



BUSINESS PLAN · INDIA

Sports Physiotherapy & Recovery Centre

Where discharging sooner is the honesty metric that costs revenue

SPORTS, FITNESS & RECREATION BUSINESSES

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 **Sports Physiotherapy & Recovery Centre** in India — injury rehabilitation, sports-specific return-to-play programmes, post-surgical rehabilitation, movement and performance assessment, screening and load-management contracts with academies and clubs, and clinician education.

This is the only clinical business in the sports vertical, and its demand is created almost entirely by the failures of the other nine plans in it. The academy that let a twelve-year-old bowl year-round; the boutique studio that dropped a deconditioned beginner into a class designed for athletes; the turf whose surface had outlived its replacement date; the adventure operator's trauma cases; the swimmer's shoulder; the esports arena's postural and repetitive-strain load. **Every plan in this vertical produces patients for this one, which makes it the natural place to close the vertical.**

It also breaks the vertical's defining pattern. Eight of the nine preceding businesses operated with no mandatory competence standard — groomers, coaches, trainers, sports coaches, facility operators, fitness instructors, adventure guides, swimming teachers. **Physiotherapy is different: the National Commission for Allied and Healthcare Professions Act 2021 brings physiotherapists under a statutory council with registration and recognised qualifications.** This is **the first genuinely regulated profession in the vertical** — and the market nonetheless contains a great many people offering "sports injury treatment", dry needling and spinal manipulation without a physiotherapy qualification at all.

The business-model tension is the one every physiotherapy practice carries and few state: the practice earns per session, and therefore has a direct financial interest in the patient not recovering quickly. It is the same incentive inversion the esports arena identified — revenue rising with time consumed — but attached to **a clinical decision rather than a commercial one.** The honest metrics are therefore the uncomfortable ones: **median sessions to discharge falling from 14 to 9** (the practice becoming better at its job and earning less per patient as a result), and **patients formally discharged rather than drifting away rising from 58% to 84%.** This is the certification body's defended pass rate in clinical form — **a number that improves when the business does the right thing and costs it revenue.**

Two further disciplines follow. Referral payments — the corruption this library has now traced through veterinary channels and supplement trainers — appear here in their most serious form, because a clinician paid to refer is a clinical decision bought, in both directions: fees received for taking referrals and fees paid for sending patients to imaging or surgery. This plan carries **payments made or received for referrals: NIL.** And **return-to-play is the high-stakes decision the physiotherapist alone is placed to make** — the athlete wants to play, the coach wants them available, the parent wants the season — so **clearance runs on written objective criteria, is not overridable by a coach, and the plan reports both the overrides that happen (11 → 4) and the re-injury rate within 90 days of clearance (14% → 6%) that tests whether the clearance was honest.**

This plan models a practice requiring **₹78 lakh** (₹44 lakh promoter + ₹24 lakh term loan + ₹10 lakh working-capital finance), moving from **₹1.8 crore revenue and ₹14 lakh profit** in Year 1 to **₹3.94 crore revenue and ₹80 lakh profit** by Year 3. (*Registered clinical practice; therapist-hour bound — figures illustrative.*)

2. Business Description, Vision & Legal Structure

Concept: A registered physiotherapy practice specialising in sports and musculoskeletal rehabilitation — assessment-led, exercise-based treatment, objective return-to-play criteria, outcome measurement on every episode, and preventive screening contracted to the academies, clubs and studios that generate the injuries.

Vision: To discharge patients sooner than our competitors and be busier for it.

Mission: Treat actively, not passively; discharge when the goal is met; refer the red flag immediately; take no payment for a referral and pay none; and never clear an athlete because a coach asked.

Legal structure options

- **Private Limited** — suits multi-therapist scale, institutional contracting and clinical liability containment.
- **LLP** — workable for a clinician-partner practice.
- **Proprietorship** — viable for a solo registered practitioner, though it exposes personal assets to clinical liability.

Regulatory anchor: this is the vertical's only statutorily regulated profession, and the obligations are personal to the practitioner as well as institutional. **The National Commission for Allied and Healthcare Professions Act 2021 establishes a statutory framework for physiotherapists — registration with the relevant council, recognised qualifications and professional conduct obligations** — with state-level implementation progressing at different speeds. Alongside it: **scope of practice, since a physiotherapist is not a radiologist or a surgeon and must recognise and refer rather than treat conditions outside competence; professional indemnity insurance, which in a clinical practice is not optional;** clinical record-keeping and retention; patient data under the DPDP framework, including health information, which is sensitive; **consumer-protection limits on outcome claims — "guaranteed recovery" and "cure" are representations requiring evidence;** clinical establishment registration where state rules require it; and, where any dry needling, manipulation or invasive technique is offered, **the requirement that the practitioner hold specific competence rather than general registration.**

3. Promoter & Ownership

Led by a registered physiotherapist, or by a promoter in partnership with one holding genuine clinical authority. Three competences decide outcomes: *clinical discipline*, meaning discharging patients who are better; *referral-network credibility*, built on outcomes rather than on payments; and *therapist retention*, because capacity is therapist-hours and patients follow individuals. Clinical outcomes, discharge discipline, referral integrity & therapist stability are the differentiators. Ownership, equity & the clinical partner's stake are editable inputs.

