



BUSINESS PLAN · INDIA

Special-Education and Therapy Centre

It earns by keeping a child and succeeds by losing him

SCHOOLS

AISEVAK.IN · BY ABL DIGITAL TECHNOLOGIES

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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 **Special-Education & Therapy Centre** in India — a fourteen-room clinical and educational facility providing assessment, special education, speech and language therapy, occupational and sensory-integration therapy, behavioural intervention, parent training and school-based inclusion support for children with autism spectrum conditions, ADHD, specific learning disability, intellectual disability, cerebral palsy and communication disorders.

This business earns by keeping a child and succeeds by losing him, and no plan for it is honest until that is said in the first paragraph. Revenue is per therapy hour. The child's goal is to need fewer hours and eventually none, and to move into an inclusive school alongside his peers. Every genuinely successful outcome therefore removes revenue, and the commercial pressure runs the other way: to keep a child on the roll, to add a session, to find a new area of need when an old one closes. That pressure is not hypothetical and it does not require anybody to be dishonest — it requires only that nobody measures the thing that would expose it. This plan measures it. Children transitioned into inclusive or mainstream settings are reported as the headline success — six in Year 1 rising to thirty-eight — and children on the roll for more than three years without documented goal progress are reported as a failure, falling from fourteen to two. Growth comes from new intake and from school-based inclusion services, not from holding on to children who no longer need what is being sold.

The second is that this centre's customer is the most motivated buyer in this entire library, and that is a warning rather than an opportunity. The parent of a newly diagnosed three-year-old will spend everything she has, will believe almost anything, and has no way whatever to evaluate a clinical claim. Autism is not cured; specific learning disability is not cured; cerebral palsy is not cured. A centre using recovery, cure or "normal school by next year" language to a family in that position is exploiting distress, and it is the medical-tourism problem this library identified earlier arriving in a far more vulnerable setting. This plan's claim is bounded and checkable: measured progress against a written baseline, on goals the family agreed, reported quarterly whether or not the goals were met — from 48% of children having a documented baseline and agreed goals to 100%, and from no routine outcome reporting to all of it. The plan also states plainly what the intervention does not do, which costs enquiries and is the only defensible way to sell to somebody who cannot check.

The third is a legal line rather than a quality preference, and a great many centres in India are on the wrong side of it. The Rehabilitation Council of India Act requires registration to practise as a rehabilitation professional, and practising without it is an offence — not a shortfall in credentials. Yet centres staffed by kind, committed, entirely unregistered people are common, and the family cannot tell the difference because the room, the fee and the manner are identical. This plan takes RCI-registered practitioners delivering therapy from 52% to 100%, with supervision hours per therapist rising from two a month to six — and treats the gap as an exposure to be closed rather than a norm to be worked within.

And the fourth is safeguarding at higher stakes than anywhere else in this vertical, because the usual reporting channel is missing. Therapy here involves physical handling, toileting support and sustained one-to-one contact — all necessary, none avoidable. The play-activity plan established that in such settings the necessary act and the dangerous one look identical and the innocent explanation is genuinely available. Here a further protection is absent: many of these children are non-verbal or have limited communication, and cannot report what happened to them. A safeguarding regime built on a child telling somebody does not work in this building. The controls are therefore environmental and absolute: observation access on every therapy room

(71% to 100%), no closed-room one-to-one under any circumstance, an unannounced parent-observation right exercised ninety-six times in Year 3, every adult verified, and concerns logged as a number that must rise — three to twenty-four.

This plan models a centre requiring **₹2.50 crore** (₹1.30 crore promoter + ₹80 lakh term loan + ₹40 lakh working-capital facility), moving from **₹1.50 crore revenue and a ₹41 lakh loss** to **₹5.04 crore revenue and ₹43 lakh profit** by Year 3, with return on capital employed reaching 15.4% on a therapist-cost base of half of turnover. (Special education and child therapy centre — figures illustrative.)

2. Centre Description, Vision & Legal Structure

Concept: A multi-disciplinary child therapy and special-education centre that measures its success by the children who leave it, prescribes therapy through clinicians who do not deliver it, and never claims an outcome it cannot evidence.

Vision: To be the centre whose best year is the one in which most children moved on.

Mission: Register every practitioner; write the baseline before the first session; report the goal result whether or not it was met; keep the door glass clear and the parent free to walk in; and never sell a session the assessing clinician did not prescribe.

Legal structure

- **Private Limited** — recommended and **lawfully for-profit, unlike a K-12 school**; professional indemnity, clinical governance and school contracting all sit better in a company.
- **Trust or Section 8** — used by many centres to access grants, CSR funding and fee-subsidy schemes, and it forfeits distribution; **choose it for the funding access, not from a belief that this work must be non-profit.**
- **Proprietorship** — unsuitable: the clinical and safeguarding liability in this work should not be held personally.

Regulatory anchor: the most consequential in this vertical, because two of these obligations are criminal rather than administrative. **The Rehabilitation Council of India Act requires registration to practise as a rehabilitation professional in the categories this centre employs — special educators, clinical psychologists, speech-language pathologists, audiologists and rehabilitation therapists — and practising without registration is an offence.** **The Rights of Persons with Disabilities Act 2016 frames the whole field: it establishes rights rather than services, mandates inclusive education as the objective, and requires the premises themselves to be accessible — a centre for disabled children that a wheelchair cannot enter is a contradiction that inspection and families both notice.** Then: **POCSO and the Juvenile Justice Act, with the specific difficulty that many children here cannot make a disclosure; clinical-record confidentiality and the Digital Personal Data Protection Act, under which a child's data requires verifiable parental consent and is treated with particular care — assessment reports and therapy notes about a disabled child are among the most sensitive records any business in this library holds;** the Mental Healthcare Act where psychological services engage it; **Consumer Protection Act exposure on outcome claims, which is where a "cure" promise would land;** professional indemnity insurance as a working requirement; **GST treatment differing between services characterised as healthcare and those characterised as education, which is a genuine structuring question to settle before the fee schedule is printed;** and shops and establishment registration, fire NOC, POSH and EPF/ESI.

3. Promoter, Clinical Governance & Ownership

Led by a promoter with clinical, special-education or rehabilitation background, with a named clinical director who is RCI-registered and holds authority over practice. Three competences decide outcomes. *The discipline to discharge*, because a

centre that cannot let a child go will keep him, and the pressure to do so is financial, emotional and constant. *Clinical governance that constrains the business* — supervision, case review, and prescription separated from delivery — which costs money and reduces sessions sold. And *the willingness to say what will not happen*, to a parent who has been told elsewhere that it will, and who will sometimes leave for the centre that promised more. **Clinical authority must sit with the clinical director rather than with the promoter where the two differ, and that should be written down before it is tested.** Ownership, equity & investor terms are editable inputs.

4. Market Analysis — India

Indian demand for child developmental therapy is large, rising and badly served — diagnosis is improving faster than provision, most districts have no qualified professionals at all, and families routinely travel long distances or wait months for an assessment.

