as an exceptional item. Other income of ₹1.74 crore is settlement float and reference-testing incentives, disclosed as a line because the float is earned on money owed to franchisees. Commitments of ₹6.06 crore against ₹5.22 crore of profit mean a trade-standard franchisor with the same central laboratory would earn ₹11.28 crore.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹58.0cr	₹5.22cr	As modelled, 940 trading centres
Trade-standard franchisor practice	₹61.6cr	₹11.28cr	**Volume-only pay, no certification, closures unpublished**
Network grows to 1,400 centres	₹86.4cr	₹10.09cr	Operating leverage sits in the central lab
Franchisee churn doubles	₹46.9cr	₹1.87cr	**Median earnings drive churn; churn kills networks**
Rejection rate rises to 6%	₹56.8cr	(₹1.28cr)	**Poor collection takes the business to a loss**
Take rate cut 3 points to defend share	₹58.0cr	₹3.03cr	The take rate is most of the business

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	860	Laboratory and network build; quality-payment covenant
Term loan	640	Analysers, fleet and systems; 5–6 years
Promoter contribution	320	Cash and network experience
Working capital facility	180	Franchise settlement and consumables
Total	**2,000**	Illustrative structure

> **A lender should read acceptance rate, franchisee churn and median earnings, and should understand that the rejection sensitivity is the one that matters most. A network acceptance rate falling from 96.6% to 94% — which sounds trivial — takes this business to a ₹1.28 crore LOSS, because every rejected sample is a full testing cost with no revenue plus a re-collection, and the arithmetic compounds across 2.94 million samples. Franchisee churn is the second exposure: doubling it takes profit to ₹1.87 crore, and churn moves on median earnings rather than on anything a patient does, which is why ₹24,800 is published. The quality-linked payment deserves a covenant because reverting to volume-only pay would lift franchisee satisfaction, accelerate signings and improve every reported figure for about six quarters before the acceptance rate caught up with it.**

- **Use of funds** — 36% central laboratory, 19% working capital, 12% logistics fleet, 11% technology and rejection tracking, 9% training academy, 7% onboarding kits, 5% licences and accreditation.
- **Repayment** — term loan from Year 3 cash flow; working capital revolving against settlement and consumables.
- **Investor exit** — sale to a national diagnostics chain, a laboratory group or a healthcare platform; or promoter buyback. **Quality-payment and certification commitments survive change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation

Paid for volume, blind to quality	THE FRANCHISEE IS PAID ON WHAT HE COLLECTS AND THE LABORATORY ON WHAT IT RUNS — NEITHER IS PAID ON WHETHER THE SAMPLE WAS ANY GOOD. The phase causing 61% of all diagnostic error sits with THE PARTY WITH THE WEAKEST INCENTIVE AND THE LEAST CAPABILITY: paid a percentage of test value, competing on convenience, often staffed by AN ATTENDANT WITH NO FORMAL PHLEBOTOMY TRAINING, WITH NO LABORATORY OF HIS OWN AND THEREFORE NO WAY OF EVER LEARNING WHETHER HIS SAMPLES PRODUCED CORRECT RESULTS. HE IS NOT CARELESS — HE IS BLIND AND HE IS PAID FOR SPEED. He cannot SEE tube selection, haemolysis, labelling, time-to-centrifuge or transport temperature: the report goes to the patient, THE REJECTION GOES INTO A SYSTEM HE HAS NO ACCESS TO, and a wrong result goes to a doctor who acts on it. So he operates for years in A PERFECT INFORMATIONAL VACUUM ABOUT THE ONE THING HE MOST AFFECTS, WHILE RECEIVING A CLEAR DAILY SIGNAL ABOUT HOW MANY PEOPLE WALKED IN — the commissary problem and worse, because THE VOLUME SIGNAL IS ACTIVELY MISLEADING, SINCE THE FASTEST DRAW IS OFTEN THE WORST ONE. NOBODY IS BEHAVING BADLY; THE INFORMATION AND THE MONEY BOTH POINT THE WRONG WAY	**REDIRECT BOTH. 30% OF FRANCHISEE EARNINGS PAID ON SAMPLE ACCEPTANCE RATE AND PRE-ANALYTICAL COMPLIANCE — time-to-centrifuge, temperature, labelling, tube selection — rather than volume alone, rising from 22%, with NIL franchisees paid on volume alone. EVERY REJECTION PUSHED BACK TO THE CAUSING CENTRE THE SAME DAY WITH THE REASON, through the software subscription, SO A FRANCHISEE CAN FINALLY OBSERVE HIS OWN WORK. REJECTION RATE PUBLISHED PER CENTRE with A ZERO READING INVESTIGATED — BECAUSE AT A COLLECTION POINT A ZERO READING MEANS SAMPLES ARE BEING ACCEPTED THAT SHOULD NOT BE. 66 TERMINATED ON PRE-ANALYTICAL FAILURE AND NIL FOR VOLUME SHORTFALL, which is how you find out what a network actually values (₹1.86cr + ₹1.24cr). GENERAL RULE: WHERE THE FRANCHISEE CONTROLS THE PHASE THAT CAUSES MOST OF THE ERROR AND IS PAID ONLY FOR VOLUME, THE PAYMENT IS THE DEFECT**
The best franchisee is the worst franchisee	A centre 40% above the network median in a good catchment, popular, punctual, fees paid on time — WHOSE ACCEPTANCE RATE HAS SAT AT 91% FOR TWO QUARTERS AGAINST 96.6%, MEANING ROUGHLY ONE SAMPLE IN ELEVEN IS UNUSABLE. He is the network's best commercial relationship and its clearest quality failure, AND THE TWO FACTS ARE CONNECTED: A FAST DRAW AND A FULL WAITING ROOM PRODUCE BOTH	**AUDIT REPORTS TO THE BOARD, SITS OUTSIDE FRANCHISE DEVELOPMENT, and NO AUDIT PAY IS AFFECTED BY NETWORK REVENUE, TERMINATIONS OR SIGNINGS — the terminations clause matters as much as the revenue one, since AN AUDITOR INCENTIVISED ON TERMINATIONS IS CORRUPTED IN THE OPPOSITE DIRECTION. THE SYSTEM REFUSES RATHER THAN WARNS: two consecutive quarters below threshold trigger MANDATORY RE-CERTIFICATION and a third AUTOMATIC TERMINATION WITH NO COMMERCIAL OVERRIDE, BECAUSE A DISCRETION THAT EXISTS WILL BE EXERCISED IN FAVOUR OF THE HIGH-VOLUME CENTRE EVERY SINGLE TIME**