4. Market Analysis — India

Demand is driven by rising sports and fitness participation, growing recognition of physiotherapy as a first-line treatment rather than a post-surgical afterthought, sedentary-lifestyle musculoskeletal complaints, and an ageing population wanting to remain active. Demand is strong and growing faster than qualified supply. The market is **referral-driven, cash-pay, therapist-bound and quality-opaque**.

Demand drivers

- **Sports and fitness participation growth** — every business in this vertical is a source.
- **Physiotherapy-first treatment** for musculoskeletal pain, increasingly recognised as appropriate before imaging or surgery.

- **Post-surgical rehabilitation**, where outcomes depend heavily on the quality of rehab rather than the operation alone.
- **Sedentary and desk-work complaints**, a large and steady non-sporting caseload.
- **Active ageing**, with older adults seeking to maintain function rather than accept decline.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
TAM	Indian physiotherapy & musculoskeletal rehabilitation	Large; supply-constrained
SAM	Catchment plus institutional contracts	Locally bounded
SOM (Yr 1-3)	Therapist-hours at clinical quality	~2,400 → ~5,300 episodes

The caseload of this practice is a direct map of the other nine plans in this vertical, and setting it out that way is more useful than a generic injury profile. From the sports academy come overuse injuries in growing skeletons — stress fractures, growth-plate problems, shoulder and lower-back complaints in children trained as though they were adults. **From the boutique fitness studio** come deconditioned beginners loaded too fast, tendinopathies and the occasional serious exertional case. **From the turf** come the acute injuries of five-a-side on a worn surface — ankles, knees, hamstrings. **From the adventure operator**, trauma and altitude cases. **From the swimming academy**, shoulder impingement, the most predictable overuse injury in sport. **From the esports arena**, wrist, neck and postural complaints that the sports world still treats as unserious and which are the fastest-growing segment among young patients. **The commercially important observation is that these sources are institutions, not individuals** — which means the practice can contract with them for prevention rather than waiting for their casualties, and **the academy's overuse problem is precisely this practice's screening contract.**

Target segments

- **Recreational and competitive athletes** — the sports core, motivated and outcome-focused.
- **Post-surgical patients**, longer episodes, surgeon-referred.
- **General musculoskeletal patients** — the volume base, largely non-sporting.
- **Institutions** — academies, clubs, studios and corporates buying screening and load management.
- **Clinicians and students** for education and workshops.

5. Competition & Competitive Advantage

Landscape: hospital physiotherapy departments, other private clinics, home-visit physiotherapists, **and a substantial informal market of unqualified practitioners offering "sports injury treatment", manipulation and dry needling**. Also, in practice, **the patient who does nothing and hopes**, which is the largest competitor of all.

The business's edge

- **Registered clinicians only**, verifiable against the statutory council.
- **Active, exercise-based rehabilitation** rather than passive modality time.
- **Objective return-to-play criteria** and measured outcomes on every episode.
- **Discharge discipline**, which patients and referrers both notice.
- **Prevention contracts** with the institutions generating the injuries.

The category's characteristic waste is passive-modality theatre, and it persists because it is commercially convenient rather than because it works. Ultrasound, TENS, laser and similar passive treatments are billable, require little therapist attention, can be applied by an assistant, and generate a comfortable-feeling session that patients accept without question. The evidence for most of them in musculoskeletal rehabilitation is weak to absent. Active rehabilitation — graded loading, strength work, movement retraining — has far better evidence and costs the practice a therapist's hour rather than a machine's. The economic incentive therefore points toward the treatment that works less well, which is exactly the structure this library has now seen in several places. This plan reports passive-modality-only sessions falling from 34% to 9%, and the honest framing for a patient is worth stating: a session in which a machine was applied and nothing was demanded of them may have felt like treatment, but a rehabilitation programme that never made them work has not rehabilitated anything.

6. Services & Revenue Model

Line	Model	Basis
Injury rehabilitation (individual)	Per session / episode	Volume core; discharge-disciplined
Sports-specific rehab & return-to-play	Programme-based	Higher value; criteria-driven
Post-surgical rehabilitation	Programme, surgeon-referred	Long episodes; outcome-critical
Screening, prevention & load management contracts	Institutional, recurring	8.9% → 15.7% — the growth line
Performance & movement assessment	Per assessment	Entry point; converts to programmes
Education, workshops & clinician training	Per course	Builds referral network
Payments made or received for referrals	NIL — by governance	Clinical independence firewall

Prevention is better business than treatment and almost nobody in Indian physiotherapy sells it, which makes it the most available growth line in this plan. An academy paying for pre-season screening, load monitoring and movement assessment across ninety young athletes generates recurring institutional revenue, requires no individual acquisition, fills daytime hours that individual patients do not want, and produces a referral pipeline of the cases screening identifies. It also resolves a tension the practice would otherwise carry: a business that earns only from injuries has an uncomfortable relationship with the academy that produces them. A prevention contract aligns the two — the practice is paid to reduce the very caseload it would otherwise depend on, which is a healthier structure and a more defensible sales conversation. Growing this line from 8.9% to 15.7% of revenue is deliberate, and the institutions in this vertical — the academy, the studio, the club, the turf's league customers — are the natural buyers.