Demand drivers

- **Rising diagnosis and awareness**, particularly of autism spectrum conditions and specific learning disability, where identification has improved substantially.
- **Paediatrician referral**, now far more common at the developmental-delay stage than a decade ago.
- **The RPwD Act's inclusive-education mandate**, which obliges schools to accommodate and creates demand for shadow and inclusion support.
- **Board accommodation provisions** for learning disability, which drive assessment demand at school age.
- **Severe supply shortage of RCI-registered professionals**, especially outside metros.
- **Parental willingness to pay**, frequently far beyond what the household can sustain.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Children with developmental needs in the catchment	Prevalence-defined and substantially undiagnosed
SAM	Families who can sustain regular therapy at this fee	Affordability-bounded, and severely so
SOM (Yr 1-3)	Billable therapist-hours × fee, plus assessment and school services	13,900 → 36,550 hours; utilisation 54% → 71%

The affordability problem in this market is severe and shapes what an honest centre can offer, so it should be stated rather than left as an assumption about the addressable population. A child in early intervention may need three to five therapy hours a week for two or three years. At any commercially sustainable rate that is a very large sum for an ordinary Indian household, and families meet it by borrowing, by selling assets, by one parent leaving work, or by stopping — usually the last, and usually without telling the centre why. The demand that appears in an enquiry log is therefore much larger than the demand that can actually be served, and a plan that sizes its market on prevalence has counted families who will never be able to pay. Three responses run through this plan. **Group programmes and parent training are built as genuine clinical formats rather than as cheap substitutes — a trained parent delivers more therapeutic hours at home in a week than a centre delivers in a month, and that is the highest-leverage intervention available to a family that cannot afford intensive one-to-one.** School-based inclusion support is developed deliberately, because it is paid by the school rather than the family and reaches children whose parents could never fund centre therapy. And a written sliding-fee and hardship process exists, applied quietly, because the alternative is that the poorest families simply stop

attending and the centre records it as attrition.

5. Competition & Position

Landscape: hospital-attached developmental paediatric units with clinical authority and long waiting lists; independent therapists practising alone, often excellent and always capacity-limited; **unregistered centres offering "programmes" with confident claims and no clinical governance, competing effectively because their promises are better**; special schools providing segregated education; and a large informal market of remedial tutors, alternative practitioners and imported "protocols" sold directly to desperate families. **Because outcomes are slow, variable and hard to attribute, families cannot compare providers on results — so they compare on confidence, and confidence is exactly what an honest provider has least of.**

The centre's position

- **Every practitioner RCI-registered**, verifiable by any family that asks.
- **Written baseline and agreed goals** before therapy begins, with quarterly outcome reporting.
- **Prescription separated from delivery**, so nobody who is paid per session decides how many are needed.
- **Transition to inclusive settings reported as success**, not concealed as attrition.
- **Observation access and an unannounced parent-visit right** on every room.
- **No equipment, supplement or proprietary-programme sales** at all.

The competitive difficulty here is unusually painful and should be stated without self-congratulation: the honest provider sounds less capable than the dishonest one, to a parent who is frightened. A family that has just received a diagnosis visits two centres. One says the child has a good chance of substantial progress with consistent work over two to three years, that some difficulties will persist into adulthood, and that nobody can predict the trajectory for an individual child. The other says its programme has helped children like hers reach mainstream school within a year. The second is what she wants to hear, it is delivered with confidence, and she cannot evaluate either claim. An honest centre loses that family, and will lose many like her. Three things make the position sustainable rather than merely admirable. **Referral from clinicians: paediatricians and developmental specialists can evaluate a claim, they refer repeatedly, and they stop referring to centres that over-promise — which makes the professional referral channel both the most durable acquisition route and the one that rewards restraint.** Evidence over time: a centre that publishes goal-attainment quarterly builds a record that a confident claim cannot match after two years. And the returning family — a meaningful share of families who leave for a centre promising more come back, and they come back because somebody told them the truth once. The plan carries the Year-1 cost of that rather than pretending honesty converts immediately.

6. Services, the Discharge Problem & the Prescription Control

Element	Character	Economics
One-to-one therapy (speech, OT, behavioural, special education)	The core; capacity is therapist-hours, not seats	₹850 → ₹1,050 per hour; 79% → 76% of revenue
Assessment & diagnostic	The entry point, and the prescription source	Conducted by clinicians who do NOT deliver the therapy
Parent training	A trained parent delivers more hours at home in a week than the centre does in a month	Highest leverage available to a family that cannot fund intensive therapy

School-based inclusion & shadow support	Paid by the school, reaches families who could not pay	4% → 10% of revenue; the growth line
Group programmes	Clinically appropriate for some goals; affordable	Built as a format, not a discount
Children transitioned to inclusive settings	The headline SUCCESS metric	6 → 19 → 38 per year
On roll >3 years without documented goal progress	The headline FAILURE metric	14 → 6 → 2
Equipment, supplement & proprietary-programme sales	Refused outright	Nil throughout

Separating prescription from delivery is the single most important governance decision in this plan, and it is worth explaining because it costs money and is easy to skip. In the ordinary arrangement, the therapist who delivers a child's sessions is also the person who recommends how many sessions are needed — and her income, her utilisation and often her incentive depend on the answer. Nobody has to be dishonest for that to bend: a therapist who genuinely believes another two sessions a week would help is not lying, and she is also not neutral, and neither she nor the family can separate the two. Add a parent who will agree to anything, and there is no counterweight in the room at all. This plan installs one. Therapy hours are prescribed by the assessing clinician, who does not deliver those hours and is not paid per session — moving from 0% of prescriptions to 100%. Reviews of intensity are conducted by the same independent route, on a schedule, and a recommendation to REDUCE hours is recorded and reported alongside recommendations to increase them. Equipment, supplements and proprietary programmes are not sold at all — not restricted, not disclosed, but refused — because in a market where the buyer cannot evaluate the product and will buy anything, disclosure is not a sufficient control and the only honest position is not to be in that business. The cost is real: these are the highest-margin lines available to this centre, and the plan gives them up.

7. Referral, Families & the Child Who Cannot Tell

Acquisition

- **Paediatrician and developmental-specialist referral**, the most durable channel and the one that rewards restraint.
- **School partnerships** for identification and inclusion support, which reach children whose families cannot fund centre therapy.
- **Parent-to-parent referral**, powerful in this community and unforgiving of over-promising.
- **Assessment as the entry point**, priced accessibly because it is where a family decides whether to trust the centre.
- **Awareness and screening camps**, conducted without converting a screening into a sale.

Retention — and its limits

- **Visible progress against agreed goals**, reported whether or not it is good.
- **Therapist continuity**, which matters enormously to a child with rigid routines and to the parent watching.
- **Parents treated as co-therapists** rather than as people in a waiting room.
- **Discharge planned openly from the beginning**, so leaving is an achievement rather than a loss.