The model P&L without a phlebotomist	A brochure whose economics only balance without a trained phlebotomist is SELLING A BUSINESS THAT CANNOT BE OPERATED PROPERLY — and the omission is EASIER TO HIDE HERE than in pharmacy, because a collection centre visibly requires only A ROOM, A CHAIR AND A REFRIGERATOR, AND A FAMILY MEMBER CAN BE SHOWN HOW TO DRAW BLOOD IN AN AFTERNOON	**CERTIFIED PHLEBOTOMIST REQUIRED BEFORE A CENTRE OPENS, RE-CERTIFIED ANNUALLY, NIL CENTRES OPERATING WITHOUT ONE; the model P&L CARRIES HIS FULL COST, materially reducing advertised owner earnings, and 28% OF PROSPECTS DECLINE (₹2.32cr). Training delivered by our own academy AND SOLD AS A REVENUE LINE RATHER THAN ABSORBED, BECAUSE A TRAINING FUNCTION FUNDED OUT OF GOODWILL IS THE FIRST THING CUT IN A BAD QUARTER**
Averages across survivors	An average computed across surviving centres REMOVES EXACTLY THE OUTCOMES A PROSPECT IS TRYING TO PRICE, and INDIA HAS NO FRANCHISE DISCLOSURE STATUTE requiring otherwise; and a franchisee told only the laboratory share IS BEING TOLD A FRACTION OF WHAT THE NETWORK TAKES	**FULL OUTCOME DISTRIBUTION PUBLISHED: 1,108 OPENED, 168 CLOSED OR EXITED, 940 TRADING, with MEDIAN franchisee monthly earnings ₹24,800 NOT AN AVERAGE and the survival curve BY SIGNING COHORT; NIL average-only figures anywhere. THE WHOLE TAKE RATE PUBLISHED AS ONE NUMBER — lab share + consumables + logistics + software = 59.6% of centre collection value, falling from 62.4% (₹64L)**
The question at the counter	A patient collecting a report WILL ASK WHAT IT MEANS, and the person handing it over is a franchisee or attendant WITH NO CLINICAL QUALIFICATION, STANDING IN A ROOM WITH A MEDICAL-LOOKING SIGN ON IT — so the answer CARRIES AN AUTHORITY IT HAS NOT EARNED AND THE PATIENT CANNOT TELL THE DIFFERENCE	**NIL RESULTS INTERPRETED OR COUNSELLED AT A COLLECTION CENTRE, EVER; the laboratory pathologist's contact PRINTED ON EVERY REPORT for clinical queries; and staff trained in HOW TO DECLINE THE QUESTION WARMLY RATHER THAN ANSWER IT BADLY — which is a taught skill, not an instruction**
The sample becomes ours at handover	NABL accreditation makes the laboratory answerable for PRE-EXAMINATION PROCESSES CARRIED OUT ON ITS BEHALF, so collection performed in premises we do not own is FORMALLY OUR OBLIGATION — while nothing obliges us to pay the collector for doing it well	Handover conditions CONTRACTED RATHER THAN ASSUMED; time-to-centrifuge within limit measured at 93% and temperature logged per consignment; consumables SUPPLIED CENTRALLY AT A DELIBERATELY THIN 22% MARGIN so the right tube is also the cheap tube, REMOVING AN ENTIRE FAILURE MODE; and Bio-Medical Waste compliance managed across 940 small sharps generators as a network obligation rather than 940 individual ones
Rejection economics and churn	Acceptance falling from 96.6% to 94% takes the business to a ₹1.28cr LOSS, because A REJECTED SAMPLE IS A FULL TESTING COST WITH NO REVENUE PLUS A RE-COLLECTION, compounding across 2.94m samples; and doubled churn takes profit to ₹1.87cr	Rejected-sample cost carried INSIDE gross margin rather than as an exceptional item, so it reduces the number people are judged on; median franchisee earnings grown ₹14,200 → ₹24,800 and published, since CHURN MOVES ON EARNINGS RATHER THAN ON ANYTHING A PATIENT DOES; franchise development paid on cohort survival at 24 months rather than signings; and no territory opened that cannot be audited on the same unannounced cycle