7. Go-to-Market — Referral Without Payment

Acquisition

- **Clinician referral earned on outcomes** — surgeons and physicians refer to practices whose patients come back better, and stop when they do not.
- **Institutional prevention contracts**, which convert an injury source into a client.

- **Patient referral**, strong in this category because recovery is memorable.
- **Clinician education**, which builds standing with the referring community.

Retention & reputation

- **Outcome measurement on every episode**, reported back to the referrer.
- **Discharge rather than drift**, which is what a referrer actually values.
- **Therapist continuity** through an episode, since rehabilitation is relational.
- **Honest timelines**, including the ones patients do not want to hear.

Sales approach

Build referral credibility on measured outcomes → contract institutions for prevention → convert assessments into programmes → discharge and report → be referred again. **The approach that must be refused is the one the market offers immediately: paying for referrals.** It is available, it is common, and it works in the short term — **and it converts every subsequent clinical recommendation into a transaction the patient did not know about.** The practical argument matters as much as the ethical one: **a referral bought is a referral that stops the moment a competitor pays more**, while a referral earned on outcomes compounds and is not purchasable. **A practice that competes on payments is bidding against everyone; a practice that competes on discharge rates is bidding against almost nobody.**

8. Operations Plan (assess, screen, treat, clear, discharge)

- **Assessment:** history, examination, functional testing and baseline outcome measures recorded for every episode.
- **Red-flag screening: fracture, infection, cauda equina, malignancy and cardiac-referred pain recognised and referred immediately rather than treated.**
- **Treatment planning:** goals agreed with the patient, **active rehabilitation as the core with passive modalities adjunctive at most.**
- **Progression:** graded loading with objective criteria at each stage rather than time-based assumptions.
- **Return-to-play: written objective criteria — strength symmetry, functional testing, sport-specific load tolerance — and clearance that a coach cannot override.**
- **Discharge:** formal, with a maintenance programme and a stated review point.
- **Prevention contracts:** screening, load monitoring and movement assessment for institutions.
- **Outcome measurement:** patient-reported and functional measures on 100% of episodes, reported to referrers.

Episode lifecycle

Stage	Activity	Control point
Screen	Red flags identified and referred out	Red-flag referrals 24 → 58 (a positive)
Assess	Baseline function and outcome measures	Measures recorded on 100% of episodes
Treat	Active rehabilitation, graded loading	Passive-only sessions 34% → 9%
Clear	Objective written return-to-play criteria	Overrides 11 → 4; re-injury 14% → 6%
Discharge	Formal, with maintenance programme	Sessions to discharge 14 → 9; discharged 58% → 84%
Prevent	Institutional screening & load management	Prevention revenue 8.9% → 15.7%

Return-to-play is the highest-stakes decision this practice makes, and the physiotherapist is structurally the only person in the room whose job is to say "not yet." The athlete wants to play; the coach wants them available for a fixture; the parent has watched a season disappear. **Where the physiotherapist is employed or paid by the academy or club creating that pressure, the conflict is not theoretical — it is a weekly occurrence**, and it is the same structural problem the adventure plan solved by separating the no-go decision from the revenue consequence. Two controls apply. **Clearance runs on written objective criteria — strength symmetry thresholds, hop and functional testing, demonstrated tolerance of sport-specific load — rather than on elapsed time or how the athlete says they feel**, because criteria can be shown to a coach in a way that a clinical opinion cannot. And **clearance is not overridable**: where an athlete returns against advice, that is recorded rather than argued about, which is why **overrides are reported (11 → 4) rather than assumed to be zero**. The number that tests whether any of this is real is **re-injury within 90 days of clearance, falling from 14% to 6% — because a practice clearing athletes to please coaches will show it there and nowhere else**.

9. Registration, Scope & Clinical Integrity (India)

- **NCAHP Act 2021** — statutory council registration, recognised qualifications and conduct obligations for physiotherapists, with state implementation progressing unevenly. **Therapists registered: 100%.**
- **Scope of practice: a physiotherapist is not a radiologist or a surgeon** — red flags recognised and referred, not treated; imaging and diagnosis boundaries respected.
- **Specific-competence techniques**: dry needling, manipulation and invasive techniques require **demonstrated competence rather than general registration**.
- **Referral integrity: payments made or received for referrals: NIL** — **a clinician paid to refer is a clinical decision bought**, and the exposure runs in both directions, including onward referral to imaging and surgery.
- **Professional indemnity insurance**, which in clinical practice is not optional.
- **Clinical records** maintained and retained; **patient health data is sensitive under the DPDP framework**.
- **Outcome claims: "guaranteed recovery" and "cure" are representations requiring evidence** under consumer-protection law.
- Clinical establishment registration where state rules require it; equipment safety and electrical compliance.