The safeguarding position in this centre has to be stronger than anywhere else in this vertical because one of the standard protections is simply absent. Every setting that works with children faces the problem the play-

activity plan set out: necessary physical contact and abusive contact look the same, and the innocent explanation is genuinely available. Here the contact is more extensive — physical prompting, sensory work, toileting support, sustained one-to-one sessions in a quiet room — and the child frequently cannot describe what happened. Many of these children are non-verbal; others communicate in ways an unfamiliar adult would not interpret; some would not distinguish an unusual act from an ordinary one. A safeguarding regime that ultimately depends on a child telling somebody does not function in this building, and pretending otherwise is the most dangerous assumption a centre like this can make. The controls are therefore environmental, absolute and independent of disclosure. **Observation access on every therapy room — glass, not a camera alone — rising from 71% to 100%, because a room that cannot be seen into should not be used for therapy at all. No closed-room one-to-one under any circumstance, with no exception for a senior clinician, a distressed child or a scheduling difficulty. An unannounced parent-observation right, exercised rather than merely offered — ninety-six times in Year 3 — because a right nobody uses is a policy and not a control. Every adult on the premises verified, including support staff and drivers. And concerns and unusual incidents logged as a number expected to RISE, from three to twenty-four, since in this setting a nil return means nobody is watching rather than nothing is happening.**

8. Operations Plan (assess, prescribe, deliver, review, discharge)

- **Assessment:** conducted by an RCI-registered clinician who will not deliver the resulting therapy, **with a written baseline and goals agreed with the family before any session is booked.**
- **Prescription:** therapy type and intensity set by the assessing clinician and reviewed on schedule by the same independent route — with recommendations to **REDUCE** recorded and reported alongside recommendations to increase.
- **Delivery:** one-to-one and small-group sessions to a written plan, **with therapist continuity protected because a child with rigid routines pays a real cost for a change of person.**
- **Documentation:** session notes and goal progress recorded contemporaneously, **and therapist time for documentation counted inside the working day rather than expected afterwards.**
- **Outcome reporting:** goal attainment reported to families quarterly whether or not goals were met — including where progress has stalled, which is the report nobody wants to write and the one that makes the others credible.
- **Discharge:** planned from the first review, with transition to inclusive settings supported and counted as the centre's headline success.
- **Supervision:** clinical supervision hours per therapist raised from two a month to six, **with case review independent of the treating therapist.**
- **Safeguarding:** observation glass on every therapy room, no closed-room one-to-one, unannounced parent observation facilitated on request, all adults verified.
- **Records:** clinical records held to confidentiality standard with verifiable parental consent, **since assessment reports about a disabled child are among the most sensitive data any business in this library holds.**
- **Fees:** published per hour with no bundling into packages that must be bought in advance; **a written sliding-scale and hardship process applied quietly.**

Control points

Area	Activity	Control point
Success is losing the child	Transitions to inclusive settings / on roll >3 yrs without goal progress	6 → 38 per year / 14 → 2

A legal line, not a preference	RCI-registered practitioners delivering therapy	52% → 78% → 100%
Nobody paid per session decides how many are needed	Hours prescribed by a non-delivering clinician	0% → 100%
A claim that can be checked	Written baseline & agreed goals / quarterly outcome reporting regardless of result	48% → 100% / 0% → 100%
The child cannot tell	Therapy rooms with observation access / unannounced parent observations facilitated	71% → 100% / 0 → 96 per year
Supposed to rise	Concerns & unusual incidents logged / adults verified	3 → 24 / 63% → 100%
Refused outright	Equipment, supplement & proprietary-programme revenue	Nil in every year
Capacity & people	Billable therapist-hour utilisation · supervision hours per therapist · therapist attrition	54% → 71% · 2 → 6 per month · 34% → 19%

The discharge metric deserves to be understood as an accounting decision as much as a clinical one, because it is where this plan differs most sharply from how the sector reports itself. In an ordinary services business a departing customer is churn, and churn is a problem. Here, a child who no longer needs therapy and has moved into an inclusive classroom is the outcome the entire enterprise exists to produce — and if it is recorded in the same column as a family that left because it ran out of money, the centre has lost the ability to tell success from failure. So the two are separated and reported separately: planned discharge with goals attained, counted as achievement; and unplanned departure, counted and investigated, because the commonest reason is affordability and the second commonest is that nobody explained what was happening. The second half of the discipline is harder. Children on the roll for more than three years without documented goal progress are reported as a failure of the centre rather than as a characteristic of the child — fourteen in Year 1, two by Year 3 — and each one is reviewed by a clinician who is not treating him. Some of those children have profound needs and will require lifelong support, which is a legitimate reason for a long relationship and is recorded as such; the metric exists to distinguish those from the ones nobody re-examined. A centre unwilling to compute that number is a centre that does not want to know it.

9. RCI Registration, RPwD & Clinical Compliance (India)

- **Rehabilitation Council of India Act registration for every practitioner delivering therapy** — special educators, clinical psychologists, speech-language pathologists, audiologists and rehabilitation therapists — **where practising without registration is an OFFENCE rather than a credential shortfall, and the family cannot tell the difference because the room, the fee and the manner are identical.**
- **Rights of Persons with Disabilities Act 2016** — rights rather than services, **inclusive education as the objective, and physical accessibility of the premises, since a centre for disabled children that a wheelchair cannot enter is a contradiction families and inspectors both notice.**
- **POCSO and the Juvenile Justice Act, applied with the knowledge that many children here cannot make a disclosure** — which is why the controls are environmental rather than reporting-dependent.
- **Clinical-record confidentiality and the Digital Personal Data Protection Act**, with verifiable parental consent — **assessment reports and therapy notes about a disabled child are among the most sensitive records any business in this library holds.**

- **Consumer Protection Act exposure on outcome claims**, which is where a cure or recovery promise would land; the Mental Healthcare Act where psychological services engage it.
- **Professional indemnity insurance as a working requirement** rather than a compliance line.
- **GST treatment differing between healthcare-characterised and education-characterised services** — a genuine structuring question to settle before the fee schedule is printed.
- Shops & establishment registration, fire NOC and accessible premises certification; POSH; EPF and ESI.

10. Organisation & Manpower Plan

Role	Yr 1	Yr 2	Yr 3
Special educators	6	9	13
Shadow teachers & school inclusion support	3	6	11
Speech-language pathologists	4	6	8
Occupational therapists	4	6	8
Clinical & child psychologists	2	3	4
Behaviour therapists	2	2	3
Front desk, coordination & scheduling	3	4	6
Support & housekeeping	3	4	5
Accounts & administration	2	3	4
Clinical director (RCI-registered, holds clinical authority)	1	1	2
Total	30	44	64

Two features of this establishment carry the plan. Shadow teachers and school inclusion support grow fastest of any group, from three to eleven — because that service is paid by schools rather than families, reaches children whose parents could never fund centre therapy, and is the practical expression of a plan whose stated objective is children in mainstream classrooms. **And the clinical director is RCI-registered and holds clinical authority over the promoter where the two differ**, written down before it is tested — the rule this library applies everywhere: **a control that reports to the party it constrains is not a control**, and here the constrained party is the one whose revenue depends on sessions being delivered rather than on children being discharged.