Growth pressure and certification supply	A rival can open a centre in a week with a trained attendant and a fridge; WE TAKE SIX BECAUSE SOMEBODY MUST BE CERTIFIED FIRST, and there is no way to present that as speed	Training academy capacity built ahead of signing demand; certification cohorts run continuously rather than on request; prospects with an existing qualified phlebotomist prioritised; growth taken from SELECTION rather than signing volume; and the certification requirement stated publicly as the reason for slower openings rather than explained away

15. SWOT Analysis

Strengths

- 30% of franchisee earnings tied to sample acceptance
- Rejection pushed back same-day; published per centre
- 66 terminations on quality; nil on volume shortfall
- Certified phlebotomist before opening; nil exceptions
- Full outcome distribution and whole take rate published

Weaknesses

- ₹6.06cr forgone against ₹5.22cr of profit
- 28% of prospects decline; slower openings
- Audit at 6.0% of revenue, which no rival carries
- Gross margin hostage to a phase we do not staff

Opportunities

- Franchisees who want to know whether they are any good
- Laboratories seeking reach without pre-analytical risk
- Training and certification as a saleable capability
- Tier-2 and tier-3 expansion where no lab is viable
- Any accreditation tightening on collection favours us

Threats

- Rival networks opening faster because they require nothing
- Acceptance-rate deterioration compounding across volume
- Franchisee churn on median earnings
- Certified phlebotomist scarcity limiting growth

16. Recommended AiSevak Tools for This Business

- **Quality-linked settlement engine** — 30% of franchisee earnings computed from acceptance rate and compliance.
- **Same-day rejection push** — every rejection returned to the causing centre with its reason.
- **Rejection rate publisher** — per centre, with zero-rate auto-investigation.
- **Certification register** — no centre can be activated without a certified phlebotomist on record.
- **Honest model P&L generator** — phlebotomist cost structurally required; no variant without it.
- **Outcome distribution publisher** — opened, closed, trading, by cohort, with medians not averages.
- **Cold-chain & time-to-centrifuge log** — per consignment, from centre to laboratory.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, centre counts, acceptance rates, take rate and median earnings are editable inputs; actual outcomes depend on selection, certification supply, transport geography and churn. Figures are in Indian rupees. **This plan inherits the diagnostics anchor's rules from `pathology-lab` and the franchise rules from `pharmacy-chain-franchise` and `food-franchise`.**
- **The central integrity finding is that the franchisee is paid on what he collects and the laboratory on what it runs, and neither is paid on whether the sample was any good.** The phase that causes 61% of all diagnostic error

sits with the party with the weakest incentive and the least capability — paid a percentage of test value, competing on convenience, often staffed by an attendant with no formal phlebotomy training, with no laboratory of his own and therefore no way of ever learning whether his samples produced correct results. **He is not careless. He is blind and he is paid for speed.** He cannot observe tube selection, haemolysis, labelling, time-to-centrifuge or transport temperature: the report goes to the patient, the rejection goes into a system he cannot access, and a wrong result goes to a doctor who acts on it. **So he operates for years in a perfect informational vacuum about the one thing he most affects, while receiving a clear daily signal about how many people walked in — the commissary problem and worse, because the volume signal is actively misleading, since the fastest draw is often the worst one. Nobody is behaving badly; the information and the money both point the wrong way.**