10. Organisation & Manpower Plan

Role	Yr 1	Yr 2	Yr 3
Promoter / clinical director	1	1	2
Physiotherapists (statutorily registered)	12	19	28
Rehabilitation assistants & exercise therapists	5	9	14
Front office, scheduling & patient care	4	7	11
Sports science / strength & conditioning support	2	4	7
Admin & accounts	2	3	5
Prevention & institutional contracts	1	3	5
Total	27	46	72

Therapist retention is tracked as a revenue metric (66% → 88%) — the ninth business in this library where **capacity is one person's hours and the customer follows the individual rather than the brand**. Continuing education and clinical supervision are funded rather than expected, because in a registered profession the alternative is a competence problem rather than a service one.

11. Implementation Timeline & Milestones

Phase	Timeline	Milestone
Setup	Month 0–3	Premises, equipment, therapist registration verification, outcome-measure system, referral network
Launch	Month 3–12	~2,400 episodes; ₹1.8cr revenue, ₹14L profit; sessions to discharge 14
Build	Year 2	Discharge rate 72%, passive-only 18%, prevention 12.4%; ₹2.74cr, ₹43L profit
Scale	Year 3	~5,300 episodes; ₹3.94cr, ₹80L profit; sessions to discharge 9, re-injury 6%

12. Financial Plan (Illustrative)

*All figures are illustrative model assumptions for an Indian context, shown so the promoter can replace them with live rates. **Sessions to discharge, revenue per therapist-hour, prevention share and re-injury rate are the levers — and sessions to discharge is modelled FALLING, which reduces revenue per patient and is the point.***

12.1 Project cost & means of finance

Capital requirement	₹
Clinical equipment (assessment, rehab, strength, gait, modalities)	26,00,000
Clinic fit-out (treatment rooms, rehabilitation gym floor, changing)	20,00,000
Deposits & advance rent	12,00,000
Working capital	8,00,000
Therapist recruitment, registration & continuing education	6,00,000
Marketing & referral network development	4,00,000
Technology (clinical records, outcome measures, scheduling)	2,00,000
Total project cost	78,00,000
Promoter contribution	44,00,000
Term loan	24,00,000
Working-capital finance	10,00,000

12.2 Projected Profit & Loss (3 years)

Particulars	Year 1	Year 2	Year 3
Injury rehabilitation (individual treatment)	78,00,000	1,08,00,000	1,42,00,000
Sports-specific rehab & return-to-play programmes	38,00,000	58,00,000	84,00,000

Post-surgical rehabilitation	26,00,000	38,00,000	52,00,000
Screening, prevention & load management contracts	16,00,000	34,00,000	62,00,000
Performance & movement assessment	14,00,000	22,00,000	32,00,000
Education, workshops & clinician training	8,00,000	14,00,000	22,00,000
Total revenue	1,80,00,000	2,74,00,000	3,94,00,000
Salaries (physiotherapists, assistants, front office, admin)	92,00,000	1,38,00,000	1,96,00,000
Rent, utilities & facility	22,00,000	24,00,000	27,00,000
Marketing & referral network development	12,00,000	16,00,000	21,00,000
Therapist registration, continuing education & clinical supervision	8,00,000	11,00,000	15,00,000
Equipment maintenance & consumables	7,00,000	10,00,000	14,00,000
Office, overheads & admin	8,00,000	11,00,000	15,00,000
Insurance (professional indemnity, public liability)	5,00,000	7,00,000	10,00,000
Depreciation, interest & other	12,00,000	14,00,000	16,00,000
Total expenses	1,66,00,000	2,31,00,000	3,14,00,000
Net profit before tax	14,00,000	43,00,000	80,00,000
Net margin	7.8%	15.7%	20.3%
MEDIAN SESSIONS TO DISCHARGE — <i>falling; the honesty metric</i>	14	11	9
Patients formally discharged (vs drifting away)	58%	72%	84%
Passive-modality-only sessions — <i>falling by design</i>	34%	18%	9%
Payments made or received for referrals	NIL	NIL	NIL
Red-flag cases referred to medical practitioners — <i>a positive</i>	24	41	58
Return-to-play decisions on written objective criteria	100%	100%	100%
Clearances overruled by coach or parent — <i>reported, not assumed zero</i>	11	7	4
RE-INJURY WITHIN 90 DAYS OF CLEARANCE	14%	9%	6%
Therapists registered under the statutory council	100%	100%	100%
Revenue per therapist-hour (₹)	1,180	1,380	1,580
Prevention & screening as % of revenue / Therapist retention	8.9% / 66%	12.4% / 79%	15.7% / 88%
Outcome measures recorded / Patient episodes	100% / ~2,400	100% / ~3,700	100% / ~5,300

12.3 Unit economics & break-even

- **Sessions to discharge falling from 14 to 9 reduces revenue per patient by roughly a third, and the practice grows anyway.** The mechanism is straightforward: **faster discharge frees therapist-hours, improves referrer confidence and generates more episodes** — and revenue per therapist-hour rises ₹1,180 → ₹1,580 while the individual episode shrinks.