11. Implementation Timeline & Milestones

Phase	Timeline	Milestone
Setup	Month 0-6	Accessible premises secured, fourteen therapy rooms fitted with OBSERVATION GLASS as a design requirement rather than an addition, clinical director appointed and RCI registration verified for every practitioner before the first session, assessment-prescription separation configured in the scheduling system, baseline-and-goal documentation mandatory before any booking, indemnity in place
Year 1	Year 1	13,900 billable hours; ₹1.50cr revenue, ₹41L loss; RCI coverage 52% and closing; utilisation 54%; baselines documented 48%; 6 transitions; 14 long-stay children flagged for independent review; ROCE (16.9%)

Year 2	Year 2	23,420 hours; RCI 78%; prescription separation 100%; quarterly outcome reporting live; observation access 92%; 19 transitions; school inclusion contracts with 4 schools; ₹2.88cr revenue, ₹17L loss
Year 3	Year 3	36,550 hours; ₹5.04cr revenue, ₹43L profit; ROCE 15.4%; RCI 100%; utilisation 71%; baselines and quarterly reporting 100%; 38 transitions; long-stay-without-progress down to 2; observation access 100% and unannounced parent visits 96; concerns logged 24

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions for an Indian context, shown so the promoter can replace them with live rates. **Therapist-hour utilisation and the school-services line are the levers. Session volume per child is not one — it is prescribed by a clinician who is not paid for delivering it, and that is the point.**

12.1 Project cost & means of finance

Capital requirement	₹
Premises fit-out (14 therapy rooms with observation glass, sensory gym, assessment room, accessibility)	78,00,000
Launch & initial operating losses	56,00,000
Sensory-integration equipment, therapy materials & assessment tools	34,00,000
Premises deposit	26,00,000
Clinical recruitment, pre-launch salaries & training	22,00,000
Technology (clinical records, goal tracking, scheduling, observation)	12,00,000
Launch marketing & professional outreach	10,00,000
Working capital	6,00,000
Licences, legal, professional indemnity & registrations	6,00,000
Total project cost	2,50,00,000
Promoter contribution	1,30,00,000
Term loan (fit-out & equipment)	80,00,000
Working-capital facility	40,00,000

12.2 Projected Profit & Loss (3 years)

Particulars	Year 1	Year 2	Year 3
THERAPISTS / BILLABLE HOURS DELIVERED / fee per hour	18 / 13,900 / ₹850	26 / 23,420 / ₹950	36 / 36,550 / ₹1,050
One-to-one therapy fees	1,18,00,000	2,22,00,000	3,84,00,000
Assessment & diagnostic	14,00,000	22,00,000	32,00,000
Group programmes	8,00,000	16,00,000	26,00,000
School-based inclusion & shadow support	6,00,000	20,00,000	48,00,000

Parent training & workshops	4,00,000	8,00,000	14,00,000
Equipment, supplement & proprietary-programme sales	Nil — refused	Nil	Nil
TOTAL REVENUE	1,50,00,000	2,88,00,000	5,04,00,000
Therapist & special-educator salaries	88,00,000	1,58,00,000	2,52,00,000
Premises rent & CAM	26,00,000	30,00,000	36,00,000
Non-clinical salaries (coordination, front desk, admin, support)	18,00,000	28,00,000	42,00,000
Clinical supervision, case review, training & CPD	10,00,000	18,00,000	30,00,000
Depreciation (fit-out, sensory equipment, assessment kits)	9,00,000	11,00,000	14,00,000
Therapy materials, assessment tools & consumables	8,00,000	14,00,000	22,00,000
Marketing & professional outreach	8,00,000	12,00,000	18,00,000
Utilities, maintenance & housekeeping	6,00,000	9,00,000	13,00,000
Finance cost	5,00,000	5,00,000	4,00,000
Administration, compliance, audit & professional indemnity	5,00,000	8,00,000	12,00,000
Safeguarding: verification, observation infrastructure & insurance	4,00,000	6,00,000	9,00,000
Technology (clinical records, goal tracking, scheduling)	4,00,000	6,00,000	9,00,000
Total expenses	1,91,00,000	3,05,00,000	4,61,00,000
Net profit / (loss) before tax	(41,00,000)	(17,00,000)	43,00,000
Net margin	(27.3%)	(5.9%)	8.5%
AVERAGE CAPITAL EMPLOYED / RETURN ON CAPITAL EMPLOYED	₹2.42cr / (16.9%)	₹2.58cr / (6.6%)	₹2.80cr / 15.4%
Therapist cost as % of revenue	58.7%	54.9%	50.0%
BILLABLE THERAPIST-HOUR UTILISATION	54%	63%	71%
RCI-REGISTERED PRACTITIONERS DELIVERING THERAPY	52%	78%	100%
Written baseline & agreed goals / quarterly outcome reporting regardless of result	48% / 0%	82% / 100%	100% / 100%
THERAPY HOURS PRESCRIBED BY A NON-DELIVERING CLINICIAN	0%	100%	100%
CHILDREN TRANSITIONED TO INCLUSIVE SETTINGS (the success metric)	6	19	38
On roll >3 years without documented goal progress (the failure metric)	14	6	2
Therapy rooms with observation access / unannounced parent observations facilitated	71% / 0	92% / 41	100% / 96

Concerns & incidents logged (supposed to rise) / adults verified	3 / 63%	12 / 100%	24 / 100%
Supervision hours per therapist per month · therapist attrition · school-services share of revenue	2 · 34% · 4%	4 · 26% · 7%	6 · 19% · 10%

12.3 Unit economics & break-even

- **Capacity here is therapist-hours, not rooms or seats, and the honest ceiling is lower than promoters expect. A therapist can deliver roughly five and a half productive one-to-one hours in a day, not eight — the work is intensive and documentation is part of it, counted inside the working day rather than expected afterwards. A centre reporting 90% therapist utilisation is either not documenting or not resting its therapists, and both show up in attrition within a year.**
- **Therapist cost is 58.7% of revenue falling to 50.0%, and it falls only through utilisation. This is a low-margin, high-obligation business and the plan says so — a 15.4% return in Year 3 on a centre of this kind is a respectable outcome, and anyone modelling substantially more is either under-paying clinicians, over-prescribing sessions, or selling something other than therapy.**
- **The school-inclusion line is the growth engine precisely because it is not funded by families — from 4% to 10% of revenue, paid by schools, reaching children whose parents could not sustain centre fees, and aligned with the RPwD Act's inclusive-education objective rather than working against it.**
- **Giving up equipment, supplement and proprietary-programme sales costs real margin. These are the highest-margin lines available to a centre of this kind and are sold routinely across the sector; the plan earns nothing from them in any year, which is a stated cost of the position rather than an oversight.**
- **Break-even: Year 3, with ₹58 lakh of losses first. The ramp is slow because RCI-registered clinicians are genuinely scarce, cannot be hired in bulk, and take time to build a caseload — and a projection showing faster is describing a recruitment market that does not exist.**