- **So both are redirected.** 30% of franchisee earnings are paid on sample acceptance rate and pre-analytical compliance rather than volume alone, rising from 22%, with nil franchisees paid on volume alone. Every rejection is pushed back to the causing centre the same day with its reason, so a franchisee can finally observe his own work. Rejection rate is published per centre and a zero reading is investigated — because at a collection point a zero reading means samples are being accepted that should not be. **66 franchisees were terminated on pre-analytical failure and NIL for volume shortfall, which is how you find out what a network actually values. WHERE THE FRANCHISEE CONTROLS THE PHASE THAT CAUSES MOST OF THE ERROR AND IS PAID ONLY FOR VOLUME, THE PAYMENT IS THE DEFECT.**
- **The model P&L must carry a trained phlebotomist, and the omission is easier to hide here than in pharmacy.** A collection centre visibly requires only a room, a chair and a refrigerator, and a family member can be shown how to draw blood in an afternoon — so a brochure whose economics balance without a certified phlebotomist is selling a business that cannot be operated properly. **A certified phlebotomist is required before a centre opens and re-certified annually, nil centres operate without one, the model P&L carries his full cost, and 28% of prospects decline after seeing it, at ₹2.32 crore.** Training is delivered by our own academy and sold as a revenue line rather than absorbed, because a training function funded out of goodwill is the first thing cut in a bad quarter.
- **The full outcome distribution is published, and so is the whole take.** 1,108 centres opened cumulatively, 168 closed or exited, 940 trading, with median franchisee monthly earnings of ₹24,800 rather than an average and the survival curve by signing cohort — because an average across survivors removes exactly the outcomes a prospect is trying to price, and India has no franchise disclosure statute requiring otherwise. **The whole take rate is published as one number — laboratory share plus consumables plus logistics plus software, 59.6% of centre collection value, falling from 62.4% — because a franchisee told only the laboratory share is being told a fraction.** And nil results are interpreted or counselled at a collection centre, because the person handing over a report has no clinical qualification and the patient cannot tell.
- **Two design choices in the revenue mix are quality decisions rather than commercial ones.** Consumables are supplied at a deliberately thin 22% margin, because a franchisor taking a wide margin on tubes gives every centre a standing incentive to buy them elsewhere, and the wrong tube is one of the commonest pre-analytical failures there is — cheap correct consumables cost us margin and remove an entire failure mode. And the software subscription matters more than its 6% suggests, because it is the mechanism by which a rejection reaches the centre that caused it within the same day, which is the only way a franchisee who has never seen a laboratory learns anything.
- **The economics are hostage to a phase the network does not staff, which is the whole reason for the payment design.** 55% of revenue is testing on samples somebody else collected, and a network acceptance rate falling from 96.6% to 94% — which sounds trivial — takes the business to a ₹1.28 crore loss, because a rejected sample is a full testing cost with no revenue plus a re-collection, compounding across 2.94 million samples. **Franchisee churn is the second exposure, doubling it takes profit to ₹1.87 crore, and churn moves on median earnings rather than on anything a patient does.** Commitments of ₹6.06 crore against ₹5.22 crore of profit mean a trade-standard franchisor with the same central laboratory would earn ₹11.28 crore.

- **Compliance and professional advice.** The Clinical Establishments Act 2010 and state rules, under which a collection centre may itself require registration and in several states must be linked to a registered laboratory with the linkage documented; **NABL accreditation under ISO 15189, which covers the laboratory and its pre-examination processes including collection performed on its behalf — the formal reason a franchisor cannot treat pre-analytical failure as somebody else's problem**; NMC conduct regulations on referral commissions, binding on the doctor who receives; Bio-Medical Waste Rules at every centre generating sharps; the Drugs and Cosmetics Act for collection consumables; PCPNDT where prenatal-related handling arises; the Digital Personal Data Protection Act 2023, under which patient identity and results at a collection point are sensitive personal data held by a party with minimal infrastructure; franchise contracting under general contract law, since India has no franchise disclosure statute; GST; and shops and establishments, EPF/ESI and POSH. Professional advice should be taken on collection-centre registration and linkage by state, accreditation scope for pre-examination processes, waste compliance across a distributed network and franchise agreement terms.

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