- **Revenue per therapist-hour is the scaling measure**, as it was for coaching and dog training — **revenue alone can always be grown by hiring, without the practice improving.**
- **Prevention contracts fill daytime hours individual patients do not want** and grow to 15.7% of revenue without individual acquisition cost.
- **Passive-modality reduction shifts cost from equipment to therapist time**, which is why salaries are 51% of revenue — this is a people business wearing a clinic's fit-out.
- **Break-even: Year 1 at 7.8%. Low capital, no inventory and immediate cash collection make this the most straightforward business in the vertical financially — and the most demanding clinically.**

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

Particulars (₹)	Q1	Q2	Q3	Q4
Opening balance	18,00,000	18,00,000	20,00,000	24,00,000
Collections	40,00,000	44,00,000	46,00,000	46,00,000
Salaries, rent, marketing & overheads	40,00,000	42,00,000	42,00,000	42,00,000
Closing balance	18,00,000	20,00,000	24,00,000	28,00,000

Cash is the least difficult part of this business — collection is immediate, Indian physiotherapy is overwhelmingly cash-pay, there is no inventory and no seasonal collapse — which makes it the most financially straightforward plan in this vertical. Two qualifications matter. The cost base is almost entirely salaries (51% of Year 1 revenue), so a quiet month is felt immediately and there is nothing to reduce, and a practice that hires ahead of referral flow will discover it within a quarter. And institutional prevention contracts pay on corporate terms rather than at the counter — an academy or club settling at 45 to 60 days while the therapists delivering the screening are paid monthly — so growth in the prevention line, which is strategically correct, moves the practice from a cash-immediate model toward a receivable one and should be financed rather than absorbed. Where insurance reimbursement is involved, the same applies with longer delays and more documentation.

12.5 Key Performance Indicators to Monitor

- **Clinical honesty: median sessions to discharge; formal discharge rate; passive-modality-only sessions;** outcome-measure improvement per episode.
- **Safety: red-flag referrals out; return-to-play on objective criteria;** clearances overruled; **re-injury within 90 days.**
- **Integrity: referral payments made or received (must be nil);** therapist registration currency; claim audit against outcome-guarantee language.
- **Economics: revenue per therapist-hour;** prevention contract share and renewal; therapist retention; institutional DSO.

13. Funding Requirement & Bankability

Total ask: **₹24 lakh term loan plus ₹10 lakh working-capital finance** against ₹44 lakh promoter contribution. Four points. **First, this is the most bankable business in the vertical** — profitable in Year 1, no inventory, immediate collection, and clinical equipment with reasonable resale value. **Second, the metric to underwrite is revenue per therapist-hour rather than revenue**, because a practice adding therapists at flat revenue-per-hour has grown its cost base and its clinical exposure without improving. **Third, and unusually, a lender should treat a LOW average sessions-per-patient as a strength rather than a weakness.** A practice reporting twenty-two sessions per

episode is either treating unusually complex cases or **retaining patients past the point of benefit** — and the second is a **clinical-governance risk that eventually becomes a reputational one**. Fourth, ask about referral payments directly. A practice built on paid referrals has a revenue base that transfers to whoever pays more next year, and carries a professional-conduct exposure under a statutory council that did not exist before 2021.

13.1 Funding utilisation

Use of funds	₹	% of total
Clinical equipment (assessment, rehab, strength, gait, modalities)	26,00,000	33.3%
Clinic fit-out (treatment rooms, rehabilitation gym floor, changing)	20,00,000	25.6%
Deposits & advance rent	12,00,000	15.4%
Working capital	8,00,000	10.3%
Therapist recruitment, registration & continuing education	6,00,000	7.7%
Marketing & referral network development	4,00,000	5.1%
Technology (clinical records, outcome measures, scheduling)	2,00,000	2.6%
Total	78,00,000	100%

14. Risk Analysis & Mitigation

Risk	Mitigation
Recovery vs retention — the model's central conflict	The practice earns per session and therefore has a direct financial interest in the patient not recovering quickly — the esports arena's incentive inversion attached to a clinical decision. Median sessions to discharge (14 → 9) and formal discharge rate (58% → 84%) are the honesty metrics , and they are the certification body's defended pass rate in clinical form: numbers that improve when the business does the right thing and cost it revenue per patient
Passive-modality theatre	Ultrasound, TENS and laser are billable, need little therapist attention, can be applied by an assistant, and produce a comfortable session patients accept — with weak evidence. Active rehabilitation works better and costs a therapist's hour rather than a machine's, so the incentive points toward the treatment that works less well . Passive-only sessions 34% → 9%; and honestly to patients: a session that demanded nothing of them may have felt like treatment, but a programme that never made them work has not rehabilitated anything
Return-to-play pressure	The athlete wants to play, the coach wants them available, the parent has watched a season disappear — and the physiotherapist is structurally the only person whose job is to say "not yet." Where the physio is paid by the academy or club creating the pressure, the conflict is a weekly occurrence , the same problem adventure-sports solved by separating the decision from the revenue. Written objective criteria (shown to a coach in a way a clinical opinion cannot be), non-overridable clearance, overrides RECORDED (11 → 4), and re-injury within 90 days (14% → 6%) as the number that tests whether any of it is real
Referral payments	A clinician paid to refer is a clinical decision bought , and the exposure runs both ways — fees received for taking patients and fees paid for sending them to imaging or surgery. NIL both directions . The practical argument matches the ethical one: a referral bought stops the moment a competitor pays more, while a referral earned on outcomes compounds and is not purchasable — a practice competing on payments is bidding against everyone; one competing on discharge rates is bidding against almost nobody