12.4 Projected Cash Flow — Year 1 (quarterly, illustrative)

Particulars (₹)	Q1	Q2	Q3	Q4
Opening balance	56,00,000	42,00,000	30,00,000	20,00,000
Fees, assessments, school contracts & programmes	28,00,000	34,00,000	42,00,000	46,00,000
Therapist salaries, rent, supervision, materials, interest & overheads	42,00,000	46,00,000	52,00,000	54,00,000
Closing balance	42,00,000	30,00,000	20,00,000	12,00,000

This centre's cash position is unusually clean and its risk lies elsewhere, which is worth stating because it changes what a promoter should watch. Fees are collected per session or monthly in advance, there is no meaningful receivable outside the school contracts, and the plan deliberately refuses to sell prepaid packages — so unlike the coaching centre in this vertical, there is no large unearned liability and no refund exposure built into the model. The pressure is entirely on the cost side: therapists are hired before their caseloads fill, and a clinician recruited in month one may take four months to reach utilisation, during which she is paid in full. That gap is the whole of the Year-1 loss. Three consequences follow. Recruitment is paced to referral flow rather than to room availability, because an empty room costs rent and an under-occupied therapist costs a salary many times larger. The school-contract line is pursued partly because it fills therapist time predictably — a shadow-support contract is a known number of hours a week, which one-to-one referral flow is not. And the facility is modest at ₹40 lakh, because this business does not need working capital so much as it needs

patience — the risk is not that the money arrives late but that the caseload arrives slowly, and no facility fixes that.

12.5 Key Performance Indicators to Monitor

- **Success and its opposite:** transitions to inclusive settings; planned discharges with goals attained, reported separately from unplanned departures; children on roll beyond three years without documented progress, each reviewed by a non-treating clinician.
- **Governance:** RCI registration coverage; hours prescribed by a non-delivering clinician; recommendations to REDUCE intensity recorded alongside increases; supervision hours per therapist; case reviews independent of the treating therapist.
- **The claim:** written baselines and agreed goals; quarterly outcome reports issued regardless of result; marketing language audited against what the evidence supports.
- **Safeguarding — metrics that must rise:** observation access by room; unannounced parent observations facilitated; concerns and incidents logged and closed; verification coverage including support staff.
- **Capacity & people:** billable therapist-hour utilisation; documentation time inside the working day; therapist attrition; time-to-caseload for new clinicians; school-services share of revenue.

13. Funding Requirement & Bankability

Total ask: **₹80 lakh term loan plus a ₹40 lakh working-capital facility** against ₹1.30 crore promoter contribution. Four points. **First, this is a for-profit company with distributable surplus, though many centres adopt a trust form for grant and CSR access — a choice that should be made for the funding and not from a belief that the work must be non-profit.** Second, the security position is weak: therapy-room fit-out and sensory equipment in leased premises have little realisable value, so this is a cash-flow lend against caseload and clinician retention. Third, the diagnostic question is therapist-hour utilisation and time-to-caseload, not enrolment. A promoter who can state his billable utilisation, his RCI coverage and how long a new clinician takes to fill is running the centre; one who quotes rooms and children on the roll is quoting a floor plan. Fourth, and specific to this sector: ask for the RCI register and the long-stay list. Unregistered practice is a criminal exposure that would close the business, and a centre unable to produce the number of children who have been on its roll for three years without documented progress has either not computed it or does not wish to — and in a service where the provider decides how long the service continues, that single figure is the closest thing to an independent check that a lender or a family will ever get.

13.1 Funding utilisation

Use of funds	₹	% of total
Premises fit-out (14 therapy rooms with observation glass, sensory gym, assessment room, accessibility)	78,00,000	31.2%
Launch & initial operating losses	56,00,000	22.4%
Sensory-integration equipment, therapy materials & assessment tools	34,00,000	13.6%
Premises deposit	26,00,000	10.4%
Clinical recruitment, pre-launch salaries & training	22,00,000	8.8%

Technology (clinical records, goal tracking, scheduling, observation)	12,00,000	4.8%
Launch marketing & professional outreach	10,00,000	4.0%
Working capital	6,00,000	2.4%
Licences, legal, professional indemnity & registrations	6,00,000	2.4%
Total	2,50,00,000	100%

14. Risk Analysis & Mitigation

Risk	Mitigation
The business earns by keeping a child and succeeds by losing him	REVENUE IS PER THERAPY HOUR; THE CHILD'S GOAL IS TO NEED FEWER HOURS AND EVENTUALLY NONE, AND TO MOVE INTO AN INCLUSIVE SCHOOL. EVERY GENUINELY SUCCESSFUL OUTCOME THEREFORE REMOVES REVENUE, AND THE COMMERCIAL PRESSURE RUNS THE OTHER WAY — TO KEEP A CHILD ON THE ROLL, TO ADD A SESSION, TO FIND A NEW AREA OF NEED WHEN AN OLD ONE CLOSURES. THAT PRESSURE DOES NOT REQUIRE ANYBODY TO BE DISHONEST; IT REQUIRES ONLY THAT NOBODY MEASURES THE THING THAT WOULD EXPOSE IT. IN AN ORDINARY BUSINESS A DEPARTING CUSTOMER IS CHURN — HERE, IF A DISCHARGED CHILD IS RECORDED IN THE SAME COLUMN AS A FAMILY THAT RAN OUT OF MONEY, THE CENTRE HAS LOST THE ABILITY TO TELL SUCCESS FROM FAILURE → transitions to inclusive settings reported as the HEADLINE SUCCESS (6→38 a year), planned discharge with goals attained separated from unplanned departure (which is counted and investigated, since the commonest cause is affordability and the second is that nobody explained what was happening), and CHILDREN ON ROLL BEYOND THREE YEARS WITHOUT DOCUMENTED GOAL PROGRESS REPORTED AS A FAILURE OF THE CENTRE RATHER THAN A CHARACTERISTIC OF THE CHILD (14→2), EACH REVIEWED BY A CLINICIAN WHO IS NOT TREATING HIM — WITH PROFOUND-NEED CHILDREN RECORDED AS A LEGITIMATE LONG RELATIONSHIP, BECAUSE THE METRIC EXISTS TO DISTINGUISH THOSE FROM THE ONES NOBODY RE-EXAMINED. A CENTRE UNWILLING TO COMPUTE THAT NUMBER IS A CENTRE THAT DOES NOT WANT TO KNOW IT; and growth taken from new intake and school services rather than from retention
"Cure" language, and a parent who will believe anything	THE PARENT OF A NEWLY DIAGNOSED THREE-YEAR-OLD WILL SPEND EVERYTHING SHE HAS, WILL BELIEVE ALMOST ANYTHING, AND HAS NO WAY WHATEVER TO EVALUATE A CLINICAL CLAIM — THE MOST MOTIVATED BUYER IN THIS ENTIRE LIBRARY, WHICH IS A WARNING RATHER THAN AN OPPORTUNITY. AUTISM IS NOT CURED; SPECIFIC LEARNING DISABILITY IS NOT CURED; CEREBRAL PALSY IS NOT CURED. A CENTRE USING RECOVERY, CURE OR "NORMAL SCHOOL BY NEXT YEAR" LANGUAGE TO A FAMILY IN THAT POSITION IS EXPLOITING DISTRESS — THE MEDICAL-TOURISM PROBLEM THIS LIBRARY IDENTIFIED EARLIER, ARRIVING IN A FAR MORE VULNERABLE SETTING → the claim bounded and checkable: MEASURED PROGRESS AGAINST A WRITTEN BASELINE on goals the family agreed (48%→100%), REPORTED QUARTERLY WHETHER OR NOT THE GOALS WERE MET (0%→100%) INCLUDING WHERE PROGRESS HAS STALLED, WHICH IS THE REPORT NOBODY WANTS TO WRITE AND THE ONE THAT MAKES THE OTHERS CREDIBLE; marketing language audited against what the evidence supports; and WHAT THE INTERVENTION DOES NOT DO STATED PLAINLY, WHICH COSTS ENQUIRIES AND IS THE ONLY DEFENSIBLE WAY TO SELL TO SOMEBODY WHO CANNOT CHECK

RCI registration is a legal line, not a preference	THE REHABILITATION COUNCIL OF INDIA ACT REQUIRES REGISTRATION TO PRACTISE AS A REHABILITATION PROFESSIONAL, AND PRACTISING WITHOUT IT IS AN OFFENCE — NOT A SHORTFALL IN CREDENTIALS. YET CENTRES STAFFED BY KIND, COMMITTED, ENTIRELY UNREGISTERED PEOPLE ARE COMMON, AND THE FAMILY CANNOT TELL THE DIFFERENCE BECAUSE THE ROOM, THE FEE AND THE MANNER ARE IDENTICAL — SO IT IS SIMULTANEOUSLY A LEGAL EXPOSURE THAT WOULD CLOSE THE BUSINESS AND A CLINICAL ONE THE PARENT IS PAYING FOR → RCI coverage of practitioners delivering therapy 52%→100%, treated as a gap to be CLOSED rather than a norm to be worked within; registration verified before the first session rather than assumed from a qualification; supervision hours per therapist 2→6 a month with case review INDEPENDENT of the treating therapist; and the clinical director RCI-registered and HOLDING CLINICAL AUTHORITY OVER THE PROMOTER WHERE THE TWO DIFFER, WRITTEN DOWN BEFORE IT IS TESTED
Nobody paid per session should decide how many are needed	IN THE ORDINARY ARRANGEMENT THE THERAPIST WHO DELIVERS A CHILD'S SESSIONS ALSO RECOMMENDS HOW MANY ARE NEEDED, AND HER INCOME AND UTILISATION DEPEND ON THE ANSWER. NOBODY HAS TO BE DISHONEST FOR THAT TO BEND: A THERAPIST WHO GENUINELY BELIEVES ANOTHER TWO SESSIONS A WEEK WOULD HELP IS NOT LYING, SHE IS ALSO NOT NEUTRAL, AND NEITHER SHE NOR THE FAMILY CAN SEPARATE THE TWO — ADD A PARENT WHO WILL AGREE TO ANYTHING AND THERE IS NO COUNTERWEIGHT IN THE ROOM AT ALL. THE UPSSELL RISK IS REAL AND SPECIFIC: EXTRA SENSORY SESSIONS, "INTENSIVE" PACKAGES, PROPRIETARY PROGRAMMES, IMPORTED EQUIPMENT AND SUPPLEMENTS → therapy hours PRESCRIBED BY THE ASSESSING CLINICIAN WHO DOES NOT DELIVER THEM AND IS NOT PAID PER SESSION (0%→100%), with intensity reviews by the same independent route and RECOMMENDATIONS TO REDUCE HOURS RECORDED AND REPORTED ALONGSIDE RECOMMENDATIONS TO INCREASE; and equipment, supplements and proprietary programmes NOT SOLD AT ALL — NOT RESTRICTED, NOT DISCLOSED, BUT REFUSED, BECAUSE IN A MARKET WHERE THE BUYER CANNOT EVALUATE THE PRODUCT AND WILL BUY ANYTHING, DISCLOSURE IS NOT A SUFFICIENT CONTROL AND THE ONLY HONEST POSITION IS NOT TO BE IN THAT BUSINESS. THE COST IS REAL: THESE ARE THE HIGHEST-MARGIN LINES AVAILABLE TO THIS CENTRE AND THE PLAN GIVES THEM UP
The child cannot tell	THERAPY HERE INVOLVES PHYSICAL PROMPTING, SENSORY WORK, TOILETING SUPPORT AND SUSTAINED ONE-TO-ONE SESSIONS IN A QUIET ROOM — ALL NECESSARY, NONE AVOIDABLE — AND THE PLAY-ACTIVITY PLAN ESTABLISHED THAT IN SUCH SETTINGS THE NECESSARY ACT AND THE DANGEROUS ONE LOOK IDENTICAL AND THE INNOCENT EXPLANATION IS GENUINELY AVAILABLE. HERE A FURTHER PROTECTION IS ABSENT: MANY OF THESE CHILDREN ARE NON-VERBAL OR COMMUNICATE IN WAYS AN UNFAMILIAR ADULT WOULD NOT INTERPRET, AND SOME WOULD NOT DISTINGUISH AN UNUSUAL ACT FROM AN ORDINARY ONE. A SAFEGUARDING REGIME THAT ULTIMATELY DEPENDS ON A CHILD TELLING SOMEBODY DOES NOT FUNCTION IN THIS BUILDING, AND PRETENDING OTHERWISE IS THE MOST DANGEROUS ASSUMPTION A CENTRE LIKE THIS CAN MAKE → controls environmental, absolute and independent of disclosure: OBSERVATION ACCESS ON EVERY THERAPY ROOM — GLASS, NOT A CAMERA ALONE — 71%→100%, BECAUSE A ROOM THAT CANNOT BE SEEN INTO SHOULD NOT BE USED FOR THERAPY AT ALL; NO CLOSED-ROOM ONE-TO-ONE UNDER ANY CIRCUMSTANCE, with no exception for a senior clinician, a distressed child or a scheduling difficulty; an UNANNOUNCED PARENT-OBSERVATION RIGHT EXERCISED RATHER THAN MERELY OFFERED (0→96 a year), BECAUSE A RIGHT NOBODY USES IS A POLICY AND NOT A CONTROL; every adult verified including support staff (63%→100%); and concerns logged as a number expected to RISE (3→24), since IN THIS SETTING A NIL RETURN MEANS NOBODY IS WATCHING RATHER THAN NOTHING IS HAPPENING