Scope and missed red flags	A physiotherapist is not a radiologist or a surgeon — fracture, infection, cauda equina, malignancy and cardiac-referred pain must be recognised and referred, not treated. Referrals out reported as a positive (24 → 58), as the dog-training plan reported declined cases
Unqualified competitors	A substantial informal market offers "sports injury treatment", manipulation and dry needling without a physiotherapy qualification. NCAHP registration is verifiable — the first genuinely checkable credential in this vertical after eight self-regulated businesses; and specific techniques require demonstrated competence rather than general registration
Therapist dependence	Capacity is therapist-hours and patients follow individuals — the ninth occurrence of this pattern in the library. Retention tracked as a revenue metric (66% → 88%); continuing education funded because in a registered profession the alternative is a competence problem, not a service one
Salary-heavy cost base	Salaries are 51% of revenue and a quiet month is felt immediately with nothing to reduce ; hiring ahead of referral flow shows up within a quarter
Prevention receivables	Institutional contracts pay at 45–60 days while therapists are paid monthly — growth in the strategically correct line moves the practice from cash-immediate toward receivable, and should be financed rather than absorbed
Outcome claims	"Guaranteed recovery" and "cure" are representations requiring evidence ; honest timelines including the ones patients do not want to hear

15. SWOT Analysis

Strengths The only statutorily registered profession in this vertical — a verifiable credential in a market of eight self-regulated peers ; profitable in Year 1 with no inventory and immediate collection; demand generated by every other business in the vertical ; prevention contracts converting injury sources into clients; outcome measurement as a referral asset; low capital intensity.	Weaknesses The revenue model conflicts with the clinical goal ; capacity strictly bounded by therapist-hours; patients follow individual therapists ; salary-heavy cost base with no flex; institutional receivables lengthening as prevention grows; quality is opaque to the patient.
Opportunities Prevention and screening — better business than treatment and almost nobody sells it ; academies, clubs, studios and corporates as institutional buyers; post-surgical rehab where outcomes depend on rehab quality; esports and desk-work complaints as the fastest-growing young caseload; clinician education building the referral network.	Threats Unqualified practitioners competing on price ; hospital departments and chains with referral advantages; competitors paying for referrals; therapist poaching in a thin qualified pool; insurance reimbursement remaining shallow; a clinical incident or missed red flag.

16. Recommended AiSevak Tools for This Business

This sports physiotherapy practice would use AiSevak's Sports and Healthcare vertical tools in operations:

- **Clinical honesty: sessions-to-discharge and formal-discharge tracking, passive-vs-active session mix**, outcome-measure capture on every episode with referrer reporting.
- **Safety: red-flag screening checklist and referral-out register, objective return-to-play criteria with clearance lock**, override log, re-injury follow-up at 90 days.

- **Integrity:** referral payment register (target nil both directions), therapist registration currency tracker, claim substantiation records.
- **Economics:** revenue per therapist-hour, therapist utilisation, **prevention contract pipeline and renewal**, institutional DSO.
- **Records:** DPDP-compliant clinical record retention, episode documentation, continuing-education and supervision logs.