The honest provider sounds less capable than the dishonest one	A FAMILY THAT HAS JUST RECEIVED A DIAGNOSIS VISITS TWO CENTRES. ONE SAYS THE CHILD HAS A GOOD CHANCE OF SUBSTANTIAL PROGRESS WITH CONSISTENT WORK OVER TWO TO THREE YEARS, THAT SOME DIFFICULTIES WILL PERSIST INTO ADULthood, AND THAT NOBODY CAN PREDICT THE TRAJECTORY FOR AN INDIVIDUAL CHILD. THE OTHER SAYS ITS PROGRAMME HAS HELPED CHILDREN LIKE HERS REACH MAINSTREAM SCHOOL WITHIN A YEAR. THE SECOND IS WHAT SHE WANTS TO HEAR, IT IS DELIVERED WITH CONFIDENCE, AND SHE CANNOT EVALUATE EITHER CLAIM — AN HONEST CENTRE LOSES THAT FAMILY AND WILL LOSE MANY LIKE HER → three things make the position sustainable rather than merely admirable: CLINICIAN REFERRAL, since PAEDIATRICIANS AND DEVELOPMENTAL SPECIALISTS CAN EVALUATE A CLAIM, REFER REPEATEDLY, AND STOP REFERRING TO CENTRES THAT OVER-PROMISE — WHICH MAKES THE PROFESSIONAL CHANNEL BOTH THE MOST DURABLE ACQUISITION ROUTE AND THE ONE THAT REWARDS RESTRAINT; EVIDENCE OVER TIME, since a centre publishing goal attainment quarterly builds a record a confident claim cannot match after two years; and THE RETURNING FAMILY, since a meaningful share of those who leave for a centre promising more come back — AND THEY COME BACK BECAUSE SOMEBODY TOLD THEM THE TRUTH ONCE. The Year-1 cost is carried rather than assumed away
Affordability, and the demand that cannot be served	A CHILD IN EARLY INTERVENTION MAY NEED THREE TO FIVE THERAPY HOURS A WEEK FOR TWO OR THREE YEARS. AT ANY COMMERCIALLY SUSTAINABLE RATE THAT IS A VERY LARGE SUM FOR AN ORDINARY INDIAN HOUSEHOLD, AND FAMILIES MEET IT BY BORROWING, BY SELLING ASSETS, BY ONE PARENT LEAVING WORK, OR BY STOPPING — USUALLY THE LAST, AND USUALLY WITHOUT TELLING THE CENTRE WHY. THE DEMAND IN AN ENQUIRY LOG IS THEREFORE MUCH LARGER THAN THE DEMAND THAT CAN ACTUALLY BE SERVED, AND A PLAN SIZING ITS MARKET ON PREVALENCE HAS COUNTED FAMILIES WHO WILL NEVER BE ABLE TO PAY → PARENT TRAINING built as a genuine clinical format rather than a cheap substitute, since A TRAINED PARENT DELIVERS MORE THERAPEUTIC HOURS AT HOME IN A WEEK THAN A CENTRE DELIVERS IN A MONTH, AND IS THE HIGHEST-LEVERAGE INTERVENTION AVAILABLE TO A FAMILY THAT CANNOT AFFORD INTENSIVE ONE-TO-ONE; SCHOOL-BASED INCLUSION SUPPORT developed deliberately (4%→10% of revenue) BECAUSE IT IS PAID BY THE SCHOOL RATHER THAN THE FAMILY AND REACHES CHILDREN WHOSE PARENTS COULD NEVER FUND CENTRE THERAPY; and a written sliding-fee and hardship process applied quietly, BECAUSE THE ALTERNATIVE IS THAT THE POOREST FAMILIES SIMPLY STOP ATTENDING AND THE CENTRE RECORDS IT AS ATTRITION
Capacity, clinicians, records & premises	A THERAPIST CAN DELIVER ROUGHLY FIVE AND A HALF PRODUCTIVE ONE-TO-ONE HOURS IN A DAY, NOT EIGHT — THE WORK IS INTENSIVE AND DOCUMENTATION IS PART OF IT, COUNTED INSIDE THE WORKING DAY RATHER THAN EXPECTED AFTERWARDS. A CENTRE REPORTING 90% THERAPIST UTILISATION IS EITHER NOT DOCUMENTING OR NOT RESTING ITS THERAPISTS, AND BOTH SHOW UP IN ATTRITION WITHIN A YEAR → utilisation targeted at 71% rather than higher; attrition 34%→19%; recruitment PACED TO REFERRAL FLOW RATHER THAN TO ROOM AVAILABILITY, since AN EMPTY ROOM COSTS RENT AND AN UNDER-OCCUPIED THERAPIST COSTS A SALARY MANY TIMES LARGER — AND THE GAP BETWEEN HIRING AND CASELOAD IS THE WHOLE OF THE YEAR-1 LOSS. RCI-REGISTERED CLINICIANS ARE GENUINELY SCARCE, CANNOT BE HIRED IN BULK, AND TAKE TIME TO BUILD A CASELOAD — A PROJECTION SHOWING A FASTER RAMP IS DESCRIBING A RECRUITMENT MARKET THAT DOES NOT EXIST. Compliance: RPwD Act with PHYSICAL ACCESSIBILITY OF THE PREMISES, SINCE A CENTRE FOR DISABLED CHILDREN THAT A WHEELCHAIR CANNOT ENTER IS A CONTRADICTION FAMILIES AND INSPECTORS BOTH NOTICE; DPD Act with verifiable parental consent, SINCE ASSESSMENT REPORTS AND THERAPY NOTES ABOUT A DISABLED CHILD ARE AMONG THE MOST SENSITIVE RECORDS ANY BUSINESS IN THIS LIBRARY HOLDS; Consumer Protection on outcome claims; professional indemnity; and GST treatment differing between healthcare- and education-characterised services

15. SWOT Analysis

Strengths Transitions to inclusive settings reported as the headline success rather than concealed as attrition; therapy hours prescribed by a clinician who does not deliver them and is not paid per session; every practitioner RCI-registered and verifiable; written baselines with quarterly outcome reporting regardless of result; observation access on every room with an exercised parent-visit right; no equipment, supplement or programme sales at all.	Weaknesses Success removes revenue, permanently and by design; therapist cost at half of turnover in a business that cannot be scaled by adding rooms; a slow ramp set by the scarcity of registered clinicians; the highest-margin lines in the sector deliberately forgone; an honest claim that converts worse than a confident one; ₹58 lakh of losses before break-even.
Opportunities Diagnosis improving faster than provision, with most districts having no qualified professionals at all; the RPwD Act's inclusive-education mandate creating school-funded demand for shadow and inclusion support ; paediatrician referral rewarding restraint; parent training as the highest-leverage format for families who cannot fund intensive therapy; board accommodation provisions driving assessment demand.	Threats Unregistered centres competing effectively because their promises are better; a safeguarding incident involving a child who could not report it; families exhausting their resources and stopping without explanation; loss of a senior clinician in a market where replacements are scarce; a regulatory action on unregistered practice at any competitor, which would move the whole market at once.