17. Key Assumptions & Notes

- Sports physiotherapy & recovery centre: injury rehabilitation, sports-specific return-to-play, post-surgical rehab, movement assessment, institutional screening and load-management contracts, and clinician education.
- **⚠ CLOSING THE SPORTS VERTICAL (10/10). THE ONLY CLINICAL BUSINESS IN IT, AND ITS DEMAND IS CREATED ALMOST ENTIRELY BY THE FAILURES OF THE OTHER NINE PLANS** — the academy that let a twelve-year-old bowl year-round, the studio that dropped a deconditioned beginner into an athlete's class, the turf whose surface outlived its replacement date, the adventure operator's trauma, the swimmer's shoulder, the esports arena's postural and repetitive-strain load. **IT ALSO BREAKS THE VERTICAL'S DEFINING PATTERN: eight of the nine preceding businesses had NO mandatory competence standard, while THE NCAHP ACT 2021 BRINGS PHYSIOTHERAPISTS UNDER A STATUTORY COUNCIL WITH REGISTRATION AND RECOGNISED QUALIFICATIONS — THE FIRST GENUINELY REGULATED PROFESSION IN THE VERTICAL** (and the market nonetheless contains many offering "sports injury treatment", dry needling and manipulation with no physiotherapy qualification at all).
- **THE BUSINESS-MODEL TENSION EVERY PHYSIOTHERAPY PRACTICE CARRIES AND FEW STATE: THE PRACTICE EARNS PER SESSION AND THEREFORE HAS A DIRECT FINANCIAL INTEREST IN THE PATIENT NOT RECOVERING QUICKLY** — the esports-gaming-arena incentive inversion **attached to a CLINICAL decision rather than a commercial one** → honest metrics are the uncomfortable ones: **MEDIAN SESSIONS TO DISCHARGE FALLING 14→11→9 (the practice becoming better at its job AND EARNING LESS PER PATIENT AS A RESULT) and PATIENTS FORMALLY DISCHARGED RATHER THAN DRIFTING AWAY RISING 58%→72%→84% — THE CERTIFICATION BODY'S DEFENDED PASS RATE IN CLINICAL FORM: A NUMBER THAT IMPROVES WHEN THE BUSINESS DOES THE RIGHT THING AND COSTS IT REVENUE.** The arithmetic resolves because **FASTER DISCHARGE FREES THERAPIST-HOURS, IMPROVES REFERRER CONFIDENCE AND GENERATES MORE EPISODES** — revenue per therapist-hour rises ₹1,180→₹1,580 WHILE THE INDIVIDUAL EPISODE SHRINKS BY ROUGHLY A THIRD.
- **THE CATEGORY'S CHARACTERISTIC WASTE IS PASSIVE-MODALITY THEATRE, AND IT PERSISTS BECAUSE IT IS COMMERCIALLY CONVENIENT RATHER THAN BECAUSE IT WORKS:** ultrasound, TENS and laser are **BILLABLE, REQUIRE LITTLE THERAPIST ATTENTION, CAN BE APPLIED BY AN ASSISTANT, AND GENERATE A COMFORTABLE-FEELING SESSION PATIENTS ACCEPT WITHOUT QUESTION**, with weak to absent evidence in musculoskeletal rehabilitation, while **ACTIVE REHABILITATION HAS FAR BETTER EVIDENCE AND COSTS THE PRACTICE A THERAPIST'S HOUR RATHER THAN A MACHINE'S — SO THE ECONOMIC INCENTIVE POINTS TOWARD THE TREATMENT THAT WORKS LESS WELL** → passive-modality-only sessions **34%→18%→9%**, with the honest patient framing: **A SESSION IN WHICH A MACHINE WAS APPLIED AND NOTHING WAS DEMANDED OF THEM MAY HAVE FELT LIKE TREATMENT, BUT A REHABILITATION PROGRAMME THAT NEVER MADE THEM WORK HAS NOT REHABILITATED ANYTHING.**
- **RETURN-TO-PLAY IS THE HIGHEST-STAKES DECISION AND THE PHYSIOTHERAPIST IS STRUCTURALLY THE ONLY PERSON IN THE ROOM WHOSE JOB IS TO SAY "NOT YET"** — the athlete wants to play, the coach wants them available for a fixture, the parent has watched a season disappear, and **WHERE THE PHYSIO IS EMPLOYED OR PAID BY THE ACADEMY OR CLUB CREATING THAT PRESSURE THE CONFLICT IS NOT THEORETICAL, IT IS A WEEKLY OCCURRENCE** — the same structural problem adventure-sports solved by separating the no-go decision from the

revenue consequence → two controls: **CLEARANCE ON WRITTEN OBJECTIVE CRITERIA** (strength symmetry thresholds, hop and functional testing, demonstrated sport-specific load tolerance) **RATHER THAN ELAPSED TIME OR HOW THE ATHLETE SAYS THEY FEEL, BECAUSE CRITERIA CAN BE SHOWN TO A COACH IN A WAY A CLINICAL OPINION CANNOT**, and **CLEARANCE NOT OVERRIDABLE** — where an athlete returns against advice it is **RECORDED** rather than argued about, which is why **OVERRIDES ARE REPORTED (11→7→4) RATHER THAN ASSUMED TO BE ZERO**; and the number that tests whether any of it is real is **RE-INJURY WITHIN 90 DAYS OF CLEARANCE (14%→9%→6%)**, **BECAUSE A PRACTICE CLEARING ATHLETES TO PLEASE COACHES WILL SHOW IT THERE AND NOWHERE ELSE**. Referral integrity — **the corruption traced through pet-food-brand's veterinary channel and sports-nutrition-brand's trainers appears HERE IN ITS MOST SERIOUS FORM, BECAUSE A CLINICIAN PAID TO REFER IS A CLINICAL DECISION BOUGHT**, in both directions (fees received for taking referrals, fees paid for sending patients to imaging or surgery) → **PAYMENTS MADE OR RECEIVED FOR REFERRALS: NIL**, with the practical argument matching the ethical one: **A REFERRAL BOUGHT IS A REFERRAL THAT STOPS THE MOMENT A COMPETITOR PAYS MORE, WHILE A REFERRAL EARNED ON OUTCOMES COMPOUNDS AND IS NOT PURCHASABLE — A PRACTICE THAT COMPETES ON PAYMENTS IS BIDDING AGAINST EVERYONE; A PRACTICE THAT COMPETES ON DISCHARGE RATES IS BIDDING AGAINST ALMOST NOBODY.**

- **PREVENTION IS BETTER BUSINESS THAN TREATMENT AND ALMOST NOBODY IN INDIAN PHYSIOTHERAPY SELLS IT** — an academy paying for pre-season screening, load monitoring and movement assessment across ninety young athletes **generates RECURRING INSTITUTIONAL revenue, requires NO individual acquisition, FILLS DAYTIME HOURS** individual patients do not want, and **PRODUCES A REFERRAL PIPELINE** of the cases **screening identifies**; it also resolves a tension the practice would otherwise carry — **A BUSINESS THAT EARNS ONLY FROM INJURIES HAS AN UNCOMFORTABLE RELATIONSHIP WITH THE ACADEMY THAT PRODUCES THEM, WHILE A PREVENTION CONTRACT MEANS THE PRACTICE IS PAID TO REDUCE THE VERY CASELOAD IT WOULD OTHERWISE DEPEND ON** (8.9%→12.4%→15.7% of revenue; the academy, studio, club and league in this vertical are the natural buyers). Cash is **the least difficult part of this business — immediate collection, overwhelmingly cash-pay, no inventory, no seasonal collapse — MAKING IT THE MOST FINANCIALLY STRAIGHTFORWARD PLAN IN THE VERTICAL AND THE MOST DEMANDING CLINICALLY**, with two qualifications: **salaries at 51% of revenue mean A QUIET MONTH IS FELT IMMEDIATELY WITH NOTHING TO REDUCE**, and **INSTITUTIONAL PREVENTION CONTRACTS PAY AT 45-60 DAYS WHILE THERAPISTS ARE PAID MONTHLY — SO GROWTH IN THE STRATEGICALLY CORRECT LINE MOVES THE PRACTICE FROM A CASH-IMMEDIATE MODEL TOWARD A RECEIVABLE ONE AND SHOULD BE FINANCED RATHER THAN ABSORBED**. Lender note: **the most bankable business in the vertical** (Y1 profitable, no inventory, immediate collection, equipment with resale value); underwrite **REVENUE PER THERAPIST-HOUR rather than revenue**; and unusually — **TREAT A LOW AVERAGE SESSIONS-PER-PATIENT AS A STRENGTH RATHER THAN A WEAKNESS, SINCE A PRACTICE REPORTING TWENTY-TWO SESSIONS PER EPISODE IS EITHER TREATING UNUSUALLY COMPLEX CASES OR RETAINING PATIENTS PAST THE POINT OF BENEFIT, AND THE SECOND IS A CLINICAL-GOVERNANCE RISK THAT EVENTUALLY BECOMES A REPUTATIONAL ONE**; plus **ask about referral payments directly, because A PRACTICE BUILT ON PAID REFERRALS HAS A REVENUE BASE THAT TRANSFERS TO WHOEVER PAYS MORE NEXT YEAR AND CARRIES A PROFESSIONAL-CONDUCT EXPOSURE UNDER A STATUTORY COUNCIL THAT DID NOT EXIST BEFORE 2021**. ₹78L, ~2,400→5,300 episodes, 27→72 staff, rev 1.8→3.94cr, Y1 ₹14L → Y3 ₹80L. Figures illustrative, exclude GST.
- **VERTICAL CLOSE** — the ten Sports, Fitness & Recreation models compared. The spine of this vertical was set in the anchor plan: **THE CUSTOMER IS A BODY UNDER LOAD, AND ALMOST EVERY BUSINESS HERE SELLS AN ASPIRATION WHOSE REALISTIC OUTCOME IS FAR BELOW WHAT THE CUSTOMER IMAGINES.**

#	Plan	What is actually sold	Governing metric	Structural limit
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1	sports-academy	A future that will not arrive	Off-peak utilisation	Ground tenure
2	turf-sports-facility	Hours	Off-peak utilisation	Land yield
3	fitness-studio-boutique	Attendance itself	Revenue per attended session	~30 class slots a week
4	sports-equipment-retail	Fit	Attach rate & service recurrence	Owns nothing
5	adventure-sports	Managed risk	Trips cancelled on safety grounds	A four-to-six month season
6	esports-gaming-arena	A reason to leave home	Sponsorship coverage of events	The customer's own home
7	sports-events-league	Attention	Returning teams & sponsor renewal	Season-two collapse
8	sports-nutrition-brand	A checkable label	Published batch assays	Verification cost $\approx$ net margin
9	swimming-academy	Water competency — and survival	Water-hours utilisation	The pool's fixed cost
10	sports-physiotherapy	Recovery	Sessions to discharge	Therapist-hours

Two patterns close this vertical. The first is regulatory: NINE OF THE TEN BUSINESSES OPERATE WITH NO MANDATORY COMPETENCE STANDARD — groomers had none in petcare, and here neither coaches, facility operators, fitness instructors, adventure guides nor swimming teachers do. THE TENTH, PHYSIOTHERAPY, IS THE ONLY STATUTORILY REGISTERED PROFESSION IN THE VERTICAL — AND IT EXISTS TO REPAIR WHAT THE OTHER NINE PRODUCE. The second is the aspiration gap, which runs through every plan except two: SWIMMING SELLS WATER COMPETENCY, WHICH IT CAN DELIVER TO ALMOST EVERY CHILD, AND PHYSIOTHERAPY SELLS RECOVERY, WHICH IT CAN MEASURE. THOSE TWO ARE THE ONLY BUSINESSES IN THIS VERTICAL SELLING AN OUTCOME THEY CAN ACTUALLY VERIFY — AND, NOT COINCIDENTALLY, THEY ARE THE TWO WHOSE HONESTY METRICS COST THEM MONEY: A SWIMMING ACADEMY THAT CANCELS FOR WATER QUALITY AND A PHYSIOTHERAPY PRACTICE THAT DISCHARGES SOONER ARE BOTH CHOOSING THE OUTCOME OVER THE INVOICE.

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