16. Recommended AiSevak Tools for This Centre

This centre would use AiSevak's Schools vertical tools in operations:

- **Success and its opposite: transition register reported as achievement, planned-discharge versus unplanned-departure separation with reason capture, long-stay-without-progress exception list routed to a non-treating clinician for review.**
- **Governance: RCI registration register with expiry tracking, prescription-by-non-delivering-clinician workflow, intensity-review scheduler recording reductions as well as increases, supervision-hour and case-review logs.**
- **The claim: baseline and goal documentation gate before any booking, quarterly outcome-report generation regardless of result, marketing-language audit against evidence.**
- **Safeguarding:** observation-access register by room, closed-room booking block, unannounced parent-observation request handling and log, verification register including support staff, concern and incident log with closure tracking.
- **Capacity:** billable therapist-hour utilisation with documentation time counted, time-to-caseload for new clinicians, attrition by discipline, school-contract hour commitments, sliding-fee and hardship register.

17. Key Assumptions & Notes

- Special-education & therapy centre: fourteen-room facility providing assessment, special education, speech and language therapy, occupational and sensory-integration therapy, behavioural intervention, parent training and school-based inclusion support for children with autism spectrum conditions, ADHD, specific learning disability, intellectual disability, cerebral palsy and communication disorders. **Sixth plan in the schools vertical; the CLINICAL / DUTY-OF-CARE sub-model, and the most safeguarded plan in it.**

- **△ CONVENTIONS SET HERE: (a) □ THE BUSINESS EARNS BY KEEPING A CHILD AND SUCCEEDS BY LOSING HIM — every successful outcome removes revenue, so TRANSITIONS TO INCLUSIVE SETTINGS ARE THE HEADLINE SUCCESS METRIC and CHILDREN ON ROLL BEYOND THREE YEARS WITHOUT DOCUMENTED PROGRESS ARE THE HEADLINE FAILURE METRIC; planned discharge must be recorded SEPARATELY from unplanned departure or the centre loses the ability to tell success from failure. (b) "CURE" LANGUAGE IS INDEFENSIBLE AND THE PARENT WILL BELIEVE ANYTHING — the honest claim is MEASURED PROGRESS AGAINST A WRITTEN BASELINE ON AGREED GOALS, REPORTED QUARTERLY WHETHER OR NOT THEY WERE MET, plus a plain statement of WHAT THE INTERVENTION DOES NOT DO. (c) RCI REGISTRATION IS A LEGAL LINE, NOT A PREFERENCE — practising without it is an OFFENCE, and the family cannot tell the difference. (d) NOBODY PAID PER SESSION SHOULD DECIDE HOW MANY ARE NEEDED — prescription separated from delivery, with REDUCTIONS recorded alongside increases; and equipment, supplements and proprietary programmes REFUSED RATHER THAN DISCLOSED, because where the buyer cannot evaluate the product and will buy anything, DISCLOSURE IS NOT A SUFFICIENT CONTROL. (e) THE CHILD CANNOT TELL — the play-activity convention with the reporting channel removed, so controls must be ENVIRONMENTAL, ABSOLUTE AND INDEPENDENT OF DISCLOSURE: observation glass on every room, NO CLOSED-ROOM ONE-TO-ONE EVER, an EXERCISED parent-observation right, and a rising concern log because A NIL RETURN MEANS NOBODY IS WATCHING. (f) THE HONEST PROVIDER SOUNDS LESS CAPABLE THAN THE DISHONEST ONE — sustained by clinician referral, which rewards restraint, and by evidence accumulated over time. (g) CAPACITY IS THERAPIST-HOURS AND THE CEILING IS ~5.5 PRODUCTIVE ONE-TO-ONE HOURS A DAY — a centre reporting 90% utilisation is not documenting or not resting its therapists.**
- **Economics & cash — THIS IS A LOW-MARGIN, HIGH-OBLIGATION BUSINESS AND THE PLAN SAYS SO: A 15.4% RETURN IN YEAR 3 IS A RESPECTABLE OUTCOME, AND ANYONE MODELLING SUBSTANTIALLY MORE IS EITHER UNDER-PAYING CLINICIANS, OVER-PRESCRIBING SESSIONS, OR SELLING SOMETHING OTHER THAN THERAPY (Y1 –₹41L, Y2 –₹17L → Y3 ₹43L; revenue ₹1.50cr→₹5.04cr; billable hours 13,900→36,550 at ₹850→₹1,050; utilisation 54%→71%; therapist cost 58.7%→50.0% of revenue, FALLING ONLY THROUGH UTILISATION; ROCE (16.9%)→15.4%; school-services share 4%→10%; BREAK-EVEN YEAR 3 WITH ₹58 LAKH OF LOSSES FIRST, THE RAMP SET BY THE SCARCITY OF RCI-REGISTERED CLINICIANS WHO CANNOT BE HIRED IN BULK AND TAKE TIME TO BUILD A CASELOAD — A PROJECTION SHOWING FASTER IS DESCRIBING A RECRUITMENT MARKET THAT DOES NOT EXIST; cash unusually clean, with fees per session or monthly in advance, NO PREPAID PACKAGES AND THEREFORE NO UNEARNED LIABILITY OR REFUND EXPOSURE, so THE RISK IS NOT THAT THE MONEY ARRIVES LATE BUT THAT THE CASELOAD ARRIVES SLOWLY, AND NO FACILITY FIXES THAT). Regulatory (section 9): RCI ACT REGISTRATION FOR EVERY PRACTITIONER, WHERE PRACTISING WITHOUT IT IS AN OFFENCE; RPwD Act 2016 with inclusive education as the objective and PHYSICAL ACCESSIBILITY OF THE PREMISES; POCSO and JJ Act applied knowing many children cannot disclose; DPDP ACT WITH VERIFIABLE PARENTAL CONSENT ON RECORDS THAT ARE AMONG THE MOST SENSITIVE ANY BUSINESS IN THIS LIBRARY HOLDS; Mental Healthcare Act where engaged; Consumer Protection on outcome claims; professional indemnity as a working requirement; GST TREATMENT DIFFERING BETWEEN HEALTHCARE- AND EDUCATION-CHARACTERISED SERVICES; fire NOC, POSH, EPF/ESI. Lender note (section 13): for-profit with distributable surplus, though a trust form is common for grant and CSR access and SHOULD BE CHOSEN FOR THE FUNDING, NOT FROM A BELIEF THAT THE WORK MUST BE NON-PROFIT; security weak, so a cash-flow lend against caseload and clinician retention; THE DIAGNOSTICS ARE THERAPIST-HOUR UTILISATION AND TIME-TO-CASELOAD, NOT ENROLMENT; and ASK FOR THE RCI REGISTER AND THE LONG-STAY LIST, BECAUSE UNREGISTERED PRACTICE IS A CRIMINAL EXPOSURE THAT WOULD CLOSE THE BUSINESS, AND IN A SERVICE WHERE THE PROVIDER DECIDES HOW LONG THE SERVICE CONTINUES, THE NUMBER OF CHILDREN ON ROLL FOR THREE YEARS WITHOUT DOCUMENTED PROGRESS IS THE CLOSEST THING TO AN INDEPENDENT CHECK THAT A LENDER OR A FAMILY WILL EVER GET. ₹2.50cr; billable hours 13,900→36,550; revenue ₹1.50→5.04cr; 30→64 staff; RCI coverage 52%→100%; ROCE (16.9%)→15.4%. Figures**

illustrative, exclude GST.

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